'NAVIGATING THROUGH': A GROUNDED THEORY OF THE DEVELOPMENT OF ETHICAL PRACTICE IN UNDERGRADUATE NURSES

by

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ABSTRACT

This thesis presents an exploration of the perspectives of nine newly graduated registered nurses on their undergraduate ethics education in preparation for practice as registered nurses. Data gathered from interviews, document audit and a literature review structure this research. Grounded theory methodology was utilised to analyse the comprehensive data gathered during the research process and resulted in a theoretical description and explanation of the process of learning ethics and ethical practice during three years of undergraduate nursing education.

Nursing practice has an ethical component that is, on a daily basis, significant and challenging. To this end, one of the key tasks of undergraduate nursing education is to adequately prepare its 'neophytes' for the ethical demands of practice. To date, very few studies have investigated the ethics preparation for student nurses, particularly in New Zealand. This study aims to partially redress this lack by offering insights into undergraduate ethical learning.

The findings of this study revealed that participants learned ethics and ethical practice through faculty education, role modelling nurses in practice, journaling and reflection tutorials, and experimentally. It was also found that participants held 'ethical ideals' that reflected the patient-focused professional ethical values developed during their nursing education. These 'ethical ideals' were held as a standard and a guide to practising ethically. Participants' ethical perspectives widened as they began to 'test their ideals' in the 'real world' of nursing practice and perceive contextual obstacles that confronted them. Thus, it was found that the 'ideal' was problematic to enact in the 'real' world of nursing practice. Hence, 'navigating through' emerged as the core process that was adopted by participants as they endeavoured to preserve their 'ethical ideals', negotiate contextual obstacles and successfully reach graduation. This meant that they endured a measure of 'powerlessness' to impact ethically upon the contexts that they found themselves in.

It is envisaged that the findings from this project may inform undergraduate nursing education as to how to better prepare its neophytes for the ethical demands of practice.

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CHAPTER ONE: INTRODUCTION AND OVERVIEW

"Members of the health care professions face moral and ethical dilemmas as a routine part of their working lives, to a degree unequalled by any other profession" (Ridley, 1998, p. 1).

Introduction

Nurses face ethical issues and decision-making that incorporates the wider 'bioethical' sphere, as well as the realm of 'nursing ethics' (Johnstone, 1999). To this end this, the first chapter, will outline the nature of bioethics and the bioethical context in contemporary New Zealand as well as the ethical issues within the nursing practice context. Nurses' unique moral perspective, that has developed from more prolonged contact with the receivers of health care as well as the recent development of nursing as a profession, has prompted the formulation of 'nursing ethics' and corresponding codes of ethics. To this end, the ethical context of nursing practice is explained and addresses client-patient issues, intercollegial issues, as well as wider professional issues.

There is evidence to suggest that nurses face enormous challenges in their work place environments. These challenges proceed from political whims, nurses' supposedly inferior position to the medical profession and administrators, as well as the daily decisions that they must make in the face of patients in pain, decreasing resources, and overwork. How nurses manage this context is also briefly explored with regards to 'responsible-subversion', the doctor-nurse game' and 'oppressed group behaviour'. The exploration of the ethical context of nursing practice and whether nurses are actually 'free to be moral' raises the question as to what strategies nursing education utilises to adequately prepare newly graduated nurses for this highly complex environment. This chapter moves from the wide view of ethics and bioethics within New Zealand to the ethical challenges at the bedside. Furthermore, challenges faced by newly graduated nurses as they embark into the 'real world' of ethical practice are also explored. Considering the challenges embedded in nursing practice it is argued that a critical task of nursing education is to prepare morally competent graduates.

What is ethics?

Ratanakul (1986, p. 24) defines ethics as, "a branch of philosophy that is concerned with questions such as what is morally right, what human values or good are to be realised and, who is a good person?" Critical, rational reflection upon the answers

that individuals, groups and societies give to these questions assists in proposing norms, standards, rules and principles. These guide moral judgements and what is deemed to be right or what ought to be done, thus giving rise to *normative ethics*. *Descriptive ethics* concerns itself with explicating what constitutes the values and beliefs held by individuals within cultures and sub-cultural groups, whereas, *metaethics* concerns the nature, logical form and language of ethics (Davis, Aroskar, Liaschenko, & Drought, 1997; Johnstone, 1999; Ratanakul, 1986). Furthermore, bioethics is a branch of ethics. Medical ethics and nursing ethics are sub-branches of bioethics (Johnstone). Some discussion will now follow regarding these concepts.

What is bioethics?

Ratanakal (1986) points out that all the life sciences have far-reaching implications for individuals, society and the evolutionary future of humans. Bioethics therefore concerns itself with; the practice and discoveries of the scientific community, the way life and death is viewed, as well as understanding freedom and how selfhood is conceived. Thus bioethics embraces the actual interface between scientific research and healthcare practice.

Science has been able to tamper biologically with the very character of human life in the realm of in vitro fertilisation, organ transplants, artificial hearts, genetic engineering, cloning and invention of new life forms (Ratanakul, 1986). Ridley (1998) identifies bioethical issues as; informed consent, confidentiality, reproductive rights, abortion, active/passive euthanasia, research with living subjects, mental incompetence, allocation of health care resources, health care policy, organ procurement, transplantation, gene therapy, genetic engineering, and genetic diseases. New technologies bring potential benefits but also deep and unfamiliar ethical difficulties. Choices are available that did not exist a few years ago (Thompson & Thompson, 1992). Bioethics attempts to deal with these issues via reasoned criticism of positions and perspectives on particular issues. Thus interested parties engage in ethical debate.

Bioethics in New Zealand

According to Campbell (1995), as far as bioethics is concerned in New Zealand, two landmark events have occurred. The first is the Treaty of Waitangi in 1840. This was drawn up between the chiefs of the indigenous Maori people and the British Crown. The Treaty has specific implications for nursing with the emergence of cultural safety. The second is the Cartwright Inquiry published in 1988.

Treaty of Waitangi

For decades the treaty was virtually ignored. However, in 1975 the government enacted the Treaty of Waitangi Act that established the Waitangi Tribunal. The Tribunal, whose powers and members were extended in 1985, hears Maori land claims against the Crown dating back to the Treaty signing date (Burgess, 1993). To the Maori people, their lands were closely linked with their spirituality and wellbeing. Rapid transfer of land to individual European settlers by way of the Native Lands Act 1862 and the New Zealand Settlements Act 1863 eroded the Maori concept of tribal ownership of land. This loss of land resulted in the demoralisation of Maori and a fifty percent drop in their population by 1891 (Doms, 1989).

In 1988, it was recommended that, "The Treaty should be treated as a principal constitutional document to which legislation must conform" (The Royal Commission on Social Policy, p. 90). Furthermore, the principles of participation, protection and partnership were also to be recognised. As described by Durie (1992), *partnership* refers to an ongoing relationship between the Crown or its agencies and Iwi. *Participation* emphasises positive Maori involvement in all aspects of New Zealand society. *Active protection* requires that the Crown actively protect Maori interests. Durie contends that in regards to health, active protection is essentially about health promotion and prevention initiatives. Therefore, proactive approaches towards enhancing Maori health are to be actively sought.

Cultural safety

At this time of renewed commitment to the Treaty, the concept of cultural safety emerged from within nursing, more specifically from a student nurses' hui in Christchurch. Underpinning this nursing initiative was the premise that, "As long as Maori people perceived the health service as alien and not meeting their needs in service, treatment, or attitude, it was culturally unsafe" (Ramsden, 1990a, p. 19). The central aims of cultural safety are, "To educate registered nurses so that they become open minded and non-judgemental" and "To educate registered nurses so that they do not blame the victims of historical and social processes, for their current plight" (p. 19). In 1988, the Nursing Council of New Zealand (NCNZ) required all schools of nursing to address their commitment to the Treaty of Waitangi. This was a progressive move for its time and demonstrated commitment to attempting to achieve the aforementioned aims (Ramsden, 2000).

Cartwright Inquiry

In 1988, District Judge Silvia Cartwright conducted a full investigation into a research project undertaken by Professor Green. Over 15 to 20 years Professor Green, at National Women's Hospital in Auckland, conducted an experiment without the knowledge or consent of the patients in the study. To prove his hypothesis of the non-progression of carcinoma in situ, women who had continuing abnormal cervical smear results were not fully treated (Campbell, 1992; 1995). Furthermore, anaesthetised women at the same hospital had been subjected without their consent to vaginal examinations by groups of medical students (Kuhse, 1997). This was not all. Twenty two hundred newborn baby girls had vaginal swabs taken without parental consent. Two hundred foetal cervixes were also collected from stillborn baby girls for histological studies, also without consent from their parents (New Zealand Herald, 1987b, p. 14, as cited in Johnstone, 1999).

Campbell (1995) explains that following Judge Cartwright's report, the nature of bioethical research in New Zealand radically changed. Research ethics committees were reconstituted to equal numbers of 'lay' persons and health professionals. Committees must have a 'lay' chairperson as well as members with knowledge of ethics, women's health issues and Maori culture. Furthermore, patient advocates were appointed in all hospitals, one of who was to serve on each ethics committee. Discussions conducted on these committees were to include the values of the community at large. Maori representation was to be more than mere tokenism, reflected in Maori membership increasing from a minimum of one to three members.

In response to the Cartwright Inquiry, The Health and Disability Commissioner Act 1994 was enacted with a concomitant appointment of a Health and Disability Commissioner (Robyn Stent). Her brief was to consult widely and prepare the Code of Health and Disability Services Consumers' Rights 1996. Central to this code, which became part of New Zealand law in 1996, concerns informed consent and reiterates that no health care procedure shall be carried out without the knowledge and consent of the patient/s concerned (Skegg, 1995; 1996). This circumscribes the scope of the traditional autonomy of the medical profession and enhances the autonomy of the patient (Campbell, 1992).

The Hippocratic Oath does not mention patients' rights and is therefore at odds with the notion of informed consent, in that physicians were not to reveal knowledge of medicine to lay people (Ratanakul, 1986). Campbell (1995) draws attention to the

notion that the 'Hippocratic Tradition' placed emphasis on the benevolent disposition of the doctor whose primary concern was to judge the 'best interests' of the patient. However, according to Veatch (1999), the Judeo-Christian belief that all people are capable of using knowledge responsibly, plus the secular liberal political philosophy that views education, and the 'right' to know, as important, have also contributed to the wider move towards informed consent. Veatch's view is that the concept of 'informed consent' deviates from medical paternalism, where the doctor decides what is in the patient's best interests.

Medico-centricity of bioethics

Ratanakul (1986) argues that scientific-technological values have come to dominate over other significant human goals and purposes in living. Furthermore, mainstream Western bioethics have, through the power of naming, sustained attention and institutional support, made so called 'exotic' issues such as; abortion, euthanasia, organ transplantation, reproductive therapy in vitro fertilisation and genetic engineering, *the* most pressing bioethical concerns. What has ensued is an essentially medico-centric sense of bioethics (Johnstone, 1999; Thompson, Melia, & Boyd, 1994). This state of affairs has effectively marginalised nursing ethics in mainstream bioethics discourse (Johnstone).

Nursing ethics

Throughout the fabric of the entire profession of nursing is an unbroken thread of ethical literature. This literature has given attention to the ethical development of the nursing student, formulation of codes of ethics as well as presenting a nursing position on ethical issues (Davis, et al., 1997). It has its own rich history, theoretical underpinnings and practical applications. Nursing ethics, as a sub-branch of bioethics, therefore examines ethical and bioethical issues from the perspective of nursing theory and practice (Johnstone, 1999; Sturch, 1994).

Nursing has its own set of unique moral experiences, which those that do not practice nursing are not privy to (Johnstone, 1999). In this regard, nurses have a perspective on healthcare that is unique. Charon (1998) points out that as people interact over a period of time they come to share a perspective, in other words, an angle on reality that is socially and culturally structured. What they see is interpreted through that perspective. Similarly, as nurses interact over time, they too have come to share a perspective on healthcare that is unique.

Nursing experiences give rise to issues, language, concepts and metaphors that exclusively reflect the moral nature of nursing practice (Johnstone, 1999). Charon (1998) subscribes to the notion that a perspective it is made up of words, a conceptual framework, assumptions and value judgements. Thus, personal experience, plus the words used, makes up a perspective that is different from others. This conceptual framework, assumptions, values, and ideas influence our perception and subsequently influence our actions. Hence nurses view and experience the context of health differently from other health professionals. According to Johnstone, the starting point from which to advance meaningful nursing ethics discourse, should be nurses' experiences. Examining nurses' moral experiences and how their actions are morally justified, facilitates understanding of the nursing perspective (Woods, 1995). Furthermore, Johnstone, Hunt (1994) and Thomasma (1994) contend that the existence of ethics from a nursing perspective is no less warranted than any other ethical perspective.

The International Council of Nurses (ICN) (1973) Code for Nurses, endorses that each nurse takes personal responsibility for nursing practice, and that when acting in a professional capacity he/she should at all times maintain standards of personal conduct, which reflect credit upon the profession. The New Zealand Nurses Organisation (NZNO) (1995) Code of Ethics affirms this view by specifying that wherever nurses practice, the requirement placed upon them to act ethically is paramount. Furthermore, NCNZ Code of conduct for nurses and midwives (1995) states that the nurse or midwife, "Complies with legislated requirements." "Acts ethically and maintains standards of practice." "Respects the rights of patient/clients." "Justifies public trust and confidence" (p. 2). Furthermore, the Code of Health and Disability Services Consumers' Rights 1996 attests that consumers have rights and providers have duties. Nursing is one such provider (Skegg, 1996).

Davis, et al. (1997) and Kuhse (1997) purport that social beings often absorb many values, beliefs and rules unquestioningly. Hunt (1994) proposes that instructions followed unquestioningly are a demonstration of uncritical habit and routine. For nursing, having ethics or morality that can rightly be called 'our own' requires us to give reasons for our views, and attend to the consequences of our actions and omissions (Kuhse). To this end Barnett (1997) contends that professionals are to speak out on their subject, this being a right and a duty, especially for those professions who owe their status and social legitimacy to the wider society. This articulation however, can pose

problems in that nurses struggle to verbalise their moral concerns and their moral voice is systematically silenced by medicine (Rogers & Niven, 1996).

Evidence of this struggle is that nurses and midwives lacked effective action during the unethical research practices that became evident during the Cartwright Inquiry (Johnstone, 1999). It was accepted that medical staff intimidated the nurses and that the context was extremely unsupportive for those who did attempt to question. However, these nurses and midwives had a moral duty to be accountable for their part in the research. They not only *should* have been able to speak out, but they *should* have spoken out (Rogers & Niven, 1996). Johnstone's view is that nurses and midwives not being held to account effectively preserved the status quo and the prevailing hegemonic power of the medical profession.

Codes of ethics

Nursing ethics provides guidance in ethical decision-making and behaviour based on core nursing values. Traditionally, nursing's underpinning values have been epitomised in ethical codes worldwide and in New Zealand (ICN, 1973; NCNZ, 1995; NZNO, 1988; 1995; McBurney & Filoromo, 1994). Codes of ethics serve the profession in assisting to maintain the standards of the profession and are a reflection of the central values of the profession (Barnett, 1997; Davis, et al., 1997; Fry, 1994). Codes of ethics aim, "to provide guidance to nurses on how to decide and act morally in the contexts in which they work" (Johnstone, p. 47).

Codes are living documents and as professions question their own core values as well as the values of society, these codes are reaffirmed, modified or disregarded. For example, cultural safety values are recent additions to the core values of nursing practice in New Zealand (NCNZ, 1995; Ramsden, 1990a; 2000). The Code of Ethics (NZNO, 1988) was silent on the Treaty of Waitangi, possibly because cultural safety had not yet emerged within the profession. Hence, this rendition differs from the (NZNO, 1995) edition. Within this latter text, cultural safety in nursing is defined as:

> The effective nursing of people from another culture by a nurse who has undertaken a process of reflection and rigorous examination of their own cultural identity. Cultural safety in nursing happens when people feel fully able to use a service provided by people from another culture, without risk to their own". Furthermore, *cultural values* also come to the fore and are defined as: "Morals, beliefs, attitudes, and standards that derive from a particular cultural

group. Culture is not only seen as ethno specific, but must include groups from within cultures e.g. cultures of class, socialisation, sexual orientation, age, etc (p. 9).

Finally, ethics' development within nursing enhances nursing's professional status (Ellis & Hartley, 1995; Rutty, 1998). Indeed, one of the characteristics of a profession is that it has its own code of ethics (Barnett, 1997; Rutty; Veatch, 1999).

Ethical issues that concern nurses

Nurses are concerned about the wider bioethical issues in the research and delivery of healthcare (Benjamin & Curtis, 1992; Davis, et al., 1997; Johnstone, 1999; Rogers & Niven, 1996; Thompson & Thompson, 1992). Most nurses, however are more concerned about the ethical issues that confront them every day as they go about their work with their patients, and also the actual effects of ethical decisions on their patients (Andrew, 1997; Fenton, 1994; Johnstone, 1999; Kennedy, 1994; Kuhse, 1997; Lakeman, 1996; Woods, 1993, 1995, 1999). These concerns relate to such matters as the organisation of the patient's day, skilled attention to the patient's physical, psychological and emotional needs, humanisation of the environment, and counteracting institutionalisation and dependency. These nursing issues are often overlooked while more attention is given to the big dilemmas of medical ethics (Thompson et al., 1994).

Woods (1995) specifies three categories common to most nursing practice. "These issues include:

a) **Client/patient issues**, such as 'Not for Resuscitation' orders, confidentiality, informed consent and palliative care.
b) **Inter-collegial issues**, such as the unsafe practice of peer and other health professionals, and the oft quoted doctor – nurse relationship.
c) **Professional issues**, such as the effects on nurses and their patients of health service re-organisation and current working conditions" (p. 11).

In the same vein, Krawczyk (1997) identifies informed consent, treatment options and maintenance of life and, or, resuscitation. Benjamin and Curtis (1992) highlight the issues of restraining, persuading, and deceiving of patients, as well as the giving of placebos. Davis, et al. (1997) point out nurses' concern over keeping confidences, patient advocacy and the so-called non-compliant patient. End of life decisions (Kuhse, 1997) and feeding and hydration of patients (Fenton, 1994) also pose as ethical issues for nurses. Furthermore, Yarling and McElmurry (1986) name; patients

in pain, cardiopulmonary resuscitation, withholding of life-sustaining treatment, informed consent procedures, the use of placebos, harmful care by another practitioner and professional control of information as issues that concern nurses.

Neil Pugmire – the whistleblower

Ethical issues faced by nurses bring to mind the plight of the whistleblower, Neil Pugmire. Pugmire sent a letter to the Minister of Parliament Phil Goff, warning about the release of a dangerous psychiatric patient back into the community (Hubbard, 1994). Pugmire believed that the patient concerned, a known paedophile, would re-offend when released back into the community. In Pugmire's view, the Mental Health (Compulsory Assessment and Treatment) Act 1992 failed to recognise dangerous paedophiles (McErland, 1995). Unfortunately for Pugmire, Mr Goff released the letter rather than exerting his influence behind the scenes (Hubbard). This, in effect, made Pugmire responsible for breaching patient confidentiality.

Sletteboe (1997) points out that a moral dilemma presents a choice of two unwanted alternatives. It seems that Pugmire was faced with such a dilemma. On the one hand, he had to consider whether to breach patient confidentiality (which was against the law), and on the other, the high probability that a dangerous paedophile would re-offend when released back into the community. It would seem that for Pugmire, from his own position as charge nurse, he would have had an in-depth understanding of patients' psychological conditions in his care. Perhaps this prompted his decision to appeal to the minister for assistance. The issue however, for Pugmire's employers, was that he had failed in his duty to follow their policies and procedures (Rogers & Niven, 1996).

Initially, Pugmire was suspended from his position as a charge nurse at Lake Alice Hospital, pending an inquiry over the alleged breach of confidentiality. He was then offered a demotion, with a corresponding drop in salary of $20,000 or termination of his employment. Pugmire responded to this move from Good Health Wanganui Ltd, by seeking a court injunction to have the suspension lifted. The final outcome of this difficult experience for Pugmire was that he was reinstated to his job, a redress of the Mental Health Act 1992 was induced, as well as the subsequent development of legal protection for whistleblowers (McErland, 1995).

Pugmire and his family experienced a great deal of stress over the incident. McErland (1995) points out that during the Pugmire incident, a comprehensive message

was given that 'speaking out' was just not worth the risk. However, Pugmire's view was, "I had to do it." " It was my duty" (Hubbard, 1994, p. 22). Pugmire's experience is a poignant example of the potential ramifications that can eventuate when nurses 'speak out'.

Political pressures

Political forces also place ethical demands on nurses. Kilday (1999) explains that the move from a health culture to a business culture in the early 1990's in New Zealand, and the ideology of cost containment meant that the nursing budget came under close scrutiny. As a result, staff levels reduced by eighteen percent during this time, with a concomitant increase in the casualisation of nursing. Furthermore, nurses expressed feeling 'pushed' and having less available time to spend with individual patients. According to Williams (1996), it was ironic that many nurses in senior positions were made redundant, and thus eroding nursing leadership and placing in jeopardy the quality and safety of nursing practice. These issues reflected a health system that had been deliberately put under stress by political agendas. Ashton (1995) interpreted the reforms to be an enactment of an ideological commitment to competition rather than clear evidence that it would save money as well as bring improvement in the health of New Zealanders. In a survey of one hundred and twenty-four nurses, it was evident that the majority of these nurses opposed the reforms (Wills, 1991).

Bureaucratic pressures and hospital policies

In 1996, the then Health and Disability Commissioner Robyn Stent, conducted an inquiry into Canterbury Health, following several deaths of patients in the winter of 1996. This inquiry identified the complexity of the nursing environment at that time. Clearly evident was the significant shortage of medical and nursing staff. Many departments within the hospital were working under conditions of 'overload', thus causing patients to be put at risk. Nurse/patient ratios in the emergency department were the lowest in Australasia (HDC, 1998).

It is noteworthy that Stent utilised The Code (1996) to present her findings. She pointed out that under Right 4(5) of The Code, providers have a responsibility to co-operate with each other to provide quality and continuity of care. Her findings indicated that co-operation between Canterbury Health and its staff broke down at Christchurch Hospital during 1995 and 1996. Poor management by Canterbury Health led to low morale, distrust and poor communication. "As a result, control processes stopped

functioning and recommendations, which could have improved the standard of care for consumers, were not implemented" (HDC, 1998, p. 10).

NZNO voiced its concern to the Canterbury Health Human Resources Manager in August 1995 regarding "the absence of consultation and the lack of any meaningful involvement by management of nurses, NZNO and Unit Managers in processes that would address the very real problems facing nurses at Christchurch Hospital" (HDC, 1998, p. 85). Nurses also voiced their concerns regarding increased casualisation of the nursing workforce, disestablishment of senior nursing staff and lack of educational resources, supervision for newly graduated nurses and adequate orientation for new staff. Stent found that the use of casual nurses by Christchurch Hospital was high in comparison with other Crown Health Enterprises. Yet, Stent acknowledged that nurses worked hard to manage in the difficult situations that presented themselves during this stressful time. It thus appears that political forces in the guise of hospital policies, restructuring and decreased funding can place nurses and the patients, for whom they care, in a compromised position.

Are nurses free to be moral?

Hunt (1994) holds that nurses often express unease about a lack of freedom to care for patients and clients, as they themselves would like to be cared for or have their loved ones cared for. In Hunt's view, many of the ethical issues that nurses raise come back to this unease in one way or another. More often than not discussions end up in an exploration of the constraints on nurses' freedom to care. Furthermore, Yarling and McElmurry (1986) identify that one of the reasons why nurses face certain ethical issues is that, "nurses are often not free to be moral" (p. 33). They see this to be directly related to nurses' sub-collegial relationship to physicians and nurses' employee status in relationship to the hospital. These challenges are further compounded by the move in nursing education to emphasise patient advocacy and subsequent commitment of the nurse to the autonomy and well-being of the patient.

Bandman and Bandman (1992) point out that nurses are in a strong position to advocate the patient's rights and interests. Essentially one's rights cannot be protected unaided by others and this is clearly evident when patients are sick or frightened and unsure about what is happening to them. Thus they are often not in a position to defend their rights. There are times when advocating for the rights of the patient places the

nurse at variance with established authority structures. Advocacy is precarious as it lacks institutional support.

Yarling and McElmurry (1986) support this view. They point out that in practice, nurses are not able to actualise this commitment due to pressures to conform to the power structures of the hospital and physicians. According to Davis and Slater (1988, p. 18), "Nurses have responsibilities but not always the authority to match these responsibilities." Woods (1993) too identifies nurses' lack of autonomy as one of the reasons why they are unable to always behave in ways that they consider are ethical. Gaul (1987) highlights that the results of ethical decision-making often places the nurse at perceived and real risk in terms of bureaucratic and role expectations. Furthermore, "At times, although it should be otherwise, deciding and acting morally can require enormous courage and even 'moral heroism' on the part of those choosing to take a moral course of action" (Johnstone, 1999, p. 429). This is fuelled by lack of sovereignty over their own practice as well as the burden of enormous responsibilities without corresponding legitimated authority.

Disturbing consequences of constraints on nurses

The previous discussion has identified several contextual constraints on nurses' ability to enact appropriate ethical decisions that they deem to be appropriate to meet the needs of those they care for. These constraints have consequences for nurses and some of these will be briefly explained. They are, 'moral distress', 'responsible subversion', 'oppressed group behaviour', 'doctor-nurse game' and, 'nurses eating their young'.

Moral distress

When nurses are constrained in implementing the course of action that they deem to be 'right' for the patient, moral distress is experienced (Fry, 1994; Johnstone, 1994a). Moral distress is associated with feelings of guilt, anger, frustration and powerlessness (Johnstone). According to Fry: "Constraints may include a lack of power or decision making authority, institutional rules and authority over the nurse, or even lack of respect for the nurse's role in decision-making" (p. 268).

Responsible subversion

Hutchinson (1990) identifies the phenomenon of 'responsible subversion', where nurses bend the rules for the sake of the patient. As nurses work within a patient

care context where others impose the rules on them, nurses experience conflict as institutional and, medicine's rules conflict with theirs. In Hutchinson's view, the behaviour is responsible in that the nurse utilises 'best nursing judgement' to decide what rule to bend as well as when and how to do it. The behaviour is subversive in that it violates hospital administration's or doctors' rules.

Munhall (1990) acknowledges Hutchinson's (1990) findings and names them as 'serious business'. Munhall admits concern that nurses are bending or breaking rules rather than questioning or changing them. Because nurses do not perceive legitimate ways to change the system they have employed 'responsible-subversive' methods of engaging in patient advocacy. What Munhall also highlights as alarming is what, if any, ethical or moral reasoning is at play as nurses engage in responsible-subversion and the subsequent 'covering' required to hide responsible-subversive actions. Munhall commends the work of Hutchinson, in that it has brought to light 'responsible-subversion' and that its use by nurses to manage the conflicts they face. Munhall advocates 'changing' the rules and questions, "Is 'going underground' an effective way of claiming power and decision-making rights?" (p. 22).

Oppressed group behaviour

Roberts' (1983) has a stronger opinion. He identifies nurses as an oppressed group. Roberts backs this claim by pointing out that, forces outside nurses' control, control them. These forces have greater prestige, power, and status and exploit the less powerful group, in other words, nurses are dominated by a more powerful culture that does not value their particular characteristics. This results in 'horizontal violence', or conflict within the oppressed group. Roberts identifies two fears held by the subordinate group. They are firstly, realisation that the subordinate group could be destroyed if it was to attempt to revolt and therefore, submission is opted for, and secondly, fear of change itself and of alteration to the status quo, even though the status quo is oppressive.

Roberts (1983) points out that to facilitate liberation from oppression, an understanding of its very nature is necessary. Development of unity and pride within the oppressed group is critical where, "Nurses themselves need to take action to free nursing from the sub-servient role into which it has evolved" (Pavlovich-Danis, Forman, & Simek, 1998, p. 20).

Doctor-nurse game

One of the ways that nurses manage their lack of autonomy is by opting to play the doctor-nurse game. According to Sweet and Norman (1995), the idea of the doctor-nurse game was first described in the 1960s. It is characterised by (female) nurses learning to show initiative and offer advice whilst appearing to defer passively to the doctor's (male) authority. It reflected the gendered roles inherent in society of the aforesaid time (Sweet & Norman) and the view that nurses were handmaidens to the doctor (Pavlovich-Danis et al., 1998). Sweet and Norman point out that even though there is a vast amount of literature on the doctor-nurse game, little of it is empirical.

Sweet and Norman (1995) explain that relationships between doctors and nurses have evolved over the past two decades and that nurses more frequently offer advice in a more straightforward way and that this in turn, reflects the change in the status of women and the emergence of nursing as an autonomous profession, no longer controlled by medicine. Adamson and Kenny (1993) however, identified that medical dominance of nurses affected the level of satisfaction that nurses experienced in the workplace. Interestingly, these researchers point out that developing assertiveness and communication skills may not go far enough to deal effectively with the working conditions and structural features of the health care service.

Willis and Parish (1997) argue that assertiveness and interpersonal skills arise out of nursing knowledge and confidence in that a sound knowledge base is the key to sharing care amongst professionals, and the foundation of assertiveness. This knowledge must be clearly communicated in the clinical notes and records that doctors routinely consult. Willis and Parish's research showed that pain experienced by residents was not always recorded, or it was recorded in an illusive manner. They argue that the oral culture of nurses is no longer adequate to fully express the assessments that nurses make during their prolonged contact with the patient. Willis and Parish point out that, nursing as a subordinate group, is struggling for professional autonomy and that assertiveness is only part of the solution. They argue however, assertiveness based on power, which has knowledge underpinning it, will go a long way to disband the doctor-nurse game.

Nurses eating their young

Meissner (1986; 1999) questions the practice, of nurses 'eating their young'. According to Meissner, nurse-educators, nurse-administrators and staff nurse colleagues are all offenders. All are far too hard on novice nurses. Nurse-educators engage in authoritarian teaching styles and assigning unrealistic study loads, nurse-administrators expect performance of new graduates equalling that of experienced employees and staff nurse colleagues, by rarely praising new graduates, and labelling their suggestions as unrealistic causing them to wonder whether to surrender to the 'status quo'.

This raises another issue, namely, the preparedness of newly graduated nurses to face the socialising process that ensues once they enter the real world of practice. Registered nurses themselves enact this process, unfortunately having learnt these habits from the treatment they themselves experienced. Kelly (1998) found it concerning that new graduates experienced conflict in that they wanted to do what their team valued while at the same time believing that what one was doing was wrong. Pressure to 'fit in or get out', work speedily, and the inability to speak up when experiencing a patient being mistreated or disrespected produced acute feelings of guilt. The plight of these new graduates is well articulated by Kelly. She states, "They described the stresses of trying to be good nurses under frightening conditions, inadequate staffing, to 'finish their work on time' despite their inexperience, care for 'too many' acutely ill patients, and perceived a lack of support from both co-workers and nursing management" (p. 1138).

In a previous study, Kelly (1991) found that student nurses also valued 'fitting in' and 'going along' with the values of the environments in which they received their clinical education. They chose to retain their own ideas and values until such a time as these could be implemented. When looking forward to when they would be new graduates they perceived themselves as being powerless to create change. Biley and Smith's (1998) research found that newly graduated nurses' need to become an accepted team member, dampened active initiation and participation in change. These new graduates felt pressured to maintain the 'status quo'. Walker (1998) also found that newly graduated nurses saw themselves as powerless to change the 'status quo'.

Ethics education for undergraduate nurses

In light of the mushrooming of biomedical, technical and scientific advances, and the increasing complexity of the nursing context, there is a corresponding need to incorporate the teaching of ethics into nursing curricula (Aroskar, 1977, 1993; Hussey, 1990; Kaane, 1994; Ketefian, 1981; Magnussen, 1994; Patterson & Vitello, 1993; Quinn, 1990). The ethics education that student nurses receive must be in keeping with the current health environment and the poignant contextual challenges embedded there. Woods (1994) advocates that ethics education for nurses should closely match their workplace experiences. Ethics education, to be meaningful, must draw extensively on the lived moral experience of nurses and the key ethical issues faced by them (Johnstone, 1999). Scott (1998) advocates for a clearer picture to be drawn as to what the actual moral dimensions of practice are. That picture then needs to inform education as to what ethical behaviour/s nurses need to learn to prepare them for ethical practice. Rogers and Niven (1996) state, "It is critical that nurses in Aotearoa/New Zealand develop a body of literature which reflects the particular nature of nursing practice in our own culturally complex society" (p. 97).

Aroskar (1977) asked the question, "what is the present system of nursing education doing to help students and graduates learn to cope satisfactorily with these situations?" (p. 260). More recently, Arndt (1994) and McAlpine (1996), strongly suggest that there is a need to critically examine nursing education's role in preparing nurses to be ethically competent. Is it sufficient for this education to help students to cope in the ethical context that they will enter or should education equip them to bring change? An investment of time by nurse educators to prepare the new graduate for the social forces that will undoubtedly affect them on graduation is critical (Kelly, 1998; Woods, 1999).

It is a fundamental and unavoidable moral responsibility for nurses to identify and to respond effectively to both simple and complex moral problems (Johnstone, 1999). Educating nurses to be ethically competent is therefore, a critical task of nursing education (de Casterle, Grypdonck, Vuylsteke-Wauters, & Janssen, 1997; Kaane, 1994). Fry (1989a) states that, "The overall goal for the teaching of ethics to nurses is to produce a morally accountable practitioner who is skilled in ethical decision making" (p. 485). Furthermore, teaching student nurses to act ethically is nothing short of a mandate for educators (Woods, 1999), and must be empowering for the nurse (Allmark,

1995). In Woods' view, educators must be committed to the ideals that promote ethical practice and oppose those that do not. He points out that ways must be found to equip nurses to challenge 'the system'. Student nurses must be able to act ethically irrespective of the strength of the contextual pressures and, educators need to teach them how.

Summary

This chapter has explored the wider bioethical context of healthcare, and more specifically within New Zealand. Nursing ethics' task is to outline the unique moral perspective of nursing practice, explain its discourse, reflect on society's and the profession's values and explicate these in ethical codes of practice as well as equip its members for ethical practice. Thus nursing ethics has an important part to play in the preparation of undergraduate nurses. Ethical issues that concern nurses have been explained and the ethical context of nursing practice has been to some extent explicated. The challenges within this ethical context have been highlighted and give rise to the critical task of nursing education to prepare its neophytes for the ethical demands of practice. This education must develop, " a nursing ethic that is strong enough to withstand the everyday pressures of modern health care delivery" (Woods, 1999, p. 430)

CHAPTER TWO: ETHICS EDUCATION IN NEW ZEALAND AND SUGGESTED METHODS BY WHICH NURSING STUDENTS LEARN ETHICS

"Nurse educators have an obligation to ensure that ethics is a foundational area in all nursing curricula for the 21st century" (Aroskar, 1993, p. 6).

Introduction

Thus far it has been argued that nursing ethics has a unique perspective within the wider bioethics sphere that has developed from prolonged interaction amongst nurses in the somewhat challenging contexts that they find themselves in. This chapter progresses to explicating what is deemed to be appropriate and adequate ethics preparation for practice as a registered nurse. To this end the NCNZ's (1996a) standard of ethics preparation expected upon registration as a nurse, is highlighted. Literature is also explored to ascertain what is deemed important to teach undergraduate nurses to prepare them for the ethical demands of practice. This exploration reveals the contemporary methods by which student nurses learn ethics. They are faculty education, role modelling experienced nurses in clinical practice, journaling and reflection, and experimentally. What are not evident in the literature are the perspectives of student nurses on how they learned ethics and ethical practice and whether that learning adequately prepared them for the ethical demands of the practice setting. This study's purpose is to contribute to addressing that lack.

Bearing in mind the challenging and complex ethical context of nursing practice, it is essential that undergraduate ethics education prepare its neophytes for the ethical demands of the practice setting. Therefore, ethics education must prepare new graduates to, cope with the ethical challenges of nursing practice, actively and competently articulate ethical concerns, and initiate effective change within the increasingly complex healthcare environment.

Nursing ethics education within New Zealand

Currently in New Zealand, undergraduate-nursing education spans a period of three years. Students are required to complete 1500 hours theory education and 1500 hours clinical experience in a variety of practice areas. During these three years the education that student nurses receive must prepare them to meet the Competencies for Entry to the Register of Comprehensive Nurses (NCNZ, 1996a). On successful completion of three years of undergraduate nursing education and passing of the prescribed State examination, graduates are entered on the Register of Comprehensive

Nurses (Nurses Act 1977). One of the aforesaid competencies relates to ethical accountability and states that, "The applicant practices nursing in accord with values and moral principles which promote client interest and acknowledge the client's individuality, abilities, culture and choice" (NCNZ, p. 18). To further enhance this competency there are nine 'generic performance criteria' and seven 'mental health performance criteria'.

On the basis of these requirements, and lack of published evidence, it can only be supposed that in New Zealand all undergraduate programmes have ethics education incorporated into their curricula so as to prepare students to meet the competencies for registration. How this is managed is up to each individual School of Nursing. These competencies are however, the standard for practice as a beginning registered nurse. According to this measurement then, it could be assumed that upon registration NCNZ would deem the nurse is competent to practice ethically.

There has been a recent review of undergraduate nursing education in New Zealand (KPMG Consulting, 2001).

> The logic of the review process was based on the premise that in order to understand the educational requirements for the preparation of nurses in the future it is critical to understand both the context in which practice may occur and the nature of future practice. For this reason the review commenced with a detailed environmental scan that was used to inform the subsequent phases (p. 2).

In this review, the complexity of the ethical context of nursing appears unconsidered, as the development of ethical competence is not identified as a suggested curriculum thread. The report seems to focus on fashioning graduates to be 'fit for service', with a concomitant meeting of employers' needs. Nursing ethics is, at best, obscure. The possible future implications of this are that less importance could be placed on preparing student nurses to adequately meet the ethical concerns within the practice setting than technical and procedural competence.

What should be included in ethics education for undergraduate nurses

Hussey (1990) outlines three arguments to justify the inclusion of nursing ethics into curricula. They are the ability to recognise moral issues, the ability to think about moral issues, and the ability and motivation to act in moral situations. Johnstone (1999) and Hussey advocate that nursing ethics should be taught both separately and

throughout the curricula and that students need to be prepared to function ethically in a social and political context. Respected nursing authors recommend that the following ethical approaches and theories be in included in undergraduate nursing education. They are, values clarification, principle-based ethics, virtue ethics, deontology, utilitarianism and the ethic of care. These will be briefly explained.

Ethics Content

There is some consensus on what the actual content of an undergraduate ethics course should contain (Davis & Slater, 1988; Fry, 1994; Ketefian, 1999). These authors recommend including deontology, utilitarianism, traditional ethical principles, virtue ethics and values clarification, as well as the ethic of care. Fry, a highly qualified and well-respected nurse ethicist was, on behalf of the ICN, approached to compile an ethics resource for nurses, teachers and students of nursing that was relevant to the rapidly changing health care environment, in which nursing practice takes place. Fry's recommendations for what should be included for undergraduate ethics education are therefore deemed to have considerable merit. That Rogers and Niven (1996), as New Zealand authors of an ethics text, chose to address utilitarianism, deontology and virtue ethics as well as values, rights and justice indicates that this content would be relevant in an ethics course for undergraduate nurses in this country. As an Australian nurse ethicist, Johnstone (1999) also refers to the aforementioned concepts and theories. There is therefore, considerable support for the inclusion of these ethical concepts and theories in undergraduate ethics education.

Values clarification and instillation

"Professional values are standards of action that are accepted by the practitioner and/or professional group and provide a framework for evaluating beliefs and attitudes that influence behaviour" (Eddy, Elfrink, Weis, & Schank, 1994, p. 257). Nursing education thus has a mandate to design ethics courses that teach those principles and values (Magnussen, 1994). The purpose of ethics education is to develop professional values, these being important as they provide the necessary foundations upon which to build an ethical position (Woods, 1997). This holds in that, a person's beliefs and values influence the decisions they make (Thompson & Thompson, 1992). According to Quinn (1990), "at the heart of one's approach to dealing with clinical dilemmas are the personal and professional values and ideals one brings to the situation" (p. 727).

Values are often taken for granted and rarely examined. Unexamined value systems potentially pose the problem of nurses imposing their values and beliefs onto the patients in their care. This is at variance with informed consent, self-determination or choice. Part of ethics education is therefore to provide the context where student nurses can examine the values that they hold. This entails, knowing themselves, what they believe in and what they value. The purpose is not to destroy these values but to undergo an honest appraisal of them to see whether they are adequate and appropriate. It may be that they warrant modification or replacement (Davis, et al., 1997; Davis & Slater, 1988; Thompson & Thompson, 1992).

Thompson and Thompson (1992) suggest that this is done best in groups where individuals are exposed to a variety of value positions different from their own. Trust and mutual respect are inherent ingredients for successful values clarification within groups (Thompson & Thompson; Woods, 1999). Fry (1994) contends that appreciating that nurses, patients, family members, doctors and institutions bring different values to situations in the practice area enhances understanding of all those involved. It is helpful for students to distinguish, articulate and discuss these, thus developing moral reasoning skills (Fry; Quinn, 1990). It is also important that students understand that they must respect and tolerate the values of others, especially those whom they will nurse (Parsons, Barker, & Armstrong, 2001). There are times when values are in conflict and thus an ethical dilemma ensues (Sletteboe, 1997). Furthermore, deeming a value to be absolutely right or wrong is inappropriate as different values come into place in differing situations (Tschudin, 1992). Codes of ethics however, can provide some clarity as to the values deemed appropriate for a particular profession.

Professional codes of ethics provide a consensus of the values a profession espouses. Similarly, codes provide a benchmark as to what the public can expect from a profession. Values identified in the Code of Ethics (NZNO, 1995) are, autonomy, beneficence, non-maleficence, justice, confidentiality, veracity, fidelity, guardianship of the environment and its resources and being professional. Tschudin (1992) identifies caring and partnership as inherent values in nursing. Similarly, Kuhse (1997), van Hooft (1999) and Watson, (1985) identify caring to be a central value of nursing and that caring indicates a relationship where caring is about something or someone. Quinn (1990) identifies seven values to which the professional nurse should be committed. They are, "altruism, equality, aesthetics, freedom, human dignity, justice and truth" (p. 727). Thus, values clarification and instillation are deemed to be important in

undergraduate ethics education. Furthermore, virtue ethics can also contribute to ethical development of the student nurse.

Virtue ethics

Virtue ethics has merit in that it considers the motives of the decision maker and the development of moral character. Educating student nurses as to the kind of person a nurse ought to 'be' and not just what should be 'done' as a nurse concerns virtue ethics (Fry, 1994). According to Johnstone (1999) it is imperative that nurses learn not only 'ethical competencies' of 'knowing that', but also what it means, and how to be, a decent (virtuous) human being (nurse) in a morally problematic world. Hussey (1990) explains that a good person is not good merely because of his or her good deeds, but because those good deeds are done knowingly. A choice is made to do them for the reason that they are good.

To be virtuous pervades the wider legal requirements for registration for nurses. To be registered in accordance with the Nurses Act 1977, the NCNZ must be satisfied that the nurse is of good character and reputation, and is a 'fit and proper person' to be registered. There is an expectation that they have moral character of a high standing. Not only does the profession expect this as a whole, but statutory bodies and the general public do as well.

The assumption is made by Sellman (1997) that nursing students already posses the virtues that are deemed necessary to be caring in that they are drawn to a caring profession. Noddings (1984) names this inherent ability as 'natural caring'. She proposes however, that ethical caring requires an effort that goes beyond natural caring. Perhaps this is what Sellman promotes when he suggests that nursing education develop the existent virtues within students. To this end he proposes that nursing education revisit the Nightingale emphasis on virtue ethics rather than teach rules and principles of ethics' theory.

Deeper investigation is required into Sellman's (1997) view to ascertain whether students do, in fact, bring the so-called 'virtues that are deemed necessary'. In Hunt's (1993) opinion, persons require family or community experiences to foster virtues. This, of course, also raises the question as to who will decide which virtues are more appropriate for nursing than others and whether virtues are culture specific or not. It also raises the question as to the validity of excluding rules and principles of ethical theory.

