The ethical development of undergraduate nursing students: A longitudinal parallel mixed methods study

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Abstract

There is significant support for the teaching of ethics in health care and nursing education. However, currently there is limited knowledge of how students studying in these areas apply ethics in their professional practice, and how this is influenced by what they experience during their education. Undergraduate education shapes the kind of nurses that will work in health care, hence the importance of developing *good* nursing students cannot be ignored. This research study aims to evaluate and explore how students develop ethically over a three-year degree program. The study's outcomes intend to guide the development and delivery of nursing curricula in the future.

A three-year longitudinal, prospective, parallel mixed methods research approach was adopted to explore the perceptions of ethics and evaluate the ethical development of nursing students, during a Bachelor of Science (Honours) in Nursing at the University of Malta, from their first year to their third year of studies. Ten semi-structured interviews were carried out over three years and 36 (Year 1) and 39 (Year 3) Defining Issues Tests (DIT2), were eligible for analysis. Quantitative and qualitative data were converged at the end of the three years.

Survey data showed significant (N2 score $p=0.04$) development of students related to an increase in their education level. However, the mean N2 scores were lower than expected, with the highest scores attributing moral reasoning based on personal interests. DIT2 developmental scores showed no significant differences when correlated with sociodemographic variables. Qualitatively, students understood ethics from a perspective of character, humanity, and professional issues. Although there is an understanding of ethical principles, students are often unaware of how this understanding occurs and how it can be applied to nursing practice. Practice was considered to have the highest impact on their development, with a focus on role models and relationships. Furthermore, students perceive ethics to be a complex and ambiguous subject.

This study shows that students ethically developed during their undergraduate studies. Overall, moral development mean scores were lower than expected for university students. There was a discrepancy between the lower quantiative moral reasoning scores and reference to ethical principles during interviews. Students expressed an understanding of ethics

predominantly in relation to nursing practice. Their development was highly influenced by contextual, social and environmental factors. This study highlighted the impact of continuous ethics education throught the academic years and beyond, providing opportunities for decision-making in practice, supportive educational enviroments and adopting a positive active learning approach to ethics education with a focus on day-to-day ethical issues that were relevant to students. Moreover, ethics education should equip students with the neccessary tools to confidently voice their ethical concerns. Thus, an integrated student-centred nursing curriculum based on a multifaceted approach along the whole programme that supports positive ethical education environments and opportunities for decision-making in practice should be adopted.

Declarations

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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Date 17.12.2022

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by in-text references. A reference list is appended.

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List of Abbreviations

2-sig Level of statistical significance

ANOVA Analysis of Variance

CANCER10 Religious orthodoxy score in DIT2

CNM Council of Nurses and Midwives

COVID-19 Coronavirus Disease 2019

DIT Defining Issues Test

DIT1 Defining Issues Test 1

DIT2 Defining Issues Test 2

DOC9 Religious orthodoxy score in DIT1

Dscore Religious Orthodoxy score DIT1

EBT Ethical Behaviour Test

ECTS European Credit Transfer and Accumulation System

ED Ethical Development

EU European Union

FCM Four Component Model

GPA Grade Point Average

HUMLIB Humanitarian Liberal Score

CONSTRAN Consolidation Transition Score

ICN International Council of Nurses

Index P: Postconventional moral schema score in percentage

KDIT Korean Defining Issues Test

MCAST Malta College of Arts Science and Technology

MJT Moral Judgement test

MUMN Malta Union of Midwives and Nurses

N2 Moral Development Score

NDT Nursing Dilemma Test

NUMCD Cannot decide choices

p Level of statistical significance

Pscore Postconventional moral schema score

QUAN-QUAL Quantitative and Qualitative

RSS Really Simple Syndication

SD Standard Deviation

UK United Kingdom

UM University of Malta

UNESCO United Nations Educational, Scientific and Cultural Organisation

USA United States of America

Preface

I had never given much thought to nursing before deciding what career to pursue after my GCSE's. After a few months into the program, I believed that I had made the right decision and have been proud to form part of this profession since that very day. However, as a nursing student and nurse working in practice, I was constantly facing situations in which I had to take decisions, whilst feeling like I did not have the adequate preparation. I distinctly remember my first reflective writing as a nursing student regarding the relationship of students with nurse mentors. This idea stemmed from a struggle that I was going through because of an unethical clinical practitioner. My interest in ethics and professional issues within nursing has been there ever since. I worked in an orthopaedic setting for eight years, whilst mentoring, supervising, and instructing clinical skills and recently took a full-time academic post. My experiences as a mentor, lecturer and instructor ignited the idea that issues of character and morality were most often hidden and not discussed but perceived to be a missing link in nursing practice by several practicing nurses.

Considering this, during the initial development of ideas for this project, only the influence of virtue-ethics in nursing education was going to be adopted. However, upon further reflection, it became apparent that there were no actual studies that looked at what nursing students think about ethics and what approach might resonate with them in Malta. Opting for only one approach in this project could have created a cognitive and a strong researcher bias from the start.

As a nurse, I sought ways in which I could answer the moral dilemmas that I was facing day to day in my nursing practice. My rides back home consisted of reflections on my practice and all the challenges this brings about. During this process of reflection, I realised that virtue ethics does not always guide my ethical decision-making both at work and outside of my work. Further reflection led to a realisation that one can be guided by several principles and that ethics might not always provide a definite answer. Evolving from these experiences and views the purpose of my study is to map out the moral development of nursing students in Malta with the intention of supporting informed curriculum changes and clinical nursing practice that are sensitive to the local context.

Chapter 1: Introduction

This chapter aims to provide a contextual background to this study as well as to justify the relevance and importance of this research area of interest. The chapter commences with an exploration of nursing as a vocation, profession, and practice, and moves on to provide a discussion of nursing ethics and ethics education. This chapter also sets the context for this research study being held in Malta. The development of nursing from a Maltese context and the current healthcare and nursing ethics scenario is reviewed. Delving into these ideas provides a backdrop for understanding the foundations of this research study. Furthermore, it also provides an insight into the development of the research questions identified. This process is necessary since it is the first exploration of nursing ethics education in Malta. The context for this research study further informs the discussion of the findings that emerged.

Healthcare has always been important and in modern times many societies have tried to ensure a better quality of life for all individuals without discrimination. Research in health is not only important to provide the necessary care, but to also provide high quality care, that all human beings deserve. Furthermore, education is considered as one of the main pillars of society. Universities aim to educate students to a high level of knowledge, as well as support students in the process of moral development (Arthur et al., 2009; Van Stekelenburg et al., 2020). The integration of ethics into nursing education has been thoroughly advocated since the inception of the nursing profession, although this effect is not always evident. There is significant support for ethical health care practice and teaching of ethics in healthcare (Armstrong, 2006; Benner, 2012; Lützén & da Silva, 1996; Parsons et al., 2001; Sellman, 2011). However, the practical applications of ethics education and the bridging between moral development and behaviour are to date very limited. Considering this, this research study aims to explore ways in which ethics education in undergraduate nursing curricula enables student development, in the hope of fostering ethical nursing practice.

1.1 The development of nursing

Nursing covers such a wide variety of activities, that throughout history it has been difficult to find the terminology that defines and encapsulates nursing in one simple statement. A phenomenological study by Bishop et al. (1990) defined *nursing* as a "moral practice based on the moral requirement to promote well-being of the patient by caring for him and her by a personal relationship" (p.104). However, the International Council of Nurses (2002) defined *nursing* as:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (ICN, 2002, para. 1).

The ICN definition seems to lack the moral perspectives of nursing practice. Gastmans et al. (1998) also support a definition of nursing as a moral practice. The authors refer to the definition of MacIntyre (1981) in which he defines the concept of *practice* as "any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence" (p.187-188). Through this definition, the authors focus on the scope of nursing practice in relation to a caring behaviour, caring relationships, and providing good care. Following MacIntyre (1981), nursing can be viewed as a practice that is part of a social construct. In view of this, nurses as a coherent group with a social system of rules, need to have insight regarding their contributions to society through agency, responsibility, virtue and values (Peter & Liaschenko, 2003). This can be interpreted as nursing ethics being inevitably interdependent on the healthcare organisations in which nursing is functioning at the time.

The different perspectives of the definition of nursing are also evident in how nurses, themselves understand nursing and what caring for vulnerable human beings consists of. Nurses

with a predominantly medical background, will think of nursing within a hospital scenario, whilst other nurses coming from a different background might look at the role of nursing as caring for persons within their own homes. This highlights the complexity of the nursing profession. However, even though there are these different world-views on what it means to be a nurse, a common concern for all nurses irrespective of their world-view is the well-being of the persons that are recipients of care (Sellman, 2011). Nursing as a profession is concerned with the continuous care of vulnerable human beings and their betterment. The interest for the well-being of others is ethical in nature, thus one can argue that the core of the nursing profession is based on ethics.

In order to understand nursing better and provide a context for this research study, this section explores the development of nursing as a profession, both internationally and nationally. The author of this work has a background of nursing in Malta, a profession that has had strong ties with the United Kingdom (UK). The UK has contributed to the development of nursing as a profession, as well as healthcare systems, that stems from the 180 years of imperial colonisation of Malta up until 1979. Nursing throughout history has often been regarded as a vocation, however this perspective has been largely replaced in recent years by the conception of nursing as a profession and practice. A profession consists of a unique body of knowledge, altruistic service to society, a code of ethics, higher education and socialisation, autonomy in practice and decision-making, as well as control of work conditions (Peter & Liaschenko, 2003). Nursing practice has the focus of care, and this practice is not grounded in specific tasks but the holistic care that nurses and patients are involved in (Benner, 2015; Bishop et al., 1990). Practice can be viewed as moving beyond technical abilities to further include ideals, values, virtues and goals (Armstrong, 2006; Begley, 2005; Gastmans, 2002; MacIntyre, 1981). In fact, Peter and Liaschenko (2003) view the holistic care perspective as a possible exclusion of individual tasks. The authors mention that individual tasks in nursing care, such as offering a bedpan, will not be viewed as having moral status due to the shift of nursing worldviews. Furthermore, Hoeve et al. (2014) mention that as nurses become more scholarly, care-associated tasks are often delegated to less-valued professional categories with lower academic qualifications. The authors also identify the lack of public awareness regarding the autonomous role of a nurse and the impact that nursing research has on an individual's health as a concern in nursing populations.

Nursing in the UK developed during the Crimean war, majorly influenced by Florence Nightingale (Cohen, 1984; McDonald, 2014; Nightingale, 1992). Nursing found a lot of resistance in establishing itself as an occupation and even further resistance as a profession. Florence Nightingale fought for visibility and the importance of nursing (in terms of moral virtue), similarly to nuns and religious figures. However, this role placed nursing in a marginalised, subservient position to doctors, with Nightingale emphasising that this subservience is a necessity for good nurses. To justify women being able to care for men, the religious figure or 'angel' role provided a means of how nurses could care for male bodies. Thus, nursing has developed to be known as stereotypically a female gendered profession. During this period, the nurse-doctor relationship mirrored a husband-and-wife relationship in terms of power, which is a complete subordination to the husband, alongside the wife's legal and autonomous personality being completely disabled. This stereotypical characterisation of women negates the interest of women in justice and logic, other than for the sole purpose of caring (Fowler, 2017; Hoeve et al., 2014). Furthermore, nursing was also hampered by the same social and legal structures that were placed upon women generally, that is, those of a voiceless individual not involved in social activism (Fowler, 2017).

Another figure that shaped nursing in the UK is Mary Seacole. There is a debate about the importance that Mary Seacole had in the development of nursing compared to Florence Nightingale (McDonald, 2014). Seacole was a Jamaican-English nurse and documented her struggles in traveling to Crimea, to nurse wounded soldiers. She funded her own trip and opened the *British Hotel* for wounded soldiers in Crimea. Seacole is much less known in nursing history compared to the romanticised 'lady with the lamp', and it is believed that this is due to her race and social status. Compared to Seacole, Nightingale was wealthy and white, and thus, afforded an education, whilst placing herself at the ideal social strata with the social connections to push nursing forward (Dillard-Wright, 2022; Staring-Derks et al., 2015). The influence of Nightingale founded nursing through a gendered, colonialist, elitist narrative and this identified a need to develop reparatory histories in nursing (Dillard-Wright, 2022).

Nurses view their role in healthcare as essential in the provision of optimal healthcare. Many of the nurse leaders in history were activists for women's suffrage who marched in the suffrage parade in Washington, D.C., USA (United States of America) in 1913. As a result, nursing and feminist ethics have become intertwined in modern perspectives of nursing philosophy. The subordination of nursing was also evident in education with prominent physicians speaking out against the education of women, even suggesting that education can cause degradation of a woman's reproductive abilities. Physician opposition to nursing education continued for decades to protect medicine's own dominance (Ehrenreich & English, 2010; Fowler, 2017). A major objective of nursing education at the time was moral development and, as a result, ethics was predominant throughout nursing curricula. This coincides with the image of nursing being intrinsically, morally good. Over the years, the importance of ethics in the nursing curricula has dwindled and in modern nursing, ethics tends to be placed as an afterthought into the curricula, mostly dominated by medical content, even though the importance of ethics education is thoroughly advocated. In the USA, the majority of nurse leaders went on to chair nursing councils and associations that actively influenced the future of the nursing profession (Fowler, 2017).

1.1.1 Relationships in nursing

There is an urgent need for ethical consideration in the nursing profession, because nurses and the patients they care for, form part of a society. The emergence of Western ethics through works of literature by Homer, Plato, Aristotle, and many other later thinkers is based on systemically looking at right or wrong behaviours of people. Thus, ethics cannot be understood without understanding the relationships between people. In the nursing profession, the concept of the nurse-patient relationship emerged in the middle part of the 20th century. This is central to nursing practice, even in the current day. Patients view nurses as skilled companions who discern the care needs and provide these in a professional manner (Vanlaere & Gastmans, 2007). The vocational start of nursing provided a basis for nurses to be trained, not only in nursing preparation, but also for moral formation (Fowler, 2020). This training was based on a

relationship approach that takes a deductive approach to ethical duties in the context of specific relationships.

At the beginning of the 20th century, nurses were involved in master-servant relationships with health professionals having a patriarchal role in monitoring bodily functions (Dingwall et al., 2002). The personhood of the nurse and patient were deemed to be separate or irrelevant to the nurse-patient relationship (Armstrong, 2006). In contemporary nursing, there has been a fundamental change by broadening the nurse-patient relationship and including biopsychosocial models of care. This led to a more humanistic approach to nursing, in which a greater range of ethical theories could be accommodated and developed. Nursing is different from the purely scientific subjects because it is not based on generalisable truths but concerns particular patients, in specific contexts, that are unique (Gastmans et al., 1998). This new perspective on nursing practice required reciprocal participation of both nurses and patients to achieve quality care. Though Peter and Liaschenko (2003) argue caution when referring to this relationship, since it is not independent of the contexts and complex environments in which they occur or take place.

Nursing relationships do not only evolve as an individual nurse-patient relationship because nursing is also related to social relationships. Fowler (2017) discusses the social involvement of nursing through individual and community flourishing. In literature on the nursing profession, there is an awareness of the need for nurses to be involved in social issues. This is because nurses care for the unfortunate who are subject to health disparities, injustice and are more than ordinarily vulnerable (Sellman, 2011). However, society in this century is showing passivity towards social and care issues, with nursing, not exempt from this lack of social involvement, not only in health structures but in all aspects of socio-political domains.

Whilst a fully comprehensive and all-encompassing definition of the term *nursing* is not consistent within published literature, historically, care has been a central tenet of nursing. Throughout the years, the evolution of nursing, that is, from a vocation to a profession and practice, has brought with it a distinct identity from a subservient role that fought for its place in healthcare, to a profession that is a prominent contributor to the well-being of society. In view of this development, the following section provides context to this research study that is relevant to

nursing as a profession, yet one that is interdependent on other roles within healthcare teams and the approaches developed in nursing education. Furthermore, thus far, the development of nursing ethics as well as the approach utilised in nursing education are discussed with an emphasis on further understanding moral development in nursing. Moreover, this section includes an exploration on the development of and the current situation of nursing ethics in Malta.

1.2 Ethical and moral

In this research study the terms ethical and moral will be often utilised interchangeably relating to nursing ethics and healthcare ethics. The terminology of ethical and moral will be adhered to depending on the context of its use. In language relating to nursing and healthcare there is evident use of both ethics and morality and thus a choice was not made in adhering to a specific term. This interchangeability in terminology is also reflected in the keywords utilised for the literature review. However, the choice of terminology had to be determined in the formulation of a research question, where the term *ethical* was adopted in view of the link that this dissertation has to the teaching of *ethics in nursing*, the alternate term teaching *morality in nursing* is not referred to in educational research and thus this distinction is fixed. One other context in which these terms are not interchangeable is in the development of a theoretical framework. Chapter 2 in this dissertation is based on theories that are derived from the field of psychology and these theories only use the term *moral.* Thus, in these instances it seemed best to follow the language of the literature under discussion. The use of terminology in this situation is similar to the data collection tool utilised in this research study, which is moral judgement developmental measure based on theories emerging from psychology. Thus, the focus of this research study is the ethical development of student nurses, which considers morality both as a term which is partly interchangeable with ethics, but in some respects constitutes a specific theoretical context.

1.3 Healthcare ethics and nursing

Nursing ethics in history has mostly been associated with the fields of principlism in bioethics and biomedical ethics. These ethical perspectives mainly address issues such as abortion, euthanasia, and refusal of treatment, through a highly medicalised and problematised approach. There is a tendency to lift issues from bioethics, superimpose them on nursing concerns and label them as nursing ethics, when nursing can provide a unique understanding that is not discussed. For example, with regards to euthanasia, rather than looking at the dilemma surrounding the legality of these decisions, a nurse might provide insight on ethical issues in relation to the relatives involved in such a decision. Principlism in bioethics does not consider the history, the cultural context, social context, and ethical traditions of nursing (Fowler, 2017; Gastmans et al., 1998). Furthermore, nursing has been stereotypically associated with the feminine gender, with men historically excluded from formal nurse education and this history can inform modern ethical nursing concerns, which is different to other healthcare and medical professions (Kearns & Mahon, 2021). In a chapter within the *Encyclopaedia of Applied Ethics*, Gallagher (2012) mentions that nursing ethics is a subset of healthcare ethics or bioethics. Furthermore, the author refers to philosophical nursing ethics and empirical nursing ethics as approaches to inform an understanding of nursing practice. Gastmans (2013) defines the ethical essence of nursing practices as *"*providing care in response to the vulnerability of a human being in order to maintain, protect and promote his or her dignity as much as possible*"* (p. 146).

In general, nursing has long been disregarded within bioethical literature. Fowler (2017) mentioned that in an informal review of USA bioethics texts, nursing was only mentioned in two books. One book had 67 chapters and 88 authors, only 4 of which were nurses. There is only one brief chapter of ethical issues in nursing practice. All the nursing references are in that one chapter. The latest United Nations Educational, Scientific and Cultural Origranisation (UNESCO), (2016) core curriculum guide on bioethics is, again, targeted at medical education with nursing and other healthcare professions listed as other possible professions that can benefit from this curriculum. Modern nursing ethics literature reaches back to 1873, with the first publishing of articles on nursing ethics and the first nursing ethics book being published in 1900,

in the USA. Alongside the rise in bioethics, in the 1960s, nursing ethics literature grew with the first nursing ethics journal in the USA.

Historically the influence of several nursing ethics texts and articles were lost in the transition between hospital programmes to university degrees, as a result of the professionalisation of nursing (Fowler, 2017). Due to this movement, ethics was no longer taught by nursing faculty but was integrated into bioethics through external departments, such as philosophy and theology. This is still a predominant situation in Malta since nursing ethics is taught by lawyers, theologists and philosophers with minimal input of nursing faculty, especially in postgraduate education. The embracing of bioethics as the dominant form of ethics education in nursing, erodes the moral identity of nursing and inhibits the development of nursing ethical theory in literature (Fowler, 2017; Woods, 2005). The history of nursing ethics is vital as it forms the narrative behind current nursing identities and can serve to unify a group of professionals between generations (Fowler, 2017). This perspective is supported by MacIntyre (1981) in his theory regarding practice, when he referred to the need for practitioners to be aware of those that have preceded them in their practice and whose work extends into the present.

Ethics is not a subject confined to philosophy or theology, but it is part of all areas of life, including professional areas, such as nursing. However, these perspectives have greatly shifted in western countries, albeit not disappeared. As a profession, nursing is distinct in its role within the healthcare team and has a unique perspective that can contribute to the understanding of health care ethics. The complexity of the work that nurses do might be challenging to understand by those who are not engaged in this practice daily. There are several inter-related concepts in ethics between all healthcare professions, however each one has a distinct role that contributes to healthcare ethics. This leads to a need for nursing to develop its own ethical philosophy and identify the ethical issues that nurses face. This does not negate the need to relate to other health professions within a team, but rather focuses on how nursing as a distinct role can enrich decisions made by the healthcare team.

Fowler (2017) stated that there has been little research examining the moral identity of nursing, despite the increased interest in nursing ethics in the 70s and 80s in relation to bioethics,

including abortion, euthanasia, terminating life support, patient rights, and human research. Historically nursing has often relied on the medical profession for its advancement, including ethical theory and nursing ethics stemming as an afterthought of the medical profession (Liaschenko & Peter, 2016; Woods, 2005). Moreover, Fowler (2017) also described the relationship of nursing ethics and bioethics as "Stockholm syndrome" (p. 294), with the unchallenged adoption of bioethics as a dominant paradigm in nursing. Therefore, current nursing ethics literature might not be an accurate representation of a nursing ethical framework derived from its historical and socio-cultural context. This may result in literature on nursing identity being less specific due to the lack of understanding of the historical perspective of nursing.

Nurses are ethically accountable for adhering to the role and identity of nursing. The professions' central tenet of care supports the moral identity of nursing. There is a positive correlation between professional identity and the development of morality in nursing students, which supports the notion that fostering a positive nursing identity through historical perspectives results in a positive impact on moral development (Haghighat et al., 2020). Milliken and Grace (2017) developed the concept of ethical awareness that focuses on the understanding of professional responsibility of nurses with the aim of furthering the goals of nursing as a profession. This process involves the understanding that good, in nursing action and ethics, is a constant in everyday action, with the most seemingly mundane actions having ethical implications (Robichaux et al., 2022). The recent Coronavirus disease 2019 (COVID-19) pandemic has emphasised the need for nurses who act for the good of patients in challenging situations and who are motivated to address unjust practices and policies, such as complete restriction of visiting family, lack of contact with loved ones, unfair distribution of resources and much more.

As Gallagher (2012) previously also implied, nursing ethics draws upon several established ethical approaches. In fact, nursing ethics draws upon care ethics, social ethics, principlist ethics and other traditions of ethics. However, it also expresses distinct perspectives of ethics in itself because of the nature of what nursing is. The debate regarding what nursing is, can be understood from a variety of approaches and philosophical perspectives. Thus, care

ethics, social ethics, principlist ethics can be drawn upon to inform ethical issues, not only in nursing but in several other professions within healthcare or otherwise. Nursing has specific responsibilities, expertise, positions, topics, and perspectives that inform its practice. However, nurses do not work in isolation from other healthcare professions, and the relationship of nurses with other professionals working in a team can result in ethical dilemmas based on the different worldviews of these professionals. Where this happens, a dichotomous perspective on healthcare ethics can cause a divide and unproductive discussion between these professions, rather than fostering an environment of collaboration. As a result, whilst retaining what is specific to nursing ethics, a shift towards a discussion in relation to building bridges with healthcare ethics promotes this collaborative approach.

The above section has attempted to explore the nature of nursing ethics, either as a distinct ethics or as a subset of a general whole. It is argued that blending nursing ethics and assimilating it into other ethical perspectives has historically resulted in nursing adopting the views of other professionals rather than building its own path. The value of ethics that has a unique perspective of nurses is vital, with nursing having responsibilities, expertise, positions, and perspectives that might diverge or provide added insight to ethical situations and strengthen the professional identity of nurses.

1.4 Ethics education in nursing

In an analysis of nursing ethics education, Woods (2005) mentioned that the awareness of ethics education has been increasing in recent years. With this premise, one would assume that current students should be increasingly ethical in practice. However, this might not be the case, as is frequently observed in clinical practice. There is an undisputed need for effective ethics education programs for nurses, with mounting evidence showing that nurses who do not have a strong foundation in ethics, increasingly suffer from moral distress, and this distress demotivates nurses with repercussions on patient care (Oh & Gastmans, 2015; Silverman et al., 2021). In the USA, in the Carnegie Report, Benner (2012) called for major changes in professional nursing education in view of the increasing complexity of health care environments. This report emphasises the cognitive, skill-based and ethical development of nurses as domains for

improvement. The ICN code of ethics (2021) provided a clear guide on the key ethical objectives for educators in nursing and encourages the training for decision-making abilities. This Code further guides nurses on how to communicate nursing ethics to other professions within the healthcare team. However, even if we recognise the need for ethics education, the process of how students develop this area of competence during their education is a further question.

When considering the content of ethics courses, Cannaerts et al. (2014) determined that many nursing courses included ethical principles, ethics codes, and ethical theories, such as the four-principles approach, deontology, and utilitarianism. Only three studies mentioned virtue ethics and one study referred to empathy as a care ethic framework used to develop a very specific ethics course content and method. These course contents indicated that medical and rather rationalistic approaches in nursing ethics teaching remain influential (Benner et al., 2008; Cannaerts et al., 2014).

Beauchamp and Childress (2019), DeGrazia (1992) and Rest, Thoma, et al. (1999) abandoned the view of morality based on a foundational principle that would provide a key to solving all moral problems and moved towards a community's agreement about how to fulfil shareable and moral ideals that apply to the specific context of that community. DeGrazia (1992) argued that non-philosophers working in the bioethical field are unable to reach a consensus on the right ethical theory that would serve to justify moral judgements. The deductivist and principlistic model by Beauchamp and Childress (2019), developed in their book the *Principles of Biomedical Ethics* has been criticised by Toulmin (1981) who argued that ethical theory is needed and principlism cannot provide action guides and propose an indicative model based on Aristotle's work. Deductivist theories are criticised in view of their inability to determine an answer for moral problems using a top-down approach. Jonsen and Toulmin (1988) proposed an alternative to deductivism, that is casuistry. They argued that practical wisdom is required to determine which ethical norms apply to cases. DeGrazia (1992) argued that the usefulness of principlism is very limited in relation to modern bioethics and creates complex questions when principles oppose each other. The author mentions that when moral certainties exist in bioethics, they are related to a particular case, not abstract theoretical constructs or norms.

The work of Beauchamp and Childress (2019) continue to have a huge influence on healthcare and bioethics. The principles of autonomy, beneficence, nonmaleficence and justice have been repeatedly iterated in healthcare education. The authors claimed that the principles provided permit each principle to have weight without assigning priority and overriding of principles depending on the context. However, no guide is provided on how to decide what principle overrides the other. However, DeGrazia (1992) argued that principlism is a promising model for bioethical theory as it acknowledges a lack of supreme moral principle and acknowledges the need for justification of intuitive decisions. This bioethics framework is one of the main approaches taught in formal ethical education in nursing (Benner et al., 2008). The authors further argued that a biomedical approach needs to grow in its role as advocate and in its social domain, which are areas of concern for nurses.

Robichaux et al. (2022) prompted the use of Rest's (1982) four component model as a framework for guiding nurse education. This framework was not utilised as a decision-making tool, but rather as a developmental one. The authors stated that it is unclear what is the best or most effective method for ethics education, the authors suggest that, irrespective of the method used, nurses still lack confidence in expressing ethical concerns effectively. Thus, literature is increasingly supporting multi-professional and multi-modal approaches using simulation, skill-based approaches, and theoretical content (Ertuğrul et al., 2022; Grace et al., 2022; Hsu, 2011; Knudsen Oddvang et al., 2021; Koskinen et al., 2022; Krautscheid, 2017; Lee et al., 2020; Sedgwick et al., 2020). The best approach for education is still unclear, however there is a suggestion that faculties do not clearly understand what is needed to develop the moral agency of student nurses, with clinical and academic educations lacking sufficient abilities in teaching ethics content (Cannaerts et al., 2014; Numminen & Leino-Kilpi, 2007; Robichaux et al., 2022; Sedgwick et al., 2020). Further research focusing on education and clinical instructors and cooperation between theory and practice in ethics education is required (Numminen & Leino-Kilpi, 2007).

The value of higher education is not only concerned with providing knowledge and cognitive capacities, but also interested in developing student character and moral traits (Cannaerts et al., 2014). For example, Dewey's perspective towards education that is not only

concerned with academic abilities but also progressive education through socially-engaging experiences can lend itself to the moral development of students in higher education (Dewey, 1916a; Kohlberg & Mayer, 1972). A meta-analysis by Schlaefli et al. (1985) determined that moral education, in its various forms, has a significant influence on student moral development. However, they also mention that education needs to occur over a sustained period. It is well-known that moral development happens over small increments over a period of time, which might not occur in a linear trajectory but consists of transitional stages (Dawson, 2002; Rest, Narvaez, Bebeau, et al., 1999).

Fowler and Davis (2013) referred to nursing ethics education and the ethical issues that arise as an emerging area of research. However, the majority of ethics education research in nursing relates to curricular methods, content, or single issues in nursing. This means that there is a need for research within academic and faculties in relation to ethical issues that will directly influence students and faculty members on a day-to-day basis (Fowler & Davis, 2013).

With modern societies fraught with turmoil and societal goals focusing on efficiency and capitalist economies, higher education is not only responsible for providing workers to meet market requirements, but also fostering the development of ethically competent students.

1.4.1 Ethical competency

Research on ethical competencies is still an emerging area, with a significant emphasis on the nursing profession in the literature (Koskenvuori et al., 2019). Ethical competency can be defined as the personal capacity to be aware of ethical issues, the courage, willingness and skills to make ethical decisions and ultimately translate this to action and behaviour (Kulju et al., 2015). This definition was further reviewed by Cannaerts et al. (2014); Gallagher (2006); Lechasseur et al. (2016) who identified ethical sensitivity, ethical knowledge, ethical reflection, ethical decision-making, ethical action and ethical behaviour as terminology associated with competence. Even though these are different terminologies, they are all inter-related to each other. A multi-professional model proposed ethical attitude, ethical basis, and ethical cultures as a domain for competence. This model is supported through allowing time for reflection,

interdisciplinary teamwork, role-model leadership, active methodologies, development of caring skills and moral values in nursing education (Enderle et al., 2018). All these terminologies are closely related to care ethics, cognitive domains, social domains in practice and individual attributes. *The Scope of Professional Practice* published on the website for the Deputy Primeminister (2018) for nurses in Malta refers to ethics in relation to the code of ethics only, ethical competence is not listed as a basic competency for nursing practice. This is similar to the competencies listed for senior staff nurses, which mostly relate to adhering to the normative code of ethics (Nursing Services Directorate, n.d.).

Ethical competency development and training is primarily delegated to clinical practice settings with a theoretical emphasis on dilemma ethics, rights-based and ethical principles. This is locally evident with minimal academic input regarding ethics and ethical competency passes in all practical placements, which constitute half of the nursing degree. Benner et al. (2008) argued that this approach is insufficient to address ethical issues in daily nursing practice with the lack of positive agenda targeting everyday ethical behaviour. They further argued that ethical principles are useful in dilemmas and complex situations, but they do not provide a basis for decision-making in nursing practice (Robichaux et al., 2022). A supportive, ethical climate in clinical practice as well as academia that adopt a positive approach with space for discussion in a multi-professional team can enhance the development of ethical competencies (Koskenvuori, Numminen, et al., 2019; Numminen et al., 2015; Olson, 2021).

1.5 Nursing and ethics in the Maltese context

Malta is a developed country with a population of 516,100 individuals (National Statistics Office, 2020). Malta has a long and complex history of foreign rulers. It gained its independence from the UK in 1964 and remained part of the Commonwealth. Malta was considered as a small island developing state until 2004, when it joined the European Union (EU). Malta, as a small island state, involves the close involvement of politicians in the micro-levels of society, with politicians maintaining very close connections to the constituents that vote for them. In fact, elections in Malta are characterised by door-to-door meetings between members of society and politicians. This creates a transactional approach to politics whereby

many constituents expect favours or assistance in exchange for their vote. Healthcare in Malta has been influenced by such micro-political involvements throughout history. In Malta, the Council of Nurses and Midwives (CNM) and the Malta Union of Nurses and Midwives (MUMN) have no nursing members with a background or academic interest specific to nursing ethics. The University of Malta that trains most nurses locally, ultimately working in local practical settings has no nursing ethics faculty.

The first training program for nurses in Malta during the 1960s started through constant reinforcement from the medical profession in Malta. Until the 20th century, the education for nurses in Malta was delivered by medical professionals and surgeons. In 1952, Malta was registered with the General Nursing Council of England. In her historical account of professionalisation in Malta, Sharples (2017) commented how nurses were encouraged to study abroad in areas of education that the doctors deemed to be required, with nuns acting as a bridge between nursing staff and medical professionals, as well as nuns being viewed as the nursing elite at the time. This predominant presence of the medical profession in the development of nursing identity in Malta was very much evident, and a subservience to medicine and the inferiority of the nursing profession was, thus, a prevalent image. This subservience also led to the medical profession's presence in the political domains of society with the absence of a nursing voice (Sharples, 2017). The close link between politics and interference in nursing professionalisation is evident throughout history. Ministers who were mostly doctors were involved in the decision-making regarding nurse training and identity.

Throughout history, education in Malta has been socio-culturally influenced by strong Catholic ties. Moral and ethical education in Malta has been largely the responsibility of religious organisations of The Society of Christian Doctrine. Children in Malta attend weekly extra-curricular religious lessons up until their early adolescent years. Furthermore, Malta still has a significant number of catholic primary, secondary and post-secondary schools that are run by the Archdiocese of Malta. In 2018, Malta introduced the first ethics curriculum for students in state schools between the age of 5-16 that opt out of religious education. This was a result of an increasingly diverse student population in Maltese schools. The relationship between education, healthcare and ethics has historical roots, even in nursing education and service provision.

The education of nurses in Malta was mainly based on an apprenticeship system with very low academic requirement up to the late 1980s. In 1987, a plan was set to introduce nursing education to the tertiary level through a curriculum in nursing studies at the University of Malta by the University of Liverpool and later University of Manchester. A diploma program was offered alongside a degree programme, as a separate and isolated education degree in 1988 at the newly founded Institute of Health Care within the University of Malta. The degree programme is still running, whsilt the last cohort of students who pursued a diploma at the University of Malta will graduate in 2022. Throughout this process, nurses were not involved in any decisions regarding their training and future, with nursing in Malta adopting a passive approach to their work and development resulting in delayed professionalisation (Sharples, 2017).

The National Health Systems Strategy for Malta (Parliamentary Secretariat for Health, 2014) stated that actions targeting health practitioners will focus on ensuring they uphold respect for their patients, their needs, decisions, and empathy. All the above highlight traits associated with a moral practitioner. The Patient Charter issued by the Healthcare Standards Division (2016), within the Maltese Ministry for Health highlighted the principles of dignity and respect, showing the importance of providing more than just physical care. Regulatory bodies for nursing indicate the need for nurses admitted to the professional register to be of good character. Having said this, how this is brought about is not stated (Healthcare professions Act., 2003). In all these documents, the moral aspect of healthcare professions and being a good practitioner is quite evident, however none of these documents provide examples or guidance on how this can be achieved or measured.

There are currently no research studies that have longitudinally explored student moral development in Malta. However, a dissertation successfully completed by Camilleri (2011) evaluated the interrelationships between moral and intellectual development of nursing students using a cross-sectional method in a four-year degree program. This research study showed that nursing students use a conventional level of moral reasoning with medium positive correlation to intellectual development. Moreover, a study completed as an undergraduate degree attempted to explore the moral development of Maltese youths between the age of 13-25 (Camilleri, 2008).

This study concluded that Maltese youths have moral judgment levels like youths in other countries. There are no studies in Malta that explore moral development from a student perspective or longitudinally attempt to explore this development.

As documented by Mallia (2013) in the *Handbook of Global Bioethics*, stated that he, himself occupies the only academic post in bioethics at the University of Malta and is involved in teaching at the Faculty of Health Sciences, including nurses. The bioethics committee and health ethics committee in Malta only have one qualified member from the nursing profession. The chair of the bioethics committee is a member of parliament. The role of the health ethics committee is based on granting permission for clinical health research. Other health research ethics committees are based at the University of Malta, through various faculties that grant research approval to their respective students. What seems to be missing from these committees is the active involvement in clinical ethics within healthcare organisations and the presence of other healthcare professionals within several committees responsible for decisions relating to ethics in Malta. In Cauchi (2003), the bioethics committee in Malta published a document summarising the conference proceedings entitled *Ethical Issues in Practice: Guide for Nurses, Midwives and Family Medicine* with a section for ethical issues in practice for nurses and midwives. This section is written by several professionals from medicine and theology, involving the minor input from two nurses. This document highlights various issues relating to ethical dilemmas and competence, as well as historical and professional issues in nursing and midwifery. In Cauchi (2001) the same committee further published work relating to interdisciplinary ethics without the involvement of nurses in the publication. This again might indicate the lack of nursing presence within the field of health ethics in Malta.

Understanding how nursing students learn about ethics and their moral development can contribute to the development of a curriculum that empowers nurses in the field of ethics. Furthermore, it can instil confidence and courage in nurses and nursing students to communicate their understanding of the subject and clinical situations in a comprehensive and informed manner, paving the way for further involvement of nurses in ethical decisions being made on a national level that can influence their practice.

Most nursing students in Malta undergo their formal training at the University of Malta, which is the only university on the Island. The University offers a baccalaureate programme consisting of 3 years of full-time study or 5 years part-time study. The intake consists of approximately 90 students per year. The part-time degree hosts 3-5 students per year. Since 2020, the University of Malta started offering a preparatory programme for students who do not have the necessary academic qualifications to join the nursing degree. In relation to ethics, the current curriculum has one formal study-unit (2 European Credit Transfer and Accumulation System-ECTS) in the first year of study, prior to any practical experience, which translates for 14 hours of lectures. This study-unit is combined with legal issues in nursing. The learning objectives of this study-unit identify critical thinking regarding ethical issues, codes of ethics, scope of practice, legislation, patient's rights, and contemporary legal and ethical issues. The suggested reading list is based on bioethical and principlistic models, with an emphasis on legislation. However, other study-units informally refer to ethical content throughout the program of studies. At the end of the programme, nurses can register with the Council of Nurses and Midwives and commence employment. There is no formal accredited preceptorship programme after graduation or renewal of council registration. Nursing education in Malta, as with many other countries in the EU, has an equal focus on practical and theoretical components. The individuals involved in the education of nurses can be categorised into mentors, practice educators and lecturers.

The section above highlights how nursing in Malta has greatly evolved in the last two decades. However, this evolution was not always based on input from nurses themselves. There is still no input from nurse ethicists in the micro, meso and macro levels of society. Furthermore, there is minimal structured ethical content in education curricula with a limited amount of time for discussion and development of ethical competencies.

1.6 Overview of the research problem and questions

The idea to carry out this research study stemmed from observations of student nurses who are very technically competent, have vast amounts of knowledge, but at times are unable to relate to people as human beings and engage in reflective conversations. From experiences as a

mentor and supervisor, students struggle to express concerns about ethical issues and at times are unethical themselves without consciously being aware of being so, such as ignoring patients when they are distressed, disposing of medication that was left near the patient by the morning shift, refusing to wash patients' hair and referring to patients using derogatory terms and facial expressions, showing disgust during bathing and toileting. Furthermore, students delegating basic care needs, such as feeding, toileting and cleansing, to less qualified staff, is on the increase, with the intention of providing the nursing students with more time and energy to focus on the perceived "advanced" nursing skills. The typical focus of many students is to be knowledgeable and do well in academia, without consideration of other forms of development that could be happening during their training. This can be attributed to higher education priorities such as grades, awards, and achievements, which is a possible reason why students place such an emphasis solely on a knowledge-based nursing, with limited acknowledgement to the caring aspects of nursing. This is also evident in the enthusiasm that most students show for acute setting placements, such as hospitals compared to placements in care-based settings, such as residential homes.

Even though there are areas for improvement in nursing education, one can notice a difference between the approach that first year students have with those around them and the approach that third year students have. This led to a question about what kind of development is happening and how this development is happening. A few years back, the author believed that this might be related to professionalism. However, after research on professionalism and further reading, there was a constant recurrence of ethics (Grech, 2015). When looking at nursing curricula, practice, and international research, it was noted that there is still a limited understanding as to how students develop in and ethical manner in nursing. This led the author to hypothesise that change and ethical development is happening in an undergraduate programme, but not understood. Exploring this development will help educators and mentors in practice by fostering positive student learning experiences, as well as bringing together the various facets of nursing education, with the goal being the improvement of patient care. Undergraduate education shapes the kind of nurses that will work in health care, hence the importance of developing good nursing students cannot be ignored, as these will ultimately translate to good nurses.

Newly graduated nurses tend to not be assertive in the face of moral conflict, but rather choose to compromise and deal with their own moral distress at the expense of going against what they have been taught is the right thing to do (Woods, 2005). This is of great concern, since these nurses have completed a carefully planned ethics education curricula and still feel compromised in their practice (De Casterlé et al., 1997; Woods, 2005). As students progress in their training, ethical dilemmas about what ideal practice ought to be, versus what the real practice results in, is a dichotomy that features very strongly (Swisher, 2010). The difficulty in navigating such situations in this dichotomy, understanding such dilemmas and being unable to decide on what one ought to do, has been shown to possibly lead to the passive acceptance of patient care and nursing practice. Without critically thinking about nursing practice in view of these difficulties, there could be assimilation of unsafe and unethical practices (Woods, 2005). Thus, the need to foster the development of ethically competent nurses that actively participate in patient care and their development, whilst being able to mitigate ethical dilemmas is necessary.

The main research questions are:

1. How and to what extent do nursing students ethically develop during an undergraduate programme?
2. How does education influence ethical student development?

Hypotheses:

1. Nursing students will develop ethically during a three-year programme
2. There are several aspects that can influence ethical development

Sub-questions:

1. What do students understand by ethics and ethical development?
2. What influences student nurses' ethical development?
3. What are the students' perceptions and experiences of ethics education and ethical development?
4. What is the relationship between nursing education and ethical development?

Objectives:

1. To quantitatively evaluate the ethical development of students during a three-year degree nursing programme and identify any correlated socio-demographic factors
2. To qualitatively explore influences on the ethical development of student nurses
3. To qualitatively explore student perceptions and experiences of ethics education and ethical development

Due to the complexity of the research area and phenomenon under study and the need to explore casual explanations for development, which requires an understanding of context and processes, a mixed methods approach was chosen. The need to answer two main complex questions, which contributed to informing the overall research study, lent itself to the need for mixed- methods approaches. The proposed research project has adopted a longitudinal (prospective) convergent parallel mixed methods research design. According to Creswell and Clark (2017) and Tashakkori et al. (2020) advantages of using mixed methods research include (a) simultaneously addressing exploratory and explanatory questions through an integration of approaches; (b) all tools can be used for data collection without restriction; (c) provides better inferences by integrating the outcomes of multiple strands of study (d) inductive and deductive logic can be used to solve problems with a greater assortment of divergent and convergent perspectives.

1.7 Overview of chapters

This dissertation is structured along seven chapters, commencing with this introduction and background. This project sets off by presenting a theoretical framework utilised in this research study, which shall aim to explore the concepts of morality and moral development. Literature regarding theoretical approaches to development based on psychological theories will be discussed, incorporating multiple perspectives to this development. This chapter was carried with the intention of informing the findings of this research study in a comprehensive manner.

The next chapter consists of a systematic literature review of empirical research, which looks at moral and ethical development, as well as ethical education of nursing students, whilst using a

range of research methods. A further search was carried out for studies that used the same quantitative development tools as that utilised in this research project in healthcare and higher education students. The aim of the second part of the literature review is to inform the findings of the quantitative strand of this research study. This chapter will critically appraise the main findings of the research study.

Chapter 4 provides a detailed examination of the research methodology and methods utilised in this dissertation. A theoretical framework for mixed methods research is presented, including ontological and epistemological considerations. Chapter 4 also presents the process utilised in relation to collecting and analysing data bilingually, summarising the process adopted for analysis, coding, and finalising themes. Chapter 5 presents the qualitative, quantitative and mixed methods findings. The findings are presented separately at the beginning and combined at the end of the chapter. Supporting quotations for the themes identified are presented in this chapter. Results of the descriptive and inferential statistical findings are presented in tables and discussed in this chapter. Discrepancies and congruencies in both strands of data are identified, discussed and evaluated.

Chapter 6 consists of a discussion of the findings as a whole and the interconnectivity of themes identified. This chapter critically discusses the results of the findings and their possible implications. The first section of the chapter explores the longitudinal development perspective, and the second section explores a discussion along the identified themes referring to findings from both quantitative and qualitative data strands.

The dissertation concludes with a chapter that highlights the significance of this research study, new insights and the implications of this research study on education and practice. An overview of the findings and how they relate to the research questions is provided. The strengths and limitations of this research study are discussed, alongside the mitigation strategies. Recommendations for the nursing education are presented emerging from the findings of this research.

Chapter 2: Theoretical Framework

Before moving onto the literature review, findings, and discussion of this research study, it is important to attempt to understand the salient theoretical background of the concepts under study, that are morality and moral development. Morality and moral development are broad and complex in nature, and thus a philosophical background was deemed necessary to explore how these concepts are understood within this research study. Furthermore, empirical[1] research alone was not sufficient in providing adequate understanding that can inform the findings of this research study. Incorporating a theoretical review of the concepts under study and empirical research from the literature review relating to moral development provides a wider context of understanding moral development as a concept, through a variety of theories.

There are several developmental theories in psychology and morality (Lourenço, 2016). However, seminal works that have informed moral development through cognitive, affective, intuitive and social perspectives were considered with the aim of providing further understanding of the concept of moral development. In this research study, ethical and moral development are used interchangeably, as both terms are used in nursing literature. Even though the terms have been defined independently in philosophical research, the aim of this research study is to understand this kind of development in general from a nursing perspective. The theories discussed in this chapter support both the quantitative and qualitative findings of this research study. This chapter commences with the discussion of cognitive developmental theories through the work of Kohlberg. Differential views and criticisms of cognitive theories are discussed through care and feminist perspectives. Affective and intuitive theories that inform moral development are discussed. The chapter continues with social domain theories of moral development and ends with an integrated theory through a Neo-Kohlbergian approach.

[1] Empirical research refers to any publications that are based on data collected and analysed irrespective of the research design.

2.1 Cognitive developmental theories

This section explores theories of cognitive development. The emphasis is on Kohlberg's approach to development. Having said this, Piaget is discussed as a foundation for understanding the Kohlbergian theory. Criticisms of cognitive developmental theories are also discussed. A neo-Kohlbergian theory of development is explained in more detail later in this chapter with integrated frameworks. Even though neo-Kohlbergian theory stems from cognitive development theories, it can be considered as an integrated theory in view of neo-Kohlbergian's higher development stages relating to other developmental domains, not just the cognitive. Fundamentally, theories of cognitive development relate to cognition, which involves the thinking and reasoning processes necessary in moral reasoning and judgements. Although not the only determinant, cognition is a vital contributor for moral decision-making and behaviour.

2.1.1 Piaget and moral development

Influential work surrounding moral development was commenced in 1932 by psychologist Jean Piaget. Piaget studied the development of children from birth to adolescence and upwards. He was the first psychologist to identify stages in moral development, explained in his book *The Moral Judgment of a Child* (1932).

Piaget (1965) developed a constructivist approach using two stages of children's moral development. The first stage is related to the understanding of rules and the child's moral judgments. Piaget found that children ages four to severn thought in terms of moral realism or heteronomy, meaning that facts are moral truths. This also suggests that morality, for Piaget at this stage, are sets of rules that are fixed. Piaget characterised this stage as a child's moral perspective, in which the child is aware of moral duties and rule but does not see them as human devices for regulating cooperative action in society (Rest, 1979; Turiel, 2001). The second stage is associated with children from 10 years of age, upward. In this second stage, children realise that rules are not fixed, but can in fact be changed according to the situation. Piaget referred to these changing in rules as moral autonomy. In moral autonomy, the child realises that moral

rules are based on cooperative arrangements agreed upon mutual benefits and thus, can be adapted accordingly. Thus, Piaget associated moral development with cognitive ability. Furthermore, Piaget believed that these cognitive abilities evolve and there is development and progression by which these cognitions are elaborated based on experiences that one goes through.

Although Piaget studied girls and boys at a young age, he stated that it is difficult to make comparisons because the test was not the same for boys and girls. However, Gilligan (1982) critiqued Piaget for his research because it suggested that girls could have less advanced and complex ways of rationalising moral decisions. Apart from having the exclusion of the female gender in participants and researchers, Piaget also provided a very rigid view of morality that is based on the understanding of conventional rules. Although the work of Piaget was novel, it did not provide a comprehensive study of moral judgment. His work is limited to the cognitive structures that underline an individual's verbalisations on how these structures change over time (Rest, 1979). From Piaget's cognitive development approach, the focus is on attempting to understand how an individual views the rest of the world, including their concerns, and plans of action. In contrast, a behaviouristic approach attempts to discover human behaviours from an external point of view. There is a distinctive difference between the research approaches required to study these two types of perspectives on moral development. Neo-Piagetian theories were later developed by authors, such as Fischer (1980) and Pascual-Leone and Goodman (1979), to account for socio-emotional and environmental development, thus moving away from the individualistic developmental approach adopted by Piaget.

2.1.2 Kohlberg and moral development

Kohlberg formulated his theory in the 1970s, following the work of Jean Piaget and John Rawls (Rawls, 1971). Rawls, Piaget, and Kohlberg approach questions about morality from an interpersonal approach with the authors viewing good as heterogenous. The final stage of development of Kohlberg's work is similar to Rawls' and Piaget's concept of justice, which is based on fairness, equality and cooperation in society (Boyd, 2016). Kohlberg's fusion of the

work of Piaget and Rawls provided an interdisciplinary approach and addressed issues of the day, such as social justice and normative ethics with controversial issues that divided society at the time (Rest et al., 1999).

Lawrence Kohlberg (1964) based his work on stages like Piaget. However, Kohlberg further explored morality by providing dilemmas to children, in which it is difficult to decide between what is right and wrong. This research has further elaborated on the cognitive developmental approach and further applied this approach to education. Kohlberg's work contrasts with a that of a behaviourist approach in moral development and argues that morality cannot be defined in terms of conformity with group norms. He further elaborates that a person's morality cannot be assessed without knowing an individual's perspective and intentions. Similarly to Piaget, Kohlberg viewed morality from an individualistic perspective, away from context and relationships. The author further mentioned that individuals do not organise their behaviour simply on the context and environment they are in, but they learn, plan and act in a complex manner. Thus, Kohlberg assumed that the individual determines right and wrong, not society (Rest & Narvaez, 1994). Kohlberg's research was different than that of Piaget because it was based on complex, moral dilemmas with subjects between the age of 10 to16 years rather than children. Kohlberg's work identified moral thinking clusters that are distributed into the following stages (Kohlberg, 1964):

- Stage 1: Punishment and obedience orientation
- Stage 2: Naive Instrumental hedonism
- Stage 3: Good boy or good girl morality of maintaining good relations, approval of others
- Stage 4: Authority maintaining morality
- Stage 5: Morality of contract, individual rights and of democratically accepted law
- Stage 6: Morality of individual principles and conscience

Stage 1 was of lower moral value and this value increases with the highest moral value placed on Stage 6. The premise is that earlier stages fail to make distinctions between the moral

value of human life and physical objects. According to Kohlberg, the highest level of moral development is based on the ability to reason from a justice perspective. Developing these stages provided a way of classifying an individual's perspective of thinking in terms of moral philosophies (Rest, 1979). Stages 1 and 2 are perspectives of individuals who consider their self-interests. Stages 3 and 4 pertain to individuals who see themselves as part of a group that share values, and stages 5 and 6 relate to rational moral individuals who have made moral commitments and standards on which a good and just society is based (Kohlberg & Hersh, 1977).

A perceived limitation of cognitive moral development theories is the relationship between judgment and behaviour. According to Kohlberg and Hersh (1977), moral judgment is not a sufficient condition for moral action since other variables influence such action. This includes emotion, purpose, ego and will (Kohlberg & Hersh, 1977). However, cognition is a necessary facet of moral behaviour. Kohlberg changed his scoring system several times and in his later approach emphasised the development of community norms, relating to care and justice (Reed, 1997; Rest, Thoma, et al., 1999). These changes stemmed from alternative views spearheaded by feminist and care perspectives.

2.2 Care ethics and moral development

Moral psychologist Carol Gilligan criticised Kohlberg's theory of moral development stating that it fails to consider gender. In a book entitled *In a Different Voice*, Gilligan (1982) suggests that there are key differences between moral perspectives of women and men in moral reasoning. The participants in Kohlberg's first research studies were all white males and thus, Gilligan argued that moral development can be viewed from a feminist perspective, distinctively arguing that feminine views are different from those of men (Gilligan, 1982).

Gilligan developed this theory as an argument to Kohlberg's theory regarding the stages of moral development. In further studies using the interviewing tool developed by Kohlberg, most women showed lower levels of moral development compared to men. Gilligan believed that this should not be accepted as a truth but challenged Kohlberg's process of theory development.

In view of the hypothesis that men and women have different perspectives on morality, a general objective assessment is not appropriate, since women tend to emphasise empathy as well as care and score lower in Kohlbergian interviews. This is because care and empathy are not regarded as highly as justice and duty in Kohlberg's objective measuring scale, which could explain why women scored lower. However, these claims have been criticised since dichotomously distributing males and females into two different categories on how they view morality, is a result of societal expectations and norms. Furthermore, care has been associated with someone who is in power and someone who is less powerful (receivers of care), this notion places the care-receiver at an inferior position, cementing stereotypes. However, Gilligan's theory gained popularity, especially with women and feminists who could relate to what she was writing, and saw this as a relevant model (Tschudin, 2013). Gilligan further contributed to giving a voice to previously ignored individuals within the realm of ethics, morality, and psychology. Gilligan also challenged previous assumptions about moral development that had been accepted as the norm, such as the morality associated with justice and that human beings make autonomous and individual moral decisions without any other influences (Held, 2014).

Although feminist philosophy contributed to the development of care ethics, these should not be equated. Gilligan's work is highly criticised for associating care with the feminine gender. Gilligan's approach to care ethics has been criticised for reinforcing women's traditional role in society and as not lending itself to the inclusions of political and social contexts of caring relationships (Held, 2014). However, Gilligan acknowledged that the most advanced form of moral reasoning combines concepts of care and ethics of rights and justice, fusing together Kohlberg's work and her own. Feminist philosophy also critiques this association of morality, that is of men being referred to as rational beings, whilst women being more emotive. In fact, this supports the notion that men are superior to women in view of their rational abilities (Alcoff & Kittay, 2007; Held, 2014).

In her book *Moral Boundaries: A political argument for an ethics of care*, Tronto (2020) further criticises Kohlberg and Gilligan due to their theories maintaining the position of a privileged group in society, with no regard to social inequality. She argued that these theories are elitist in nature and the cognitive reasoning ability of an individual does not necessarily translate

into action. Tronto suggested that moral theory cannot be understood without looking at a political perspective, and that care work is very much devalued in society. She argued that placing value on human activities of care would transform our values through a political and moral process. The impact of care and its values are not only relevant to the personal relations but also to public life in a wider context of political, social, and global relations (Held, 2004, 2014; Tronto, 2020). A comprehensive definition of care is provided by Fisher and Tronto (1991):

> On the most general level, we suggest that caring be viewed as a species activity that includes everything we do to maintain, continue and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, our environment, all of which we seek to interweave in a complex, life-sustaining web (p. 103).

The link between care ethics and feminist ethics encourages a philosophy that directs attention to an aspect of humanity and its value, which has been neglected by centuries of moral philosophies dominated by men (Alcoff & Kittay, 2007). There is also an association between care ethics and virtue ethics, with care viewed as a desired virtue. Thus, McLaren (2001) suggested a connection between care ethics and virtue theory by arguing that care ethics, on its own, reinforces stereotypical feminine traits that relate to oppressive relationships and ignores the wider political context. Thus, McLaren suggested that virtue theory includes this political perspective whilst still relating to aspects of care, similar to Tronto (2020). Other feminists have argued that care ethics primarily focuses on caring relationships and the inequalities of power. Held (2004) argued that virtue ethics is distinct from care ethics because virtue theory still focuses on the individual and their dispositions, whilst care ethics focuses on the caring relations between persons. Thus, in relation to moral development, ethics of care does not assume that individuals enter a moral decision autonomously, free and as equal individuals, yet it is grounded in the realities of inequalities, relationships and context (Held, 2004). Eva Kittay further supported care ethics by suggesting that humanity and dependency should be associated with theories of justice, and care should be considered as a moral attribute (Kittay, 2019).

Johnstone (2005) refers to nursing ethics as ethics based on care and feminine principles. In nursing, Hunt (1991) mentions that it is time for treatment and cure to be subordinate to care in nursing practice. Ethics of care theories support a strong relationship between caregiver and care-receiver, which can be iterated in the therapeutic nurse-patient relationship Johnstone (2005) refers to nursing ethics as ethics based on care and feminine principles. In nursing, Hunt (1991) mentions that it is time for treatment and cure to be subordinate to care in nursing practice. Ethics of care theories support a strong relationship between caregiver and care receiver, which can be iterated in the therapeutic nurse-patient relationship (Tschudin, 2013). Conceptualisations of care and justice are utilised by nursing students to solve ethical dilemmas and thus one approach is not superior to the other, but instead complementary of one another (McLeod-Sordjan, 2014). Stemming from feminist perspectives, Noddings (2013) approached moral education from a care perspective, where teachers are fully present when engaging with students. Through the latter position mentioned, Noddings (2013), addressed criticisms towards care ethics as being implausible and relate to close personal relationships. This notion can be transferred to the nature of care in nurse relationships. Apart from care ethics, the importance of virtues, within nursing ethics, to inform practice and education as well as the role they play in character formation of nursing students cannot be dismissed. Thus, virtue and care ethics can inform moral development from a perspective of an individual's moral character and the caring relationships with others.

These criticisms of Kohlberg and moral development theories based on cognition led to a further discussion about care in moral reasoning that was mostly disregarded in cognitive development. Morality was predominantly discussed in terms of justice associated with the male gender. However, feminist theories provided a voice to moral development through a wider lens of integrating empathy and care as a high level of moral reasoning abilities.

2.2.1 Affect, intuition, and moral development

Cognitive developmental theories are further criticised for their lack of consideration to feelings and emotions in moral judgements. Kohlberg's work seems to imply that the manner of

how one feels about a decision is not sufficient to inform moral reasoning (Pritchard, 1999). However, Rest,et al. (1999) emphasised that reasoning and judgment are only a section of morality, and that emotion is another relevant domain in moral decision-making. However, morality cannot be based on feelings and emotions alone.

Providing an insight into rationality and ethical character, in his book *Moral Knowledge and Ethical Character,* Audi (1997) highlighted the relationship between rational action and self-deception. The author critiques the dependence of moral theories on rationality stating that it may act according to rational thoughts, however for very poor reasons. Furthermore, Audi hypothesised that self-deception is a reason why individuals might not know the reasons for their actions, and thus moral decisions operate beyond the level of consciousness.

As previously discussed, theoretical perspectives that have emphasised aspects of care in morality provide another dimension to moral reasoning and development. Furthermore, morality is not only a concept reduced to one element of an individual but comprises the development of a moral character. However, moral reasoning and moral development is not only influenced by cognition and care, but emotions will influence this development as well as moral reasoning abilities of an individual.

Noddings (2013) argued for an ethics of care approach to moral education in terms of the contribution of emotions to inform an individual's moral decisions. She argued that abstract and universal principles do not contribute to an individual's development, but rather the attention provided to the individual context or person that informs moral reasoning. This is supported by Hoffmann (2000) who focused on affective empathy as the main driver for moral decisions, rather than cognition. Although he acknowledged the role of cognition for the development of the self, Hoffmann proposes that empathy is correlated with principles of care and justice. Thus, Hoffmann (2000) links cognition to the emotional domain. Nussbaum (1999) also supported this idea of human beings intertwining emotion with moral reasoning.

This is supported by Haidt (2001), drawing from the work of Hume (2006), who proposes that moral decisions are driven by emotional intuition. Gibbs (2013) further developed an

alternative theory of Hoffman (2000) into a position that included both affect and cognition as motivators for moral action. Gibbs (2013) proposed that the advanced stages of moral development are constructed through a social perspective. It is argued that reasoning and decision-making are regarded as a higher level of moral development. However, moral reasoning needs to inform behaviour and one can reason morally but not act morally (Rest, 1984; Gibbs, 2013). Killen (2015) criticised the dichotomy between judgement and behaviour, emotions and judgement and nature versus nurture. Killen (2015) criticised the limitation of the judgement-behaviour dichotomy due to its lack of consideration to the multifaceted situations of moral judgements and action. Furthermore, behaviour alone is not the basis for morality. Emotion and judgement are both important aspects of morality and are interrelated and coexist within individuals. Furthermore, children are actively relating to the social information, rather than passively absorbing information that they are exposed to. Moreover, to compare moral judgements and their relationship to action, one needs to remove the multifaceted variables that a moral agent functions in, which defeats the purpose of understanding a complex phenomenon (Turiel, 1983).

2.3 Social domain theory and moral development

Domain theories are emerging as the dominant paradigm in socio-moral development. Although domain theory attempts to distance itself from the work of Kohlberg and Piaget, it is partly derived from both authors' works. Cognitive development theories and social domain theories both rely on structured stage models (Glassman & Zan, 1995; Lourenço, 2014).

Social domain theories arose from the work of Piaget and are criticical the work of both Gilligan and Kohlberg because of their lack of consideration of context and the assumption of a linear process of development (Nucci et al., 2017; Smetana & Turiel, 2006; Turiel, 1983). Turiel developed the social domain theory in 1978-1983, and this was later developed by Nucci (2001) as well as Smetana and Turiel (2006). Smetana and Turiel (2006) argued that social, personal, and moral domains develop in parallel, which contrasts with Kohlberg's successive approach. Social domain theory asserts that individuals obtain and develop their moral thinking through social interactions. Social domain theories provide a framework for the development of moral

judgement, reasoning, and behaviour. This approach includes an understanding of morality from a justice perspective but integrates with it other forms of social knowledge such as context-dependent rules, social interactions and experiences (Smetana, 2011; Smetana et al., 2018; Turiel, 2008). In contrast with Kohlberg and Piaget, this theory asserts that children can distinguish between a moral domain, which consists of prescriptive norms that influence interpersonal relationships, and a social domain. This pertains to the conventional understanding of consensually agreed upon rules that support the function of social systems (Nucci et al., 2017; Yoo & Smetana, 2022). Social domain theories indicate that individual's reason about social interactions through the moral, societal, and personal domain, through independent autonomous moral thinking and interdependent thinking (Killen, 2018; Nucci, 1981; Richardson et al., 2012; Smetana, 2011; Smetana & Turiel, 2006; Turiel, 1983). Furthermore, social domain theory delves into the different varying contexts, cultures and development of how individuals weigh right and wrong (Smetana, 1983). Regarding moral development, Turiel (2001) highlighted that the majority of research on moral development is associated with childhood. However, development occurs at later stages in relation to the social world and extrinsic factors, such as peer interactions through conflict, discussion, argumentation, and disputes. Education that utilised social domain theory to adopt a socio-cognitive pedagogical approach has been shown to positively influence students in both their conventional and moral development (Nucci et al., 2015).

Social domain theory has been criticised for its inconsistencies, such as the lack of empirical evidence that follows a longitudinal dimension through different ages, which might suggest limited strength in understanding development (Fowler, 1998; Lourenço, 2014). Furthermore, this theory presents itself as an alternative theory to moral development, however there are theoretical similarities between both approaches (Glassman & Zan, 1995). Therefore, social domain theories are better viewed as an added insight to moral development, rather than an alternative theory to cognitive developmental theories by Kohlberg and Piaget (Lourenço, 2014). Turiel (2006) described an individual's ability to make moral judgements based on social relationships, emotions, social practices, and social order. From this perspective, judgements are characterised, generalisable and based on consensus or agreement. The generalisability of judgements and morality is influenced by culture. Turiel (2006) indicated that the concepts of

rights, welfare and justice are found in western and non-western cultures, even though some differences exist.

The perspectives discussed above regarding moral development provide a wide understanding of the different debates that occur in relation to morality. Although these perspectives differ in their origins, development, and assertions, they have been deemed relevant to comprehensively understand the complexity of moral development. This debate is still ongoing with a shift towards the development of integrative frameworks and models of moral development and education that relate to the different approaches that are discussed below.[2]

2.4 Neo-Kohlbergian theory of moral development

Walzer (1983) described the development of a common morality principle. It is understood that morality is not an individual applying a foundational principle but a community reaching an agreement about shared moral ideals. This criticised Kohlberg's six stage theory as being too individually oriented and assuming that abstract principles provide guidance in making specific moral decisions (Rest et al., 2000). As a result of the criticism of Kohlberg's theories, a neo-Kohlbergian approach was developed to address these gaps. The starting point of a neo-Kohlbergian perspective is still based on cognition, developing into a personal construction of basic epistemological categories (Rest, Thoma, et al., 1999). The focus is on the attempt of individuals to make sense of their own social experience, development over time and characteristics in developmental change in adolescents and adults - shifting from conventional to postconventional moral thinking (Rest, Narvaez, Bebeau, et al., 1999). Rest, Narvaez, Bebeau, et al. (1999) suggested that Kohlberg's theory is not analysable in six distinct sequential stages but more fluidity is required when interpreting this theory. This led to the development of moral schemas by James Rest.

James Rest and colleagues developed a four-component model (FCM) of moral behaviour from a neo-Kohlbergian perspective (Rest, Narvaez, Bebeau, et al., 1999; Rest et al.,

[2] Further research regarding the social neuro-scientific processes of moral development is available but goes beyond the scope of this chapter, which is to develop a theoretical framework that will support the findings of this research study.

2000). Neo-Kohlbergian perspectives agree with Kohlberg with regards to social interactions within the world that inform individual cognition or social cooperation. Moreover, this ideology is in line with Piaget's view in the sense that individuals do not passively understand the social world, but rather self-construct and organise it. Both Kohlberg and Neo-Kohlbergian perspectives agree that social moral concepts are developmental and move from less complex to more complex and defensible positions. The four components of this model are ethical sensitivity, reasoning, motivation, and action. The four components asserted by the FCM model are the prerequisites for moral action and, although related, are considered to be conceptually distinct, which include affective and cognitive processes (Thoma, 2014). Moral sensitivity refers to sensitivity to moral issues, the individuals concerned and how these are affecting the individual. Moral reasoning is necessary for an individual to decide what is considered the right and fair action, whilst consequently giving priority to the values of others, beyond personal values. Finally, having the courage to implement the action decided upon in the previous stages of sensitivity, reasoning, and motivation (Rest 1986; Rest 1994). Neo-Kohlbergian's believe that some individuals do not have insight into the processes that inform their moral judgements and thus verbally expressing insights about moral judgement might not provide an appropriate understanding of moral development (Thoma, 2014). A distinct difference with neo-Kohlbergian approaches is that there is no single philosophical theory that relates to postconventional thinking, but assumes that there is a set of systems that can be based on postconventional reasoning (Thoma, 2002).

Rest asserted that cognitive, affective, and behavioural components are interrelated and that these are included in the components of the model. This contrasts with Kohlberg's moral stages that are described in terms of cognition and moral thinking structures alone. The four components represent a process that is based on the context and content of a moral situation. The majority of research in the four-component model has been carried out in the professions of nursing, dentistry, doctors, counselors, teachers, veterinarians and journalists with a breadth of longitudinal research rendering this theoretical framework to be valid and rigorous in the evaluation of development (Rest & Narvaez, 1994).

The four-component model provided the basis of schema development from stages. Schemas are said to capture patterns based on experience around particular areas; it is believed that moral schemas help individuals interpret and understand social situations and are central in problem solving (Rest et al., 2000; Thoma, 2014). The development of schemas shifts from hard stages to soft stages that allow shifting distributions moving from less to more complex. Furthermore, the component models conceive social and role systems in society and move away from directly assessing cognitive reasoning. A neo-Kohlbergian approach moves away from universality, and instead favours cross-cultural similarities, avoiding moral reasoning based on relativism. The schema view is based on deveopmental process of moral thinking and focuses on how individuals understand, organise and prioritise moral content (Thoma, 2014).

Hence, based on Kohlberg's work, Rest developed the six stages into moral schemas. *Schemas* can be defined as a "characteristic of some population of objects, a set of rules which would serve as instructions for producing a population prototype and object typical of the population" (Evans, 1967, p.1). Thus, justice and moral development involve the successive progression from the personal interest schema (derived from Kohlberg's stage 2 and 3), The maintaining norms schema (derived from Kohlberg's stage 4) to the postconventional schema (derived from Kohlberg's stage 5 and 6) as shown in Table 2.1. Thoma (2014) hypothesised that different communities have a mix of common and unique experiences that frame the social construction of a moral perspective at a given time. Agreements and concerns are debated within a community and become shared experiences that inform individual moral thinking. This view equates morality with common law, which also shares some common principles across cultures but also some unique features based on the specific experiences of the various communities (Thoma, 2014).

Kohlberg expresses development in terms of macro-morality (morality of society and questions of moral authority) and micro-morality (how a person interacts with others in everyday situations). The three moral schemas in the defining issues test (DIT) and the FCM model are answering the macro question of morality, which represents the foundation of moral reasoning abilities (Rest et al., 2000; Thoma, 2014).

Table 2.1

Kohlberg's Stages of Development and Moral Schemas

Moral Schema	**Descriptor**	**Kohlberg Stage**
Personal interest schema	Justify decisions based on personal repercussions and interests, consequences of action and concern for those with whom the individual has a close personal relationship	Stage 1 Stage 2 Stage 3
Maintaining norms schema	The roles of social norms in organising and maintaining order in society	Stage 4
Postconventional schema	Reasoning based on the central role of moral criteria in the formulation of laws and norms, the appeal to an idea that a community should be ordered and the subjecting to critique of moral systems that address the community as a whole	Stage 5 Stage 6

The personal interest schema, derived from Kohlberg's Stage 2 and 3, develops in childhood. This perspective considers the gains and losses everyone may experience personally within a moral dilemma (Rest et al., 2000; Thoma, 2014). This is regarded as a more primitive form of thinking as the individual is concerned for those with whom one has an affectionate relationship (Rest et al., 2000). Individuals who use the personal interest schema to analyse moral dilemmas do not consider co-operation on a society-wide basis. This schema justifies a morally right decision by appealing to the personal consequences of an action on the individual making such a decision. This schema also considers concerns of individuals in relation to whom they have an affectionate relationship with through micro-moral considerations (Rest et al., 2000).

The maintaining norms schema, based on Stage 4 of Kohlberg's theory, represents the society wide moral perspective. This is considered as an increasingly developmentally advanced socio-centric perspective that takes into consideration the cooperation between people who are not friends and family or well-known acquaintances (Rest et al., 2000). This schema prioritises

an understanding of rules, roles and importance of authorities, with the establishment of social order as a definition of morality (Rest et al., 2000). It is also informed by adolescents developing an understanding of political thought and adolescent authoritarianism (Thoma, 2014). The characteristics of the maintaining norms schema can be defined as a perceived need for generally accepted social norms, the necessity that the norms apply society-wide, the need for the norms to be clear, uniform and categorical, that the norms are establishing a reciprocity and the establishment of hierarchical role structures of authority and duty (Rest et al., 2000; Thoma, 2014). The main priority for individuals that score in this schema is establishing social order and the moral obligation to maintain this order. This can be translated into the establishment of laws or maintining an established way of doing things (Thoma, 2014).

Finally, the postconventional schema, derived from Kohlberg's Stage 5 and 6, suggests that all moral obligations are based on criteria that emphasise shared ideals that are fully reciprocal and open to scrutiny (Rest et al., 2000; Thoma & Dong, 2014). In a postconventional approach, ideals are shareable and open to debate as well as tests of logical consistency (Rest et al., 2000). The schema does not relate to any particular philosophical thought, but comprises of appeal to an ideal, shareable ideals, full reciprocity and primacy of moral criteria (Rest, Narvaez, Bebeau, et al., 1999). The postconventional schema is based on the primacy of moral criteria in that the person realises that laws, codes, roles are social arrangements can be set up in a variety of ways. This schema proposes an idea that humans can interrelate towards organising a society with shareable ideas that are not based on idiosyncratic preferences or personal intuition, but that these justifications can be challenged by logic and experiences (Rest, Narvaez, Bebeau, et al., 1999).

Kohlberg and neo-Kohlbergians affirmed the idea of a pivotal developmental progression from conventionality to postconventionality (Rest et al., 2000; Thoma, 2014). The contrast between the maintaining norms and postconventional schema is the maintaining norms schema gains consensus by appealing to established practice and existing authority, whilst the postconventional schema gains consensus by appealing to ideals and logical coherence (Rest et al., 2000). Thus, the major progressive shift in these moral schemas occurs between conventional and postconventional thinking. This has also been linked to the development of political thoughts

and has been shown to distinguish conservative and liberal religious perspectives (Thoma, 2006; Narvaez et al., 1999).

The DIT is a method for triggering moral schemas and establishing patterns within these schemas (Thoma, 2014). Through the use of an empirical measure, research shifts away from simply assessing verbal arguments for moral choice, since verbal interviews might only be evaluating verbal articulation. The use of empirical measures thus removes this verbal constraint (Rest et al., 2000). It supports a development model that defines growth as a gradual shift from lower to more complex understandings of social and moral cooperation (Thoma, 2014). When participants of the DIT read the moral dilemmas and the issues that the statements of the DIT present, the different moral schemas are activated to the extent that a person has developed them (Rest et al., 2000). In addition to moral judgment development, the DIT is also an information processing task. It can indicate that a more consolidated a person is in one of the schemas, the greater the ease and consistency in information processing. However, the greater the mix of schemas, the more difficulty the person has in deciding and being consistent (Rest et al., 2000). Several research studies published and unpublished have used the DIT or reviewed the validity and reliability criteria of the DIT through 400 publications and 1500 reports (Rest, Narvaez, Thoma, et al., 1999).

2.4.1 Neo-Kohlbergianism and the professions

In his paper, Pritchard (1999) discussed the Kohlbergian approach to the moral development of professionals in education. Pritchard related the personal interest perspectives of moral schemas, maintaining norms and postconventional to professional practice. Professionals are committed to serving others, whilst still considering their own interests. The main responsibilities of professionals are to clients and the public. Professions already have a set of rules and principles that one must follow, thus this means that maintaining norms and postconventional schemas are highly relevant to professional education. Pritchard links moral development with professional ethics through the postconventional schema of a neo-Kohlbergian approach, as a critical dimension for moral judgment. He argues that this critical feature is vital

in professionals who are not only expected to follow norms, regulations, or codes, but to critically address areas of concern.

Within the nursing profession, ethics is highly relevant to all its members and is expected to be taken seriously. However, codes of ethics are loosely written, thus leading to a degree of autonomous interpretation. Therefore, the professional requires a level of critical thinking when referring to the code of ethics. Pritchard (1999) disagreed with Kohlberg (1964) in that professional ethics requires a degree of conventional thinking and maintaining norms within the profession itself, thus indicating that maintaining norms through moral judgment is not necessarily inferior to postconventional thinking. Pritchard (1999); Sidgwick (1998) argued against trying to find the foundations of morality and instead proposed focusing on finding common ground to progress in resolving moral issues and navigating our complicated world through applied perspectives. A further criticism of moral development theories, based on one aspect such as moral reasoning, is that there are other dimensions to development, including sensitivity, character, and motivation that all constitute a larger whole. Rest and Narvaez (1994) supported this claim that there is a range of necessary research on moral development in professional life beyond Kohlberg's view on moral judgement. Kangasniemi et al. (2015); Rest and Narvaez (1994) showed that there is very limited research on professional ethics in nursing education, even though professional ethics has been a widely adopted approach and its importance is quite obvious within the nursing profession. The authors argued that a further understanding of how professional ethics can support nurses in moral decision-making is required.

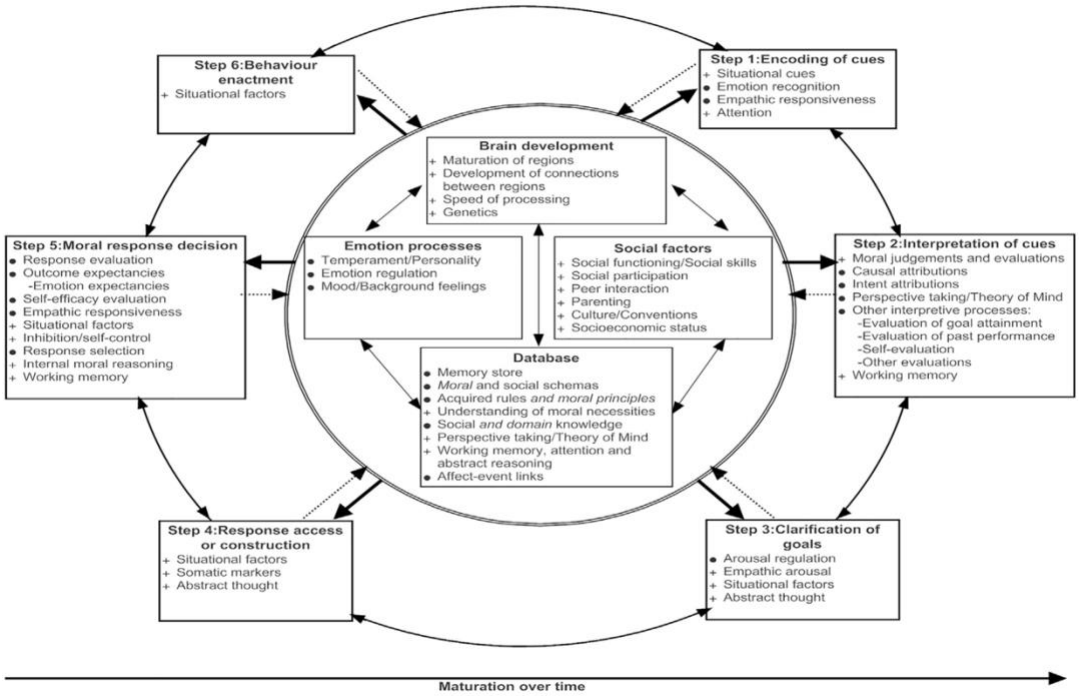
2.5 An integrated approach to moral development

The different theoretical perspectives to moral development are currently leading to research that looks at integrated or multi-modal frameworks that provide an increasingly comprehensive understanding of moral development (Garrigan et al., 2018; Malti et al., 2021; Rutland et al., 2010). An integrative approach that accepts cognitive, affect and social theories in moral development can explore moral behaviour using the social information processing-moral decision-making framework shown in Figure 2.1 (SIP-MDM) (Garrigan et al., 2018). The

authors propose a framework on how moral decisions can be based on both intuitive, social, and cognitive processes. However, using integrative frameworks poses the limitation of attempting to develop a theory about several different aspects without a specific focus and might be overly complicated. Garrigan et al. (2018) suggested further research into the relationships between different aspects of integrative frameworks and their vertical relationships is required, along with situational factors and processes. Yet, there is no single theory or framework that comprehensively informs moral development.

Figure 2.1

Multi-Modal Framework for Moral Decision-making (Garrigan et al., 2018)



2.6 Conclusion

This chapter has discussed the theoretical framework utilised in this research study. The cognitive, social, affective and intutiative theories of moral development integrated with the four-component model for moral decision-making attempts to comprehensively map the process of moral development as highlighted in Figure 2.2. Through adopting a pluralistic approach to

development that did not solely focus on one assumption, such as initially planned in this research study through development of virtues, the different perspectives on moral development can inform this research study. Although Kohlberg's theory of moral development has been criticised for its lack of consideration of domains other than the cognitive, a neo-Kohlbergian approach considers social cooperation, justice, and conscience to be higher levels of moral development. However, neo-Kohlbergian theory does not negate the need to consider affective, intuitive and cultural facets of development and thus, this research will attempt to explore and discuss how these different approaches contribute to student ethical development.

To conclude, the mixed methods approach adopted in this research study will pluralistically explore intuitive, affective, and socio-cognitive elements of student development. Although this chapter has a significant focus on cognitive theory, all theories will be considered to have equal value to student development. The following key theoretical assumptions will be adopted in this research study:

1. Moral development gradually develops over time, not as rigid stages but through fluid schemas
2. Moral development is integrative informed by cognitive, affective, social, and intuitive processes
3. Moral decisions follow a process of interrelated components; sensitivity, reasoning, motivation and action
4. Moral development happens in a context and can be culturally dependent

Figure 2.2

Theoretical Framework for Moral Development

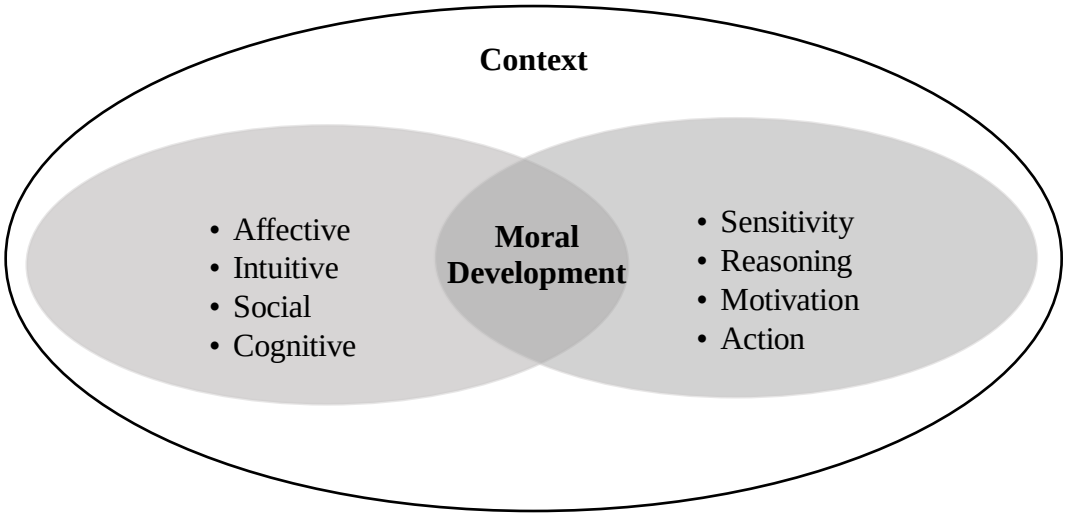


Figure 2.2 portrays how the chosen theoretical approaches feed into moral development alongside the process of moral reasoning that is based on the FCM. None of the proposed approaches and theoretical dispositions are superior to the other or provide a complete understanding of moral development, however they are all relevant to the concepts at hand. Moral development can be viewed from several perspectives that have developed in tandem along the years. Attempting to combine two contentious concepts does not provide complete understanding but will contribute to a critical reflection of the findings of this research study. This highlights the complexity and multi-faceted approach required to understand moral development. However, this area of research is not only vital but has a direct impact on nurse well-being and their active role in society. The advancement of technology and rapid development of the current generations of youth highlight the need to equip adolescents, through education, with the right tools to make moral decisions based on various ethical perspectives. Evidence suggests that most adults do not reach the highest levels of moral judgment and are thus, presumably making decisions based on poorly developed tools (Rest, 1979). However, the

ethical decisions that individuals in modern society must make, are becoming more complex in relation to our personal, professional, economic, and environmental development.

The next chapter will critically identify and appraise any pertinent literature in relation to moral development of nursing students, healthacare and undergraduate students. The chapter will summarise key findings for research studies to compare the results of this study to international perspectives. Furthermore, this process will explore new insights regarding the moral development of student nurses.