Nightingale emphasised the development of character formation or, in other words, the cultivation of virtue (McBurney & Filoromo, 1994; Sellman, 1997). She valued virtuous behaviours such as punctuality, observation (the ability to notice matters of importance), intelligent obedience and congruence between work and out of work character (Sellman, 1997). Within Nightingale's ethos, the good nurse was a virtuous nurse and the core principle of caring for the sick was rooted in the moral imperative of agape (selfless love). Even though there has been a shift towards preventing disease, sickness and dying has not gone away. Therefore, the moral objective and imperative to care for the sick remains. It is Bradshaw's (1999) view that,

> The moral reasons to submit oneself to the service of people who are strangers, and who may seem at times unappreciative, unattractive, difficult and even dangerous, giving the kind of self-denying and compassionate service of washing, cleaning, holding, that being a nurse involves, still apply as they did in Nightingale's day (p. 480).

"Virtue ethics claims that, if an agent acts from virtue, this will be sufficient to make the action good" (van Hooft, 1999, p. 190). Van Hooft enhances this concept by promoting the notion of moral comportment where the whole of the inner life, emotional or rational and intentional actions comprises virtue ethics. From his perspective, emotional caring and impartial and principle-based thinking are mutually inclusive in moral decision-making. In his view, "caring is not just a matter of feeling rightly, it is also a matter of thinking rightly" (p. 195). Lutzen and Barbosa da Silva (1996) and Hussey (1990) support this view. They hold that intellectual virtues and moral virtues complement each other where the good is chosen knowingly for the reason that it is good. Benner (1991) too agrees that rights and principles cannot stand-alone because they are unable to provide a positive statement of the good. According to Ratanakul (1986) being virtuous and of a good moral character is insufficient to facilitate judging whether acts are morally right or not. Hence principles help decide right actions.

Principle-based ethics

Beauchamp and Childress (1994) identified four primary principles and these have carried considerable weight in approaches to bioethical quandaries. These principles are: autonomy, nonmaleficence, beneficence and justice. Davis and Slater (1988) recommend that students have an understanding of ethical principles in that the

principle-based approach equips students to make ethical decisions based on reason rather than emotions. The four principles "should assist nurses to identify the elements of an ethical dilemma, to reason through it and to articulate an ethical stance" (p. 19).

Autonomy

An autonomous person is able to act freely according to a self-chosen plan (Beauchamp & Childress, 1994). Within an ethical context, where the interest is decision-making, the focus is on autonomous choice. Pragmatically, Beauchamp and Childress point out that within a healthcare environment where persons are temporarily constrained because of their illness, persons' decisions may rarely be fully autonomous. Thus if a substantial degree of understanding and freedom from constraint has been attained, then this would be reasonable. Free choice is tempered however with not violating or impinging on the significant moral interest of others (Johnstone, 1999). It is also needful to add, that not all persons seeking healthcare are constrained. Thus, it is important that nurses carefully contemplate how to appropriately facilitate participation in decision-making by patients and that nurses respect patient's choices, even though they may not always agree with them. Underpinning respect is the premise that the patient is a dignified human who is able to determine what counts as his or her own interests (Johnstone, 1999). Nurses also need to be mindful that, "Autonomy, in terms of the individual, centred upon self, single-person decision-making, is foreign to many cultures in our society who emphasise the group" (Rogers & Niven, 1996, p. 12). For some patients group-family-whanau may determine what moral action is most appropriate for the patient. To disregard this process may in fact, harm the patient.

Nonmaleficence

The principle of nonmaleficence involves 'doing no harm' (Johnstone, 1999). Beauchamp and Childress (1994) conceptualise nonmaleficence as, " one ought not to inflict evil or harm" (p. 191). Johnstone points out that this guiding principle cautions nurses to guard against unjustly injuring a person, causing a person to suffer an avoidable harm, violating a person's interests and well-being, allowing needless physical pain or, unrelieving a patient's distress. When assessing the balance between benefits and harm, then the duty not to inflict harm should take precedence over the provision of benefits (Davis, et al., 1997).

Beneficence

Beauchamp and Childress (1994) identify beneficence as an obligation to prevent evil or harm, to remove evil or harm and to do or promote good. Therefore the principle of beneficence connotes an obligatory action to help others further their important and legitimate interests. Nurses can exhibit beneficence by demonstrating care, compassion, empathy, kindness, altruism, mercy, love, friendship and charity (Johnstone, 1999). Promoting health, preventing illness, restoring health and, alleviating suffering is, for the nursing profession, indicative of the commitment of beneficence (Fry, 1994). However, according to Johnstone, beneficence has a utilitarian intent. The nurse is not required to act beneficently towards the patient if the end result is significant distress for the nurse.

Justice

Justice is broadly conceptualised by Beauchamp and Childress (1994) as fairness, equitability as well as awarding appropriate treatment in light of what is due or owed to persons. Within this approach to decision-making they say there is, "recognising an enforceable right to a decent minimum of health care within a framework for allocation that coherently incorporates utilitarian and egalitarian standards" (p. 387). Johnstone (1999) explains that a range of theories have emerged regarding justice. For nurses, Johnstone suggests that 'justice as fairness' and 'justice as equal distribution of benefits and burdens' are particularly relevant. Rogers and Niven (1996) point out that patients deserve fair treatment, and Fry (1994) highlights that nurses make decisions about what is a just and fair allocation of health care resources among patients they care for. Thus four primary principles identified by Beauchamp and Childress (1994) have been briefly described as an approach to ethical decision-making. The ethical theories of deontology and utilitarianism will now be outlined.

Deontology

Underpinning deontology is the concept of duty and obligation, deontology being derived from the Greek term for duty (deon) (Beauchamp & Childress, 1994; Kuhse, 1997). In this particular ethical perspective, behaviour is consistent in that if obligations and duties are known then the outcome can be predicted. A decision or action is worthy in that it is based on duty or obligation as opposed to consequences of that particular decision or action (Ridley, 1998; Veatch, 1999). This particular ethical

approach can be attributed to the 18th century moral philosopher Immanuel Kant, who proposed that rational authority devoid of subjectivity was the highest level of morality (Blackburn, 1996).

Deontology claims universal applicability in that judgements made will be consistent in any similar situation regardless of contextual determinants. There are no exceptions (Ridley, 1998; Thompson & Thompson, 1992). In other words, if an action proceeds from duty then the moral agent has acted rightly, regardless of the end result of the action (Rogers & Niven, 1996). Essentially then, "an agent's fundamental ethical task is to perform certain actions, the ethical nature of which cannot (solely) be dependent on the value of their consequences" (Kuhse, 1997, p. 84).

Utilitarianism

Converse to deontology is the ethical perspective of utilitarianism or teleology (derived from the Greek word 'end'). Philosophers Jeremy Bentham and John Stuart Mill posited this perspective in the 18th century (Beauchamp & Childress, 1994; Kuhse, 1997). Utilitarianism focuses on what is good and right as an outcome or consequence. 'Good' is defined as happiness or pleasure; 'right' is defined as the greatest good for the most people with harm occurring to the least amount of people (Ridley, 1998; Thompson & Thompson, 1992). Or more simply put, "the greatest good for the greatest number" (Thompson & Thompson, p. 28).

In utilitarianism, all possible actions are surveyed as to what the possible outcomes will be in terms of greatest happiness and the least suffering. An action is decided upon in terms of the greatest good and the least harm (Ridley, 1998). Harms and benefits are weighed, and a decision made as to what is the greatest possible good over harm for the most people (Davis, et al., 1997). This decision-making process is determined from an impersonal perspective where equal consideration is given to all effected parties (Beauchamp & Childress, 1994). Often a decision regarding distribution of resources among large groups of people where an attempt is made to ascertain the balance between efficiency and equity. Utilitarianism has however the potential to yield inequitable outcomes (Rogers & Niven, 1996).

Kohlberg/Gilligan debate and the ensuing ethic of care perspective

Kohlberg (1981) defined the moral agent as one characterised by making an objective analysis of moral dilemmas and the ability to use principles to make a rational justification of choices made. Moral development is a developmental process, from a concrete egotistic view of oneself (pre-conventional), to understanding and upholding conventional or society's rules and expectations. From this standpoint the group is valued and one has a feeling of belonging (conventional). Movement towards principled thinking is characterised by a questioning of 'society's view'. This indicates autonomy, in that the moral agent thinks for himself (post-conventional). In this autonomous state the agent is in the best position to assume ethical or moral posture and exercise (objectively) the principle of justice (de Casterle, Roelens, & Gastmans, 1998; Kohlberg, 1981; Manning, 1998). Kohlberg came to these conclusions through researching the moral responses to an ethical dilemma by male participants.

Gilligan, a previous student and colleague of Kohlberg's, challenged the inclusion of only male participants in his research and the apparent disregard for the contextual and relativistic factors of moral decision-making (Brell, 1989). Gilligan (1995) states,

> It was startling then to discover that women for the most part were not included in research on psychological development, or when included were marginalized or interpreted within a theoretical bias where the child and the adult were assumed to be male and the male was taken as the norm (p. 120).

Gilligan argued that there was a feminine gender-related perspective in moral decision-making and that moral concern involved competing needs and corresponding responsibilities rather than rights and duties (Gilligan, 1982; 1987; 1995).

What emerged from Gilligan's (1982) research was that women used a different language to describe moral concerns. This language identified a concern with avoiding hurt, in that the decision the moral agent makes has an affect on others with whom the agent is connected. Furthermore, the expression of care was seen to be a fulfilment of moral responsibility. Gilligan found that female responses reflected a care perspective more than any other. She therefore argued that care and responsibility within personal relationships should be valued at least as importantly as abstract reasoning.

The ethic of care

Care as ethical reasoning (moral orientation of care) is utilised to resolve ethical conflict, to reach a solution, and to decide what to do in a particular situation. The moral conflict or problem is identified within its context. The others, who are involved in the conflict, how they are interrelated, as well as feeling concern for relationships and individuals, are considered. It does not involve the application of abstract ethical principles or impartiality. Furthermore, it also does not however, mean mindless emotional responses and reliance on gut feelings. Moral responsibility and possible choices of action are defined by the context of the situation and the relationship of self to the others involved in the conflict (Fry, Killen, & Robinson, 1996; Gilligan, 1982; 1987; 1995). Central to the 'ethic of care' is the commitment to obligations and responsiveness within relationships. The moral agent responds to need, considers care and responsibility in relationships, thus paying attention to and not turning away from need (Harbison, 1992).

The 'ethic of care' then, subscribes to the view that engaging in abstract thought is problematic in concrete moral situations. From the 'ethic of care' perspective, caring is central and provides the moral impetus to act. This action occurs within a particular relationship. Foundational is the commitment by an attentive provider to meet the needs of a care-recipient. Furthermore, the 'ethic of care' acknowledges that contextual factors may impact on the moral responses of the moral agent (Le Veille Gaul, 1995).

Thus several ethical approaches and theories suggested for inclusion in undergraduate nursing ethics' education courses have been briefly outlined and explained. Contemporary methods whereby nursing students learn ethics, as identified in nursing literature will now be highlighted and explained.

Contemporary methods whereby nursing students learn ethics

The preceding discussion has explained the suggested ethics content within undergraduate nursing education. How student nurses learn ethics and ethical practice will be discussed. These methods are, faculty education, trial-and-error, role modelling of nurses in the practice setting and, guided reflection.

Faculty education

Johnstone (1999) highlights that most ethics education for nurses occurs in a formal classroom setting and that faculty educators have the responsibility to initiate and drive the ethics education of student nurses. In New Zealand, this mandate is

embedded in the ethical competencies defined by NCNZ (1996a). However, as Krawczyk (1997) highlights, there are few studies that describe how ethics is actually taught in schools of nursing and more studies should be conducted on the effect of ethics instruction on nursing students' ethical awareness.

Gaul (1987) undertook a quantitative study to compare 17 nursing students in a baccalaureate programme who undertook an elective ethics course, and 20 students who did not. The ethics course consisted of studying the major ethical principles and theories and guided ethical case analysis with emphasis on the role and responsibilities of the nurse. Regardless of the fact that the sample size was small and limited to one university, there was a strong correlation between ethical choice and ethical action as opposed to a weak negative correlation in the control group. This finding lends support for a separate ethics course. Krawczyk (1997) conducted a study amongst 180 students of nursing utilising Rest's Defining Issues Test. This objective test consists of rank ordering multiple-choice questions and does not require any human judgement in scoring. The students were divided into three groups over one year. Group A had a separate ethics course taught by a professor of ethics, Group B's ethics education was integrated throughout the curriculum and Group C were exposed to no ethics in their theory courses. Findings showed that Group A scored highest. This study also lends support for a separate course in nursing ethics for baccalaureate students.

Trial-and-error

In trial-and-error experience, a particular solution is tried to ascertain whether it works or not. If the solution does not work, another solution is attempted. This process continues until a suitable solution is found (Beanland, Schneider, LoBiondo-Wood & Haber, 1999). Woods' (1992) study involving 16 nurses in clinical practice revealed that 70% of these nurses had received less than 10 hours ethics preparation during their pre-graduate nursing education. Of those who had undertaken post-graduate study, 50% could not recall ethics being addressed within the courses they were involved in. According to Woods, the study identified a potential deficit in ethics preparation for practice in both undergraduate and post-graduate nursing education. Furthermore, these nurses did demonstrate an awareness of the complexity of various ethical issues within the practice setting. However it was found that they were constrained to respond due to inadequate ethics' education and lack of autonomy to consistently behave in ways deemed ethically appropriate.

Woods (1997) furthered his investigation into the process of ethical decision-making among experienced nurses. Utilising Grounded Theory methodology he researched eight experienced registered nurses, who had a minimum of four years post registration nursing experience. He found that the eight nurses in the study learned nursing ethics predominantly through a process of self-learning and discovery. In the light of an absence of any formal or informal ethics preparation, these nurses reverted to modifying already established values to assist them to analyse and deal with ethical situations. Hence, they were left to their own resources and learned by trial-and-error whilst in the clinical setting. Most participants identified that moral decision-making was a process of learning from experience and maturity. Woods concluded that these nurses when students, learned about moral values and ethical decision-making in an unplanned, uncoordinated and informal way. Furthermore, when dealing with ethical decision-making, participants indicated that they did not receive adequate support or guidance in ethical matters. They identified feeling unprepared for the ethical demands of practice.

The nurses Woods (1992; 1997) researched, did not learn about professional ethics or moral decision-making in an organised or formal fashion in clinical settings. They recalled very little or no formal ethics preparation. These nurses had basically taught themselves, they were left to their own resources resulting in making decisions on already established personal and family values. Carefully planned formal instruction/education in professional values was clearly missing. They did however, role model the practice of more experienced nurses whom they respected.

Role models in the practice setting

Ethics education also takes place in the workplace, "the actual 'hands-on' contexts in which nurses work" (Johnstone, 1999, p. 433). Excellent nursing care by outstanding nurses often helps other nurses recognise the moral sense of nursing practice (Benner, 1984). Students learn nursing by being involved in clinical experience with excellent practitioners who not only model practice, but also help student learn the meaning of that practice (Bishop & Scudder, 1999; Scott, 1996; Quinn, 1990). "Excellence in practice is acquired by observing, copying and learning from an expert practitioner" (Scott, p. 60). Ratanakul (1986) supports that virtues are developed, not only throughout childhood, but can be learned by encouragement and habit as well as by observing admired and respected adults.

In Woods' (1997) study of 8 experienced nurses it was found that they, as students and beginning nurses, had learnt how to practice ethically by role modelling other admired and experienced nurses. The effect that these role models had on the participants lasted over many years. Participants also learned from their nursing tutors or lecturers who visited them in their practice settings. It was found that participants chose these role models, and that a role model may seem morally impressive to one person, and not so to another. Participants also learned from nurses who behaved in ways that contravened the values of the participants. Hence the participants learned ethical behaviours from good, as well as, bad role models.

Pang and Wong (1998) promote role modelling as a clinical teaching strategy and tested its effectiveness in a longitudinal study. Pang and Wong applied this model to create a learning context for students to acquire a moral sense of nursing. Students were to write in their journals positive and negative examples nursing practice. These entries were discussed in class, and the teacher facilitated students' appraisals of these entries, thus encouraging sincere inquiry. Pang and Wong seem to assume that the teacher espoused the core values of the nursing profession, and could therefore successfully guide discussions surrounding what is a good nurse, as opposed to a bad nurse. It was found that, coupled with introspective self-examination and dialogue, student nurses were able to differentiate between good and bad nursing and emulate the good (Pang & Wong).

Conversely though, Greenwood (1993) cautions that student nurses can become desensitised to human need through being repeatedly exposed to poor nursing practice in clinical environments. He suggests that this happens through the habituation process where there is loss of responsiveness to a repeated or continuously present stimulus. According to Greenwood, people habituate to repeated mundane stimuli and that this phenomenon could account for the failure of some student nurses and registered nurses not to notice events and situations that are unethical.

Fry (1994) advocates for informal instruction in the clinical setting, where students and their teachers analyse ethical conflicts as they occur in nursing practice. Teaching ethics should be a regular feature of the teacher and student in the clinical areas where students meet the challenges of nursing practice (Woods, 1994). Tutors working alongside students in the practice area should spend time noticing and discussing aspects of the experiences students have encountered (Hussey, 1990).

Guided reflection

The strongest theme that has emerged in the literature reviewed is the notion that students learn ethics by journaling and reflecting on the actual experiences that they have encountered in clinical practice (Bowman, 1995; Durgahee, 1997; Johns, 1993, 1996; Kendrick, 1994; Patterson & Vitello, 1993; Quinn, 1990; Webb & Warwick, 1999). The strength of this theme may have some bearing on the fact that reflective practice has recently emerged as a major teaching and learning tool in nursing education (Johns, 1996). It may also be that this method for learning ethics has been readily adopted due to nursings' oral tradition and the tendency for nurses to express themselves in telling stories.

Students bring into the classroom an issue from practice. This issue will usually have been written about in their journals. It is thought that the classroom is a good place to reflect, away from the demands of practice. Webb and Warwick (1999) stress that it is more logical to deal with ethics by its relevance to clinical issues as they arise from practice, as opposed to pre-meditated case stories that don't truly reflect clinical practice.

Bowman (1995) promotes the use of story telling (narrative ethics) as a teaching and learning strategy, because it develops critical thinking skills. It facilitates learning to articulate a position, provides rationale for that position and to consider alternatives, and hence develops moral reasoning skills (Fry, 1994). It also invites responses from peers, sharing stories with others and reflecting about the self. The intention is that the discussions surrounding stories from practice are not superficial, but relevant and grounded in practice.

According to Woods (1999), student nurses can also learn to be moral by reflecting on the stories of experienced nurses. Carefully introducing nursing narratives, or stories, can help students understand moral decision-making. Narrative ethics richly describe the contextual situation. Often case studies omit such description (Davis, 1991; Rogers & Niven, 1996). Davis encourages utilising the personal stories that students, as recipients of healthcare, have experienced, these being a perfect source of thick description. Nursing education in ethics should address the key ethical issues faced by nurses and should draw extensively on the lived ethical experiences of nurses (Fry, 1994; Quinn, 1990; Woods).

It is expedient that learning happens in a guided manner rather than by trial-and-error where both students and their patients are vulnerable (Woods, 1999). Davis and Slater (1988) point out that an ethically knowledgeable nurse alone, or in conjunction with a philosopher or religious leader, is required to facilitate ethical reasoning. When educators expose students to these stories it is important that a safe environment is chosen, whether that be in the educational or practice setting. Durgahee's (1997) research identified that some students felt vulnerable in reflective groups in that they were not used to questioning established practices or asking themselves difficult questions.

Journaling and reflection gives students an opportunity to evaluate their own values and how these influence practice and ethical decision-making (Bowman, 1995). Values, according to Quinn (1990), influence the decisions made in practice. Students need to reflect on the value systems of other individuals and cultures as well as the values of the profession of nursing. Values clarification can occur when there is reflection and discussion about one's responses to a patient in a specific situation where the patient has differing health beliefs from the student. Kaane (1994) also invites connections being made between cultural background and moral views, and that this link requires explicit attention.

Who should teach ethics?

There is an important variable that is not addressed in the literature reviewed, that being, the level of skill of the nurse educator facilitating the group process. If the journal is a tool in which to identify ethical themes and contextual elements that influence nursing (Quinn, 1990), then it seems that part of the educator's role would be to assist students to identify these ethical themes. How can an educator do this if he/she does not have knowledge of ethics theory? Surely nurse educators also then run the risk of facilitating journaling and reflection sessions on 'gut response' alone. Johnstone (1994) cautions sole use of 'gut response', this approach being problematic when there are several people in a situation, all who have differing feelings and viewpoints. It is also interesting to note that McAlpine, Kristjanson, and Poroch, (1997), categorise 'gut level' responses at the lowest level of professional response.

If, as Durgahee (1997) highlights, there needs to be enough structure to facilitate students' movement beyond superficial discussion to the systematic application of an ethical decision-making framework, then it seems crucial that nurse educators have

knowledge of ethics theory. Quinn (1990) supports this view and suggests that educators may need considerable faculty remedial work in formal ethics theory and analysis in order for them to feel comfortable guiding reflection sessions. Furthermore, Arndt (1994) and Johnstone (1999) have also expressed concern that there are not sufficient nurses qualified to teach ethics. Fry (1989a) believes that the success of ethics teaching within nursing education and practice is largely dependent on the ability of teachers to teach ethics.

Generally, the nursing profession has a dearth of nurses who have a qualification in philosophy or ethics. The potential result of this is that the formal ethics education that nurses receive, can potentially be limited, misguided or omitted. Sometimes the problem is managed by recruiting moral philosophers from other departments (Johnstone). Hussey suggests that if students are to understand the abstract and theoretical aspects of moral concepts and theories then they require teachers with expertise in moral philosophy. NZNO (1993, p. 8) promotes that, "Those responsible for teaching nursing are nurses with appropriate academic and professional qualifications." Arguably then, those teaching ethics should be appropriately educated for this task.

Johnstone (1999) recommends that to teach ethics effectively at an undergraduate level requires a minimum of 26 hours and that ethics should be taught separately. In Woods' (1992) research approximately 10 hours was spent learning about ethics in pre-graduate nursing education for the 16 nurses involved in the study. Aroskar (1993) however, identifies that teaching of ethics to student nurses is often dependent on available time, interest and expertise of individual faculty. Parsons et al. (2001) found in their pilot Delphi study involving eight faculty staff that 72% believed that insufficient time was allotted to ethics teaching. How much time was allocated however, was not explored.

It seems that there is little research regarding the ethics content in nursing schools' curricula and the ethical preparation of teachers. Woods (1994) expresses that there is a dearth of research in nursing ethics in New Zealand and that this must be addressed. It seems that there is also a lack of evaluating and ascertaining students' moral development and subsequent behaviour in the practice setting. What to teach, how to teach, and how to evaluate that teaching is a huge challenge for the nursing profession.

Summary

Overall, it is evident from the literature reviewed that students learn ethics through formal faculty education, informal role modelling of clinicians in practice, reflection on actual experiences within the practice settings, as well as by trial-and-error. Overall, it has been found that there is little research regarding the ethics content in nursing schools and the ethics preparation of teachers, as well as a lack of evaluating or ascertaining students' moral development and subsequent behaviour in the practice setting. The reflective journal emerged as a tool to capture the experiences of nursing students. It has been depicted as a springboard for discussion and reflection with the view to developing students' ability to gain a new perspective on their experiences. It is envisaged that this new perspective then provides a vehicle to change behaviour. There is a need to examine the moral context of nursing practice and findings must inform faculty as to the ethics preparation student nurses need to practice ethically. There is also a need to find out from undergraduate nurses their perspectives of how they learn ethics and ethical practice. This research attempts to contribute in some way to meeting that need.

CHAPTER THREE: METHODOLOGY

" research is a rigorous, systematic inquiry or investigation, and its purpose is to validate and/or refine existing knowledge and to generate new knowledge" (Axford, Minichiello, Coulson & O'Brien, 1999, p. 3).

Introduction

"All research makes some kind of assumption about issues such as what things there are in the world, how we can know certain things, and what knowledge is counted as legitimate" (Davidson & Tolich, 1999, p. 25). These epistemological assumptions are embedded within and underpin the research process. Thus quantitative and qualitative research has differing starting points and embedded assumptions as to what is deemed to be true in the world. To this end, qualitative and quantitative researchers approach their enquiring from differing philosophical standpoints.

As both quantitative and qualitative research methods are utilised within the profession of nursing, this chapter will provide an explanation of the philosophical underpinnings of these two research approaches. Subsequently, the role of qualitative research in nursing will be discussed more fully, as well as the utilisation of qualitative research in nursing ethics. Because grounded theory is the chosen methodology for this study, its philosophical underpinnings and the theoretical perspective that informs it, namely symbolic interactionism, will also be explicated. The utilisation of grounded theory in nursing research, and more specifically, nursing ethics is also explained. Finally, it is argued that grounded theory is an appropriate methodology for this study that explores the perspectives of newly graduated nurses on their undergraduate nursing ethics education in preparation for practice as registered nurses.

Underpinning assumptions in quantitative and qualitative research approaches

The beginnings of modern Western science are generally traced back to the 16th century. At that time there was a gradual shift in the interests of scholars from theology and armchair speculation, to engaging in systematic description, explanation and concomitant attempts to control natural phenomena. That is, mediaeval thinking, where phenomena were the result of the supernatural world, was increasingly challenged throughout the 16th century and beyond, as scientists espoused scepticism, determinism and empiricism (Polgar & Thomas, 1995).

During this era, propositions or statements made regarding truth were opened up to doubt and analysis. The previously held belief that if something was 'mystical' or 'magical' then there was no need to try and explain what was happening or why, was questioned (Davidson & Tolich, 1999). This emergent and questioning science began demanding explanations rather than answers that were accepted simply on authority, tradition, or common sense. Thus a new belief emerged, holding that natural phenomena were linked to laws and causes. The emergent nature of enquiry involved observation and verification ascertainable through the five senses and extensions of these, for example, microscopes and telescopes (Erlandson, Harris, Skipper & Allen, 1993). To this end, quantitative research methods facilitated verification or falsification of emergent explanations against criteria of belief, evidence and truth (Greenwood, 1994).

In recent years, strong counter pressures have emerged against this scientific tradition. Quantification and context stripping were challenged, and exploring meaning and purpose was promoted as an equally valid avenue to explore phenomena (Creswell, 1994; Guba & Lincoln, 1994; Polit & Hungler, 1999). It was posited that human behaviour, unlike that of physical objects, couldn't be understood without reference to the meanings and purposes that human beings attach to their actions. Qualitative research methods emerged utilising systematic analysis of meaningful social action to elicit understandings and interpretations of how people create and maintain their social worlds. This was accomplished through direct detailed observation of people in their natural settings as well as in depth discussion with those people (Davidson & Tolich, 1999). Qualitative data, it was argued, could redress the aforesaid imbalance by providing contextual information and rich insight into human behaviour (Guba & Lincoln).

Quantitative and qualitative research methods therefore have differing starting points, assuming different things about the world. To this end, throughout the research process ontological, epistemological, axiological, rhetoric and methodological assumptions guide the investigator. These assumptions underpin the research process and lead to differing interpretations and meanings depending upon the approach. Hence, both quantitative and qualitative research reveals valuable insights and can bring understanding to phenomena in our world. These underpinning assumptions will now be explicated.

Ontological assumptions

Ontology deals with the nature of 'reality' (Guba & Lincoln, 1994). Its assumptions relate to what kinds of things actually exist in the world (Davidson & Tolich, 1999). There is an inherent belief in the quantitative research methodology that the human person and their social world can be measured by reducing it to its consistent parts. These, one at a time or in combination, can be isolated and objectively measured. Hence, it is assumed that study of this nature is context-free (Beanland, et al., 1999; Creswell, 1994).

Ontologically, qualitative researchers assume that the individuals involved in the research situation construct reality, therefore subjective data is deemed to be 'real' (Creswell, 1994). Reality is subjective and mentally constructed by individuals (Greenwood, 1994; Polit & Hungler, 1999). Qualitative researchers endorse the wholeness of human beings in that they attribute meaning to individuals' experiences that evolve from the lives that they live. Life is therefore seen to be a matrix of contextual variables that involve the human being and their interaction with their environment (Beanland et al. 1999; Creswell).

Epistemological assumptions

Epistemological assumptions refer to the relationship between the researcher and that being researched (Creswell, 1994; Guba & Lincoln, 1994; Polit & Hungler, 1999), what can be known (Guba & Lincoln), and what counts as legitimate knowledge (Davidson & Tolich, 1999). In quantitative research what is real is independent of the researcher. It is 'out there' and objectively studied. This particular view of the world envisages the inquirer as one who metaphorically stands behind a one-way mirror, viewing natural phenomena as they happen and recording them objectively. It is assumed that the inquirer does not influence the findings as they are discovered through objective observation, as they really are (Guba & Lincoln; Polit & Hungler). This means that findings from studies that rigorously follow prescribed procedures, when replicated are deemed to be 'true' (Guba & Lincoln).

Conversely, the qualitative approach assumes that no problem can be understood or solved in isolation from its greater environment (Creswell, 1994). It is presumed that the very formulation of hypotheses and theories are creative acts that are influenced by questions asked and how researchers explain their findings (Polgar & Thomas, 1995).

Thus, epistemologically, qualitative researchers' emphasis is on eliciting the 'meaning' of the lived experience of the participants. This data counts as legitimate knowledge.

Axiological assumptions

Axiological assumptions refer to the role of values in the research process (Creswell, 1994; Guba & Lincoln, 1994; Davidson & Tolich, 1999; Polit & Hungler, 1999) and encompass the relationship between the knower and what can be known (Annells, 1996). In quantitative research values are kept out of the research process as they are seen to contaminate the facts. Reporting the 'facts' and arguing closely from the evidence gathered in the study is valued (Creswell, 1994). Science is believed to be value-free, the researcher's values having no place in the research process except when choosing the research topic. Personal involvement with the research subjects is seen to contaminate the reliability of the study. To this end, subjects for quantitative studies are randomly selected (Davidson & Tolich, 1999).

Qualitative researchers admit the value-laden nature of the research process and actively report their values and biases (Creswell, 1994). According to Davidson and Tolich (1999), every observation made is impregnated with theory. Even before the study begins, researchers have a theory or some idea as to what the findings will look like. In qualitative research subjectivity and values are acknowledged as being inescapable and furthermore, seen as being desirable (Polit & Hungler, 1999). Further to this belief, research participants are purposively and, or theoretically sampled.

Assumptions concerning rhetoric

Creswell (1994) explains that rhetoric concerns the language used in the research process. In quantitative research, language is impersonal and formal. It is based on words such as relationship, comparison, control, objectivity and measurement, and is reported in the third person. Qualitative researchers utilise language in a more personal and informal way. Words that might be used throughout the research process are understanding, discovery, experience and meaning. Furthermore, the research adopts the definitions that evolve during engagement with the participants in the study (Creswell). As the intention of qualitative research is to describe or explain phenomena or culture, "the report is generally written in a way that allows the researcher to convey the richness of the research" (Beanland et al., 1999, p. 424). The qualitative researcher frequently utilises direct quotes from the participants to illustrate themes that have

emerged in the data. Narrative is therefore essential to facilitate conveyance of the depth and richness of the data (Beanland et al.).

Methodological assumptions

The methodology of a research project incorporates the entire process of the study (Creswell, 1994), how knowledge is obtained (Polgar & Thomas, 1995; Polit & Hungler, 1999), and how best to discover reality (Annells, 1996). In quantitative methodology, knowledge and discovery occurs deductively. Theories and hypotheses frame the research, and cause and effect are measured. Concepts, variables and hypotheses are chosen before the study begins and remain fixed throughout the study. Being able to generalise the findings is the end point of the research process (Creswell).

Qualitative methodology is inductive and 'context-bound'. Categories emerge from the participants in the study and information gathered leads to patterns or theories that help explain phenomenon. The accuracy of the information given by the participants is verified by 'triangulation' among different sources of information (Creswell, 1994). To this end, qualitative studies aim to discover 'meaning' and to uncover multiple realities, rather than to generalise the findings, they are almost always conducted using small, non-random samples. Qualitative methods lend themselves to nursing research in that they explore the lived experiences of persons within their contexts.

Qualitative research: Its place in nursing

The nature of human experience cannot be easily measured in quantitative terms, the context in which nursing practice occurs is complex, and cannot be completely controlled. Studying human beings tends to limit the amount of control the researcher can exert over the variables involved. Another difficulty is the feasibility of randomly selecting sample sizes that are large enough to support causality and generalisability. Many variables of nursing are not yet clearly defined and therefore cannot be effectively manipulated. Understandably then, this has considerable influence on how nurses conceptualise health care and how they plan and carry out research. For these reasons, purely quantitative methods are limited in nursing research as the subjects and settings are human. Many nursing studies therefore utilise qualitative methods (Beanland et al., 1999; Hewitt-Taylor, 2001).

Individuals' experience, and perspectives of health and illness, can be explored by adopting qualitative methods of inquiry. Dewar and Lee (2000), for example,

examined how individuals with catastrophic illness and injury managed their personal and social world. Similarly Mohr (2000), investigated how families actually experienced care in mental health settings for children and adolescents. She also elicited the perspectives of parents whose children were hospitalised in psychiatric hospitals. DePalma (2001) ascertained patients' and families' perspectives of quality of life post-traumatic brain injury.

All of these studies describe experience and, or perspectives on experience. Furthermore, qualitative research facilitates gaining insight into subjective experiences through the personal points of view, as well as reasons for the actions of those participating in those experiences (Polar & Thomas, 1995). Hence, qualitative research can explain relationships among phenomena and inform nurses as to why certain events occur. This equips nurses to anticipate the effect that certain interventions, nursing care, or omissions in care might have, and therefore assist in making nurses knowledgeable regarding therapeutic actions (Greenwood, 1994). Qualitative research contributes to nursing's body of knowledge by describing what exists in practice, explaining why certain events occur and predicting the effects of nursing care and interventions. Grounded theory is frequently utilised to conduct qualitative research and its methodology lends itself to explore uncharted waters, where little is know about a phenomena. The nature of this methodology will now be explored.

The nature of grounded theory

Barney Glaser and Anselm Strauss, Professors of Sociology at the University of California in San Francisco, formulated grounded theory as a methodology useful for approaching social research. Glaser and Strauss' (1967) work, was the outcome of their perception that the then current sociological trend was to over-emphasise verification of theory. In their opinion, there was a corresponding de-emphasis on the discovery of concepts and hypotheses in designated research areas. They saw the priority given to testing existing or emerging theory, to be at the expense of generating theory. Hence the purpose of grounded theory is to discover theory inductively, systematically gathering data from social research.

Grounded theory's intent is to discover the chief concern or problem of persons in the substantive area, as well as what might account for most of the variations in the processing of it. To do this, the researcher is motivated by a desire, not only to find out what is really going on with regards to the participants, but how they process what is

going on for them (Glaser, 1992). Important in grounded theory is the context in which people function. Interactions, behaviours and experiences within the context, as well as individuals' perceptions and thoughts about them, are central to theory that is grounded (Holloway & Wheeler, 1996). In other words, "What is going on and how" (Becker, 1993)?

Grounded theory can be either substantive or formal. A substantive theory is one that is generated within a substantive, or empirical area of inquiry and its application is specifically in that area. A formal theory is one that is developed for a formal or conceptual area of inquiry that is stimulated by and built on previous substantive theory, or theories. This study is substantive in that it focuses closely on the particular context of nursing practice, and more specifically newly graduated nurses' perspectives of their undergraduate ethics education in preparation for registration. Hence, the exploration is from, "the perspectives of the substantive area participants" (Glaser, 1992, p. 5).

To reach the goal of conceptual understanding, it is imperative that the grounded theorist records events and detects happenings strictly from the perspectives of those in the substantive area. To this end, the researcher enters the area with as few predetermined ideas as possible. This allows him or her to remain open to what is actually happening (Glaser, 1978). Glaser cautions that, "Knowing the problem of the research ahead of time derails the joint collection and analysis of data" (1995, p. 8). When the researcher enters the field with no preconceived interest or problem, the main concern and the basic social-psychological process that handles it, is free to emerge. In other words, "what is the core process that continually resolves the main concern" (Glaser, 1992, p. 22)?

Philosophical underpinnings of grounded theory

Grounded theory is situated within the postpositivist paradigm of inquiry (Annells, 1996; Guba & Lincoln, 1994; Morse & Field, 1996). Positivism is often used to identify the scientific paradigm, where, as previously highlighted, natural phenomena were linked to laws and causes verifiable through observation utilising the five senses. Postpositivism does not fully discount scientifically verifiable truth. Within this paradigm reality is assumed to exist, but its apprehension is imperfect. Reality is therefore apprehended as closely as possible, but never perfectly. The researcher adopts a somewhat 'objective' stance and findings are subjected to verification as to their 'fit' with pre-existing knowledge. Inquiry is conducted in naturalistic settings where an emic

viewpoint is sought. Hence, "Grounded theory is an interpretive style of qualitative research in the postpositivist tradition in that the process and outcomes are judged on the basis of traditional scientific criteria" (Benoliel, 1996, p. 414). This research project largely follows the Glaserian grounded theory methodology. Annells (1996) refers to this as the classic method explicated by Glaser and Strauss (1967) and subsequently defended by Glaser (1992). Furthermore, Glaser and Strauss' and Glaser's grounded theory methodology is theoretically informed by symbolic interactionism, and draws on the works of Dewey (1929), Mead (1934) and Blumer (1969).

Symbolic Interactionism

Dewey (1929), when exploring human interaction, compared the animal and human world, and postulated that animals merely react to stimuli, whereas humans respond to their world according to the meanings given to events and objects interacted with, within that world. Thus humans indicate and communicate to each other by posture, facial expressions, signs and sounds. These responses are understood because of shared meaning. Furthermore, language too has meaning. It is not just a construction of sounds but the meaning that has been awarded those sounds. Therefore, to recognise, grasp, understand an object, event or words is to grasp their meaning, predetermined by previous interactions. Thus meaning is the sense it makes. To this end a 'thing' is what it is, because of the meaning awarded it.

Mead (1934) viewed the human being as an actor who was not simply at the mercy of different stimuli at play in the central nervous system, in that humans act and determine their environment and are not simply a set of passive senses played upon by outer stimuli. Thus, "The organism goes out and determines what it is going to respond to, and organises that world" (p. 25). To this end, the human acts rather than reacts, action is constructed as opposed to a mere releasing of it (Blumer, 1969). Furthermore, within the environment of human beings there are objects. These objects are socially constructed and may be physical, imaginary, conceptual or concrete. The nature of an object relates to the meaning it has for the person, or persons, and how the they are prepared to act toward it.

John Dewey (1929) and George Herbert Mead (1934) laid the foundations of this perspective. Herbert Blumer, a student of Mead, further theorised symbolic interactionism. Blumer's (1969) intention was to map out the theoretical schema of

human society implicit in Mead's work and subsequently coined the term 'symbolic interactionism' (Porter, 1998).

According to Blumer (1969), to understand the actions of people the researcher needs to see the objects of those people, from 'their' perspective. Exploration involves finding out how certain people see what they are acting toward. This involves making an effort to get inside the world of those people and to understand the meanings they attribute to it. This is ascertained by how those people act toward objects in a variety of different situations as well as reference to those objects in conversations with members of their own group. "The task of the research scholar who is studying a sphere of social life is to ascertain what form of interaction is in play" (Blumer, 1969, p. 54). Thus symbolic interactionism theoretically informs grounded theory in that it explores interactions within the social sphere.

Methodological assumptions underpinning grounded theory

The purpose of grounded theory methodology is to generate knowledge of complex phenomena that are directly linked to the human world we seek to understand (Wilson & Hutchinson, 1996). It is envisaged that studies describe what is going on and progress to what the underlying 'how' and 'why' are (Becker, 1993). Initially, a description is offered of what is happening in the social setting among a group of individuals expressed in narrative report of categories or types. Analysis of this data coupled with triangulation facilitates progression to discovery or conceptualisation of the tentative relationships among variables. A core category accounts for a major portion of the variation identified. This identifies what is going on, how and why. Thus, an explanation evolves as a theory regarding social phenomenon. Therefore, grounded theory involves description, "What is going on here?" and explanation, "What is going on and how?" "These questions are answered by explanations or theory regarding a social phenomenon" (Becker, 1993, p. 255). It is assumed that the theoretical propositions that emerge from the theory that is grounded, can be verified in future research as well as inform the substantive area on possible interventions that might address the area of concern explicated by the participants in the research.

Data gathering and analysis in grounded theory

To develop a theory that explains basic patterns common in social life, the grounded theorist enters the substantive field to collect data utilising in-depth interviews, observations and other fieldwork techniques (Glaser & Strauss, 1967;

Holloway & Wheeler, 1996). This study gathered data in the substantive area via in-depth interviews with recently graduated registered nurses.

In each area of life there are people who are 'in the know'. The researcher can never know as much as those who live in 'their' substantive world. However, what the researcher can do is contribute a substantive theory that explains how those 'in the know' handle their knowledge and subsequent actions (Glaser, 1978). To this end, the grounded theorist brings an abstract conceptual understanding that accounts for the actions of subjects in the substantive area as well as an explanation of subjects' main concerns and how they are processed (Glaser & Strauss, 1967). As Glaser points out, "They need their main concern attended to in the theory" (p. 9).

In grounded theory, data gathered are analysed according to the constant comparative method. Data are coded 'line by line' and the emergent conceptual units are noted. Analysis involves identifying concepts and codes (Glaser, 1992; Glaser & Strauss, 1967). These concepts and codes are termed Level I substantive codes and represent the participants' own words for their experiences. Level II categorical codes are a more abstract conceptualisation of the data. Furthermore, Level II codes are named and clustered to form categories, the categories being theoretical abstractions about 'what is going on' in the area studied. These theoretical abstractions are referred to as Level III conceptual and theoretical codes, and formulate the building blocks of the emerging theory (Wilson & Hutchinson, 1996).

As relevant ideas from the literature and other documents become part of the data, the analytic process of constant comparison and theoretical sampling take place, thus providing some degree of internal validity to the research. Memos (theoretical notes) provide the researcher with theoretical ideas (Holloway & Wheeler, 1996; Morse, 1992). The emerging theory and gaps point the researcher to the next step in the data collection process. Data collection stops at theoretical saturation, in that all gaps are filled and each category is saturated, "In other words you realise you have heard or seen it all before" (Giddings & Wood, 2000, p. 8).

Categories are linked together to form a core category. The very nature of the core category will eventually emerge and appear to be woven through the entire study almost like a 'story line' (Holloway & Wheeler, 1996). The core category that emerges is the basic social-psychological process that describes and explains the processing of the main concern of those in the substantive area. This fits the realities under study in the eyes of the subjects, practitioners and researchers in the area. Furthermore, a

theoretical framework develops. From this, theoretical propositions can be formulated for subsequent testing and verification.

The place of wider literature in the grounded theory method

Glaser and Strauss (1967) recommend that the researcher enter a prospective area of study without any preconceived ideas. This recommendation poses challenges for the beginning researcher embarking on a thesis research project. Course requirements dictate that the thesis student, undertake an initial literature review that explores the researcher's area of interest to ascertain the specific research question, provide a background to the chosen topic to gain ethical approval for the research project to proceed and, identify a research question that provides direction as to the choice of methodological approach.

According to Glaser (1992), choosing a problem and finding a substantive area to research it, leads to forcing the data and potentially derailing the researcher forever from being sensitive to the grounded problems of the area as well as their solutions. However the researcher may begin their study with a partial framework of 'local' concepts, as well as gross features of the structure and processes in situations. These initial concepts can give a beginning foothold on the relevancy of concepts not known to the problem. Hence, this researcher's beginning foothold is clearly portrayed in the literature review section.

According to Backman and Kyngas (1999), for the novice grounded theorist reading the literature can help to clear one's thoughts and narrows down the topic of research. It can also alert the researcher of uncharted waters (Stern, 1994). It would seem then that some semblance of a literature review therefore directs the researcher to adopting a grounded theory methodology, as it did for this researcher.

This researcher has identified in the literature review section, a synthesis of the articles reviewed in preparation for beginning a thesis study. The researcher has endeavoured to suspend what she already knew about the experience being studied and to approach the data without preconceptions as instructed by Backman and Kyngas (1999). She allowed the data from the substantive area to dictate the direction of the research process. What the researcher already knew was accessed at later stages in the research process when related literature was introduced as part of the data.

Utilisation of grounded theory in nursing research

Grounded theory has been used as a research methodology in nursing since 1970 effectively exploring nursing practice (Backman & Kyngas, 1999; Benoliel, 1996). It is particularly useful for nursing research due to its orderly and systematic method of data collection and analysis. According to Holloway and Wheeler (1996), this is the way in which health professionals go about their work.