Chapter 3: Literature Review

The literature identified in this chapter provides a deeper understanding in the discussion of the findings of this research study. The chapter is distributed into two sections, with the first section identifying and reviewing research studies that have attempted to empirically understand moral development in higher education students. Moreover, this section, specifically, considers research studies that have delved into ethical development of nursing students using a variety of research designs. The second sections identifies and reviewes published studies, focusing on higher education students other than nursing, these have been included in this study since they utilise empirical measurement tools that are identical to the ones in this research study. This search was carried out to be able to compare results of the quantitative findings with existing norms.

3.1 Introduction

Altough previously published research has identified the necessity of addressing and improving the ethical development of nursing students, the process of how this development occurs is minimally addressed (Benner et al., 2008; Woods, 2005). This chapter seeks to identify literature relating to ethics education, and nursing and the moral and ethical development of student nurses. The terms moral and ethics are being used interchangeably in this chapter. Having said this, it is important to highlight that any philosophical discourse about the latter terms goes beyond the scope of this research study, and thus is not discussed. Due to the lack of consensus in terms of the definition of development, ethics and morals, this literature review attempts to initially commence by identifying operational definitions that are utilised in this thesis. PubMed was utilised to derive operational definitions for terminology in this research study.

Table 3.1

Key Concepts and Terms Utilised in Search 1

Key Concepts	**Synonyms**	**Truncations**	**Descriptor**
Nursing Students	Nursing Student Nurse Student	Nurs* student*	Students enrolled in an undergraduate programme leading to licensure as a professional nurse. Individuals enrolled in a school or formal educational program (MeSH).
Undergraduate	Baccaleaurate Bachelor Degree Higher Education College	Undergraduate* Bac*	A four-year program or three-year in nursing education in a college or university leading to Bachelor of Science in Nursing. Graduates are eligible for state licensure as RN (Registered Nurse). Year introduced: 1971
Ethical Development	Ethical Competence Ethical Reasoning Ethical Judgement Ethical Decision-making Moral Development Moral Competence Moral Reasoning Moral Judgement Moral decision-making	Ethic* Moral* Develop* reason* Judgement Competenc* Decision?making	The process by which individuals internalize standards of right and wrong conduct (MeSH) Year introduced: 2003

An extensive search of available literature using iFind/HyDI identified several research articles relating to the following topics: (a) assessment tools for ethics education; (b) teaching

methods for ethics; (c) sepcific bioethical issues in nursing; (d) moral sensitivity; and (e) moral development[3]. However, only research related to development, that was based on the title and abstract of the study, were analysed in-depth. Furthermore, a search for DIT-related studies resulted in most of the research in business and accounting literature. A more advanced search was carried out using the Cochrane Database for Systematic Reviews (CDSR). A search through the reference lists of all relevant articles was carried out and this yielded further research through a snowball method. The first search utilised the key terms and combinations shown in Table 3.2.

Table 3.2

Search 1 Key terms

(Ethic* Develop* OR Moral* Develop*)	AND	**Undergraduate***	AND	**Nurs* Student***
OR		OR		OR
(Moral* reasoning OR Ethic* reasoning)		Bac*		Nurs*
OR		OR		
(Moral*decision?making OR Ethic* decision?making)		Degree		
OR		OR		
(Ethic* judgement OR Moral* judgement)		College		
OR (Moral competenc* OR Ethic* Competenc*)		OR Higher education		

In view of the different aspects of this research, a separate search for studies in healthcare that utilised the DIT were included as shown in table 3.5, which provides a summary of search 2. A Really Simple Syndication (RSS) feed was set up to send alerts through emails when new articles in the search had been published. Unfortunately, this process did not lead to further

[3] A number of unpublished doctoral and postgraduate dissertation were identified in the search as being related to this research question. However, only one dissertation was included in view of it being the only work published in the context of this research study.

identification of literature since most of the literature focused on education techniques or reviews regarding curriculum content. However, two research articles were identified as possibly informing the findings of this study (Robichaux et al., 2022; Haghighat et al., 2020).

The findings of this literature review are discussed in two sections:

1. Moral development and nursing students; and
2. The DIT and healthcare or undergraduate students.

The first section discusses studies that have utilised different research methods and tools to explore the ethical or moral development of nursing students. The second and third sections include studies that used the DIT1, DIT2, DIT short forms or adapted DIT as a data collection tool.

3.2 Inclusion and exclusion criteria

Studies that included nursing students were considered, whilst other studies that included populations from other professions, including medicine, social work, and journalism were excluded for the purpose of this study. This ensured that only literature relevant to the thesis question was identified. All studies related to student nurses' ethical/moral reasoning, development, decision-making and judgement were included. Studies that looked at testing the validity of assessment tools for these outcomes were excluded, as well as studies related to the transition from a nursing student to a qualified nurse since they do not look at the development of nursing students, which is the scope of this thesis. Literature that examined the effect of an educational intervention over a short period of time was excluded. Studies of various methodologies are also included. Participants in the studies being analysed varied with regards to setting, nationality and age. Studies that included undergraduate and postgraduate students were included, but those that included postgraduate students only were excluded. Further to this, only studies in English were included, however, if any studies were identified but written in other languages an attempt to locate the English version was done. Research prior to 1985 was not included in view of the shift in nursing education during that period. Filters utilised in this search consisted of peer-reviewed journals and articles.

Figure 3.1

PRISMA Flowchart for Search 1 (Page et al., 2021)

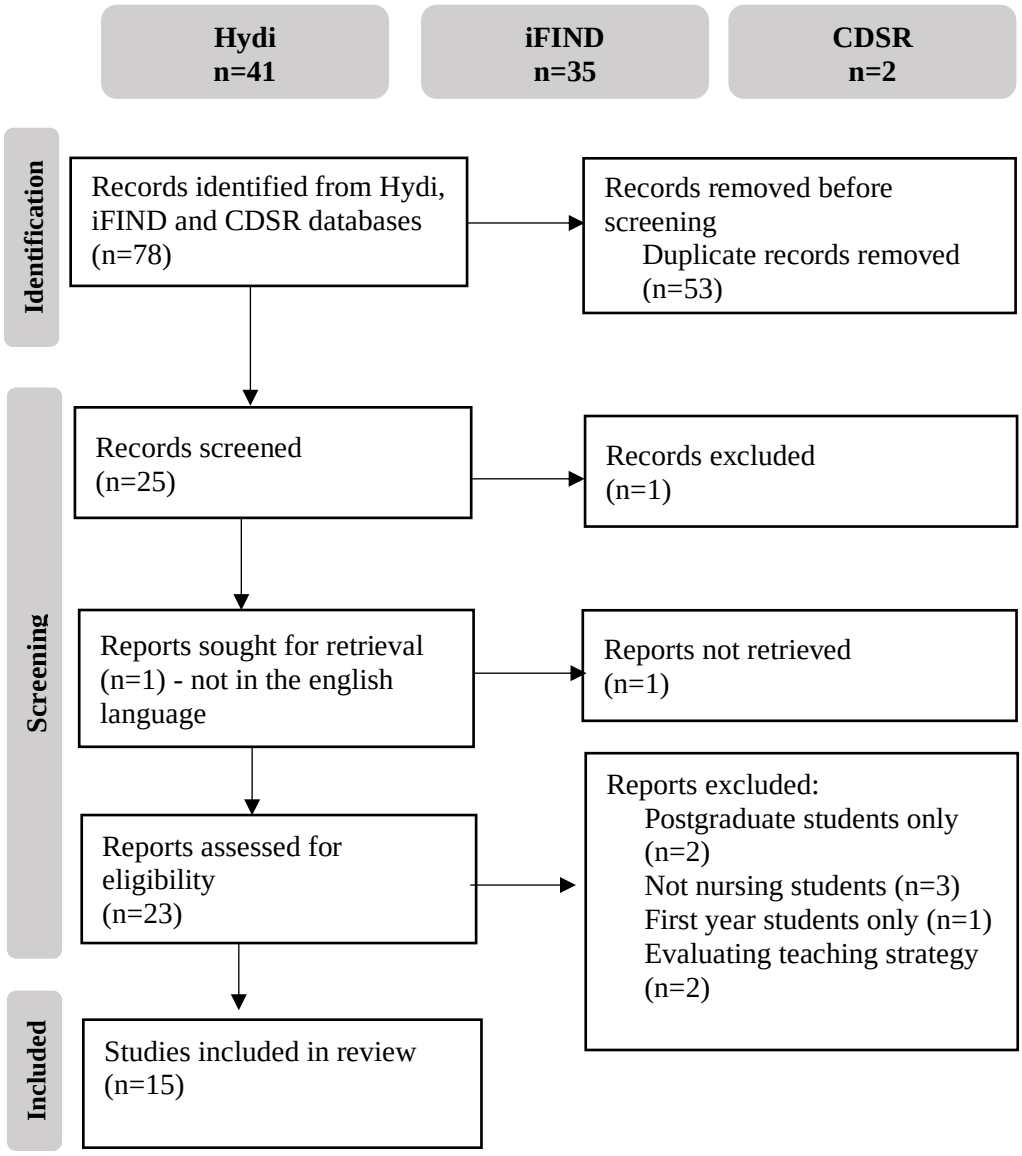


Table 3.3 provides a summary of the articles retrieved in relation to the moral development of nursing students. From the literature retrieved, 15 research studies explored the development of nursing students' ethical or moral development. This section does not include interventional studies that look at specific education methods or evaluation methods for ethics education. The reason for this is that other literature has identified the hours and method of delivery as having the highest impact on student education and not the content (Benner et al., 2008; Park et al., 2012). Furthermore, the scope of this research study is to explore nursing student development. Thus, most of the research included in this section is longitudinal or cross-sectional in nature. A total of 13 studies utilised a quantitative approach, and two studies used a qualitative approach. Ten of the quantitative studies identified, used the DIT in nursing students. One of the quantitative studies is a dissertation published in partial fulfilment of a master's degree programme at the University of Malta. This dissertation was included in view of its relevance to the local context. Further description of these studies can be found in Table 3.3. No research studies were identified that adopted a mixed methods approach, that is, integrating both qualitative and quantitative strands of data in nursing. Furthermore, many quantitative studies used a cross-sectional approach. From the literature identified, only four studies in relation to moral development have been published in the last 10 years. The studies retrieved are international with literature published in the USA, Europe, South Korea, Turkey and Iran. The upcoming chapter shall provide a further explanation of the summarised content in Table 3.3.

Table 3.3

Summary of Studies Retrieved Search 1

Nursing student moral development					
Date	**Authors**	**Title**	**Aim**	**Method**	**Findings**
1987	(Felton & Parsons)	The impact of nursing education on ethical/moral decision making	Determine the influence of the level of education on responsibility and ethical dilemma resolution	n=227 undergraduate n=111 postgraduate DIT USA	Graduate students had a higher mean score (Dscore M=28.21) than the undergraduate students (M=25.78) Formal education had an impact on moral reasoning (p=0.002) Most dilemmas were resolved both undergraduate and graduate students
1989	(Mustapha & Seybert)	Moral Reasoning in college students: implications for nursing education	Comparing liberal arts and nursing groups moral development	n=266 DIT Shipley Institute of Living scale USA	Females have significantly higher score than males Nursing group Pscore (24.31) Liberal arts group scored higher than nursing group, although the highest scores were found in the nursing group
1997	(Krawczyk)	Teaching ethics: effect on moral development	To assess the moral judgement of first year and senior baccalaureate nursing students	n=180 Cross-sectional USA	Senior students score higher than first years (p<0.001) high correlation with education Higher moral judgement for groups that had discussion and decision-making in the programme
1997	(Duckett et al.)	Progress in the Moral Reasoning of Baccalaureate Nursing Students Between Program Entry and Exit	Reviewing changes in moral reasoning and the link to student characteristics between entry and exit	n=348 DIT USA	Pre entry/exit Female students higher scores than men Exit score were within means for undergrad students DIT scores were significantly increased between entry and exit
1997	(De Casterlé et al.),	Nursing Students' Responses to Ethical Dilemmas	Measure ethical reasoning and implementation of ethical decisions	N=2624 DIT Nursing Dilemma Test	Nursing students prefer conventional thinking (Stage 4) Ethical reasoning higher in female students (p<0.05) Higher score for implementing ethical decisions for males

Nursing student moral development					
Date	**Authors**	**Title**	**Aim**	**Method**	**Findings**
		in Nursing Practice		Belgium	
1998	(Sivberg)	Self-perception and value system as possible predictors of stress	Measuring longitudinal principle based moral judgement as a predictor of stress	n=122 Swedish version DIT Multi-centre Longitudinal 3 years Sweden	Only one centre showed significant increase in moral development. Pscore means first year 41.1% and final year 44.8% College A College B 34.5% and 37.5% Highest scores at third year 26.9
2001	(Nolan & Markert)	Ethical reasoning observed: a longitudinal study of nursing students	Examine the effectiveness education Explore their ethical understanding of students	Longitudinal 4 years Questionnaires and responses to 5 vignettes about ethical dilemmas UK	The students' ability to think from an ethical perspective progressed as they became more mature as individuals and professionals within the system. This did not however, grant such nurses immunity to ethical difficulties in the workplace
2004	(Auvinen et al.)	The development of moral judgement during nursing education in Finland	Examines the effect of ethics education on the development of moral judgement	n=106 Cross-sectional multi-centre Finland	1st Year Pscore 40.6, Year 3 47.1 No significant relationship between Pscore and age, sex, previous occupational education, parents education or voluntary work and ethical teaching factors Higher Pscore for students who met ethical problems in practice
2004	(Kim et al.)	A longitudinal study on the development of moral judgement in Korean Nursing Students	To determine the moral judgement scores for each academic year and compare them with sociodemographic factors	n=37 Longitudinal quantitative KDIT South Korea	The moral development for stage 5A (morality as a social construct) was consistently the highest across the four years of the students' course, showing significant differences in some sociodemographic factors including home, birth order and monthly income. The score was higher for 4th years (Pscore 47.47) students compared with first years (46.13)

Nursing student moral development					
Date	**Authors**	**Title**	**Aim**	**Method**	**Findings**
2009	(Callister et al.)	Ethical Reasoning in Baccalaureate Nursing Students	To describe ethical reasoning in nursing students enrolled in a nursing ethics course	Grounded Theory 70 Nursing students USA	Themes identified: 1. Lacking the confidence as a student nurse to take an ethical stand 2. Advocating for patients 3. Being just in the provision of care 4. Identifying the spiritual dimensions of nursing practice 5. Confronting the 'real world' of health care Making a commitment to practice with integrity; Caring enough to care.
2011	(Camilleri)	Interrelationship between moral and intellectual development in nursing students	Identify the correlation between moral and cognitive development	n=311 nursing students Cross-sectional Thesis DIT1 Malta	No statistical significance between gender Mean Pscore of 21.32 No association between year of studies or intellectual development and moral development
2012	(Park et al.)	The relationship of ethics education to moral sensitivity and moral reasoning skills of nursing students	Relationship between academic class, moral sensitivity and reasoning between curriculum design components	n=946 Cross-sectional KDIT1 short form South Korea	No significant DIT score in senior compared to freshman students Scores higher for programmes with richer ethics components
2013	(Basalan İz & Altug Ozsoy)	Determination of nursing students' moral judgement: A city in west region of Turkey	To define nursing students moral judgement ability	n=304 DIT Social and self-moral evaluation Turkey	Student DIT mean scores Pscore=33.9 Lower score than global studies, scores similar to other professional groups in Turkey
2013	(Bužgová & Sikorová)	Moral judgement competence of nursing students	Lind's Moral Judgement Test	n=662 nursing and midwifery students	C index influenced by type of study and age Part-time students and those over 30 years had the lowest c-index scores

Nursing student moral development					
Date	**Authors**	**Title**	**Aim**	**Method**	**Findings**
		in the Czech Republic		Cross-sectional study Croatia	
2017	(Ranjbar et al.)	Becoming a nurse as a moral journey: A constructivist grounded theory	Explore the process of moral development in Iranian nursing students.	Grounded Theory 19 Nursing Students and 3 lecturers Iran	Three levels of moral development, getting to know the identity of nursing (moral transition), accepting nursing identity (moral reconstruction), and professional identity internalization (professional morality), were connected to the levels of professional identity formation

Moral development and nursing students

The following section attempts to critically analyse the research studies identified by looking at the evaluation tools utilised, participant recruitment, socio-demographic correlations, as well as development changes and influences on development. The first section will evaluate quantitative research studies, and this is subsequently followed by qualitative research. The section concludes with a comparison of all the findings within these research studies of both methodologies.

3.2.1 Participants in qualitative and quantitative studies

The study by De Casterlé et al. (1997) had a total of 2624 nursing students, whilst other studies consisted of populations ranging between 37-946, as shown in Table 3.3 (Auvinen et al., 2004; Basalan İz & Altug Ozsoy, 2013; Bužgová & Sikorová, 2013; Duckett et al., 1997; Krawczyk, 1997; Mustapha & Seybert, 1989; Park et al., 2012; Sivberg, 1998). Studies with lower populations adopt both a quantitative and qualitative method (Callister et al., 2009; Kim et al., 2004; Ranjbar et al., 2017). Nolan and Markert (2002) had the lowest participant rate of 15 students. Small populations in quantitative research studies undermine the generalisability of the findings, however the participants under study consist of a specific cohort of individuals.

The majority of first year students in Auvinen et al. (2004) were aged between 20-25. In both first and final year groups, only five students were men. Twenty-two participants had a previous occupational education and a majority were Lutheran church members. Auvinen et al. (2004) also delved into parental characteristics and most parents had an occupational education. Furthermore, the authors asked students if they had encountered ethical issues in clinical practice and to describe the quantity and quality of these problems. Forty-six students encountered problems and seven did not. These background questions could provide explanations for differences in results. Duckett et al. (1997) recruited 348 students, from the University of Minnesota in foundation nursing programs with a mean age of 25 and measured the DIT score

and correlation that these had with academic scores at entry and just before graduation. Basalan İz and Altug Ozsoy (2013) included a population of 920 students between the age of 21-24 from two colleges in Turkey.

Bužgová and Sikorová (2013) recruited participants between the age of 19-53. This study included part-time students and postgraduate students from midwifery and nursing at one university in the Czech Republic. Felton and Parsons (1987) also included postgraduate nursing students in their study. This research study included six different nursing schools in the USA who had 18 semester hours of course work related to ethics. The population consisted of 361 senior nursing students and 185 graduate nursing students. Mustapha and Seybert (1989) recruited 266 participants in two general education curricula, whereby the participants consisted of three groups, that are nursing students, liberal arts students in a traditional curriculum, and liberal arts students in a foundation curriculum. The studies mentioned include participants from undergraduate and postgraduate programmes. The extent and influences on development on postgraduate students may differ from influences on undergraduate students. Furthermore, the comparison with liberal arts students was carried out in view of the contrasting educational approach utilised in such programmes. Thus, in the studies included in this thesis, participants consist of full-time and part-time nursing students from foundation to graduation years, undergraduate and postgraduate nursing students, midwifery, and liberal arts students.

Krawczyk (1997) and Sivberg (1998) opt for a slightly different aim and thus, recruited participants from different programmes and colleges with the aim of comparing the differences between programmes and colleges. Krawczyk (1997) aimed at comparing the involvement of moral development of three undergraduate programmes. One programme included a short course in ethics with student participation, whilst the second programme integrated ethical content into nursing theory, and the last programme discussed ethical issues in clinical seminars when the students raised specific concerns. This research study recruited 180 first year students and 50 final year students. Sivberg (1998) involved 122 nursing students from three different colleges in Sweden with a mean age of 27 in first year and 30 in third year. The aim of this research study was to longitudinally identify the relationship between personality-related, value-system and sociodemographic variables and the principle-based moral judgement abilities in nursing

students. Additionally, Kim et al. (2004) longitudinally assessed 37 nursing students in on University in Korea, over a four-year period. Longitudinal studies decrease variables within their population. There is a further analysis of change over time that is not accurately explored with other research designs.

There is inconsistent participant recruitment in the studies identified. Studies either opt for undergraduate nursing students or considered other populations alongside undergraduate nursing students. Both approaches provide useful insight into the moral development of undergraduate nursing students. Furthermore, the population under study is a specific cohort of individuals, which might be a suggested reason for the very small number of participants recruited.

3.2.2 Quantitative evaluation tools

In the studies identified, most of the research on nursing utilised the DIT, or variations of it such as translated tools or shortened tools to measure moral development (Auvinen et al., 2004; Basalan İz & Altug Ozsoy, 2013; De Casterlé et al., 1997; Duckett et al., 1997; Felton & Parsons, 1987; Kim et al., 2004; Krawczyk, 1997; Mustapha & Seybert, 1989; Sivberg, 1998). The DIT is the most utilised tool for the evaluation of moral development and has been translated into several languages. Apart from the DIT, the authors Baxter and Boblin (2007); Felton and Parsons (1987) also distributed the attribution of responsibility instrument (AR), to measure the attribution of responsibility in ethical dilemmas. Content validity tests for the AR were carried out and a pilot study determined a Cronbach Alpha score of 0.85. De Casterlé et al. (1997) utilised a combination of DIT and Nursing Dilemma Test that are referred to as the Ethical Behaviour Test. McLeod-Sordjan (2014) stated that the NDT is not a very reliable test in view of a Cronbach Alpha of 0.57, which could explain why most studies did not use this tool further. The Ethical Behaviour Test (De Casterlé et al., 1997) contains five stories depicting nurses in daily ethical dilemmas. Within the test, every story is followed by four questions to highlight student reasoning and rank in order of importance five arguments supporting their choice (This testing system is highly correlated with the DIT). The following question, that is to what extent

would they implement their decision in difficult situations, was asked to the students. The study Sivberg (1998) utilised a Swedish version of the DIT and personality-related questions, such as interpersonal values and self-values. Alongside the Turkish version of the DIT, Basalan İz and Altug Ozsoy (2013) also used the self-moral evaluation scale and social moral evaluation scale in two major colleges in Turkey. In conjunction with the DIT, Mustapha and Seybert (1989) distributed the Shipley Institute of Living Scale (SILS) that is used to estimate intellectual functioning levels. The Moral Sensitivity Questionnaire developed by Lützén et al. (1994) was utilised alongside the Korean version of the DIT in Park et al. (2012).

Bužgová and Sikorová (2013) utilised the Moral Judgement Test by (Lind, 2005). The Moral Judgement Test still uses Kohlberg's cognitive theory of moral development. It has been developed to identify the developmental stage of moral judgement and allows for regression and stagnation in competence, not only progression. The MJT consists of two dilemmas, and for each dilemma participants must decide between six arguments in favour or six arguments against the dilemma based on Kohlberg's moral stages. These arguments are rated on a scale, with a result expressed as a C-index (consistency). This index is defined as the participants' ability of an individual to consistently select or reject arguments on a particular moral issue (range 1-100). This C-index does correlate with P or N2 scores of the DIT but determines the extent at which one follows a particular moral value. Nolan and Markert (2002) utilised a survey developed specifically for their research study that was tested for inter-rater reliability. A description of this data collection tool is not very clear in the research paper. This tool was not utilised in further research. This shows a broad range of evaluation tools utilised along the years to evaluate moral development. Furthermore, the MJT and NDT stem from Kohlberg's theory of moral development and utilise a similar approach as the DIT.

3.2.3 Developmental changes

Auvinen et al. (2004); Duckett et al. (1997); Kim et al. (2004); Krawczyk (1997); Mustapha and Seybert (1989); Nolan and Markert (2002) argued that moral development in nursing students was significantly higher between entry and graduation. Bužgová and Sikorová

(2013); Felton and Parsons (1987) supported this finding through the indication that postgraduate students had higher moral development scores and c-index scores respectively, when compared to undergraduate students (p=0.002). De Casterlé et al. (1997) found higher DIT scores as students enrolled in higher levels of education. Contrastingly, Park et al. (2012); Sivberg (1998) did not find any association between year of study and moral development. However, Park et al. (2012) did show an increased moral sensitivity in relation to education with a score of 136.95 (SD 12) and 140.43 (SD 10.98) for freshman and senior students, respectively. Sivberg (1998) indicated moral development in one out of three colleges of health (*p=0.028).* The mean Pscore was 44.3% for students at this college. Thus, it is evident that education has a positive impact on moral development. Bužgová and Sikorová (2013) found the highest C-index score in postgraduate midwifery students. They determine that the moral judgement competence of the overall student is mostly low to medium c-index scores. Except for Sivberg (1998) and Park et al. (2012), the majority of studies supported an increased level of moral development in students throughout their educational programmes.

In the research studies located, there are varying differences in the scores and schemas of moral development. In a study by Rest and Narvaez (1994), the mean moral scores for nurses in the DIT should be 44.6. The highest scores reported are from Finland, Belgium, and South Korea (Auvinen et al., 2004; De Casterlé et al., 1997; Kim et al., 2004). In the Finnish study, first year students scored 40.6 and third year students scored 47.1. In South Korea, first year students scored 46.13 (SD 9.73) and fourth year students scored 47.7 (SD 11.21) (Kim et al., 2004). Professional programme students have a mean score of 42.03 according to De Casterlé et al. (1997). These scores are similar to Park et al. (2012) with a mean score of 45.52 (SD 14.84) and 45.83 (16.07) in freshman and senior participants respectively, even though no longitudinal development could be determined. Between the first and final year in three different programmes, Krawczyk (1997), in their research study obtained Pscores of 27.9 and 38.14 in Programme C, 42.02 and 44.92 in Programme B and 42.11 and 51.78 in Programme A. This indicates that the average Pscores are similar for Auvinen et al. (2004), Kim et al. (2004), Duckett et al. (1997); Krawczyk (1997) and Park et al. (2012). Auvinen et al. (2004) reported a Cronbach Alpha score of 0.71 and Park et al. (2012) had a Cronbach Alpha of 0.79 for the MSQ

and 0.62 for the DIT Pscores. Felton and Parsons (1987) reported a Cronbach Alpha score of 0.79 for DIT scores showing an acceptable level of internal consistency.

Although most research studies show higher levels of moral development scores and significant progress between entry and exit, some studies have shown lower levels of Pscores (Basalan İz & Altug Ozsoy, 2013; Mustapha & Seybert, 1989; Sivberg, 1998). The other two colleges included in the study by Sivberg (1998) had a mean Index P of 37.3%-38.9% and 35.5%-37.7% for first and third year respectively. Mustapha and Seybert (1989) obtained a mean score of 24.31 in the nursing student cohort. Basalan İz and Altug Ozsoy (2013) had an average Pscore of 33.9 (SD 12.8). These scores correlated with lower levels of moral development scores in nursing students.

Locally, the dissertation by Camilleri (2011) indicated mean Pscores of 21.61 for first year students and 23.57 and 18.15 for fourth year students. This does not necessarily highlight regression in moral development since the study was not carried out with the same cohort. This correlational study also identified a significant association between increased moral development and intellectual development. However, this was not associated with the year of study. The overall scores of this study are much lower than expected DIT means.

3.2.4 Preferred stages and schemas of development

De Casterlé et al. (1997) explored the relationship between ethical reasoning and practice. In this research study, nursing students related to Stage 4 statements, implying that nursing students prefer a conventional level of moral reasoning, and thus guided by professional and social norms. Furthermore, University students compared to technical students were increasingly able to use fifth and sixth stage reasoning. The undergraduate full-time and part-time cohort in Bužgová and Sikorová (2013) supported these findings, with students preferring Stage 5 and 6. Auvinen et al. (2004) also reported that final year students had chosen Stage 5 and 6 moral statements, which relate to the postconventional moral reasoning. Furthermore, in Auvinen et al. (2004), first year students had a significantly higher reference to Stage 3

statements (p=0.018) that relate to good human relationships. Kim et al. (2004) also reported the highest development scores for Stage 5a in all years of study. This indicates that nursing students' reason is morally based on unbiased regulations instead of personal interests. This study also reported a decrease in Stage 2 and 3 scores as students progress in their education, indicating a rejection of personal interests and maintaining norms schemas. Mean score relating to Stage 5b are also reported with Turkish students (Basalan İz & Altug Ozsoy, 2013). Overall, most studies reported that nursing students preferred Stage 5 and Stage 6 moral statements. However, the study with the largest population size indicated that nursing students preferred Stage 4 statements. This suggests that nursing students are most likely to be at a conventional or postconventional level of moral development by the end of their studies.

3.2.5 Ethics education: curriculum and pedagogy

The differences between group scores in Krawczyk (1997) is attributed to planned opportunities for group participation and ethical decision-making, even though all groups were at the same educational level. The group with the highest scores had more than twice (42 hours) as much class time devoted to ethical content. This finding can be supported by the study of Park et al. (2012), where they determine that the amount of ethics content is associated with increased moral development. Although both studies show the importance of time allowed for ethics content, the quality and class format of these courses can have a higher impact on moral development. Auvinen et al. (2004); Duckett et al. (1997); Mustapha and Seybert (1989), did not find any connection between teaching methods and moral development. Research has shown that most of the adult population will not move past the conventional stages of development without significant intervention. According to (Duckett et al., 1997); Sorensen et al. (2017) and Auvinen et al., (2004) argued that they were unable to determine whether *any* teaching method would influence moral development, instead they suggested that nursing education may improve moral judgement scores.

Students appreciated the different aspects of ethics education that included self-reflection, workshop, and instructional dialogue. The overarching requirement is that content is realistic,

practical and suited to students' own practice (Kim et al., 2004; Nolan & Markert, 2002). While ethics education, in a lecture format, may deliver a great deal of information to several students in a short period, it is limited to one-way communication; therefore, it has disadvantages for achieving objectives related to problem solving, decision-making, or critically analysing. Many studies report that group discussions, based on case analyses, may be the most effective teaching format for delivering ethics content (Clarkeburn, 2002; Schlaefli et al., 1985; Park et al., 2012). In Nolan and Market (2002), at the start of their training, nursing students had no previous exposure to ethics and the only critical influences on their thinking were parents and teachers. This meant that students were mostly familiar with issues that have been aired in the media such as, euthanasia and abortion. At the end of their training, students believe that including ethics courses in education is extremely important.

Although it is evident that education is an important influence on students' moral development, the strategies utilised in teaching ethics content determines the extent of this development. The content of ethics curricula is not regarded as important as the mode of delivery through active learning strategies and opportunities for decision-making and problem solving. Above all, further time allocated towards ethics in the curriculum has a positive impact on moral development.

Further studies have explored moral development through other research methodologies, such as grounded theory and phenomenological inquiry. The following section evaluates two qualitative research studies related to moral development.

3.2.6 Studies with qualitative methodologies

Literature analysed for the purpose of this thesis, includes Ranjbar et al. (2017), who adopted a grounded theory approach, and Callister et al. (2009) who used a qualitative descriptive approach. Through a constructivist approach, Ranjbar et al. (2017) identified three levels of moral development in relation to identity. These consist of:

i. Moral Transition: Getting to know the identity of nursing

ii. Moral Reconstruction: Accepting nursing identity
iii. Professional Morality: Internalisation of professional identity

In this research study, all participants experienced changes in a different degree with regards to their moral competence, the most significant being the gradual change that occurs over time. In this research study, Iranian nurses indicated high levels of moral development, through the influence of education. The transition between one phase of identity and another occurs in succession, and students could not regress back to a previous level. This contrasts with literature identified in the medical profession, whereby students showed regression or no progression in development as they progressed in their education (Hren et al., 2011; Lind, 2000; Murrell, 2014). Ranjbar et al. (2017) argued that Year 1 students are mostly self-oriented and make decisions based on their own benefits, whilst final year students increasingly base their decisions on social/professional systems. Students commenced their moral transition phase through indirect recognition of the meaning of nursing through descriptions of others, such as course instructors. This was followed by direct experience of students in clinical practice. Through these experiences, students attained an increasingly complex understanding of nursing. The acceptance of one's nursing identity occurs because of students' direct experience of the clinical environment, whereby a student is confronted with actual ethical issues. During this phase of moral reconstruction, students actively choose to be a nursing student but passively develop attributes without consciously thinking about the changes that they are experiencing. This development becomes apparent to students once questioned. During the last phase of professional morality, students fully internalise professional nursing attributes into their own identity. The characteristics of good nurses in practice, translate to other environments outside healthcare organisations. As students progress in their education, they gain greater insight into moral issues that may arise in professional and personal lives. Callister et al. (2009), Ranjbar et al. (2017), as well as Mustapha and Seybert (1989) mentioned the role of participatory peer-supported learning in undergraduate education.

The study by Callister et al. (2009) focused on the ability of nursing students to recognise ethical dilemmas. The reflective writing of participants was analysed and students revealed high levels of critical thinking and in-depth commitment to ethical nursing practice. They identified

the themes of practicing as a professional, lacking the confidence as a student nurse to take an ethical stand, advocating for patients, justice in care provision, spiritual dimensions of practice, confronting the real world of healthcare and caring enough to care. The authors described student development as a process of "becoming" that involves being ethically prepared for clinical practice. This process consists of nurses becoming more confident to resolve ethical dilemmas and conflict, practicing virtue ethics and becoming a role model among nurses through appropriate behaviour and actions. Furthermore, dilemmas were mostly resolved by all students with no significant difference between undergraduate and postgraduate students (Felton & Parsons, 1987). However, the authors perceived this negatively since resolving dilemmas easily might indicate that nursing students do not even recognise such situations as dilemmas and can show a lack of insight to situations that require ethical consideration.

In both the study by Ranjbar et al. (2017) and Callister et al. (2009), the authors suggested that when students move to clinical practice, the student integrates professional identity and moral competencies. However, Ranjbar et al. (2017) also stated that acceptance of nursing identity is related to an increased commitment towards their programme and are less likely to drop out. In relation to moral dilemmas, the authors determined that exposure to difficult ethical situations increases student competencies (Auvinen et al., 2004; Baxter & Boblin, 2007; Callister et al., 2009; Ranjbar et al., 2017).

Ranjbar et al. (2017) very closely linked professional practice and ethics with moral development. The authors further suggested that the process of moral development is not clearly understood through naturalistic studies. Callister et al. (2009) further emphasised the need for understanding the lived experiences of nursing care provision. Many studies identified in relation to ethical development adopted a quantitative methodology. Moral development happens alongside the formation of professional identity. These changes are the result of being confronted with moral issues, and which require morally-based decisions. The decisions among the first years are mostly self-oriented and in the final year are more based on social/professional oriented system. Ranjbar et al. (2017) and Callister et al. (2009) argued that nursing students develop along their three year programme, similarly to studies of a quantitative nature. However, these research studies provided further depth into how the process of development occurs. Developing

a nursing identity and experiencing moral dilemmas and ethical situations will support this development.

3.2.7 Influences on development

Nolan and Markert (2002) determined that students in their 1st and 4th year of study were mostly influenced by upbringing and education. Most students also believed their personal values will conflict with the nursing code of conduct. Students did not view clinical experience as being the most influential in this research study. In contrast, clinical experience is mentioned as highly influential in student development in the grounded theory studies by Ranjbar et al. (2017) and Callister et al. (2009). Faculty members included in the study by Krawczyk (1997) have also highlighted that students with clinical experience were better able to identify ethical dilemmas. The participants in Basalan İz and Altug Ozsoy (2013) selected family as the most important personal value and professionality as the most important work-related value. Most participants in this research study had nuclear families with moderate income.

Furthermore, Ranjbar et al. (2017) indicated that higher stages of moral development are linked with better clinical competency. This is also related to Callister's (2009) findings, whereby students believed that the ability to make ethically-sound decisions in clinical practice referred to an end point of the 'becoming' process. Ranjbar et al. (2017) suggested that the development of a nursing identity influences student moral development. The authors also determined that personal factors and useful work experiences played a significant role in moral competence development. Moreover, Auvinen et al. (2004) indicated that students who had met ethical problems in practical training had higher moral development scores when compared to those who had not.

The different programmes in the research study by Krawczyk (1997) highlighted the significant differences in moral development, with the programme A, including a 3-credit ethics content module on a full academic term, with the final objective of self-direction in ethical reasoning. The faculty members that were involved in the highest scoring programs had academic qualifications in theology or else attained a doctoral level of studies. This programme

also exposed students to different ethical viewpoints and allowed practice in developing a stance and argumentation in relation to ethical issues. This is similar to the findings by Mustapha and Seybert (1989), whereby students in the nursing group that had ethical content and the liberal arts group with decision-making and inquiry in training had higher scores.

In the grounded theory study by Callister et al. (2009), students expressed the challenges of "real life" healthcare practice. Students confront harsh realities, even as novice nurses. Despite these harsh realities in this research study, students are committed to practicing with integrity, such as reporting medication errors and justly caring for patients, irrespective of their character or perceived difficult behaviours. This is the only research study in which students highlighted spirituality as a domain for healthcare ethics.

After identifying the content of the curricula included in their research study, Park et al. (2012) argued that moral sensitivity and virtue were a minor part of the content, with a focus on decision-making models, codes of ethics, professional standards, and principles of bioethics. They suggested that this could mean that ethics is associated with moral reasoning rather than moral sensitivity of students. Increased hours of education are associated with higher principled moral reasoning in senior nursing students. Basalan İz and Altug Ozsoy (2013) also measured self-moral evaluations with the DIT, which showed a statistically significant relationship between academic achievement ($p<0.05$) and knowledge ($p<0.05$). Krawczyk (1997) determined that nursing students develop ethically between their first and final year. The most significant development was shown in students who had more ethics instruction hours and had practice in presenting their ethical stance. Felton and Parsons (1987) determined that students with more formal education reason at morally higher levels.

The main influences on moral development identified include clinical practice and experience, academia, education, upbringing, identity, and hours of ethics education. The focus of development relayed by students in both quantitative and qualitative research is through practical education. However, educational strategies that include decision-making, inquiry and argumentation positively support student ethical development.

3.2.8 Gender and sociodemographic factors

De Casterlé et al. (1997) found significantly higher ($p<0.05$) levels of moral development in females in professional groups of nursing students. This change was not significant in groups of technical students, university students or experts. However, males had a higher correlation between ethical reasoning and implementation ($p<0.0001$). Significantly higher levels of Pscore were identified in females ($p<0.05$) (Duckett et al., 1997; Mustapha & Seybert, 1989). Similarly to De Casterlé et al. (1997), Duckett et al. (1997) revealed a higher score in males for implementing ethical decisions, even though females had significantly higher development scores. Felton and Parsons (1987), as well as Nolan and Markert (2002) only recruited female participants, whilst Ranjbar et al. (2017) and Sivberg (1998) did not focus on gender or sociodemographic variables in relation to moral development. Despite this, Ranjbar et al. (2017) acknowledged this as a need for further research and a limitation to their study.

Park et al. (2012) noted that several differences in student characteristics were present in their sample including age, gender, number of siblings, religion, income, and intellectual abilities. The study retested the data and included these characteristics as covariates. This resulted in a relationship between academic year and patient-centred care ($p<0.01$) and conflict ($p<0.05$). Auvinen et al. (2004) did not perceive any association between age, sex, previous occupational education, parent's education or participation in voluntary organisation and moral development of students. Kim et al. (2004) did not discover any significant association between sociodemographic factors and moral development. This is also supported by Rest (1979), where moral judgement is observed to increase with age but age does not promote moral development. Bužgová and Sikorová (2013) correlated age with c-index score, where participants who are older had lower c-index scores. In Duckett et al. (1997), no significant difference in moral development scores was found in relation to age. However, significant prior college credits and academic scores on admission were significantly related to moral development. Basalan İz and Altug Ozsoy (2013) found a relationship between the students' academic grades and higher DIT score in junior students, however this was not evident in senior students. Kim et al. (2004) suggested that participants with a high monthly income from big cities showed increased moral

judgements based on their own personal interests, with their own self being the goal and thus, are considered to have lower levels of moral development.

Basalan İz and Altug Ozsoy (2013) established moderate levels of moral development in nursing students, which were lower than international norms. The authors attributed this to socio-cultural differences, the educational system, economy, and values in Turkey. The authors also attributed stressors of final year students, such as preparation for real life as negatively affecting students' moral development. Camilleri (2011) also found lower scores in Maltese students when compared to international norms.

There are inconsistent findings in the literature regarding gender and level or moral development. Other sociodemographic factors, such as previous experiences in work or family, do not significantly influence moral development. Age-related development is not assumed and thus indicates that, irrespective of the age, individuals do not develop morally. This suggests that although participants develop morally in education programmes, it is not just because they get older but because they participate in educational programmes. Even though there are no consistent findings regarding sociodemographic influences, two studies determined higher implementation scores for males when it comes to implementing decisions (De Casterlé et al., 1997; Duckett et al., 1997). Furthermore, the student's cultural background can influence moral development scores (Basalan İz & Altug Ozsoy, 2013).

3.2.9 Findings relating to secondary outcomes

Research studies further assessed sensitivity to moral issues. Callister et al. (2009) and Park et al. (2012) indicated that nursing students are sensitive to ethical issues, are able to recognise ethical dilemmas in practice and use critical thinking to analyse their involvement and actions. Park et al. (2012) argued that nursing education may have an impact on student moral sensitivity, however education is Korea is not as effective as western education in developing principled thinking (Kim et al., 2004; Park et al., 2012). Furthermore, Park et al. (2012) did not

indicate any significant differences between curricular design components and moral sensitivity, unlike the significant association found between curriculum design and moral reasoning.

Identified articles further explored self-confidence, the student's ability to take an ethical stand and likelihood of implementing ethical decisions. De Casterlé et al. (1997) found a positive significant relationship between ethical reasoning and implementation of decisions. However, reasoning could be just one of the determinants for ethical behaviour. Implementation scores suggest that students have some difficulty in implementing their ethical decisions. Similarly, Ranjbar et al. (2017), Callister et al. (2009) and Nolan and Markert (2002) argued that nursing students lack the confidence to take an ethical stand. This is similar to the research carried out with practicing nurses (Cannaerts et al., 2014; Robichaux et al., 2022). However, Kim et al. (2004) revealed that overall, students perceive their self-levels of moral judgement abilities were above average and had high levels of self-confidence, suggesting a discrepancy between self-awareness of confidence and actual confidence in practice. This can suggest that even though students score high on moral development scores, this does not necessarily mean that they will take a stand about their opinions or implement their decisions. Overall, it is suggested that nursing students lack the confidence and courage to translate their reasoning into practice.