Utilising grounded theory as a qualitative research methodology can facilitate a growing body of knowledge based on, not only rich description, but also explanation of the practice of nursing. To this end: "The task of the research scholar who is studying a sphere of social life is to ascertain what form of interaction is in play (Blumer, 1969, p. 54). Hence grounded theory is helpful to explore processes within the health care environments. It is important to note that grounded theory moves beyond describing the experiences, perceptions and perspectives of those under study. The intention is to move systematically from description to development of a theory grounded in the data that can explain the phenomenon under study (Glaser, 1995; Glaser & Strauss, 1967). Therefore, "To be credible the theory must have explanatory power" (Holloway & Wheeler, 1996, p. 107).

On exploring the perspectives and experiences of family caregivers having a school-age child with asthma, Palmer (2001) generated a substantive theory that had, as its core process, 'becoming a vigilant caregiver'. According to Palmer, this theory is useful for health professionals to understand what is going on in families' experiences with asthma as well as knowing that families undergo a process of 'becoming vigilant' as they came to terms with and managed their child's asthma. Assisting parents and caregivers in the process of vigilance can improve the quality of health that these families receive.

Carr (2001) utilised grounded theory to explore long-term interpersonal relationships between patients and their primary health care providers in an urban outpatient HIV and AIDS clinic. A basic process of 'negotiating trust' was identified in this study. The concept of negotiating trust had the potential to explain a very wide range of attitudes, conditions, and consequences. The core variable incorporated explanations as to how trust was developed and which conditions, for example discomfort or fear exhibited by the health professional during a discussion regarding death, affected how much the patient could 'trust'. Furthermore, failure to provide

adequate information was also perceived as a failure on the part of the provider and damaged 'trust'. Hence a description and explanation of the substantive area and the basic social-psychological process of negotiating trust.

Scharer (1999) also explored relationships. This author utilised grounded theory to learn about the process of relationship building between nurses and parents in child psychiatric units. The grounded theory is rich and textured as it explores this phenomenon from the perspectives of the patients and the nurses, using both semi-structured interviews and participant observation. The study contributes to knowledge about what actually occurs between parents and nurses when a child is admitted to a child psychiatric unit.

These studies indicate the use of grounded theory's specific characteristics of exploration and explanation of processes of interaction within the context studied, from the perspectives of those within the substantive areas studied.

Utilisation of qualitative research in nursing ethics

Qualitative research methods have been utilised to explore and describe the ethical context of nursing practice by eliciting nurses' stories of their ethical experiences in the practice setting. A literature review of qualitative studies by Redman and Hill (1997) spanned the years 1993-1994 and revealed some clear areas of ethical concern for nurses. Nurses practicing in community and home care settings faced conflicts regarding the availability of resources for people in need. Intensive care nurses consistently experienced conflicts related to patient and family suffering and pain, in particular balancing the net good or harm of life-prolonging aggressive interventions. Nurses in administrative roles showed common areas of conflict regarding staffing, standards of care and availability of resources. Several studies identified that nurses saw doctors as a source of ethical conflicts.

In qualitative research understanding the experiences of nurses and patients is usually expressed in themes. Vulnerability, suffering, moral blurring and moral blindness were themes that emerged from Ray's (1998) study exploring the meaning of the experience of caring for technologically dependent patients. What it was like to nurse patients on ventilators was explored. This research brings to light ethical issues of concern to nurses, what it is like to be 'connected' to patients who are suffering, as well as concepts to describe what the experience means for these nurses. To this end, narratives utilised in qualitative research can bring to light the "particular knowledge of the embodied knower" (Benner, 1991, p. 1).

Polit and Hungler (1999) point out that scientific methods cannot be used to answer moral or ethical questions. As moral and ethical questions are deeply inherent in the nature of nursing practice, it is appropriate that a qualitative design be adopted to investigate the perspectives of newly graduated nurses in regards to their ethics preparation for practice as registered nurses. Furthermore, qualitative methods are extremely useful in uncovering the nature of people's actions, experiences and perspectives (Glaser, 1992).

"Given then, that the problem is best studied by using a qualitative approach, how does a researcher select the 'best' or the most appropriate method?" (Morse & Field, 1996, p. 28). This depends on the nature of the problem or area of inquiry and, as well as, the type of question that requires answering. Grounded theory as a methodology, not only elicits rich descriptive data, it goes beyond this to develop a theoretical framework that is explanatory. It is a useful methodology to employ in nursing research, and more specifically nursing ethics, in that it can facilitate exploration, description and explanation of the ethical contexts that registered and student nurses find themselves in, as well as how they manage ethically in these environments.

Utilisation of grounded theory in nursing ethics research

Redman and Hill (1997) point out that few qualitative studies in nursing ethics move beyond what actually exists in the practice setting to development of an explanatory theory. This results in, the 'how' and 'why' ethical conflicts develop, or 'why' they are experienced, remaining hidden. Lack of explanatory theory limits the ability to construct interventions to prevent or resolve the conflicts that nurses face in their practice. Giddings and Wood (2000) suggest that more research is needed that focuses on the theoretical components of practice. Grounded theory is therefore a fitting methodology to explore the ethical sphere of nursing practice, as its intended result is explanatory theory.

Some grounded theory studies however are descriptive. They utilise the constant comparative analysis method, theoretical sampling, and saturate a small number of categories that emerge from the analysis. This is grounded theory that arrives at a descriptive analysis (Giddings & Wood, 2000). Kelly (1991), for example, examined and described what English nursing undergraduates internalised as professional values. Two concepts emerged, 'respect for patients', and 'valuing the rights of patients'. These students valued 'fitting in' with other staff in their clinical areas and 'going along' with

the norms of these environments. This research has merit in that it describes perceptions of student nurses regarding what they valued in nursing, however, the research lacks conceptualisation of the underlying social process at an abstract level and does not 'push' the results towards model development (Morse & Field, 1996).

Subsequently however, Kelly (1998) underwent a follow-up study with newly graduated nurses to as to describe, explain and interpret how they perceived their adaptation to the 'real world' of hospital nursing. 'Preserving moral integrity' was the basic social-psychological process that explained how these nurses adapted to the real world of nursing. Moral distress was a consequence of the effort to preserve moral integrity and was displayed as self-criticism and self-blame. In this study Kelly moved beyond description to explanation of the real world of nursing for these new graduates. These findings can serve to inform nursing educators to invest time in preparing the new graduate for the social forces that will surely affect them when they enter the 'real world' of nursing practice. It can also inform the practice area of how to support newly graduated nurses on their entry into practice.

Woods (1997), Radwin (1998) and Lipp (1998) all utilised grounded theory to explore moral decision making of experienced nurses. For Woods, 'maintaining a nursing ethic' emerged as the core variable and reflected that which all participants commonly experienced. It served as the central guide or driving force behind every moral decision and action. For Radwin, 'knowing the patient' was the basic social-psychological process that reflected the process of decision-making. Lipp found that nurses relied on experience when engaging in ethical decision-making. She expresses concern that this may mean that nurses learn by making mistakes. Woods found also that nurses learned by trial-and-error. Radwin too expressed that expert nurses learned experientially. These three studies can inform and support each other and bring a significant finding to the profession of nursing showing that currently nurses are predominantly learning to make ethical decisions experientially. Both Woods and Radwin utilise grounded theory to explain moral decision-making. Lipp has engaged in a descriptive grounded theory study. Thus, all three studies contribute to nursings' body of knowledge regarding ethical practice.

Why is grounded theory a fitting methodology for exploring the perspectives of newly graduated nurses on their ethics preparation for practice?

According to Glaser and Strauss (1967), grounded theory lends itself to nursing in that researchers and practitioners face issues relating to human behaviour in organisations, groups and other social configurations. Grounded theory has the potential to provide images of the powerful influence of social and contextual forces on the life experiences of vulnerable people in crisis and change (Benoliel, 1996).

In their role as students, undergraduate nurses are vulnerable to the powerful social and contextual forces that shape their ethics education. These have the potential to help or hinder their learning as well as to influence what they learn. Benoliel (1996) points out that context can facilitate, hinder, and influence human goals and social psychological processes.

Hutchinson (1993, p. 182-183) explains that, "If little is known about a topic and few adequate theories exist to explain or predict a group's behaviour, the grounded theory method is especially useful." Cheintz and Swanson (1986) also support this view. They say that, "Grounded theory makes its greatest contribution in areas where little research has been done" (p. 7). According to Stern (1994), the strongest case for the use of grounded theory is in investigating relatively uncharted waters, or to gain a fresh perspective in a familiar situation. Research investigating undergraduate ethics education is just beginning to emerge in New Zealand (Woods, 1992; 1994; 1997) and is relatively uncharted, therefore there are few variables and theoretical propositions identified which can be utilised for further research.

Grounded theory also explores social interaction and how individuals respond to the actions of others. Student nurses interact with their teachers, other nurses, and health professionals, their peers, as well as patients and their families. What is their basic social-psychological process? What is their main concern and their continual processing of it? "Using the grounded theory approach, it is possible to study the meanings of events for people" (Backman & Kyngas, 1999, p. 147) and explain a given social situation by identifying the core and subsidiary processes operating in it (Byrne, 2001).

As student nurses interact with those in the learning environment, what goes on that facilitates the learning of ethics? What do the events that surround the learning experience mean for these student nurses? What did they learn? How did they learn it?

Where did they learn it and from whom? Hence, grounded theory can explicate the contextual factors that impact on student nurses' learning of ethics.

Cumulative works are necessary to build a body of knowledge valuable to nursing as opposed to scattered research attempts (Axford, et al., 1999). To this end the beginning research in New Zealand that addresses ethical contexts and education in nursing by Woods (1992; 1994; 1997) will be added to. Furthermore, few qualitative studies exploring ethical contexts move beyond what actually exists to theory development (Redman & Hill, 1997). Hence the explanatory nature of grounded theory makes it an appropriate methodology for this study. This grounded theory is also a response to Woods' (1994) comment that there is a dearth of research in nursing ethics in New Zealand and that this must be addressed. This study will contribute to addressing that lack.

Finally, grounded theory is appropriate for eliciting the perspectives of newly graduated nurses on their ethics preparation for practice as registered nurses, in that the emergent theory can subsequently inform the educational and practice setting in which student nurses learn. As Glaser (1995) explains, "professional and layman participants alike can use substantive theory to understand and intervene to help resolve their main concerns and to indicate how to act toward them" (p. 5).

The study of newly graduated nurses' perspectives of their ethics preparation for practice as registered nurses

Procedures for recruiting participants and obtaining informed consent

Participants for this study were accessed through new graduate programs in five Christchurch hospitals. Initially, co-ordinators of these programs handed out to new graduates a copy of the 'flyer' (Appendix 1) and the information sheet (Appendix 2). This initial contact was in their study days. Some new graduates, for various reasons, were not able to attend the study days where the information sheets were handed out. In this case co-ordinators of the programs posted the information sheet out to them. 'Flyers' were placed on hospital notice boards by either the new graduate program co-ordinator, or the researcher. The 'flyer' and the information sheet explained the study and asked for those interested to contact the researcher independently.

The researcher made follow-up visits to new graduate's study days, providing a five-minute explanation of the study and inviting volunteers to make telephone contact with the researcher. During the telephone call, further explanation of the study was

given and any questions that the participants had were answered. After ascertaining that the volunteer graduated from a three year Bachelor of Nursing undergraduate degree within New Zealand, and that he or she was in their first year of nursing practice, a time and place to meet for the interview was negotiated. After further explanation of the research process in person, each participant signed a formal consent form (Appendix 3).

Role of the participants in the research process

Each participant was initially asked to participate in 1 - 2 interviews of approximately 1 – 1½ hours in duration, in a place and at a time that was mutually acceptable by both participant and researcher. The researcher requested second interview from three of the nine participants that offered to be part of this research. Each interview consisted of a several open-ended questions, and replies were audio taped by the researcher. Field notes were also scribed during the interview and immediately after the interview, so that the researcher could capture her thoughts and insights from the interview.

How information and material gathered during the research process was handled

All information and material gathered was kept in strict confidence. All cassette tapes, notes and information regarding the participants were stored safely in a locked metal cabinet for the duration of the research project. The researcher, her supervisor and the transcriber, who signed a confidentiality agreement prior to processing taped interviews (Appendix 4), were the only persons who had access to the audiotapes and transcriptions. All transcriptions, field notes, and information relating to the participants are currently stored safely in a locked, fireproof cabinet. It will be kept for audit purposes for 5 years (January, 2008), and then destroyed.

The participants

Nine participants offered to take part in this research, seven of these were female and two were male. Five participants graduated from the local School of Nursing, the remaining four participants graduated from four other Schools of Nursing within New Zealand. This mix of participants was deemed to have met the intention of the researcher not to limit the research to the polytechnic where she is a lecturer. A wider substantive selection was aimed for, so as to lessen the potential 'limitation' to the research due to the lecturer's involvement in the School of Nursing. This mix of

participants occurred spontaneously. Furthermore, interviews were conducted over a nine-month period.

It was intended that this research would access newly graduated nurses who were in their first year of practice. Initially, seven participants were undergoing orientation in their newly acquired places of work as registered nurses, one participant had been working as a nurse for 2 months and one participant had been working as a nurse for 2 weeks. Later however, when taping was checked, one interview was significantly distorted due to background noise. The participant willingly agreed to be re-interviewed. This participant had thus been in practice as a registered nurse for approximately 4 months. Overall though, it was pleasing that most participants had had little or no experience as newly registered nurses. It is the researcher's opinion that this factor strengthens the research, in that participants' undergraduate nursing ethics' education was hoped to still be fresh in their minds and that memories were not dampened by new experiences as registered nurses.

Data analysis

All tapes were transcribed by a transcriber and checked for clarity and correctness and stored on floppy disk. Raw data was copied into the researcher's home computer. Each interview was named by the participant's code and line numbers were inserted. The raw data was subsequently printed out and checked for accurateness. Methodically, the researcher read the transcriptions, musing on each line of raw data and identifying concepts, points of interest or merely jotting down thoughts and musings. The initial analysis of data was done by hand. This process facilitated the emergence of embryonic substantive codes.

Following this initial process, the researcher returned to her computer and organised the same or similar ideas, concepts and codes into groups, each of which was given a tentative name. Concurrently, the participant's code and line number was inserted after each small piece of data. In this way, where the piece of data was taken from within the transcribed interview was clearly noted. Thus initial emergence of substantive codes eventuated. Through this stage, the researcher typed her thoughts and comments regarding emerging codes in a different font. These memos were later woven into the analyses embedded within the writings of this thesis. Field notes too were incorporated into these groupings, however they remained distinctive and are named as *field notes* within the write-up.

As interviews progressed, groupings that were similar were clustered together and conceptualised (named) appropriately. Further analysis facilitated the collapsing of codes into categories. Cutting up the printed copies of initial coding, placing similar concepts and themes together, and inserting them into named envelopes, was utilised during this part of constant comparative analysis. Codes were switched around to ensue the correct 'fit' with emerging categories. Much time, thinking and musing was spent on this process. Eventually, categories were conceptually named to reflect the inherent codes. Concurrent to this process emergent findings were written-up into a thesis document that was reworded and reworked until participants' perspectives of their undergraduate nursing education became clearly evident. The following chapters are the findings and evidence of much rumination until the core category emerged, and its supporting sub-cores within it. That was a great moment.

Ethical concerns

No physical risks were foreseen to impact upon participants, however some psychological implications needed consideration prior to, and during, ethics approval for the research to proceed. It was seen that, potentially there could be psychological risks to participants in that talking about ethical experiences that had happened in the past, may bring to mind uncomfortable ethical dilemmas that participants faced whilst they were student nurses. It was possible that participants may have seen or experienced unethical practice, and there was the potential for them to be emotionally upset by this.

To cushion this possible effect, the researcher endeavoured to vigilantly observe the body language of the participants. At no point during any interviews did participants become visibly upset. Ethics approval was granted on the condition, that if a participant became upset, taping would discontinue and the researcher would give an appropriate amount of initial support to the participant. The researcher was to be clear about her role of researcher as opposed to counsellor, however initial support was to be given. This support was not required.

Prior to the consent form being signed, and as part of the information period prior to beginning the interview, the researcher offered each participant two pamphlets. These pamphlets outlined avenues that participants could choose to explore if they wanted to talk to someone regarding their experiences in the practice setting. These brochures were, Health and Disability Consumers Advocacy Service (n.d.) and, Code of Health and Disability Services Consumers' Rights (n.d.).

It was explained that if the participant wished to anonymously report an incident experienced during his or her education, they could access the Advocacy Officer assigned to each particular hospital. Prior to giving any direct advice to participants regarding unethical or illegal behaviour or incidents shared within the research setting, the researcher would discuss it in full with her research supervisor and therefore receive advice on how to proceed. This option was not required.

Consent for research to proceed

As the researcher is a Massey University thesis student, ethics approval was sought from, and given by, Massey University Human Ethics Committee. Also, as Christchurch Polytechnic Institute of Technology was to provide the bulk of the funding for this research project, and that the researcher was an employee further consent to proceed was sought, and given, by Christchurch Polytechnic Institute of Technology's Academic Research Committee. Participants each gave consent that was informed by means of an information sheet and further verbal informal discussion between the researcher and potential participant. Each participant signed a written consent form. Participants also understood that they had a right to withdraw from the study at any time up until the end of the second interview, and their data would be destroyed.

Dissemination of the research findings

The research results are recorded in a thesis document and a copy held at Massey University library, Palmerston North and Christchurch Polytechnic Institute of Technology library. The main findings will also be published in a peer-reviewed journal as well as presented at, at least one nursing or ethics' conference. A summary of the main findings will be offered to all participants as well as to hospitals that have provided access, should they wish to receive these.

The contribution of this study to the health care context

Credibility and trustworthiness

In quantitative research, validity refers to how accurately the instrument used measures the concept being researched (Beanland et al., 1999). In qualitative research, validity refers to how accurately the research findings represent reality (Morse & Field, 1996; Roberts & Burke, 1989), and that the findings are a true reflection of the opinions or actions of the people in the study (Davidson & Tolich, 1999). This is referred to as

'credibility' (Beanland et al.; Cheintz & Swanson, 1986; Erlandson et al., 1993). According to Lincoln and Guba (1985), trustworthiness refers to the believability of a researcher's findings. What the researcher has done in designing, carrying out, and reporting his or her study is that which persuades the reader that the results are credible.

To ensure that this grounded theory is credible and trustworthy, the researcher has made a conscious effort to eliminate preconceived ideas, which are explicated and made visible in Chapter One and Two, about the phenomenon under study. Throughout the study, as suggested by Morse and Field (1996), data dictated the identification of concepts, not the researcher's personal biases and prejudices. Categories emerged from the informants and were not identified 'a priori' by the researcher (Creswell, 1994). According to Hutchinson (1993), quantitative researchers criticise qualitative research as being too subjective, and therefore see it to be inherently unreliable and invalid. Also maintained is the invalidity of informal and formal interviews because participants may lie, distort the truth or withhold vital information, thus biasing the data.

Hutchinson (1993) rebuts this by highlighting that within the grounded theory method, data are compared and contrasted again and again so as to provide a check on its validity. Further review of literature after the theory has emerged links the emergent concepts, constructs and properties of the grounded theory with existing theory and research. Hence as this particular grounded theory emerged, it was verified with the research findings of others (Holloway & Wheeler, 1996; Morse & Field, 1996), as well as the wider literature. This process of triangulation has been central to this research (Beanland et al., 1999; Davidson & Tolich, 1999) and thus gives the findings credibility.

Furthermore, for a grounded theory to be credible it must have explanatory power (Holloway & Wheeler, 1996). Analysis of the data given by participants has been pushed beyond description to explanation in that a core category has emerged and its sub-core categories. Within these, numerous codes and categories not only describe undergraduate ethics education in preparation to graduate as a registered nurse, it also explains the processes that participants engaged in to reach graduation.

To this end, it is deemed that the research has internal credibility and trustworthiness. External credibility must eventuate as other researchers endeavour to test the theoretical propositions explicated in Chapter Eight.

Transferability

According to Glaser (1992) and Glaser and Strauss (1967), findings can be transferred depending on their usefulness and 'fit'. Furthermore, transferability of findings may however, occur because of shared characteristics between settings and the human beings that inhabit those settings. Should readers of this research deem the findings to be useful and to 'fit' with their respective substantive environments then transferability can be opted for, as Glaser promotes (1992, p. 15), "Grounded theory provides a bridge to seeing the same problems and processes in other areas." Therefore, strategies to solve these problems may subsequently be implemented.

Summary

This chapter has explicated the underpinnings of both quantitative and qualitative research methodologies. It has been pointed out that quantitative research methods do not always reveal the textured nature of the lives of human beings and the contexts in which they live. Hence qualitative research methodologies have emerged to explore human phenomena in nursing. To this end, summaries of some previous qualitative research studies that bring to light the ethical context of nursing practice are identified. As little research has been done in specifically undergraduate nursing education substantive contexts, grounded theory became the chosen method to engage in researching undergraduate ethics education in preparation for practice as a registered nurse. It has been highlighted that grounded theory's intention is to bring to light the main concern of participants situated in the substantive area, and furthermore to reveal the basic social-psychological process that they utilise to resolve this concern. To this end, the following four chapters report the data, the analyses of the researcher and a vast array of emergent codes and categories. Finally, a core category emerges and is explicated.

INTRODUCTION TO THE DATA

The following conventions have been adopted within the data chapters and are presented here to assist reader interpretation.

Table 1 Key to the interview abbreviations

001 – 009	'code number' for each participant
/1 or /2	first or second interview
1-	line numbers within interview data
...	material edited
[ ]	insertion of additional material by researcher, usually explanatory
italics	researcher's question or comment
(field note)	Field note and date of reference

CHAPTER FOUR: DEVELOPING A PATIENT-FOCUSED ETHICAL PERSPECTIVE

It [ethics] can be from your family, the way that you've been brought up and the values and beliefs that your family instils in you as you grow up. However that's enhanced with nursing and the training that you have (009/1/184-7).

Introduction

Nine participants from the substantive area of undergraduate ethics education in New Zealand provided data for this study. This is the first of four chapters that reports the analysis and integration of substantive data. Various abstract constructs and categories emerged during constant comparative analysis. Field notes, analytical memos and related literature augment emergent constructs and categories. Throughout these chapters, key categories and supporting codes provide theoretical abstractions about 'what is going on' for participants during their undergraduate ethics education in preparation to practice as registered nurses.

This particular chapter seeks to explicate the notions of ethics and ethical practice prior to, and upon entering the classroom setting. It identifies that new entrants to a nursing degree programme bring with them personal knowledge and understanding of what is right and what is wrong and that this emerges from the beliefs, values and virtues developed during their upbringing and previous experiences. Throughout their nursing education these beliefs, values and virtues were honed so that upon graduation participants held professional beliefs, values and virtues. Furthermore, in the classroom, participants learned notions of ethical theory, which incidentally were perceived by participants to be insufficient, however, ethical theory, coupled with the law and cultural safety education, equipped participants with expected behaviours that were assumed to give care that was ethical. This chapter describes the professional values and attributes that were deemed by participants, to be essential constituents of ethical practice. These professional values, attributes and subsequent behaviours emerge as strongly 'patient focused'. Exploration of this 'patient focused perspective' will now ensue.

Developing beliefs, values and virtues

During data gathering, participants identified sources that had influenced their development of their held personal and professional beliefs, values and virtues. Three categories emerged that reflected these sources. These were, 'childhood upbringing', 'previous personal experiences' and 'inherent virtues'. These were seen by participants to be contributors to the formulation of beliefs, values and virtues that accompanied them into their undergraduate nursing education. It became evident that participants acknowledged their backgrounds, family values and life's experiences as precursors that influenced how they might want to behave as a nurse.

Childhood upbringing

Participants identified that they had developed beliefs and values that were a direct result of the upbringing that they had had. This process of early moral development occurred over time, beginning at birth.

> Most babies are born with a natural ability to be moral, but it is something that needs to be nurtured (004/1/93,4).

Another participant identified the nurturing aspect of the development of early ethical values.

> It's just like an upbringing thing and the way that you were raised. There's something out there besides nursing education that helps you, that fosters that respect for others (001/1/1170-2).

Woods (1997) also found that during early childhood cultural moral values are passed on from adults to children. Hence, for participants, sociocultural mores, including moral ones, were initially learned during their upbringing.

> You tend to establish, even though you probably don't know it at the time, the whole ethical thing while you are growing up. [Ethics involves] all those things that you can and can't do, why you can and can't do them and the consequences of those actions … like the things that you got in trouble for when you were a child (005/1/11-23).

Kohlberg (1981) too identifies early moral development as being facilitated by the physical consequences of action in that, "Avoidance of punishment and unquestioning deference to power are valued in their own right" (p. 17). Yet moral development is not only developed via consequences but also the values held by others around persons whilst they are growing up. This is evident in this participant's words,

> My mother is very caring and my Dad is too. My whole family is very caring. I guess you are brought up with that (009/1/206-9).

It is suggestive in the aforementioned excerpt that being brought up in a caring environment has meant that this participant had learned caring from those around her. Kohlberg (1981) identifies also that children learn moral values by following the examples of others. Thus, participants acknowledged that their upbringing had an influence on their held beliefs and values and that these accompanied them into their nursing education.

Previous personal experiences

According to participants, beliefs and values tended to be evolutionary. As participants emerged from their early upbringing, beliefs and values were further developed through personal experiences.

> What happens in your life … develops it (004/1/102-4).

And furthermore,

> Beliefs have come from my experiences and my upbringing and my parents. They've come from my family culture, my experiences when doing voluntary work and living in a different culture where I didn't speak the language. This was an incredibly disempowering situation. Personal growth gives you a little bit more understanding, and a little more empathy (002/1/965-88).

The previous excerpt indicates awareness that experiences can illuminate understanding and enhance empathy. Thomasma (1994) suggests also that as new challenges are met, values are not only formed but undergo re-establishing. Not only do, 'childhood upbringing' and 'previous experiences' further develop beliefs and values, 'inherent virtues' also contribute.

Inherent virtues

Participants had the view that ethics had an intrinsic element and that to be drawn to nursing, persons would have inherent virtues that reflected the assumed caring nature of the nursing profession. These virtues were understood to be in every good person.

> Maybe you have to have a sort of certain personality, be honourable, trustworthy and all those things that are inherent in yourself, but they are also inherent in every good person (005/1/310-3).

Sellman (1997) agrees that for an individual to be drawn to nursing he or she would have a general tendency toward certain virtues. He suggests compassion, generosity and caring. The following participant identifies that being moral has an instinctive element.

> You can learn about it [ethics] and learn how to be moral and what being moral means and what being ethical means. But I think to apply it in practice; you have got to have it pretty much instinctively (004/1/69-72).

Hence participants viewed those drawn to nursing as having already acquired virtues that would fit them for nursing. Participants went on to explain that nursing involved caring and therefore those drawn to nursing would be inherently 'caring'.

> I think that caring people, who like looking after [people], and want to do what's right for the person, are drawn to nursing (009/1/171,2).

Miller and Zamora (1990) also make the assumption that most students that come into nursing have some capacity for caring. Furthermore, Kolb (1984) identifies that learners bring with them some rough ideas in their minds about the subject or topic to be studied. Thus participants have identified that nurses bring with them into the profession, ethical beliefs and values formed during their childhood upbringing and previous experiences. Inherent virtuous qualities and a genuine desire to care for others in some way also accompany them. Participants' genuine desire to care for others is seen at this early point, in its embryonic form.

Developing Professional beliefs, values and virtues

Prior ethical knowledge and intrinsic virtues were seen by participants to be insufficient to practise as a registered nurse. Beliefs, values and personal attributes that were brought into nursing underwent a process of honing and fine-tuning. Indeed, Mayeroff (1971) too subscribes to the view that there are times when caring requires unusual aptitudes and special training. For participants, honing and fine-tuning of their inherent virtues facilitated the development of professional beliefs, values and attributes.

Honing beliefs, values and virtues

Substantive data reflected that participants were of the persuasion that their undergraduate nursing education honed and enhanced the beliefs, values and virtues instilled prior to their entry into nursing. Thus, participants linked prior ethical learning and the enhancing effect of nursing education as these next two quotes signify.

> I think that nursing education is a lot about honing of those skills, like polishing them and … giving them a 'nursey' direction. Everyone has personal virtues, some of them may not be as outstanding as others, but I think it's about polishing them and giving them nursing labels … (001/1/1291-6).

> There are definitely things that can be taught and can be nurtured and further developed through nursing training …(004/1/769-71).

One participant pointed out that others had said that he had changed.

> I know that some people have actually said that I have changed (007/1/370).

When asked what was different he added,

> I have just learned a wee bit more compassion and I have got more empathy (007/1/374).

The previous quote suggests that virtues can be enhanced and developed during one's nursing education. Hence, previously acquired ethical beliefs, values, attributes and a desire to 'care' underwent honing and fine-tuning during participants' nursing education. Thus professional values and virtues were developed.

Adopting professional values and virtues

From participants' perspectives, nurses were required to have a higher moral standing than others, which was assumed to be in keeping with the standards of the profession and expectations from society in general.

> Nurses have to be more moral than your average person on the street is … because of our profession we have got more responsibility than the average citizen has (004/1/14-22).

And therefore,

> We definitely have to be more moral than other people are and be more ethical (004/1/40,1).

Behaving in a way that was more moral than others in society was linked to the relationship that the nurse has with vulnerable persons. Part of the professional role of the nurse was protecting the vulnerability of those requiring nursing care.

> [In your role as a nurse you are] morally taking care of them when they are ill and they are doing something that is going to make them feel humiliated about later on. You make sure you care about them in that if they are running around stark naked, that being their behaviour because of their illness, morally you would try and save that person's dignity. So you go and take that person aside and try and get some clothes on them, so that they can keep their dignity (004/1/57-66).

Professionalism was seen to be morally taking care of patients who were vulnerable. Thus, the nurse had a special obligation to actively protect them. Lutzen and Barbosa da Silva (1996, p. 206) assert that, "The empathic nurse is one who has insight into the human experience of vulnerability and is aware of patients' vulnerability because of their dependency on others to make decisions that can be seen to be in their best interests." Hence, in participants' view, nurses take on some values that are higher, different, and more demanding of the self than if they were outside the profession of nursing. Being professional involved the adoption and development of professional values. Some examples are,

To be true to yourself and your patients (006/1/374).

Being honest (004/1/67).

Trust and loyalty (001/5/11).

Confidentiality (001/1/34).

Honesty … integrity and accountability (001/1/1280-4).

I want to be honest and fair (002/2/208).

Thus professional values were developed and virtues enhanced throughout three years of undergraduate nursing education, and reflect the expectation enshrined in law (Nurses Act 1977, p. 406) in that, "The person is of good character and reputation, and is a fit and proper person to be registered or enrolled in accordance with his [sic] application." This suggests that the newly graduated nurse be of good moral character. It also suggests links to virtue ethics, where action is motivated by the agent's virtue or good character (Lutzen & Barbosa da Silva, 1996)

Ethics knowledge

The following substantive data reflects participants' acquired knowledge regarding ethics theory. Participants' responses were closely aligned to traditional ethics theory. Almost all participants identified principle-based ethics (Beauchamp & Childress, 1994), which are, beneficence, nonmaleficence, autonomy and justice. One participant identified and offered an explanation of utilitarianism. When asked what their understanding of ethics was, participants identified the following theoretical concepts.

> [There are] Autonomy, beneficence, nonmaleficence and justice (008/1/19).

Some participants offered an explanation as to what these ethical principles might mean.

> Beneficence is obviously 'doing good' so trying to do something over and above what is happening at the moment. Nonmaleficence is to at least to do no harm. You may not be doing any good but you are just not going to cause any harm to anyone (008/01/36-40).

Autonomy is about choice.

> It is upholding the man's choice (007/1/257).

Autonomy was expressed as patient control.

> [Autonomy is] making sure they are in control but you are providing a bit of back up (006/2/93).

Explanations of the ethical principle of justice were linked to the law and fairness. This particular interpretation of justice was linked to the law.

> Justice, I figure is where in your own practice, what you would be doing would be legal (008/1/40-3).

The principle of justice was investigated further in follow-up interviews and links were made to fairness.

> Justice would be doing right for your patients and trying to make sure that everything is fair and that they are getting what they want and not what other people push on them and all the other things that come into that like helping them to be autonomous (006/2/89-91).

Essentially then, participants' understanding regarding justice was linked to the law and fairness.

> Justice is exercising fairness and obviously I think of the judicial system (002/2/24).

One participant named a further traditional ethical theory, that being utilitarianism.

> I don't remember a lot of flash names… I think it was Utilitarianism. We were looking at things [in class] like the 'greater good' and looking at what you do for the whole unit (008/1/514-7).

During initial interviews, one participant referred to codes of ethics when asked what the term 'ethics' brought to mind. No explanation was given as to how this might guide practice or the significance of a Code of Ethics.

> I think they [faculty tutors] tried to teach us about it [ethics] like the overheads and the handouts and spending time in class discussing the code of ethics and things (004/1/555-7).

Further exploration as to the significance of Codes of Ethics in follow-up interviews identified that they were used to guide practice.

> A Code of Ethics … I think of guidelines … something to base your practice on (002/2/28-34).

> A Code of Ethics … [At the beginning of my education] my understanding was that it was a board of people who decided what was good and what was bad but … towards the end my understanding would have been some principles governing practice (008/2/032-35).

Participants had some understanding of principle-based ethics theory. Codes of Ethics were understood to guide practice. This theoretical knowledge added to participants' held beliefs, values and virtues that they had brought into their nursing education. However, it became evident that participants viewed that this theoretical knowledge as limited, and indeed left them feeling a lack of ethical preparation for the practice setting.

Lacking ethics knowledge

Participants endeavoured to explain their understandings of ethics and ethical practice in theoretical terms and struggled to identify ethical constructs. They were clear in their expressions that there was a sense of significant 'lack' in their theoretical knowledge. Three sub-categories express this lack, they are 'lacking ethics theory', 'lacking ethical language' and 'lacking ethics preparation'.

Lacking ethics theory

Participants identified a lack of ethical knowledge and concurrent ethical equipping for entry into, and interacting with the ethical context of practice. Participants expressed concern over this perceived lack. Ethics being taught throughout the course was remembered by this next participant, however remembrance was vague.

> I guess there are those principles that they teach you, nonmaleficence and veracity, but I don't remember there being any specific classes on ethics. I just remember it vaguely coming through in places (006/1/538-40).

> I kind of know what it means in a round about sort of way (001/01/503-4).

This phenomenon of 'lack' regarding ethics education that emerged in interviews with participants, was further investigated in follow-up interviews, where there was an attempt to ascertain the number of hours that might have been spent learning theoretical concepts of ethics. Participants estimated between ten and thirty hours were spent in the classroom learning about ethics. The following quotes express this.

How many hours do you think over three years were spent on ethics?

> I can't really remember, maybe about 20 hours of it is teaching [ethics] (007/1/25).

> The actual topic of ethics itself, probably ten to twenty. It may have been more (008/2/210).

> Not very much ... we did a few papers that incorporated nursing ethics ... maybe actual class time, maybe 10 hours in the first year. We also looked at ethics and cultural safety ... we had some workshops ... we also looked at it indirectly, so maybe in total for three years maybe 30 hours. I guess that it is a high guess, but that is where I would put it (002/2/423-8).

Woods (1992), in a New Zealand context found that approximately 10 hours was spent learning about ethics in pre-graduate nursing education for the 16 nurses that he researched. He concluded that this identified a paucity of ethics education. Later research confirmed this apparent deficit (Woods, 1994). Johnstone (1999) recommends a minimum of 26 hours and that ethics should be taught separately. It seems that there is an improvement in the number of hours spent on ethics education since Woods' (1992; 1994) research, however, ethics education seems scattered throughout other courses and therefore falls short of Johnstone's recommendation of 26 hours separately taught ethics hours.

Overall, it was evident that ethics theory was taught in the classroom setting, however participants had difficulty in recollecting their classroom ethics education in theoretical terms. Participants expressed a lack in their theoretical understanding of ethics. They went on to express that they also lacked the ability to articulate an ethical viewpoint.

Lacking ethics language

Having limited theoretical knowledge regarding ethics engendered participants to feel constrained in articulating what ethics meant, as well as being able to articulate an ethical viewpoint, as this participant expresses.

> When I first heard you at the information session... I sort of thought, "God, I wouldn't know what to say." It is something that seems to be 'airy fairy', something that you can't really put your finger on ... I've had a think about it and I can come up with lots of examples of what ethical behaviour perhaps is. But it is still hard to define I think (006/01/4-9).

This participant also appears to have difficulty in articulating ethics.

> [Ethics is] something that you can't really explain (005/01/4).

Again, a lack of the ability to articulate an ethical point of view was highlighted.

> We only knew sort of like a dictionary meaning for those words [ethical principles] so it was quite hard to make an ethical debate with someone...you could bring it and say, "Oh well, what about nonmaleficence, perhaps you should be looking at that?" "That's how I would see it." But if someone asks or questions you about it you can hardly argue a point on the amount of education we got on them (008/01/60-5).

Quinn (1990) would agree with this participant in that what is taught in the classroom and the related experiences in the practice setting, should facilitate learning how to reach a decision and also how to defend it as ethically appropriate. Niven (2000) also contends, "Nurses must be able to articulate and defend the decisions they make when facing ethical dilemmas" (p. 13). Data suggests strongly that participants lacked theoretical knowledge of ethics and identified a lack in the ability to articulate an ethical point of view. This resulted in an overall sense of a lack of ethics preparation to match the practice setting.

Lacking ethics preparation

When one participant was asked whether she felt prepared for the ethical challenges 'out there' she replied,

> No, not at all! That's why I want to take some more education on it (008/1/513).

This participant summed up by saying,

> I feel unprepared for the ethical stuff out there (008/01/512,3).

Another participant expresses, when analysing her ethics preparation for practice as a registered nurse.

> [It's] lacking. [It's] lacking because I can't tell you what I'm supposed to know … I remember my first year learning briefly about, and not very much, nonmaleficence and beneficence and it went under this tiny heading. I don't think I added anything to it over the three years (001/1/626, 631, 962-4).

It seems that student nurses get a 'snap shot' of formal ethics education and are therefore unprepared for ethical debate *(field note, 10.5.02).* This is an issue that requires addressing by nursing education and will therefore be reconsidered in Chapter Eight. Participants were exposed to some traditional ethics theory in the classroom during their three years of undergraduate education. According to participants, this preparation was inadequate to meet the challenges in the practice area and to articulate an ethical viewpoint.

Ethics and its relationship to the law

Two categories emerged that reflected participants' perceptions of the law and its relationship to ethics. On the one hand, 'adhering to the law' was seen to be a requirement of ethical practice, on the other 'considering rule-bending' also emerged as a way of circumventing rules and regulations when the law was deemed to constrain ethical practice. Participants did identify however, that there were legal constraints that ensured a society's norms had at least, some consistency, as "the law is a body or system of enforceable rules developed to govern the members of society" (Burgess, 2002, p. 1). This was evident when ethics was linked to the practice setting and demonstrated awareness that there was a relationship between law and ethics (*field note, 27/4/02)*. The law could potentially pose a problem for the nurse who grappled with the legal parameters of practice and the needs of the patient.

Adhering to the law

The following examples indicate participants' awareness of the legal parameters pertaining to their practice and that the law must be adhered to.

> Obviously, the law is your base anyway. Upon that are your principles and scope of practice. You are not going to perform an operation yourself. It is not within your scope of practice (005/01/325-7).

Some things were identified as illegal and therefore should not be done.

> Obviously there are certain things that are illegal, like killing someone (004/01/137,8).

> You're not allowed to help with euthanasia (002/1/10,11).

Contravening the law could result in the loss of registration as this participant points out.

> Perhaps the law tends to dictate your ethics and how you work. Obviously, otherwise you would lose your registration. So within that, you make your own decisions (005/1/240,1).

There is evidence here to suggest that participants considered the legal parameters of their nursing work and that the law was to be considered when making ethical decisions. Hence for participants, there was a connection between the law and ethics. There were times however, when the law might constrain ethical practice and this posed a dilemma for participants. One way to circumvent this quandary was 'considering rule-bending'.

Considering rule-bending

Participants understood that there was a clear link between ethics and the law, however there were times when they questioned the law's suitability for the individual. The law could constrain the nurse in the provision of care that was ethically appropriate for the individual patient. Some participants identified that they would engage in rule-bending for the sake of the patient and that this was the 'right' course of action in that it was ethical. Here are some examples of participants grappling with the law and the relationship with the patient.

> What's right may not necessarily be legal (009/01/6).

The following excerpt indicates a grappling with the law on one hand, and maintaining the nursing relationship on the other.

> Say for example, you are aware that a person smokes marijuana. You are meant to report it, but you choose not to for the benefit of the person … It is the individual case you see, everyone is so individual, and the circumstances are so different. You are not going to destroy your nursing relationship with them if you actually 'dob' them in. So for the benefit of everyone, the community included, it would not be wise to actually do that so … it is a tough call (003/01/26-39).

Thus, in the eyes of participants, the law could constrain ethical practice and rule-bending was considered as an option so that the nurse-patient relationship was not

damaged. One participant identified that he had engaged in rule-bending as a student nurse.

> [In the hospital that I was a student in] they had a policy that stroke victims had pureed vegetables and others did not. One chap wanted pureed vegetables with his corned beef [he had not had a stroke] ... the nurse said, "No!" ... But the man wants them with his corned beef. He always has them ... I thought that there was no reason for it. It was a power thing ... so all I did was go along with it and then went down to the kitchen later and changed over the menus (007/1/242-52).

Hutchinson (1990) first identified rule-bending amongst nurses. Rule-bending addresses an underpinning phenomenon where, "A conflict exists when the accepted rules in a given situation prohibit nurses from doing what they believe is in the patient's best interest" (p. 7). Hutchinson identifies that when nurses break the rules for the sake of their patients, nurses' behaviour is 'responsible' because they use their best nursing judgement to choose which rule to bend. They also choose when and how they will do it. In converse, rule-bending is 'subversive' when nurses violate rules made by doctors, institutions and administrators. It is then not surprising that participants in this study also describe rule-bending behaviours they believed to be in the patient's best interest. Hence, from the view of participants there might be times when ethical practice contravened the scope of the law.

In a follow-up interview this following participant was asked if she would ever consider breaking or bending the law. She replied,

> It would depend greatly on the patient's wishes and if I thought I would be able to justify it within myself as well as to a council or Board of people who would decide as to whether or not I would keep my registration (008/2/398-400).

Participants in this study linked ethics to the law and identified that the law placed legal parameters upon their work. Data suggests that the law was considered when ethical decisions were made however, sometimes the law was deemed unethical for the individual. Furthermore, participants in this study identified that they would consider engaging in rule-bending to protect the relationship that they had with the patient, thus indicating a commitment to the nurse-patient relationship.

One further category emerged that participants identified was linked to ethics and ethical practice, was cultural safety.

Ethics and its relationship to cultural safety

Throughout the research there were numerous times when participants linked ethics and ethical practice with the concept of cultural safety. According to participants, there were similarities between ethics and cultural safety, as the individual was to be respected and this involved respecting their beliefs, values and needs. It was deemed important that participants would need to understand where others were coming from and that their cultural backgrounds differed and needed to be respected. This involved being non-judgemental, and not making assumptions about patients. Five sub-categories reflecting participants' understanding of cultural safety, follow.

Unique to nursing in New Zealand

The concept of cultural safety was identified as being unique to the New Zealand context.

> I guess if you take it [cultural safety] out of New Zealand, and because it refers to the Treaty of Waitangi and Maori and that we are in a bicultural society here as opposed to multicultural. I guess if you took it out of New Zealand it would be different. The ethics and the cultural safety would be different or the syllabus might need to be changed to suit that particular country (009/1/964-9).

Cultural safety was taught in the classroom.

> Cultural safety … is a theory or an approach that we learnt a lot about at Polytech (008/2/330-1).

NCNZ (1996a) states, "The applicant practises nursing in a manner which the client determines as being culturally safe" (p. 8). Cultural safety was introduced into nursing curricula in 1990 (NCNZ, 1996b). It would follow then that cultural safety should be taught in nursing schools so as to meet NCNZ requirements. Education regarding cultural safety was seen to enhance ethical awareness.

> Cultural safety makes you more aware of the ethical component, and then there are the other general ethics like beneficence and nonmaleficence (003/1/284-88).

Hence cultural safety was identified as unique to New Zealand and linked to ethics.

Focuses on the individual

Participants underwent cultural safety education in the faculty setting. This directed them to focus on the individual and to respect their needs. For these following participants, cultural safety focused on the individual.

> I was educated very much to believe that it [cultural safety] is just about an individual and about nursing people individually (004/404-6).

Cultural safety was linked to providing care that met the needs of each individual patient. Underpinning the concept of individualised care was the assumption that the nurse-patient relationship would be enhanced. Cultural safety also involved appreciating difference, rather than being judgemental toward difference.

Involving difference

Exploring and appreciating difference was initiated by faculty emphasising exploration of one's own culture. This participant realised that her own culture had differences to other cultures as she expresses,

> They [tutors] emphasised [looking at] our own culture, so you apply it to yourself and that is where you start thinking about your own culture and … hey … this is what we do and this is what they do and … oh … that is different (004/1/469-72).

This next participant's excerpt identifies an emphasis on others being different.

> Well, you have got to understand that they come from a different place and that they have learnt different things and different ways (006/1/831,2).

To enact cultural safety, difference was to be respected.

> Respecting another's culture and where they are coming from, that they will have differing opinions and realities (004/1/55-8).

Interestingly, participants focused closely on the notion that others were different. However, as Ramsden (1995) attests, "Cultural safety was designed to focus on the nurse as the bearer of personal and corporate culture, attitudes, preconceptions and power" (p. 2). Thus the nurse is a culture bearer. This notion was more obscure.

Refraining from making judgements or assumptions

According to data given by participants in this study, it seemed participants wanted to give culturally safe care. This entailed abstaining from making judgements or assumptions regarding patients, and to establish a therapeutic relationship that will benefit them, for example,

> [If] someone is in the sex industry and your morals have been, "Oh my goodness!" You know, like prostitutes … they are all dirty and they are bad people and they are out there sleeping with everyone's husbands and this and that and you actually begin to nurse someone that works in the industry and you realise, "Wow!" … You become more culturally sensitive and you think, "That

> was actually quite bad to generalise." Just because she does that for a living ... you realise she is actually a great person and who knows what background she has had that has pushed her into this industry (004/1/594-601).

Interestingly, and perhaps inadvertently, the above participant begins by checking any judgemental thoughts and conclusions she may be formulating, however, the final phrase is telling, in that an assumption has been made that the prostitute has been pushed into the industry. This indicates how difficult and challenging it is to, not only suspend one's own judgements, but to be mindful of them in the first instance. Participants did however indicate that judgements needed to be withheld.

> Cultural safety is about treating people with respect. It is getting alongside them. It is about not making judgements (002/1/288-90).

Therefore the need for 'culturally safe' care must be ascertained.

> It makes it a bit tricky, but it also goes to show, you can't judge a book by its cover. You can't make assumptions. You should check it out first, which you should do anyway with anyone because some cultures or religions and things that you can't see (005/1/920-24).

Finally, and Jeffs (2001) agrees,

> [Cultural] safety is defined by the person that you are in partnership with (002/1/322).

As participants expressed their understanding of 'cultural safety' it was evident that focusing on the patient was fostered during their 'cultural safety' education. To provide 'safe' care, participants understood that each individual had differing needs and that there was a need to ascertain what the patient's needs were. 'Cultural safety' education could thus be said to have the potential to develop moral awareness and motivate ethical practice. It is evident in the data that 'cultural safety' was believed to enhance the nurse-patient relationship. A by-product of this process was a developing relationship with the patient and a positioning of the nurse from which he or she could engage in ethical practice. Thomasma (1994) offers, "A relationship is the most elusive of all realities, yet the most important to human beings" (p. 94). How participants further pursued the nurse-patient relationship ensues.

Ascertaining needs

This category emerged as a mental and physical characteristic pivotal in guiding ethical practice. From the data it became evident that participants used a variety of ways in which to find out what a patient might need in specific situations. Early in their undergraduate nursing education, participants essentially engaged in 'ascertaining needs' as expressed by the patient. 'Ascertaining needs' focused on needs that the patient themselves expressed to the nurse. These ways are reflected in the following sub-categories.

Focusing on the patient

In quest of 'ascertaining needs', participants turned their attention toward the patient. The following quote demonstrates an ethical commitment to the patient and what they might express as their needs.

> Ethics is about … finding out what they need and what they might want. [It is finding out] what these people want to achieve and working with that (002/1/265-8).

'Focusing on the patient' seemed to be a deliberate act to find out what the patient might need and what might be 'going on' for them. Mayeroff (1971) articulates, "Only by focusing on the other am I able to be responsive to its need to grow" (p. 21). When the nurse finds out what is going on for the patient that can then motivate nursing actions that are congruent with what the patient might need.

> Ethics, I suppose is about doing right by the patient in nursing (009/1/8).

Central to nursing practice is the patient (Melia, 1994). This participant states that the patient should come first.

> Patients come absolutely first … that is your grounding and from there you work up … we are here to help our patients, they come first and everything else is secondary to that (002/2/9-14).

And where did you learn that?

> At Polytech (002/2/18).

Hence, as participants showed a commitment to finding out the patient's needs, this initially entailed 'focusing on the patient'. The information gained was seen to motivate ethical practice, in that care given would reflect congruence between the patient's needs and the actions that the nurse might take. Blumer (1969, p. 66) asserts,

"Symbolic interactionism involves *interpretation*, or ascertaining the meaning of the actions or remarks of the other person and *definition*, or conveying indications to another person as to how he [sic] is to act." It can be supposed then, that as the patient expresses his or her needs; the nurse interprets that expression and acts accordingly. Thus, 'focusing on the patient' was the first step in 'ascertaining needs'. The second step was 'spending time' with patients.

Spending time with the patient

Participants, whilst they were students, were in a unique position in that they had a significant amount of time that they could spend interacting with one or two patients. The time spent inadvertently contributed to developing the nurse-patient relationship. The four substantive codes, 'facilitating healing', 'creating a bond', 'listening' and 'being there', reflect the characteristics that contribute to this sub-category. It appears that participants were in a privileged position, in that they generally had fewer patients than the registered nurses that they worked alongside. Essentially then, participants had the time.

> I was a student and didn't have much to do. If you're a student you only have one patient (001/1/780,1).

In follow-up interviews participants were asked specifically how many patients they cared for at any one time. Examples of a reply are,

> In year one we had one patient (002/2/381).

> [In the] first year we had one initially. I think we were up to two by then end of it when we were doing our practical. In the second year I had two or three patients ... by then I was having four, but they were quite light patients, I might have one that was a wee bit heavier and probably three that were really quite light. Towards the end I had a full load (008/2/109-12).

'Having time' as a student facilitated finding out what was worrying the patient as this participant found.

> Well, as a student you got to talk to them quite a lot and you had more face-to-face contact with them and you got to talk to them and find out what was worrying and concerning them (006/2/136,7).

Being allocated a reduced workload enabled participants to spend time with their patients. As participants spent this time, they were able to focus on the patient, and this contributed to 'ascertaining needs'. Within the above quote, it seems evident that the

participant views 'spending time' as a way of facilitating the patient to express their needs. 'Spending time' with the patient also provided an environment conducive to 'facilitating healing'.

Facilitating healing

Participants also believed that 'spending time' with the patient could have a positive impact on the patient's ability to recover from their health-related episode.

> You can actually spend time [with the patient] and that makes a difference (005/1/442/3).

'Spending time' with the patient was not only perceived to make a difference but also to promote recovery.

> I think you can always make time to ask or to slow things down to ensure that they understand. It's only a couple of minutes. It is not going to take half an hour or anything like that. Whilst you are doing that you can prepare for other things. The more people know about what is happening, the happier they are about it and about the outcome and they will probably recover better (005/01/69-74).

For participants, 'spending time' could enhance recovery. Euswas' (1991) research amongst 30 patients with cancer identified that there was a therapeutic effect on the patient, "When the nurse and the patient realise the caring moment is occurring" (p. 150), as there is an exchange of warmth, respect and fulfilling of patient's needs. So, 'spending time' with the patient contributed to 'facilitating healing' it also contributed to 'creating a bond' with the patient.

Creating a bond

'Spending time' with the patient was seen to create a bond, and hence a relationship. Because of that, this participant endeavours to ascertain and act on what the patient expresses as his or her needs.

> They tell you a lot of stuff too. They disclose quite a lot. I guess that is why you feel quite a bond towards them, to do what they want. I mean if you were only with them five minutes a day, it would be very easy to say, "Well, I know what's best (008/01/198-201).

Generally, participants had the luxury of time that could be spent with the patient. This time was conducive to 'ascertaining needs'. Participants perceived that sustained contact with the patient resulted in the patient confiding in the nurse. 'Spending time' with the patient assisted the nurse in ascertaining what was important to the patient. Providing the patient with a 'listening ear' meant that when the patient

expressed their concerns, wishes, and needs, the nurse thus learned of them. This assisted in engaging in actions that might ethically meet the patient's needs. The next substantive code encapsulates 'listening'.

Listening

'Listening' to the patient was another way of 'ascertaining needs'. 'Spending time' with the patient meant that there was the unspoken message to the patient that he or she was important and could share their troubles or concerns. Concomitantly, the nurse 'listened'. Sometimes a cue in the patient's clinical notes provided a springboard to find out what out what is going on for the patient, as the following participant found.

> So I guess it is just a matter of being friendly and perhaps if you have already read the notes or know something about that person, you know something is on their mind at the moment. Then you can discuss that with them. You can start bringing that into it and asking them how they feel about something. They feel then that you have listened to them and that you have obviously got an interest in them (008/01/421-28).

Christensen (1990) defines 'listening' as, "the nurse's work of concentrating on what the patient is saying and taking heed of this" (p. 42). It seems evident that participants too concentrated on 'listening' to the patient and valued making the patient's choices count, as this participant expresses,

> A lot of these patients that come into the hospital, they are sometimes not listened to, and their wishes or their choices don't matter or don't count (005/001/63,4).

Within the nurse-patient relationship, 'spending time' and 'listening' assisted in 'ascertaining needs' and was believed to make a difference to the patient's experience of their care. 'Being there' was also valued.

Being there

Another aspect of 'spending time' with the patient entailed 'being there' as opposed to engaging in a nursing intervention. The following quote is evidence of this.

> You can actually spend the time and that makes a difference. Just being there (005/01/422,3).

Christensen (1990) also found this concept to be evident amongst nurses and names it 'being present'. Christensen also links 'being present' as a component of 'spending time' with the patient. 'Being there' for participants, seems to have an altruistic component to it. This quote reflects this.

> There is a big difference between the ones that go to work and get paid and get the money and go home and the ones that stay afterwards and hold the patient's hand for ten minutes (006/1/505,6).

Swanson (1991) too found 'being with' central to caring and involved becoming emotionally open to the other's reality and what the patient might be experiencing. According to Swanson, what the patient might be experiencing 'matters' to the one caring. It seemed to matter to participants as well. In the following example it is evident that the participant values time spent 'being with' the patient.

> I'll grab my notes (it was quarter past ten at night) and write them whilst sitting beside the patient. She [the patient] didn't have to talk. She could every now and then, but it was the company. That extra little bit of time. Perhaps it will make the person sleep a lot better that night (005/01/949-54).

The nurse 'being there' for the patient was also recognised by Benner (1984) in her research amongst registered nurses. Benner refers to it as 'presencing'. According to Benner, 'presencing' is not so much about 'doing for' the patient, as it is 'being with' the patient. For participants, 'being there' for the patient was believed to enhance their health. It also denoted a commitment to the patient that valued the connecting of two people, the nurse and the patient, on an emotional level. This enhanced the nurse-patient relationship. In 'ascertaining needs', participants also engaged in 'identifying' with the patient.

Identifying

Participants referred to a further way of 'ascertaining needs' and that was by 'identifying' with the patient, or their family respectively. This assisted in attempting to envisage needs from the patient's perspective. Participants utilised this ethical approach, as is evident in the following data.

> Right from year one [in the nursing course] especially during Gerontology I always used to think, "Would I have liked that if someone treated my grandmother like that?" I am not my grandmother but I always think about how I would feel if it was a family member, or how would I feel if it were me. That is my perspective (008/1/170-6).

This next participant confirms this notion.

> You are sort of imagining yourself in that sort of situation (006/2/182).

This ethical approach might be likened to utilising the golden rule, as Wattles (1996) explains, "The practice of the golden rule sometimes involves an explicit

imaginative role reversal, putting oneself in the other person's situation" (p. 19). 'Identifying' was utilised to assist in ethical decision-making:

> [I contemplate], if this was my grandmother or mother what would I have done? I think that's how I make decisions sometimes, even if they are only small ones (009/1/176-8).

Thomasma (1994) promotes acting toward individuals, as one would want them to act towards themselves, this being a fundamental principle in the healing relationship. This next quote reveals a cognitive effort to check behaviour according to how the participant might like to be treated.

> Is that the right thing to be doing? Would you want that to be done to you (001/01/1164)?

It seems clear from the above data that participants adopted an ethical approach that attempted to ascertain what the patient might need by 'identifying' with the patient. Mead (1934) himself refers to this concept by saying, "It is the ability of the person to put himself in other people's places that gives him his cues as to what he is to do under a specific situation" (p. 270). According to Noddings (1984) the ability to 'step out' of one's personal frame of reference into that of the other is a characteristic of a caring relationship. It is becoming increasingly evident, that for participants, caring is embedded within the nurse-patient relationship. Categories and codes to date reflect this intangible characteristic. Several sub-categories and substantive codes that formulated the category of 'ascertaining needs' have been thus far explained. Participants, on numerous occasions said that 'respecting' the patient was important. This category will now be explored.

Respecting

According to the Collins Pocket Reference English Dictionary (Collins) (1992) respect means to treat with esteem and to show consideration for. Participants' highly valued respecting the patient and this was shown in a number of tangible ways. The following two sub-categories explain how participants demonstrated their respect.

Being professional

'Being professional' entailed adopting behaviours that reflected the essential values assumed to be demonstrated by the professional nurse. The following participant observed behaviour that she deemed to be, not only unprofessional, but immoral as well.

Hence professional values within the profession reflect what is deemed to be ethical practice. She states,

> [Patients] still had a right to go in there and be treated fairly ... not only at 'handover' but anywhere in the hospital ... I wouldn't sit there and talk about how fat a patient was and laugh about it ... To me, that is not what nurses do (004/01/246-52).

Part of showing respect to the patient was that disparaging comments were not to be made behind the patient's back, but also that derogatory remarks should not be said in front of the patient. 'Respecting' the patient was also about valuing the person as a human being and being regardful of their impaired intellectual or physical functioning.

> He [the caregiver] was talking in front of the patient about how he was a vegetable and how there was nothing left for him and how he may die early because of pneumonia. He was talking about his life right there in front of him. I realised at the time and I thought, 'Oh my goodness, this is so wrong. I can't believe that we are having this discussion in front of this man" (001/01/877-883).

'Being professional' entailed protecting the dignity of the patient as this participant explains,

> [Behaving professionally would include] covering them up when you are washing them and making sure that the curtains are pulled around and sort of making sure the gown has not slipped off their shoulder (006/2/431,2).

'Respecting' involved behaving in a professional manner. This entailed refraining from gossiping 'behind the patient's back' and taking care in what was said in front of the patient. What was said to the patient was also to be said in a respectful manner. In a sense it seems that participants valued protecting the patient's dignity. A commitment to the patient is emerging where participants move toward the patient in an attempt to apprehend their reality (Noddings, 1984). Perhaps, if you were committed to someone, it might be unlikely that you would make derogatory comments about them or want to hurt their feelings in any way.

Findings of a study amongst 23 senior baccalaureate nursing students (Kelly, 1990), suggested that respect was identified as a professional value and an expression of what the ideal nurse would do. Respect was shown to a patient by listening, being honest and treating the patient like a human being. Furthermore, participants in this study also valued 'maintaining confidentiality'. This sub-category will now be explored.

Maintaining confidentiality

Participants identified an historical principle in nursing, that of confidentiality. Situated in the Nightingale pledge is the phrase, "and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my profession" (McBurney & Filoromo, 1994, p. 72). The Code of Ethics (NZNO, 1995), when outlining respect as an ethical principle also promotes confidentiality as an underlying value of the nurse-patient relationship and thus an underlying value of the nursing profession. It is evident that participants also saw 'maintaining confidentiality' as an ethical responsibility that the nurse had toward the patient.

> I think this is like something you learnt like about confidentiality. It's the patient's own information. There's confidentiality and respect and somewhere I obviously learnt about respect because it is just so huge in my mind (001/01/887-90).

Confidentiality involved personal privacy and keeping one's voice down. This was learned in the classroom setting.

> I remember in those clinical practice units, I think you learn about things in there, like about a hospital ward, about keeping your voice down. I think that you learn about that in a theoretical sense, because I can remember that being stressed as quite important you know, knowing that you should have curtains between you and the next person and that privacy's lacking. You need to do that and consider basic privacy, respect for the person (001/01/901-9).

Confidentiality was then utilised in the practice setting.

> Things like confidentiality and privacy and honouring a 16-year-old that has had an abortion not to tell her parents (006/1/213,4).

An aspect of 'respecting' was 'maintaining confidentiality'. Respect was reflected in how the patient was spoken about and how they were spoken to. Participants demonstrated a high level of respect for the patients that they were caring for. Because of this respect they valued keeping patient information confidential.

Promoting autonomy

Thus far, how participants pursued the nurse-patient relation has been unveiled in the two categories, 'ascertaining needs' and 'respecting', characteristics of each being revealed further in sub-categories and codes. There is a third category, that of 'promoting autonomy'. It involves the sub-categories of 'informing', 'sharing power'

and 'advocating'. Yet again, several codes support these sub-categories. Initially, promoting self-determination and the uniqueness of each individual was valued.

> People need to be separate. They need to achieve things for themselves and have ownership. You can't just make blanket rules (002/01/260,1).

Ownership included control and autonomy over one's body as this participant suggests,

> It's about the patient having control and autonomy over their own body (001/01/598).

For patients to maintain their separateness, control, and autonomy it was deemed important by participants that the patient, not only needed to be kept informed, but also that the health professional gained informed consent. Informing the patient is characterised by the substantive codes of 'facilitating understanding' and 'finding out'.

Informing

Informed consent was paramount in ethical nursing practice and surfaced as a strong code that supported the autonomy of the patient. 'Informing' the patient of their options and offering choices were valued highly by participants. It needs to be taken into account that recent emergence of the Code of Health and Disability Services Consumers' Rights 1996, may have some bearing on the strength of this substantive code. After the Cartwright Inquiry in 1988, and the subsequent Health and Disabilities Commissioner Act 1994, highlighted and reiterated the obligations of gaining informed consent from patients as a legal requirement. This is reflected also in Competencies for Entry to the Register of Comprehensive Nurses (NCNZ, 1996a) and states that the nurse, "Ensures that each patient is fully informed to maximise the potential for decision-making and choice" (p. 4). Thus it would seem that informed consent would be taught in the faculty setting, and it was.

> Talking to the patient and gaining informed consent are obviously covered in our three years of study (005/1/81,2).

This was confirmed in follow-up interviews by the following quote.

> Informed consent was discussed quite often in the first year, and especially when you are dealing with the elderly. You are trying to put that into practice, the whole informed consent [thing] and trying to ask all the time before you did things (008/2/258-60).

When further questioned on the above participant's understanding of what informed consent entailed, she pointed out,

> It is also giving them the right to say no to staff too, and trying not to coerce them (006/2/372).

The law supports participants in their understanding of informed consent. According to the Code of Health and Disability Services Consumers' Rights 1996, consumers have the right to be free from discrimination and to make an informed choice. Data revealed that participants were told of informed consent whilst in the classroom setting. Their understanding of this concept is explicated in the next substantive code, 'facilitating understanding'.

Facilitating understanding

Informed consent involved a full explanation followed by the nurse asking permission.

> You would explain to the patient as to what you are about to do or what you want to do and the reasons behind it and then ask them if that is okay (008/2/275,6).

Ensuring consent was informed, and that understanding had been facilitated, also entailed consideration of other treatments that the patient might wish to use prior to consenting to interventions traditionally offered by the hospital setting, for example,

> It is also giving them the right to use acupuncture and all the complementary therapies that they might want to use. They are entitled to use those. It is their right to go and investigate those before they agree to surgery or some other sort of intervention (006/2/373-5).

Furthermore, to facilitate adequate 'informing', this participant concludes that,

> It's giving them lots of information so that they can choose. [It's about] an informed choice (006/2/376).

According to the participants in this study, informed consent was an ethical requirement of practice. Less emphasis was placed on the legal requirements to gain informed consent. Legally however, participants were correct in their rendition of informed consent in that, "Before making a choice, or giving consent, every consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent" (Code of Health and Disability Consumers' Rights 1996 (p. 3). It is probable that recent changes in the law in New Zealand have influenced the strength of this code. If, as part of the 'informing' process, participants could not answer the questions that their patients asked they proceeded to attempt to find out.

Finding out

This substantive code reflects the energy that participants invested into informing' the patient. If there were something that they did not know, they would go and find out.

> If you can't answer anything ... you go and look it up ... or you go to someone who knows exactly what's going to happen to him or her so things aren't a surprise. It should be quite clearly spelt out for them (001/01/573-8).

Part of 'informing' was the commitment by the participant to find out the answers to any questions that the patient might have. Finding the answer and bringing that back to the patient contributed to 'informing'. This is an example,

> I have learnt so much by saying, "I don't know." "I will go and find out." It means then that you are teaching them [the patient] and you are also teaching yourself at the same time (006/1/465-7).

This participant confirms this data in a follow-up interview.

> [If] I don't know the answer I am quite willing to say that I don't know and I will find out (006/2/395).

'Finding out' not only facilitated choice and consent that was informed but it enhanced the learning of participants as well.

Within the sub-category code of 'informing', the substantive codes of 'facilitating understanding' and 'finding out' reflected the commitment that faculty and participants had in informing the patient and gaining consent. 'Informing' was a vehicle that promoted autonomy. Informed consent is enshrined in law and it was also taught in the classroom to prepare participants to meet Competencies for Entry to the Register of Comprehensive Nurses (NCNZa, 1996). Participants subscribed to the view that consent must be informed and they attempted to ensure that this occurred. A further sub-category that supports the category of 'promoting autonomy' is 'sharing power' with the patient.

Sharing power

Participants were dedicated to 'promoting autonomy' for patients and there seemed a general consensus amongst them that health professionals *per se*, had more power than the patient. This participant expresses this notion.

> You can say all the right words but you are still operating within the paternalistic framework. Although we empower our patient, we still have complete control

> over what information they get or we care to give. Even though there has been a power shift ... I think we are certainly moving in the right direction. But in a paternalistic system, we still hold most of the power. We have all the information and the knowledge (002/01/349-54, 364-71).

Indeed, in the profession of nursing there is a greater awareness of the potential power that the nurse can have over the patient (Darbyshire, 1993; Ramsden, 1990a; 1990b; 1990c; 1992; 1993). This is quite possibly further fostered by cultural safety education in New Zealand nursing schools (NCNZ, 1996b), and more recently, Ramsden (1995, p. 21) has stated in regards to cultural safety, "It should be taught as a power analysis, for to earn a patient's trust you have to shift the power base." Incidentally, Mayeroff (1971) suggests that within the caring relationship the 'care-er' and the 'cared-for' should exist on the same level. However, Lupton (1995, p. 160) argues that within social relationships, "there is never an absence of power." Thus, in an endeavour to balance out the power between themselves and the patient, participants subscribed to 'consulting' and 'helping decision-making'.

Consulting

Mostly participants did not agree that the patient's own wishes were not consulted or respected. It seems apparent that they did not support the idea that health professionals made decisions about the patient without consulting with them or their family, or conversely, that the health professional might over-ride the wishes of the patient. The ensuing quote demonstrates this.

> Quite often the medical staff would make up their minds who was and who wasn't [for resuscitation in event of cardiac arrest] and then tell the family which way to go and then get them to sign the form. I don't think that there was a lot of discussion about it ... I didn't think it was up to them [the medical staff to decide] who had quality of life and how long that person should live for (008/1/91-100).

Clearly from the above incident, the participant was unhappy about the lack of discussion and the family being told which way to go. The participant also confronts a potential dilemma for health professionals as to whether to engage in paternalism or to act according to the expressed wishes of the patient. Clearly, for the participant, discussion with the patient was paramount. Essentially, collaborating with the patient is a way to ensure care is patient-focused and also minimises paternalism (Lindeke & Block, 1998). Power, according to Euswas' (1991) research amongst 30 patients with cancer was, for these patients, a realisation of regaining control. To assist the patient in

regaining control in the following excerpt, the participant sees her role as a facilitator and advocator. She is the most comfortable when the patient has more power.

> If I can be in a situation where the patient has more power and I am the facilitator and advocator rather than [the situation where], "I am the nurse, you have just had a tonsillectomy and this is what you need" (002/01/580-2).

According to Beauchamp and Childress (1994) the medical profession has enjoyed the freedom to decide what was in the patient's best interests and to make this decision for them. Over the last thirty years this has been challenged and assertions of autonomy rights have cast doubt on the validity of paternalism. Thus tension between medical beneficence and promoting autonomous decision-making has ensued. Clearly participants have adopted the latter. This next participant, in a follow-up interview reiterates this substantive code of 'consulting'.

> [It is about] asking, consulting, talking to the patient instead of over them or at them or about them. It is recognising them as a person (006/2/428,9).

Participants valued consulting with the patient regarding any choices that needed consideration. Patients' choices were to be supported. Clearly participants were uncomfortable about the lack of discussion with the patient and their family. Participants also began to see that patients were not always consulted fully prior to decisions regarding healthcare were made. Clearly, for the participants, discussion with the patient was paramount. Beauchamp and Childress (1994) point out that the principle of beneficence and subsequent paternalistic actions of the medical profession can be tempered by incorporating the patient's autonomy in that the patient's preferences help to determine what counts as a medical benefit. Hence participants valued 'helping decision-making'.

Helping decision-making

Participants did not subscribe to the view that patients were told what was going to be happening to them as opposed to being informed of the options and choices being offered. They did not value rushing the patient and therefore disallowing time to think through the options available to them. This participant values 'spending time' with the patient when there was a decision that needed to be made regarding that patient:

> I just thought the way it was discussed and the amount of time given to it was inadequate. Quite often they would call the House Surgeon to do it [gain consent for a 'not for resuscitation' order] and they would be out of the ward in five to ten minutes. I would think this is a decision where a family or a patient makes a

> decision about what is going to happen to them if something goes wrong. I think that five or ten minutes aren't really enough to make a decision like that (008/1/112-8).

As identified earlier, participants did not support talking behind the patient's back. It was important to them that issues were discussed openly and that the patient was fully involved in the decision-making process as this participant points out.

> ... Nurses are involved with patients and their families and it is important that they don't speak behind their back. Although sometimes it is important to get that information, but not to be making decisions with the family [exclusively], to gather information yes, but always take it back to the patient, everything, I think (008/01/645-9).

Involving the patient in decision-making was an active process. Essentially, in the following excerpt the nurse did have more power as she (the nurse), knows that the patient is dying.

> But I also thought about the patient. If I were in the last two hours of my life I would want someone there. So, I think it was just the fact that they had the decision to be made in their hands.

In the above excerpt, the nurse had it in her power to ring the family to come and sit with the patient, or not. According to the participant, it was up to the family to decide. To 'share power' would be to inform the family and then let them decide. Lindeke and Block (1998) support this participant's approach to ethical decision-making by involving the patient, in that it empowers the patient. In this excerpt, there is also a hint of 'identifying' with the patient, an approach previously explicated.

Keeping the patient and their family informed and involved in the decision-making process enacted 'sharing power'. This process promoted autonomy and thus facilitated self-determination and choice for the patient. Participants valued these notions. 'Advocating' for the patient's needs was also valued.

Advocating

The third sub-category of 'promoting autonomy' is 'advocating' and involved making it clear to the patient that the nurse was on their side. To this end the nurse was to move towards the patient, stand with them and support them, as is evidenced in this quote.

> You just want to let people know that you are on their side in a way, and that you are there for them (008/1/416,7).

It was clear that participants closely aligned themselves to the patient and to what the patient expressed as their needs. To date, in the data, few other factors have been considered by participants. Other factors do emerge and will be explored and explained in later chapters. Early in their nursing education participants focused on supporting their patients' choices and promoting these to others in the health-care team.

> If they say yes or no, you have to go with what they say. That can be a dilemma in itself. If they don't want treatment or they want to explore other options, you have to stand with them. You have to be truly patient because you are the link between them and everything else, aren't you (006/1/353-9).

Thus the nurse would then be an advocate for what the patient wanted

> You have got to be an advocate for your patient sometimes (006/1/349,50).

'Advocating' was confirmed in follow-up interviews. The following participant refers to advocacy as a value of the nursing profession.

> As part of the profession, I think the advocate role was definitely a value that you could say that nurses had. It was one that students often talked about. Perhaps also just sort of like a mediator as well and translating all your information between other roles and disciplines and the patient and finding out what the patient sort of needs to know. It sort of comes under 'advocacy' a bit more (008/2/9-14).

Part of 'promoting autonomy' was acting as an advocate. This involved supporting the patient in seeking options and supporting them in the decisions that they made. Ellis (1995) asserts that advocacy for patients involves informing them of their rights within the health-care setting, and ensuring that their voices are heard in the decision-making process regarding their care. Hence 'informing the patient' goes hand-in-hand with advocacy, and for participants cast doubts on paternalism.

Summary

According to participants, the beliefs, values and virtues that had been fashioned during their childhood upbringings and personal experiences accompanied them into, and underwent honing and refining, during their nursing education. Traditional ethical notions learned, focused mainly on principle-based ethics as defined by Beauchamp and Childress (1994). Participants identified a lack in their ethics knowledge, their ability to articulate an ethical position and, their preparation for the ethical challenges in the practice setting. Ethics was also linked to the law. Participants identified that the law governed practice, but it could also negatively impact on the nurse-patient relationship

and the provision of care that was deemed to be ethical. Rule-bending was considered an option to circumventing this problem. Ethics was further linked to cultural safety, and focused on how the individual should be treated. The individual's needs were to be ascertained, so as to facilitate caring in a safe manner. Caring 'safely' correlated to caring 'ethically'. Thus, ethics theory, the law, cultural safety and characteristics of the nurse-patient relationship were taught in the classroom.

Continued exploration of ethics and ethical practice illuminated numerous categories and codes that reflected the allegiance participants had to espoused attributes, values and behaviours that were indicative of how to practice ethically. These attributes, values and behaviours engendered a 'focus' on the patient'. According to the Collins (1992), focus is defined as, not only the point at which rays meet, but also 'to concentrate' and furthermore, 'a point on which interest and activity is centred'. 'Focusing' for participants was not about 'looking' at the patient, but about 'giving attention' to him or her. Charon (1998) attests that, "People interact over a period of time; out of that interaction they come to share a perspective; often each perspective tells us something very important about what is really true" (p. 1). Therefore, as participants interacted with faculty tutors and patients in the practice setting, they adopted an ethical perspective that closely focused on the patient. Ensconced within this ethical perspective were the attributes, values, virtues and behaviours that were seen to assist and motivate participants to enact, in what they deemed to be ethical practice. Ideally then, these professional ethical attributes, values, virtues and behaviours would underpin and inform their future nursing practice.

CHAPTER FIVE: EXPERIENTIALLY LEARNING ETHICAL PRACTICE

I think probably you have your gut instincts as to what maybe is right and then you have your knowledge that you've learned through your education at Polytech. As a student, you've always got a 'buddy' or a tutor to bounce something off, to confirm that what you think is right ***is*** *right (009/1/163-7).*

Introduction

In the previous chapter it emerged that participants in this study had, by interacting with the patient and faculty education, developed an ethical perspective that closely focused on the patient. As participants 'focused on the patient' they utilised a variety of ways to ascertain what the patient's needs might be. Thus, participants learned ethical practice through classroom teaching and patient interaction. This chapter focuses on the learning of ethical practice from nurses, clinical tutors and by experimentally engaging with the practice setting. According to the Standards for Registration of Comprehensive Nurses (NCNZ, 2002) it is stipulated that, "Teachers are available to give support to students as and when required, in the practice setting" (p. 9). Therefore, clinical tutors are positioned within the practice setting to assist in the learning of undergraduate nursing students. Furthermore, student nurses are assigned registered nurses to assist them in their learning of nursing. These nurses also supervise students' nursing practice and were referred to by participants, as 'buddies'.

Four main categories are explored in this chapter. They reflect the four major experiential methods by which participants learned ethical practice whilst engaging with the practice setting. These methods are 'observing role models', 'seeking guidance', 'journaling and reflecting' and 'experimenting'. Essentially, whilst learning through these modes, participants' 'patient-focused' ethical perspective underwent enlargement as they soon discovered that 'focusing on the patient' and the attributes, values and behaviours that facilitated this phenomenon, reflected an 'ideal' way to practice. They began to understand that an 'ideal' way to practice may not always be workable in the practice setting.

Observing role models

Learning ethical practice eventuated by observing the practice of other nurses and health professionals in the practice setting. 'Observing role models' naturally occurred as part of being in the student role. Inexperience and lack of inclusion in decision-making processes meant that participants opted for this observing role. Yet, whilst 'observing', participants in this study were not passive, they were 'evaluating' and 'responding' to what they saw. Whilst they 'observed' they were generally silent and concomitant feelings of 'powerlessness' coexisted with 'observing role models' as participants perceived that they could not do anything about what they deemed to be 'unethical practice'. Four sub-categories support 'observing role models', they are, 'evaluating', 'responding', as well as, 'observing dubious role models' and 'observing helpful role models'.

Evaluating

'Evaluating' is a thinking process and can be defined as to "judge value of" (Collins, 1992, p. 168), and occurred as participants observed the behaviour and actions of others around them. Participants evaluated what they observed through their own 'patient-focused ethical perspective', judging whether what was done, or said, was in accordance with what the patient expressed as their needs. It emerged that a concurrent process was occurring. Participants also evaluated what was 'observed' according to their 'developing nursing knowledge'. From this latter 'evaluating' participants, based on their 'developing nursing knowledge', made nursing assessments. These are conceptualised as 'nurse assessed needs'. Thus participants made 'thinking' judgements on what they saw.

Evaluating according to 'patient expressed needs'

This substantive code explains one aspect of what participants were doing whilst they were 'observing' in the practice setting. As this particular participant 'observed' the practice of those around her, she evaluated what she saw as to how closely the behaviour might match the patient's needs. This appeared to constitute whether behaviour was right or wrong.

> If there is something going on and in your own mind you can identify why it is wrong and that maybe it is wrong because it is perhaps not in the patient's wishes ... (005/1/43-6).

Participants evaluated what they saw as to whether it might be in accordance with 'patient expressed needs' ascertainable by methods previously identified. They also evaluated, by utilising their body of 'developing nursing knowledge'. From this base, 'nurse assessed needs' emerged.

Evaluating according to 'nurse assessed needs'

As participants were 'observing role models' in the practice setting they evaluated what they saw according to their 'developing nursing knowledge'. An example of this is embedded within this next situation. It involves the participant, her 'buddy' nurse, and a patient who has had a total knee replacement operation. When the 'buddy' nurse undressed the wound, it was obviously infected. Whilst the participant was 'observing', she was 'evaluating' what she saw according to her 'developing nursing knowledge'. The participant makes a nursing assessment. Thus the concept of 'nurse assessed needs' begins to formulate.

> I was a third year, but just still watching and I noticed just how red the knee was. There was a real blotchy red outline around the wound. I wanted to say at the time, "Wow, that looks quite inflamed and red" (004/1/275-7).

Later, when the 'buddy' nurse handed over to the oncoming shift, the participant 'observed' that the 'buddy' nurse covered herself by lying with regards to the infection.

> At 'handover' I heard that nurse blatantly lie and say, "Oh, I took down the dressing and there was no sign of inflammation. It looked fine. I had to sit through thinking that even a layperson off the street could have seen the state of that knee when it came down and realised, "Oh! There is something not right here" (004/1/287-91).

The participant's evaluation is clear,

> That was a case of neglect … and she was trying to cover herself (004/1/292-4).

Not only was the participant able to evaluate the wound according to her 'developing nursing knowledge', she also evaluated the behaviour of the nurse according to her held professional ethical values. Embedded within this perspective, which emerged in Chapter Four, is the belief that nurses should not lie and this reflects the assumptions underpinning the virtuous nurse.

Responding

As participants 'observed' the behaviours and actions of nurses in the practice setting they 'responded' emotionally to what they saw. Several substantive codes assist in explicating 'responding'. These include, 'attuning to gut feelings', 'observing silently' and, 'feeling powerless'.

Attuning to gut feelings

Substantive data suggests that what participants 'observed' evoked emotional responses thus pointing to the germination of 'gut feelings'. The participant in the following excerpt expresses what she was feeling.

> I felt uncomfortable with the decision that was being made. I didn't feel that I could speak to someone, or had I done being told, "Well, you are a student and you don't understand" ... that was the feeling I got (008/1/470-3).

In a later interview, this participant explains more fully her understanding of 'gut feeling'.

> I think initially the 'gut feeling' business comes in when ... something doesn't sit right with you so, I think that it is sort of your 'first flag' [that tells you]: "Oh, there is something wrong here" (008/2/368-71).

The participant was further asked to explain.

What do you think causes the gut feeling?

> I think it is just something ingrown in your own values. It just comes up (008/2/375).

Earlier, the beliefs, values and virtues, coupled with their formulated professional ethical values were outlined and explained. The previous participant links her 'gut feeling' to her values. It could thus be argued that her 'gut feeling' was an emotional response as to whether there was congruence between own personal values plus her developing professional ethical values, which incidentally, focused closely on the patient. It seems that 'gut feeling' was a guide as to whether there was congruence between her held ethical values and what she saw in the practice setting. Johnstone (1999) points out that, "Many nurses respond to moral problems with a 'gut response" (p. 183). This initial response to a clinical problem may be that 'something is not quite right'. Here is another example of the emergence of an emotional response to what is being observed.

> When you go out into clinical and things are really awful and you don't agree with what is happening. Sometimes you can't even articulate why you are feeling that something is not right or several things are not right (002/1/736-9).

This quote is an example of the initial emotional responses that participants had whilst they 'observed' in the practice setting. Nussbaum (1986) validates the role of feelings in ethical practice and links thinking and feeling together. He states, "We discover what we think about these events partly by noticing how we feel (p. 15)." These two processes were also occurring within participants whilst they were 'observing role models' in the practice setting. Generally, participants felt that they could not 'speak up' when 'observing' in the practice setting because of their role as students. Hence they were 'observing silently'. This response will now be explored.

Observing silently

Participants quietly observed the practices of health professionals in the practice setting. The following participant points out that because she was a student she was 'just watching'. Being a student also meant that she did not feel that she could contribute to the ethical decision that was being made about the patient that she was looking after.

> I was caring for a patient and he went down hill very quickly... they watched the heart monitor and it got slower and slower and they actually turned it off before it had stopped ... They looked around the room and said, "Is anybody unhappy with this?" I was only a student; I was in the background just watching the whole thing. I didn't help or anything. I just watched and I didn't feel that I had the right to say, "No, do something" (006/1/12-82).

She had a response to what she saw – a feeling was evoked.

> It just seemed such a waste, it seemed really sad (006/1/154).

For this participant, because she was a student, she watched and didn't feel that she could say anything. The participant was concerned as to why the patient had not been more actively treated and it seems that there was a lack of structured opportunity for the participant to clarify the reasons for the decisions that were made. Both previous quotes indicate that the participant ethically responded to what she 'observed' and experienced a corresponding ethical response. Her perspective was a morally sighted one that evoked response.

Thus far it appears, that as participants interacted with, and viewed the practice setting, they were 'evaluating' and 'responding' according to whether what they saw matched with their 'held' professional ethical values. Johnstone (1999) suggests that to

be morally sighted one must be able to distinguish certain 'moral properties' in the world. For participants, these 'moral properties' seemed to correlate to their held professional ethical values. Hence it seems that participants were morally sighted.

Woods (1997), in his research among eight experienced nurses, found that some nurses, many students and new practitioners simply did 'nothing' when they were confronted with an ethical problem. He continues to explain that it is possible that they simply 'did not perceive' a potential ethical problem or that involvement was warranted. Not so with participants in this study. On the one hand, they were generally 'observing silently' however, on the other, data suggests that they were morally sighted. They did not however, readily involve themselves in the confronting moral quandaries that they observed. They were very clear as to why this might be; the constraining factor was that of 'feeling powerless'.

Feeling powerless

An initial exploration of this substantive code will provide the platform for later and deeper investigation of its relevance for participants and their ability to engage in ethical practice. Because of participants' role in the practice setting as learners, they often felt powerless to 'speak out' about unethical practice that they saw. 'Feeling powerless' impeded participants' involvement in ethical practice.

> That was huge [the nurse lying about the wound not being infected] and I left it because of the power thing (004/1/298).

Later when reporting to the next shift the 'buddy' nurse lied and said that the wound was not infected when she had looked at it. The participant was faced with the dilemma of, do I tell or not? Being in the student role impacted on her decision.

> I morally had to make a decision there, do I tell or not? I decided that because I was only a student, the fact that I wasn't being included in the staff and I felt like a real outsider ... so, being a student there made me choose something that was immoral (004/1/307-13).

The participant goes on to explain the powerlessness embedded in the student role. Powerlessness is linked to the ability of 'buddy' nurses to fail the student or that nurses will turn against the student.

> I think it can be almost dangerous being a student in that you can make decisions because of your lack of power and your fear of someone failing you and the nurses turning against you. You have to make a decision sometimes that isn't safe (004/1/320-3).

Fear of failing and the potential of nurses to turn against participants was a significant factor that impeded ethical expression in the practice setting for participants and will be more fully explored in the following chapter. Woods (1997) also found that perceived powerlessness was one factor that motivated withdrawing from ethical problems. According to Woods, 'silently observing' (his rendition of the phenomenon), was the most minimal level of moral involvement. Perceived powerlessness constrained the ethical involvement of participants in Woods' research, it also constrained the ethical involvement of participants in this research. Even though participants did not readily 'speak out' or question the unethical practices that they might have 'observed', they were strengthening their ethical resolve, as explained in Chapter Four, determining that they would not practice in such a manner.

Observing dubious role models

On the whole, participants perceived that they could not do anything about the practice of other registered nurses. However, when observing other nurses behaving in an unethical way, this served to further strengthen their ethical resolve. This method of learning ethical practice was however, not quintessential, yet participants did express that they did not want to practice in the unethical manner that they had seen.

> I can see a nurse yelling at a patient and I am not able to do anything about it, I am totally dis-empowered, but it is not how I want to practice (002/1/744-6).

This participant also observes behaviour that she determines she will not enact.

> You learn the finer points being out there and seeing other nurses being immoral, seeing things that you don't like and deciding, "God! I don't ever want to do that to a patient, I never want to." Or, "I would never want to nurse like that; I never want to be in the staff room talking like that." You learn morality from watching other people and their practice (004/1/126-30).

A participant in Turnbull's (2001) research learned from 'good' and 'bad' role models as evidenced in this quote,

> I think good role models are very important but I also think even bad role models are very important ... you learn so much from them ... so many days I'd go home and think I am **not** going to be like that ... that's **not** what I'm going to be like (p. 109).

For this next participant the 'bad ones' were measured against an established standard and were a reminder to the participant to move back to the standard if he strayed.

> You use the bad ones as stoppers. You have a minimum standard and you put them there and you try and recognise that you are getting close to that point (007/1/39,40).

There was awareness on the part of this participant that strength was needed to remain true to his 'ideals'.

> I was all prepared probably in that I had the strength to keep the ideals (007/1/44,5).

In Chapter Four, there emerged a description of the professional ethical values and behaviours that participants held. Essentially, these were added to early in this chapter. This occurred as 'ascertaining needs' incorporated the substantive codes of 'patient expressed needs' and 'nurse assessed needs'. These constructs appeared to be 'idealistic', as participants were discovering that the practice setting challenged implementation of these. In the above quote, the participant refers to the concept of 'ideals'. Thus, these constructs are conceptually named 'ethical ideals' (Appendix 5). When participants observed practice that did not match their 'ethical ideals', it further strengthened their ethical resolve not to practise in such a manner.

Observing helpful role models

It would be grim if participants did not offer explanations of situations in which they had seen nurses act in an ethical manner autonomously. Participants did 'observe', what they deemed to be, ethical practice. Here is an example,

> I remember having a patient. I was helping the nurse take her down to theatre. She [the patient] was about 19 and she was having a hysterectomy … we were heading down to theatre and we were in the elevator. The girl said to my buddy: "Will I be able to have children after this?" We didn't even get out of the elevator. She had no idea of what was going on. She thought it was a procedure and she was going to be able to have kids later on, but it was a hysterectomy. It was all coming out. She was informed, but she wasn't … they said hysterectomy and she knew she was having a hysterectomy but she didn't know the implications of that. She said, "Yes, yes, yes, I understand," but she didn't know what it meant (006/2/353-64).