Park et al. (2012) also compared their findings to scores from 1994. The authors found higher conventional scores in Korean college populations since 1994 and attributed this to social and cultural changes in Korean society. This can indicate a possible decline in moral reasoning along the years. Furthermore, Kim et al. (2004) reported that nursing students mean Pscores, which are within norms. However, they reported lower scores in final years compared to first year students and suggested that this is a result of students being affected by moral conflicts and novel nursing situations and were thus, unable to make decisions in view of the multi-faceted circumstances that they encounter. This means that by the third year of studies, students are still unable to navigate complex ethical situations, suggesting that this development will continue after students graduate. This is supported by Bužgová and Sikorová (2013) that showed higher c-index scores postgraduate students.

Camilleri (2011), De Casterlé et al. (1997) and Duckett et al. (1997), determined that higher moral reasoning scores were positively associated with academic achievements and duration or level of college education. The mean Pscores are higher than the Pscore norms of college students with a significant entry between entry and exit showing that higher education has an influence on moral development. The authors also noted that participants with the lowest moral development score, gained the most developmental scores (Duckett et al., 1997). Further to this, Sivberg (1998) also evaluated self-perception and values. They concluded that self-perception and having a value system are predictors of moral stress, with students showing difficulties in coping at the end of their training. Higher moral development scores are associated with personal values of sociability and teamwork, similarly to the higher stages of development in Neo-Kohlbergian theory.

In relation to secondary outcomes, most research studies looked at moral sensitivity, confidence in ethical decision-making and implementation and academic achievements. Higher academic achievements correlate with higher levels of moral development. Nursing students are sensitive to ethical issues, however, lack the confidence to take an ethical stand (Ranjabar et al., 2017; Callister et al., 2009; Nolan and Markert, 2002; Park et al., 2012). The implementation of ethical decisions is higher in male students rather than female students (De Casterlé et al., 1997; Duckett et al., 1997). However, this result is based on perceived scores and not observational data, thus possibly indicating higher confidence in the belief that decisions will be implemented by male students compared to female students.

3.3 Recommendations from identified studies

All researchers agreed that ethics education is necessary, considering the possibly limited exposure that students have to ethical issues prior to higher education. Most research articles derive recommendations based on education and future research. There is a consensus in the literature that curricula that foster critical thinking, principled thinking and reflection with decision-making opportunities, will increase student moral development (Auvinen et al., 2004; Callister et al., 2009; Camilleri, 2011; Clarkeburn, 2002; Kim et al., 2004; Mustapha & Seybert, 1989; Park et al., 2012; Sivberg, 1998). The environment in which students learn, and the format

of teaching ethics, as well as the pedagogical approach adopted has also significantly influenced the development of students in higher education (Auvinen et al., 2004; Callister et al., 2009; Clarkeburn, 2002; Felton & Parsons, 1987; Krawczyk, 1997). Ethics education that facilitates discussion and challenges student assumptions, their own beliefs and how this influences their practice is recommended (Bužgová & Sikorová, 2013; Callister et al., 2009; Camilleri, 2011; Felton & Parsons, 1987; Park et al., 2012). To support this, Bužgová and Sikorová (2013) suggest a model for ethical discussion and argumentation, that is the Konstanz Method of Dilemma Discussion, which is designed to improve transactional discussions through the challenging of assumptions and responding to counter arguments.

The emphasis of recommendations is the method of teaching rather than the content and is deemed to be the most influential (Auvinen et al., 2004; Krawczyk, 1997; Park et al., 2012). However, Sivberg (1998) highlighted the need for ethics curricula to include self-image. Nolan and Markert (2002), as well as Kim et al. (2004) suggested utilising ethical issues that are of interest to students and adopt this as a training strategy, with ethical issues discussed in education that students are likely to meet in practice. The authors further recommended opportunities for experience in the clinical area for ethical decision-making. Park et al. (2012) suggested the integration of several ethical approaches and the opportunity to choose between students' preferred approach based on a specific context as part of a caring relationship.

Krawczyk (1997) and Park et al. (2012) further recommended adequate ethics education hours in a curriculum because the more hours dedicated to ethics education, the higher the development. The authors also suggested training and education for teachers involved in student education alongside the development of ethics educational resources. Clarkeburn (2002), as well as Mustapha and Seybert (1989), argued about utilising the whole degree programme for integrating ethics education and improving moral reasoning, and not simply using a semester or short courses for this. Camilleri (2011) suggested supporting student academic development since this was correlated with higher moral development scores. Clarkeburn (2002) believed that the exposure of students to ethics in the first year may be the best time for impacting their moral sensitivity and moral reasoning because the students may have a strong incentive to make decisions by themselves and may have already reached the prerequisite levels. Subsequently,

students being exposed to ethics education and thus, having experiences with ethical issues in clinical practice, may be more effective for developing moral reasoning skills because they can reflect on their previous experiences. The length of ethics education may be one critical factor in the development of students' moral reasoning skill. Ethics education lasting 3–12 weeks (with at least weekly meetings) may be a desirable length to produce the outcome in students' moral reasoning skill; longer duration treatments (13–28 weeks) did not have a greater impact on students' moral reasoning than medium duration treatments (3–12 weeks) (Auvinen et al., 2004).

It is also suggested that strategies should be developed to increase student self-confidence in ethical decision-making (Kim et al., 2004; Krawczyk, 1997). The influence of role models in student education and the need for these role models to be competent in teaching ethics is highlighted by Kim et al. (2004). The authors argued that the nursing profession needs to provide ethics education, not only to students but to nurses, who act as role models and practise ethically, even in challenging work environments.

Further recommendations related to research in ethics, include De Casterlé et al. (1997) who recommended further research with different kinds of dilemmas and their predicted outcomes on students' ethical behaviour. Apart from further research to explore the relationship between gender and other determinants of nurses' ethical behaviour, Duckett et al. (1997) recommended further experimental or quasi-experimental designs to exclude whether the emphasis on empathy in nursing enhances moral sensitivity. Moreover, they compare nursing students to other types of university students to differentiate the effects of a nursing curriculum. De Casterlé et al. (1997) further recommended that educators and leaders in nursing practice find ways to improve nursing ethical expertise.

The main recommendations from all the studies that were analysed, attempt to inform curricular changes and educational pedagogy across the whole curriculum. The emphasis is on the method and duration of delivery rather than content of nursing curricula. It is suggested that ethics education is grounded in practice as this was identified as a key area in which students learn about ethics. Therefore, practice settings need to have trained mentors and supervisors in ethics. Furthermore, strategies should be targeted at increasing student self-confidence,

argumentation abilities, critical thinking, and providing opportunities for decision-making. Further, quasi-experimental research is recommended.

From the research identified, students referred to practice settings as an area in which they learned about ethics and thus, looking at ethics that is grounded in practice rather than an abstract view will promote ethics in the nursing context. In real nursing practice, situations do not present themselves in neat structures that fit within theoretical frameworks but present themselves in an actual context and situations (Schön, 2017). Using only abstract theories and principles can result in the dissociation from the reality of nursing students. Research suggests that an emphasis on the analysis and appropriate responses of professional and personal values, health care contexts, ethical problems, and methods of decision-making should be applied. However, this should also be applied using actual situations from nursing that are directly relevant to student concerns. Students should be made aware of the different theoretical approaches and they should be free to choose the preferred model that works best for them (Park et al., 2012). Effective nursing ethics education starts with nursing students' actual experience, addressing conflict with colleagues, offering a variety of theories of ethics and decision-making models, and promoting ethical behaviours and relationships.

3.4 The DIT and healthcare or undergraduate students

The following section of the literature review identified research studies within undergraduate populations and healthcare students that utilised the DIT. The aim of this review is to further identify research that includes similar populations to nursing. This second part of the literature review was carried out after the findings of this research study, in view of the lower than norm Pscores and N2 scores identified in the findings. An attempt to understand the reason behind why these scores are lower, through the various studies using the DIT with other students from health professions or overall undergraduate populations, will provide an increasingly comprehensive approach to understanding the results of this study. The concepts utilised for this search consist of the *defining issues test, health students* and *undergraduate*. Relevant synonyms and alternate keywords were identified as shown in table 3.4. A further search was also carried out in the list provided by the Centre for the Study of Ethical Development at the University of

Alabama, which provides a database of studies that utilised the DIT since 2006. One research study was identified through this search that focused on general undergraduate student populations, including students from the health professions.

Table 3.4

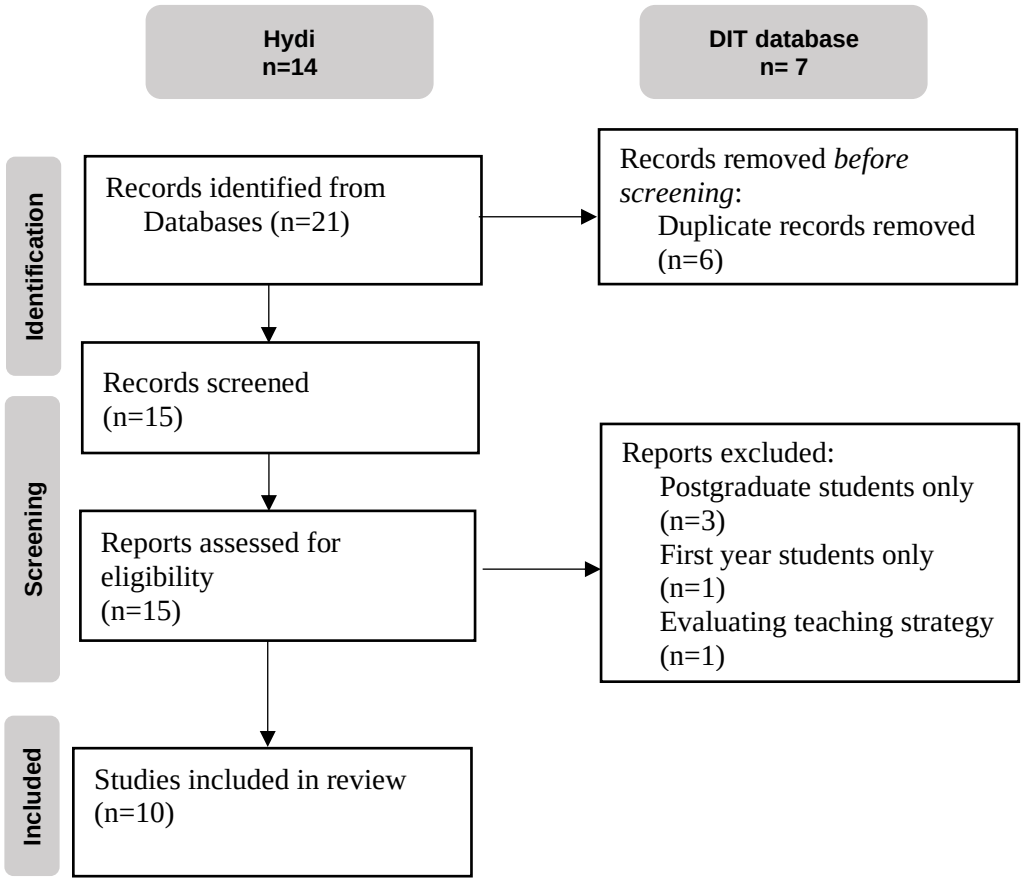
Search 2 Key terms

Defining Issues Test	AND	**Health* student***	AND	**Undergrad***
OR		OR		OR
DIT2		Physical therapy/Physio*		Bac*
OR		OR		OR
DIT1		Midwife*		Degree
OR		Or		OR
DIT		Dent* (Dental/dentistry)		College
		OR		OR
		Pharma*		Higher education
		OR		
		Medic*		

A total of 15 studies were deemed suitable for this literature review and screened in full text. Studies that assessed the impact of a teaching strategy (n=1), as well as other studies that did not include undergraduate students (n=3), were excluded. Studies that did not delve into longitudinal development were also excluded, such as research relating to one year of study only (n=1). The search was filtered to studies in the English language, peer-reviewed journals and articles. After full-text review 10 studies were included in the appraisal. This process is summarised in Figure 3.2 below.

Figure 3.2

PRISMA flowchart for Search 2 (Page et al., 2021)



3.4.1 Summary of identified studies in search 2

The studies identified consisted of physiotherapy students and occupational therapy students (Geddes et al., 2009; Larin et al., 2009), pharmacy (Gallagher, 2011; Latif, 2004, 2009; Peeters & Vaidya, 2016), medical students (Hren et al., 2011; Murrell, 2014; Self et al., 1998) or dentistry (Bebeau & Thoma, 1994). One further study that evaluated all students in undergraduate education was also included (O'Flaherty & Gleeson, 2014). No research studies were identified relating to student midwives. Compared to the literature identified in the nursing profession, studies in the health professions had a much higher population size ranging from 51

to 1543 participants. The studies retrieved are international, including Europe and the United Arab Emirates (UAE). However the majority of literature that includes health students was published in the USA. The research studies identified adopted a longitudinal or cross-sectional research design. Only one research study adopted a mixed methods approach to evaluate the development of pharmacy students. Table 3.5 provides a comprehesive summary of the studies included in this section of the literature review.

Table 3.5
Summary of Studies Retrieved in Search 2

Healthcare professions/undergraduate students and DIT					
Date	**Authors**	**Title**	**Aim**	**Method**	**Findings**
1994	(Bebeau & Thoma)	The Impact of a Dental Ethics Curriculum on Moral Reasoning	Explore the effects of a problem-oriented dental ethics curriculum consisting of 39 contact hours over 4 years	n=720 USA Cross-sectional DIT Open-ended questions regarding the value of ethics instruction	Mean Pscore for first year students 46.71 SD 12.51 and Senior students scored consistently higher than freshman students ($p<0.01$) Positive change was observed as students progress in their education Gender was not related to DIT score differences Some students showed regression in their development, this was associated with students who initially had higher scores, suggesting that development is not linear
1998	(Self et al.)	Clarifying the relationship of medical education and moral development	Assess the development of moral reasoning skills of medical students between first and fourth year	n=95 DIT USA	Statistically significant development in p-scores between first year, mid-point and final year No significant correlation between Pscores and age Positive correlation between gender with women scoring higher during all three phases of data collection Development attributed to ethical education involving small group discussion and dilemmas
2004	(Latif)	An assessment of the ethical reasoning of United States Pharmacy students: A national study	Measure and compare ethical reasoning of pharmacy students and assess differences in ethical reasoning based on sociodemographic factors	n=755 first years 809 third years 24 pharmacy schools DIT USA	Pharmacy students from Southeast region scored significantly lower on ethical reasoning that other regions First and third year pharmacy students score lower than other health professions Average Pscore 35.5 (SD 16.0) first year and 35.9 (SD 19.7) in third year
2009	(Geddes et al.)	Does moral judgement improve in OT and PT students	Development of OT and PT moral judgement scores over 6 years in five consecutive cohorts	n=548 Longitudinal DIT Canada	DIT scores higher than overall norms for college students. No differences between male or females, OT or PT, previous education, and year of entry Significant increase in moral judgement score over a 2-year

Healthcare professions/undergraduate students and DIT					
Date	**Authors**	**Title**	**Aim**	**Method**	**Findings**
		over the course of pre-licensure training			programme of study
2009	(Larin et al.)	Measuring moral judgement in PT students from different culture	Compare the level of moral judgement between two groups of students over an education programme	n=51 (38 west, 13 Arabi) DIT Canada and United Arab Emirates	DIT entry and exit to compare moral judgement between both groups. At both entry and exit Western culture students had higher Pscores. (51.1 and 29.9 respectively) DIT score for Western group increased Arab countries remained constant DIT might not measure moral judgement uniformly across cultures
2009	(Latif)	The influence of pharmacy education on students' moral development	Assess the relationship between pharmacy education and moral development and sociodemographics	n=71 Longitudinal DIT2 USA	Mean score at the beginning N2=38.68, 3 years later 42.32 ($p<0.01$). Females scored significantly higher than males No significant difference between age, GPA and N2 scores
2011	(Gallagher)	Assessment of levels of moral reasoning in pharmacy students at different stages of the undergraduate curriculum	To demonstrate the development of moral reasoning among pharmacy students through a 4-year degree programme	n=332 Students; 13 Faculty DIT UK Cross-sectional pilot study	Increase in score associated with advancement in program (N2 27.90 SD 10.76 in year 1 and 39.96 SD:12.44 in year 4). Majority of improvement occurred between year 3 and year 4 after ethics teaching in the curriculum
2011	(Hren et al.)	Regression of moral reasoning during medical education: Combined design study to	Comparison moral judgement scores or 3 consecutive cohorts of second year students and all of the 6 study years with age-matched control	n=1543 2-4th year medical students DIT2 USA Cross-sectional	Direct causative relationship between the regression in moral reasoning development and clinical teaching during medical curriculum Third year medical students scored higher on postconventional schema score No difference among three cohorts of second year students.

Healthcare professions/undergraduate students and DIT					
Date	**Authors**	**Title**	**Aim**	**Method**	**Findings**
		evaluate the effect of clinical study years	without university education		The longitudinal study of three cohorts showed regression from postconventional scores to maintaining norms scores after exposure to the clinical curriculum
2014	(O'Flaherty & Gleeson)	Longitudinal study of levels of moral reasoning of undergraduate students in an Irish university: the influence of contextual factors	Correlating moral reasoning score between year 1, the middle and year 4 of an undergraduate programme	n=259 DIT2 Ireland	Students in the humanities scored consistently higher (29.42 year 1, 34.01 and 37.75 respectively) than other students Scores in this study are consistently lower than international means Female scores were consistently higher than those for males but not statistically significant. Mean Pscore values was 25.91, 30.63 and 32.87 respectively. Statistically significant differences in development were noted Personal Interest scores decreased as students progressed in education ($p<0.001$). Maintaining norms did not statistically change along the years
2016	(Peeters & Vaidya)	A mixed-methods analysis in assessing students' professional development	To describe and approach for assessing Doctor of pharmacy professional development. Qualitative data from portfolios along with DIT scores.	n=192 USA Longitudinal 3 years DIT2 Qualitative analysis of professionalism and ethics portfolios	Longitudinal study 3 years with qualitative data collection from written reflections and quantitative data from DIT DIT supported qualitative data with increases in N2 scores as students gained more experiences in clinical reflection about ethics in the profession

3.4.2 Findings relating to health and undergraduate students

The research study by Larin et al. (2009) included two student cohorts: one with physiotherapy students in the UAE and another cohort of physiotherapy students in Canada. The DIT was administered on entry and exit of their programme. However, one cohort was four years (UAE) and the other cohort two years (Canada). In this research study, students in Canada obtained significantly higher N2 scores ($p< 0.001$), N2 scores (51.1) when compared to UAE students (29.9). Furthermore, development was only evident in the cohort from Canada ($p<0.01$). The authors attributed these differences to the educational system in the different countries and the previous experience at a university level for Canadian students. The authors further highlighted that students from UAE might have been guided by Islamic principles rather than principles of justice, which attributed to their conventional scores. These differences are also ascribed, to the educational environment, including lack of heterogeneity in the UAE students. The authors propose a cultural and religious, sensitive measure for moral development and cross-cultural considerations for ethical decision-making. The study by Larin et al. (2009) determined that moral judgement scores are higher in western culture compared to United Arab Emirates, with physiotherapy students having higher Pscores and increased development in Canada.

A national cross-sectional study of 755 first year and 809 third year pharmacy students by Latif (2004) used the DIT to measure the levels of moral judgement. The authors did not find significant differences between schools in the USA or the year of study. Thus, there was no evidence of development between the first (Pscore 35.5) and third year students (Pscore 35.9). The authors reported significantly higher scores for female students. However, the overall score was lower than other health professional norms or adults. The authors explained these findings in view of the education system that focuses on cognitive factors during admission. The degree attracts students with lower levels of moral reasoning and pharmacy students only have minimal exposure to liberal arts education concerning complex, social and moral issues. Latif et al. (2010) included 71 students that completed the DIT prior to the beginning of their first-year classes and after successfully completing a Doctor of Pharmacy degree in the USA. The findings revealed that there was significant development ($p<0.01$) between entry and exit of studies with a mean N2 score of 38.68 and 42.32, respectively. In this research study, females scored significantly higher than males at 44.98

and 38.89 respectively. Furthermore, the authors did not find any correlations between age and grade point average (GPA) scores. The authors attributed this development to the opportunities for peer discussion regarding moral dilemmas, small-group discussions and problem-based learning, as well as the analysis of ethical dilemmas throughout the programme. In their cross-sectional pilot study, Gallagher (2011) distributed the DIT to 332 students in the UK. Students significantly developed during their training ($p<0.001$), with a coefficient variability of 0.92. The mean score for Year 1 was 27.90 and 39.96 for the final year of study, at 95% CI. The authors also stated that students were required to develop an ethics portfolio during their training and were trained in ethical decision-making with the opportunity for peer discussion. Peeters and Vaidya (2016) used the DIT as part of a mixed method approach to assess pharmacy students' professional development (n=584). The DIT was used alongside the coding of 192 final reflections written by students. The DIT was administered in first, second and third year of studies. The internal consistency Cronbach alpha score for N2 Score was 0.7. N2 scores for Group A were 38.4 (SD 13.7) and 43.2 (14.3) between year 1 and years 2. Group B scores were 35.8 (15.1) and 45.8 (14.3) between Year 1 and Year 3. This indicated that students developed morally during their education., which was also corroborated by the qualitative findings of this research study. The authors asserted that this means that students have developed professionally and throughout use moral judgement tests as a measure of professional development.

Hren et al. (2011); Murrell (2014) and Self et al. (1998) utilised the DIT to evaluate developmental changes in medical student populations. Hren et al. (2011), tested 207 and 192 second year medical students from two consecutive years of study. This was followed by the testing of 707 students across the six years of medical study, using a Croatian version of the DIT2. This research study adopted a cross-sectional and longitudinal approach to eliminate limitations of the different research approaches. The researchers did not find any correlation between age and DIT scores, with a statistically significant correlation for females in higher scores. Developmentally, third year medical students score higher on postconventional schemas, whilst year 3 and 4 students had a lower personal interest score than the first, second and sixth year students ($p<0.001$). This indicated that students in clinical learning situations regressed in moral reasoning, with a convergence towards maintaining norms schema. The authors attributed this regression to the hierarchical nature of medical practice with students being at the very bottom seeking approval from their superiors. Furthermore, medical students are faced with medically oriented ethical dilemmas, and yet cannot

personally relate to the issues that they are faced with, without any support of guidance to address these concerns. The hidden curriculum of medicine that consists of values, attitudes, beliefs, and behaviours expectations from medicine, can offer opposite values to the formal curriculum that students perceive as inconsistency and contradictions in learning, which can lead to cynicism and moral relativism.

Self et al. (1998) evaluated the moral reasoning of medical students in four classes (n=95) in the US at the beginning, after ethics training, and at the end of their studies. The mean Pscore was 47.7 at the beginning of the first year, 53.7 after ethics training and 56.5 at the end of their medical training. The change in Pscores was statistically significant ($p<0.0001$). This significant change was only present in females, with a non-significant change for men. Further to this, there was no significant correlation between age and DIT scores. Arguably, therefore, male students did not develop morally during their years of training, whilst females did. Additionally, in their cross-sectional study, Murrell (2014) included 162 students who answered the DIT. The researchers in this study did not report Pscores or N2 scores but opted for Levene inferential statistics to test the homogeneity between group variances. Thus, it is difficult to compare with other DIT studies. The authors stated that the mean scores related to a conventional level of moral judgement. In relation to development, there was no significant changes in Pscore levels between the pre-clinical and clinical medical years or exposure to a professional ethics course. The average Pscores in this research study were comparable to the means of college students

In O'Flaherty and Gleeson (2014), the DIT is utilised for one Irish University with 689 students. The DIT was administered in three phases, at the beginning, midpoint, and end of their studies. Only 259 students completed the DIT2 of all three occasions. Students included education, business, humanities, engineering, science, and computer sciences. This research study revealed a significant relationship between GPA and moral development ($p<0.05$). The average mean score was of 25.91 (SD11.07), 30.63 (SD14.66) and 32.87 (SD14.61) for the respective phases. This resulted in statistically significant development between all phases of data collection ($p<0.005$). Students under the Humanities department had consistently higher scores than other disciplines, even though these were not statistically significant. However, students from all disciplines indicate a developmental trend in Pscores. Mean Pscores for female students were also consistently higher during all three phases of data collection. The scores in this research study are lower than international mean scores,

representing close ranges to senior high school students. The authors attributed the lower scores alongside the three phases to a low score at the point of entry and the pre-university education experience of students. The developmental scores and gains were comparable to international peers. The authors believe that the emphasis of education curricula on knowledge transmission, as well as book and rote learning without the active involvement of critical thinking skills and self-directed learning do not support moral development. The authors further mention that academic achievement and work ethic dominated Irish education systems and thus, most students enter higher education without the necessary skills to cope at this level.

From the research identified regarding other healthcare professions, most studies indicated positive developmental changes associated with education (Gallagher, 2011; Latif, 2009; O'Flaherty & Gleeson, 2014; Peeters & Vaidya, 2016; Self et al., 1998). However, Murrell (2014) did not discover any changes in moral development of medical students, whilst Hren et al. (2011) showed regression in moral development possibly associated with the exposure to clinical practice in curricula. Latif (2009) argued that the pharmacy students obtained lower Pscores when compared to other healthcare professionals and O'Flaherty and Gleeson (2014) revealed lower scores in undergraduate students compared to international norms. Larin et al. (2009) compared western and non-western cultures, which showed significantly higher scores in western cultures. There was also no significant development of students in non-western cultures. Authors also sustained that courses that include liberal arts and humanities improve student moral reasoning (Latif, 2004; O'Flaherty & Gleeson, 2014). This can suggest that curricula with approaches that consider humanities and liberal arts support moral development. Similarly to research studies in nursing, authors recommended active learning pedagogies that foster critical thinking skills.

3.5 Limitations of identified studies

Studies that adopt a cross-sectional design are subject to selection bias and increase heterogeneity with the participants. Such studies can also be influenced by confounding factors within different groups of nursing students that can have an impact on the moral development of such students. The qualitative studies included a purposive sample of participants leading to possible sampling bias. Studies within specific countries cannot be

generalisable to populations in different cultures. The study by Nolan and Markert (2001), as well as Kim et al. (2004) had very small samples of students from one centre. Larin et al., (2009) also has a small sample size, however the authors compared Western and non-Western cultures in their study. Cross-sectional studies are not the ideal method for evaluating development of students, in view of the increased varibales of populations under study. However, longitudinal studies have a higher rate of drop outs. The tools that were identified may, or may not, reflect the realm of nursing since some were not specifically developed for nursing or health populations, and those that were specific to the nursing population were not extensively tested for validity and reliability. Duckett et al. (1997) mentioned that the DIT is primarily aimed at measuring justice-based moral reasoning and might not be particularly sensitive to aspects of care that are relevant to nursing practice.

3.6 Gap in research literature

None of the studies identified in the nursing student population adopted a longitudinal mixed methods approach with the integration of quantitative and qualitative approaches. The studies that adopted a mixed methods approach, included either two quantitative approaches or a combination of surveys and reflective writing evaluations. From the research identified, as well as the theoretical frameworks of moral development, an integrative and multifaceted approach to evaluating the impact of nursing education and the progress of moral reasoning is necessary. This research study attempts to converge the findings from both quantitative and qualitative data strands to create an increasingly comprehensive understanding of the ethical development of nursing students. Furthermore, the last identified study that explored moral development in nursing students was carried out 10 years ago. Therefore, this study aims to provide moral development insight with regards to a new generation of nursing students and future nurses.

3.7 Conclusion

From the literature analysed, it can be determined that nurses developed ethically during their higher education journey, with an emphasis on learning from practice. In relation to DIT2 results, nursing students preferred Stage 5 schemas, which relate to postconventional moral reasoning. Culture will influence DIT2 scores, such as non-western cultures, educational experiences and values within a specific society (Basalan İz & Altug Ozsoy,

2013; Larin et al., 2009). Furthermore, most nursing students do not have the confidence to take an ethical stand, even though they are sensitive to ethical issues. When looking at moral development scores from students in other healthcare professions, some students demonstrated, regression in moral development, which suggests that development in non-linear and educational strategies need to be sustained after graduation. Negative experiences in practice and unsupportive environments can also be a reason for moral regression. Lower levels in moral development are also associated with the level of development that students have at entry level within a higher education setting (O'Flaherty & Gleeson, 2014). Higher moral development scores are also associated with students that study humanities and liberal arts (Mustapha & Seybert, 1989; O'Flaherty & Gleeson, 2014).

A shift in ethics education research with a focus on the implementation of educational pedagogy is evident. With regards to ethical development, there has been a void in exploring and understanding nursing students' ethical development, for the last 10 years. Locally, no currently published studies have evaluated student moral or ethical development. The next chapter discusses the methodology and methods utilised in this thesis.

Chapter 4: Methodology and Methods

4.1 Introduction

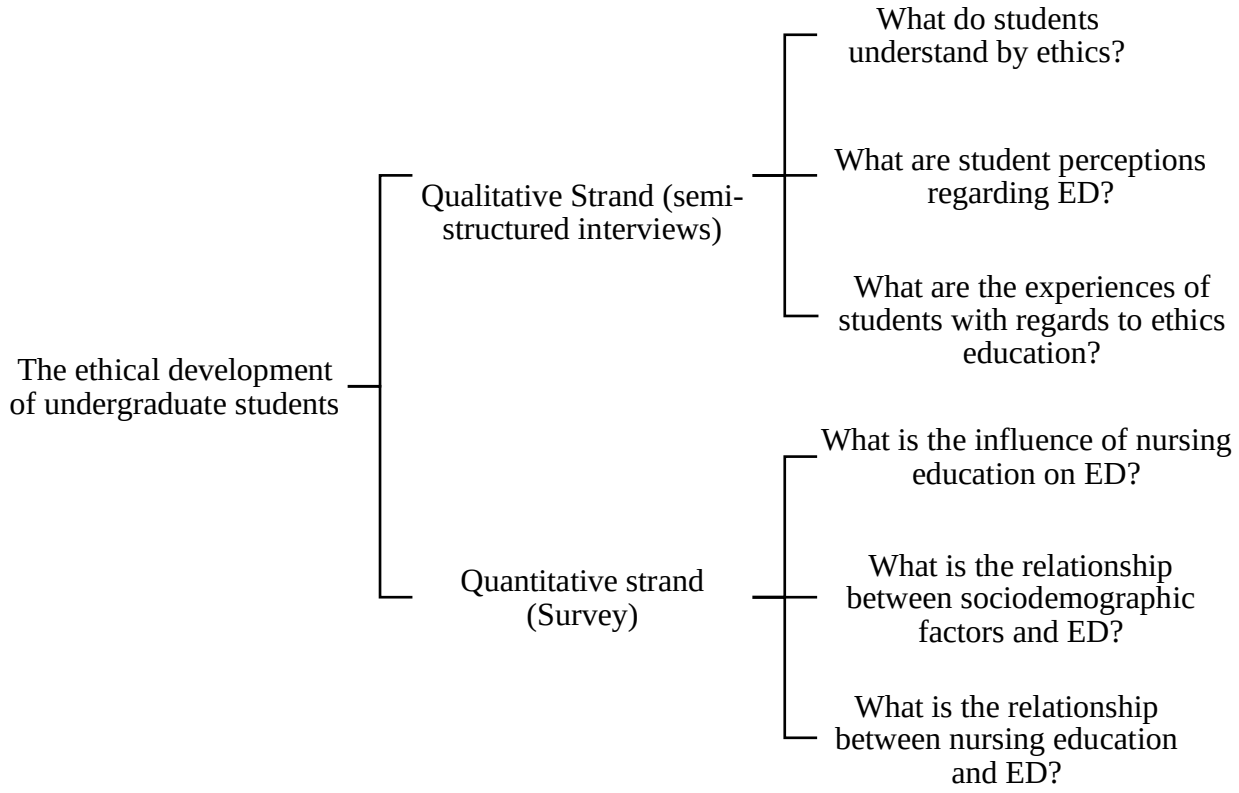
This research study adopted a longitudinal (prospective) convergent parallel mixed-methods research approach. This mixed methods study explored perceptions of ethics and the ethical development of nursing students during an undergraduate nursing course. According to Burke Johnson et al. (2007, p. 123), mixed methods research is a type of research in which the: "researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration".

Convergent parallel design is a type of design in which qualitative and quantitative data are collected in parallel, analysed separately and then merged through interpretation of results. In this study, surveys were adopted to test the theory that predicts that students will positively develop ethically during their three-year programme at the University of Malta. The qualitative data consisted of semi-structured interviews that explored the phenomenon of student understanding of ethics and their perceptions on how this process of understanding and learning occurs. The reason for collecting both quantitative and qualitative data was to converge and compare the results from the two forms of data to bring greater insight into the problem that would otherwise not have been obtained by either datum separately. This multifaceted approach attempted to explore a complex phenomenon that is, the process of learning ethics and developing ethically. Due to the complexity of the situation and the need to evaluate the relationship between variables, mixed methods research was deemed appropriate. Furthermore, using mixed methods investigated this problem from various angles and explored information through different approaches. Advantages of using mixed methods research included providing stronger inferences by integrating the findings of multiples strands of data, as well as having a variety of research tools available for data collection that can be used to solve potential problems (Creswell & Clark, 2017; Tashakkori et al., 2020).

However, there were disadvantages to mixed methods research, which were addressed. Mixed methods research required a considerable amount of time and resources since the researcher collected more types of data and analysed more information (Creswell & Clark, 2017). This study was carried out over a period of five years, and thus provided adequate time for data collection and analysis. The aim was to obtain different, yet complementing data regarding the same topic. A convergent study design also promoted the retention of participants, which is often an issue with longitudinal studies. The research questions guiding this study are depicted in Figure 4.1

Figure 4.1

Research Questions



4.2 Philosophical foundations for mixed methods research

Any form of research is founded on a philosophical background that includes a set of beliefs and assumptions that shape the outcome of the research study. These assumptions function in a broad manner and construct a worldview that informs a research study (Creswell & Clark, 2017; Lincoln et al., 2018). Crotty (1998) suggested four levels of philosophical assumptions for developing a research study as highlighted below:

i) Identifying worldview (epistemology/ontology)
ii) Identifying a theoretical lens
iii) Developing a methodological approach
iv) Informing methods of data collection

Based on these suggestions, this section will commence by identifying the worldviews informing this research study. The overarching worldview is that of dialectical pluralism (DP), which rejects monisms and reductionist solutions. Constructivist and pragmatic approaches are adopted to inform the qualitative and quantitative strands of this research study. The use of plural worldviews and the integration of various research methods are grounded in the philosophy of DP.

4.3 Theoretical framework

The meta-paradigm of DP is adopted as a paradigm that will inform the integrated methodologies and methods within this research study. DP provides a metaparadigm, in which divergence in methodologies, methods, philosophies and values are accepted and used to provide a deeper research process (Binnie et al., 2021).

4.3.1 Dialectical Pluralism

The overarching worldview adopted by this study is that of dialectical pluralism. It is based on the assumption that reality is plural and dynamic (Burke Johnson & Stefurak, 2013). Dialectical pluralism provides a process in considering multiple perspectives even when contradictory (Greene, 2012). Mixed methods research can be interpreted in a dialectical manner; in mixed methods research two parts which are separate but interdependent on each other are joined together. Dialectical pluralism means “listening, understanding, learning and acting” (Burke Johnson, 2017,para. 16). This contention lends itself to the purpose and aims of this research study. Not only does this study aim at exploring the influence that ethics education has on student development, but also understanding student development by considering various perspectives, how they link together, the connection between theory and practice, as well as possible ways to act on shortcomings in ethics education.

Dialecticism has its roots in history with Socrates, Plato and Aristotle and Hindu, Jain, and Buddhist philosophies. For Socrates, the dialect involved questioning others errors in their reasoning and obtain the wisdom that they do not have the answer. For Aristotle, deductive and inductive reasoning were labelled as dialectical reasoning because it is something new and progressive. With eastern philosophies, the dialect is often referring to the joining of opposing parts to form a holistic complementary whole. Currently, dialectical thinking is revised to help deal with contradictions and the nature of intersubjective and subject reality and knowledge (Burke Johnson, 2017). Dialectical thinking lends itself to the complexity and multifaceted reality. The idea of dialectical pluralism was built upon the work of Jennifer Greene (Greene, 2007). This was further developed by Burke Johnson in relation to articulating the philosophical assumptions relating to DP in mixed methods research (Tashakkori et al., 2020).

This research study will have an interactive mixed methods research approach, whereby the research attempts to listen to qualitative and quantitative related epistemologies, and other useful insights to produce a superior whole (Burke Johnson et al., 2007). The whole might be divergent, convergent or a combination of both. The purpose of DP is to provide a way to combine divergent ideas and values to social science research (Burke Johnson, 2017). Kuhn (1970) argued that people in different paradigms experience different worlds, this lends itself to the interpretation of the study's results. Using DP, the researcher acknowledges the fallibility of knowledge and aims at producing somewhat heterogenous and homogenous wholes that respect multiple standpoints, with weight being placed on solutions that work in theory and practice (Burke Johnson, 2017). This research study attempts to observe a phenomenon from different standpoints through the convergence of concurrent research methods with the aim of reaching theoretical and practical recommendations for ethical student development. Furthermore, through DP this research study adopts different theories and methods to analyse and interpret data with the aim of better informing the findings of this research. The values that emerge from the interview questions and surveys, will be varied and on occasion contradictory, and can thus be interpreted using DP.

4.3.2 Constructivism

Constructivist worldviews are very much utilised within qualitative research. Through a constructivist approach, one seeks to understand the meaning of phenomena formed through participant assumptions. When participants provide their perceptions and understandings, they speak from meanings shaped by social interaction with others and their own personal histories. Constructivism employs a bottom-up approach from individual perspectives to broad themes and patterns that shape understandings of the phenomenon at hand (Denzin & Lincoln, 2018). This bottom-up approach has been adopted for the analysis of interview data within this research study. Furthermore, analysis of the topic itself, through the perspectives of students, provides an opportunity for key stakeholders within an academic environment to voice their opinions. Multiple perspectives from the participants will be sought through multiple interviews with the same participant over a three-year period, supporting a constructivist approach.

4.3.3 Pragmatism

Pragmatism refers to a set of insights that can help in a discussion about the strengths and weaknesses of mixed methods approaches (Biesta et al., 2010). Therefore, it is not simply an underpinning for mixed methods research. Moreover, pragmatism has been considered as one of the best worldviews that provides a foundation for mixed methods research (Tashakkori & Teddlie, 2010). The focus is on the consequences of research and on the primary importance of the question rather than the methods. This is pluralistic and oriented towards real-world practice and what works being adopted as the truth (Tashakkori & Teddlie, 2010). In pragmatism, the ontological perspective of reality is that it can be viewed as being perceived and reframed in different contexts and situations. Thus, pragmatism combines both deductive and inductive thinking to reality, as the researcher mixes data and integrates varying components. Understanding of a given inquiry problem can be significantly enhanced by exploring convergences in stories generated from alternate paradigms (Greene et al., 1989).

This research study adopts a non-interventionist design. The aim is to gather data through observation without any specific intervention. The nursing programme was not amended, or else no further education regarding ethics was provided to this student cohort. Although the questionnaire and interviews themselves are not aimed at intervening in student education, there is a possibility of influencing student perspectives. However, these interventions are thought to be of minimal influence on the central phenomenon.

4.3.4 Ontological and epistemological assumptions of world views

Constructivism embraces the possibility of multiple realities that are subjective. Acquiring knowledge through a constructivist approach is transactional and dialectical. This supports the dialectical paradigm approach. Pragmatism denies that knowledge can be gained in any other way, other than through intervention. The ideas that one holds about what can be known and what it means to know something, are important to understand research as a process through which we generate knowledge. However, all knowledge contains a subjective element or is entirely produced by the knower, referred to as subjectivist epistemology (Biesta et al., 2010). Dewey (1916) viewed the question of knowing as:

> Because of the appearance of incompatible factors within the empirical situation.… Then opposed responses are provoked which cannot be taken simultaneously in overt action, and which accordingly can be dealt with, whether simultaneously or successively, only after they have been brought into a plan of organized action. (p. 326).

This means that the acquisition of knowledge requires action. However, although action is a necessary condition for knowledge, it is not a sufficient one; reflection and thinking are also required. From this, it follows that knowing, the acquisition of knowledge, is not something that takes place somewhere deep down inside the human mind; knowing is itself an activity (Tashakkori & Teddlie, 2010).

Dewey's transactional constructivism maintained that there is no gap between human beings and their environment because individuals are participants in an ever-evolving universe. At the level of research design, this approach connects with interventionalist designs, whereas pragmatism supports this notion. Dewey would argue that it is possible to

gain knowledge other than through action, and thus, it can be argued that that act of observation is not a neutral registration of reality but involves particular selections from an infinite number of possibilities. Dewey's pragmatism supported the notion of truth and emphasised that research can only ever provide human beings with insights of what has already been possible, and not about what is or will be the absolute truth.

Giving that the complexity of teaching and learning research is a natural phenomenon within itself, there is a need to generate an open and multifaceted approach towards knowledge acquisition. Adopting a mixed methods approach was considered to provide a better understanding on this phenomenon. DP adopts a pluralist approach to ontology and a dialectical approach to epistemology. DP acknowledges the fallibility of knowledge and had the goal of somewhat producing heterogenous and somewhat homogenous wholes that take into consideration multiple standpoints. These truths aim at providing a solution that works in theory and practice in the eyes of the people who set the standards/values, that are, the participants (Burke Johnson, 2017). DP allowed learning from different and contradictory ideas, dialogical ideas, and hermeneutical ways of thinking. Thus, any action is interpretative in nature and will be continually reinterpreted in the future.

DP is a process philosophy, with the notion that reality is complex, dynamic, and interactive. This philosophy rejects dualisms because each perspective might be important and needs to be taken into consideration. Ontologically, DP recognises subjective, intersubjective, and objective realities. Subjective realities are personal, intersubjective realities are based on social, cultural and language variables and objective realities are viewed as material, physical and process realities. DP takes the existence of multiple realities as a strength to be embraced (Burke Johnson, 2017).

The fact that research in the social and the behavioural domain can find regularities and correlations that give the impression of a degree of causal connectedness, does not automatically commit the researcher to the adoption of a mechanistic ontology. This is because many of the connections that exist in the social domain are achieved through interpretative acts. Rather, when teaching and learning are connected, it is because those who learn have, in some way, interpreted and made sense of the teaching. The link between teaching and learning is thus established through interpretation— which means that to make

sense of research that finds such correlations, one needs to bring in a social ontology rather than a mechanistic one (Vanderstraeten & Biesta, 2006).