The behaviour demonstrated by the nurse 'buddy' matched the participant's 'ethical ideals', as the 'buddy' nurse role modelled how to enact the professional ethical value of 'informed consent'. Thus the participant 'observes' what she deemed to be ethical practice. As the participant did not comment positively or negatively about this situation, it may be surmised that, the 'ethical ideals' held by the participant matched what the nurse did for the patient. Thus, ethical calm ensued for the participant.

Observing failed advocacy

There were times when participants observed registered nurses' expressing ethical concerns and the subsequent 'over-riding' of these by doctors. The substantive codes of 'advocating', 'over-riding' and 'submitting' all seem to be present for 'advocacy' to fail. In the following situation the participant observed an incident where a woman was being prepared for surgery. The woman had signed a consent form for an abdominal hysterectomy. Once in theatre, the attending surgeon wanted to perform a vaginal hysterectomy. The nurses expressed concern at this and thus engaged in 'advocating'.

Advocating

Collins (1992) defines 'advocacy' as, "one who pleads the cause of another" (p. 7). Thus, to experience 'failed advocacy', one must first engage in pleading the cause of another. This is what the participant observed,

> The nurses actually brought it up with him and said that she hadn't actually consented to it and they did not want to be a part of the operation (005/1/111,2).

Johnstone (1999) points out that, "Moral indifference is characterised by an unconcerned or uninterested attitude toward demands to be moral; in short it assumes the attitude of why bother to be moral" (p. 169). This unfortunate attitude confronted the nurses and the participant. The participant observed nurses expressing concern over a moral issue, and incidentally a legal issue as well.

Over-riding/Submitting

The nurses that the participant observed raised the issue, and also had to strengthen their concern, by arguing with the surgeon. The surgeon did not heed their concerns and performed the hysterectomy vaginally. Eventually the nurses 'submitted' to the surgeon and helped him with the surgery.

> They said [the nurses] that they wouldn't do it and while he was out of the room talking to someone else they had said no they didn't want to be a part of it. They argued with him and I am not sure what the consensus was but he did do it that way and they assisted him (005/1/122-5).

Unfortunately, this participant observed 'failed advocacy'. The nurses had attempted to object to a procedure being carried out that was not legally consented to. The concerns and objections of the nurses were 'over-ridden' by the doctor's demands. Hence, in this situation the doctor's ethical decision-making 'over-rode' that of the

nurses'. In the end, the nurses 'submitted' to the demands of the doctor, and essentially enacted the moral decisions of another. Woods' (1997) research revealed that nurses often 'submit' to the decisions of others in the practice setting because of perceived powerlessness. It is highly probable that this was the case in this particular situation also. The 'observing' participant certainly identifies her perceived 'powerlessness', but also her evaluative process.

> I, being a student, I just obviously stood there in silence. But they [the nurses] did speak up. They did say and give their opinion, however they still went through with it and legally they would still be held accountable for assisting in that procedure (005/1/183-6).

The participant is aware of the legal issues of not gaining consent that is informed and specific. These concepts had been taught in the classroom, as established previously. Furthermore, illustrated in this scenario is the silent role of the student nurse. As the participant reflects on the dilemma she reiterates that the correct consent wasn't given and that on the strength of that, what was done was deemed to be unethical. Hence informed consent is topical *(field note, 5/4/02)*. Furthermore, Johnstone (1994b) contends that nurses do not have ultimate control over their practice resulting in legitimated powerlessness. Legitimated power is awarded to the doctor and thus to challenge this is to put oneself at considerable risk.

It was evident from the data, that participants felt powerless to bring any change. They also noticed that registered nurses' position within the health care sector was also essentially a powerless role. This decision was reached by 'observing' how nurses managed ethical dilemmas and quandaries, and that often nurses' ethical concerns were over-ridden by others, thus an enactment of the ethical decisions of the over-rider resulted. To participants, their observations led them to conclude that.

> You get the impression that it's up to the doctor (009/1/137).

Johnstone (1994b) attests, "ultimately it is still the doctors who have over-riding (legitimated) authority in healthcare contexts" (p. 4). According to Johnstone, underpinning this notion is the general acceptance that doctors have more experience and knowledge than nurses, and are therefore in the best position to make ethical decisions. Essentially then, whilst participants were 'observing' in the practice setting, they were not passive. They 'evaluated' what they saw, and 'responded' to what they saw. On the whole, they did not involve themselves with the ethical quandaries that they 'observed' due to 'feeling powerlessness' in the practice setting. Although participants

gave the appearance of passively 'observing' they were 'actively learning'. They learned that registered nurses too were relatively powerless.

Seeking guidance

'Seeking guidance' in the practice setting was another avenue through which participants learned ethical practice. This avenue was more overt. As explained earlier, participants were under the jurisdiction of the 'buddy' nurse or clinical tutor. As they were learners in the practice setting, part of the student role was to seek guidance and clarification when making a decision. Participants therefore accessed their role models to give them this guidance. Guidance given tended to be, not only 'helpful' but also, 'unhelpful'. Furthermore, clinical tutors were instrumental in fostering 'gut feelings' within participants, and promoted these as a guide to ethical practice. Correspondingly, ethical theory was absent in guidance provided by role models.

Helpful 'buddy' nurse guidance

'Helpful 'buddy' nurse guidance' occurred when 'buddy' nurses took the time to verbally guide participants and to make explicit links between theory and practice. The following situation experienced by a participant, illustrates this 'helpful guidance'. A mother and daughter presented at an outpatient's clinic because the daughter was very sick. Unbeknown to the mother the daughter had had an abortion and now had an infection related to this. The daughter did not want her mother to know of the abortion.

> "What can I tell my Mum so that she thinks there is something reasonable wrong with me, so that she is not going to suspect what it really is?" That was really hard because, how do you come up with a lie for a kid to tell her Mum? (006/1/230-4).

This posed a dilemma for the participant as she grappled with two competing ethical values, that of veracity and confidentiality. The participant turned for guidance to another nurse.

> I went and got one of the other nurses and said, "Wow! What do I do here?" Well ... basically, we didn't give her a lie, we just said, "Tell your Mum that you have a bit of an infection and that we have given you antibiotics and it should clear up." "You can tell your Mum that we are doing some tests to find out what is going on." That wasn't a lie (006/1/240-4).

This ethical dilemma posed a positive learning experience for the student. When faced with a situation that the student could not handle, she was able to seek guidance from another nurse. This nurse willingly gave guidance. The participant, as a student

nurse, thus learned how to balance veracity and confidentiality. Overall, the final ethical decision was congruent with the participant's 'ethical ideals' (Appendix 5). The patient's needs were attended to and the nurse-patient relationship was preserved. Hence, the participant was satisfied with the result and confirms that learning in the practice setting is thus enhanced when the 'buddy' nurse is willing to provide the support and guidance that student nurses need (Turnbull, 2001).

Unhelpful 'buddy' nurse guidance

Participants in this study valued 'helpful' guidance from 'buddies' in the practice setting. There were times when guidance that was given failed to provide a positive learning experience for participants. The following scenario is an example of this.

> I am sort of glad that I did feel like that [why hadn't they done more. I am glad that] I was wary enough to ask, "what's going on?" I did ask questions of the nurse afterwards, you know, "Why didn't they do anything?" "Why didn't they do more?" But the response I got from them was: "With experience you will just learn it." "It is something that comes with being on the job and doing it."

What did you learn from that do you think?

> That it doesn't help being told you are going to learn that on the job, that doesn't help at all (006/1/171,2)

The nurse's response evoked apprehension for the participant and furthermore, the participant's ethical response was not explored.

So how do you think *that you would learn that way [by learning on the job]?*

> When they say, "You will learn it." "It is something that comes with experience," it makes you really nervous about the next time as to whether you are going to be involved in that decision next time … Am I going to be able to deal with it the next time? Am I going to know enough the next time? (006/1/175-82)

As the participant reflects on the situation at hand, she puzzles over why so little was done for the patient that she was caring for. Holly (1989) points out that in pondering about an experience one can form connections and learn from the experience. When the participant attempted to elicit the assistance of the registered nurse as to why so little had been done for the patient that she was looking after, the registered nurse failed to assist the student in formalising connections.

Helpful tutorial guidance

As identified earlier, tutors were strategically placed in the practice setting to assist and support students and their learning. Hence participants not only sought guidance from their nurse 'buddies', they also actively sought guidance from their clinical tutors. Mostly, participants saw these clinical tutors to be a support to their learning. A key component to the success of participants' learning was a positive relationship with their clinical tutor.

Establishing a positive tutor-student relationship

Interacting with tutors in the practice setting could enhance the ethical learning of participants. A key to enhanced learning was the ability of the clinical tutor to develop a positive relationship with participants in the practice setting. Participants wanted to trust their clinical tutors and to be honest with them as this quote demonstrates,

> It is the same with the tutors, the relationships that you have with them. The ones that you can approach and say, "Hey! Look! That placement wasn't so good." You can be totally honest with them and say, "Look, I don't feel that mark was so fair or that comment that you made was fair. Depending on the relationship that they've established with you, you know that they are not going to turn around and fail you for it or put you down in the staff room or to other tutors or look down on you (004/662-8).

'Safety' for participants was the level of freedom they felt they had in expressing themselves honestly without fear of ramifications in their assessments. Feeling 'safe' enough to talk about issues was appreciated by participants. Turnbull (2001) also found that student nurses value feeling safe and non-threatened whilst with their clinical tutors. Accordingly, students first determine their level of personal safety within the tutor/student relationship. They do this prior to sharing their individual concerns and needs. Turnbull's work confirms this in the following quote,

> I've had a couple of tutors that have really allowed me to feel quite safe … to talk about things (002/1/922-7).

Being genuine in the support and help given to participants whilst they were students was seen to be an expression of 'being moral'.

> You can sense that they are being honest when they are using their morals, when they are honestly doing their best to help you as a student. They support you and try to understand where you are coming from (004/1/672-4).

Crowley (1989) proposes that teachers must seek to create a caring dialogue with their students. In this relationship the teacher does not sit in judgement but rather seeks to enter the world of the student in order to see things as the student sees them. Within this relationship there is dialogue in which self-understanding is facilitated as the student offers explanations rather than justifications for actions and choices. Thus, as the one cared for, the student is able to develop an understanding of self through sharing and reflection. The teacher also shares her explanations, thus shared understanding emerges. Hence the teacher role models the receptivity of caring essential to the nurse-patient relationship. From a positive tutor-student relationship base, participants could access support and help from their tutors.

> Talking with the tutors was the best opportunity. Most of the tutors I found were very good in regard to the ethical side of things (003/1/520,1).

And so, participants valued a good relationship with the clinical tutor. Within this positive relationship, ethical learning was enhanced.

Augmenting 'gut feelings'

In the main, when participants approached their clinical tutors for guidance in the practice setting, it was evident that they promoted ethical decision-making on a 'gut feeling' level. As aforementioned, Nussbaum's (1986) view is that emotional responsiveness contributes to ethical behaviour. Clinical tutors promoted this approach to ethical practice in their students.

> I've had several tutors tell me that you actually go with your gut feelings ... Go with your gut feelings, because you're more than likely to be right. So I think that's really encouraging (009/1/189-93).

It is evident that the participant in the previous quote accepts her tutor's guidance. This is understandable as, has already been established, participants 'responded' within themselves in the practice setting. They therefore, it seems, understood when their clinical tutors spoke of 'gut feelings'. Essentially then, clinical tutors confirmed the validity of 'responsiveness' within the ethical decision-making sphere in nursing practice. This validation gave participants confidence.

> It was really helpful because it also gave you confidence to know that maybe what you were thinking was right and that you should act on your instincts when something is not right or that not enough is being done (009/1/65-8).

In a follow-up interview, one participant answered the following, when asked,

When tutors gave guidance, did they use an ethical language?

> No not really, not that I found. They looked at your role, the boundaries of your role and really they were trying to get you to look at all the different angles of certain situations. Quite often there would be tricky ones and they would throw in a few cultural issues in there as well … I think they were more willing for you to be aware of the fact that there are some situations that will make you feel uncomfortable and I guess they sort of let you decide where you sit with that (008/2/221-6).

It may be assumed that clinical tutors have a wealth of experiential knowledge, and accordingly, have an intuitive grasp of each situation (Benner, 1984). Johnstone (1999) accedes that expert nurses can make impeccable moral judgements on the basis of, a 'virtuous caring' nature of the nurse-patient relationship, the wealth of knowledge gained from nurses' vast experience and, the level of personal commitment made by the nurse to carefully chosen moral values. Hence experience has the potential to develop a 'gut response' that is entirely ethical. Johnstone names it a guiding framework of care. It is highly probable that clinical tutors utilised 'gut feeling' to make ethical decisions themselves and therefore turned their attention to developing this guiding ethical framework within participants, who were their students. Hence there was no substantive evidence that ethical theory was linked to what participants saw and experienced in the practice setting. This was confirmed by this participant's words,

> The tutor would just wind up and say, "These are legal and ethical issues." So, we would then move along. We never discussed it in full (008/2/214-6).

Clinical tutors in the practice setting were instrumental in attuning participants to developing 'gut feelings' in regards to ascertaining what might be ethical practice. Essentially, ethical theories were not accessed or utilised within the practice setting by participant's clinical tutors. Clinical tutors did however give support and guidance in the practice setting. Mostly tutors were supportive, but not always,

Dubious tutorial guidance

Clinical tutors could also present as an ethical dilemma for participants whilst they were students. It raised the question of what to do when a clinical tutor behaved in a dubious way. Unfortunately in this situation, the clinical tutor did not develop a positive learning relationship with the participant.

> [On one occasion] she pulled me aside and told me that I didn't have the right personality to be a nurse and I just about gave up nursing in the first year. She was nasty as hell (004/1/724,5).

Student nurses in a previous study by Campbell, Larrivee, Field, Day and Reutter (1994) identified that one of the most influential factors that impacted their learning in the clinical context was their relationship with the clinical instructor. Good relationships with clinical instructors were highly valued by those in the study. This is evidenced in a quote from a participant in their study,

> Instructors who are rigid in their dealings with students and staff and who don't try to establish a good relationship just make you scared and hinder your ability to learn (p. 1127).

In the following situation in this present study, another participant is faced with an ethical quandary in regards to a midwife in the practice setting. She seeks guidance from her clinical tutor. The participant found herself in a clinical placement that had been problematic in the past. The person in charge was seemingly a nice person but her midwifery practice was, according to the participant, dubious. An ethical quandary emerged regarding a new mother who was having difficulty breastfeeding her baby. The new mother was under a great deal of personal stress at the time, over and above the arrival of a baby. The aforementioned midwife had said to the new mother,

> "You are not going to be able to breastfeed." I thought it strange because we encourage breastfeeding. All the pamphlets were on the wall and it was written into the philosophy of the place (002/1/418-21).

According to the participant, what the woman needed was to be assisted to relax so that her milk would be produced properly, hence she engaged in 'evaluating' according to her 'developing nursing knowledge' and identified 'nurse assessed needs' accordingly. She turned to her clinical tutor for guidance.

> We went to our tutor and explained our concerns and she said, "Well, you know we have been down this road before and there is not much that we can do and you should just take it in your stride and reflect on it" (002/1/439-442).

This participant looked to her clinical tutor for guidance, however the sort of guidance that the participant wanted was not forthcoming. Regardless as to whether the midwife or the student nurse was 'right' in this situation, it is clear that the clinical tutor role modelled maintaining the 'status quo' by discouraging challenging or questioning of decisions made by other health professionals. To say that 'we have been down this road before' could be considered unhelpful for the student and her learning. There is however, something far more insidious occurring within this dilemma. What is of concern is that the clinical tutor effectively silences the ethical voice of the student and

stifles exploration of possible options to address the problem for the participant concerned.

It seems evident from data that 'buddy' nurse and tutorial guidance and the relationship that participants had with these, was pivotal in assisting participants to learn ethical practice. This learning depended on role models having the necessary expertise to make formal links between theory and practice. Clinical tutors tended towards developing 'gut response' as an ethical approach. Thus far no formal links between the practice setting and ethics theory seem forthcoming from clinical tutors or 'buddies'.

Journaling and reflection

'Journaling and reflecting' are processes utilised to develop learning in nursing students (Taylor, 2000). Journaling and reflection is a teaching and learning method utilised by Schools of Nursing in New Zealand to facilitate development towards Competencies for Entry to the Register of Comprehensive Nurses (NCNZ, 2002), where newly graduated nurses are expected to have 'reflective thinking' skills. Journaling involves writing about incidents that happen in the practice setting. Reflection involves thinking back on those incidents critically and exploring ways to change problematic situations for nurses. The process of 'reflecting' often occurred in discussion tutorials with peers and clinical tutors. Participants learned notions of ethical practice in journaling and reflection tutorials in the practice setting. The concept of journaling and reflection was initially taught in the classroom. This method of learning ethical practice will now be explored.

> [Journaling and reflection was] in the first year at Polytech. We talked about them a lot (008/2/249).

Participants were expected to write in their journals as part of their undergraduate education.

> Everyone had to keep a journal. We had to have three, two page long journal entries every week that we were in clinical (006/1/324,5).

Sometimes participants spontaneously wrote in their journals so that they could process what had happened in the practice setting.

> If something was really bugging me and I couldn't think it through myself, I would go home and try and write about it. Sometimes the little light bulbs would go on (008/1/365-7).

Holly (1989) explains that writing can be cathartic, as it was for the above participant. Ideally, journaling and reflection is a method of maximising the learning that students elicit out of the experiences that they have had. Schon (1983) suggests that when practitioners notice what they've been doing and how well, or not well, it has been working they can change the way they have been doing it. In writing, noticing is facilitated. Schon refers to this as reflection-on-action.

Learning ethical practice by reflecting and discussing

Throughout their three years of nursing education, participants were to write in their journals and share what was written with others in their clinical group. Participants engaged in journaling and reflection tutorials with their tutors and peers. It seemed that this was a regularly set aside time, situated away from the actual work environment, either in a classroom or in a private room within the practice setting. During this tutorial time, students were to read from their journals. Discussion and future actions were contemplated.

> If the tutor felt that you had something that was worthwhile sharing, some sort of dilemma or some sort of problem between you and the staff, then they would ask if you would read it out at the next tutorial. Everyone would then discuss it and decide what perhaps they would have done, or to help the person to decide what they were going to do, that kind of thing (006/1/325-30).

Reflection was utilised to explore ways to approach ethical issues in the practice setting. Furthermore, during reflection tutorials, participants valued 'receiving validation' of the 'evaluations' and 'responses' they had made. They received these from both tutors and peers.

Receiving validation

Participants could access support and validation of their 'responses' and 'evaluations' during reflection times.

> [Reflection tutorials were the time for me] to get affirmation from my group and peers, so that I could make sure that I had done everything right (007/1/329-30).

This next participant too highlights the desire for validation and support.

> If you don't have a lot of other people around you, especially when you are a student you feel quite powerless. You sort of need a few people, even if it is the other student next to you saying, "Yes, I agree with you." "I think that is right, you have to look at what is best for your patient." You then feel a bit more like, "Oh yes! I am on target" (008/1/473-8).

Not only does the participant 'evaluate' the behaviour that she observes, she also expresses a desire to have someone external to her evaluation to offer some sort of confirmation of her thoughts. Holly (1989) proposes that when we share our stories with others we are testing them. In this testing of our observations and perceptions consensus is sought. If those listening to our stories offer a difference of opinion, rethinking can occur. Smith (1998) found that student nurses provided support for each other as they reflectively deliberated, where they shared their own and each other's experiences to examine meaning.

Guiding reflection

Essential to journaling and reflection is the notion of guidance where supervision and guided reflection converge with maintaining a structured diary (Johns, 1993). Tutorials were a place where issues experienced in the practice setting could be raised and aired for discussion.

> Often we were in journaling and reflection groups. You would get good feedback. If someone brought up something that they didn't think was right, usually other students would have input as well and the tutor was just a kind of mediator who helped and gave advice (009/1/53-7).

Teekman (1997) proposes that journal entries be a springboard for discussion with peers, preceptors and nursing educators. Thus student nurses can more successfully evaluate, validate and refine their conclusions. This process requires close monitoring and guidance from clinical tutors. In the following quote the clinical tutor played a role in identifying what might be an ethical issue that might require consideration. Hence, the clinical tutor had a role in guiding the developing moral sightedness, in that she alerted the group to 'moral properties' (Johnstone, 1999) embedded in their stories.

> It was actually imperative that we discussed ethics. It wasn't just that you knew what ethics were. [In a journaling and reflection session] we must have been sitting around and saying, "No, nothing happened in my world" and I think she [the clinical tutor] actually said, "Well, what about this" (005/1/696-700)?

Clinical tutors would offer their own stories and participants could draw on these stories at a later date.

> I think that it's from having either seen the situation before or you've heard horror stories. You know in those journaling and reflection sessions, sometimes your tutors will not tell you horror stories but explain to you a situation they've been in where it hasn't worked. So maybe you just file that (001/1/978-82).

Thus, participants could draw on the wealth of experience of their clinical tutors, as Woods (1999) promotes, "there is a rich and deep seam of reflective interpretation and even practical wisdom 'embedded' within the experiences of every nurse" (p. 427).

Developing critical thinking

Utilising critical thinking assisted in attempting to reveal the underlying causes for problems encountered in the practice setting. In this next excerpt the participant is 'focusing on the patient' and that it is unethical to pull the bell out of the wall and thus remove the patient's 'lifeline'. Utilising reflection, this participant critically thinks by attempting to see the situation from the perspective of the nurse involved.

> Maybe if I was her and I was getting frustrated and he was my patient, maybe I could say to one of my work colleagues, "I've got a really heavy load, he's a really demanding patient, would you be able to help me with one of my other patients." That's the reason why she snapped, because they work well as a team on that ward so I don't really see her reasoning for it, unless she was just in snap mode (009/1/320-25).

Thus critically reflecting on practice can develop ethical practice.

> You are told not to do any harm to someone. Generally we don't think we are, but you have really got to look at it. Are you really? That is the thing that you have always got to keep reflecting on (008/1/684-7).

In the above excerpt the participant critically reflects on her perceptions of 'harm'. She inadvertently identifies that she may have an assumption about 'harm'. Perhaps her idea of 'harm' may be different to how the patient perceives 'harm'. Mead (1934) proposes, "The individual experiences himself as such, not directly, but only indirectly, from the particular standpoints of other individual members of the same social group, or from the generalised standpoint of the social group as a whole to which he [sic] belongs" (p. 138). This in turn can influence behaviour, and arguably then, ethical behaviour. Reflecting back on past experiences in a critical manner could potentially change future practice.

Changing future practice

Reflecting on practice has a role to play in improving practice that is ethical.

> So reflection helps you look at what happened. You may say, "Well ok, you didn't speak up for your patient then which is quite bad." You feel a bit guilty about it. Quite often the tutor and other people would talk about it and we would come with better strategies as to what you could do next time it happens. (008/1/478-82).

Woods (1999) suggests that teachers of nursing guide and lead their students as they confront everyday moral issues, hence engaging in guided reflection. Fry (1994) too suggests that analysing ethical conflicts as they occur in the practice setting can enhance ethical practice. Journaling and reflection tutorials are an opportune time for this to occur.

> Some tutors were really good at getting an issue out and saying, "Ok! Shall we look at how this might have been different and I remember learning in those situations, different approaches to things (001/1/937-9).

According to Blumer (1969), as ascertained in Chapter Three, humans act towards their world. They meet and handle this world through a defining process by making indications to themselves. On that basis, they move towards constructing action. Thus,

> It is good for future planning I guess, which is one of the things that we do (008/1/478,9).

Emancipatory reflection

Writing in a journal has the express purpose of exploring and growing from experience as one reflects on practice. Within stories, assumptions, values, images of self and the profession can be illuminated (Holly, 1989). The next participants' reflections demonstrate what Taylor (2000) identifies as 'emancipatory reflection' where wider hegemonic processes constraining nursing are exposed.

> Nurses sit around in their tea break complaining about the things that they feel they can't change and they never take it further. In this way I think reflection is really good, even if I didn't particularly like writing it down. It was sort of identifying the issue. You find an issue and start thinking about it. For example, Mrs S has been on her bell all day. This issue is that you are under-staffed, not that Mrs S is ringing her bell (002/1/871-78).

The participant understands that 'emancipatory reflection' can lead to change, or in other words, praxis.

> You actually take it back to what the problem is and then try and do something about it. If the process of reflection were not learnt about then you would only get as far as complaining about it. You wouldn't move through the whole process (002/1/880-6).

For nursing, central to reflection is the potential for emancipatory effect as explained by Taylor (2000), "Emancipatory reflection leads to 'transformative action' which seeks to free nurses and midwives from taken-for-granted assumptions and oppressive forces which limit them and their practice" (p. 148). To this end students of

nursing engage in journaling and reflection sessions. However, in this study emancipatory reflection was an espoused-theory where, as Argyris and Schon (1974) explain, there is a verbal allegiance to theory. This fell short of being a theory-in-use, which, Argyris and Schon explain to be, actual actions. It is suggested that numerous reasons evoked this incompatibility and these will be explored in the next chapter.

Lacking links to ethics theory

Although clinical tutors attuned participants to their 'gut feelings' and also guided them, they did not however, utilise ethics theory to bring further meaning to the ethical issues apparent in the practice setting. The following participant shows this.

> We discussed [ethical things that went wrong] with our tutors and peers as to how to do it and how to go about it. Most of them [the tutors] would sort of say, "Well, you have learned something from that and that is the best thing you can out of it" (008/2/155-7).

> So you could probably see why they say: "Right now, there are ethical issues there, what about the legal ones or what is your role in this." In this way they [the tutors] tried to bring it back to you [the student], so we never really quite got into using the [ethical] language. It was just: "Yep, you are aware of if, yep, let's go"(008/2/231-3).

It was not evident within the substantive data that tutors utilised ethics theory in their guided reflection during 'journaling and reflection' tutorials. If clinical tutors developed ethical learning by adding ethics theory, students' ethical learning from their ethical experiences could be maximised *(field note, 31/8/02)*. Furthermore, as participants engaged in 'journaling and reflection' tutorials, they sought validation of the 'evaluations' and 'responses' that had occurred in the practice setting. During discussions, future behaviours and ways to manage the ethical context were explored. Linking issues raised whilst 'reflecting' with ethical theory was absent.

Debriefing with peers

On a regular basis, participants talked with their peers about the ethical experiences that they had had in the practice setting. This process elicited support. Rather than purposeful reflection, participants preferred to verbally 'debrief'. Participants also found support from their peers. This would make sense in that their peers shared their ethical perspective.

> The best reflection is when you are just talking to other students (002/1/849).

Debriefing was used to 'unload'.

> I've had lots of discussion with other students. It's really good to debrief with them. Everyone's had countless ethical decisions and just saying stuff that they just thought was terrible (009/1/566-69).

Debriefing with peers provided a medium for siphoning off feelings of distress and unease, as participants talked with one another about what had distressed them, they experienced a sense of ethical relief. Campbell et al. (1994) also discovered that student nurses felt understood by their peers where they could use each other as 'sounding boards' and 'shoulders to cry on'. Sharing one's concerns with peers knowing that one will be treated with understanding and thus 'providing one another with emotional support' was seen to be crucial to students' learning. Essentially, debriefings with peers made participants feel better and provided a means to coping with the ethical challenges that they faced.

> I happened to live with four other nursing students, so in a sense it was great. We would all get home and we would say, "Oh, do you know what this nurse did?" (005/1/350-2).

Hence debriefing is clearly a process of 'dissipating' feelings. This process is essentially palliative (relief of symptoms) and doesn't deal with the ethical problem at hand – that nurses' ethical concerns are over-ridden by themselves, other nurses, as well as doctors *(field note, 23/5/02).*

What 'debriefing with peers' did not appear to do however, was to provide strategies to effect change. This was not on the agenda of participants, or it seems, their peers. Essentially, having one's feelings dissipate, mainly by being able to talk about issues as well as having one's perspective validated meant that the participants could progress on from what was troubling them. Interestingly, Holly (1989), even though she is talking about writing in a journal, expresses that when emotions are vented it may be that we feel enough relief to stop short of affecting actual change. This is what seemed to be happening with participants. When the emotion had gone, they could progress.

Journaling and reflection was a method identified by participants in this study that facilitated their learning of ethical practice. Essentially participants, with their tutors, explored various options for future ethical practice. This exploration was at a 'theories espoused' level and did not progress to 'theories-in use (Argyris & Schon, 1974). Throughout this process ethical theory was not accessed or referred to. 'Gut feelings' were valued and purported to be a way of determining whether an action might

be ethical or unethical. As participants 'debriefed' amongst themselves they gained valuable relief of distressing feelings and support throughout their ethical journey towards graduation. One final category reveals how participants learned ethical practice; they actively experimented within the practice setting.

Experimenting in the practice setting

Throughout this study it has become evident that participants' learning of ethical practice happened by 'observing' and 'seeking guidance' from role models. They also engaged in journaling and reflection. This, along with 'debriefing' with their peers provided 'relief of feelings' and validation of the 'evaluations' and 'responses' participants had to what they 'observed' within the practice setting. Much of this work was hidden. This final category was deemed to assist participants to learn ethical practice whilst in their clinical placements. They learned by actively experimenting within their respective environments. Four sub-categories reveal how participants tested out their knowledge of ethical practice. They are 'suggesting tentatively', 'trial and error', 'making mistakes' and by 'experience'.

Suggesting tentatively

Participants further explored the ethical context by 'suggesting tentatively' in the practice setting. This was a way of testing the 'responses' and 'evaluations' that they had made through 'observing'. They also tentatively tested their body of 'developing nursing knowledge' by ascertaining 'nurse assessed needs'. Tentativeness was a way of staying within the parameters of the student role and managing uncertainty as to whether their suggestions would be right or not. Tentativeness was also related to participants' insight into their lack of experience within the practice setting.

> I did make suggestions but I always felt quite inadequate and stupid, just because I wasn't the one with the star. I always looked up to people. I believed that I had no experience and so I did make suggestions, but they were always extremely tentative (001/1/700-3).

This next particular participant made suggestions that were based on a strong knowledge base and yet had her suggestions discarded. In a sense, even in this early exploration of ethical decision-making, participants experienced an over-riding of their suggestions as this example shows,

> I remember asking about giving some morphine to a man in a surgical ward because he was saying he was in a lot of pain and he had some left on his chart to give … She [the nurse] gave him codeine (001/1/714-20).

The participant analyses the nurse's response.

> I think that is interesting. A patient asks for a certain drug, so why do people have this thing about morphine? I think nurses think ooooh; I don't want them to get addicted. But if the person's in pain, shouldn't you give it to them? I have this belief, and I think I got it from Polytech, that if someone is in pain, they're not going to become addicted to morphine (001/1/721-29).

The nurse's response was incongruent with the participant's knowledge. Furthermore, making tentative suggestions involved a degree of 'risk' for the participant.

> It was always quite scary asking them if they should give some morphine because they were likely to say no, because of this strange mindset around that drug (001/1754-6).

To further confirm this category, here is another example of a participant offering a suggestion in a tentative manner. Notice that the suggestion is based on acquired 'developing nursing knowledge'. His suggestion is unexplored by those in the practice setting.

> I had just read [a research article] on Diabetes where they had surveyed 3,500 participants to discover whether pricking the thumb [for a droplet of blood to measure blood glucose] or the ear lobe was more/less painful. They found out that the ear lobe was the best place to do it … they said [the staff], "Well, we don't do it that way." So I thought, "Okay, fine" (007/1/336-91).

It has been established earlier that participants were 'evaluating' what they 'observed' in the practice setting against what was their own 'developing nursing knowledge'. When participants made tentative suggestions they 'tested' their knowledge at a beginning level in the practice setting. Participants hesitated to make suggestions. Those suggestions were, more often than not, rejected. It could be said that this inhibited their ethical learning. Pryjmachuk (1996) proposes that for learning to be successful, learners need both the opportunity to test and to refine theories. They also need to experiment and reflect on the utilisation of those theories. This researching process develops expertise. This opportunity for learning was not fully realised by participants in this research. Furthermore, it seems evident that participants also deemed meeting 'nurse assessed needs' as ethical practice.

Trial-and-error

It has been outlined previously that participants identified a lack of ethical theory in the classroom setting. The assumption has been made from data supplied by participants, that 'buddy' nurses and clinical tutors did not make overt links between ethical theories and the practice setting. In this first quote the participant identifies that, in nursing, guidelines and theories were first learned in the classroom setting and subsequently there is some apprehension as to how theory might be outworked in practice. It seems probable that with ethical theory 'lacking' in the classroom setting and furthermore, absent in the practice setting, that apprehension for participants may be more heightened. Notice the uncertainty in the following quote.

> Nursing is one of those 'hit and miss' things when you are learning. You have got your rules, you have got your guidelines and your theories, but you are still going to make mistakes while you are learning. You just hope it is not a big one (008/1/488-91).

For some participants, learning ethical practice involved some degree of 'trial-and-error'. This method did not appear to be a comfortable way to learn.

> You learn how to learn. You can't possibly learn everything there is to know. To learn it all at Polytech is unrealistic. It is like you do have to learn some things later and get that extra knowledge. I just think that ethically you learn by trial and error. It is a little bit dangerous isn't it (006/1/730-6)?

This next participant also identifies this method of learning.

> You would definitely learn ethics through trial and error and practice through your clinical experience (004/1/118, 9).

Participants brought with them into the practice setting their professional 'ethical ideals' that focused closely on the patient. Learning by 'trial and error' was problematic for participants because it could have detrimental effects on the patient. This contravened their 'ethical ideals'. Woods (1997) found that the eight experienced nurses in his study, with little formal or informal ethics preparation were often left to their own resources and learned by trial-and-error. It seems in this study, that learning via this method was not predominant and this is heartening. For participants, concern for the patient also motivated a discomfort towards 'making mistakes' in the practice setting.

Making mistakes

'Making mistakes' in the practice setting was daunting for participants. They were concerned as to the implications that these might have on the patient as this participant expresses,

> Everyone will say, "Well, you will make mistakes, that is what you do while you are learning." That is so true, but it doesn't excuse the fact that it has probably impacted on that person's life and it probably still is today, some of those decisions (006/1/493-6).

The participant is perplexed by the explanation of having to learn by making mistakes. She questions,

> How badly are you going to stuff up before you figure it out (006/1/611)?

This participant is also uncomfortable with 'making mistakes' as a method of learning.

> I think that is going to be a big thing with me. I don't like making mistakes. I really beat myself up when I do stupid things (006/1/615,6).

In the study amongst nursing students conducted by Campbell et al. (1994), one participant expressed,

> [Clinical instructors] ... offer you alternative ways of doing things and explain why; they also protect the patient and the student, and prevent you from making serious errors (p. 1127).

Hence, 'making mistakes' that have a negative impact on the patient may be minimised where clinical tutors provide guidance to their students. Overall, 'trial-and-error' and 'making mistakes' in the practice setting was uncomfortable and problematic for participants. This supports Kleehammer and Fogel's (1990) finding that student nurses were highly anxious with regards to making mistakes in the practice setting. Furthermore, participants in this study identified that they did however, learn by 'experience' in the practice setting. This method was a more comfortable informal method of learning.

Experience

Initially, participants identified that they 'lacked experience' in the practice setting. This participant expresses the novice role of the nurse.

> If someone had put me on a ward in the first year when you don't know anything and you don't know the difference. Perhaps you don't have anything to compare it to (0055/1/741-4).

Participants however, accepted that they would need to learn through the experiences that they had,

> I was not skilled enough, but that will come with experience (002/1/641,2).

Participants expressed that they did indeed learn ethics by experience.

> [We learned ethics] through our practice as well as through exposure to environments [hospitals, resthomes] (005/1/39-41).

Fortunately for participants they did have 'buddy' nurses and clinical tutors in the practice setting to guide them, as identified earlier. These role models were strategically positioned to be able to make explicit links between the ethical experiences in the practice setting and traditional and contemporary ethics theories. Sadly, these explicit links were rarely made. Yet, validation of responses and evaluations were given to participants and this tended to focus on 'gut feeling' responses. However, for this next participant her clinical tutor offered a suggestion to the participant as to how to manage a situation where the lack of experience was acutely felt, that of asking for help.

> "Well, you work in a team and there is going to be somebody in your team that you can align yourself with, a preceptor or mentor that you can go and discuss things with ..." As long as you perhaps do the right thing and put your hand up when you don't know because you are learning and you are going to make mistakes and you can't beat yourself up too much over it. You have just got to try and figure it out as to what you should have done and try and remember that next time you come across something like that [you will have a better idea of what to do]... It is just a step at a time and we will see how you go (006/1/591-8).

It would appear that participants felt the tension of meeting the practice setting with the daunting task of learning how to practice ethically. Teekman (1997) too identifies that learning from experience is quite a 'scary' business. It is noteworthy that Pryjmachuk (1996) asserts that novice nurses have some idea as to how to act in certain situations, however is unsafe to do so due to the risk to the patient if a mistake is made. Pryjmachuk suggests providing guidelines for practice. Ethical guidelines could provide a framework through which novice nurses (students) could more confidently meet the challenges of the 'real world'.

Summary

This chapter has explicated means by which participants, whilst they were student nurses, explored the ethical context of nursing practice. Role models in the practice setting were observed and looked to, to provide guidance and links between theory and practice. Participants utilised the ethical constructs identified in Chapter Four, as well as, 'patient expressed needs' and 'nurse assessed needs (Appendix 5), to guide 'evaluating' and 'responding', to what they observed and experienced in the practice setting. They also began to experimentally test out their 'developing nursing knowledge' by 'suggesting tentatively'.

Experiences were brought to 'journaling and reflection' tutorials for student nurses and their tutors to discuss and reflect on. Reflection here involved seeking validation of 'responses' and 'evaluations' made in the practice environment. It also involved thinking about what might be done 'better' next time rather than challenging the 'status quo'. As part of their learning, participants offered suggestions in a tentative manner in the practice setting. These suggestions were generally discarded. It would follow then that, if participants' suggestions went unheeded, that their challenges might go unheeded as well. Much ethical relief was found by 'debriefing' amongst peers and tutors. Overall, it was found that little ethics theory was utilised by clinical tutors or 'buddies' in assisting participants to make ethical links to the situations that they had found themselves in.

It was identified in Chapter Four that participants learned ethics and ethical practice, by faculty education (principle-based ethics, the law, cultural safety and, the nature of the nurse-patient relationship), role modelling nurses in the practice setting, journaling and reflection, and experimentally ('suggesting tentatively', 'trial-and-error', 'making mistakes', and 'experience') (Appendix 6). Learning experimentally posed a challenge for participants, and was a 'scary' way to learn. Learning by 'experience' in a guided manner was the most comfortable way to learn, essentially because it posed the least risk to the patient. Exploring the practice setting was 'scary' as participants encountered some barriers to their learning of ethical practice. There were however, further barriers and obstacles looming on the horizon, yet to be discovered. These will be revealed in the next chapter.

CHAPTER SIX: REFOCUSING THE ETHICAL PERSPECTIVE

I think you could see something even pretty serious, for example, if you saw someone taking drugs out of the cupboard. You would still be tossing up, "Oh God, what am I going to do about this?" I could be putting my career and all myself and this ward at great risk if I do something about it (004/1/351-7).

Introduction

Earlier in this thesis it has been established that as participants interacted with their faculty tutors and their patients they developed an ethical perspective that closely focused on the patient. Subsequent to this interacting, a relationship formulated between the student nurse and the patient. Moral behaviours and values held in high esteem gave the appearance of 'ethical ideals' that motivated participants to ascertain ethically appropriate nursing care for their patients. As participants continued to 'meet' the practice setting they underwent a refocusing of their ethical perspective. Other factors in the ethical context also required consideration, as well as endeavouring to ethically meet the needs of the patient. As participants' ethical gaze widened, they expressed discomfort at how these factors impinged upon and impeded giving care that was considered ethical.

Several factors impacted strongly on how participants could be true to the 'ethical ideals' held within their own ethical perspective. Having to pass the course, the relatively powerless position of the student role, observing buddy nurses' ethical decisions over-ridden and experiencing the over-riding of their own ethical concerns and attempts at advocating meant that at times, participants sacrificed their 'ethical ideals'. They became mindful of other contextual factors that needed careful consideration when acting according to the expressed needs of the patient, this included their body of 'developing nursing knowledge' and that what the nurse assessed as need, might be at variance with what the patient might have expressed as their needs. This process caused a further widening of their ethical perspective.

Finding a balance

As has already been established, participants held an ethical perspective that focused closely on the patient and the patient's needs. This ethical perspective was weighted heavily towards 'ethical ideals' (Appendix 5) that supported and promoted the patient and their needs. As participants continued to interact with, not only their patients, but also the wider ethical context of the practice setting, they found that other factors also carried weight. Hence, participants found themselves weighing up 'patient expressed needs' with other demands in the practice setting. Often the 'ethical ideals' held within this ethical perspective, had to be sacrificed to meet more pressing demands, as McCaugherty (1991) points out "reality is more untidy" (p. 540). Thus participants found themselves 'balancing' their 'ethical ideals' with contextual factors that needed serious consideration. Within this category of 'finding a balance' there are several sub-categories that signify contextual factors that participants had to weigh up alongside their 'ethical ideals'. These included, incorporating 'developing nursing knowledge', 'promoting independence', 'defining professional boundaries, moving from 'patient expressed needs' to 'nurse assessed needs', 'being finite' and 'being socialised'.

Incorporating 'developing nursing knowledge'

As participants progressed through their undergraduate nursing education, their 'developing nursing knowledge' grew. This knowledge incorporated an understanding of behaviours that promoted health for individuals. In previous chapters, there was evidence that participants utilised their 'developing nursing knowledge' to assist the 'evaluations' they made of what they 'observed' in the practice setting. As participants progressed in their education they themselves were, not just 'observing' but were more involved with the care of their patients. Hence they began to make some of their own ethical decisions. Participants found that when they were making these ethical decisions their 'developing nursing knowledge' and subsequent 'nurse assessed needs', might conflict with 'patient expressed needs'. Hence participants focused, not only on the patient and their expressed needs, but also on other factors. Thus their perspectives widened as they engaged in 'balancing'.

The following participant's story is an example of 'balancing'. 'Balancing' caused a widening of ethical perspective, or, focusing more widely. Yes, the nurse was there to be sympathetic, listen to the patient's worries and to hold their hand, however, there were times when what the patient needed, according to participants, was to be

strongly encouraged to engage in certain behaviours that would improve their health status.

> They [the nurses] have to keep on at them [the patients] about how to mobilise and trying to reinforce the things learnt from physiotherapy. So quite often you would be the old dragon actually. So there is no hand holding going on there. I suppose, finding a balance has been one of the hardest things for me. Finding a balance between being professional and realising that you are not necessarily their friend, but you are there to be sympathetic and to listen to all their worries. You have sort of a friendly role, but you are detached. It was important for me to find that line (008/1/323-56).

Notice how the participant's perspective has widened to include her nursing knowledge and commitment to promoting healthy behaviours in those she cares for. There's been a shift in thinking. The participant considers on the one hand, the patient's needs for emotional warmth. On the other, the participant considers the patient's need to mobilise, even though mobilising was not what the patient expressed that they wanted at that time. In a study by Nolan and Smith (1995) amongst first year medical, dental and nursing students it was found that these participants experienced conflict in that, on one hand they wanted to respect the patient's autonomy and, on the other there were times that they needed to tell patients what to do. Similarly in this study, 'finding a balance' and weighing up the ethical principles of beneficence and autonomy has widened the ethical perspective. Here is another example of 'balancing' 'patient expressed needs' and 'nurse assessed needs'.

> You are still learning so much, for example, mobilising. "You [the patient] don't want to walk now, well how about we sit you in the chair for lunch and we will put you back later." You do need to get them up so that they get better. But you also have got to consider that they don't want to (006/2/404-8).

As participants engaged in 'balancing', nursing knowledge was weighed against 'patient expressed needs'. There is some movement towards *weak* paternalism as participants chose to utilise their nursing knowledge and thus a 'best interests' approach is enacted. According to Beauchamp and Childress (1994), the 'best interests' standard is where a surrogate decision-maker determines the highest benefit among the options that are available. Weightings differ according to perceived benefits and risks to the patient. Thus, participants engaged in 'balancing'. They 'balanced' 'patient expressed needs' with 'nurse assessed needs' based on their body of 'developing nursing knowledge' and this meant that promoting healthy behaviours may have weighed more

heavily than what the patient defines as his or her needs. Another code which weighs more heavily than 'patient expressed needs' is, 'promoting independence'.

Promoting independence

Promoting independence is an interesting code in that it also deviates from the concept of aligning oneself with 'patient expressed needs'. Again, in this code the participant's 'developing nursing knowledge' becomes evident. It reflects promoting self-care (Taylor, 2001). Participants, as their 'developing nursing knowledge' expanded, adopted nursing interventions that contributed towards a healthy outcome for the patient. Participants encouraged the patient to do what they could for themselves, even if they did not want to. The assumption was that the more the patient could do for themselves the better it would be for them, hence, in their best interests *(field note, 7/7/02)*. Thus the tension: aligning oneself with 'patient expressed needs' or 'nurse assessed needs' based on 'developing nursing knowledge'.

> When you help them out with a shower, you also give them the opportunity to do as much of it as they possibly can. I had a man in a Rest Home and when I went to go and help him with a shower I said, "Here, use this flannel and you can wash your face." He said, "No! No! I have been here for years. The nurses have been doing my face for years"... They [patients] need to think that they can do things for themselves if they want to get their independence (005/01/957-76).

It seems that the participant utilises the ethical principle of beneficence, in that 'promoting independence' is a valued nursing intervention and seen to be 'doing good' for the patient. However, this involves a degree of paternalism. In this case 'weak' paternalism is utilised (Beauchamp & Childress, 1994) in that, as the man in the scenario is in a Rest Home, it can be assumed there would be some form of compromised ability present. Thus, as participants understood healthy interventions and practices, they edged towards 'weak' paternalism. Further 'balancing' occurred as participants defined boundaries between themselves and patients. This was part of developing professionally.

Defining professional boundaries

In the following excerpt, the participant again experiences a widening of her ethical perspective in that she must define the professional boundaries between being the patient's friend and being the patient's nurse. Being the patient's nurse involved a professional stance. The participant grapples with her 'ethical ideals' that entail gaining rapport and, in a sense, being the patient's friend.

> I was working with youth that had eating disorders. One of them wanted to go for a walk. I thought, I am supposed to gain rapport and that is where I found the difference in gaining rapport and being their friend. There is a certain line and it is really hard to maintain. She quite often wanted to go out and run all day if she could. It was an exercise thing. She was trying to lose weight. She was allowed fifteen minutes and I had to escort her. She was constantly pushing the boundaries even to get another minute of exercise … so I actually had to put my foot down and say, "No we are going to head back now." That's what I found really hard … I thought overall, I'm not their friend; I am their nurse. So I had to sort of force her into going back (008/1/872-89).

Interestingly, in the above scenario, the participant realised that being true to the 'ethical ideal' of acting according to 'patient expressed needs' contravened her 'developing nursing knowledge'. The participant realised that there are professional boundaries that the nurse must define, and that at times, this involved having "to put my foot down." With the widening of perspective, tolerance for 'weak' paternalism has again crept in. The ethical motivation of the participant is beneficence, and therefore the paternalism engaged in can be somewhat ethically justified (Thompson, Melia & Boyd, 1994). Furthermore, the ethical motivation is also in the patient's best interests. Thus, there were times when 'patient expressed needs', were according to participants, not in their best interests. As a result, 'ascertaining needs' entailed 'nurse assessed needs', where the nurse assesses the patient's need for nursing care.

It is noteworthy that Noddings (1984) also reveals that 'caring-for' can give rise to conflict, "when what the cared-for wants is not what we think would be best for him [sic]" (p. 18). Hence, the decision was made by participants to, at times, utilise their 'developing nursing knowledge' of healthy practices. This added knowledge widened the ethical perspective of participants as this knowledge too, had to be considered when ascertaining what might be the patient's needs. With this dimension added to the decision-making process, there is again some leaning towards paternalism. Participants didn't like paternalism, as identified in Chapter Four, however as participants' nursing knowledge developed, it was adopted in certain cases.

It is evident in the previous scenario that the participant was grappling with her 'ethical ideals'. In the situation with the patient who has an eating disorder, it may not be in her best interests to be allowed to run all day, even though the patient wants this. The participant's already firmly established ethical perspective undergoes enlargement and thus incorporates added factors that are to be considered when making ethical decisions that still 'do good'. Thus, the 'ethical ideal' of 'nurse assessed needs' is

utilised and correlates with a 'best interests' approach (Beauchamp & Childress, 1994). Furthermore, 'best' entails maximising benefit.

Furthermore, the participant goes on to reiterate this progression from an established ethical perspective that focuses on 'patient expressed needs' being in their best interests, to considering that meeting these 'needs' may not necessarily contribute to positive health outcomes.

> Boundaries ... I didn't really like the idea of them at first to be honest. I thought, "Well, this isn't patient focused and shouldn't they be able to do what they want?" So, it is about having to see, I suppose the greater good, the overall outcome which is another reason ... At the time the patient's wishes may have been to go home and spend the weekend with her family, and that is quite important. But it may have also been quite detrimental to her [health] outcome (008/1/436-44).

Kolb (1984, p. 30) points out that, "Learning is therefore by its very nature a tension and conflict-filled process." This was so for participants. They generally felt uncomfortable with the process of readjusting their ethical perspectives, however as their perspectives were widened through the experiences that they had, they were able to refocus on the patient with somewhat widened ethical gazes that considered other factors, one being a healthy outcome. This outcome was, on one hand defined by participants as health professionals, and hence paternalism. On the other, due regard was also given to what the patient expressed to be their needs.

Hence, a widening perspective incorporated considering that which the patient wished, may not necessarily be in their best interests *(field note, 9/7/02)*. In widening their perspective however, participants did not forfeit their 'ethical ideals', as their focus was still on the patient. Their perspectives were just widened to incorporate other factors alongside:

> It depends on the patient. I mean, if we have a young, fit, twenty year old with appendicitis, what is in the patient's best interests is what the patient wants because they have all the faculties to make an informed decision. When things get more clouded it comes down to nursing judgement and a lot of it is around power (002/2/39-42).

In the above excerpt, the participant indirectly refers to *weak* paternalism. In *weak* paternalism, a person's autonomy is compromised in some way and thus it is acceptable to paternalistically override their wishes (Johnstone, 1999). Hence, the focus continues to be on the patient, however other factors are now 'seen' as the ethical gaze widens.

'Balancing' of one's resources also entailed realising that there were constraints to meeting all the needs in the practice setting, due to 'being finite'.

Being finite

Participants realised that there were limits to their ability to engage in ethical practice. In the end, 'balancing' meant that some things had to be let go in order to maintain equilibrium. Participants realised that they could not meet everybody's needs.

> You still have to live with it at the end of the day. You still have to find a place where it can sit with you so that you feel good about it. There are still decisions that you see going on every day that you don't feel right about, even stuff that you see on the news. But you can't go on thinking about it, otherwise you will get upset and you will never get along with things in your own life. Yeah, It's hard (008/1/545-50).

Smith (1998), in a study that utilised 25 undergraduate nurses, found that although participants valued 'attachment' to the patient, they concluded that some degree of distancing was necessary to preserve the ability to function and thus to prevent 'burn out'. Noddings (1984) explains that periodically there are conflicts of caring and cites the example of conflict over meeting competing needs of differing persons. She suggests that sometimes conflict cannot be resolved and must simply be lived. This conflict is evident in the following quote,

> You have to look at the fact that you might be on a crusade for one person; it is not going to help if you are not going to be there for the next twenty years to look after people who need it (008/1/540-3).

As participants further engaged in the practice setting they became aware that they were 'finite' and thus were not able to solve all the ethical problems that surrounded them. They were also unable to meet everyone's needs. Smith (1998) also found that when student nurses realised that they were unable to put everything right in the practice setting, their initial high aspirations had to be adjusted somewhat. Participants, to manage this phenomenon engaged in 'balancing'. The final sub-category that supports 'balancing' is 'being socialised'.

Being socialised

As participants engaged in the practice setting they experienced a widening of their ethical perspectives. 'Being socialised' was also seen to be a potential factor that could deflect participants from focusing on the patient. This participant dreaded being socialised into focusing on other issues rather than the patient:

> It scared me that I would become like that [not contacting the wife of a man who was dying so that she could decide whether she wanted to come in during the night and sit with him]. I think you could after a while, despite the good intentions that you have. Sooner or later you are socialised to the thought and you get burnt out and it is then that you have enough trouble dealing with your own problems rather than other peoples' problems. I think that scared me. I could see me going down that path in three or four year's time (008/1/283-88).

This next excerpt highlights that socialisation minimises noticing things:

> The little things that happen everyday that start to perhaps be, not so ethical. Maybe because whoever does them gives their little wee spiel of why it is valid. It may not be, but they seem to back up their idea, so perhaps you just start to not really notice things like that so much (005/1/715-8).

Noddings (1984) has an opinion on this phenomenon. She states, "Clearly, there are those who are out of touch with their feelings; the "I must" has faded to a whisper and finally been stilled" (p. 104). Greenwood (1993) expressed concern when it was found that repeated exposure to less-than-caring nursing practices could cause desensitisation to human need. For this next participant, 'being socialised' meant that some 'ideals' had to be sacrificed, for example, informed consent.

> When we first learned about it [informed consent], you would go up to a patient and say: "Oh, would you like to go for a shower today?" You would then ask: "Is that ok with you?" It doesn't happen ... [It is more] we are having a shower today: "Would you like it before breakfast or after?" Or [you might say]: "I have only got time to do it now, could you put your dressing gown on," and if someone gets up and puts their dressing gown on, I guess people take that as informed consent.

How do you *feel about that?*

> It is so against everything we learned ... I mean by the end you were already socialised and you were doing what other nurses were doing and you did have a lot of pressure, once again it was that power [thing]. Everyone looked at you as if you were a 'lazy' nurse, or you don't push the patients far enough to get results (008/2/277-88).

The previous excerpt from a follow-up interview, confirms that it was a pressurising factor in the practice setting to 'push' patients along a bit. This contravened participants' 'ethical ideals'. Notice the hierarchical approach in that other nurses pressurize the student and subsequently, the student pressurizes the patient. This contravenes the 'gaining informed consent' and 'spending time'. Interestingly, Chevasse (1992) also points out that nursing students are socialised into a hierarchical environment where students are at the bottom and the only people below them are the

patients. Furthermore, nursing students acquire two variations of beliefs, values and actions during their professional socialisation, firstly from nursing theory, and secondly from nursing practice (Greenwood, 1993). Essentially then, students encounter a, "severe dissonance of values but learn to conform to survive (Chevasse, 1992, p. 2).

Participants' perspectives widened as they realised that there was more to the 'real world' of nursing than just the patient and what the patient expressed as their needs. The revelation that the 'real world' of nursing practice, did not match their 'ideal world' where the patient was the focus, catapulted participants into the 'real world' of nursing practice. Preceding this revelation was 'seeing' and subsequent 'perceiving' of hindrances to 'patient focused care'.

'Perceiving' the practice setting

One of the definitions of 'perceiving' in the Collins (1992) is 'understanding'. Another definition is 'observing'. In Chapter Five it was identified that participants adopted an 'observing' role in the practice setting. The observations made there, were at a different level than what this category will expose. Earlier, they 'evaluated' and 'responded' to what they saw in the practice setting according to the 'ideals' held within their ethical perspective as well as their 'developing nursing knowledge'. As they progressed through, participants not only 'observed' they also had 'understanding'. This 'understanding' was a process that had developed over time. As participants 'understood' the obstacles in the practice setting through the experiences that they had had, they attempted to navigate through these obstacles.

In a sense then, 'understanding' encapsulates 'revealing' and 'unfolding'. Thus 'perceiving' is placed in this part of data analysis, because 'understanding' came with experience in the practice setting. It involved the realisation that the 'ideal' was not always reflected in the 'real' world of nursing practice. 'Perceiving the practice setting' over-arches several sub-categories that explain the perceptions that participants had of the 'real world' of the practice setting. They 'perceived' factors that impacted on their, and other nurses', actual or potential ability to provide care that firstly, focused on the patient, and secondly, upheld their 'ethical ideals' (Appendix 5). These factors will now be explored.

'Perceiving' the 'real world'

In the following excerpt there are the essential elements of the 'ideals' held within participants' perspective of 'focusing on the patient', that of; 'spending time',

'identifying with the patient', ascertaining 'patient expressed needs' and 'protecting the dignity of the patient', are evident.

> There was an elderly gentleman who was living in a hospital that was attached to a rest home. I had enough time to be able to develop rapport with him and make contracts with him as he had some issues around motivation and wasn't so keen to sit up in the morning. To me it was OK. (002/1/84-88).

This participant brings these 'ethical ideals' into the practice setting and the registered nurse attempts to adjust these 'ideals' by superimposing the 'real' over the participant's 'ideal'. Interestingly the participant 'submits' because of her student role, however she reiterates her 'ethical ideals' to herself, thus strengthening her ethical resolve. Furthermore, she analyses why the registered nurse would think differently. The registered nurse did not support this approach and hence the participant experiences an adjusting of her ethical perspective by the over-riding of the registered nurse.

> The senior nurse was saying, "Don't do that because when you are gone, I won't be able to do that and so you should make him get up at seven o'clock in the morning just like everyone else and make him have breakfast at the table" (002/1/93-97).

The participant, because she was a student, 'submitted' to the senior nurse.

> I can sort of see what she was saying. I'm here and I'm sort of part of the student role and at the end of the day she is a senior nurse and that's just how it went down (002/1/101-3).

However, the participant reiterates her own ethical perspective and the 'ideals' embedded within it. She utilises the ethical approach of 'identifying with the patient' and by 'maintaining the dignity of the patient'.

> I don't like to wake people up at seven o'clock in the morning, especially if they are in their eighties. I don't think that I would want to get out of bed when I am eighty-three years old … when you are new you are sort of terribly, horribly concerned that someone has got soup stains on their cardigan and you want to go and change it. But when you're a more experienced nurse you are most probably going to say, "In a utopian world then I would be able to change it but I don't have time to do it so, it is not a priority and I'm not going to think about it. You would then get a lot more blasé" (002/1/107-22).

Notice how the participant focuses on the patient. Notice too that her perspective widens to incorporate another factor, that of 'not having enough time'. She 'sees' that in the 'real world' some ideals will not be attended to, in fact, in the 'real world' some of the ideals will be lost completely, in that she states: "You would then get a lot more

blasé." Turnbull (2001), found whilst reviewing literature related to 'An ideal/real dichotomy' that common amongst authors, was the identification of confusion and conflict that arose because the actual practices that nursing students encountered in the practice setting did not reflect what they were taught in the classroom. Participants in this study too, found this confusing and experienced conflict as a result of this dichotomy. As new perceptions entered upon the horizons of participants their ethical perspective widened to incorporate them. Their ethical gazes swept further. As they related to others in the 'real world' they also 'saw' factors that others could 'see'.

Seeing the bigger picture

Participants held in their focus the patient and 'the patient's needs'. As participants' own 'developing nursing knowledge' grew, there was the realisation that this body of nursing knowledge still had significant gaps. Registered nurses in the practice setting, having had more experience and thus a broad 'body of nursing knowledge', could provide knowledge to bridge the gap between what the participant, as a student nurse knew, and what the registered nurse knew. Hence the transference of nursing knowledge, widened the cluster of factors that needed to be considered when making an ethical decision in the practice setting. Participants realised that there may be more to the picture than just what they 'saw'. Thus, they opened themselves to absorbing nursing knowledge. This nursing knowledge in turn, meant that again 'weak' paternalism was considered.

> I mean it is the little things like, 'such and such' doesn't want a shower, I would probably still even run it past the registered nurse mainly because people would look at you and say, "Oh that student was a bit lazy." Or perhaps it might be something that might affect their care. I might not have seen the bigger picture. Perhaps they might have needed to get up to go to the shower because of a skin condition that they were having. Or perhaps it is time to get them off their pressure areas. Or perhaps it is part of the rehabilitation (008/2/52-7).

Here is another example of the lack of nursing knowledge and how the student nurse might 'get stuck on one point' because he or she does not see the 'whole picture' due to lack of experience.

> [For example, if my patient doesn't want to have thickened fluids and she hates them. [As a student you might say] "Let's change [the fluids]. But you may not have a really good understanding of why [the patient is on thickened fluids]. You can get stuck on one point (008/2/66-8).

The participant confirms,

> Some of us [as students] get a bit 'holier than thou' and on a bit of a 'soap box'. [We wondered why] none of the other nurses would listen ... [Students] don't see the rest of the picture (008/2/70-3).

Participants, as they progressed through their undergraduate nursing education were acutely aware that there were factors in the practice setting that they did not yet know or did not yet 'see'. They were open to 'seeing' these factors. Hence as 'seeing' occurred their ethical gazes widened. It was not only what participants 'saw' that gave them understanding and widening perspectives, there were even more powerful learning experiences awaiting them. They also grappled with 'powerlessness embedded in the student role'.

Powerlessness embedded in the student role

It was established in Chapter Five, that participants observed in a silent manner due to their role as student nurses and perceived powerlessness within the practice setting. Feelings of powerlessness also resulted from 'failed advocacy' and 'over-riding' of their ethical concerns by health professionals within the practice setting that 'held' power over participants.

Experiencing failed advocacy

This next participant tells of a psychiatrist who prescribed medication that made the patient drowsy. The patient had a mental illness and seemed to be quite an active man. What concerned the participant was the medication regime prescribed for the patient and the resulting drowsiness that occurred. Notice this example of one participant engaging in 'advocating'. Unfortunately her concerns were over-ridden to the detriment of the patient. This was distressing for the participant and the end result was that the participant felt powerless. Eventually the patient fell in the shower because he was overmedicated.

> She [the psychiatrist] didn't like him, so she fully charted him to his eyeballs (001/1/78-90).

It was the participant who had advocated on behalf of the patient.

> I was in a meeting and she [the psychiatrist] completely just totally didn't listen to what I was saying (001/1827-8).

Not only was the participant not listened to; the registered nurse wasn't listened to either.

> As a student, I felt really without power, like my opinion didn't count. I'm not sure that the registered nurse's opinion counted either … [Anyway] ethically you just don't do that to somebody … You don't drug them to the eyeballs and leave them on the bed for six days … He wasn't floridly psychotic … He had some behavioural issues. Do you medicate for behavioural issues? I don't think so! And I didn't think so at the time either and so it upset me (001/1/840-9).

In this situation the participant experiences an 'over-riding' of her ethical concerns, in that the psychiatrist did not change the dosage of the medication. Hence 'failed advocacy' was the outcome. The participant attempts, in line with her 'ethical ideals', to engage in 'advocating'. It failed and she experienced feelings of powerlessness. The end result was that the patient fell in the shower and also spent the time that he was in the hospital for respite care, on his bed. This was ethically unacceptable to the participant.

Evident within this scenario are the 'evaluative' and 'responsive' processes that the participant engaged in. She 'evaluated' what was happening to her patient according to, not only her 'ethical ideals', but also her 'developing nursing knowledge', in that she says, "you don't medicate for behavioural problems." Thus it is evident that practising ethically was also about implementing appropriate health care. On the basis of her evaluation she engaged in 'advocating' for the patient. She also responds emotionally to the effects over-mediation had on her patient in that she says, "So it upset me."

Consequently, there were times that participants were unable to enact their own ethical decisions. This was not only due to their 'perceived lack of power', it was also their 'experienced lack of power'. The sub-category 'intensifying feelings of powerlessness' expresses this poignant point still further.

Intensifying feelings of powerlessness

In Chapter Five it was established that participants, due to their 'learner' role in the practice setting perceived that they were powerless to impact the ethical context surrounding them. This powerlessness was reinforced as participants experienced an over-riding of their own ethical concerns that were expressed to others in the practice setting, and their subsequent 'failed advocacy' experiences. Thus powerlessness was reinforced.

> You don't really feel like you have got any power (009/1/291-3).

Powerlessness was linked to the lack of experience and being in the student role.

> I guess, in a couple of years time, when I've got more experience, obviously I've got to be more competent in my head with the right decision. I want all that experience now, but obviously you haven't so you 'play along' (009/1/477-80).

Lack of experience and powerlessness in the student role are illustrated in this quote.

> It was out of my control ... I didn't have the power to do anything about it ... I didn't have the experience either (002/1/478-89).

This participant sums up regarding powerlessness,

> Students have got 'diddly-squat' power at all (004/1/210).

Lacking in experience, being learners in the practice setting and experiencing an over-riding of attempts at 'advocating' reinforced and strengthened a sense of 'powerlessness' within participants. This 'powerlessness' was further entrenched as participants 'perceived' and thus 'understood' another factor in the practice setting that they had to contend with, 'needing to make an impression'.

Needing to make an impression

This sub-category emerged, as participants grappled with ethically endeavouring to meet the patient's needs, 'advocating for the patient' and 'having to pass the course'. There were times when participants wanted to challenge behaviours that they saw in the practice setting that undermined the patient's needs, however, they were constrained to do so because they did not want to upset the nurses who might be involved with writing their final reports. 'Needing to make an impression' was given considerable weight in the decision-making process for participants. This caused a compromising of their 'ethical ideals'. There were times when participants decided not to speak up so as not to upset the buddy nurse. Participants were aware of this behaviour and were not comfortable with it. This scenario illuminates that 'advocating' enacted by the participant results in her feeling unpopular.

> There was a very sick gentleman and he was in a room by himself ... His only form of communication was the bell and he used to ring the bell a lot. I remember one nurse got particularly perturbed by it and went and pulled the bell out of the wall and said, "Stop doing that." I went to check on him because he hadn't rung for ages and he was furious and his tracheostomy was gurgling. I had to suction him ... I went to talk to her about it but she wasn't my buddy. But I consulted with my buddy first. He thought it was disgusting and consequently I just sort of said to him, "Don't say it was me." I thought of myself as very unpopular (009/1/296-308).

'Needing to make an impression' meant that 'advocating' was constrained.

> I think, several times I said something, but more often than not a student feels like they shouldn't interfere and you are so worried about fitting in and getting on the good side of people that you don't want to upset the apple cart (006/2/122-4).

McCleland (1998), in a New Zealand study, found too that undergraduate nurses felt compelled to fit in. Furthermore, Kelly (1991) in a study amongst English student nurses found that 'fitting in' and 'going along' was given considerable importance, in that they wanted to be accepted in the practice setting. Participants in this present study also seemed to see it as crucial to be accepted. It was perceived that a poor impression might impact negatively on their assessments. Pleasing the buddy nurse was a pressurising factor in the practice setting.

> It is an uphill struggle trying to be accepted by them or trying to at least pass your grade and get along in their clinical area (004/1/709-12).

> You have to pretend not to see things ... how can you 'dob' in your buddy when you are supposed to work with them on the ward (004/1/325-33).

The following excerpt proves to be a dilemma for the participant. She grapples with enacting the 'ethical ideal', 'advocating' for the patient and the possible consequences this action.

> I guess that that is the selfish part of you that you want to make a good impression ... Obviously you want to do right by the patient but you're not always going to be as outspoken as maybe you would be if you were a registered nurse (009/1/343-8).

As participants continued to focus intently on the patient, they also noticed other factors in the practice setting that might constrain them. 'Needing to make an impression' was seen to be crucial in propelling participants forward to a successful graduation. Participants were reluctant to jeopardize their progress in the course even if this meant sacrificing their 'ethical ideals' in the process. However, 'needing to make an impression' did not deflect participants from their 'ideals', they sidelined their 'ideals' to meet a greater personal need, 'needing to pass the course'.

Needing to pass the course

Having to pass the course caused participants to be ethically hamstrung. This contributed to their powerlessness to activate 'advocating' due to understanding that it was risky business. Hence participants over-rode their own ethical concerns *(field note,*

23/5/02). Consequently, it appears that there was considerable pressure on the student nurse to maintain the student-'buddy' relationship due to the possible adverse consequences of being ostracized or failed the course. Turnbull (2001) also found that students felt the need to perpetually prove themselves to make sure that they passed their course. This next quote also reiterates this.

> I was also trying to meet my own requirements for Polytech so that I actually passed the course. I was also looking out for myself as well. I also didn't feel that confronting the nurse about this issue [not listening to the patient] would affect any change either (002/1/773-77).

When participants considered challenging unethical behaviour in the practice setting they had to weigh up.

> If word gets out that the student is actually making comments like that everything hinges on what is going to get written up for us. You know, assessments. So, students are frightened that they are not going to graduate because of that. If you are off side with you fellow staff then that can be disastrous. You will get a very poor write up and that also hinges on your future employment prospects as well. So students are very much caught up in that ethical dilemma of how much do I push this (003/1/524-34).

Another participant reiterates,

> They give me my appraisals and everything (005/1/772).

This participant explains that if the situation warranted it, a student might push it.

> It is usually when something goes absolutely wrong or is dangerous or for some other really big reason they will really only push it. If it is just a minor ethical thing, [for example] if they don't agree with the person's practice or whatever, they won't push it (003/1/533-7).

It is understandable that participants were hesitant to 'speak out' too forcefully whilst they were students. Darbyshire (1989) also questions how a student nurse could possibly attempt to advocate for patients when there have been historical incidents where the ramifications of senior nurses opposing doctors orders, hospital policies or even the law, have been catastrophic. 'Needing to make an impression' and 'needing to pass the course' were factors that participants had to consider before they did anything in the practice setting. As part of their weighing up as to what to do, or what might be the right thing to do, they considered what impression their actions might make on the staff that they were working with, or alongside. It seems that participants weighed the pros and cons. 'Needing to make an impression' and 'needing to pass the course' went into the weighting process and perhaps this also impacted on the degree to which the

participant could enact their own decisions, choices, and interventions *(field note, 11/5/02).* Participants thus, at times, over-rode their own ethical concerns for the sake of 'having to make an impression' and 'needing to pass the course'. Turnbull (2001) too found that the fear of failure amongst nursing students was of immense concern to them.

Lacking support to 'speak up'

There appeared to be little support offered to participants to 'speak up' in the practice setting. According to the data, clinical tutors that 'guided' participants in the practice setting did not actively support participants to attempt 'advocating'.

So did your clinical tutor ever help you or support you in speaking out?

> Not really, I think probably some of them would have but I think that they would only back me up if I was prepared to do it and I guess I don't know if I would have been. [It] sounds awful, but it is a reality when you are a student because you have got your evaluation going on (008/2/161-3).

Perhaps participants did not request help in 'advocating' for their patients for the express reason that it might impact on their chances at passing the course.
This next participant makes a suggestion

> We don't have enough support in that area. If the tutor actually said at the start of every placement, "Hey, look if you see something that is unsafe here there is a way of reporting it in a confidential way without it coming directly through you." You could then go to someone over and above where you felt safe to disclose what you had seen or what you had heard without being identified (004/1/362-7).

Participants generally did not feel that they had received the support to 'speak out' in the practice setting. Participants also felt heavily their need to pass the course. Thus, 'advocating' was sacrificed for a more pressing need.

That clinical tutors did not actively support participants in 'speaking out' is not entirely surprising as the profession as a whole severely lacks strength in this area due to its apparent subordinate positioning in the practice setting (Yarling & McElmurry, 1986). There was one avenue to 'speak out' that did not seem to attract negative connotations; that was 'writing in the clinical notes'.

'Covering your back' – a response to powerlessness

Participants were taught by clinical tutors to document any ethical concerns that they might have. Documentation was important for these participants because if there was any questioning as to why their ethical decisions were not enacted, there was a written explanation as to how the ethical decision of the nurse was over-ridden.

> I just get the feeling that when you come across ethical and legal things in a hospital that the nurses can report it and document it. They are not always the ones actioning it I suppose. It's most likely that they need permission from doctors or other members of the Multidisciplinary Team (009/1/142-6).

Students see nurses needing permission from doctors. Are they learning here that it is the doctor who gives the ok? They see nurses enacting the moral decisions of others. Nurses are clearly down in the pecking order and students are well aware of this; they see it happening *(field note, 24/5/02)*. Thus, participants learned that ethical issues that they perceived that they had no control over could escape later repercussions if they were clearly articulated in the clinical notes. It seems that documentation is a way of covering one's back and an audit trail as to what happened from the nurse's perspective. It may be that this is an expressed way of nurses being able to wield some power. It is also a form of protection for the nurse. As students, participants utilised the clinical notes to document their concerns and any actions that they may have taken to meet the patient's needs.

> As a student, because everything that you did had to be past your buddy, quite often they would say, "Oh yeah, whatever." I would also say what the person [the patient] was feeling, what they wanted and what they didn't want. I would always document it, despite what everyone else said that you didn't need to document that or whatever. I still documented it (008/1/499-504).

Documentation was used as a safety net.

> When you are a student you do not want to appear unsafe. So something that you have failed to do, like at [names a hospital] they love their daily showers. If you know someone who does not want their shower or they are just not up to it and you put 'not showered today', the afternoon nurse might find that and think that this is a slack student (008/1/570-4).

This participant provides rationale for documenting.

> It is about putting down, I didn't do it and this is why. It is covering your own butt really. It is the same with legal things I guess. If you didn't give them their medication, document "why, why, why." I know that it is quite unfair that we document stuff that we do to save our butt and then we never document the good stuff (008/1/578-82).

Parker and Gardner (1993) support the above participant's point of view in that the 'good things' that nurses do are often absent in the clinical notes. These authors refer to it as 'the silence of the nursing voice'. They suggest that nurses document more fully the intricacies of the nursing care that they give. These intricacies should not just focus on technical interventions but also the support and comfort that nurses give their patients. The nuances in the following quote reflect full description, however, the quote has an air of agitation about it.

> I remember one of my tutors saying, "Always write ... I called the surgeon, they declined to do anything." I'll write what I did, the interventions and the reassurances that I gave. [I'll write down] whatever I gave to the patient, as well as information that they give to me ...[I write it] in quotation so I've got exactly what they've said (001/1/265-68).

Parker and Gardner (1993) also recommend that the patient and their family's voice should also be represented in the clinical notes. Participants, on one hand, by documenting are making the nursing voice heard. However, on the other, the motivation behind documentation in this study was a protective strategy. This does not seem to be Parker and Gardner's intention when encouraging nurses to articulate more fully in the clinical notes. They concede that the medical voice is strong, has authority, is assured, collegial and confident. Conversely, the nursing voice is weak. Sadly, in this study, use of the clinical notes to document concerns or interventions surrounding ethical practice was motivated by fear.

> I guess its fear. I suppose in a way it's practising in fear because you hear of so many people who have had their registration taken off them (001/1/278-80).

Throughout this thesis it has become increasingly clear that participants sought to implement care that was in accordance with ethically meeting the patient's needs. Documentation was utilised by participants to 'cover their backs' in case there were any ramifications to the care that they gave. It was also a place to outline the reasons why certain interventions were implemented or not, with the corresponding ethical rationale. It also appears that the clinical notes were a place in which to make the patient's voice,

and his or her choices, more evident. Thus as participants became aware of wider contextual issues that might hinder their ability to give 'patient-focused' care, at least then, the clinical notes offered a place where those contextual constraints could be highlighted, thus offering some protection for the participant if his or her interventions might be questioned.

Summary

This chapter has explored impasses that participants in this study encountered and endeavoured to 'navigate through' to progress to a successful graduation. Several major factors constrained the abilities of participants to enact the 'ethical ideals' that they held regarding the centrality of the patient in the health care context. 'Perceiving' these factors facilitated participants' undergraduate nursing education journey from beginning to graduation. Participants began to 'understand' that they must balance 'patient expressed needs' with 'nurse assessed needs' and 'professional boundaries'. As participants' body of 'developing nursing knowledge' grew, it was also drawn upon when making ethical decisions. 'Patient expressed needs' were, at times, held less highly, as participants saw the 'beneficence' in their own nursing knowledge. Thus some tolerance of *weak* paternalism became evident in the decision-making process. However, participants still highly valued 'patient expressed needs' and that ascertainment and consideration of these was paramount in ethical decision-making.

Initially, many 'ethical ideals' held within participants' perspective of 'focusing on the patient' (Appendix 5) were exclusive of other factors. Participants realised that enacting these 'ethical ideals', in their purest sense, would not 'work' entirely well in the practice setting. Thus participants experienced a widening of their ethical gazes to include other factors in the practice setting. These factors were, at times, pressurising for participants and caused dissonance. They did not want to give up their 'ethical ideals'. Still, due to the 'perceived' and 'actual' powerlessness experienced in the practice setting, participants had to relent. Pressure to 'make an impression' and to 'pass the course' posed a strong threat to the 'ideals' held. Even though participants did not fully enact the 'ethical ideals' that facilitated focus on the patient, they did not lose sight of them. Their ethical perspectives widened as they encountered and considered contextual obstacles through which they must navigate to reach successful graduation.

CHAPTER SEVEN: 'NAVIGATING THROUGH' THE ETHICAL CONTEXT OF UNDERGRADUATE NURSING EDUCATION

I had three years to do it, to get it over and done with, to get my registration ... To a certain extent I probably compromised my beliefs to do the mileage and get the assignments done and things like that (007/1/225-7).

Introduction

In this grounded theory study, constant comparative analysis of data has facilitated the emergence of categories and codes that reflect the continual resolving of the 'main concern' of participants in the substantive area under study. As Glaser (2001) promises, the over-arching resolving process materialises out of the data and culminates in a core category that appears to group all codes together and offers explanatory and suggestive power. This chapter describes the sub-core categories, categories and substantive codes that culminate in the core category 'navigating through' that has, as Holloway and Wheeler (1996) explain, woven its way through this study, almost like a story line.

This study has explored the substantive area of undergraduate ethics education in preparation for practice as a registered nurse. The previous chapters reveal the challenging pathway that participants took through their undergraduate ethics preparation. Continuously, they were confronted with a mis-match between their perceived 'ideal world' and the 'real world' of nursing practice. 'Ethical ideals' were held in high regard and motivated participants to identify and enact caring behaviours. Initially, their main focus was almost solely on the patient and ascertaining the care that they might need. As they proceeded through, it became experientially apparent that contextual obstacles also required attention. Perceiving and understanding these factors in the 'real world' of nursing practice brought about a widening of their ethical gazes. Participants continuously resolved their main concern, the 'ideal versus real' worlds of ethical nursing practice, by cautiously 'navigating through' these differing contexts towards a successful graduation.

Formulating 'ethical ideals'

Prior to, and proceeding through their undergraduate ethics education, participants formulated and subsequently held 'ethical ideals' (Appendix 5), that motivated them to be attentive to the patients for whom they were providing care. These 'ethical ideals' were also a vehicle for ascertaining and determining what behaviours might be ethically appropriate for each patient and thus provided a framework to guide behaviours that were deemed to be ethical practice. It became apparent that the professional ethical values that underpinned and motivated participants' practice were 'held' as 'ethical ideals', for the following reasons. Firstly, literature explicated in Chapter Two supports the assumption that values predetermine behaviours. Secondly however, as explained in Chapters Five and Six, contextual considerations impeded enactment of 'ethically appropriate' and 'values determined' behaviours. Thus professional ethical values identified by participants and confirmed by literature, are conceptualised by the researcher to be 'ethical ideals'. Initially though, formulation of values begins prior to entry into undergraduate nursing education.

Early formulation of professional values

It is evident in this research that participants brought with them into their undergraduate nursing education beliefs, values and inherent virtues that were fostered during their upbringing and previous experiences.

> I think it is something [ethics] that you learn from your parents and it is something that you learn from society and that which you see around you (004/1/88-90).

Thus, accompanying participants into nursing were ethical motivators that governed their understanding as to what might be 'right' or 'wrong'. Woods' (1997) research supports this finding in that the eight participants in his study who also identified that 'early childhood experiences' and 'socio-cultural norms' influenced their perceptions as to what might be 'right' or 'wrong'.

Mostly, participants identified that to be drawn to nursing, one would have to have at least a desire to care for others and that that would demand a higher level of moral behaviour than those in society who were not caring for vulnerable persons. Miller and Zamora (1990), Noddings (1984) and Sellman (1997) support the notion of an intrinsic caring attitude in those drawn to nursing. Participants expected that they

would undergo the development of professional beliefs, values and virtues and that this would occur throughout their nursing education.

> [You bring with you] the human, personal, and all the experiences that you have as a child, the caring, and then you come into nursing and get some theory and some sort of structure (009/1/227,8).

> A lot of things that I value are personal. I guess they might be fine tuned a little with the training (006/1/473,4).

Participants were clear that their nursing education would enhance their values. Indeed, part of nursing education is to socialise its neophytes with regards to the values of the profession (Thompson & Thompson, 1992).

Focusing on the patient

Participants brought with them into their undergraduate nursing education beliefs, values, virtues and a caring attitude that served as foundational to their understandings of ethics. These notions formed their ethical perspective upon entering their undergraduate nursing education. As they entered the classroom setting, they very soon developed further notions of ethics. These notions included their understanding of principle-based ethics, the law, cultural safety and the nature of the nurse-patient relationship. The nature of the nurse-patient relationship incorporated an array of knowledge, attitudes and skills that were, despite challenge, formulated, established and preserved throughout three years of undergraduate nursing education. Thus, as participants interacted with classroom tutors and patients in the practice setting, they developed an initial ethical perspective in which the patient was their central focus.

> Definitely, patient first, if the patient can make any kind of decision, then go with that ... it is certainly not been what I have found in practice. It has been an idealistic concept that I have been introduced to at Polytech (002/2/66-80).

> [It's about] what is going on for them (008/1/63).

Hence, being 'patient-focused' can be directly attributed to the education that participants received. Being 'patient-focused' was a concept learned in the classroom setting, reinforced by clinical tutors and 'buddy' nurses in the practice setting. Consequently,

> It was all being formulated whilst I was doing my training (002/2/92,3).

In Chapter Four, several categories, with their supportive codes, explicated the developing perspective of participants that focused closely on the patient. A conceptual framework emerged from substantive data (Appendix 5), which identifies the constructs that participants deemed to constitute ethical practice. These constructs reflect values and behaviours held as 'ethical ideals' by participants. This framework emerged as a moral standard to guide ethical practice and the 'ideal' utilised by participants in the practice setting to evaluate and respond to the 'real world' of nursing practice. Reiteration of the main categories within this conceptual framework now follows.

Ascertaining needs

Two substantive codes are embedded within this category. They are *'Patient expressed needs' and 'Nurse assessed needs'.*

As participants 'focused on the patient' in the practice setting in an attempt to ascertain what the patient might need from them or other health professionals, there was an initial focusing, in a sense, a 'looking'. They proceeded to find out what the patient might need by 'spending time', 'listening', 'being there' and 'identifying' with the patient. However, early in their nursing education, participants appeared to focus more narrowly on 'ascertaining needs' reflected in 'patient expressed needs'. Participants wanted to learn of the wishes, choices, and needs originating from within the patient.

> I guess it is something you get from spending time with the person and assessing what they want and talking through these things with them, instead of just making decision. It is about putting ideas to them. It they decide to do things, at the end of day, it is their choice (008/01/444-7).

Later, in their nursing education, as 'developing nursing knowledge' expanded, participants also comprehended that, on the basis of nursing knowledge, the nurse was strategically positioned to assess the patient's need for nursing care. This process is reflected in Lutzen and Barbosa da Silva's (1996) words,

> The nurse's recognition of a patient's right to be involved and informed as an aspect of care is, however, an ideal that depends on the nurse's judgment of the patient's ability to understand as well as to make realistic choices (p. 206).

This transition was also identified in participants as they proceeded through.

They engaged in nursing assessments that did not only isolate 'patient expressed needs'.

> I suppose for me it's assessment, like you know, and just a feeling like, you know when one of your patients hasn't been around for a while and you know that they are not very well and that they may cut themselves. In a cutting situation, when the patient isolates themselves, they are more likely to be cutting, so I would be thinking, I haven't seen them for a few minutes ... it's like a body of knowledge and having seen the situation before (001/1/995-1007).

Ideally, 'nurse assessed needs' were to be met in conjunction and with due regard for, 'patient expressed needs'. How this decision was to be reached and implemented reflected meeting the needs of the patient in an ethical manner. Due regard for what the patient expressed as their needs and what the nurse could offer, required careful appraisal, to facilitate an ethically acceptable outcome for both the patient and the nurse. Hence, it may be argued that 'ethics' is at the very centre of nursing (Kelly, 1990; Woods, 1997).

> Ethics is about keeping checks and balances relating to power (002/2/438-9).

Watson (1985) sheds some light on this two-faceted interpretation of 'needs'. She endorses that both the patient and the nurse have perceptions of the experiencing of the health-illness condition of the patient. The nurse occupies a key position where he or she can assist the patient to gain more self-knowledge, self-control and readiness for self-healing. For this reason, "a high value is placed on the relationship between the nurse and the person" (p. 35). Euswas (1991) too explicates ascertaining the patient's needs for assistance as a joint perception by both the patient and the nurse. Christensen (1990) conceptualises this process as mutual work. Both the nurse and the patient work together in partnership toward a positive outcome for the patient. Lastly, Noddings (1984, p. 113) recommends that the one-caring and the cared-for, "must together consider what is right-in-this-case."

Periodically though, for participants, 'weak' paternalism eventuated as meeting 'nurse assessed needs' was more heavily weighted than 'patient expressed needs'. This enabled, what was deemed by the nurse to be a 'healthy' outcome for the patient.

Evidence that the 'ethical ideal' of ascertaining 'patient expressed needs', was however preserved, in that participants felt uncomfortable when they, or for that matter other health professionals, over-rode 'patient expressed needs'. It can be assumed that if participants utilised 'ethical ideals' to ascertain 'patient expressed needs', they would

also utilise these to guide ascertaining 'nurse assessed needs'. Thus focus remained on the patient and finding ways to ethically meet his or her needs.

Respecting

Participants valued 'respecting' the patient. The patient was to be respected as a human being with needs that were specific to him or her. As the patient expressed these needs to the nurse, the nurse was to give due regard to this private information.

> Respect what they [the patients] believe and what they think and work with what they believe. If they think they've got a sore toe, they've got a sore toe (001/1/368-72).

One way of showing respect towards the patient was to behave in a way that reflected the professional nature of the nurse.

> You can be a clown in your personal life but you have to remember when you are at work that you are taking a professional approach (001/1/65-7).

> If you are offending someone and putting down someone's views and the way that they do things and not respecting that, then the patient picks up on it. They are not going to feel like you care for them ... you are not going to be able to establish a relationship that benefits their health (004/1/479-483).

Confidentiality was also to be maintained and interestingly, this is supported by the Nightingale pledge (McBurney & Filoromo, 1994), ICN (2000) and NZNO (1995) as explained in Chapter Four and finally, NCNZ (2002) states that upon graduation, the newly graduated nurse: "Ensures the client's right to privacy" (p. 18). Participants' valued protecting the personal privacy of the patient's body as this quote poignantly enunciates.

> After lunch, people would be toileted and they would end up being in a standing hoist ... with their pants down ... All it would take was somebody to whip the curtain open which was dividing the bedroom from the dining room and often it would remain open for periods of time ... It was really undignified and uncalled for (002/2/311-19).

Furthermore, cultural safety education also facilitated an emphasis on 'respecting the patient' as this participant explains.

> I mean the basis of cultural safety is just respecting the individual and respecting their beliefs, wants and needs and so forth (009/1/247-8).

The concept of respect has previously been identified as an integral component of caring ethically (Kelly, 1990).

The final category that reflects the 'ethical ideals' of participants is 'promoting autonomy'.

Promoting autonomy

'Informed consent' was pivotal in this category. Participants were committed to finding out information for their patients, assisting and supporting patient's decision-making and endeavouring to make sure that patients understood any procedures or actions that participants were planning to implement. The following example demonstrates this.

> The nurse ... fully informs her patient ... the patient understands where they're going and is able to work with the nurse in the best way that they can, so it's like a team approach. You learn from that in the fact that the patient feels that they have some control over their health care (001/1/592-7).

'Informed consent' too is supported by legislation in New Zealand in the Code of Health and Disability Services Consumers' Rights 1996 where consumers have the, "Right to be fully informed" and the "Right to make an informed choice and give informed consent" (p. 3). NCNZ (1996a) also promotes 'informed consent' in that the newly graduated nurse must practise ethically as he or she, "Recognises the clients' right to choices and when relevant accords to clients opportunities for self-determination in all aspects of nursing care" (p. 18).

To 'promote autonomy' participants began with the view that they, as nurses, held more power than the patient. They then endeavoured to balance out that power structure between themselves and their patients by 'consulting' with the patient, 'helping with decision-making' and ascertaining 'patient expressed needs' and attempting to act according to those needs. Ideally, 'promoting the patient's autonomy' also involved the nurse acting as an advocate for the patient and his or her needs, which did appear to be problematic to implement for those in this study, and will be further explicated later in this chapter. Therefore,

> I think that with nursing, when it comes to those sorts of decisions [whether or not to sit with someone who is dying], unless you have a really good reason for it, you should be giving it to the patient and their family to make... You are facilitating. They make the decision (008/1/303-7).

In essence, participants made respect for autonomy a trump moral principle, rather than one moral principle in a system of principles, thus giving it excessive value (Beauchamp & Childress, 1994). However, this is understandable in the current health care climate in New Zealand as 'informed consent' is positioned within the Code of Health and Disability Services Consumers' Rights 1996. It may be supposed that this further strengthened participants' allegiance to 'informed consent'.