4.3.5 Axiology

In social research, axiology refers to the values and ethical positions held by researchers. DP provides a process for dialogue regarding multiple social, economic, and political values. Consideration to different ethical theories and values that are relevant to the research study relate to the following: virtue ethics, care ethics, social justice. The researchers' broad social values adopted in this research study include respect for participants, compassion, integrity, and empowerment. Furthermore, epistemic virtues and values relating to discovery, understanding practical knowledge, open-mindedness, self-reflection, and curiosity contribute to the overall research project (Burke Johnson, 2017).

4.4 Methods

The upcoming section of this chapter provides a detailed description of the research process, the challenges encountered and how these were addressed. Moreover, Figure 4.2 provides an in-depth graphic representation of the process.

4.4.1 Initial participant recruitment

Participants for this research study consisted of nursing students enrolled in the 2018 cohort for an undergraduate nursing degree at the University of Malta. The minimum number of students recruited for the qualitative study depended on data saturation. In relation to quantitative data, a power calculation was not carried out in view of the specific and small target population of this study. Invitations to participate in this research study were sent out via email (Appendix 1). Students who chose to participate were provided with an information letter and a face-to-face explanation of the study. Consent forms were signed separately for quantitative surveys and interviews. Only students from the degree cohort were recruited, the diploma cohort were not included in this study since the University no longer offered this programme.

4.4.2 Qualitative data collection

Qualitative data collection was carried out at the University of Malta. Interviews were carried out in a quiet room without interruptions on the premises of the Faculty of Health Sciences, near the student lecture rooms. Participants were recruited via homogenous purposive sampling and an invitation letter. Inclusion criteria of participants included students who had been accepted to study at the University of Malta Nursing degree in 2018. The same individuals were followed up for the full duration of their programme of studies. The number of individuals interviewed was determined once sufficient data to develop an in-depth understanding had been established. Interviews were semi-structured in nature (Appendix 3). Interviews were initially video recorded via a small video capturing device to decrease visibility, having video recordings was thought to allow the researcher to analyse non-verbal behaviours after the interview had been conducted and eliminate the use of field notes, making the interviewer more attentive towards the interviewee. Recordings were password protected and confidentiality was ensured by researcher. First year interviews were recorded, however the data gained from such recordings was minimal and it was decided that audio only should be utilised in consecutive years. This respected the participants since no extra data that was not sufficient for the research purposes was gathered. After the initial email via the University of Malta registrar and Faculty of Health Science administration team, eight students expressed interest to participate in the study. After meeting the first eight students, two of students informed the researcher that some of their colleagues wished to participate, and thus the researcher's contact details were provided. Another two students participated through this snowball sampling method. All the participants that wished to participate were interviewed. After the first 10 interviews, it was noted that similar replies were gathered from multiple participants, deeming the sample size to be effective in reaching data saturation and no further attempts at recruiting students were made. None of the students dropped out during the duration of this research study.

4.4.3 Quantitative data collection

The DIT2 (Appendix 2) was administered to students during their first and final year of studies. The initial plan consisted of a 2nd year mid-point quantitative data collection point, however this coincided with the COVID-19 pandemic and resulted in insufficient

collection of surveys. The only method for collection at the time was through online email reminders. However, this was not deemed to significantly influence the results of this method because moral development occurs gradually over time. The first-year survey was distributed between January and February 2019, and the final year survey was distributed during May/June 2021.

The DIT2 is an updated version of the DIT, which is a pen-and-paper or online measure of moral judgement derived on Kohlberg's theory of moral development (Kohlberg, 1984). The DIT2 has updated scenarios, which are shorter and provides clearer instructions. The measure consists of 12 issues devised after a hypothetical dilemma for students to rate and rank in terms of importance. This is different than analysing interview responses, which was the method utilised by Kohlberg. Instead of scoring responses in the six stages of moral development devised by Kohlberg, the DIT measures responses based on how much they activate the three schemas developed by Rest et al. (1999). These three schemas consist of the personal interest schema, the maintaining norms schema or the postconventional schema. The schemas attempt to measure how individuals conceptualise the development of social justice.

Validity for the DIT has been assessed in terms of seven criteria (Rest et al., 1999). In relation to this research study, the following criteria are relevant:

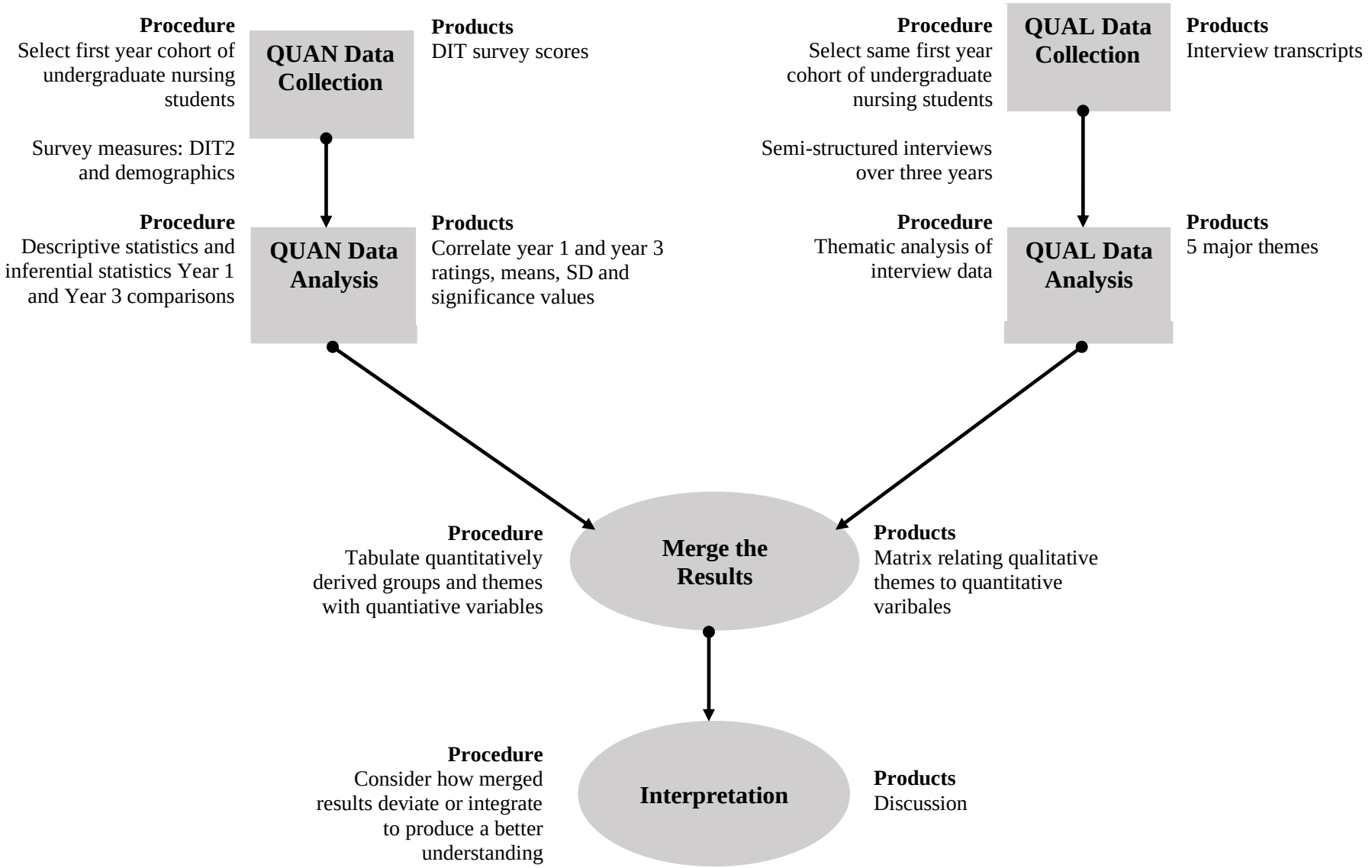
i) The differentiation of various age and education groups: Studies show 30%-50% variance of DIT is attributable to the level of education.
ii) Longitudinal gains: A 10-year study of male and female college and non-college attendees from diverse backgrounds show effect sizes of 0.80, making the DIT gains in college one of the most drastic.
iii) The DIT is significantly related to cognitive capacity: the recall and reconstruction of moral comprehension though postconventional moral arguments and the cognitive developmental measures.
iv) The DIT is sensitive to moral education interventions: One review of over 50 intervention studies reports effect size for dilemma discussion interventions to be 0.41 with moderate gain, whilst effect size for comparison groups was 0.09, showing minor gains.

v) The DIT is significantly linked to prosocial behaviours and professional decision-making with one review reporting 37 out of 47 correlations statistically significant.

Reliability estimates for the personal interest schema and maintaining norms were developed from seven cohorts of professional school students (n=495). For the personal interest scores, scenario discrimination correlations were above 0.30, which is acceptable. For the maintaining norms schema, the same cohorts (n=244) of students the correlations were 0.38 to 0.58, which indicate very strong internal consistency. For the postconventional schemas, correlations were 0.34 to 0.58. The schemas have a coefficient alpha of 0.61, 0.73 and 0.74 respectively.

Figure 4.2

Depiction of the Convergent Mixed Methods Design Utilised (Adapted from Creswell & Clark, 2017; Wittink et al., 2006)



4.5 Ethical considerations

4.5.1 Permissions and approvals

Ethical approval was initially granted by Swansea University after minor amendments and consequent approval was sought and granted from the University of Malta. Approval to carry out this research study was granted by the Dean of the Faculty of Health Sciences and the Head of the Nursing Department within the University of Malta. Furthermore, permission from the University of Malta registrar was granted to send emails to students via the university database (Appendix 5).

4.5.2 Informed consent

An information sheet was provided before the students signed an informed consent. The information sheet provided a clear definition of the research purpose, with approximate completion time for both interviews and surveys (Appendix 6). The details of the researcher and supervisory team were clearly highlighted, alongside research ethics committee approvals. No significant risks related to study participation were identified, however the contact details for the University of Malta counselling services were provided. Participation to the study was entirely voluntary and students had the right to withdraw at any moment without giving a reason, sustaining a penalty, or being discriminated against. The informed consent specified that students had the right to access their personal information to object to the processing of such information, erase and restrict such information (Appendix 6). Consent forms for the interviews were signed on paper, whilst survey consent forms involved clicking on *consent* or *do not consent* prior to commencing the online survey and after the information page. Consent for paper surveys was obtained by virtue of completion, including the information sheet that was printed alongside each survey.

4.5.3 Confidentiality and data protection

Data was processed in accordance with the UK Data Protection Act (Data Protection Act, 2018) and the EU general Data Protection Regulation (EU) 2016/679. All information

was kept strictly confidential, and the data was only viewed by the researcher and the research team, if necessary. All electronic data was stored on a password protected drive on the researcher's personal account with double factor authentication. Paper records were stored in a locked filing cabinet in the researchers' private residence. Pseudonyms were utilised for interview data and survey data was anonymised at collection and unidentifiable. Any identifiable information mentioned by students during the interviews was left out of the final write up. Once the participant submitted their survey results, no further amendments or withdrawal of information could be done. Any data will be destroyed by the researcher five years after the PhD has been attained, that is June 2028. Requests or objections regarding data protection could be forwarded to the University Data Protection officer's contact details that were presented in the information sheet.

A debriefing sheet was sent to students after the completion of three years of interviews (Appendix 7). The researcher did not participate in any lecturing, assessment, supervision, or education-related events for the degree 2018 cohort to prevent any bias or undue pressure for students to participate in the research study. Contact with students for the distribution of paper surveys was done via an intermediary, which consisted of administrative staff at the University, and a nurse from the clinical area who was not a clinical student mentor. A closed box was kept inside the clinical labs to deposit surveys.

4.6 Language

This section will provide a brief overview of the translation process utilised during the development of interview questions and move onto the interviewing process of this research study. At the beginning of this project, a question regarding the language being utilised for interviewing emerged. With Malta being a bilingual country, the option for participants to use either English or Maltese had to be considered. The possibility of having international students or students who have various cultural backgrounds other than Maltese, lent itself to the use of both languages being used to communicate during the interviewing process. Moreover, participants might have felt more comfortable speaking in Maltese, if this was their native language, and thus might have found the Maltese language easier to express themselves in.

4.6.1 Interview questions

The semi-structured interview questions were originally formulated in English (Appendix 3). A professionally registered bilingual translator was asked to translate the interview questions (Appendix 4). The translator can speak both languages equally well. After translation to Maltese, the interview questions were reviewed by the researcher who is familiar with the concepts presented in this study and the overall aim of this research project. Some editing of terminology was done at this stage. This method of researcher reviewing and professional bilingual translators is supported by Temple (1997), as an effective method of translation. Temple (1997) argued that researchers who use a translator for their work, need to be aware of influences that are dependent on the translator. Translation is not only dependent on changing words in a sentence, but it will influence the perspective of the questions being translated, which might ultimately influence what data is derived from such interviews.

The possibility of the researcher themselves translating questions was also considered. However, the worldview that the researcher has as well as being increasingly involved in the project can create possible bias that will feature in the interview questions. The interview questions translated were reviewed by the researcher to make sure that they are understandable to nursing students, since the translator had limited knowledge of the participants involved in this study. This process ensured that questions are not a literal translation of the text, yet are grounded in meaning. As Temple (1997) also sustained, some of the main challenges with translations are the quality of translation, the interviewers past experiences and their worldview, all of which the researcher has no control over.

In the research study, interviewees were given the preference of language in the beginning of the interview and were informed that they could code-switch between languages if it was more comfortable for them. From the author's experience as a Maltese-English speaker and nurse, there was an awareness that when speaking, the Maltese population had the tendency to code-switch between different languages, even in a single sentence. The experience and interpretation of language is very subjective, thus allowing the participants this freedom allows them to answer in an individualistic, and more authentic manner, without regurgitating learnt information about ethics. To further mitigate the subjectivity of how participants understood language, the interviewer translated the question when the participant

did not seem to fully understand or showed hesitancy when trying to answer a question, even though they would have chosen to have the interview in one specific language. This method often led to a clearer understanding of the questions by students. Thus, both English and Maltese questions were included in one interview, depending on the individual participant.

4.6.2 Bilingualism

Bilingualism is defined as the aptitude to speak two languages and/or the ongoing use of two languages (Oxford English Dictionary, n.d.). However, this literal definition of bilingualism is very succinct and misses out on several aspects of speaking two languages. What this definition fails to describe is *how* an individual can speak two languages equally well. Studying in Wales and living in Malta, one can evidently note considerable differences, even though both countries use bilingualism. Delving into this aspect will briefly focus on the influences that language has on interview data.

In Wales, people either speak Welsh or English; the combination of words in Welsh and English is very minimal. This is also applicable in writing. Culturally, in everyday life most Welsh citizens speak English and are exposed to both English and Welsh written text. This contrasts with Malta in that people constantly mix English and Maltese. Maltese integrates words within sentences using both languages and amalgamates English words with Maltese, rather than using the original Maltese word. Furthermore, no one individual speaks the same way or combines these languages in the same way. In day-to-day life all signage, education and writing in Malta is based on the English language. Unless you study Maltese, you will not see Maltese written, other than in official Government communication or Maltese newspapers. The aim of contrasting these two experiences of bilingualism is to show that even though both countries are bilingual, the way in which these two languages are implemented equally is very different.

In Malta, Maltese is often associated with social use of language, whilst English is associated with education, media, and writing, even though the use of the Maltese language for social interaction seems to be gradually decreasing over time. Vinokurov et al. (2007) highlighted this in their research, by treating translation discrepancies as a reliable point of reference to uncover, otherwise hidden, meanings in data. They further maintained that different versions of translations fit into different contexts, without any correct or incorrect

translations. This ideology is referred to as the ecological model for translation (Vinokurov et al., 2007).

The pre-translation of interview questions proved to be a vital methodological approach for bilingual participants, which has been highlighted by Jagosh and Bordeau (2009). The authors conducted a qualitative study in French and English, which aimed at gathering patient perspectives of a newly implemented undergraduate medical curriculum. A challenge in this study was translating the world healer from English to French, with no appropriate French equivalent located. In the interviews, a dual-language interview set for coding and analysis was carried out. This means that none of the interview transcriptions were transcribed from one language to another. The study did not aim to analyse perspectives of both languages, however concepts that differed between English and French interviews and had theoretical and practical implications concerning translations were highlighted. A similar approach was adopted for this research study. Interviews were analysed in their original language, thus decreasing the possibility of having inaccurate translations that did not reflect what the participant wanted to express.

Research on translation theories originated in the field of quantitative research. In this context, the standard technique is to use back translation (Brislin, 1970). During the analysis of the interview data collected, the researcher analysed data bilingually, depending on participant choice during the interview. This was followed by a content analysis of a sample interview in Maltese and a translated version into English. The categories and themes derived from both sample interviews were compared and back-translated to identify any equivalence of terms and conceptual meanings (Chen, 2009). If concepts and terminology are vastly different, this would indicate the need to translate all the interview data. The aim of this process was to validate the translation of interview themes and trustworthiness of qualitative data (Esposito, 2001).

Throughout this analysis, decisions relating to translation will be highlighted and a thorough description of translation-related issues will be provided. No research project has the exact same researcher and the exact same participant. In this research study, the researcher was bilingual and of the same cultural background as the participants. Having said this, culture is not the only factor that influences the interpretation of language, but one needs to also consider the lived experiences of interviewees. Although there are these similarities in

culture, the researcher acknowledges the individuality of each participant and their relationship to language.

4.7 Qualitative data analysis

Qualitative data was analysed between December 2021 and February 2022. Analysis utilised an inductive and exploratory approach. This approach exploration of particular facts or data to obtain genral themes and conclusions that are grounded in the data and not determined beforehand (Lincoln, 1985; Patton, 2015; Tashakkori et al., 2020). The literature review of this research study was carried out before the start of the study in 2017, however by the time the data had been analysed, and the literature review had not been revisited. It was only during the interpretation phase of the results that further reading was done. This decreased the risk of bias based on existing knowledge of the topic being researched. The data was preliminarily distributed into codes before a more refined coding system was developed and applied. This approach provided a basis for decision-making in relation to first-cycle coding methods. Codes and themes were generated from the original interview transcription using NVIVO v.12. Interview analysis was carried out at the end of the three years to avoid bias by the interviewee during data collection. During interviews, students did not refer to former answers from the previous year of study, which is conducive to the assessment of development without pre-preparation for the interview.

Interview transcripts were coded independently and later reviewed longitudinally for each participant. The analysis of transcripts was carried out bilingually to maintain the original meaning of the data (Appendix 8). Some features of NVIVO v.12, such as text-based queries, could only be utilised minimally in view of the nature of the Maltese language. The initial phase of coding consisted of open coding in Maltese and English, without the use of child codes. This exploratory phase was an attempt to analyse the data in an unbiased way as much as possible. The subsequent phase reviewed all codes generated through NVIVO and similar codes were aggregated under a common parent code. For example, empathy, care, and honesty were individual child codes that were aggregated under the parental code of values. All the coded data was reviewed as references relevant to a specific code and was rearranged or reclassified under different, or new, categories if necessary. For example, during the first cycle of coding, all values were grouped together, and this created a code with several aspects of data that were referring to different values. Thus, the decision was made to create child

codes with the specific values mentioned by students. This process included a combination of descriptive and NVIVO coding because students gave examples of values but did not necessarily give that value a name. This above process created categories that are conducive to analysing connections and developing themes. During the writing of the analysis and description of themes, some child codes were deductively reorganised to provide an increasingly comprehensive understanding of the phenomenon.

First-cycle coding methods utilised consisted of in vivo coding and descriptive coding. In vivo coding attempted to keep the data rooted in the participant's own language and perspectives. During interviewing, some statements utilised impacting nouns and vocal emphasis. In vivo codes are marked with inverted commas in the codebook presented in Appendix 9. Notes taken after interviews often mentioned the students' emotions, and thus a decision to include emotion coding as a second-cycle coding method was taken. The emotional reaction of students to circumstances were coded. Emotional codes provided an in-depth insight to student worldviews, including both interpersonal and intrapersonal experiences. In vivo codes were further analysed during second-cycle coding by including in vivo codes as a subcategory through the thematic analysis process.

During second-cycle coding, one of the largest codes referenced was that of ethical and unethical examples. When further reading through the references of this data, one could attribute examples of attitudes, beliefs, and values. Thus, value-coding was adopted as a second-cycle coding method. The principle of value coding is the interconnection between attitudes, beliefs, and values. Emotion and values coding are very closely interwoven with one's value system reflecting participant's needs and wants (Saldaña, 2021). Table 4.1 highlights the coding methods utilised and the relevant research supporting the use of such coding methods.

Table 4.1

Coding for Qualitative Analysis

First Cycle Coding	In Vivo Descriptive Coding	Charmaz, (2014); Corbin & Strauss, (2014) Auerbach and Silverstein (2003); Creswell and Clark (2017); Smith & Osborn, (2008)
Second-Cycle	Value coding Emotional Coding	McLeod and Thomson (2012) Saldaña (2003)

During the qualitative analysis, memos were compiled based on each participant's longitudinal development (Appendix 10). The aim of this research study was to map out the ethical development of students. Thus, quotations of relevance to the research questions, similarity, and patterns within the three interviews were vital in order to avoid reducing data to an individual point in time and instead maintain continuity during the analysis process.

An attempt to deductively code the interviews through the application of the schema theory of ethical development was unsuccessful. The three schemas of ethical development, that are, personal interests, social norms and postconventional schemas were applied to all the codes derived from interview data, in an attempt to determine data relevant to this theoretical framework. This provided some relevance to the text as shown in the table 4.2 below. However, not enough themes and codes were substantially relevant to the DIT2 schemas. The reason for this could be that the interview questions attempted to answer a different question compared to the quantitative data survey. Furthermore, specific training in psychology is required to analyse interviews replies using the moral schema method, however psychoanalysing participant replies was not the aim of this research study. The DIT2 was developed to address this gap and provide a tool for researchers to analyse data without the required training.

Table 4.2

Analysing codes based on moral schemas

DIT Schema	**Associated Codes, Subcategories Categories from thematic framework**
Personal-Interest Schema (Gains/losses of each individual in a dilemma)	*Sub-Category:* Weighing consequences Benefit of the patient, Doing your best, Limits
Maintaining Norms Schema (Moral basis of society, understanding of rules, regulations, and authority)	**Top Level Category: Role Models and Relationships** *Sub-Category:* Social Norms, Laws, and Regulations, Good and Bad Right thing to do *Category:* Attitude, Behaviour
Postconventional Schema (Moral obligations, shared, reciprocal and open to scrutiny)	*Sub-Category:* Doing what you are supposed to *Category:* Dignity, Patient Rights Values

4.7.1 Theming the data

One of the most challenging and time-consuming processes was theming the data. The reason being that several of the codes generated are inter-related. The process for generating themes is highlighted in Table 4.3 below. This process is based on the thematic analysis technique proposed by by Braun and Clarke (2006). This method commences with familiarisation with the data through transcription, translation and writing memos. This process is followed by the systematic generation of codes as proposed by Saldaña (2021). Codes are subsequently collated into themes, reviewed and themes are names with ongoing analysis to refine and clearly define each theme. Extracts of data that related back to the identified themes are presented and tabulated in Chapter 5.

Table 4.3

Theme Generation

Phase 1	Transcription	Data transcribed and reviewed for errors in Maltese
Phase 2	Translation of sample interviews	10 interview samples were translated
Phase 3	Coding	Codes generated from text 2 sample interviews coded in both Maltese and English Codes checked for duplications and similarities Codes grouped into categories (English and Maltese) Categories grouped into themes (English and Maltese)
Phase 4	Analysis	Categories interpreted in English and analysis to form a conceptual/interpretative theme not a descriptive theme in English Two critical colleagues reviewed themes to ensure that they are relevant to the data; one individual from the nursing field and one individual from the healthcare field Themes in English and data in Maltese answer research questions
Phase 4	Writing	Method clearly outlined Themes provided a basis for discussion in text

After the derivation of categories, subcategories, and codes through two cycles of coding and longitudinal memo writing, reflection and analysis was carried out to develop emerging themes. The relationship between categories of data is highlighted in Figure 4.1. Further codes in relation to the respective sub-themes can be found in Appendix 9. This research study aims at exploring the understanding and perceptions of ethics of student nurses. The themes identified are described below:

Theme 1: Students understand ethics as part of a person's character

Supporting subthemes:

Ethics is about one's beliefs

Ethics reflects on one's emotions

Ethics occurs during action (behaviour)

Ethics means one's attitude

Ethics is based on values

Belief that ethics is inherently part of your character

Theme 2: Students think that ethics is a (i) humane approach to care

Supporting subthemes:

Ethics is providing holistic care

Ethics is safeguarding dignity

Ethics is required because of the vulnerability of patients

Ethics is about patient rights

Theme 3a: Students understand ethics as part of (ii): education and practice

Supporting subthemes:

Ethics is associated with right/good and wrong/bad

Ethics is associated with procedures

Challenges can be present when understanding and applying ethics

Reflection can contribute to the understanding of ethics

Theme 3b: Student think that they learn ethics through (ii): education and practice

Supporting subthemes:

Knowledge gained through practical settings

Knowledge gained through experience

Knowledge gained through theory

Knowledge gained through reflection

Theme 4a: Students understand ethics as part of (i): relationships

Supporting subthemes:

Relationships between nurses and patients

Relationships between nurses and students

Relationships with other students

Relationships between nurses and relatives

Theme 4b: Students think that they learn ethics through (i): role models and relationships

Supporting subthemes:

Learning through the relationships between nurses and patients

Learning through the relationships between nurses and students

Learning through the relationships with other students

Learning through the relationships between nurses and relatives

Theme 5: The students think that ethics is (iii): professional issues

Supporting subthemes:

Ethics is understood as the role of nursing

Ethics is understood as developing a professional identity

Theme 6: The students think that ethics is (iii): complex and ambiguous

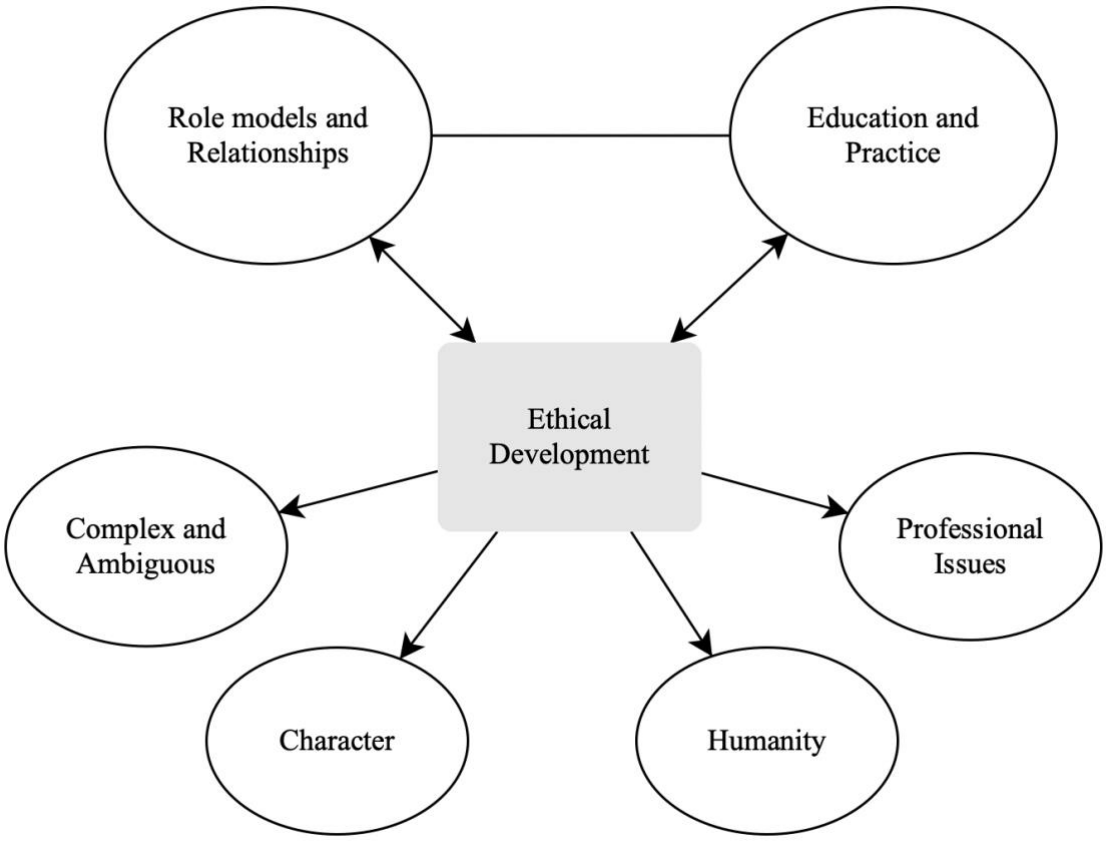
Supporting subthemes:

Ethics is understood as having a dilemma

Ethics is understood as making decisions

Figure 4.3

Relationship Between Themes



4.7.2 Challenges of thematic analysis

Thematic analysis is a straightforward method of analysing text-based data. However, the generation of themes is a lengthy process. During Phase 1 of theme generation the dilemma regarding language was predominant. After translation of 10 sample interviews, the researcher felt that the English language was not relaying the same emotion and cultural connotations that Maltese was. Thus, it was decided that coding will be carried out in Maltese. However, to check for reliability, two samples of the same interview were coded in Maltese and English. Although the codes generated were not identical, they conveyed similar meanings. Despite this, there was a shift in the way codes were written, especially in 'in vivo' coding and choice of quotations to include in this research project (Appendix 9). During the process of coding data, the researcher faced a further challenge. Throughout her education and research, all reading was carried out in English. This meant that even though the

researcher attempted to code all data in Maltese, it was very challenging to apply descriptive and longitudinal coding methods in Maltese. This meant that after the first cycle of coding, the researcher shifted to English to relate to education and previous research studies. All Maltese codes and quotations were translated in brackets by the researcher for ease of understanding of readers. These codes were sent to an official translator and back translated for validity and reliability. Along this process, there was a gradual shift from Maltese to English starting from the raw data and concluding in conceptual themes. This process was deemed as being the most effective way of generating codes and themes as it reflects the researcher's background and the participants themselves in the use of bilingualism. However, a detailed record of the evolving codes and themes from English to Maltese was kept in order to ensure that meaning was not lost during this process.

A further challenge of this thematic analysis was the derivation of longitudinal themes. By using NVIVO, this process was facilitated by comparing files from single participants and reviewing the frequency and relevance of themes. However, in thematic analysis the frequency and number of sources of a code of theme does not necessarily correlate to importance. Although the major codes answered the research questions, it was in more minor codes that the depth of student experiences could really be identified. Some of these codes relate to the feelings and strong emotions relating to unethical practice, for instance, being hurt, fearful, flustered, as well as losing hope. Thus, in the following chapter, all codes generated will be treated with equal value in terms of meaning and importance. To understand the development of students, longitudinal coding was adopted and predominant codes in specific years of study have been highlighted in the presentation of results. Longitudinal coding was applied using memos. Each participant's interview was read consecutively from Year 1 to Year 3 and an interpretation of the overall interview was compiled into the memo, alongside relevant quotations to support interpretations generated. Analysing development using only text is a very challenging feat, due to complexity of the concept of development itself. The memos generated were grounded in the qualitative research questions to understand how students change or maintain their understanding or practices, as well as providing a plural understanding of student replies. An attempt to use a longitudinal data matrix for each participant did not help with reflecting the meaning of student replies. The reason for this is that interviews were carried out over a period of three years and most research that has utilised longitudinal matrices was held over a much longer period of time (10 years or more). This means that the level of development and change

correlates to duration, which is expected. In view of this, a longitudinal data matrix will only be provided for the overall identification of codes and themes of the ten students collectively. NVIVO matrix queries were used in conjunction with memos to connect the frequency of themes mentioned to student overall development.

The topic itself was also a challenge to research in view of the subjectivity and multiple realities involved in student understanding. The generation of themes and the coding process took longer than expected in view of the reflection and detailed memo writing required in order to understand spoken language and translate that to one code of datum. Although a large amount of data was gathered from the qualitative aspect of this research study, the process of reflecting on the data, and spending the time required on thinking until the themes were representing what the participants are saying, contributed to the development of a comprehensive and organised derivation of themes.

4.8 Quantitative data collection

The aim of the quantitative data collection was to identify the influence of nursing education as a whole programme on student moral development, as well as identifying factors that correlate with the moral development of students.

4.8.1 Quantitative participant recruitment

Participants were recruited via non-probabilistic convenience sampling, using volunteer sampling. All of the students within the 2018-degree cohort were invited to participate via email, this technique only led to nine surveys being completed. An alternative recruitment method was developed, a previously timetabled slot that will not be utilised was identified, and the researcher attended the class to invite participants to fill in the survey. The researcher provided a short introduction to the study during class and an intermediary (nurse colleague) remained in class, to answer any queries that the students may have. Further details regarding recruitment strategy are highlighted in section 4.8.4. The location where the survey was carried out had a Wi-Fi connection to provide ease of access to the online survey. The Defining Issues Test by James Rest (1974) was used to assess moral judgement of student nurses. A demographics questionnaire was included with the DIT-2 to investigate

how these variables correlate to changes in moral judgement. An information sheet was available at the beginning of the survey and students had the right to choose whether they wanted to consent to the survey at the beginning, or not. Students were advised that once they start the survey, the researcher is unable to edit or delete the survey in view of its anonymity. Survey responses are summarised in Table 4.3.

4.8.2 The DIT-2 test

The DIT2 Test is a more-up-to date, shorter version of the DIT1. A limitation is that the DIT1 had been tested in hundreds of studies and has a more extensive research base compared to the DIT2. However, more than 13,000 respondents have participated in the DIT-2. The DIT-2 can be administered to subjects with a 21-year old's reading level, or else can be administered in groups and take 35-45 minutes to complete and it is not time-specific. The DIT provides six scenarios regarding the following: (i) a father must decide if he should stealing food for his starving family from a warehouse of a rich man hoarding food; (ii) a newspaper reporter must decide whether to report a damaging story about a political candidate; (iii) a school board chair must decide whether to hold a contentious and dangerous open meeting; (iv) a doctor must decide whether to give an overdose of pain medication to a suffering but frail patient; and (v) college students demonstrate against foreign policy, should students have taken over. The student needed to complete three tasks after reading the scenarios: (i) decided their preferred course of action out of three options; (ii) ranked the relative importance of 12 statements regarding the scenario that influenced the initial choice of action; and (iii) selected the four most important statements for their chosen course of action from the 12 statements in the previous task. All scoring was completed by the Centre for the study of Ethical Development at the University of Minnesota, USA. The scoring systems have standard reliability checks and meaningless item checks to purge any random responses.

The indices measured consist of developmental indices and experimental indices. Developmental indices refer to the three moral schemas and an N2 score. The experimental indices consist of: (a) number of cannot decide choices; (b) humanitarian/liberalism; (c) religious orthodoxy; and (d) antisocial scores.

4.8.3 Moral judgement scores

The DIT2 provides N2 scores and Pscores, which represent moral judgement scores. The P and N2 index scores are highly correlated and redundant with the other. However, the N2 score is increasingly valid since it takes into consideration the decreased preference for Stage 1 and Stage 2 considerations in the surveys as well. Confirmatory factor analysis of over 44,000 subjects indicated that DIT items aggregate around three general moral schemas (Rest et al., 1997). These are:

i) **Personal interest schema** that clusters arguments that appeal to personal interests, relating to Stage 2 and Stage 3 considerations. Stage 2 focuses on the direct advantages of the actor and on the fairness of simple exchanges of favour for favour. Stage 3 focuses on the good or evil intentions of the parties, the concern for maintaining friendships, good relationships and maintaining approval.

ii) **Maintaining norms schema** clusters arguments relating to social laws and norms, relating to Stage 4 considerations that focus on maintaining the existing legal system, maintaining existing roles and formal organisation structures.

iii) **Postconventional Schema** appeals to moral ideals and/or theoretical frameworks for resolving complex moral issues (Pscore range 0-95). This schema represents Stage 5 and Stage 6 considerations. The focus of these stages are on organising society by appealing to consensus producing procedures, insisting on due process and safeguarding basic rights.

The N2 score is an interpretation of acquisition of new thinking (degree to which postconventional items are prioritised) and rejection of simplistic thinking (lower rating of personal interest items). This is an improved score interpretation because from an education perspective this is the desired development, because students are not only acquiring improved moral thinking but clearly identifying and rejecting biased or simplistic moral solutions (Rest et al., 1997). The N2 score is considered to be an improved score based on six criteria for construct validity. The Pscore will be taken into consideration when comparing the findings of this study to studies that utilised the DIT1 scores.

Interpreting moral judgements scores (N2 and P score) can be explained by education level, cognitive development, public policy attitudes and intervention effects. The DIT scores higher in heterogenous samples depending on the level of formal education (30%-50% variance in DIT scores, their cognitive development and correlates with public policy attitudes, for instance, abortion, euthanasia, religion, free speech, LGBTIQ rights, student demonstration. DIT scores have also shown significant gains due to moral education programs of more than 3 weeks and strong significant gain during liberal arts programs at a college level).

The DIT can be more difficult for students whose first language is not English as well as for those students who might not be sufficiently motivated and give meaningless responses. To address these concerns, the reliability checks provided a way to identify subjects who did not abide by the researcher's test instructions. Furthermore, the participants in this study were bilingual, however, the literacy of English varied between participants. Thus, the researcher explained the process of the survey before the students commenced and an intermediary was available to answer any queries or difficulties that the participants might have had, even though the test was initially distributed online prior to the interviews being conducted. The sample story of the DIT2, which also had written instructions was available at the beginning of the survey. The students were also able to commence the survey again at a later date if they did not wish to complete it during one sitting. In this research study, the data obtained from the DIT2 was scored by the Centre for the Study of Ethical Development, University of Minnesota, USA. Compared to the DIT 1 and short-form versions, the DIT2 in an analysis construct validity is a valid measure in relation to moral reasoning developing in soft stage models of neo-Kohlbergian theory (Choi et al., 2020). The analysis is carried out at the Centre for the Study of Ethical Development to ensure consistency in scoring and reporting of scores and includes a sufficient number of respondents with various ages and educational levels. Norms for the DIT2 were developed by Dong (2009) as shown in Figure 4.2 and 4.3, for personal interest, maintaining norms, Pscores and N2 scores. Norms were generated from 652 DIT2 data sets scored between 2005 and 2009 (n=53,261). In this sample, participants that did not state that their primary language was English were not included and thus, participants who did not select the English language as their primary language might have obtained lower scores. No norms for non-English language participants were available. The analysis is carried out at the Centre for the Study of Ethical Development to ensure consistency in scoring and reporting of scores and includes a sufficient number of

respondents with various age and educational levels. In this sample, participants that did not state that their primary language is English were not included and thus, participants who did not select English language as their primary language might have obtained lower scores. However, Bebeau (2002) identified lower Pscores for foreign trained vs US trained medical residents. The researcher attributes the familiarity of the English language as a likely influence on the comprehension of the DIT, and therefore the prevalence of postconventional items.

Figure 4.4

DIT2 Means and Standard Deviations for N2 score and Type Indicator by Educational Level (Dong, 2009)

	Summary Scores					
Educational	N2 Score			Type Indicator		
Level	Mean	Std. Deviation	N	Mean	Std. Deviation	N
Grade 10-12	30.97	14.83	2284	4.31	1.87	2285
Voc/Tech/Jr.	27.20	14.37	986	4.12	1.65	986
Undergraduate	34.76	15.45	32974	4.69	1.87	32970
Graduate	41.33	14.57	15494	5.33	1.72	15492

Figure 4.5

DIT2 Means and Standard Deviation for Schema Scores by Educational Level (Dong, 2009)

	Schema Scores								
Educational	Personal Interest (Stage 2/3)			Maintain Norms (Stage 4)			Post Conventional (P score)		
Level	Mean	Std. Deviation	N	Mean	Std. Deviation	N	Mean	Std. Deviation	N
Grade 10-12	27.70	12.60	2285	35.30	13.41	2285	31.64	14.33	2285
Voc/Tech/Jr.	26.32	11.90	986	39.97	13.08	986	27.99	13.72	986
Undergraduate	25.04	12.36	32989	35.06	13.89	32989	35.09	15.21	32989
Graduate	20.61	11.46	15496	34.07	14.36	15496	41.06	15.22	15496

4.8.4 Challenges to quantitative data collection

The survey was initially distributed via email through the Office of the Registrar at the University of Malta. This process yielded a total of nine surveys. In view of this low response, a further reminder was sent a week later. This reminder did not generate further

replies, therefore, the researcher gained permission from the Head of the Nursing Department at the Faculty of Health Sciences, to distribute the online survey in class via an intermediary. A slot where the students were supposed to have a two-hour lecture, yet instead only actually had a one-hour lecture was identified in order to ascertain that none of the students' free time was jeopardised. The researcher provided a brief explanation of the research study as well as projected the necessary link for the survey on the lecture room screen. Students completed the surveys online via their own devices. They were informed that this was not compulsory, will not influence their grades and that they could refrain from continuing at any given time if they so desired.

During the second year of studies, that is April 2020, this process was not possible to replicate in view of students switching to online education and lockdown still in place because of the COVID-19 pandemic. An attempt to gather quantitative data was done, using email, and sending reminders via faculty administration office and class representatives. However, this still did not gather a significant amount of results. This was understandable, in view of the anxiety and uncertainty brought about by a global pandemic. The distribution of paper surveys or meeting large groups of students was not possible, since all form of in-university or practical placement education was halted. Thus, a decision was made to not include this year as part of the quantitative data analysis. The qualitative aspect of research was completed before the first cases of COVID-19 were detected in Malta. In hindsight, although the collection of additional data would have been ideal, the results between the first and third year of study were not so distinct, and therefore, this was not detrimental to the reliability of this research study. However, the COVID-19 pandemic could have influenced the responses of students in their third year of study even due to disruption of their education throughout this programme. Whilst not being a priority of this study, it should be highlighted that students experienced education during the COVID-19 pandemic and thus, some aspects of this have been reflected through the results of the qualitative data. This, therefore, has provided a unique perspective to this research study.