For participants, the aforementioned professional ethical values emerged as 'ethical ideals'. Quinn's (1990, p. 727) definition confirms this,

> Moral ideals are those beliefs, values and attitudes considered so important to an individual or group that they serve as general guidelines for conduct. The moral ideals of nursing are those fundamental beliefs and values, such as advocacy, respect for autonomy and concern for patient well-being, that we as a profession believe should inform all of our professional encounters (p.727).

Hence, general guidelines for conduct are embedded within the initial patient-focused ethical perspective formulated within participants and constituted a conceptual framework that, not only guided participants to endeavour to provide 'ethical care', but also explains what constituted 'ethical practice' for participants. These 'ethical ideals' in turn, nurtured the nurse-patient relationship.

Nurturing the nurse-patient relationship

Essentially the aforementioned 'ethical ideals' support and promote a central activity of the nursing profession; 'nurturing the nurse-patient relationship', where nurses personally connect with their patients and give of themselves on an emotional level (Benner, 1984; Christensen, 1995; Watson, 1985).

> I value giving something of myself, sharing the experience of another, being there, helping them through times of hardship. That's really important to me. I value walking the path that they walk, walking beside them, looking at ways you can help them along and to stop them tripping (001/1/1105-9).

Essentially, participants demonstrated characteristics and professed to hold 'ethical ideals' that clearly reflect a caring ethic that is situated within the interconnectedness of relationships as identified by Gilligan (1982) and Woods (1997), and referred to by Noddings (1984) and Watson (1985) as a 'moral ideal'. A pivotal characteristic of a caring ethic is the commitment to obligations and responsiveness within relationships. The moral agent responds to need, considers care and responsibility in relationship, thus paying attention to, and not turning away from need

(Harbison, 1992). Thus, from the previous and several other examples, it is abundantly clear that participants were 'patient-focused'.

> It [the patient] is your focus (008/2/311).

The standard promoted in the classroom contributed strongly to development of the ethical perspective held by participants. Woods (1999) recommends that nursing ethics educators be committed to promoting the 'ideals' of ethical nursing practice. It seems that this promotion has, indeed, been the case with the participants in this study. Conversely though, and Woods concedes that to be realistic, it has been accepted that nurses grapple with lack of control over their practice. It therefore comes as no surprise that when participants entered the 'real world' of the practice setting, their 'ethical ideals' underwent challenge. Hence, their ethical perspectives were fine tuned, adjusted, refocused and widened. This happened in the practice setting as participants saw that the 'ethical ideals', in their pure sense, did not work entirely well in some situations. Kolb (1984) claims that experience is a source of personal learning and development. That is, experience can be the link between the classroom and the 'real world'. According to Kolb, the practice setting is where ideas presented in the classroom are tested, where the theory is tested against reality. Successes or failures are reflected upon and lead to refinement and further development of our view of the world. This is the process that participants experienced. This is the process of learning.

Testing the 'ideals' in the 'real world'

Meeting the 'ideal versus real' worlds of nursing practice

It has been maintained that participants, during their undergraduate nursing education, developed a perspective that had, as its central focus, the patient. The notions adopted prior to becoming a student nurse formulated an initial perspective. As participants entered the classroom setting, further ethical notions were adopted. These notions were elicited from ethical theory, didactic teaching regarding 'ethical ideals' that underpinned and were embedded within the nurse-patient relationship as well as, the legal parameters of the nursing profession and cultural safety education (Appendix 6). These 'drivers' all fostered turning participants' attention towards the patient. Thus participants learned idealistic concepts whilst interacting with their patients, tutors and peers. There was however, a 'real world' that was perceived to be different to the 'ideal

world' of nursing practice. Participants began to make the transition from being solely in an 'ideal world' to entering the 'real world'.

> I think you learn it [ethical practice] from your tutors and your peers. You go in with this wonderful idea of nursing that you are going to save the patients and to save the world. Soon you realise that there are boundaries and that you are just not going to be everything to everyone ... I think we did learn a lot from our tutors in the first couple of years, just talking about it and doing things the right way. It was like going in with a group of individuals with the same sorts of ideas and having your tutor there who acts like a filter or barrier until you really do hit the 'real world' (008/2/314-22).

> [At Polytech you learn] the utopian. This is how it should be in the perfect world and then we go out [into practice] and it is so drastically different (002/1/686,7).

As they met the 'real world' of nursing practice, 'ethical ideals' were tested and reflected upon. How this was done now follows.

Evaluating and responding

Participants took their 'patient-focused' perspective, with its established 'ethical ideals' into the practice setting. As participants 'observed' in the practice setting they found themselves to be engaging in two covert reactions to what they saw. Firstly, they 'evaluated' what they saw according to as to whether the behaviours were in accordance with meeting the patient's needs and developing nursing knowledge.

Meeting the patient's needs

This entailed participants utilising their 'ethical ideals' as a point of reference.

> He [the 'buddy' nurse] didn't spend any time with his patients. He didn't talk to anyone. He didn't even help the other nurses out. He was just lazy actually. That's not ethical really (005/1/381-4).

'Developing nursing knowledge'

This entailed participants utilising their understanding and knowledge that were developing regarding what might constitute a healthy outcome for the patient.

> [The patient that I was looking after] was a Diabetic. She had Actrapid prescribed for her blood sugars if they were more than 20. We were supposed to give her a titrated dose ... my 'buddy' really only gave her Actrapid if her blood sugars were over 25, between 25 and 30. My 'buddy' said there was no point giving it to her because she always had high blood sugars and she was a lady in her eighties ... It went against what had been prescribed ... It was probably physically unsafe to let her blood sugars go that high (002/1/1084-95).

Secondly, participants identified that they 'emotionally responded' to what they saw in the practice setting.

> I am learning this stuff at [nursing] school but it isn't happening over there [in the practice setting]. These people aren't behaving like the [nursing] school says. I knew where I wanted to be and I couldn't understand why these people weren't there already. [I thought] I know what you are doing is wrong but you are acting as if it is okay. Something is not gelling (007/1/208-11).

Participants were becoming aware of 'gut feelings' and that what they 'observed', triggered these feelings. It seems evident in the data given by participants that 'gut feelings' were directly attributed to the 'ethical ideals' held by them. When participants 'observed' what they deemed to be ethical practice, this matched their 'ethical ideals' and moral calm ensued. When what they 'saw' contravened their 'ethical ideals', participants experienced feelings ranging from ethical unease to ethical distress. Thus the 'ethical ideals' that participants held in the practice setting were utilised as a standard, a benchmark for measuring whether care was ethical or unethical. Hence, participants demonstrated that they were morally sighted in that they, according to Johnstone's (1999) definition, were able to distinguish certain 'moral properties' in the world and also according to Hussey (1990) in that they demonstrated the ability to recognise moral issues.

Participants were not passive whilst they were 'observing' in the practice setting. They were actively learning that the 'ethical ideals' that they held were not always held or outworked by others, in the 'real world' of the practice setting. They continued to test their 'ethical ideals' in the 'real world' by making suggestions.

Suggesting tentatively

It was understood full well by participants that they were learners in the practice setting and that they lacked experience. They did however, have a body of 'developing nursing knowledge' that had a sound theoretical basis, as well as their foundational 'ethical ideals'. Participants tentatively made suggestions whilst they were in the practice setting in accordance with this knowledge, yet data has revealed that the 'buddy' nurses that they worked alongside rarely supported participants' suggestions. Thus a valuable avenue to extend participants' learning and confidence was lost. Here is an example of a participant utilising his 'developing nursing knowledge' (correct lifting techniques) and 'ethical ideals' ('ascertaining the patient's needs'), making a tentative suggestion and this not being heeded.

> When I was first practising, I was taught how to do lifting properly. [It is amazing] how many nurses out there do not know the techniques as to how to lift properly (003/1/537-9).

Hence the quandary,

> It is really hard as a student to deal with because you know that you are not only putting the patient at risk, you are putting yourself at risk. If you hurt the patient your likelihood of graduating is near zilch (003/1/540-3).

> You don't want to hurt the patient and you also don't want to upset your buddy (003/1/545,6).

So the participant attempts to address it and makes a tentative suggestion.

> When you actually say, "Well, we don't believe that that is an actual safe way of moving a patient." It is really hard; you are caught in the dilemma. I have said it on a number of occasions but I have never pushed it. I have actually said, "Oh well, this is our way." It is hard to take it beyond that. You put it out there that you are not keen on it and if you push it then they just view you as being arrogant (003/1/546-56).

From the participant's perspective the knowledge regarding correct lifting procedures was underpinned by research.

> It is based on research of the best way to do it. It is based on the best practise (003/1/560).

The participant sums up by saying,

> It is difficult from a student's perspective in that you are trying to get a good reference and you are trying to learn at the same time. You are trying to work in your own ethical boundaries and find out what they are [as well as considering] that you do not agree with your buddy and the way that they do things (003/1/592-5).

This example is one of many previously outlined in Chapter Five, where participants attempted to test our their 'developing nursing knowledge'. Often these suggestions were unheeded. This however did not cause participants to surrender their 'ideals', but it strengthened them.

Strengthening ethical resolve

'Buddy' nurses and tutors acted as role models for participants whilst they were in the practice setting. Interestingly, these role models strengthened participants' 'ethical ideals'. When participants observed what they deemed to be, according to their 'ideals', ethical practice, their 'ethical ideals' were reinforced. When participants

observed what they deemed to be unethical practice, their 'ethical ideals' were also strengthened. Unethical practice was simply seen as a way 'not to practise'. Thus, it was evident from participants' data that the 'ethical ideals' that were established in the classroom and by interacting closely with the patient, again served as a benchmark and standard with which to measure ethical or unethical practice. It is thus evident that the 'ideals' held by participants guided them in their 'evaluations' of, and 'responses' towards, practice 'observed'.

> No one died or anything, he [the buddy nurse] still got the things done, but he just didn't have that touch that would change how someone felt while they were in hospital ... that which makes the person feel better, makes them have a good memory about their stay. It's nothing medical, no injections; it's how you act with other people (005/1/416-26).

> The slack ones ['buddies'] probably made more of an impact than the good ones. Because I wanted to be good, I always remember the bad ones (007/1/35-6).

Whilst strengthening of participants' 'ethical ideals' occurred, there was a corresponding widening of their ethical perspective. This happened as participants came to realise that nursing practices that they 'observed', did not always meet their 'ideals' and that there were weighty contextual factors that also needed attention.

Widening the ethical perspectives

'Widening the ethical perspectives' of participants was a continuous process throughout three years of undergraduate nursing education. Foundational notions of ethics prior to, and upon entering the classroom setting formulated an initial perspective. This widened with classroom teaching related to 'ethical ideals', as well as ethics theory, the law and cultural safety education. Further widening occurred as participants interacted with the practice setting as the following discussion reveals.

Perceiving the obstacles

Early in their undergraduate nursing education, participants had not yet been exposed to the wider factors that the nurse needed to consider when determining ways to ethically meet the patient's needs. As they entered the practice setting they were 'met' by the 'real world'. This 'meeting' caused a widening of participants' 'ethical gazes' as they came to perceive that there were obstacles that presented themselves, and impeded enactment of their 'ethical ideals'. Thus their 'ethical gazes' widened to incorporate these factors as these too, required due consideration. Participants came to

the realisation that they were 'finite', and that realistically, they could not meet everyone's needs. Their body of 'developing nursing knowledge' engendered 'nurse assessed needs' and the required decisions as to which nursing actions might be ethically appropriate. On the one hand, 'patient expressed needs' had to be ethically considered and balanced with 'nurse assessed needs', and sometimes meeting 'nurse assessed needs' won over. They also came to realise that there were 'real' barriers to implementing ethically driven nursing care (Appendix 7). Initially perception occurred.

> Being in practice is when you can actually 'see' in real terms. It changes from being an abstract concept to being something that is real (002/2/363,4).

The obstacles perceived, understood and considered by participants during 'realisation' are as follows.

Competing needs

The following excerpt tells of a custody battle involving a 13-year-old child. The participant was caught between the two parents, both of whom claimed custody. In the end the participant realises that there can be more factors to consider than just the patient (in this case a child).

> It was just lucky that I had the support of good buddies. They approached the social worker and they sorted out the legal aspects and what the rights were. You don't know what it was like. You can't fulfil everybody's needs ... being an advocate for the child was not that easy (003/1/112-129).

Hospital policy

There were times when 'hospital policy' had to be considered when attempting to ethically meet the patient's needs.

> It would really depend. If it was a policy, like a hospital policy, like visiting outside of hours, or getting a special meal up from the kitchen for someone who has flown 5,000 miles to see their family member, I think I could deal with that. I could justify myself in those situations. I think before you go and make any decision whether it is illegal or unethical or ethical or against policy you have really got to say to yourself, "Why am I doing this, how can I justify it (008/2/402-7).

Differing apportioning of authority

Participants began to perceive, that differing health professionals in the practice setting were apportioned greater or less authority. It was observed that doctors had more

authority than nurses and that there were times when nurses had to 'submit' to that authority.

> One particular instance I remember is a gentleman with a disability who had difficulties swallowing. He was getting malnourished. The nurse was trying to get a gastric feed put in. Unfortunately the doctor did not think that the gentleman should have it. He thought he should slowly fade away. The patient was only 19 years old and he was living in a flat. He was otherwise okay ... In the end she did nothing. She felt like she had her hands tied because his immediate family had said no. She had actually asked them if she could get a second opinion for him (009/179-108).

The registered nurse faced the dilemma of going against the family's and the doctor's wishes, to ask for a second opinion. In the end, she 'submits' to the wishes of the family and the doctor, and sacrifices her own ethical concerns in the situation. It is common for nurses to do this due to their relatively powerless position within the healthcare sector and limited autonomy over their own practice (Chevasse, 1992; Yarling & McElmurry, 1986). One further example poignantly expresses this dilemma.

> If you are the first one on the scene ... you have got to think, "Well, this person really doesn't want to live but they [the medical profession] have decided they are going to." So you have got to start performing CPR [cardiopulmonary resuscitation] or life saving measures ... You have got to look at who you are going to support I guess, whether you do what the patient's wishes are or what the establishment's wishes are (008/1/141-8).

Observed powerlessness in nurses

As the above excerpt and the following example demonstrate, it would appear that nurses have less autonomy over their practice than doctors:

> They [the doctors] have the decision at the end of the day. They [the nurses] can say: "We are not going to do anything." A nurse can sort of say: "Oh no, I don't agree with that," but I think a lot of it, the big stuff comes down to the doctors. I think the little stuff comes down to us (006/1/209-12).

> But the nurse had sat on it and told me for two or three days how angry she was that she wasn't being listened to. She had voiced it once or twice and wasn't being listened to. She sat there sort of stamping her foot and said, "They are not listening to me" (008/1/795-8).

This participant learns that doctors have the final decision. It seems probable that, if participants observed the ethical concerns of registered nurses in the practice setting being over-ridden, that they would seriously contemplate whether or not they themselves, as students would engage in advocating *(field note, 19/10/02)*.

Legal parameters

The legal parameters of nursing practice also required careful consideration. In attempting to ethically meet the needs of the patient, participants realised that the law may compromise what they deemed to be 'ethical care'.

> Are you going to accuse someone who is smoking marijuana? You are caught in this absolute dilemma as to what is right and wrong and not necessarily from a legal perspective. The legal provides boundaries as to what you are meant to be doing, but in reality it doesn't work. I think some laws are too rigid and it shouldn't be that way (003/1/292-303).

Developing nursing knowledge'

As participants' referred to and utilised their 'developing nursing knowledge' it was found that this enabled the ascertaining of 'nurse assessed needs', however periodically 'patient expressed needs' might be at variance with 'nurse assessed needs'. Sometimes, 'nurse assessed needs' based on 'developing nursing knowledge' weighed more heavily than 'patient expressed needs'. However, participants emerged from three years of undergraduate nursing education still feeling uncomfortable with not meeting 'patient expressed needs'.

> Maybe it has been decided that the person is going into a Rest Home and although the person is not happy with that, you can see the reasons why they need to go. You can see that they are not coping on their own. You can see that really there is no other choice. But it still doesn't feel good. So those are the types of things you have really got to think about even though you may be powerless to stop it. Overall, you see there is not other choice. You have still got to make it feel/sit right with you at end of the day I guess (008/1/694-700).

Woods (1997) too identified factors within the practice setting that may inhibit enactment of ethical practice for experienced nurses. These were, 'powerlessness within the system', 'the need to conform within the system', 'the demands of expediency and time factors' and also, 'respecting the doctor's orders'. It has been revealed that participants within this study faced similar obstacles. What was interesting was that they had perceived these long before they were registered and experienced. These factors have also been discussed previously by other authors, that doctors and nurses do not have equal shares of authority, power and responsibility for promoting healing in their patients (Adamson & Kenny, 1993; Gianakos, 1997), doctors tend to dominate the decision-making process (Melchert, Uden, & Norberg, 1997), nurses have difficulty translating their knowledge and values into reality due to opposing values of the

institutions in which they work (Ketefian, 1981; Yarling & McElmurry, 1986), nurses need to provide patient care within a context of rules defined by others (Hutchinson, 1990) and also experiencing legal constraints to what is deemed by the nurse to be ethical practice (Andrew, 1997; Hubbard, 1994; Hutchinson, 1990).

Preserving patient-focused 'ethical ideals'

Participants underwent three years of undergraduate nursing education. During this time, they formulated, developed, established and preserved 'ethical ideals' that reflect core values of the nursing profession (Benner, 1984; Christensen, 1995; Fry 1989b; Quinn, 1990) and are explicated in detail in Chapter Four and Appendix 6. Preserving patient-focused 'ethical ideals' emerged as a sub-core category that strongly competed for identity as the core category. However, it did become increasingly evident that, as participants cautiously 'navigated through' they carried with them from onset to completion, patient-focused 'ethical ideals' that served as a guide along their journey.

Many situations in the ethical context caused active protection of these 'ideals'. Some situations caused a tempering of 'ethical ideals', for example, a body of 'developing nursing knowledge' and 'competing needs'. Other situations caused a 'surrendering' of 'ethical ideals' because contextual obstacles were perceived to be insurmountable and were thus circumvented. Overall, it is undoubtedly clear that participants did 'preserve' these 'ethical ideals' and that these were carried into newly graduated roles as registered nurses. However, these 'ethical ideals' were often espoused rather than put into action (Argyris & Schon, 1974). It appeared that the contextual obstacles posed as a significant hindrance to putting 'ethical ideals' into practice consistently. It was the 'navigating through' these challenges that eventually took pre-eminence.

Numerous examples throughout this study exemplify participants' commitment to 'ethical ideals' that they learned early on in their undergraduate nursing education. They remained centrally focused on, and committed to the nurse-patient relationship.

> Despite all the pros and cons that you weigh up at the time, it comes back to the patient (005/1/171-2).

'Ethical ideals' are the embedded assumptions that underpin participants' understanding and beliefs as to what might constitute ethical caring. Even though their ethical perspectives underwent refocusing, these participants emerged out of three years of undergraduate nursing education with their 'ethical ideals' intact. The 'ideals' are

critical *(field note, 3/1/02)*. Watson (1985) promotes, "Both theoretically and empirically the concept of caring is not merely characterised by certain categories or classes of nursing actions, but as ideals, which persons desiring care and persons (nurses) doing those actions hold before them" (p. 34). Participants in this study held 'ethical ideals' that provided a guide for ethical practice (Appendix 5). Thus it is argued that 'ethical ideals' are critical.

'Navigating through'

The core category 'navigating through' emerged by constantly comparing and analysing substantive data. Five sub-core categories support the core variable. They are, 'formulating 'ethical ideals', 'testing the 'ideals' in the 'real world', 'widening the ethical perspectives', 'preserving patient-focused 'ethical ideals' and 'enduring powerlessness'. 'Navigating through' is also an explanation of how participants continually resolved their main concern, namely the 'ideal versus real' dichotomy.

It is evident that participants, whilst they were student nurses, had to navigate their way through their undergraduate ethics education. This journey was not straightforward, it twisted and turned, in and out, under and over, and also around contextual factors seen to be significant factors impeding enactment of ethical practice in accordance with established 'ethical ideals' (Appendix 7).

'Navigating through' also encapsulated a 'realisation' that the 'real world' was not a mirror match of the 'ideal world' and that 'being finite' and weighing 'patient expressed needs' with 'nurse assessed needs' meant that often they must tolerate ambiguity. Furthermore, the aforementioned contextual factors needed careful consideration. 'Navigating through' also reflects the over-arching hurdle of meeting course requirements and receiving favourable reports from 'buddy' nurses. This was understandably, rated as considerably important. This posed added challenges. As a result of the culmination of all the previous categories, codes and substantive codes previously mentioned throughout this study, that required careful consideration, participants adopted a conservative approach to ethical decision-making. Firstly though, three further obstacles that participants had to surmount are explained. They needed to create an impression, pass the course, and decide their level of ethical involvement in the practice setting.

Needing to create an impression

Participants wanted to be accepted by the 'buddy' nurses that they worked alongside. This meant that they refrained from 'speaking out' about practice that they perceived might be unethical. Participants were aware that 'speaking out' could upset the 'buddy' nurses that they worked with and, for the sake of getting through the course they silenced themselves. The following quotes are evidence of this.

> I think you want to be liked or get on with people on a ward, so you don't really want to make an enemy of yourself (009/1/309,10).

> [As a student] what do you do when you have four nurses and you are down to two? What do you do? Make waves? (007/1/234-5).

> A good nurse is someone that doesn't rock the boat. Someone who just gets in there and does it and goes home again (006/1/383-4).

Participants needed to protect the relationships that they had with their 'buddies'. They were careful not to offend them. They also had the added pressure of 'needing to pass the course'.

Needing to pass the course

Making a good impression contributed to the chances of participants receiving a good evaluation and passing the course. Participants did not want to jeopardise this in any way. There were times when they sacrificed their 'ethical ideals' so that they would pass the course.

> There are times when I thought maybe I should have said something about that, or maybe gone to another nurse. But also there's that horrible pressure that, I mean, it's really selfish, but when you're actually having to have your evaluation form signed to actually pass your course, you don't really want to have a blow out with your buddy. I know it sounds quite selfish but for the sake of you getting through your course, you probably do not want to stir up too many people (009/1/348-55).

> It's an uphill struggle trying to be accepted by them or trying to at least pass your grade and get along in their clinical area (004/1/709-12).

The pressure to please their 'buddies' and to pass the course contributed to their powerless position to impact ethically in the contexts in which they were learners. Considering the factor of 'having to pass the course' also posed a threat to the 'ethical ideals' held within the ethical perspective of participants. In the end, there were times

when passing the course won over. Participants admitted that it was selfish and that they didn't like it. It was however a powerful factor that compromised their 'ethical ideals' *(field note, 9/7/02).*

> I mean, if you look at it, you are throwing six months, a whole semester, or putting your career back six months if you fail that (008/2/165,6).

Part of 'navigating through' involved weighing of options, choices, and their potential consequences. This resulted in deciding the degree of ethical involvement.

Involving themselves with ethical decision-making

Participants in this study, because of their learner status and lack of experience did not fully participate in ethical decision-making in the practice setting. Han and Ahn (2000) assert that student nurses have no right to participant in ethical decision-making in the practice setting. This makes little sense, as engaging in nursing is in itself an ethical pursuit (Kelly, 1990; Watson, 1985; Woods, 1997). Realistically, participants in this study did contribute to ethical decision-making at a beginning level (Appendix 7). This would seem appropriate, in that being a student nurse also involved learning how to make ethically defensible decisions. Furthermore, contextual obstacles confined their involvement to a minimum (Appendix 7). Levels of ethical involvement are as follows.

Observing silently

This phenomenon occurred as participants observed behaviours of other health professionals within the practice setting, due mainly to the fact that they were learners and guests in the practice setting. This study has demonstrated that they were however, not passive but actively 'evaluating' and 'emotionally responding' to what they saw. Often, 'observing silently' occurred because of apprehension regarding the potential of negative ramifications of speaking up.

> I thought that I would say something to her afterwards and then I thought that surely I wouldn't need to. It was blatantly obvious that it was infected. She would just get shirty with me for stating the obvious and think that I am a cocky shit. So I didn't (004/1/275-83).

> I think you could see something even pretty serious, for example, if you saw someone taking drugs out of the cupboard. You would still be tossing up, "Oh God, what am I going to do about this?" I could be putting my career and all myself and this ward at great risk if I do something about it (004/1/351-7).

Seeking guidance

Part of the student role meant that often the 'buddy' nurse made the more complex ethical decisions. Essentially the 'buddy' nurse was the one who had overall responsibility for the patient, so this pattern of decision-making would make sense.

> As a student you're not the one making the decision, you've always got someone registered making the decision (001/1/689-90).

> If it were a 'big' thing, I would have gone to a tutor (006/2/229).

> If I was hearing a patient telling me that they did not want to be resuscitated or that they wanted to withdraw from treatment, I didn't feel that I was in the best position to be able to discuss those issues, being in the student role. So I would have discussed it with other nurses on the ward. I wouldn't have felt comfortable making decisions like that by myself (008/2/42-6).

Expressing concerns

Participants circumspectly expressed their concerns in relation to what they might have observed in the practice setting. Factors embedded within the practice setting impacted in how strongly participants were able to voice their concerns. Firstly, they chose 'suggesting tentatively' to protect their movement through their nursing education. They needed to pass their course and this entailed remaining 'on side' with their 'buddies'.

> If I don't agree with something, but I have been told to do it because the person in charge has told me to … I raise concerns with that person. If they still said, "Go ahead and do it," I would personally have an ethical problem with it. However, if it's still within the law and the senior nurse has said this is why we are doing it, this is the reason why, then I will do it … I would however, voice my concerns (002/1/ 24-81).

Secondly, they utilised another avenue to express their concerns. They documented their concerns in the clinical notes. This research did not reveal any negative ramifications of this method. It did relieve the burden however, of holding an ethical opinion or concern, especially if 'suggesting tentatively' yielded an over-riding of their ethical concerns.

> Often it was situation that was out of the nurse's control … so document the situation, but at the end of the day, I guess it was the doctors who decided what happened to the patient (009/1/38-41).

Submitting

Participants', due to their learner status in the practice setting and their attentiveness to 'needing to make an impression' and 'needing to pass the course', frequently 'submitted' to the ethical decisions of others.

> Sometimes when you're with a buddy, you get the feeling that they don't really want you around because are a bit of an annoyance. I guess you do not really want to step out of line. It annoys them (009/1/341-3).

> I didn't want to contradict the nurse, she was a registered midwife and I was a nursing student ... we had different view points ... she had experience and I didn't, however saying to the woman, "You are not going to be able to breastfeed," even when there were all the breastfeeding pamphlets on the wall ... The poor woman was made to feel like a failure ... It was out of my control ... so I just gave her back rubs and sort of tried to build her confidence (002/1/418-478).

Woods' research (1997, p. 156) revealed eight levels of ethical involvement that experienced nurses utilised in their nursing practice. They were, 'silently observing', 'submitting to the decisions of others', 'responding when approached', 'protesting exclusion', 'compromising pragmatically', 'covert/overt subversion', 'wider moral protests' and 'radical risks' (whistleblowing). Interestingly, participants in this study seemed to utilise the first two levels identified by Woods. This is confirming of Woods' explanations of ethical involvement and adds strength to the concept that part of ethical decision-making for nurses is to choose their level of involvement. Part of that process involves 'weighing' the consequences of ethical involvement.

Enduring powerlessness

Factors explicated to date placed considerable pressure on participants to preserve their 'ethical ideals' whilst they 'navigated through' towards graduation (Appendix 7). To meet these needs they 'endured powerlessness'. Efforts to address their feelings of powerlessness were restricted to 'debriefing' with their clinical tutors and peers who accompanied them into the practice setting. Other factors were more pressing, namely, 'needing to create an impression' and 'needing to pass the course'. This meant that they regularly experienced feelings of powerlessness. Numerous examples throughout this research indicate the inherent powerlessness within the student role, for participants. The following examples add further validity.

> I didn't have the power to do anything about it (002/1/485).

> My own ethics or values or morals would tell me to go with what my patient's wished … although I think you would find yourself pretty quickly ostracised from the rest of the staff for doing such a thing … (008/1/150-3).

> You can feel quite disempowered because it is so different from what you are expecting and what you were led to believe as to how it is going to be (002/1/740-3)

Pressure to pass the course over-rode the ethical compulsion to speak up or bring change to the practice setting. Perhaps this is a reasonable expectation for student nurses. Should they have the extra burden of challenging the practices that they see, when they also see their 'buddy' nurses bending to the ethical decisions of others? *(field note, 29/7/02).* Due to feelings of powerless and possible negative effects of 'speaking up' participants endured powerlessness. Thus, feelings of powerlessness also impeded taking a more active approach to ethical involvement in the practice setting.

Summary

This chapter has given an overview of the research involving nine newly graduated nurses and their preceding undergraduate ethics education in preparation for practice as registered nurses. It was found that professional ethical values were instilled during their undergraduate nursing education and that these were developed by faculty education (principle-based ethics, the law, cultural safety education, and the nature of the nurse-patient relationship) (Appendix 6), and interacting closely with the patient. These professional ethical values accompanied participants throughout their nursing education, and were utilised to inform their practice. Participants soon learned that the professional ethical values that they had adopted were problematic to implement in the 'real' world of nursing practice. This realisation came as they began to 'test' their professional values in the practice setting. Hence, professional ethical values became 'ethical ideals', reflecting an 'ideal' way to practise. These 'ethical ideals' were utilised as a guide to practising ethically, and also, a standard from which to appraise their own, and others' ethical practice (Appendix 5).

As participants experienced the practice setting they were bombarded with situations and contextual obstacles that challenged the implementation of their 'ethical ideals'. These obstacles impeded ethical involvement in the practice setting and engendered feelings of powerlessness within participants to impact ethically on the environments in which they found themselves. Hence participants underwent a process

of 'widening their ethical perspectives' and, effort was expended in 'navigating through' these obstacles.

Furthermore, reaching a successful graduation required considerable attention (Appendix 7). Upon graduation, participants firmly held an ethical perspective that focused closely on the patient and his or her needs. Participants had experienced incongruence between their 'ethical ideals' and the 'real world' and had graduated knowing that the 'ideals' underwent challenge in the 'real world'. They learned that the 'ideals' must be flexible enough to work in many situations, where the nurse may not have perceived control. Thus 'navigating through' undoubtedly required careful consideration and attention.

CHAPTER EIGHT: DISCUSSION AND RECOMMENDATIONS

"learning from reflective thinking is certainly not something that happens 'automatically'; rather it requires active involvement and a clinical environment that is supportive towards the learner's needs" (Teekman, 1999, p. 1125).

Introduction

This thesis explores the process of learning ethics and ethical practice within the classroom and practice settings, and reflects the perspectives of 9 newly graduated registered nurses on their undergraduate ethics education whilst they were student nurses. Previous chapters have outlined and explained a vast array of codes and categories that represent early formulation and establishment of an ethical perspective that focused closely on the patient and a subsequent widening of this perspective to incorporate perceived and experienced contextual obstacles that confronted participants, as they interacted with the practice setting. Participants learned ethical concepts in the classroom, from role-modelling educators, clinical tutors and 'buddies' in the practice setting, by journaling and reflecting and, by experimenting in the practice setting. These findings confirmed wider literature that proposed that student nurses learned through these methods.

This chapter initially outlines five theoretical propositions that have the potentiality to explain phenomena within the ethical context of undergraduate nursing education, and may pose as propositions for testing in future research studies. This chapter also presents the recommendations deemed by the researcher to be worthy of promotion within the profession of nursing, and more specifically, nursing education. Furthermore, the chapter concludes with an explication of the limitations to this study. Essentially it is acknowledged that 'navigating through' is the core category and the process by which participants from the substantive area of undergraduate nursing education continuously processed their main concern, the 'ideal versus real' dichotomy, as they progressed toward a successful graduation.

Theoretical propositions on 'navigating through' the ethical context of undergraduate nursing education

The general aim of this study was to explore the perspectives of newly graduated nurses on their undergraduate ethics education for practice as registered nurses. How they learned, what they learned, in what contexts they learned and, from whom they learned, ethics and ethical practice was also of interest. Data analysis revealed 'held' professional ethical values were utilised as 'ethical ideals', as the outworking of professional ethical values in the practice setting were constrained by perceived, and experienced, contextual obstacles that were carefully navigated around and through. These 'ethical ideals' did not just appear out of nowhere. They were fashioned initially prior to entrance into nursing education and added to and reinforced by teaching and learning methods utilised in faculty and contextual settings.

Participants learned ethics and ethical practice, by interacting with faculty educators, role models in the practice setting, journaling and reflection tutorials and experimentally ('suggesting tentatively', 'trial-and-error', 'making mistakes' and 'experience') (Chapter Five & Appendix 6). Participants 'navigated through' both the 'ideal' and the 'real' worlds of nursing practice as they learned ethics and ethical practice.

Five key theoretical propositions that capture relationships between emergent concepts and thus offer tentative explanation of processes occurring within the substantive area of ethics education for undergraduate nurses, in preparation for their advancement to registered nurse status. They are as follows:

Student nurses learn, and have reinforced, professional ethical values by interacting with role models, both in the faculty and practice settings. These interactions build on beliefs, values and inherent virtues that accompany them into their undergraduate nursing education.

It appears, that whilst children grow and develop within the social contexts that they find themselves in, they fashion and adopt beliefs, values and virtues reflective of those 'held' by others around them (Chapter Four). Furthermore, it seems evident that, at least to some degree, an intrinsic desire to care and help others in some way may accompany student nurses into their nursing education. Thus upon entering nursing education, foundational beliefs, values and virtues appear to be honed, enhanced and

'built upon', in the process of the development of professional ethical values that, it is intended, will underpin future practice as a registered nurse. These professional ethical values are identified and explicated in Chapter Four, early in Chapter five and Appendix 5. Didactic teaching regarding traditional ethics theory (principle-based ethics), the law, cultural safety and concepts that enhance the nurse-patient relationship seem to contribute to the development of professional ethical values (Chapter Four).

It would appear that role models (clinical tutors and 'buddy' nurses) reinforce these professional ethical values in the practice setting (Chapter Five). Reinforcing occurs whether role models emanate these values or not. Observing nursing practice that reflected the professional ethical values that participants espoused, generated 'ethical calm' and congruence was experienced. When practice was observed that did not match 'held' professional ethical values, incongruence was experienced and concomitant ethical unease or, at its worst, moral distress. However, incongruence engendered further allegiance to 'held' professional ethical values in that a mismatch is an example of 'how not to practise'. Thus role models in the practice setting have the potential to strengthen professional ethical values.

Student nurses experience incongruence between held 'ethical ideals' and the 'real world' of the practice setting.

In Chapter Four, descriptions of 'held' professional ethical values and the 'developers' of these values are encapsulated (Appendix 5 & 6). As developing professional ethical values accompany student nurses into the practice setting they are 'met' with a dichotomy. An initial perspective of nursing practice is formulated by the professional ethical values promoted in the classroom and, whilst 'spending time' with the patient. Furthermore, this perspective is closely 'patient-focused'. With further interaction in the practice setting, it became increasingly obvious, as other contextual obstacles (Chapters Five & Six) came into view, that care, motivated by these professional ethical values, was 'idealistic'. Thus, the 'ideal versus real' worlds of nursing practice were encountered. Participants found that the 'ideal' does not always work well in the 'real world'.

Student nurses cautiously navigate their way through and around perceived and experienced obstacles in the practice setting in their pursuit of graduation.

It seems that, numerous contextual obstacles were present in the undergraduate ethical context that participants found themselves in. These obstacles are identified and described in Chapters Five, Six and Appendix 7. These obstacles required consideration when participants sought to implement their 'ethical ideals'. Contextual obstacles were seen to be considerable enough to potentially impede student nurses in their progression through to a successful graduation.

Contextual obstacles for nurses endeavouring to give care that is deemed to be 'ethical' are significant enough to have been previously identified by numerous authors in nursing literature (Adamson & Kenny, 1993; Gianakos, 1997; Hubbard, 1994; Hutchinson, 1990; Ketefian, 1981; Melchert, et al., 1997; Woods, 1995; Yarling & McElmurry, 1986). It is to be noted that participants faced many of the contextual constraints to implementing ethical practice that registered nurses encounter. However, participants face the added pressures of, being a learner, and a guest in the practice setting, 'needing to make an impression', as well as 'needing to pass the course'. Hence, 'navigating through' was of great concern to them.

During navigation, decisions were made. They included 'observing silently', suggesting tentatively', 'expressing concerns', and 'submitting' (Chapters Five, Six & Appendix 7). These reflected the level of ethical involvement deemed 'safe' enough not to detract from participant's positive performance in the practice setting. These actions are explained more fully in Chapter Seven and Appendix 7. Sadly, 'expressing concerns' was deemed to be as far as participants should 'push' to illuminate or challenge what they perceived to be unethical practice, without being subjected to possible negative consequences, namely receiving a poor evaluation from 'buddy' nurses, and the possibility of failing the course. 'Navigating through' included perceiving the obstacles, considering possible implications for confronting obstacles, circumventing the obstacles, finding ways to still ethically meet the patient's needs and successfully passing the course. This required considerable emotional energy and ethical balancing.

Newly registered nurses hold patient-focused 'ethical ideals' that motivate and guide practice that is deemed to be ethical and nurturing of the nurse-patient relationship.

Appendix 5 reflects a conceptual model that incorporates constructs that emerged from this research project (Chapter Four). It is clear that these constructs were found to be 'ethical ideals' that were utilised to guide practice deemed to be ethical. Bandman and Bandman (1992) point out, "Models are idealised patterns, greatly simplified, for looking at complex events in terms of their essential qualities. A model is an abstract representation of a significant portion of reality" (p. 13). These 'ethical ideals' correlate to professional ethical values. These were highly visible throughout this research.

With an identified lack of ethics theory for participants to link their ethical experiences to (Chapter Four), it seems that the professional 'ethical ideals' were seemingly consciously and sub-consciously, referred to in the 'real' world. Thus some sense of ethics theory had indeed been referred to. This was not directly identified as such by participants, but it seems apparent that these ideals reflect the characteristics of caring, which have been previously identified by other nursing authors and theorists (Benner, 1984; Benner & Wrubel, 1989; Christensen, 1995; Euswas, 1991; Swanson, 1991; Watson, 1985; Woods, 1997).

Contemporary ethics theory has been generated from within the nursing profession (Swanson, 1991; Watson, 1985) and more widely from feminist theory (Gilligan, 1982, 1987, 1995; Noddings, 1984). The ethic of care (Gilligan, 1982), the ethic of caring (Noddings), caring as an ideal (Noddings; Watson, 1985), and a nursing ethic (Kelly, 1990; Woods, 1997), all point to a relationship between caring and ethics within a contextual relationship. For nurses, this relationship, and thus the focus of care, is on the person (Sprengel & Kelley, 1992). Gilligan (1995) suggests that there is a different way of thinking about oneself as a moral agent and a different emergent voice that reflects interconnectedness, responsibility and care. It seems apparent that this occurred in this study, as participants spoke in the language of care, which Parker (1990) points out, is the language nurses are more likely to use. Thus 'ethical ideals' identified in this study, reflect previously identified aspects of 'caring' and these have the potential to motivate and guide practice that is deemed to be ethical and nurturing of the nurse-patient relationship.

Student nurses experience feelings of powerlessness and an inability to impact ethically on their environment due to their learner role in the practice setting.

In Chapters Five and Six, it has been identified that participants endured feelings of powerlessness during their undergraduate nursing education. This was clearly a result of a lack of exploration of their suggestions that were offered, perceiving the relatively powerless role of registered nurses who surrounded them, experiencing an over-riding of their expressed ethical concerns, silencing themselves, submitting to the decisions of others, and finally, needing to please their 'buddies'.

It is important to highlight that the perspectives of registered nurses who worked alongside participants whilst they were students were not explored in this study. Previous New Zealand studies have however explored other perspectives and priorities in the 'student-buddy' relationship. Findings from these studies clearly highlight some significant contextual constraints that 'buddy' nurses face. For example, Booth (1997), Dyson (1998) and Orchard (1999) report that on top of an already busy and heavy workload, registered nurses in the practice setting were allocated a student nurse, with, in almost all situations explored, no previous consultation or permission from the registered nurses themselves. Turnbull (1998) reports that 'buddy' nurses identified that students in the ward setting increased the overall workload of the ward and that no additional time was allocated to the 'buddy' who was expected to be a nurse and a teacher. Furthermore, registered nurses were educationally unprepared to the role of ' buddy' nurse to the student (McCleland, 1998; Orchard, 1999; Thompson, 1997a). Orchard points out that in some cases registered nurses who were allocated a student nurse were given extra patients as the student was seen as an extra 'pair of hands'.

Orchard thus contends that: "The assumption that the registered nurses could supervise and educate students during their clinical practice experience plus be given and increased workload was seen as un-realistic benefiting neither the student nor the patients receiving nursing care" (p. 70). This state of affairs culminates in a socialisation of the student nurse into subservience, students remaining silent, uncomplaining and feeling powerless. McCleland concludes that students ended up suffering in silence and Booth (1997) points out that students' inexperience and unassertiveness and feelings of being unable to change anything, resulted in feeling powerless to act. It may be that these constraints contributed to the lack of exploration by 'buddies' of students' tentative suggestions.

Implications for faculty nursing education

Instil professional ethical values

It was established from literature in Chapter Two, and participants in Chapter Four, that personal and professional values and ideals brought to nursing encounters influence the behaviour of the nurse (Eddy et al., 1994; Quinn, 1990; Thompson & Thompson, 1992; Woods, 1997). Moral values, according to Fry (1994) are, "Those values ascribed to human actions, behaviours, institutions, or character traits" (p. 292). Furthermore, Tschudin (1992, p. 28) asserts that, "Values are here to help us choose between alternatives, make decisions, and resolve conflict" (p. 28). Nurses' work is chequered with interactions with others, be they patients, their families, colleagues or the wider community.

Complex circumstances also arise from burgeoning technological approaches to healthcare and the concomitant ethical considerations of technology on patients (Aroskar, 1993; Hussey, 1990; Kaane, 1994; Magnussen, 1994; Patterson & Vitello, 1993). Correspondingly, alternatives, decisions and conflict arise on a regular basis. Instillation of professional ethical values can assist the nurse to meet these challenges and endeavour to act in ways that ethically meet the needs of the patient. Values instillation is therefore vital for preparation for practice as a registered nurse for three reasons, firstly, to prepare the newly graduated nurse to meet the complexity of the ethical context of nursing practice, secondly, to prime neophytes with the values reflective of the more widely established values of the nursing profession, and thirdly, to provide some consistency in the expected behaviour of nurses within the nursing profession.

Certain tangible methods emerged in Chapter Four (Appendix 6), which may effectively assist in the instillation of professional ethical values in undergraduate nurses. Traditional ethics theory, namely the four principles approach (Beauchamp & Childress, 1994), the legal parameters pertaining to nursing practice (Code of Health and Disability Services Consumers' Rights 1996; Nurses Act 1977; Privacy Act 1993), cultural safety education (NCNZ, 1996a; 1996b; Ramsden, 1990a) and didactic teaching related to the characteristics of the nurse-patient relationship, may be instrumental in fashioning professional ethical values.

Observing role models in both the classroom and practice setting may reinforce professional ethical values. Participants, whether they observed 'helpful' or 'dubious'

actions, experienced a strengthening of the values that they held. Greenwood (1993) expresses concern that student nurses can become desensitised to human need through being repeatedly exposed to poor nursing practice. This was not found to be the case in this study. Participants appeared to be acutely sensitive to human need upon graduation. What was evident however, was that as 'developing nursing knowledge' expanded, participants found that they weighed 'patient expressed needs' with 'nurse assessed needs'. Periodically, interventions that promoted a healthy outcome according to 'developing nursing knowledge' were adopted. However, it was noteworthy that this caused differing levels of unrest in participants. Any degree of constraint to the autonomy of the patient was distressing for participants. Participants were thus quite highly sensitised to the professional ethical values that they had adopted, as well as to the patient.

It may be assumed therefore that the classroom education that participants received had a major part to play in the initial germination and establishment of professional ethical values. As participants' values reflected those embedded within a patient-focused caring relationship, it may also be assumed that education regarding concepts that pertain to caring may have also had a significant part to play. For example, nursing theories generated by respected nursing commentators, of whom Benner (1984), Christensen (1995), Swanson (1991) and Watson, (1985) are a few, capture the characteristics embedded within the nurse-patient relationship, and more specifically, facets of the process of 'caring'. Facets identified within these theories reflect several of the constructs participants in this study held as 'ethical ideals'. Utilisation of these theories may also contribute to instillation of professional ethical values. Codes of ethics (ICN, 1973; 2000; NCNZ, 1995; NZNO, 1988; 1995), policies and competencies (NCNZ, 1995; 1996a; 1996b), and cultural safety (NCNZ, 1996b; Ramsden, 1990a; 1990b; 1990c; 1992; 1993; 1995) are also potential 'drivers' of professional ethical values development.