4.8.5 Reliability checks

The DIT-2 consisted of several reliability checks that purged out participants who might have provided bogus replies. The reliability checks consisted of rate and rank

consistency, M-meaningless items, missing data and non-differentiation of rate and ranks. In this study, a total of five surveys were purged in Year 1, and three surveys in Year 3 based on these reliability checks. Thus, this resulted in a total of 36 surveys in Year 1 and 39 surveys in Year 3. The reasons for exclusion and purged surveys can be found in the Table 4.4.

Table 4.4
Survey Responses

DIT-2	**Year 1**	**Year 3**
Surveys started	97	60 (25 online, 30 paper)
Demographics only completed	45	2 (online)
Completed less than three stories	11	16 (9 online, 7 paper)
Total surveys sent for analysis	41	42
Surveys purged due to DIT reliability checks	5	3
Surveys included for analysis	36	39

4.8.6 Analysis

Statistical Package for the Social Sciences (SPSS v.24) was used to complete the analysis of the quantitative data. The analysis of the survey results was conducted by the Centre of Ethical Studies, University of Alabama. This ensures reliability and consistency when analysing of DIT2 survey data.

Descriptive and inferential statistics were analysed as highlighted in Table 4.5. All statistics were analysed at 95% confidence interval. In all circumstances, the null hypothesis (data is normal) was accepted if the p-value was larger than 0.05 level of significance and the alternative hypothesis was accepted if p-value was less than 0.05. Tests of normality were carried out for all Year 1 and Year 3 dependent variables and values were larger than 0.05. Thus, data was deemed to be normally distributed (null hypothesis accepted) using the Shapiro Wilks test (data sample less than 100) and thus, parametric tests were utilised in statistical analysis (Figure 4.3).

Figure 4.6

Test of Normality for Dependent Variables Year 1

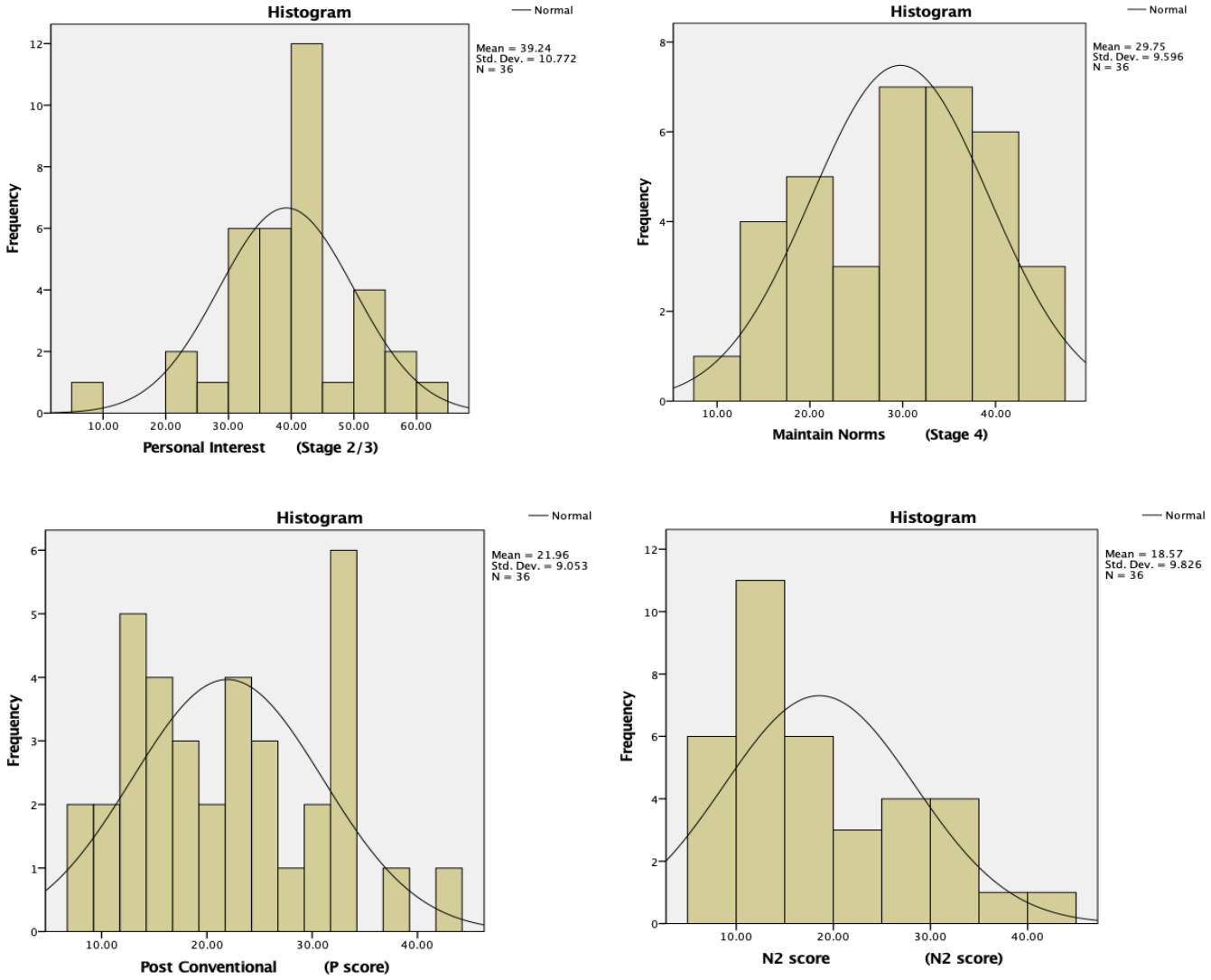


Table 4.5

Tests of Normality p-values Year 1

Tests of Normality

	Shapiro-Wilk	
	Statistic	Sig.
Post Conventional (P score)	.961	.229
Personal Interest (Stage 2/3)	.956	.159
Maintain Norms (Stage 4)	.965	.308
N2 score (N2 score)	.907	.005

Figure 4.7

Tests of Normality for Dependent Variables Year 3

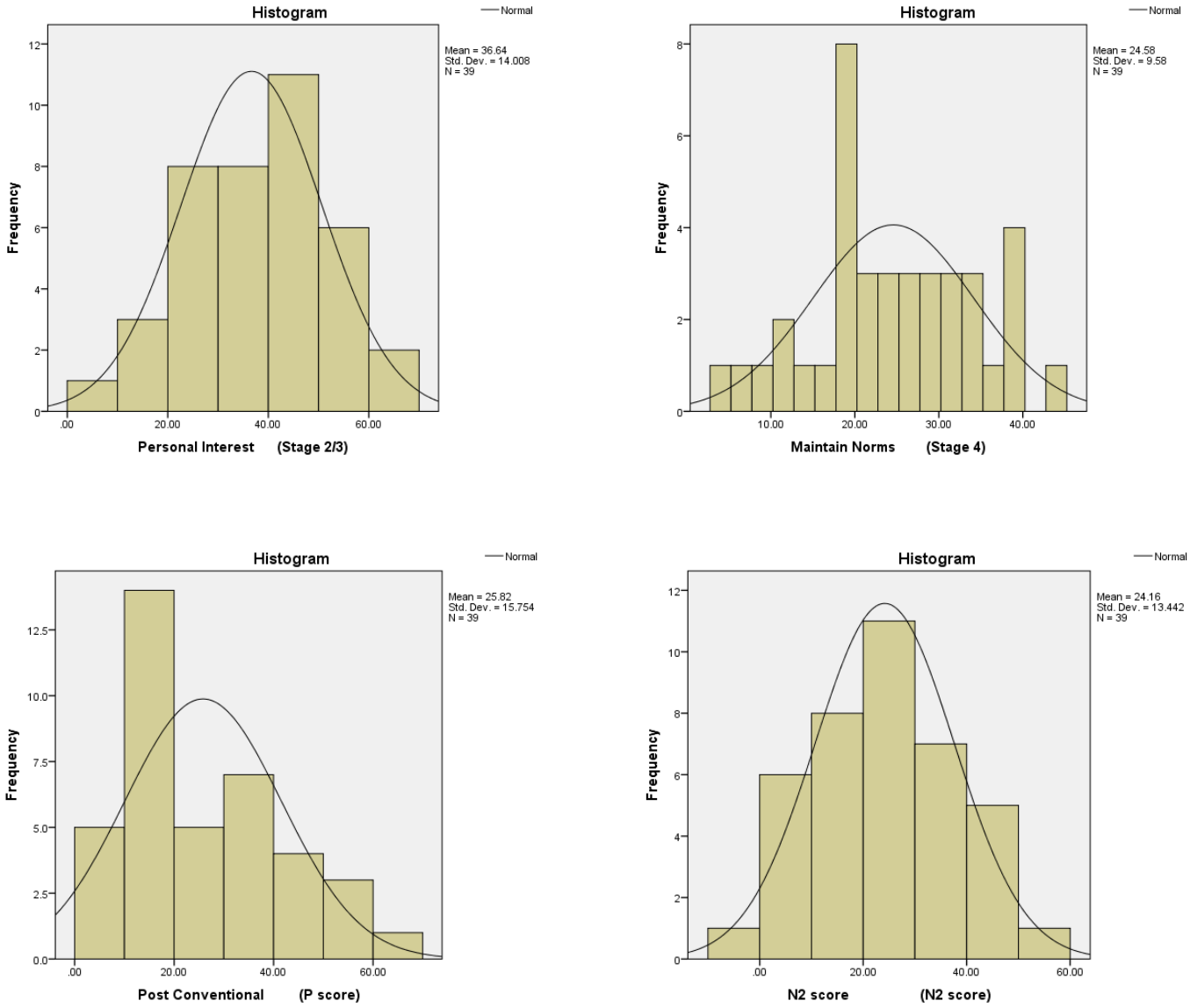


Table 4.6

Tests of Normality p-values Year 3

Tests of Normality

	Shapiro-Wilk	
	Statistic	Sig.
Post Conventional (P score)	.940	.038
Personal Interest (Stage 2/3)	.980	.716
Maintain Norms (Stage 4)	.981	.733
N2 score (N2 score)	.983	.823

Table 4.7

Dependent vs Independent Variables- Quantitative Analysis Summary

		Dependent Variables			
		N2 score	**Postconventional score**	**Maintaining Norms**	**Personal Interest**
Independent Variables	Age (Continuous)	Pearson correlation	Pearson correlation	Pearson correlation	Pearson correlation
	Gender (Nominal) Year 1	One-way ANOVA	One-way ANOVA	One-way ANOVA	One-way ANOVA
	Gender Year 3	Independent sample t-test	Independent sample t-test	Independent sample t-test	Independent sample t-test
	Language (Nominal)	Independent sample t-test	Independent sample t-test	Independent sample t-test	Independent sample t-test
	Nationality (Nominal)	Independent sample t-test	Independent sample t-test	Independent sample t-test	Independent sample t-test
	Education (Nominal)	Analysis of scores between year 1 and 3-no independent analysis			
	Previous work experience	Independent sample t-test	Independent sample t-test	Independent sample t-test	Independent sample t-test
	Relationship Status	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc
	HumLib (Nominal)	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc
	Cancer10 (Nominal)	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc		
	NUMCD	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc		
	CONSTRAN/ TYPENEW	One-way ANOVA Tukey Post-Hoc	One-way ANOVA Tukey Post-Hoc		
	Utiliser	Pearson Correlation	Pearson Correlation		

When correlated with independent variables, no dependent variables indicated statistically significant differences, thus when comparing N2 scores of Year 1 and Year 3, a paired sample t-test was utilised. Developmental phase indices and experimental indices HUMBLIB, NUMCD and CANCER10, CONSTRAN, UTILISER and TYPENEW were compared to the independent variables as shown in Table 4.7.

Cronbach's alpha is an indicator of instrument reliability and internal consistency as discussed by Cronbach (1951). Cronbach's alpha measures the different set of test items resulting in the same measurement outcomes. Cronbach's alpha statistics were calculated for the N2 scores in this research study for Year 1 and Year 3 as shown in Figure. Each subset of N2 scores for the five stories within the DIT2 were included in the analysis. A limitation of Cronbach's alpha for this research study was the number of scales, with only five stories included. Many authors suggest a level of 0.70 for an instrument to have acceptable levels of self-consistency, however this varies in the literature. It should not be assumed that a very high value is necessary since it does not reflect the unidimensional nature of the scale and might indicate an inefficient level or redundancy items (Taber, 2018). Cronbach's alpha scores were also expected to be lower if students from only one educational level were included (Rest et al., 1997).

Table 4.8

Cronbach's Alpha Scores

Reliability Statistics					
Year 1			**Year 3**		
Cronbach's Alpha	Cronbach's Alpha Based on Standardised Items	N of items	Cronbach's Alpha	Cronbach's Alpha Based on Standardised Items	N of items
.657	.658	5	.465	.456	5

4.9 Conclusion

Throughout this chapter, the parallel method for data collection and analysis was critically discussed. This research study has adopted a DP paradigm that includes constructivist and pragmatist ontology and epistemology. Further to this, the aim of this research study was to explore the understanding, perceptions, and development of undergraduate student nurses in relation to ethics. In view of this broad question, the need to carry out an in-depth investigation that presents both narrative and numerical data was necessary. To achieve these aims, interviews and surveys were identified as the most appropriate method. The challenges and limitations encountered in this phase of the research

were highlighted and the measures to mitigate such limitations were discussed. Analysis of the quantitative data was carried out using SPSS and qualitative data utilised NVIVO. A summary of the quantitative and qualitative data has been presented in this chapter. The analysis of qualitative findings was carried out bilingually and once the codes and themes were finalised, they were translated to English. The next chapter presents findings from the methods of data collection and analysis discussed in this chapter.

Chapter 5: Summary of Findings

This chapter aims to provide a summary of the research findings compiled from the primary research carried out. Moreover, it attempts to answer the following key research questions: (1) *How and to what extent do nursing students develop ethically over a three-year degree programme?* (2) *How does ethics education influence ethical student development?* (3) *To what extent do quantitative and qualitative findings converge?*

The second key question is followed by five subquestions that are also answered throughout this chapter. These are (i) *What are the students' perceptions and experiences of ethics education?* (ii) *What is the relationship between nursing education and ethical development?* (iii) *What influences student nurses' ethical development?* (iv) *What do nursing students understand by ethics and ethical development?* and lastly (v) *How does nursing education contribute to student ethical development?*

5.1 Findings from longitudinal qualitative interviews

Semi-structured interviews were carried out with 10 students over a period of three years. The data was initially analysed as an individual interview and afterwards, as a longitudinal interview with individual participants, and collectively. The findings presented below are presented through themes, showing individual, collective, and longitudinal development of nursing students.

5.1.1 Overall qualitative findings

The qualitative research interviews resulted in the development of six main themes. A summary of the codes utilised to derive these themes can be found in Appendix 9. The emergent themes were derived using a deductive approach and re-analysed in relation to the quantitative data findings. The longitudinal analysis of student development is further discussed in section 5.1.6.

The participants of the qualitative research project were all students in their first year of study, following an undergraduate nursing programme. Any participants that were interested in engaging in these interviews were recruited.

Table 5.1

Interview Participant Characteristics

Pseudonym	**Student background**	**Motivation to join Nursing**
Student A	Previously had training in a medical background. Lives with family. Female	Having a job that allows Student A to spend time at the patient's bedside.
Student B	Enrolled in nursing as an interim programme to follow medicine and surgery. Lives with family. Male	Would like to be able to help people when they are experiencing illness. Provides an example of helping a friend in a medical crisis.
Student C	Mature student (23 years) with previous work experience in full-time jobs and has post-secondary education in philosophy. Male	Believes that nursing will provide more job satisfaction than previous employment because he will work with people.
Student D	Older sister who is a nurse. Lives independently. Considers herself an optimist. Female	Since a young age she was always caring and wanted to nurse children; she enjoyed studying biology and felt like nursing fit.
Student E	Did not follow traditional route of academia to join nursing. Lives independently. Female	Was encouraged to join by others in view of her character of helping others and believes it is a good job for her.
Student F	Joined nursing after post-secondary education. Lives independently and with family. Female	Always wanted to be a nurse from a young age, believes that is very satisfying and believes she has the stamina to be a nurse.
Student G	Experienced illness of close family relatives during programme.	Always wanted to work with people, inspired by a relative who was a midwife because of the

Pseudonym	Student background	Motivation to join Nursing
	Claims to be a pessimist. Lives with family. Female	teamwork involved. Was going to enrol in a pharmacy course prior to nursing.
Student H	Joined nursing after post-secondary education. Lives with family, very shy and reserved and soft-spoken character Male	Experienced healthcare due to illness of grandparents and was inspired by the nurses who took care of these relatives. Always wanted to be a nurse.
Student I	Joined nursing after post-secondary education. Experienced illness of a close family member. Female	Always liked health-related jobs and she liked nursing and medicine because you help people recover from illness.
Student J	Joined nursing after post-secondary education. Recent loss of a close family relative Female	She was interested in pharmacy or medicine, biochemistry. Nursing was her second preference but the acceptance letter for nursing arrived before. She started enjoying the nursing lessons and decided to stay in nursing because she was helping people in their most vulnerable moments.

The six themes identified through the qualitative aspect of this research study consist of:

- Theme 1: Character
- Theme 2: Education and Practice
- Theme 3: Role Models and Relationships
- Theme 4: Humanity
- Theme 5: Professional Issues
- Theme 6: Complexity and Ambiguity

The themes identified above provide an insight of student understanding of ethics, student perception regarding their own development, and the role of education in their ethical development. Furthermore, these themes provide an in-depth understanding of student development at an undergraduate level that provide an additional dimension to quantitative methods of evaluating development. The following section offers a brief description of every theme that shall, then, be discussed and analysed in more detail later on in this chapter. Each

theme description is followed by an example of a datus that supports the major code that relates to the overall analysis and study conclusions.

Theme 1: Character

This theme includes reference to moral characters, which lends itself to a virtue-ethics based approach and intuition. This theme consists of the idea that one is intuitively ethical without actively developing, most often based on character and upbringing. Furthermore, a major category that featured in all of the interviews is that of values. This category refers to a range of values that students mentioned throughout their interviews, and thus, are considered to be ethical. The concept of behaviour and attitude was derived from the several codes that were categorised as *ethical* or *unethical* based on the student's observation or experience. This theme presents an understanding of ethics in relation to moral judgement and behaviour, as well as the affective domain that informs these judgements and behaviours. The generation of codes based on the datum is shown in Table 5.2.

Table 5.2

Codes and Related Datum for Theme 1

Theme 1: Character		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
Values	Ethics, I think are values that are your own…because not everyone sees things the same way.	VALUES[4] percieved be to personal and belonging to the individual, often seen to be part of the individuals' CHARACTER. Ethics understood as values.
Attitudes	Even in their attitude you notice...you can compare the attitude of people"	Ethical and unethical ATTITUDES are described both of others and of students themselves. Strength to be a nurse is a predominant attitude that features.
Beliefs	more insight into things...for example appreciating life a bit more	A student BELIEF is that nursing has helped them appreciate life in view of the ilnesses they meet on a regular basis.

[4] Terms in capital letters refer to other codes or themes identified in the findings.

Theme 1: Character		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
		This is associated with building CHARACTER through nursing
Emotions	Our biggest fear is that we would be on a night shift as a reliever and there wouldn't be anyone from the ward or the ones on the ward are your age...with panic what are you going to do about these questions? My fear is that I do not handle it the way I should handle it.	EMOTIONS are linked to BEHAVIOUR, feeling anger, fear etc when faced with unethical practice. Frustration is linked to students being unable to bring about change. Guilt is often a motivator for ethical BEHAVIOUR. Most emotions are negative and seem to be what students remember the most from their practice.
Behaviours	I was in an oncology setting and you hear patients saying that nurse did not treat me well or that nurse did this, and you start listening and trying to understand and say I do not want to do this and learn a lot from their experiences. When you are in the first year it is worse…even now I know it bothers me. There is nothing to do…I say in the future I will not act like them	Related to action, BEHAVIOUR is often discussed in relation to third parties, often explaining unethical behaviour and students own behaviour of not speaking up when they come across unethial situations. This is also linked to ATTITUDE. Several data excerpts in relation to this theme, since students found it easier to provide examples.

Theme 2: Education and Practice

The theme *education and practice* reflects a link between theoretical/'classroom' ethics and practical nursing ethics. These two areas are not intended to be in opposition, yet instead integrate together to constitute nursing education in an effective and comprehensive manner. This theme includes an exploration of the development of ethical knowledge and student perceptions regarding their learning needs and development from all aspects of the nursing curriculum. The codes related to this theme and the generation of this theme can be found in Table 5.3.

Table 5.3

Codes and Related Datum for Theme 2

Theme 2 Education and Practice		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
Theory	I do not think that there was a lot of education [about ethics] from theory...I could not understand what the lecturer was talking about...I couldn't understand the whole concept of it [ethics].	Most referenced in Year 1 of studies and often refer to the study-units they are undergoing at a certain period of time. Students do not believe they learn from THEORY, however when asked how they know what is the right decision, they refer to lectures relating to palliative care and clinical skills. Lectures are seen as boring and minimal class discussion.
Experience	I think mostly from experience, example in first year you now know how to handle certain situations...even seeing other nurses doing things. The more practice and experience you have the more you know how to handle ethical questions.	Students think that they learn from EXPERIENCE, this is mostly EXPERIENCE in clinical PRACTICE. This theme is also related to EXPERIENCE of others and having discusions with mentors and tutors in education and practice about these experiences. This is linked to the NURSE-STUDENT relationship.
Procedures	I have seen this, not the first time. That the nurses I am with ask me if I know how to do a catheter and I say yes. So they tell me that it is up to me to do it. Afterwards, another catheter comes up and the nurse does it...and they tell me that they are going to do it their own way...meaning no aseptic technique.	Several examples of ethics related to clinical PROCEDURE. This can be understood as organisational guidelines which are mostly related to clinical care such as infection control. Most often these PROCEDURES were a DILEMMA for students because of the theory-practice dichotomy and differences. These examples are also associated with EMOTIONS.
Reflection	We need to be less passive in certain situations. We should not say I do not know and stop there...but ask why? What can be done better? Because ethical issues everyone seems to know what they are but the decision to be taken no one seems to know	REFLECTION is mentioned in Year 2 and Year 3 of studies. Students believe that they learn ethics through self-awareness and REFLECTION. This is often linked to lack of ability to change things. There is limited awareness of critical reflective processes as part of a structured educational tool. This is linked to NURSE-STUDENT relationships

Theme 2 Education and Practice		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
	it...everyone says this and this should be done, but nothing is done.	where discussion and feedback on ethical issues are held.
Challenges	Sometimes even they even tell me... I would be preparing the antibiotics as we should, and obviously I still take same time to do this. There are some who tell me 'God forbid that when you graduate you continue doing this because you will never finish the antibiotics during night shifts.	There is significant pressure to work fast and save TIME. Students are perceived to work slowly and because of this they sometimes feel the pressure to take unsafe shortcuts in practice. This pressure was more evident as students progressed in their training. This CHALLENGE is sometimes accepted as a justifed reason for unethical practice.
Practice	I think that the most important is always placements...because from placements you learn most about these things. Without practice the nurse...[well], practice is everything.	Students think that they learn ethics mostly from PRACTICE, this is linked to BEHAVIOUR and ATTITUDE. Students provide examples of ethical behaviours but also state at the same time that they do not often apply ethics in PRACTICE. Certain PRACTICE settings are deemed to have more ethical issues than others.

Theme 3: Role Models and Relationships

The impact of role models from nursing practice, upbringing and education is discussed in this theme. Moreover, the power balance and hierarchical dynamics of being a student, in relation to such relationships is presented. Further to this, a discussion regarding the relevance and impact of role models in such settings, including social elements of such relationships is discussed. This theme further includes working in a team, as a perceived necessary condition of nursing practice and the effect of team dynamics on the work environment. This process of code generation is highlighted in Table 5.4.

Table 5.4

Codes and Related Datum for Theme 3

Theme 3: Role Models and Relationships		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
Nurse-patient	In primary health, I had a mentor that used to see patients once, but she still tried to refer to them by their name, ask them how their day was. There are other placements when the patients stay in the ward for a long time, so it is easier to build a relationship because you see them often and they get used to you. You feel good when you build this relationship because you see how the patient is doing, not just doing your work, and leaving and you do not care for that patient anymore. It doesn't only help you build a relationship but helps you feel good as well.	Positive ROLE MODELS are percieved to be nurses who have good therapeutic relationships with patients. There is a difference between personal and professional relationships. These relationships are also dependent on the PRACTICE setting.
Nurse-relatives	The nurse was nice and soft with the relative and I said there she used good ethics. It also counts in tough moments when relatives are grieving, and the nurse was nice and soft with the relatives after giving up hope on a patient… they need support. I think that is when such a value is important, because relatives need a lot of hope and support, and it is the nurses' role.	The RELATIONSHIP of ROLE MODELS with RELATIVES of patients is perceived to be a way in which nurses can be ethical. The experiences of students are mostly positive.
Nurse-student	It goes both ways because if you see someone doing something and you think that you did not expect to do it like that in that situation...you kind of learn from it because I liked that because it is ethically good and I try to introduce it in my own practice eventually. Or the other way round, you see someone doing something that you do not agree with and you think that it is not ethical and you try to steer away from it.	One of the main concerns for students is to maintain a good RELATIONSHIPS with their ROLE MODELS in PRACTICE. This is linked to BEHAVIOURS and EMOTIONS where students do not have dicscussions in PRACTICE and THEORY in view of the fear that they will face negative repercussions.

Theme 3: Role Models and Relationships		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
Student-student	You need at least one therapy session a week [laughs]... just talking about what happened on placement and what did not happen...I feel that it is very important to talk to people that work like you.	RELATIONSHIPS with other STUDENTS can be a source of peer-support in PRACTICE settings. However, some STUDENT-STUDENT relationships were demotivating in view of the ATTITUDE that the other students have towards nursing, such as not wanting to be a nurse.

Theme 4: Humanity

This theme lends itself to a care ethics and patient rights approach. Although most students found ethics complex, they found it quite easy to give examples of ethics when relating to patients as human beings. This theme reflects the concept of human vulnerability and dignity. The patients' rights and holistic care perspective is discussed in this theme throughout this chapter. The generation of codes is highlighted in Table 5.5.

Table 5.5

Codes and Related Datum for Theme 4

Theme 4: Humanity		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
Holistic care	I saw that I was increasingly noting aspects that in first and second year I did not think about...holistic care...even ethically.	Students refer to HOLISTICALLY CARING for HUMAN beings by taking into consideration social and psychological aspects of care. The idea of caring for a person as a whole. This became more important as students progressed in their training.
Vulnerability	The nurse spends more time with them when they are vulnerable, long shifts and when they need something they go to the nurse. Example nurses change a nappy which is very	Students refer to the VULNERABLE HUMAN condition of the patients that NURSE-PATIENT relationships are part of. Patients are seen to be more

Theme 4: Humanity		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
	degrading...they are embarrassed, or they are in pain and crying...vulnerable.	VULNERABLE than others which motivates students to act ethically.
Dignity	With ethics I understand that you do not look at a person as just a person, but you give them the dignity and you treat him as a human, you look at their rights and you show some emotion towards the patient, not just bed 22...that is what I understand with ethics.	The idea of caring for someone as a HUMAN by adopting VALUES that promote patient dignity, whilst showing EMOTION towards a HUMAN being. This is also related to PATIENT RIGHTS.
Patient rights	Your decisions should always be what is best for the patient not what is best for you...	This theme relates to codes stemming from keeping the patient's best interests at the centre of your DECISION-MAKING. This theme empahsises patient safety issues and keeping the patient first in all decisions.

Theme 5: Professional Issues

Throughout the longitudinal interviewees, students referred to professional issues in relation to the exploration of the role of a nurse and what it means to be a nurse. This theme relates to the emergence of professional identity. Furthermore, professional issues that challenge or facilitate ethical behaviours and attitudes are included in this theme. A representation of the generation of codes is presented in Table 5.6.

Table 5.6

Codes and Related Datum for Theme 5

Theme 5: Professional Issues		
Codes	**Datum Supporting Theme**	**Researcher's Interpretative Summary**
Role of the Nurse	I was not aware that a lot of tasks are referred to other people. I think I liked the idea of nurses doing most things themselves. Along the years these tasks have decreased in view of understaffing etc and without wanting to, certain things have been redirected. At the same time, I think that the more of these tasks that we give away, the less patient contact you will have	Students perceptions of what the ROLE OF A NURSE is changed during their training. This is attributed to the development of the nursing profession that students might not agree with. There is refernce to shifting away from HUMANE care and focusing on PROCEDURES.
Professional identity	people look at nursing like something that has no value compared to other professions At the end of the day you are Student H the nurse, not simply a nurse, so what affects you outside of work, if something happens to someone, even though you are not at work you will help. If you have that knowledge, you do everything to show and apply it.	Students percieve that society thinks that nursing is not as valuable when compared to other professions. This is not backed up by critical REFLECTION about this issue. By their third year of studies students feel like a nurse. They assimilate the PROFESSIONAL IDENTITY of nursing which translates as part of who they are at work or outside of work by sharing their knowledge with the rest of society.

Theme 6: Complexity and Ambiguity

Throughout several interviews, a common theme referring to ethics as a complex, difficult and somewhat ambiguous topic to learn and to apply, emerged. This merits a separate theme in view of its impact on education and student development. This complexity was frequently expressed during interviews, through specific phrasing used, including *maybe*, *I am not sure*, *I think*, and *might be*, thus, suggesting uncertainty. This theme is based on two

codes; dilemmas and decision-making. The generation of these codes is summarised in Table 5.7.

Table 5.7

Codes and Related Datum for Theme 6

Codes	Datum Supporting Theme	Researcher's Interpretative Summary
Dilemmas	You never learn like this, so once you graduate why don't you do things the same? There is a lot...you see a lot of things that you learn about, but they do not happen that way.	DILEMMAS are often associated with the THEORY-PRACTICE dichotomy. Students perceive dilemmas to be very frustrating withs students questioning what the truth is in relation to nursing practice, what the theory says or what is observed in practice. There is also a dilemma between a student nurse and a real-life nurse after graduation.
Decision-making	There will be situations when there will be tough decisions or situations that are uncomfortable and you need to take certain decisions that are difficult. So ethics helps you to fall back on, as a guide.	Ethics is viewed as an on and off switch that you can apply when one needs to make a COMPLEX or tough decision. Students do not mention that they themselves participate in ethical DECISION-MAKING.

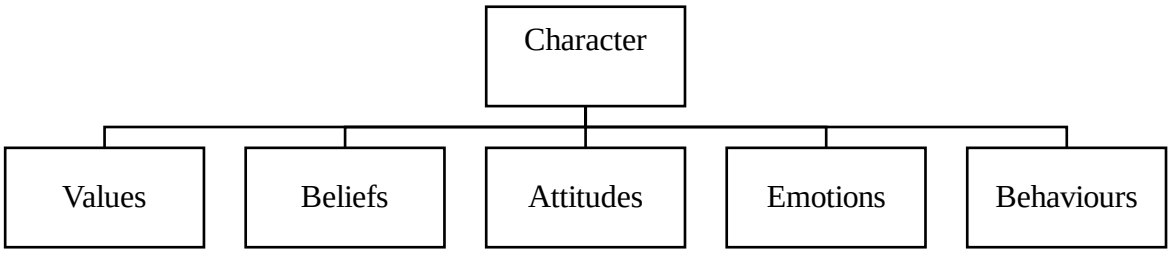
One of the main aims of the qualitative research interviews was to explore the students' understanding of ethics. The following themes provide a discussion of student perceptions regarding ethics. Throughout the interviews, all students struggled to define the term *ethics*. However, through further questions and provision of examples, participants were able to coherently describe their understanding of ethics, and it was possible to obtain a clearer understanding of the student's conception of ethics.

5.2 Character

This theme consists of the following codes and categories identified in the diagram below.

Figure 5.1

Theme 1 Character



5.2.1 Values

A value-based approach and virtue-based approach emerged through the research throughout the three years. In the interviews, students did not seem to make an explicit distinction between values and virtues. Most students had the highest references to values during Year 1, apart from Student F, who referred to values much more often in the second year of studies. This decreased reference to values from Year 1 to Year 3 could relate to the higher emphasis on knowledge and facts as student progressed along their training. Student G and C give examples of how the practical setting and the theoretical lectures targeted more practical and technical skill-based knowledge compared to their first year of studies:

> *I do not think so (learning ethics) ...last year was more focused on ethics. This year it is more like just do the skills...you do it as you should and ready*.
>
> (Student G2)

> *Now because I had my assessment and when I evaluate how the system works, it looks ironic...I found myself constantly stuck to the patient file because I want to be up to date and write everything. However, maybe it would have been more of value if I had more time to go near the patient and talk to him, in reality.*
>
> (Student C3)

In relation to values, there seems to be various perceptions as regards to the meaning of values. Some participants referred to principles of bioethics, others referred to behaviour along with values. These approaches are referred to in combination, supporting a multifaceted approach to understanding. When the students referred to values, there was a general belief that values belonged to an individual and vary from one person to the other, with an emphasis on subjectivity. This subjectivity, as a perspective, suggests that no values are in themselves right or wrong since it depends on the individual. Student I3 states "*Ethics, I think are values that are your own…because not everyone sees things the same way."* This is also supported by student B1 who sates that *"I think it is morals, how I see them on my own",* student G2 ***"****I think the values of a person as he portrays them to the person/patient, so yes, his own values",* student F2 "*kind of like values that you believe in not like everyone else's"* and student H1 "*Certain values are part of you*". When students were asked if they use values or theories in nursing practice, and to provide examples of how values can be applied to nursing practice, they did not refer to theoretical knowledge, but focused on examples from practical settings, as Student A3 states *"I do not think that I have ever practiced and said 'ah this is that theory'…I think that I follow more values than theories…for example respect, dignity, privacy, and beneficence".* This is supported by student G3 when she mentions that she applies ethics when she uses values *"I think to apply ethics I use values, instead of the ethics on how things are supposed to be done".* Students seem to have a sense of familiarity and understanding when it comes to values.

The values that students mentioned are selflessness, loyalty, equality, honesty, care, respect, empathy, and compassion. The most referenced values mentioned are empathy, compassion, respect, and care. These values are well-known to be also an integral part of nursing education along the years. Thus, the emphasis on such values might stem from a subconscious understanding or passive assimilation of theoretical sessions, even though students do not believe that theoretical approaches or lectures were relevant to their understanding of values. Students believed that these values are not necessarily taught during nursing but can be inherent in one's way of being such a *"character"* (Student G3) or adopted from one's upbringing as Student B2 explains ***"****I think I grew up with values from home, you start from nothing, and you learn on a daily basis from you family and that is the normal or what is right"*. Student H3 also refers to values as an inherent way of being by

stating that *"In everyday life, values are not simply at the place of work. Your behaviours outside and at work is the same. It is not something that changes"*

5.2.1.1. Empathy and compassion

Empathy is deemed to be a very important value that one should have, most examples relating to nursing practice. Students perceive empathy as the understanding of another individual's perspective by placing yourself in their context. Students believe that placing yourself in the context of another individual, helps in making what they believe would be the right ethical decision, as Student H2 summarises *"It is very important to understand the patient and put yourself in their situation. And say if I was instead of this patient how do I want to be cared for?".* Showing empathy also humanises care, and helps students shift away from their personal opinion about a matter and consider what others might be experiencing. This is similar to student perceptions of respect, when students acknowledge other people's opinion and care for patients in a respectful manner. Empathy is also linked to care by having to deal with a demanding environment and constantly being rushed at work or having patients who you meet for a short time. Therefore, nurses can get lost in this context and forget about these values:

> *I think empathy. Because if you are not empathic, you will see the patient as a number and will not provide the care that the patient deserves…I believe that you should treat the patient as if it is you who are a patient or your family members and ask if you would like to be treated that way?"*
>
> (Student I1)

> *That you are caring and empathic and you try to understand others, because otherwise if you only think that what you say is good [it is not right] ... You need to see what the other person is feeling, if they have a query or if they are in pain, you cannot say that it is not true, you need to understand that person…I think it is very important"*
>
> (Student I1)

Compassionate, that you try to understand others. So, if a person confides in you, you do not need to tell them that they are right or that they will get better; you do not use statements that for him will not be helpful. So, it is better to listen and remain quiet. Or else you agree with them, sometimes just saying that all will be better will not help and sometimes they do not want to hear that because they are concerned with how they are feeling now…so you listen and agree with them and tell them that it is true that it is difficult…"

(Student A2)

5.2.1.2. Respect and care

Respect is also viewed as a motivator to carry out nursing tasks, not only caring for patients simply because you want to or to gain positive clinical feedback but going above and beyond in a respectful manner. Student G3 and E2 refer to respect towards others and basing their care on this value not because they require positive feedback from their mentor or family members.

Respect…Respect towards other people and respecting everyone, you cannot just show your opinion, you need to see what they think. Not only my view but also the family and nursing.

(Student E2)

I can now say that I left the room and did everything well with respect towards the patient, not for my final or because my mentor will give me good feedback. (Student G3)

Student C2 further commented on values as a way to ground practice, in view of the busy and hectic environments that nurses work in *"…that you stay focused on care and empathy, and you do not get lost in the craziness"*. The reference to care is also highlighted by the same student in year 1 *"Just caring for those who need it, because I am currently in a ward where patients come with immediate problems and leave quickly"*

5.2.1.3. Honesty

Honesty is viewed as a value that is necessary for a good nurse-patient relationship. One student further mentions the challenge that can arise in being honest with both the patient and his relatives, whilst respecting the patient's wishes. Another student also mentions patients who might be disrespectful towards nurses and being honest about their behaviour and trying to talk to them about it. This is associated with being genuine with the patient without trying to skew the situation towards your own interests:

> *That you say the truth, I believe that it especially applies to nursing as well. A value that I am trying to learn when I do not know something, I say that I do not know and not try to twist it in my favour.*
>
> (Student B1)

> *I think honest, that you are honest with the patient, not only what his family wants but what he wants is the most important.*
>
> (Student F1)

> *Truth…honesty the most…that you are honest for me is very important because if you do not have that in any relationship you do not have anything. You need to trust, and he trusts you…and if something bothers you in someone you talk to them…even with patients if they are rude with you, you tell them that they should talk to you more politely, we are trying to help you, so you help us as well.*
>
> (Student J1)

> *Those nurses that are honest [ethical nurses] and talk to the patient in a genuine manner.*
>
> (Student J2)

5.2.1.4. Equality

Students seem to be very concerned with equality in patient care. They passionately mention examples of inequality that deem to be unethical. These examples relate to

discrimination of patients based on socio-economic reasons and race. One student further highlighted certain inequalities when working in a private hospital. He expressed that within a private hospital, nurses are providing care to those who can afford it, but not necessarily to those who need it. This also reflects the healthcare system in Malta, in which public hospitals and residences do not charge for the care provided, but they are financially sustained through public funds:

> *They [nurses] told me that in Malta that is how it works…that is life, if you are in the lower part of the chain; we write you down as not for CPR and if you are someone superior, we write you down for CPR [describing a not for CPR note because someone was considered a to be a social case[5]].*
>
> (Student A3)

> *A patient like all others, because she was different, they [nurses] were scared that she will have a contagious illness. I used to treat her [refugee of African descent] like other patients.*
>
> (Student F2)

> *If a foreign patient or a patient of different colour, I do not see him differently than someone who is white or Maltese. This makes a difference to some[nurses], even the way they talk…if you are giving handover, they do not mention the patient by their name by saying "that black one". Obviously, you realise that this person is not being equal*
>
> (Student F2)

> *I think that at some point I might think that it is a bit ironic that I am working here [private hospital], but in reality, the idea is of health care…but here only those that can afford it are admitted not those that need it the most. If this stops me, I do not know, but I think about it.*
>
> (Student C3)

[5] Social case is a discriminatory term utilised in healthcare to describe a patient that does not necessarily have a health reason for being in hospital but cannot go home in view of their social situation

5.2.1.5. Loyalty

Loyalty towards the patient is necessary for students to act as patient advocates in view of the patient's vulnerable situation. Loyalty is also considered to be a value that one should have to work with the healthcare team. Being loyal in viewed as being someone who is dependable as student F1 states: "*You have to be loyal to the patient and you advocate for him because he will not be able to do anything"*. Student A1 further mentions that *"family situations have taught me what is loyalty"*, linking again to upbringing in learning values. Student F2 relates to loyalty between colleagues as well, not just with patients:

> *If someone asks for a favour you are loyal to them and you do it, you do not say yes and forget. For example, she [person who asks a favour] goes for break and as her colleague asks you to check a blood glucose level, you say yes and you forget or do not bother.*
>
> (Student F2)

5.2.1.6. Selflessness

Being selfless can be contradictory, although some students believe that to be a good nurse you need to be selfless and put the needs of others before your own, even ignoring emotions or own situation to help others. Another student mentions a challenge in doing so. The student mentions that one is unable to completely ignore their own needs but at the same time states that for someone to be ethical they need to be focused on the needs of others. Thus, finding the right balance between the needs of others and your own is necessary:

> *If there is someone that is in need, I will close my eyes to what I am feeling and say that I am doing this for a reason that is bigger than what I am feeling.*
>
> (Student B1)

> *Nursing is having a role of a leader and advocate...putting others before yourself means you are being an advocate for the patient.*
>
> (Student B3)

I mean you cannot ever be completely for someone else and ignore yourself, but for a person to get you to say that they are ethical, they need to be quite focused on the needs of others.

(Student C3)

Most students felt that their values are reflected in their nursing practice and that these values are relevant to both their professional and private life. This might suggest an assimilation of nursing values in personal life. This can be related to believing that values are part of who you are as a person, irrespective of the role that you are currently in. One student mentions that the values she practises at home might not translate in work. However, this changed in the third year of studies:

The values that I practice at home do not come naturally to do them at work.

(Student H1)

I feel like I do practice the same values in life with my friends and family.

(Student D2)

I think that my values agree with nursing. Because that is how I see nursing [according to her values].

(Student D3)

I think for the most part, yes [nursing] reflects my ethics and morals…my morals in a natural way.

(Student C3)

…So you will then see you own values and do what you have learnt.

(Student E3)

Through the experiences expressed by the students above, there seems to be a general understanding that values are a part of who you are, some of which being considered as virtues rather than values. However, students do not mention or distinguish between the term virtue in their interviews. This indicates lack of knowledge regarding the differences between

virtues, values, morals, and ethics. Student D2 also stated that *"with values I understand ethics…I constantly use these [values]".* Thus, in this summary of findings, the term *values* was chosen to adhere to the language that students had used in the interviews. However, in the interview schedule, students were asked to describe any "values or theories" that help them in practice or are important to them and this could have influenced their responses. Moreover, having no knowledge of the term virtue could mean that students do not have the cognitive basis for understanding virtues and that the educative journey does not utilise ethical terminology.

5.2.2 Beliefs

The category of beliefs encompasses student beliefs in relation to character traits and their own nursing practice. Interestingly, Student H1 refers to ethics as a way of attempting to find a balance between illness and positivity, by expressing *"the same way that there is illness, there are also good things...there is a balance and ethics helps you find this balance".* This belief was not iterated by other students. However, there is reference to good and bad, right, and wrong as discussed in relation to practice in section 5.3.2. There was also mention of morale, where students believed that some nurses or individuals might act unethically because they are demoralised at their place of work, and they believe that such individuals also influence those around them. Student C1 expressed this by stating that *"they take from that positivity and that energy to make a difference",* whereas Student G2 argued that *"honestly they are tired of the job".*

There was a very common belief amongst students that nursing has contributed to their development in relation to appreciating life, their maturity and personal growth. One student also referred to the COVID-19 pandemic and working in such situations as helping her appreciate her family and her health:

> *Nursing exposes you to many diseases so you increasingly appreciate that you should take care of yourself… COVID irrespective of how bad it was, you realise what matters in life..."*
>
> (Student J3)

Most of the comments regarding appreciating life are common in Year 2 and Year 3 of studies, which can be linked to increased exposure to practical settings. Student A2 states: *"I think you mature a bit as well, the fact that I matured provided more insight into things...for example appreciating life a bit more".* Student D3 supports this by saying "*you are appreciating that you are a healthy person, and you are here to help the sick. So, appreciating life and that you are healthy helps because you feel mercy towards the patient who is ill".*

The above quotations reveal experiences of some students who believe that nursing is helping them become better people, and through their nursing experiences they will become increasingly open-minded individuals. This is summarised by Student G2 when she states that ***"****It [nursing] really builds character".*

Moreover, there are 20 cases with 51 references towards inherent or natural character traits in relation to ethics. As student J3 states about applying values and ethics *"I find it natural to always do this so…".* These inherent character traits are mostly linked to upbringing and on one occasion to the Roman Catholic religion. Since students believe that values and character traits are inherent, they also believed that they did not really learn about the above mentioned, but they are inherently found within themselves. This was iterated along the years and did not change for students. As Student C2 expresses:

> *I think I use it [ethics] subconsciously because without wanting to everything I do, I evaluate... I do not actively think about it. But I think the human brain, without wanting to, uses ethics in everything we do. But most of the time I am not aware of what I am doing and of my subconscious.*
>
> (Student C2)

> *It comes on its own… I think values are not something that you need to work on…Ethics…I do not think it is something you practise...it comes on its own.*
>
> (Student H3)

> *I do not think that I was necessarily taught ethics etc... I think more my own as an individual.*
>
> (Student C3)

However, although most students believe that ethics or values are inherent character traits, some also refer to having an intuition about what you should do. Further to this, Student C3 expresses that there is an element of development associated with ethics that is related to age. Student B3 and E2 also mention that they already knew about values and were already adopted as part of who they are, and thus did not believe that this aspect needed further development:

> *I think just daily living and I think that without wanting to, I am not sure if it is just me, but I imagine that everyone is like me and naturally, apart from the more we grow, the more we learn what is right and wrong.*
>
> (Student C3)

> *During lectures we mentioned a lot of them [values], but since they were inherent in me, I did not feel like I had to learn them in order to… kind of what I was doing was already in line with it so I did not have to learn it.*
>
> (Student B3)

> *Because some of them [content in ethics lectures] you would have known for a long time, such as how you should interact with people.*
>
> (Student E2)

Furthermore, some students believe that there is no cognitive aspect to ethics because it is not something you think about. As Student A2 explains: *"you kind of do them [ethics and values] without thinking about them".* This is supported by Student B2 who mentions *"I use it [ethics] naturally and not because I think about it.* Student I2 also hypothesised that once you start working, ethics will happen naturally, thus possibly viewing ethics as something related to graduated nurses and not to students. Student I2 states *"once you start working, I imagine that it [ethics] comes naturally".*

When students were further prompted regarding how they learnt about values and how these have become part of who they are, all students referred to upbringing and one

student referred to religion (Student C). With Student B and Student G having the largest number of references related to upbringing. Most of the participants within this study still lived in their parents' household, which is very common in Malta at such an age. Student C referred to religion and stated that although he is not religious, religion was present in his upbringing with his mother being very religious, and this imparted certain values that he has held onto.

5.2.3 Attitudes

Most students understand ethics as reflecting their own attitude and perception of how they, or other nurses, interact with people. The predominant, positive attitudes mentioned involve having a kind approach and being strong. This contrasts with having a sense of hopelessness which is perceived as a negative attitude that students experienced and that they observe in other nurses. Student B2 also describes attitudes in relation to context and how one is expected to act in such a context:

> *Ethics requires that you are decent in front of people...if we are during this interview for example, ethics requires that I do not shout to be heard...the way in which every person should act.*
>
> (Student B2)

> *Even in their attitude you notice...you can compare the attitude of people.*
>
> (Student G3)

In relation to strength, two students refer to compartmentalising, being less sensitive and being strong in the nursing profession. Student B2 expresses the importance of strength to not succumb to peer pressure in unethical or incorrect practices; *"You need to be strong so that you do not follow others",* whilst Student H1 refers to strength in relation to patients and clinical experiences; *"I wish that I become stronger, when you are sensitive it is quite difficult in this field"*. Some students also refer to others and themselves occasionally being discouraged in nursing. Student G2 expresses her opinion on the attitude of some nurses; *"Sometimes, there are people who discourage you...you see them coming in in the morning and they cannot wait for the day to pass...I would want to hurry up and go home"*

5.2.4 Behaviours

Behaviour was a highly referred to code in view of students finding it much easier to provide tangible descriptions of action when they talk about ethics. The predominant code was that of helping and communication. In relation to helping, students talk about nurses being present during the healing process and contributing along the way. As Student D2 states: *"My aim should always be to help".* Students also felt that helping patients was very satisfying in their work and it was one of the main reasons why they chose nursing and why they remained motivated to continue this programme.

An observed behaviour that was linked with nurses who are unethical, related to working only for renumeration and doing only what is necessary. Students think that nurses that are ethical, do things and act because they want to do so, and they want to make a difference in the lives of the people they meet. Students do not refer to instances when they are unable to help or when they do not make a difference in patient care:

> *The satisfaction that you feel when you are helping someone and making a difference…you cannot compare it to anything.*
>
> (Student F2)

> *The fact that at least you are making a difference and helping someone, that is that drive that keeps me studying and graduating.*
>
> (Student C2)

Furthermore, there was significant reference to their own behaviour as students when they observed unethical practice. This discussion resulted after students provided examples of what they perceive to be an unethical situation or behaviour. Several students said that *"I will not get involved"* and *"I will not speak up*". This might indicate that students are afraid to voice their concerns and do not have the confidence to talk about ethical issues. Most students believed that this behaviour would change once they graduate.

> *Most of the time we [nursing students] see things that are similar and say, 'My gosh!' and we notice that no one speaks up, but it is a common factor that we do not speak.*

At that time, I was shocked…and I kind of wanted to tell her but certain nurses would have been like this for a long time. And I feel like…she [nurse] would say 'instead of being thankful that I let her stay with me' (I am unmentored at the moment) ... kind of she is letting me observe, I will not butt in.

(Student J2)

When you are in the first year it is worse…even now I know it bothers me. There is nothing to do…I say in the future I will not act like them.

(Student I2)

There is nothing that you can do, I will not tell the nurse 'Do not shout'...

(Student H2)

Sometimes I stay back because I am still a student and I do not want to intervene.

(Student F2)

However, they also observe this behaviour amongst nurses who have graduated, and they highlight that no one speaks up about unethical practices. This can signify that students and nurses are concerned about the repercussions on themselves if they speak up about such instances as described by Student J2: "*Most of the time the student is scared that the nurse does not take it well or angrily responds [to the student]".*

Behaviours that were considered to be characteristics of ethical nurses or that students believed constitute someone being ethical, relate to communication, patience, respecting diversity and being an advocate for change. Communication, patience, and respecting diversity are consistent throughout all three years of study. As student E1 states: "*In nursing, communication is the best..."* Being a change-agent features in Year 2 and Year 3, possibly indicating that students are becoming more aware of the changes required, or else the changes that they wish to make in clinical practice:

Even the way the nurse speaks, you will notice if they are interested…If there is something that you can do, or something that you can keep on monitoring, you try.

You do not just go in [the room] once in the morning and during the day, that is it. You need to give him [patient] your time and attention, kind of active communication.

(Student G1)

Even the way you speak, like you are at the beach very casual, the way you speak about things... [observes this as unethical].

(Student A2)

In relation to bringing about change, students felt that it is an important aspect to have if one wishes to be ethical. However, they did mention that most of the time they do not observe a lot of change happening. Further to this, Student H2 also mentioned that it is useless discussing ethical issues because nothing will change: "*As I said there is no one to talk to about this [unethical situation] and that will possibly lead to improvement, because either way that is what will continue to be done".* This is similar to what student C2 and A2 explain:

What is not right or what can be done better or more efficiently, even if not regarding morals, ideally you have an opportunity to change or see how the system can work better, but I do not know if there are any places that have systems available to change things.

(Student C2)

It seems like everyone knows what the faults in the system are, but no one tries to change them.

(Student A2)

This perception might stem from the lack of awareness that students have on how healthcare systems work and how this change can be achieved. This could also be related to the emphasis on negative aspects, such as change that did not happen, but it is not necessarily that change is not happening but that students are not aware of the daily changes that might be happening. This can be either because students themselves do not experience change, they are not involved in situations that require decision-making or they do not have an awareness of the positive changes that are happening around them. It could also relate to the idea that, as a student, one should just passively observe and only think about their own behaviour in

isolation of the rest of the healthcare environment, as an annex to the rest of the healthcare team. Furthermore, being a public health hospital, in small Mediterranean country, can contribute to a *laissez-faire* behaviour at the place of work, with minimal action taken for good or poor work performance.

Assertive behaviours were also associated with ethical nurses and students aspiring to be assertive and make respectable clinical decisions. In Year 2, Student I says that "*If [she sees] a good nurse that knows what she is doing, she will teach [her] well".* In Year 2, students also felt more assertive in their own behaviours, stating that they trust themselves more in practice. This progression is summarised by Student E, who suggests, *"At school [university] they teach us, when you come to practice, you practice under supervision. They teach you, but you know what you are doing more, you trust yourself and you get to know who you are".* In Year 3 (Students B, A, I, E, F, H, J), this notion developed into being able to work independently, with students mentioning that they are experiencing an increase in responsibility and decision-making. This has provided students with an active opportunity to understand nursing practice. Student A expresses, *"I believe that I am the person responsible for the patient and certain things you notice more, when the patient is someone's else's and I just come and go I do not understand what would be happening".*

Two students (H and G) mentioned the need to separate your personal life from you work life by creating boundaries, Student G describes this as not "*going over the limits, your own limits and those of the patients, you help as much as you can but without crossing these limits"*. Student G further describes that *"You need to set boundaries between your work and your personal life".* Students H and G also commented on nursing being a very demanding profession that does not leave enough free time to enjoy hobbies and other activities.

5.2.5 Emotions

The category of emotions was compiled in the second phase of cycle coding. Emotions were referred to during 16 interviews, with most emphasis on negative emotions such as fear, frustration, guilt, anger, hurt and stress. This is understandable since negative emotions would leave a greater impact on individuals. The predominant emotion was that of fear. Fear was frequently mentioned during their third year of studies because students are afraid of working independently and not having any guidance. They acknowledge the lack of

staff in healthcare settings and are concerned that they will be faced with decisions that they need to make without the necessary guidance and preparation in relation to ethics. As Student B3 explains: *"our biggest fear is that we would be on a night shift as a reliever and there wouldn't be anyone from the ward or the ones on the ward are your age...with panic what are you going to do about these questions? My fear is that I do not handle it the way I should handle it".* This quote also suggests that students can be afraid of making mistakes as soon as they graduate or making the wrong decision.

Furthermore, students also referred to being fearful of not continuing to work in the same way as they do as students, by doing everything as they should. This can be interpreted as practising according to evidence from literature, which is what is emphasised during undergraduate education. Most students seem to suggest an erosion of good practice after a nurse graduates, that increases the longer that one remains in this profession. For instance, Student B3 explains: *"It is a fear that I will not continue working as I am now...because I do not know anyone who has been working for years and does everything as they should and exactly like when you are a student..."*

Emotions related to unethical behaviour or practices included anger, frustration, sadness, hurt and feeling flustered. As Student G2 mentions: *"honestly I was hurt, as if they said it about my relative...because you would have been taking care of the patient for a whole day and you couldn't care less if this patient remained alive or not".* Students A, H, J and C expressed their frustration about their observations of unethical practices and their powerlessness in doing anything in such situations, and Student C further expresses the sadness of seeing nurses aware of the situation they work in but still do not, or are unable to change it:

> *I think at that time we are a bit frustrated about the unethical things that we see…after we start saying it is better like this or this…so in a way we kind of learn and say this is how it should be done.*
>
> (Student J2)

There weren't a lot of these situations [unethical] but after this I was quite annoyed because there was no reason why we should not give this treatment and afterwards lie about it.

(Student C3)

At that time, I felt really angry and frustrated that I could not do anything.

(Student H2)

Frustrated because I keep visualising that patient.

(Student H3)

What really flusters me is that these are basic things, not because you want to go against the current, but the current is much bigger than you and it is difficult to bring change...sometimes even when I am in a ward and see these things [unethical] I feel shy, I think to myself 'this is how we do things?'

(Student A2)

In the previous section, students commented on how bringing about change is a quality of an ethical nurse, whilst here they are commenting on the difficulty of bringing about change that can be a reason for these negative emotions.

Some students referred to feeling overwhelmed with nursing practice. Student B3 also states that because nursing is so tiring, it is much more likely for someone to act unethically: *"Nursing is a tiring job, so it would be nice if you can do things in an easier manner, and I think that wish to relax a bit gets in the way of the patient sometimes".* This idea of an overwhelming sense of tiredness is supported by the following students, with Student H2 sustaining this idea quite strongly along his years of study and Student E2 feeling overwhelmed as a result of a clinical experience:

I think I was overwhelmed with this boy… 7 years in a coma...I felt it too much the fact that he cannot do anything.

(Student E2)

The hours that nurses work are too long. Physically and mentally it tires you out. You do not have time to enjoy your hobbies, just work work work and your life is only nursing and not nursing is part of your life.

(Student H2)

When students reflected on their own actions in relation to ethics, the emotion of guilt featured as either a motivator for working ethically or as a result of unethical practice. Three students sustain this:

…so this motivates me more. I do not want to leave the patient room and feel guilty because I did not so something properly.

(Student G3)

They [nurses] tell you do to this [things that are not supposed to be done] and I feel guilty doing the same things that they do.

(Student I2)

Sometimes, without wanting to, you get a bit annoyed, although I know that the patient's condition…they cannot move…and constantly in bed not wanting to do anything…pretending [that everything is done for her]…at the same time we should challenge her and I try to tell her listen try to get the glass yourself…at least she moves a bit…but she is constantly calling me…and I feel very guilty and I say let me help her anyway...because I feel too guilty.

(Student J2)

The latter experience depicts a situation where the student was trying to rationalise her actions and thinking about what she should do and relating to her emotions during this situation. The decision she made is thus, informed by her cognition whilst considering the affective aspect of this context.

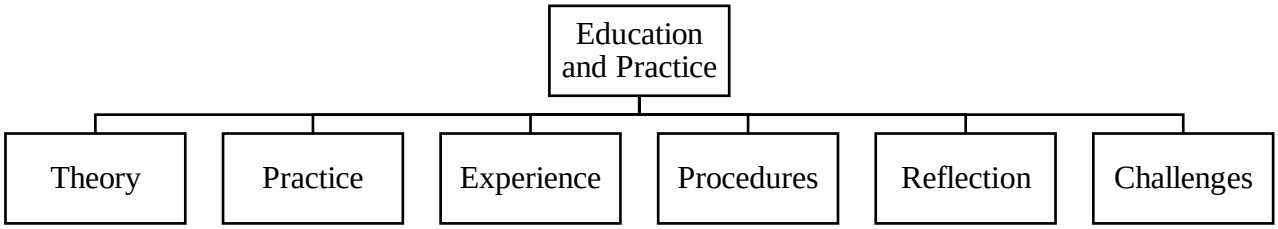
5.3 Education and Practice

The theme *Education and Practice* includes the sub-themes identified in the Figure 5.2. The following sub-themes discuss the different aspects of knowledge that students

referred to. Most commonly, students compartmentalised knowledge into different categories with a clear differentiation between theoretical, practical, experiential, procedural, and reflection.

Figure 5.2

Theme 2 Education and Practice



During the interviews there was also a considerable amount of confounding statements, with students stating that they do not apply ethics in practice, yet consequently giving examples of ethical or unethical behaviour when asked as highlighted in the quotations in table 5.2 below.

Table 5.8

Applying Ethics in Practice

Student	**Datum example of applying ethics**	**Datum example of ethical behaviour**
Student I3	When I can…I think not very often…	I think that when you are ethical, you respect the decisions of the patient and the relatives, you do not just go ahead and do things
Student G2	I do not think willingly [applying ethics] …knowingly? I will use it…but I am not using it... does it make sense?	This patient always refuses treatment and I like to ask her beforehand, because I communicate a lot with this patient
Student H2	Things just come naturally	If the patient needs something, they look for you because they know that you will

Student	Datum example of applying ethics	Datum example of ethical behaviour
		show them and explain what is happening, not just do your work
Student F3	Personally, I think it is quite difficult. Because sometimes I think, would ethics be relevant here and I do not even know?	When you are near the patient, you see how they are feeling, do things so that he feels better and you become increasingly caring
Student E2	Not really, it doesn't really come to mind [ethics in practice] ...I think if there would be more awareness on it, I would think about it more. You would know more about ethics and what is happening...practical examples	You would say because he has this and that, you friends in the course or those outside. Imagine in emergency you see everyone, imagine in Gozo, you see something happening to your friends…you do not talk because Gozo is small, even information on the telephone you do not say it

This indicates that although students are not able to define or believe that they do not apply ethics in practice, they are giving examples that highlight good ethical practice. This suggests a gap in their knowledge regarding ethics and awareness of its application in practice, or otherwise. In terms of their understanding of ethics as well as their ethical development, students seem to combine different approaches to ethics when trying to define their own understanding of ethics.

5.3.1 Theory

Many coding references to theoretical knowledge were related to Year 1. Year 2 and 3 still consisted of coding references to theory, but to a lower extent. This can be related to the introduction of the ethics study unit during the first year of studies. In Year 2, students referred to their first-year study unit as well when discussing theoretical knowledge. In Year

3, students had a further study unit on ethics and the references relating to Year 3 relate to this study unit.

Most students do not believe that lectures had a significant impact on their knowledge of ethics. Student I3 mentions: *"Maybe a bit from the lectures but not from lectures [laughs]...The study unit has no sense, everything from memory like a parrot...you study for the exam and that is it...I really did not learn anything from it"*. However, later in the interview the same student expresses the following: *"In first year I really did not know...maybe because you listen to the lesson twice you understand a bit more..."* This is an example of how students do not think that theory has an impact but refer to theory in later discussions. However, similar statements regarding the lack of understanding from theoretical sessions are written below:

> *I do not think that there was a lot of education [about ethics] from theory...I could not understand what the lecturer was talking about...I couldn't understand the whole concept of it [ethics].*
>
> **(**Student E1)

Further to this, Student E1 explains that what she would find beneficial is if the lecture material was ready beforehand and she could read and look up information prior to the lecture as well as having more resources provided that are of high quality. The student felt like she did not know what recourses were good or not, since she had to look up on her own regarding a topic she knew very little about.

Student G2 mentions: "*I am a bit sorry that this year we did not really talk about these things [ethics]. Last year we had more topics in terms of ethics...I used to enjoy that during certain lectures some talk about cases and we have a class discussion about what would happen and what we would do...this year is more this is the syllabus and that is it...full stop. It doesn't make much sense at this point".* Furthermore, she expresses that because they are a very large group, class discussions are very minimal. This is referred to by several other students. Students preferred having case scenarios and interactive sessions in small groups.

> *The lectures I did not really like because they were boring, but the PowerPoints were interesting and I enjoyed reading them, because even the case studies were*

interesting...I think if they were more interactive I would have learned more...or sometimes the lecturer used to just read the PowerPoint with a paragraph of a thousand words...if you use an example, you try to participate without making it scary by using a microphone.

(Student I1)

Lecture... I get bored easily, so I find it difficult to concentrate. If the lecturer uses a lot of examples and videos, yes. Sometimes I relate what I learnt in the lecture to placements, but rarely…during the lecture there is time to discuss, if the lectures are based on discussion from practice.

(Student G1)

With the lectures we had during first semester, to tell you the truth we did not learn a lot, in fact to do the assignment it was a bit of a problem...the lecturer did not attend regularly, and it was a huge problem and I was not really interested in the way they did ethics, I learnt from reading online, from the internet, from the lectures I did not really learn...The way in which it was taught makes a difference, most lecturers read only from the PowerPoint and do not explain, being a large class doesn't help either.

(Student H1)

I think the whole atmosphere of a lecture, you would be sitting there for a long time, listening all the time. I am more of a person who writes and reads, as in if I stay listening only it goes from one ear to the other…

I think in ethics we were not really learning a lot of ethics, like how to approach people...obviously ethics is not that only, but we were learning a lot of book-based information and a lot of literature was based on models and they were not really engaging, and that is why I was not attentive.

The lectures in the beginning were quite boring, but sometimes there are sections that are interesting, and I would like to learn more from lectures in the coming years.

(Student D1)

The fact that instead of having 15 years of sitting on a desk listening only, and it is good to listen, but you lose interest and you do not stay engaged and there are very few lecturers who keep you engaged.

Something which is very tedious, not only in ethics, but in general, is that a lot of people read from the PowerPoint...If I see someone reading from a PowerPoint I will become even more disinterested because I can do that at home. If the PowerPoint could be ready and a discussion is created, it would be better...in small groups because as we are it is impossible to have a discussion.

(Student B1)

The basics of ethics I understood nothing...after we had some examples and I understood something...I learnt a bit from lectures and assignments, things that I never heard of before...this semester we had a lot of case studies, and they help you understand more and she [lecturer] enjoyed teaching us.

(Student F1)

There are times when I did not even attend the lecture because the lecturer reads from the PowerPoint. They should give us the PowerPoint and we prepare it from home and we than discuss in the lesson. They would ask us what we would do. Even the class it should be closer together, not like the auditorium you see the laptops of everyone and a whole day in the same lecture room...you get tired.

(Student J1)

The quotes above highlight the influence that the lecturer has on the delivery of the session, especially with regards to reading from PowerPoints and attendance to lecture sessions, as one student E mentions: "*This month we did 5 lectures only...it is too little, there is need to do all of them… if the lecturer was not absent*". Sustaining Student E's experience, Student F expresses that "*the lecturer rarely attended, and he did not really explain, and when he did attend, he left early...I think if he had explained better, I would have learnt much more".* The commitment of the lecturer, the delivery method and relevance of the session has a significant impact on how interesting the students find theoretical sessions. Most students commented on the length of hours they spent sitting down without being involved and actively participating in the lectures. Student B also refers to the previous way that he learnt

by spending years on a desk without being involved in the learning process, through a didactic method. Most students also commented on the environment that they are currently being educated in; that of large classes, during which students are expected to remain seated. During the first year of studies several students commented on lecturers as being role models. Despite this, unethical behaviour was evident by the lecturers who had not attended all of their sessions.

> *You have two hours a week, not sometimes you have a lesson and sometimes no, or you go for the lesson, and it doesn't happen. I can count on my fingers the number of ethics lessons that we had...*
>
> (Student A1)

> *I think the lecturer did not really explain and he did not really attend, when he attended, he left early… I think if he had explained well, I would have learnt more*.
>
> (Student F1)

> *I think if we had a lecturer that showed initiative to teach the subject well, it would be interesting. We were not informed when lectures got cancelled, it happened twice this week and I feel like I am wasting time.*
>
> (Student H1)

In Year 2, students did not have any specific ethics study units. However, they referred to the previous study unit as not having an impact on their development, because they were unable to remember what they did. Some students also referred to not having a good base of ethics or not understanding the concept of ethics. This may suggest that students do not really understand what ethics is and what its role is in the nursing profession.

> *Last year we had a study unit...this year we did not have anything...we had an assignment, but I do not remember what I did. If the impact of the lecturer was positive last year I would have remembered now because there are lessons from last year that I still remember.*
>
> (Student H2)

I mean we had law and ethics, so not any out of the ordinary ethics, I think. I mean this year we had nothing on ethics...so I think we had some lectures last year and that's it. They were not bad because we had a discussion and we talked between us...it is limiting that the class is big, but the lecturer still tried...Maybe that is what I learnt, it helps you think a bit more, kind of stopping to think more than you did before.

(Student C2)

I was not prepared well for this question [ethical question in practice] because I do not have a good base of ethics...base of knowledge, we did have lectures on ethics but maybe I did not have a good base of knowledge that I studied in my own time or read up some documentaries on ethical dilemmas for example.

(Student I3)

Even though students felt like they did not understand ethics, Student C2 did mention that the lectures prompted her to think more than she would have usually. This might suggest that students were looking at ethics lectures in terms of gaining or retaining knowledge rather than prompting thinking or awareness regarding ethics.

Further to this, some students commented on assignments as a method of assessment. Participants felt that assignments pushed them to further research about ethics and it was one of the key learning activities when it came to ethics. In fact, in first year, most students gave the same examples of ethical practice as that of the assignment. The use of other resources and books were beneficial for students to understand ethics. This can support the use of a blended approach to being educated in ethics.

From the lectures of first semester I did not really learn, from the assignment I did my own research and I learnt something, I think I learnt about the four principles? From the assignment.

(Student F1)

Example we had an assignment case study and I had to look up research and definitions of legal aspects.

(Student H1)

> *When I started the assignment and took some books to read, I started understanding... and I found an article with the same question as the assignment... when I read, I felt that ethics was not so difficult.*
>
> (Student J1)

Utilising assignments to guide self-directed learning encouraged students to look up further resources. This component of the study unit is an assessed component that was compulsory for all students. In their work, students also refer to legal aspects of a specific scenario. As Student J1 comments, once ethics was preceded by a context it was easier to comprehend.

In relation to knowledge, several students referred to the principles of bioethics by Beauchamp and Childress, laws, regulations and code of ethics as an understanding of ethics. This is congruent with the Year 1 study unit of law and ethics, possibly indicating that although students claimed that they did not learn from their first year, they, in fact, draw upon these lectures. Although there is reference to these theoretical perspectives when students understand ethics, in the examples that students provide and through further discussions in interviews, students rarely refer to examples from practice relating to the mentioned ethical approaches. This indicates that although the education system in Malta focuses on these approaches, students do not seem to identify with these approaches in their own practice or understanding. Student A mentioned the four principles the most and mentioned that she found it difficult to use the bioethical principles when they contradicted each other. Many references to these principles occurred in Year 1 and 3 during the ethics study units. As student A1 mentions: "*Since we focused on those four principles, autonomy, non-maleficence, beneficence and justice...and ethics, kind of those stuck and I always go round those four".*

Interestingly, students referred to lectures not related to ethics and not in the ethics study units as having a positive contribution to their ethical development. As mentioned in the quotes below, lectures regarding oncology and palliation, resonated well with students. In these sessions students understood the applicability of ethics in nursing practice.

I think recently we had a lot of lectures on how to provide support, not of ethics...with cancer patients. Those lectures made me better understand how to approach people in a good way.

(Student D1)

I think even from different lectures, not just in the lectures about ethics.

(Student F2)

We had some lectures on cancer and ethics goes in a lot with cancer, she gave [lecturer] examples from her own experiences and the student was part of the lesson and maybe the topic was more interesting as well because you see how disease progresses.

(Student H1)

Some lectures… example regarding cancer and palliative care, these people are living a normal life and suddenly they need to go to therapy. It is like things are changing and they do not expect them.

(Student J1)

From the above quotes, students are relating ethics to the context of palliation and due to this association Student H also believes that ethics relates more to cancer care rather than other contexts. Student J also comments on the life-changing circumstances of cancer and palliation. It is interesting to note that students do not mention any other lectures from other study units that can relate to ethics.

Two students referred to the code of ethics as a theoretical perspective to ethics. However, these students recognise its importance but could not understand what the code of ethics means. Student I1, for instance, mentions that *"half of the code of ethics [she] could not understand... it was very difficult what they were showing"*. The perspective of this student changed in Year 3, where she expresses that *"even the ethical code, I can understand it more now, because in first year you do not understand what they are saying".* The student felt that she could understand more because she could link the code of ethics to practice. This suggests an increased understanding and change of perspective in the students as they progress in nursing training. Student B2 highlights the code of ethics as a regulatory

document for nurses and sustains that the code of ethics is rarely followed. She does this by expressing that *"when you decide to leave and go against what you signed for [student thinks that you sign and abide by the code], the contract no longer has value, how much these are followed I have doubts…"*. The opinion provided by Student B2 might reflect the lack of reference to this code in nursing practice.

Several participants did not directly refer to the code of ethics but referred to laws and regulations. There seems to be an unclear understanding and differentiations between what is *law*, what is a *regulation* and what is the *code of ethics*. What is evident is that students see legislation as something written on paper and rules are related to organisational policies, whilst ethics is not necessarily pre-defined. Student F1 refers to "*legislation and hospital rules"* and Student H3 refers to a *"set of regulations".* Student C3 felt that the legislative part was not very relevant for him, and he felt that they were things that the university had to inform students about and that was it. Student J1 refers to laws as something that can have serious repercussion if not abided by unlike ethics, sustaining that *"…apart from the law… you will be in trouble if you make a mistake".* This was not the same for ethics, where Student J1 mentions that *"it is open to interpretation for different people".* One participant went on to further express that law and ethics are in opposition to each other. This is sustained by Student A1 who highlights *that "What is best for the patient…it has nothing to do with law, because they go against each other"*.

In relation to curriculum structure, students mentioned that between the first and third year they had the exact same lectures, with the exact same notes. Two students felt that this was very confusing and could not understand the reasons behind it. However, Student B felt that it was not so bad, because he could understand more in his third year.

> *That [ethics] we had a bit in first year, then we had like a refresher this year, but at the same time it was a repetition, it was a bit confusing whether it is something new or repetition or revision...I was not quite sure what the goal was...As I understood it was not the norm that in third year we have the same things as first year, so I could not understand...the message was not received.*
>
> (Student C3)

The ethics of first year and this year was basically the same. Everything repetition, even the notes were the same.

(Student I3)

I might be wrong...the same things were mentioned from year to year but growing up with the course, the same thing you understand slowly, slowly. First year I wasn't like that on ethics, second year we repeated the same things I felt…but in the end you start thinking that you are seeing another part of it now. In third year, we talked about ethics again, but not a lot…although the same things are being presented, we understand them more, maybe because we are on the wards more.

(Student B3)

The last quotation also introduces the link between theory and practice. Although most students felt that lectures only helped them slightly in learning about ethics, the students acknowledged that they knew right from wrong in nursing practice through theoretical sessions. However, this was not always apparent at the beginning of the interviews. Student A and B also highlighted their frustration regarding knowing the theory but being unable to translate that into practice.

...the patient did not have autonomy because he was not lucid enough to make a decision, it is not like when the patient is refusing treatment and he is cognitively aware... what will I do in this situation? You know the content but when it comes to applying it you are stuck...especially when you are new in it and you do not know how to handle it.

(Student A1)

They focus more on doing ethics so that you do your assignment rather than let me explain ethics so that you can see how it is used on a day-to-day basis on the ward…maybe that is what is missing" …" during a lecture, the lecturer can repeat it over and over, If I never try it, I will never learn it.

(Student B2)

The quotation above refers to Student B being able to understand ethics and was able to complete the assignment given for assessment but could not relate this to his nursing

practice, this student also highlights the need to practice ethics in order assimilate what he has learnt. Furthermore, two students commented on the effect of these research interviews on their ethical knowledge. Student F3 says that "*even with this interview, I kind of starting to give it [ethics] more importance. It was kind of the first thing that made me aware of ethics, this interview in first year and then they kind of continued with lectures and after I started noticing what was happening on the wards*". This suggests that through interviewing, the student was prompted to reflect on ethics and ultimately ethical practice through her clinical placements. This can support what most students commented on earlier, that is, the challenge of being a very large class without individual attention.

5.3.2 Practice

When students were asked about ethics in practice, all students mentioned that they think placements are where they learn the most. However, the majority said that they have not met any ethical issues or ethics in practice and believe that there is a lack of awareness regarding ethics in practice settings. This was relevant in Year 1, 2 and 3. However, when students were prompted to give an example of ethics in practice, most were able to do so. Students view themselves as observers in practice and very rarely commented on their own ethical practice, but rather commented on situations involving ethical practice that were observed. They believe that they learn the most about ethics through their practical placements, but they are unsure of how this happens.

> *I mean you will go on placement, and somehow the placement teaches you something because you see something happening and you say this is good...you kind of observe from practice and take what you want.*
>
> (Student C2)

> *I think placements were the most important. Again, I think that this year was the main year that I learnt about ethics...even throughout the other 2 years but this year placements were quite long...so you kind of learn more and you stay longer with the staff...I think just by experiencing placements...even lectures but placements are the main factor because you observe first-hand. Like clinical skills...you learn better because you practice.*
>
> (Student J3)

I think that the most important is always placements...because from placements you learn most about these things. Without practice the nurse...[well], practice is everything.

(Student I3)

I felt that there isn't a low of awareness on ethics, in practice 'let's hurry up to finish...we have a lot of work to do... come on let's do it'. It is not a priority, and it bothers me a bit because as I said even small things don't matter.

(Student G3)

When you observe things on the ward, they stay with you.

(Student F3)

From practice you get what ethics means rather than theory.

(Student H2)

By experiencing placements...even lectures, but placements are the main factor because you are observing first-hand.

(Student J3)

When students view themselves as observers and comment mostly on ethical decisions or contexts involving others, it can suggest that they are not actively involved in ethical decision-making in practice. This is further supported because when students mentioned ethical situations, they were asked if they discussed such issues with someone and most students replied that they never did, not even with their role models in practice through education. This is further elaborated on in section 5.4.3.

Students also believe that ethics depended on practical contexts. In contexts where patients are not present for a long time, students believe that one will hardly use ethics, unlike contexts such as hospitals, mental health settings or long-term care facilities. Although, Student H3 expressed that *"The mental health hospital was where I learnt the most, it could be because there I did not have a lot of nursing skills to practice so I was more attentive and observing of such things [ethics]".* This seems to be a contradictory view because most examples of ethics are based on practical clinical skills rather than ethical issues associated with mental health. A possible explanation could be based on the role models that the student

had in a mental health setting. Examples of clinical skills are further explained in section 5.3.3.

> *There are some patients that ask [in a primary health setting], and they [nurses] explain to them about their condition but in settings like ward, where you have people that are there, it is easier to communicate and dialogue.*
>
> (Student C3)

> *In CPR, how does the doctor decide and not the patient or the relative? Things like this I have never met in practice. Maybe even because the settings that I have worked in did not really have ethical issues.*
>
> (Student A2)

> *I think that ethics can be found more in a setting such as emergency or before surgery rather than care on the ward...so far from what I am taking from the course that is what I am observing.*
>
> (Student A1)

The latter quote by Student A during her first year, may suggest that most ethical scenarios or examples mentioned in class relate to acute care settings. Apart from the context of ethics being predominant in certain healthcare settings, one participant also showed tolerance to ethical issues that she might have deemed unethical in first year but accepted in third year in view of more extraordinary ethical issues. This can relate to the notion that students believe, that by time, the quality of nursing care provided will regress.

> *We are not saying that, for example, you washed a patient and left the curtain slightly open...it is still uncomfortable, but you are not deciding between life and death [referring to resuscitation decisions].*
>
> (Student A3)

Certain contexts are also used to justify unethical practices as Student H explains below. This is also linked to lack of resources available to carry out a procedure. Contexts are also dependent on the people that make up a team, their relationships, and motivations to stay in a specific setting.

In a long-term residence...even if it was in a hospital that is very busy and you are very stressed…the long-term residence, if very calm…they could have brought from another ward or used an in-and-out catheter... but obviously, they did not make the right choice [referring to filling a catheter balloon with unsterile tap water].

What can influence is if you remain working in the same ward for a long time, you will be unhappy and maybe angry. I think unfortunately that changes someone's character when you have been there in a place for a long time, and you are unhappy.

(Student H3)

Most students claimed that they do not, or as of yet have not, applied ethics in practice, even in their third year of studies. However, this idea is more predominant in Year 1 and 2, suggesting positive ethical development, as student H1 states: "*I do not think that I applied ethics so far"*. Student H also mentioned that in his third-year assessment he could not apply ethics because of the requirements to finish on time, follow the routine and plan the whole day. As he explains, the focus of practical placements, especially in third year relates to clinical knowledge:

I... you do not really find opportunity [to apply ethics] it is more observation. It was not applicable for students.

(Student I3)

In terms of ethics, I do not think that I experienced any...big ethical issues like a medical procedure etc... But there are some minor issues that you observe in ethics.

(Student A2)

I hope that in the future I can apply ethics more. When you are a student and you are still learning, they focus a lot on exams and assessments and knowledge. Thus, because we focus a lot on that we forget slightly that the patient is the priority.

(Student C3)

The above quotes can also suggest a view of ethics as a compartmentalised task that needs to be done comparable to technical and clinical skills. Although students comment on wanting to apply ethics to day-to-day activities, in practice this might be viewed as something separate from the normal clinical routine.

Students also linked consequences of unethical practice to being a motivator of ethical decisions, whilst thinking about consequences was a positive attribute that ethical nurses claimed to possess. Student B also mentioned consequences on themselves as a student or nurse if one does not follow ethics. In Year 3, Student B further highlighted that *"in nursing practice, there are a lot of instances when you can be unethical…and you can hide it and move on".* This quote indicates that the student thinks that there are very limited consequences to practicing unethically. This might be true in view of cultural and organisational environments. This is supported by Student F3 who states that: *"I think they decide that there are no consequences. There are some who do not really bother".* However, Student A2 and J3 comment on the consequences of unethical decisions by stating that "*The damage that can be done…it [being unethical] can cause a lot of damage"* (Student A2) and *"I see it as evaluating the consequences on the patient and the situation*" (Student J3).

The quotation below by Student B in Year 1 suggests that students are not aware of the repercussions of not abiding by ethical standards and this requires a rationale to be provided for actions taken. When students provided examples from practice, they referred very often to the presence of a nurse near the patient:

> *I think that one thing that I can really learn about ethics is when I have scenarios in front of me of when ethics was not right and was not followed, because we learn that you need to do this and this for this reason. I think we would wake up more if we knew of the situations of ethics when it was not followed and the consequences not just for the patient but for ourselves as well.*
>
> (Student B1)

Most students provided examples of unethical practice that related to not being actively engaged in their own practice and being in a hurry to get things done without considering the patient that one is caring for. This is explained by Student F2 and A3 below. Time is also regarded as a challenge to be ethical in practice as highlighted in section 5.3.6

They go near her in a hurry and leave, instead of staying near her and explaining…things like that.

(Student F2)

Even a patient who is in pain, we give him pethidine [analgesia] and that is it. Stay a bit near him…I do not know… to comfort him. Even this morning I was taking the parameters and the patient was talking…I was not sure what he was saying but at least I was there, he was talking about his family…It has nothing to do with the pain, but he was confiding in me…maybe it makes him feel better.

(Student A3)

5.3.3 Procedures

When students were asked to give an example of ethics, a significant portion of examples related to clinical procedures. These examples related to anointment of the sick, confidentiality, informed consent, dying patients, infection control, medication-related events and privacy. The predominant examples related to informed consent, infection control and medication-related events with 11-14 mentions along the three years. These examples provided were also a source of dilemma for students because of the perceived unsafe practice observed and the inability to speak up due to relationship dynamics. Students were also aware of the perceived ideal way to carry out these procedures, however they were often faced with situations in which they are done differently. Student D provides an example of how it is common practice to administer medication at the incorrect time and accepts this as a small deviation from procedure. These negative examples of experiences regarding procedures, seem to be the mostly recalled episodes from practice. Students never talked about these episodes with their mentors or link lecturers:

Once there was a nurse and to clean a suture line, he left everything on the floor. The patient was sitting down, and the nurse left everything on the floor, the pack and all... to get rid of the task quickly.

(Student F2)

I have seen this, not the first time. That the nurses I am with ask me if I know how to do a catheter and I say yes. So they tell me that it is up to me to do it. Afterwards, another catheter comes up and the nurse does it...and they tell me that they are going to do it their own way...meaning no aseptic technique.

You are tired and the patient asks you from something small and you do not feel like doing it...or a stupid example for an IV you need to wipe the port with alcohol before removing and attaching. If I am tired and I do not feel like it, I just remove the stopper and connect it and do not wipe it.

(Student B3)

Sometimes when I was on placement, I used to see a lot of the same equipment being used on different patients and they do not get cleaned. If there is something, we are spreading it...not sure if this is a moral example or not. This is the first time that I saw something, and I thought that this is a bad idea and if I had to change something I would implement a better system"

(Student C2)

If before [as a student] we do a dressing the right way so as not to infect the wound, it can still be infected now, even though it is not our final exam. So why don't we do it right?