Instil professional ethical values as 'ethical ideals'

In this study, professional ethical values have been conceptualised as 'ethical ideals'. This eventuated from the dedication that participants verbally demonstrated to upholding these values, and the added consideration of contextual constraints that impede giving care according to the 'ideal'. Care given was to reflect the professional ethical values in the conceptual framework (Appendix 5). 'Ascertaining needs',

'respecting' the patient and 'promoting autonomy' in the patient were held in high regard. These were core ethical values that emanated from participants as a standard, and an 'ideal' way to practice. These 'ethical ideals' were used as a standard to appraise what they saw in the practice setting. They also had an influence on how participants responded to what they saw. 'Gut feelings' were triggered and gave participants a sense of what they deemed to be 'right' or 'wrong'.

It seems worthy at this point to remember that symbolic interactionism informs grounded theory research. Faules and Alexander (1978) explain that meaning that is attributed to messages received from one's environment, is highly dependent upon one's values and the priority of those values. These authors interpret the concept of values to mean norms and ideals. Norms are expected patterns of behaviour whereas ideals are standards of conduct or reasons for doing things. This confirms that values can be utilised as 'ideals', as was done by participants in this study.

Incidentally, the notion of promoting 'ideals' within nursing and nursing students is not new. Fry (1994, p. 292) defines a moral ideal as, "A conception of moral perfection or excellence. A possible state of affairs that is morally desirable." For Watson (1985, pp. 31-2), "The ideal and value of caring is clearly not just a *thing* out there, but is a starting point, a stance, an attitude, which has to become a will, an intention, a commitment, and a conscious judgement that manifests itself in concrete *acts*. Hence, the ideal and value of caring are twofold as it is both an intention and an action. The intention motivates the action. According to Kelly (1990), Johnstone (1999) and Watson (1985), caring is the moral ideal of nursing. It is a moral commitment to human care. This moral ideal promotes human welfare and well being in nursing care contexts (Johnstone).

Therefore, it is recommended that professional ethical values continue to be promoted as 'ethical ideals' within undergraduate nursing education, so that student nurses do indeed have a standard to measure against and an aim to endeavour to strive towards. This will assist the student nurse, as in the case of participants in this present study to, as Polanyi (1969) asserts, appraise what they know by a standard set to them. Quinn (1990) points out that promoting the moral ideals of the nursing profession is an essential component of undergraduate nursing education. Hussey (1990) promotes engendering appreciation of the ideals in moral behaviour in nursing students and Kelly (1990) expresses that, respect and caring are ideally integral to nursing practice. Woods

(1999) too contends that there must be a commitment by nursing ethics educators to promote ideals that enhance nursing practice that is ethical.

Increase education of ethics theory in nursing education

The literature review in Chapter Two, shows that there appears to be a dearth of teachers within nursing who have knowledge of ethics theory (Arndt, 1994; Johnstone, 1999) and that the success of ethics teaching within nursing education and practice is largely dependent on the ability of teachers to teach ethics (Fry, 1989a). It seems that findings in this research also support this notion, as overt links to ethical theory, both traditional and contemporary, were absent from teacher-student interactions, with the exception of Beauchamp and Childress' (1994) principle-based approach, and this was limited to the classroom setting. Furthermore, this study also highlights a tendency for clinical tutors to utilise 'gut response' without concomitant links to ethical theory.

Hussey (1990) asserts that with the increasing complexity of the healthcare setting, everyday moral intuitions and current skills in moral thinking may be inadequate. Veatch and Fry (1987) also point out that patient care problems require more than intuitive knowledge. These authors are not discounting 'gut response', they caution the sole use of it. Participants in this study were aware of their 'gut feelings' and responses to what they saw in the practice setting. Benner (1984), Johnstone (1999) and Parker (1990) all support the ability of expert nurses to make sound ethical decisions based upon their intuition or 'gut feelings', but Fry, and Hussey and Veatch, point needs consideration. Moral intuition alone is insufficient to clearly guide practice.

Participants in this study were also very clear that their undergraduate ethics education did not adequately prepare them for the contexts that they found themselves in (Chapter Four). Participants struggled to expand on any ethics theory that they might have been exposed to. Clinical tutors and 'buddy' nurses certainly did not utilise ethical theory to bring meaning to the practice setting. Clinical tutors in the practice setting did encourage participants to be attuned to 'gut feelings' and the potentiality of them to guide ethical care. However, participants struggled with articulating an ethical viewpoint on any given matter. Mainly, 'it just did not feel right' was the level of defence. Intuition and 'gut feelings' must not be underestimated or undervalued in a healthcare context that is increasingly valuing empirical knowledge. However, it seems that 'gut response' alone is insufficient to guide ethical decision-making.

It seems expedient that novice nurses be given ethical rules and standards whereby their practice can be guided, whilst they are learning to be nurses? There is evidence in this research for an increase in teaching ethical approaches that can guide the novice nurse. This would provide parameters in which experiential learning could safely take place as Pryjmachuk (1996) proposes. For the participants in this study however, 'ethical ideals' did provide a standard with which to align one self with, and hence verify if one's behaviour was ethical. However, it seems that, according to participants in this study (Chapter Four), this was insufficient.

To recap, upon entering the classroom setting participants were taught a smattering of ethics theory that centred mainly on principle-based ethics identified by Beauchamp and Childress (1994). Participants identified these to be 'beneficence', 'nonmaleficience', 'autonomy' and 'justice'. Overall there was an apparent lack of knowledge related to ethics theory, a lack of skill to articulate an ethical perspective and an overall lack of ethics preparation for the ethical challenges that would meet participants in the practice setting. In Chapter Two it was recommended by respected nursing authors that students of nursing learn principle-based ethics, virtue ethics, deontology, utilitarianism and as well as the Kohlberg/Gilligan debate and the ensuing ethic of care perspective (Davis & Slater, 1988; Fry, 1994; Johnstone; Ketefian, 1999; Rogers & Niven, 1996). This ethical knowledge was largely absent in participants in this study (Chapter Four).

Woods' (1994) New Zealand study too revealed that there was insufficient formal ethics preparation for student nurses. Of his 16 participants 70% identified that approximately 10 hours was spent learning about ethics. Later, Woods' (1997) study identified that the 8 participants could only recall formal ethics education as a small collection of lectures that were part of wider topics. Thus they essentially learned by 'fending for themselves' or were 'self taught', with regards to making ethical decisions in the practice setting. Participants in this present study identified that they spent approximately 10-30 hours learning ethical theory in the classroom and that this was scattered throughout their 3 years of undergraduate nursing education. All participants in this study could remember their ethics education within the classroom setting.

On the basis of Woods' two research studies, and the findings of this study, it appears to indicate that there is an improvement in the ethics education for undergraduate nurses in New Zealand. Yet according to Johnstone (1999), to teach ethics effectively at an undergraduate level requires a minimum of 26 hours, and that it

should be taught separately. Furthermore, all participants in the aforementioned studies identified a lack of ethics preparation for the practice setting. That is confirmed by this New Zealand study. It seems then, there is a lack of theoretical ethics education in undergraduate nursing education.

Increase education of clinical tutors in ethics theory

In this study, it emerged that the scope of the theoretical knowledge of ethics displayed by clinical tutors appeared limited. Throughout the whole of this research, clinical tutors were utilised to debrief with, hence providing a forum where emotions could be siphoned off (Chapter Five). This was a valuable exercise as it brought relief of moral distress for participants however, little education regarding ethics theory was offered to participants when they presented clinical tutors with ethical quandaries. It seems that the level of ethics knowledge was limited to 'gut feeling' and sharing of their personal stories. This confirms issues that arose in Chapter Two where a dearth of ethics knowledge was highlighted within those teaching nursing, and that significant remedial work was needed.

It would seem expedient then, that those educated in ethics theory prepare remedial courses that explore both traditional and contemporary ethics theory (Chapter Two), and that these courses be offered flexibly (by onsite and distance delivery). This would make this learning more readily available to those within the profession. Not only could this learning be available to tutors but also to registered nurses in practice. Furthermore, short onsite ethics courses could be offered by those nurse ethicists within New Zealand prepared to travel to educational and clinical settings to deliver these.

The instillation of professional ethical values is crucial for the development of ethical practice. 'Gut response' is a credible mechanism to signal to the nurse that something is 'not quite right', but it is cautioned that this alone is insufficient to engage in ethical decision-making that is defensible. Furthermore, there is evidence in this research that there was a lack of ethics education for participants, and a lack of ethics knowledge demonstrated by their tutors and 'buddies' also (Chapters Four & Five). This poses a challenge for those setting the parameters of undergraduate education in New Zealand, a challenge to increase the ethics theory component, and ideally, provide an ethics course of, at least 26 hours duration. Flexible learning packages could offer a way to promote ethics education within the wider profession with the view to increase the ethical capabilities of students, educators, clinical tutors and registered nurses.

Implications for nursing education in the practice setting

Faculty educators and clinical tutors to actively guide reflection on journal entries and situations experienced in the practice setting

The process of journaling involves systematically recording and analysing, and thus gathering a comprehensive description of social experiences and then by reflecting, making sense and meaning of those experiences (Holly, 1989). Thus ways in which nurses and nursing have unwittingly contributed to their own oppression may be illuminated, unravelled and changed (Street, 1991). The intended result is transformative action (Taylor, 2000). There was no evidence of transformative action occurring in this present study. Perhaps this was because participants lacked understanding of the journaling and reflection process, and, or because they were learners in the practice setting and their perceived and experienced powerlessness (Chapter Five).

Essentially in this present study, participants preferred to 'debrief' in reflection sessions and amongst their peers (Chapter Five). Debriefing though, is a useful tool that can support students and assists them to lift pressure and cut back on stress (McCleland, 1998). Furthermore, sharing one's concerns with peers knowing that one will be treated with understanding and thus *providing one another with emotional support* was seen to be crucial to students' learning in Campbell et al.'s (1994) research amongst undergraduate nursing students. In Bride's (1998) research, clinical tutors expressed that reflection time was utilised by students to 'debrief'. This time was valued by students and viewed as a positive learning experience. Students were keen to share their experiences and reflect on them in a safe environment.

In reflection sessions, participants expressed their feelings, and in a sense, these were siphoned off to the members of the group. Hence, a state of ethical equilibrium and calm ensued. Mostly, participants were clear in their own minds that 'next time' they would do things differently and 'speak up' if what they saw happening to the patient was unethical in their eyes (Chapter Five). Chevasse (1992, p. 2) ponders, "It is important that, after the relief of 'blowing off steam' (cathartic communication), that colleagues should together consciously and deliberately seek to find ways of modifying difficult situations." What did not emerge from this study were examples of where participants did act differently. It is possible that this may be directly attributed to the contextual obstacles outlined in Chapter Six and their learner role in the practice setting.

It seems then, that there is a mismatch as to what was expected when writing in one's journal and what participants actually did. It is possible that there was some lack of understanding as to the purpose and benefits awarded the process of journaling and reflection. In a New Zealand context Turnbull's (2001) findings amongst undergraduate nursing students are poignant and support the findings in this study. Turnbull found that a clear understanding of reflective practice is pivotal in mastering the concept. Turnbull's participants were often unable to engage in effective problem solving or to extract meaning from the incidents that they wrote in their journals, thus participants reported disillusionment and a subsequent labelling of the reflective practice process as being worthless. Teekman (1997) promotes that it is important to have some degree of instrumental (theoretical) knowledge (of journaling and reflection) as a starting point from which to reflect. Without this, learning might be severely impaired, if not impossible.

Hussey (1990) suggests that tutors pick up ethical aspects of a topic or situation and discuss them with students. In this study, clinical tutors did not fully explore ethical aspects raised during reflection sessions. Reflection tutorials seem an opportune place for this to occur. It is therefore recommended that clinical tutors enhance the ethics education of undergraduate nurses by exploring more closely the experiences that students bring to these sessions and thus utilise a narrative ethics approach, described more fully in Chapter Two. This process could be more fully enhanced by linking experiences to both traditional and contemporary ethics theory, as Benner (1984) suggests, theory can facilitate systematic examination of a series of events. However, it seems that clinical tutors did not have this knowledge themselves, and thus could not extend students' learning.

Thus, as suggested earlier, remedial ethics education may be needed. Kolb (1984, p. 30) contends that learning is, "by its very nature a tension- and conflict- filled process." The way this conflict is resolved according to Kolb, is by dialectic engagement with both concrete involvement (the experience) and abstract detachment (theory). To this end, students benefit from fully exploring the experiences that they have from numerous perspectives. This facilitates the creation of new concepts and utilisation of theories to engage in problem-solving.

Allmark (1995) discourages giving student nurses complex moral situations to discuss as this may foster feelings of being unsure and despair rather than empowerment. This is another reason why experiences that students bring to the

classroom, journaling and reflection sessions or to 'buddies' or tutors in the practice setting are ideally an opportune time to guide reflection and ethical learning. Thus learning centres as much as possible on students' own experiences (Hussey, 1990). Kolb (1984, p. 9) reiterates, "learning is best facilitated in an environment where there is dialectic tension and conflict between the immediate, concrete experience and analytic detachment." Thus, in the practice setting where journaling and reflection is positioned, is a powerful place for the clinical tutor to make relevant links to ethics theory.

Continue to value intuition and 'gut response'

Rogers and Niven (1996, p. 19) define intuition as, "an amalgam of experience, knowledge, science, reason, expertness, confidence and the ability to foresee." This definition is multi-faceted and is far more complex than purely 'gut response'. Benner (1984, p. 32) speaks of the expert nurse as one, "with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions." Teekman (1997) too explains that past experiences provide a storehouse of practical knowing, full of memories that can be utilised to bring illumination to the current situation.

It would seem that student nurses would lack a deep understanding of the healthcare context and do not have the wealth of professional experience that develops intuition. An intuitive grasp of a situation, as Benner alludes to, indicates previous picking up of cues on a sub-conscious level. An intuitive grasp does not seem to occur in a novice nurse, however 'gut response' clearly does (Chapter Five). 'Gut response' is an emotional response and is often a result of sensing that something is 'wrong' (Johnstone, 1999). These were the responses that participants had in this study. They may not have had an intuitive grasp of ethical situations, but they did respond on an emotional level and they did evaluate according to their professional ethical values, which, it has been argued earlier in this chapter, constituted the conceptual framework that was referred to. Therefore, as Benner (1984) explains, the novice nurse utilises context-free rules that guide action. It is argued that this response was directly related to their understanding of professional ethical values and evaluations of what might be 'right' and what might be 'wrong'.

In this study, 'gut response' was directly attributed to the ethical constructs that participants held as 'ethical ideals' (Chapter Five). These were not only an intellectual

guide to their practice but also an emotional guide. Johnstone (1999) stresses that 'gut response' alone is insufficient evidence from which to make an ethical decision. 'Gut response' should guide the nurse to gather more concrete data. She suggests utilising an established decision-making ethical framework to assist in this process. Clinical tutors in this study attuned participants to their 'gut response' mechanism, but failed to explain that 'gut response' was only a part of ethical decision-making. When student nurses share their responses with their clinical tutors and 'buddy' nurses, this would be an opportune time to explore any cues that the student may have noticed, thus encouraging articulation of concern. It would also be expedient to apply an ethical decision-making framework or ethical theory to the situation. Perhaps this could maximise the student's learning in particular situations.

It is undeniable that 'gut response' can play a significant part in endeavouring to find ways to ethically meet the patient's needs, as well as appraising care that has already been enacted, whether by the nurse, or another health professional. Rogers and Niven (1996) and Noddings (1984), all reiterate that emotion ('feeling' responses) does have a role in the moral life. Furthermore, Nussbaum (1986), as explained in Chapter Five, links feeling and thinking together, and Johns (1993), assert that feelings are a significant factor in ethical decision-making. It is recommended that educators in the classroom, clinical tutors in the practice setting and, registered nurses, attune student nurses to their 'gut responses'. However, this mechanism alone is insufficient on which to base ethical decisions and must be balanced with other ethical approaches and decision-making approaches that strengthen and make more defensible the decisions that nurse make.

Strengthen the voices of student nurses

Enhance communication skills.

It has been established in this study (Chapters Five & Six) that student nurses endure feelings of powerlessness whilst in the practice setting. Choosing to remain silent, making suggestions in a tentative manner or 'submitting' reflected this. On one hand, conveying ideas in a deferential manner may result in those ideas being readily dismissed (Keenan, Cooke, & Hillis, 1998). On the other hand, when student nurses have spoken up they have been labelled as 'trouble-makers' (Booth, 1997). It is thus possible, that student nurses are therefore placed in a 'no-win' situation. Yet, it is imperative that the voices of neophytes be strengthened.

Communicating ideas in a forceful manner can seem in conflict with the perceived caring view of nurse. Keenan, et al. (1998) argues that being aggressive and/or assertive does not necessarily mean that the behaviour is uncaring. "Therefore, it is appropriate and necessary at times to be forceful and firm in presenting alternative ideas to ensure that others fully understand and assess those ideas before dismissing them" (p. 69). This could be perceived as scary business for student nurses, and potentially risky, and perhaps not even considered with the view of harming their reputation in the practice setting. Lindeke and Block (1998) caution however against placing student nurses in positions where they must engage in collaboration prior to their developing strong professional values and identity. Their reasoning is that, collaboration requires strong established professional identity and confidence. Incidentally, in a study by Kleehammer and Fogel (1990) it was found that student nurses experienced talking with doctors to be a highly anxiety producing undertaking. These researchers suggest that clinical tutors could role model verbal interactions with doctors and also provide support for students when they talk with doctors.

However, student nurses could practice collaboration with their 'buddy' nurses and clinical tutors in the practice setting. Indeed, participants in this study did attempt this by 'suggesting tentatively'. Exploration by clinical tutors and 'buddy' nurses of these tentative suggestions could have the potential to encourage nursing students to articulate more clearly their ethical persuasions. Thus nursing students could more actively test their 'ideals' safely in the practice setting in preparation for later collegial collaboration with the medical profession, as well as the patient, their family, and other nurses.

To enhance communication skills in student nurses, it is possible that they could engage in role-plays where they articulate an ethical position. Opportunity could also be made for them to safely express their views in a compelling manner with their clinical tutors and peers in the practice setting, for example, in journaling and reflection sessions, or in the classroom. Classroom and clinical tutors may have to role-play this type of expression to assist in developing skills of articulation within students. If historically, ethical voices have not been heard (Gilligan, 1982; Parker, 1990), or have been expressed in deferential styles of communication (Keenan et al., 1998), then perhaps tutors may also require remedial skills in articulating an ethical position. As Keenan et al. explain, both doctors and nurses often do not clearly articulate their

objectives of care which may differ significantly, for example the doctor's aim might be to prevent death, whereas the nurse's aim might be to facilitate a peaceful death.

Perhaps student nurses, with tutorial guidance, could practice articulating an ethical position in both the language of care (contemporary ethics theory) and the language of justice and rights (traditional ethics theory), so as to become familiar with both. Bandman and Bandman (2002) suggest that utilising an ethical theory to articulate a position has the potential to bring a powerful moral force to nursing practice. Furthermore, Johnstone (1999) suggests that moral problems are resolved by, "open and honest moral debate among those involved" (p. 168). This method could be safely used in journaling and reflection sessions as well as practised in the classroom. Finally, it may be worthy to incorporate clear expression of opinions as part of the assessment process. Perhaps this would apportion it greater value.

Validate responses and evaluations

In Chapter Five it was identified, that trust and honesty seemed essential in the tutor-student relationship, and that participants appreciated it when their responses and evaluations were validated. Miller and Zamora (1990) promote the notion that a process of validation of one's experiences develops caring. They go on to say that when others in one's social network do this validation throughout one's lifetime, it is an expression of tenderness. These authors suggest that as tenderness is expressed towards students, in other words validation of their experiences, students in turn develop caring, and the emotional depth required for ethical practice. Sprengel and Kelley (1992) promote the notion that educators must relate in a caring manner so that students of nursing may acquire caring virtues. Crowley (1989), Darbyshire (1993) and Noddings (1984) all support the notion that nursing educators demonstrate caring towards their students, and develop caring relationships with them. Thus, caring is role modelled.

It is therefore suggested that 'buddy' nurses and clinical tutors explore suggestions offered by students, and encourage clear articulation of these suggestions and appraisals. This may then demonstrate a valuing of 'developing nursing knowledge'. Booth (1997) in her research amongst a group of 16 educators, nurses and students, found that there was little sharing and exchange of knowledge between the players. It was also noted that there was a lack of appreciation of students' knowledge, skills and previous life experience that they brought to their clinical placements.

Although novice nurses may not have the practical know-how embedded within the expert nurse, they do however, have a body of 'developing nursing knowledge' that provides a theoretical base that can inform the practice setting. Student nurses can contribute to the practice setting by bringing their up-to-date theoretical knowledge that is often based on current research findings (Chapter Seven). This present study indicates that student nurses do indeed have knowledge that they have gathered and that this could enhance the 'buddy' nurses' knowledge, just as 'buddy' nurses enhance the knowledge of students. Thus, as Polanyi (1969) promotes, an inexhaustible fund of knowledge may be revealed whilst engaging in verbal speculation. Furthermore, this may also facilitate 'buddy' nurses exploring their tacit knowledge, gained through experience (Benner, 1984) and moving from, as Polanyi supposes, the tacit to the articulate. Therefore, valuing students' knowledge would have the potential to strengthen students, and 'buddy' nurses may experience concomitant valuing as they discover what they intuitively know.

Implications for nursing research

This study contributes to the previous research endeavours of Woods (1992; 1994; 1997). Ethics education was not the foci of these studies, however a lack of ethics education became apparent. As there is little published research exploring ethics education within New Zealand, it would seem that there has been minimal exploration of this phenomenon in undergraduate nursing education in New Zealand to date. Thus, as Krawczyk (1997) recommends, further research is needed into nature of ethics education, ethics content in undergraduate nursing programmes and, an evaluation of current ethics courses.

Further grounded theory research

Woods' (1997) study utilised grounded theory methodology and researched 8 experienced nurses. It was found that they maintained a nursing ethic despite the contextual constraints that confronted them in the practice setting. They adopted a pragmatic compromise approach to ethical decision-making as they negotiated the process of caring ethically as other health professionals also brought their values to the patient's situation. This present study also utilised grounded theory and has explored the ethics preparation for practice as a registered nurse. Thus, in nursing ethics in New Zealand, one study explores experienced nurses and the other student nurses. It is therefore recommended, that there is scope for another grounded theory study that

explores the transition to practice, of newly registered nurses between one and five years post graduation. This would further add to understanding the ethical context of nursing and the processes that nurses utilise to give care that they deem to be ethical. In this present study, participants 'preserved' their professional ethical values, and 'held' them as 'ideals' at graduation. This preservation occurred despite contextual obstacles. Thus exploring the subsequent effects of socialisation on professional ethical values of newly graduated nurses would be of interest.

As was discussed in Chapter Three, grounded theory provides description of the substantive area being researched and thus explores, "what is going on here?" It also involves an explanation of, "what is going on and how" (Becker, 1993). Thus, grounded theory uncovers 'what is', rather than 'what could be'. Woods' (1992; 1997) studies, and this present study, have once again highlighted the complex ethical context that nurses find themselves in (Chapter Six). It is therefore also recommended, that emancipatory research positioned within the critical paradigm of inquiry (Allen, Benner, & Diekelmann, 1986; Emden, 1991; Stevens, 1989), be utilised in ethics research within New Zealand. Perhaps this would uncover creative ways to address problematic contextual constraints and identify possible ways that nurses themselves contribute to these constraints. This will be discussed more fully shortly.

Narrative ethics research

Parker (1990) supposes that the moral foundation of nursing cannot be extracted from abstract or theory that is separated from context. Parker argues that nurses need to tell their relational stories and that, "nurses collectively can fashion a tapestry of rich and diverse experiences from which to pattern a nursing ethic" (p. 34). Benner (1984) agrees with this position. She promotes the idea that lack of detailed record keeping of nurses' experiences in the practice setting, "has deprived nursing theory of the uniqueness and richness of the knowledge embedded in expert clinical practice" (p. 2). Woods (1997) also supports this argument. He proposes that exploration of the moral practices of nurses should begin in practice. This has the potential to reveal the voice and perceptions of nurses culminating in the emergence of a nursing ethic. These authors confirm Fry's (1994, p. 293) rendition of nursing ethics as, "The philosophical analysis of (1) the moral phenomena found in nursing practice, (2) the moral language and ethical foundations of nursing practice, and (3) the ethical judgements made by nurses."

It is imperative to highlight that, research of this nature is primarily interpretive and reveals 'what is' in nursing. Nehls (1995) confirms this view when she points out that narrative pedagogy is an interpretive approach to teaching and learning. Nehls argues that narrative pedagogy, and the central concept of the lived experiences of teachers, clinicians and students, is being utilised to foster educational reform. It is however, argued in response to this present research, that true educational reform must be coupled with emancipatory research, situated within the critical paradigm of inquiry.

Emancipatory research

It is recommended that emancipatory research, of which critical social theory (Emden, 1991; McCleland, 1998), action research (Carr & Kemmis; 1986; Wood & Giddings, 2000), and feminist research (Speedy, 1991), are examples, be utilised to further explore nursing ethics and ethics education within the profession of nursing. To illustrate, the philosophical underpinnings of critical social theory incorporates the assumption, that standards of truth or evidence are socially constructed. Furthermore, "social life is structured by meaning, by rules, conventions, or habits adhered to by individuals as social beings" (Allen, et al., 1986). Action research is a useful methodology for effecting change in practice, as focus groups gather information, successively plan, act, monitor and evaluate solutions to their identified contextual problems (Carr & Kemmis; 1986; Wood & Giddings, 2000). Feminist research has the potential to explore oppressive factors that constrain women, their utilisation of language, and ways in which this might perpetuate their oppression and subordination. Furthermore, Street (1991), when exploring critical reflective practice, asserts that critically reflecting on nurses' written stories, may contribute to exposing how language contributes to nursings' oppression. Street argues that there is a strong relationship between language and socially constructed forms of power and knowledge. Furthermore, the contextual constraints to the practice of nursing have been repeatedly illuminated in nursings' scholarly literature, but much less in regards to our language. Hence, "the development of nursing ethics is an essential part of the emancipation of nursing and its establishment as a true profession" (Hussey, 1990, p. 1378).

Emancipatory research has the potential to explore and test creative ways that emerge from nurses, and students themselves, to challenge and change the 'status quo', as opposed to ways that nurses or students manage to cope within the contextual constraints that confront them. Pavlovich-Danis, et al. (1998) contend that, "Nurses

themselves need to take action to free nursing from the subservient role into which it has evolved" (p. 20). Interestingly, Nolan and Smith's (1995) research amongst first year medical, dental and nursing students found that participants wanted practically based courses in ethics to help them to cope in the practice setting. This certainly appears to be a realistic request, however, it has to be questioned whether nurses *per se* want to 'cope' within the contexts that they find themselves in or, to instigate change. This is an ongoing challenge for the profession of nursing as a whole. Does nursing ethics education assist nurses and students to learn to cope within a hegemonic system or are there avenues which can be explored that can realistically equip nurses to actively bring change to their roles in the healthcare context? It is recommended that it is imperative that it does, otherwise the answer to Yarling and McElmurry's (1986) question "are nurses free to be moral" will continue to remain 'No!'

Limitations of this study

Choosing to explore the perspectives of newly graduated nurses on their undergraduate ethics education in preparation for practice as registered nurses was stimulated by two motivators, a keen interest in nursing ethics, and the pressing need to complete a Masters degree. The second motivation meant that this study spanned a finite period of time. When a researcher utilises grounded theory methodology, theoretical sampling is pursued until saturation of all categories (Glaser, 1992). Due to time constraints, some emerging categories were not fully explored. This research then, focuses on those categories that were deemed to be saturated in that no new data emerged that contributed to them.

Nine participants were accessed. Five of these were educated at the School of Nursing where the researcher is an educator. The researcher had previously taught four of these five participants. It is possible that these four participants endeavoured to please the researcher, due to previous teaching and learning contexts that they had shared. However, it is argued that the researcher had previously developed a positive tutor-student relationship with these participants, and that on this premise, open and informative communication was engaged in during the interview process. Because those participants were open with regards to their feelings of powerlessness and expressions of their experiences encountering uncomfortable contextual constraints, it is assumed that participants have given honest and rich data. Furthermore, four participants were educated at four different Schools of Nursing throughout New Zealand and were

previously unknown to the researcher. Overall then, data was consistent across all participants and across all schools and practice settings that participants found themselves in.

A further limitation to this study is the relatively small number of participants that took part. However, follow-up interviews were subsequently conducted with three participants with the express intent of confirming data and ascertaining saturation.

Glaser (2001) points out that qualitative researchers have, with years of experience, come to the realisation that there is no value-free method of inquiry that explores human existence. To this end, this research, with its qualitative approach admits and accepts subjectivity and contends that this contributes to understanding the human experience (Creswell, 1994; Davidson & Tolich, 1999; Guba & Lincoln, 1994; Polit & Hungler, 1999).

Concluding remarks

This thesis has explored the perspectives of nine newly graduated nurses on their undergraduate ethics education for practice as registered nurses. Learning of ethics and ethical practice occurred through faculty education, role modelling of tutors and 'buddies' in the practice setting, by journaling and reflection, and by actively experimenting in the practice setting. It emerged that participants, over three years of undergraduate nursing education, developed professional ethical values that focused closely on the patient and ethically meeting the patient's needs. Upon graduation, these 'held' as both a motivation and guide to determine ethical practice. It was found that the contextual obstacles 'met' by participants in the practice setting, were significant enough to impede enactment of these professional ethical values, thus they were conceptualised as 'ethical ideals', and 'held' as an 'ideal' way to practise. Participants engaged in 'responding' and 'evaluating' whilst in the practice setting, and this reflected development of 'gut response' and utilisation of their 'ethical ideals', as well their 'developing nursing knowledge', to guide appraisal of ethical phenomena in the practice setting.

As participants in this study identified that their ethics education in preparation for practice was insufficient, it would appear useful for undergraduate nursing education to explore ways to better prepare student nurses to meet the ethical demands of the nursing practice setting. This would include increasing specific ethics education in the classroom and providing remedial ethics education for those that teach nursing. Perhaps

this would facilitate, not only 'attuning' student nurses to their 'gut responses', but also making further links to ethical theory and ethical decision-making frameworks.

That participants emerged from three years of undergraduate nursing education having 'preserved' their formulated and developed 'ethical ideals', reveals considerable fortitude. The ethical context of their education was highly challenging and participants frequently 'met' obstacles that impeded their abilities to ethically meet the needs of the patient. Participants therefore, cautiously 'navigated through' contextual obstacles, endured powerlessness to impact ethically on their environments, as well as balancing their own need to proceed through to a successful graduation.

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APPENDICES

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WANTED

New Graduates

As research participants

I am interested in exploring the process of learning ethics that goes on throughout a three-year Bachelor of Nursing Programme. I would like to invite newly graduated registered nurses that are within their first year of practice to volunteer as research participants. Ideally, I would like graduants from a variety of nursing schools throughout New Zealand. If you are interested in volunteering to be a research participant, or would like more information, please could you contact me?

Esther Vallance (Researcher)
Nursing Lecturer
Christchurch Polytechnic Institute of Technology
Home phone: 351-9986
Work phone: 364-9064 ext 8295
Email: vallancee@cpit.ac.nz

Martin Woods (Research supervisor)
Nursing Lecturer
School of Health Sciences
Massey University
Work phone: 06-3565799 ext 2241

"This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/91."

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Information Sheet

I would like to invite newly graduated nurses to participate in a research project that explores undergraduate ethics preparation for practice as a registered nurse.

Esther Vallance RCpN BN (Researcher)
MA thesis student
Massey University
Palmerston North
Contact phone number:03-3649074 ext 8295

Martin Woods RGON BA MA (Research supervisor)
Nursing lecturer
Massey University
Palmerston North
Contact phone number: 06-3565799 ext 2241

I graduated as a comprehensive registered nurse in 1991 and have worked mainly in Older Person's Health, Acute Medical Nursing and Nursing Education. Over the past 10 years I have become very interested in what it means to engage in 'ethical practice' as a registered nurse. Throughout my undergraduate and postgraduate study I have focused on this topic. I am interested in exploring the process of learning ethics that goes on throughout an undergraduate nursing degree programme. I would like to explore what newly graduated nurses learned about ethics, how they learned it and in what situations that learning took place, whilst they were student nurses. I have had ethics approval to conduct this research from Massey Human Ethics Committee and Christchurch Polytechnic Institute of Technology Ethics Committee.

To this end, I would like to invite newly graduated registered nurses, from a variety of nursing schools throughout New Zealand and who are within their first year of practice, to volunteer to participate in this study.

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Typical questions that might be asked are as follows:

- What is your understanding of the term ethics and ethical practice?
- What ethical aspects of nursing did you learn during your undergraduate nursing education?
- What was your experience of the ethical context of nursing for you as a student nurse?

If selected, further questions you might like to ask will be welcome. You will be asked to sign a Consent Form, should you wish to proceed with the interview/research process.

The time commitment that will be required from you will be 1 – 2 interviews of approximately 1 ½ hours in duration. The interviews will be conducted away from the workplace environment and outside of the participant's hours of work.

All information gathered from you will be held in strict confidence. After analysis it will be presented in a final thesis document in which anonymity will be maintained. Your name and any identifying information will be available only to the researcher and the transcriber. The transcriber of the taped material will have signed a separate confidentiality form prior to proceeding. A pseudonym or a number will identify each participant.

If you decide to take part in this research, then you are reminded that:

1. You have the right to decline to take part or to withdraw from the research at any time up until the end of the second interview.

2. You have the right at any time during your participation

- To ask any questions about the research
- To refuse to answer any question
- To ask that the cassette recorder be turned off
- To examine any notes taken
- To read any subsequent transcriptions
- To terminate the meeting at any time
- To be informed of the results (on completion of the research).

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3. The proposed research may be of benefit to you, in that it might assist you to reflect on your ethics education; *or* it may possibly cause you some mental distress if these reflections are of a disturbing ethical nature. If the latter does occur, then measures will be suggested to help you to cope with this distress. Under no circumstances will I ignore your request for help. If you require support in this regard it will be given, or sought on your behalf with your permission.

4. Any cassette tapes, notes or other material relating to you will be stored for the duration of the research in a secure place. On completion of the research, the cassette tapes will be returned to you, or, if you desire will be destroyed. All other materials used in data gathering, such as transcripts or notes, will be stored in a safe place and either returned to you or destroyed following the usual requirements of research protocol.

5. A summary of the research will be offered to you at the end of the study.

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CONSENT FORM

"Newly graduated nurses' perspectives of their ethical preparation for practice as a registered nurse"

I have read the Information Sheet and had the details of the study explained to me. My questions have been answered to my satisfaction, and I am aware that I may ask further questions at any time. I also understand that this study has been given approval to proceed by Massey's Human Ethics Committee and Christchurch Polytechnic Institute of Technology's ethics committee.

I am also aware that I have the right to withdraw from the study up until the end of the second interview and/or to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used within the research, and that the researcher will undertake to take adequate precautions in regard to anonymity when using direct quotations or commentaries within the thesis. These precautions will also be extended to any other named persons or institutes.

I agree/do not agree to have the interview audio taped.

I also understand that I have the right to ask for the tape recorder to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the information sheet.

Signed .....

Name .....

Date .....

"This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/91."

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CONFIDENTIALITY AGREEMENT

I, ... have accepted the task of word processing the research data collected by Esther Vallance in order to complete an M.A. (Nursing) at Massey University.

I understand that the data gathered for this research is confidential and I agree to take all necessary steps to ensure that any material on cassette tapes, computer disks or hard drive containing data from interviews relating to the research will be:

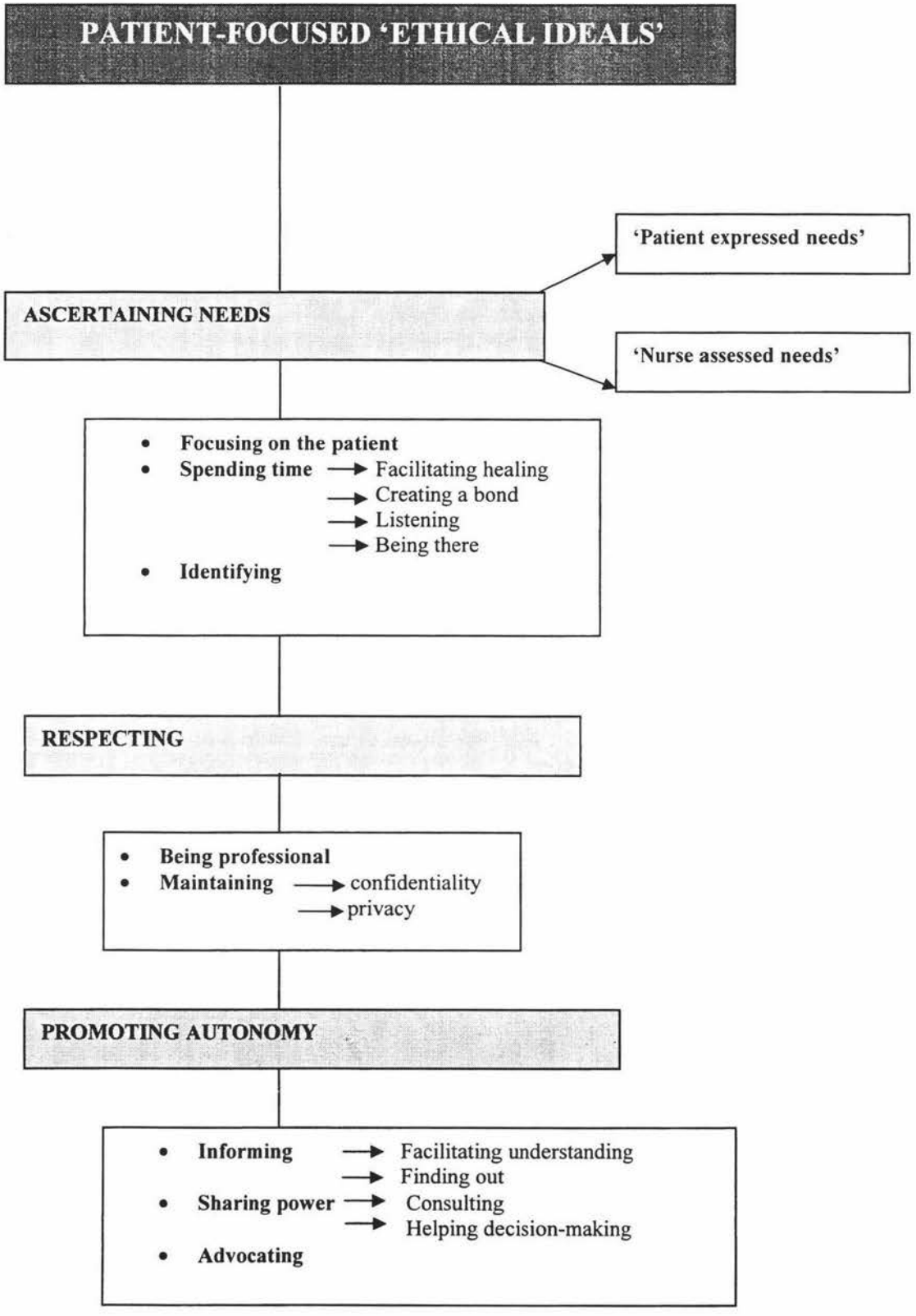
a) Heard only by me, and transcribed to disk in private
b) Stored safely until return to the researcher
c) Treated as confidential in all respects

Signed .....

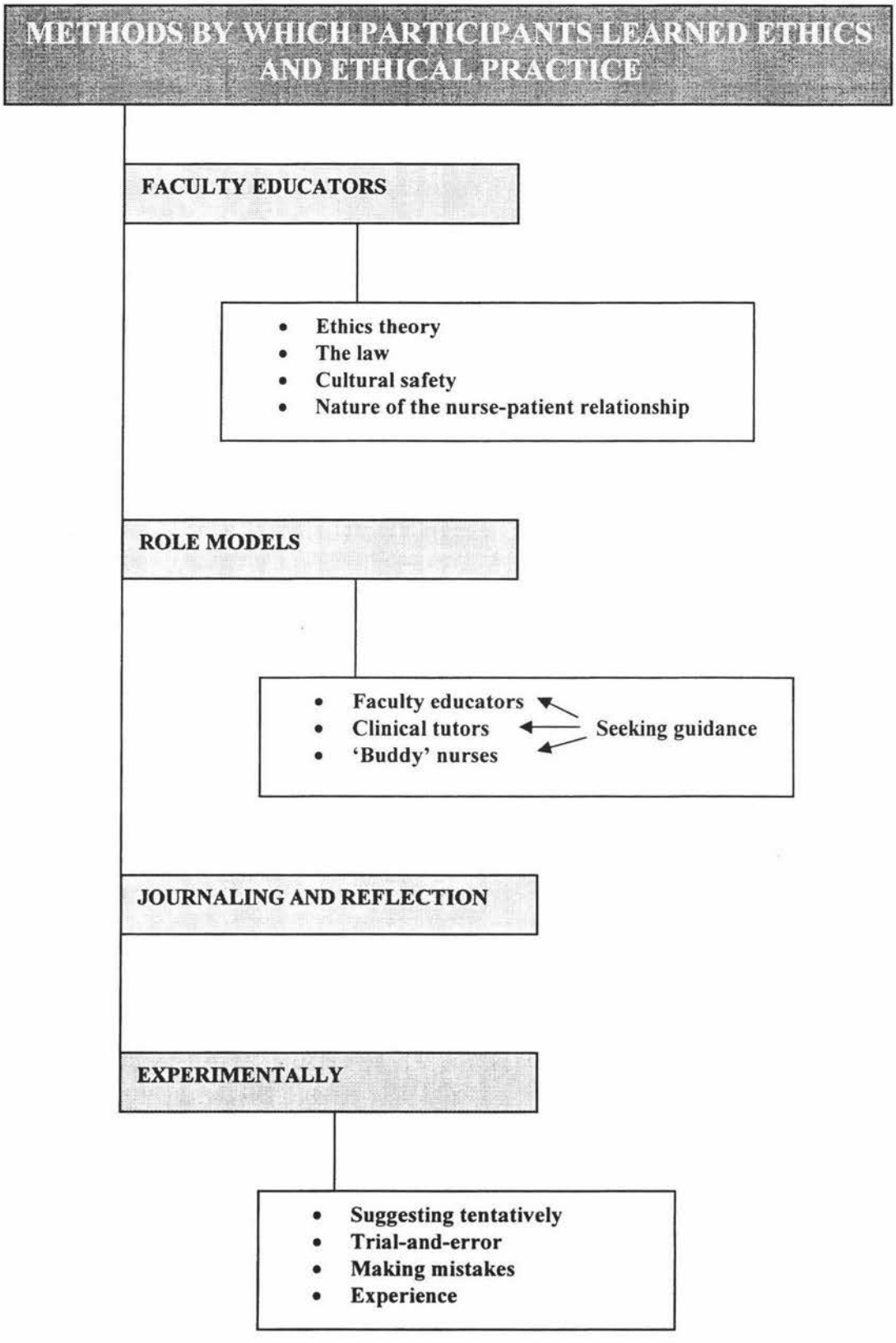
Winessed .....

Date .....

Appendix 5


PATIENT-FOCUSED 'ETHICAL IDEALS'
'Patient expressed needs'
ASCERTAINING NEEDS
'Nurse assessed needs'
• Focusing on the patient
• Spending time → Facilitating healing
→ Creating a bond
→ Listening
→ Being there
• Identifying
RESPECTING
• Being professional
• Maintaining → confidentiality
→ privacy
PROMOTING AUTONOMY
• Informing → Facilitating understanding
→ Finding out
• Sharing power → Consulting
→ Helping decision-making
• Advocating

Appendix 6


METHODS BY WHICH PARTICIPANTS LEARNED ETHICS AND ETHICAL PRACTICE
FACULTY EDUCATORS
Ethics theory
The law
Cultural safety
Nature of the nurse-patient relationship
ROLE MODELS
Faculty educators
Clinical tutors
'Buddy' nurses
Seeking guidance
JOURNALING AND REFLECTION
EXPERIMENTALLY
Suggesting tentatively
Trial-and-error
Making mistakes
Experience

Appendix 7

'NAVIGATING THROUGH'