(Student G3)

I was on placement, and I think I had a patient that needed antibiotics intravenously in the afternoon and I was taking care of him and I went for break and forgot to handover regarding the treatment. When I returned from break, I remembered and asked the nurse because I am a student...I told her that I forgot to give the treatment and I will give it now, although a bit later about 45 minutes. She told me: 'do not worry' and she signed it and the patient did not take anything' because she said it is late…but in truth I think because she did not feel like giving it.

(Student C3)

I was on a ward, and they have a lot of CPR's unfortunately and I saw this CPR and everyone was…this patient had an obstruction and she arrested, with the CPR, faecal

material came up into her mouth and she was soaked…and everyone was making jokes like she is from walking dead or she looks like a zombie.

(Student I3)

The quotes above also provide insight as to how students themselves sometimes practice unsafely, such as not decontaminating an intravenous port. This is perceived as a small error that will not really have repercussions on patient care, even though this practice is highly evidence-based and emphasised during theoretical lectures. This might also indicate that students would be imitating observed practices in the clinical areas, and thus the importance of such a task is diminished because most peers do otherwise, as mentioned by Student D3, in relation to medication administration, where something might not be considered unethical because everyone does it:

Small things! For example, treatment not given on time...that can be an ethical problem because the patient might be used to taking the medication at a certain time but because of the comfort of nurses and because they do not want to give it during another time. I think that is an ethical problem because you are not really respecting the patient. But they do this on all the wards [laughs]…the treatment.

(Student D3)

5.3.4 Experience

Students related learning in practice to experiences that they have in the clinical area and the experiences that other individuals relay. They believe that this kind of learning is unique to the clinical setting. Experiential learning is also linked to easier decision-making in practice. Student I3 also mentions that through experience, she has learnt what patients look for in nurses and helped her identify the right role models in practice. However, experience is also linked to negative aspects, such as role models not providing rationale for decisions taken and saying that the student will learn through experience, which was frustrating for Student G because she could not understand how this will happen. Students also relate to clinical experiences of their tutors by reflecting on these experiences in a class or the practical environment. Discussion and conversations about decision-making were vital for learning in practice. Student J1 and C3 also refer to life experiences and the role that these

experiences have had in developing their own practice and worldview perspective, such as the death of a close family relative:

> *From experience, you meet new cases and I think you learn more from those, even different decisions they become easier for you.*
>
> (Student I1)

> *I think mostly from experience, example in first year you now know how to handle certain situations...even seeing other nurses doing things. The more practice and experience you have the more you know how to handle ethical questions.*
>
> (Student I2)

> *The patients themselves [feedback on ethical and unethical nurses], I was in an oncology setting and you hear patients saying that nurse did not treat me well or that nurse did this and you start listening and trying to understand and say I do not want to do this and learn a lot from their experiences. You learn what is good and bad, respecting the patient and the right behaviour.*
>
> (Student G1)

> *I learnt the most when things actually happened to me and I did not know what to do and talked to the nurse or mentor and asked what I should do…*
>
> (Student B3)

> *I am pretty sure that along my career, because of the experiences you have, you will have more knowledge about ethics.*
>
> (Student C2)

Through the observation of others and seeing the outcome of different decisions that nurses took, as well as the feedback that patients give about different people, helped students understand what it means to be a good nurse. The opportunity for students to tackle different situations in practice and be actively involved in decision-making opportunities contributed to their learning.

5.3.5 Reflection

Reflection was mentioned in Year 2 and 3 as a way in which students themselves learn and as a way in which healthcare settings can function in an ethical manner. With the fast-paced environment on placements, students mention that very often they do not have time to stop, think and reflect on their own work. Student J sustains that she had one mentor who dedicated time for a reflective exercise during her placement and she felt that it was a significant contributor to her development:

> *Honestly, during placement I do not really think. But after, on my way home, I start thinking...*
>
> (Student G2)

> *To tell you the truth I do not think that you can learn or emphasise ethics...what you can do is look up for yourself. When you are in a ward and meet a case and you say to yourself 'that is how I would want to do it' and you look up about it. Education is very minimal. It must be you… that when something happens, and you are not sure how to do it you look it up.*
>
> (Student A2)

> *We need to be less passive in certain situations. We should not say I do not know and stop there...but ask why? What can be done better? Because ethical issues everyone seems to know what they are but the decision to be taken no one seems to know it...everyone says this and this should be done, but nothing is done.*
>
> (Student A3)

> *I think on the wards, although formally we do not have a lot or someone to talk to you about ethics, from there you open your eyes and start observing, on your own you will start thinking why he did this and that, did he respect that person? Could he have done something else to avoid certain things? That is how I developed in ethics. I did not have a formal education but without wanting to, on the wards, I questioned things that are happening.*
>
> (Student B2)

I think everyone needs to be a bit more self-reflective and see if they can be better in ethics and his own values. I guess both in normal situations and nursing because we are dealing with other people. I do not think that we had lectures on self-reflection, or there, was but not specifically on how to work.

(Student C3)

I have a file with all the feedback. To be fair, it would be nice if your mentor, at the end of the week, talks to you to see what you did well and what you should improve on.

(Student J3)

Most students refer to reflection as a way of trying to rationalise what is happening around them in the clinical area. However, some students do not see education as contributing to their reflections, whilst Students A and B comment on how there is minimal formal discussion regarding ethics during practice. Furthermore, some students are concerned because there is a lack of action or solutions to ethical issues that they might observe. This might stem from the way that ethics is taught in nursing, with an emphasis on bioethical principles and dilemmas as well as from an individual perspective on understanding ethics as a student. Student J3 sustains that she would like to have discussions on a weekly basis to see what she can improve on and what she did successfully. However, students do seem to emphasise on becoming more critical about what is happening around them and start developing a sense of inquiry.

5.4 Challenges

Time and taking an easy path have been identified throughout the interviews as challenges to acting ethically. This means that students believe that to work in an ethical manner is more difficult and time consuming. This was especially relevant to students because they felt that they work at a much slower pace compared to others. This influenced their own practice, with students feeling like they could have done better, but due to time restrictions, they could not. Time is also presented as a justification for not being able to act

ethically by role models. The pressure to work quickly and efficiently increased between Year 1 and Year 3:

> *Especially with time. "Too slow, you need to hurry up". So, I start asking myself as a student how should these be done; if I need half an hour, how can I only need 15 minutes? And even treatment. I find it very difficult, because if I started mixing Tazocin [intravenous antibiotic], I will finish the Tazocin and will not start six other things at the same time and not know what I am doing. They [nurses] panic me because they tell me 'you are still here?' you need to hurry up because in daily life you need to be much quicker' and without wanting to I feel that pressure to instead of wiping the port before connecting an IV, I just connect the IV…or instead of a new saline I use one that is already opened because I did not have time to get a new one. This I am feeling more now that I am a third year"*
>
> (Student G3)

> *Sometimes even they even tell me... I would be preparing the antibiotics as we should, and obviously I still take same time to do this. There are some who tell me 'God forbid that when you graduate you continue doing this because you will never finish the antibiotics during night shifts'*
>
> (Student B2)

> W*here I am on placement they use a lot of restraints, without a policy. The doctor just signs for it, they do not speak to the relatives and sometimes there are people who opt for this so that they do not waste time monitoring the patient, to get rid of this task"*
>
> (Student F3)

> *Everything not too slow but not that rush because of time...kind of 'let's go' because you need to do this and this. Carefully with the patient…*
>
> **(**Student J2)

The pressure to work fast has pushed some students to make decisions that they feel are unsafe and one student felt like this increased as they progressed in their course, which can provide an explanation of why, once nurses graduate, students observe unethical practices resulting from the pressure to constantly work faster. This measure seems to be associated

with being a good nurse; the faster one works, the better nurse they are. Students also observed that, in practice, nurses work very long hours and this could be a challenge that might lead to burnout and unethical practice. As student G3 mentions: *"Very long hours...you see, everyone is so tired".* The lack of staff available in a clinical setting contributes to burnout and being unable to provide ethical care:

> *In the wards, when there is lack of staff, some nurses take even seven patients, poor things and they have a lot of things to do and they are not as caring as they want to because they have another five patients and they cannot give all their time to one patient and sometimes they forget something that needed to be done.*
>
> (Student D3)

> *You would be tired, fed up and want to go home…you are hungry, these things will play a role. I think the long hours are a lot, 12 hours are a lot to maintain a 100% to the patient, I think it is a lot.*
>
> (Student B3)

Overall, students felt that they really learnt what ethics was through their practical placements and experiential learning. Reflection was a key activity mentioned that assists students in learning ethics. Students also referred to the theoretical sessions as being beneficial, especially small group discussions and case scenarios, even lectures that are not necessarily part of an ethics study unit. In fact, the examples of ethics brought up by students were mostly related to clinical procedures. Thus, there seems to be a distinction between their own character, behaviour and ethics in the clinical environment. Students also emphasised that being in a large class was a limitation when learning about ethics. In a practical setting, time was highlighted as the main challenge for not learning or acting in an ethical manner.

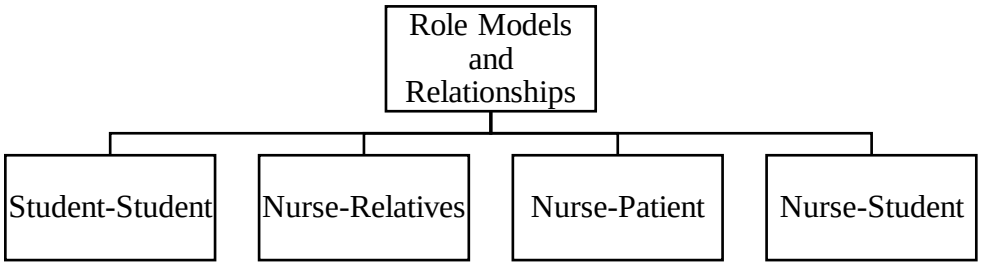
5.5 Role models and relationships

As a way of understanding ethics, students often mentioned relationships with others and the dynamics with people around them. These relationships had both a negative and positive impact. Certain relationships encouraged ethical behaviour, whilst others resulted in pressure to work unethically. The predominant relationships that students referred to are

those with nurses in the clinical settings, acting as role models. However, they also provided several examples of ethics when it comes to relationships with others and the students own relationships with patients and their relatives. Furthermore, some students mentioned the relationships and dynamics between their classmates or other students on placement. Students minimally referred to relationships with other healthcare professionals in the clinical environment, the majority of these relationships focused on other nurses. Teamwork, conflicts, hierarchy at the place of work and communication were also related to relationships.

Figure 5.3

Theme 3 Role Models and Relationships



5.5.1 Nurse-student relationship

One of the main priorities for students in practice is to maintain good relationships with nursing staff in the clinical setting, especially with their clinical mentors. Students felt that they learn and shall learn the most from observing other nurses in practice, as well as through discussions with their mentors, both through positive and negative observations. As Student H summarises in Year 2:

> *It goes both ways because if you see someone doing something and you think that you did not expect to do it like that in that situation...you kind of learn from it because I liked that because it is ethically good and I try to introduce it in my own practice eventually. Or the other way round, you see someone doing something that you do not agree with and you think that it is not ethical and you try to steer away from it.*

During practice, nurses, especially mentors, are responsible for giving a mark to students and this weighs down students, creating significant amounts of pressure. There are instances when students did not question what they observe, out of concern that this will influence their practice placement grade. Student I mentions that on one occasion she was distressed about a situation that took place at work and was crying during her clinical placement. However, she could not talk to her role models because she was scared that it would influence her marks or strain the relationship that she has with her mentor. Student I expresses the following: *I wanted to die...I cried so much...and everyone was making fun of the situation...I cried, I saw this as disrespect...If god forbid this was my grandma will they do the same?"* This is iterated by other students as shown below.

> *As a student nurse, NO! I cannot!! Not because they will shout at me, but I cannot…because they are above you, because you are still a student and they do not let you do what you want. Because they are responsible for the patients and they want to do the treatment themselves, even if I prepare it myself. They will say yes, we give it now at this time. I cannot interfere with their system.*
>
> (Student G3)

> *At that time, I could not speak up because she will eat me alive. I could not say anything because she was my mentor and it would influence my relationship with her, so I stayed quiet, apologised and that's it.*
>
> (Student E3)

> *…that someone takes it up against you…it is very easy that someone talks about you and stuff…you would be new, and your opinion will not be heard…they are all used to each other, for them, you are a foreigner.*
>
> (Student F3)

> *They will tell you, 'You are a student, and you will do everything according to theory or because you think you know more than us because you are studying.*
>
> (Student H3)

From the quotations above, students seem to believe that if they have discussions or conversations about unethical practice or communicate their opinions, which might not be the

same as that of their role-model, they will face repercussions. Some students feel like they are outsiders to the system and they are unable to voice their own opinions. This might indicate that students do not have the opportunity to develop their thinking in practice and lack the confidence to explore ethical concerns with their mentors. Most quotations in relation to this have been expressed by students in their final year of study. Students described situations when they were told to do something, and they knew that it was not the ethical way to carry those duties out:

> *I had to do it like she told me. I felt guilty, I know it is not safe for the patient and myself, it is not safe to stay without gloves and use your hands [wound dressing].*
>
> (Student I2)

> *…because you would be in a mentored placement and the nurse tells you not to do it that way, do it this way and she would not be doing it as she is supposed to.*
>
> (Student E2)

> *There are a lot of places in nursing practice that there is a system and without wanting to, you will follow that system. If there are things that should not be done in that way or are unethical, I think probably you would still end up following the system.*
>
> (Student C3)

> *When they make these decisions of not doing what they are supposed to do. For example, if a wrong medicine has been administered...because the medicine will not have big side effects we do not speak up and we do not document and obviously as a student I am aware that this is something very wrong.*
>
> (Student H3)

The quotations above indicate that students feel that they will follow the system that they are part of and the norms accepted within that system, even though they find this system to be unethical. Students felt that there is a hierarchy in practical settings and they are at the bottom of it. They feel that they are not heard, that they cannot voice their opinions, and that they are a burden to other practitioners and role models. Some students felt that once they graduate this will change. However, others believed that once they graduate they will still be

new to the clinical settings and things will remain the same or else they sometimes experience more pressure to conform with the rest of the group. When further asked if they have any way of talking to someone about their own practice, one student mentioned link lecturers but said that it is useless because nothing will change:

> *There are placements that do not respect you, the staff do not see you at the same level. They place you at a lower level...even though we are all human, although they know more... but if you know something they shouldn't tell you – you don't know anything, stay quiet.*
>
> *As students, I think that they do not do this, they do not listen to students…we are still working as a team.*
>
> (Student E3)

> *I think the thing that is mostly related to ethics is when there is someone who treats the patient wrongly and as a student there isn't much to do. If they are at a higher level than me, I cannot go and tell them that they should not treat the patients that way.*
>
> (Student G1)

> *I think that I will feel more pressure later, especially if you are working in the same ward and are part of the staff, they pretend that you need to listen to who is older than you and might know more.*
>
> (Student H3)

> *As a student I do not feel like I can contradict someone but as a nurse I can say that this is my time and I will get a wage for this…if I take an hour or two hours it is up to me…I try…*
>
> (Student I2)

In relation to this, three students sustain that they feel that they are useless when faced with unethical practice or situations when they cannot help because they are unable to bring change or take action. Student G1 expresses: *"I feel useless, I say who am I to say that this is not how it should be done?"*, and Student B2 highlights: "*I felt useless because most of the*

things that the patient needs I could not help her". This might indicate that the systems or organisations that students attend in clinical placements do not value student input or that students themselves do not realise their own input and value in practical settings.

However, when the nurse-student relationships are positive, they fostered an excellent learning environment. As Student J3 states: ***"****I really had good mentors and I integrated really well".* Positive role models according to student perspectives are in the minority. Student I also mentions that she might not be aware of ethical issues, because when ethical issues arise, students stand aside because they are difficult situations. One student also mentions that mentors that actively worked according to policy were subjected to pressure from their peers using humour. Student A also comments on the importance of students taking interest in their practice and looking for learning opportunities, however, no other students discuss this:

> A *mentor is supposed to do everything according to the rules because of students…but someone, I noticed that even as a joke between them, they pick on her telling her, 'you should do everything right because there are students and you will stop once they leave' and those that genuinely would be doing things because they feel like that is the right way not because they are mentors, others automatically turn against them although as a joke, it still hurts*.
>
> (Student G2)

> *I mean you chose to do this [mentor students]; you know what you are getting into. This is not like I grabbed you and told you to be a mentor. If you know what you are going into, you must help students as much as possible. And it must come from the students' side to show interest and if there is an opportunity to learn you go and see, but it helps to always have someone seeing what you are doing.*
>
> (Student A2)

> *At least the reasons they give me on why they do not do things like I learnt them makes sense...or the thing is that I can count them on my fingers the amount of people, so much so that I can remember their names, the people that if you had to tell me choose five nurses and I would place you on a ward with them, I would choose*

them...what they do they do with a reason and they do everything in a way that makes sense.

(Student B3)

I do not think that I had an example where I saw ethics…I mean, I think that when there are these problems, they do not show them to us…when there is something difficult, as students we stand aside.

(Student I2)

You find mentors that are good. Example, talking about my first mentor, I think for me the first placement was the one I learnt most in. Because most mentors are passive… all right maybe true they do not need to stay with you all the time, but that is what is needed because if you make a mistake, they tell you how to do things, they do not leave you to 'struggle' on your own.

(Student A2)

Even in nursing practice that one does something, and you say 'ah this person, after all these years still tried to adhere to certain regulations that are for the patients benefit. Instead of another person that you observe who has become more laissez-faire and....you know because he is fed up with work and that's it...motivated to do things in the best way possible. So you see these types of people and you think 'one is more ethical than the other'.

(Student C3)

In the quotations above students comment on the responsibility and accountability of mentors in view of mentors choosing to officially guide students in practice and provide the necessary feedback. Positive role models are also viewed as those who conventionally follow policy and regulations in contrast to other nurses who are not motivated to follow regulations and adopt a *laissez-faire* approach. Furthermore, students felt that they were being pushed into working differently than what they learnt in theory. There was a sense that what students do is separate and very different than what they should do once they graduate and this was very confusing for students. One student further expresses that he often doubts whether all that he has learnt in a classroom setting was utter nonsense, a recurrent dilemma that surfaced throughout the interviews for the nursing students along their years of study:

I talk to a lot of nurses who have already graduated, and they tell you 'you are doing things as a student for now...once you graduate these things will change and you will not continue doing them like this'. If someone who has been working for several years, tells you 'it is because you are still young that you are doing things as you should, you will realise soon that you do not have enough practice to realise and that you are wasting time' [doing things like a student].

(Student B3)

Obviously, I did not want to do this [perceived unethical clinical action] ...obviously I did not look good [with other nurses]. Kind of 'you cannot do things according to the theory'.

(Student H3)

I know that there are things…not time, but the influence of others, which scares me a lot. That there will be people who tell you 'that is because you have just graduated that you do things right, when you have been working for ten years you will not do things right'. I do not want to make an enemy out of people that I need to work with. I want to continue doing things right for the patients' benefit, and at the same time I know that to do things right, I will eventually make enemies. Even today as a student not everyone agrees with you, let alone later when I need to work with them every day, there will be huge challenges.

(Student G3)

The above quotations, during Year 3 of studies, can indicate an expectation from students that are being prepared to face clinical practice as registered nurses by leading them to believe that they will not sustain their current quality of clinical practice, even suggesting that they might start to do things 'the wrong way'. This seems to support the idea that once students graduate the expectation is that they will regress as nurses, with the suggestion that students are not 'developed' enough to understand real-life clinical practice.

In settings where nurses worked as a team, students felt more supported and motivated during their placements. However, one student felt that to work as you should and do things right you have to work alone. She observed that the nurses that worked well tended to work alone and not necessarily be part of a team. Furthermore, the longer one remains in

nursing practice, the higher the possibility of doing things 'incorrectly'. Some students expressed fear and concern about becoming the unethical nurses that they observe in practice. Student H also commented on the age gap between mentors and students and felt that he could not build a relationship with his mentors because of the widely differing perspectives on contemporary issues:

> *I notice this in those that have been nurses for a while. The new ones try to do good but once you get used to things…that is what you will continue doing…once you get used to what the ward does, you will do what the ward does.*
>
> **(**Student E3)

> *Teamwork with the staff is important and it motivates you. Because you know that you will go to work and not only work but also meet your team and work with them.*
>
> (Student J3)

> *When I start seeing that there is no compassion, it scares me. I think 'is it possible that after twenty years in this line of work I end up like this? I don't care and could not care less?*

> *I try to remember the negative so that I do not do it. It says that if I saw this wrong attitude, why is it wrong? So as much as possible I avoid doing that mistake. I do not want to end up like those that come to work for the money. I do not want to end up in that state, so if I focus on the negative, I will try to not become that type of person. So, I focus on the negative, so that I fix my negative and hopefully in the future it becomes a positive"*
>
> (Student G2)

> *Scared that I will hear something that stops me or influences me to be like everyone else…"*
>
> (Student B3)

> *Nurses that are much older and by time they got used to things…that everything is calm, like nothing affects them. It is difficult to relate to them because they have more experience and worked in more settings. Maybe by time…but I feel like I cannot understand them.*
>
> (Student H2)

If I go somewhere where I see drama between the staff, arguing... people trying to win over others…it makes me feel uncomfortable. Especially at the faculty... that is what I tell my friends. You realise that they trust you as a student and although they acknowledge that you are not part of the staff, they start telling you negative things about other staff and you know that you will work with them next week and that makes me feel uncomfortable and biased.

(Student G2)

Some students felt that they are sometimes engaged in conversations about other team members that they need to work with, and they view this as unethical. Regression of nursing practice seems to be associated with lack of compassion and wrong attitudes.

Most students felt that they did not have any discussions regarding ethical issues in the practice setting. There seemed to be a lack of understanding of ethics and the domains for assessment, both by the student and the mentors in practice. Student J comments that during her final assessment her supervisor told her that she completed the ethics domain through one scenario/decision during a five-hour assessment. This indicates an understanding of ethics being a separate skill that you do or tick off in an assessment, even though, as students, understanding ethics in terms of character and relationships are constantly present:

It happens a lot when the mentor would not know what to do and she tells me let's talk to that person. But we never really had an ethics discussion as such.

(Student B2)

I think so far mentors did not give importance to ethics…I do not know why… maybe I need to start asking.

(Student F2)

All the nurses need to be more aware of ethics, not just students. Even if you talk to the link lecturer and discuss some experiences with them… I feel that when you mention ethics, they do not know what to tell you. This mentor that I had talked to me about ethics but only because the link lecturer told me to focus on ethics in practice as

well as other skills. Before that, no one even regarded ethics in the slightest. We had a short discussion...the mentor asked me because she did not know what to tell me and I brought an example of restraints because it happens a lot. Even the final examiner asked me about ethics, what to do when relatives call. I think he asked me because it is in the marking scheme...so at least they put it there. Even the mentor, if the link lecturer did not point it out, she would not have thought about it, and with my previous mentors, we never had discussions either.

(Student F3)

We never had a discussion, or they never asked me what I would do. They kind of disregard them.

(Student A2)

Honestly, I think if during placements we focus more on them [ethical principles], example the mentor tells you this is the right and ethical thing to do, that yes. You start to remember through examples, not only having the notes and theory and you need to study them that's it, but you are also seeing them happening in front of you.

(Student G1)

The above quotations seem to suggest that ethics is just there and most of the time it is disregarded because of the lack of knowledge or motivation to talk about it. There seems to be an implication that ethics is not a priority for nurses in practice and for faculty members. This might suggest a lack of clinical and faculty expertise regarding ethics in nursing practice and thus, students do not find enough guidance on ethical issues.

5.5.2 Nurse-relative relationship

One of the main examples of unethical behaviour related to the provision of information to relatives rather than the patient. The relationship that the nurse has with relatives was also an example of someone who is ethical. This relationship was also a motivator for most students to work ethically because they viewed patients as if they were their own relatives in order to provide quality care:

The nurse was nice and soft with the relative and I said there she used good ethics. It also counts in tough moments when relatives are grieving, and the nurse was nice and soft with the relatives after giving up hope on a patient… they need support. I think that is when such a value is important, because relatives need a lot of hope and support, and it is the nurses' role.

(Student D1)

Maybe relatives are not thinking about the patient's interests. The lack of consultation with the patient really bothers me.

(Student A3)

My grandparents were always in hospital and the way in which nurses treated the relative was something that really helped me. From my experience before nursing when I visited my family members or friends and I see that particular nurse, I realise [that she is a good nurse].

(Student H1)

The majority of quotes in relation to the nurse-relative relationship are positive, with students commenting on the kind behaviour and the support that nurses provided in difficult times. Student D also regarded this relationship as a very important role of nurses

5.5.3 Nurse-patient relationship

Students viewed the relationship between the nurse and the patient as a motivator for their own nursing practice. The positive role models that students described are those that had good therapeutic patient relationships. Furthermore, the gratitude that patients expressed towards students and nurses encouraged students to continue pursuing careers as nurses. On the contrary, when patients did not show gratitude, students felt disrespected, although they attribute such patient behaviour to the patients' illness and situation. Student B3 highlights that it is difficult to go out of your way for patients because you get nothing in return. This is a very interesting perspective as several students mention that they see patients as if they are their relatives and Student B comments on the difficulty in seeing everyone as your relative and the different dynamics of familial and professional relationships:

So far nothing major, just spending time with the patient. When they thank you, you feel satisfied.

(Student F2)

These patients I am giving them everything, but they are giving me nothing. In a sense, at home my mother gives me everything I need, so when she asks me to do something it is easier because she is my mum, my dad, my friend...these are patients that come and go...so I find it more difficult [to do things for people] when they are not close to heart.

(Student B3)

In primary health, I had a mentor that used to see patients once, but she still tried to refer to them by their name, ask them how their day was. There are other placements when the patients stay in the ward for a long time, so it is easier to build a relationship because you see them often and they get used to you. You feel good when you build this relationship because you see how the patient is doing, not just doing your work, and leaving and you do not care for that patient anymore. It doesn't only help you build a relationship but helps you feel good as well.

(Student H2)

Student H comments on the context of building such relationships, with primary care contexts being more difficult to build relationships because patients only visit for a short time. However, this student also comments positively on the impact that a role model had for trying to show interest in the patient even for a brief moment.

Furthermore, some students describe how as nursing students they had an influence on patient care through spending time with patients as Student C summarises in Year 2. This shows that students see value in what they are doing, through feedback from patients that they meet:

After my placement in a nursing home finished, there was an elderly person in particular, and because we [my colleague and myself] were going to stop going on placement he was very emotional because he will miss us. I really did not think that we will have such an impact on the life of this patient.

5.5.4 Student-student relationship

The relationship with other students is very complex. Some students view their classmates as an indispensable source of support, through discussions about unethical and ethical practices observed. Others look at colleagues that are not motivated to be nurses and these can be demoralising to those interested in pursuing nursing. One student also comments about the relationships between students who are coming from different educational backgrounds. Students also refer to being 'better' or more dedicated than other colleagues, showing that there is a distinction in this group regarding who is a morally superior nursing student based on the motivations to join nursing:

> *To be honest they [colleagues on placement] continued to make me feel hopeless, because when I see them with that attitude, even in the ward 'I have a lot of hours', 'these [clinical hours] are really extra' and I think that we should be thankful that we practice and roll up our sleeves and work instead of grumbling, it really demotivates me.*
>
> (Student G3)

> *You need at least one therapy session a week [laughs]... just talking about what happened on placement and what did not happen...I feel that it is very important to talk to people that work like you.*
>
> **(**Student G2)

> *In the group chat of the course, we talk a lot between us and most often we do not feel like meeting. All that we want is to go to bed and sleep. So, I think it is quite common that we are tired and fed up with everything.*
>
> (Student B3)

It should start from when you are a student... you see students who are not dedicated and joined nursing because they want to be doctors or because they did not have enough marks. This is something that really bothers me, because I wanted to be a nurse because I am dedicated and others want to be nurses as a backup because they did not join another profession.

(Student H3)

We really do it, after each placement day we discuss what we say…we mention good things but what really gets our attention are things that we are not used to.

(Student J2)

Another student and I used to learn from each other. Example things on the windowsill that we are not supposed to have there, and we do not notice, she reminds me. So, we have each other, and we learn from each other.

(Student J3)

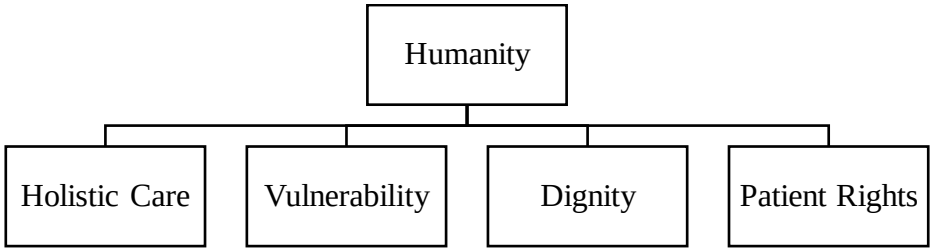
Most students comment on the positive impact that other students have on their own practice. Students mention that supporting each other through their placements because they work in a similar manner, and thus this can that provide a positive clinical and academic environment. However, working with other students who had a negative or pessimistic attitude demotivated the rest of the student team.

5.6 Humanity

The theme *humanity* was based on the central concepts surrounding patients from a student perspective. Students mentioned that patients need to be cared for in a holistic manner with dignity, whilst safeguarding their rights. This was perceived to be very important in view of the patient's vulnerability in a healthcare system as a result of illness. When taking these concepts to represent a larger whole, students mention the need to regard people as human beings.

Figure 5.4

Theme 4 Humanity



5.6.1 Holistic care

According to the interviews carried out, students view ethics as being able to holistically care for a patient. They referred to social and psychological aspects of care as being an integral part of ethics. For Student J, caring for the person as a whole being became more important as she progressed through her degree. As student D3 mentions that nurses care for a patient *"...as a whole being, that you look at the patients as a whole being...where he is coming from...".* This was contradicted by Student C who felt that by his third year of studies there was much more importance placed on the logistics and paperwork instead of patient care. This can be related to role models in practice, since Student J also sustains that she had very good role models in practice throughout her studies:

> *...It is either the work or it is related less to patient care and more on organisational logistics and paperwork and things like that...*
>
> (Student J3)

> *I saw that I was increasingly noting aspects that in first and second year I did not think about...holistic care...even ethically.*
>
> (Student H3)

The above quotations suggest that there is an understanding of ethics in relation to humanity based on a patient's past experiences and their history as being relevant to positive ethical practices of nurses.

5.6.2 Vulnerability

The idea of vulnerability is very predominant in Year 1 and 2 of studies. Associated with vulnerability, there is also a sense of pity towards patients. Students seem to react more strongly to unethical scenarios in practice in view of the vulnerability of individuals experiencing these situations. This vulnerability was also a source of concern for Student G because she felt that she worries too much about the patients she cares for. Student G earlier also mentioned the importance of boundaries in care. Students also think that this vulnerability encourages them to practice ethically. This concept is increasingly predominant in Year 1 and 2 since students start placements and start understanding what it means for someone to be ill. There was no reference to patients who are independent. The concept of vulnerability seems to create a hierarchy and power-imbalance between professionals and patients. There seems to be evidence that students do not regard themselves as being vulnerable when caring for patients:

> *You will spend you day with people who will be vulnerable, who are in hospital and would not be in their top state, so you need to help them, you need to listen and understand. There are a lot of cases of neglect and maybe they [patients] are comfortable to confide in a nurse rather than a doctor or family because you will not tell anyone, so these values will be very evident.*

> *The nurse spends more time with them when they are vulnerable, long shifts and when they need something they go to the nurse. Example nurses change a nappy which is very degrading...they are embarrassed, or they are in pain and crying...vulnerable.*
>
> **(**Student I1)

> *During my placement I saw a lot of relatives that are sad. You can see it in their eyes...because where I am at the moment, most patients cannot walk because they have a mask [oxygen], they are nil by mouth and in very poor condition...and the relatives surround the patient and I feel pity for them because they are very sad...*

He was old and I said...I really did not feel like washing him...and I said he is also a human being, poor thing...he is very vulnerable.

(Student D1)

The amount of suffering that I see certain patients experiencing… I think this is not something that I might decide to do or not, this is something that he needs.

(Student B1)

Here you see a lot of people who are weak, they want to walk but they are in pain and cannot…and you think these poor things…"

(Student J1)

Nursing is also viewed as having a key role in supporting patients when they are vulnerable in view of the amount of time that nurses spend at the patient's side. The concept of vulnerability is also associated with negative experiences and difficult emotions. These emotions might encourage students to respond to the situations that they are experiencing, such as observing a patient suffering and responding by doing all that is necessary for that individual.

5.6.3 Dignity and patient rights

With ethics I understand that you do not look at a person as just a person, but you give them dignity and you treat him as a human, you look at their rights and you show some emotion towards the patient, not just bed 22...that is what I understand with ethics.

(Student D1)

This statement refers to an outlook towards others that is not derived simply from rationally thinking and practicing ethics, but a multifaceted approach of looking at human rights and dignity with emotion. Students I, E, D, A and B often refer to calling out patients by their bed number or an object. Further to this, Student D3 comments: *"I think that with the ethics that I learnt it helped me in practice because you are being a human being to another human being, you are not treating the patient like an object"*. Student A also refers to the idea that dignity is taken for granted; the more nurses get used to a specific routine, the more dignity is overlooked: *"patient dignity, that we often take for granted. That we get to doing*

the same thing so much that we forget that it is not something normal for the patient". Taking things for granted due to routinely engaging in the same care practices can be linked to previous perceptions in which students believe that once nurses graduate, the quality of care that they provide regresses.

Ethics was also related to patient rights and was referred to in terms of patient safety, the benefit of the patient and that the patient comes first. These inter-related concepts within patients' rights are commonly mentioned through the three years of interviews. There seems to be a suggestion that keeps the patient at the centre of all decisions, thus ensuring that all decisions made are ethically and inadvertently fall into place: *"The focal point of nursing is more patient-centred and as long as you have the need of the patient in front of you, everything else just falls into place"* (Student B1). This student further explains that irrelevant of your personal issues, "*you suck it up and deal with it*" because the patient comes first. Students seem to understand that and individuals' personal interests should never come before those of the patient who is being cared for. As Student I3 summarises: "*Your decisions should always be what is best for the patient not what is best for you..."*

5.7 Professional issues

Theme 5 is that of Professional issues, which were mentioned in Year 2 and 3. In relation to ethics, students discuss their journey in forming a nursing identity and how this integrates into the understanding of self. Students further discuss their idea of what a nurse is and the role that nurses have in practice.

5.7.1 The role of the nurse and professional identity

Student C2 comments on his initial misconceptions about what nurses did. He realised that some tasks that he believed are nurse-related, are actually carried out by other professionals, as he describes:

> *I was not aware that a lot of tasks are referred to other people. I think I liked the idea of nurses doing most things themselves. Along the years these tasks have decreased in view of understaffing etc and without wanting to, certain things have been redirected.*

At the same time, I think that the more of these tasks that we give away, the less patient contact you will have.

Here, Student C2 refers to the delegation of tasks to carers, phlebotomists, and medical doctors. This student regards this delegation of tasks as possibly shifting the role of nurses away from the patient's side and decreasing the presence of nurses with patients. This student does not seem to agree with this delegation of tasks in practice.

In relation to other professions, Student H expresses the following: "*I believe that nursing is not a profession below a doctor or a midwife but at the same level*". This might suggest that students feel inferior when compared to other health professions. This hierarchy of professionals is also referred to by Student B and G, who further elaborate on negative reactions towards their choice in enrolling into the nursing degree. Student B1 describes:

In Malta, we lack respect towards all professionals, especially nursing. I feel that through my own experiences, when I told my friends that I will join nursing last year, they said "eww you are going to work with shit" and these types of comments, that show that no one knows what it means to be a nurse...this lack of knowledge from the public, forces the public to disrespect nurses.

This lack of respect and autonomy is considered to be demotivating when it comes to decision-making and fitting into the role of a nurse. Student A3 summarises: "*Sometimes I think we are nurses and health professionals as well, and all in all we still do not have a say"* Student A2 also mentions that "*people look at nursing like something that has no value compared to other professions".* She felt that this motivated her to work ethically so that people realise how important nursing is. Students believe that this hierarchy decreases one's ability to apply ethics or make ethical decisions, as these difficult decisions are relayed through other perceived more important professions.

In Year 1, most students also felt that they are good people because they joined nursing and that the nursing profession in itself is inherently good. As Student C1 mentions: *"I think one example that I am a good person is that I joined this course because I had other opportunities of jobs in which I earn more money but the value of what I would be doing is*

not as precious for me". This is evidence that the motivation to be a nurse go beyond financial reasons and is more focused on the value of the nursing profession in society.

In Year 3, most students relate to the idea that they *"feel"* like a nurse. As Student I summarises "*I say, yes I am capable of being a nurse*". This is not evident between Year 1 and 3, showing a big shift in development between year 2 and 3, possibly suggesting that students are assimilating the identity of a nurse. Students mentioned how this identity of them becoming nurses also relayed to their personal life, Student H describes

> *At the end of the day you are Student H the nurse, not simply a nurse, so what affects you outside of work, if something happens to someone, even though you are not at work you will help. If you have that knowledge you do everything to show and apply it.*

Interestingly although student H mentions that he feels like a nurse, he also mentions that he is not ready to work as a nurse because of the huge responsibility. Student H felt that he is not prepared and the pressure of moving from one ward to the next everyday will put a strain on his ability to build relationships. Student C mentions that he looks forward to starting to work as a nurse independently because *"when you graduate you can do things your own way, what you think is best and I can increasingly apply values to nursing practice".*

The professional issues mentioned above highlight the lack of autonomy and respect in the nursing profession. Students seem to be already picking up on negative views of the general public regarding their chosen profession, which demotivates students in their work. The lack of motivation was earlier described by students as a possible reason why role models act unethically.

5.8 Complexity and ambiguity

Finally, theme six identified from the interviews is that of complexity and ambiguity. Most students either said that they never encountered any ethical dilemmas or decisions or that they were several instances when they did not know what the ethical choice was. The

complexity of ethics was also mentioned in relation to theoretical knowledge as discussed in section 5.3.1.

5.8.1 Dilemmas

In relation to ethical dilemmas, the main example related to the differences between what students learn at in higher education and what they observe in practice. They highlight that there are instances when they feel like what they learnt through the University and clinical practice, was only relevant until their final placement as students. This knowledge and practice gained through university seems to be very different than the knowledge and practice expected out of students when they graduate. These perceived opposing worlds of *student* nurse and *real-life* nurse was a dilemma for students due to it being extremely stressful. As Student B3 mentions: *"I am convinced that yes some things need to be done this way. But I have that dilemma that everyone else does them differently... what is the right thing? Maybe I learnt incorrectly or made a mistake?"*. These perceived differences, as well as the conflicting information and guidance, made it difficult for the student to identify what is right and what is true. This is supported by Student C3 who questions: *"Is this being done quickly because there is lack of staff or time or because of employee apathy?"* This student seems to be struggling with trying to find justified reasons why some people would act unethically. Student C2 goes on to explain that *"ethics is not very straight forward, there are a lot of grey areas"*.

Other students refer to clinical examples, and although they relate to a variety of topics, they all centre around clinicians taking a certain course of action and the students knowing that it is not the right action: "*I do not know, I do not know...because this issue of insulin a lot of people do it. Even where I am now, they do it. Maybe they are aware, they just do not do it right... I don't know" (Student E3).* In this context, the student is talking about omitting a low dose of insulin and signing that this insulin was given. Students perceive such instances as a dilemma, even though these issues are not only ethically debated and are legally well-defined within implemented policy. These inconsistencies in practice by different role models and the different justifications that might be provided can influence the students' confidence in making straight forward clinical decisions. Furthermore, the student mentions that she is unsure of what is right, meaning that there is a certain acceptance of unethical behaviours that are evidenced by the masses as student progress in their education.

This is further emphasised during final placements when students are appropriately advised to give treatment on time for their exam, but the usual practice is for treatment to be given earlier. However, if students do so, they would risk failing their placement:

> *Especially with some nurses, when you do something, you are not supposed to, they get angry...so what am I supposed to do? Should I do it as you are doing it, or should I do it as I am supposed to and you will shout at me?*
>
> *It is a phrase in everyone's mouth...for your final placement do not do this, for your final do it this way. So once the final exam is over what happens? Everyone focuses on the final and what happens after no one sees that.*
>
> (Student G3)

> *You never learn like this, so once you graduate why don't you do things the same? There is a lot...you see a lot of things that you learn about, but they do not happen that way.*
>
> (Student A2)

Student I3 also refers to something being classified as ethics because "*it is from one perspective wrong and from the other perspective right"*, where the students understand that ethics is ambiguous in itself and based on dilemmas. Further examples of dilemmas are associated with choosing one patient over another, the reasons behind do not resuscitate orders and dilemmas in relation to patients who cannot decide in view of cognitive impairment. Student B also comments on multiple occasions when it came to accepting monetary rewards from patients. Student E did not specifically mention a dilemma but provided an example that caused her distress during her practical placement. During the interview the student said that she needed to tell someone about it: *"I think I was quite overwhelmed with a boy who has been in a coma for 7 years. I think I felt like I could not do anything".* Her dilemma is related to helplessness, possibly being incongruent with her understanding of what nursing is, that is to care and help patients get better or provide palliative care.

5.8.2 Decision-making

During the interviews, there is reference to decisions that do not necessarily have a positive or negative outcome. For instance, Student A3 sustains:

> *Generally, you do not know what you are going to do and what is best [laugh]. Because it can go both ways, if you do it you can harm the patient but at the same time you are listening to what the patient wants and feels because ultimately he knows what he is going through".*

Student I3 also refers to applying ethics in practice when making difficult decisions: "*There will be situations when there will be tough decisions or situations that are uncomfortable and you need to take certain decisions that are difficult. So ethics helps you to fall back on, as a guide"*

Student B describes difficulty in making ethical decisions because he feels like he is *"bombarded with ethical issues, when I say I can do this...but I should do this*". This can reflect the student's internal conflict with the decision he is taking. In contrast, Student D2 expresses the following: "*I never encountered an ethical dilemma...we had a case study last year but I never met them...I always knew what the right decision was..."*. This was further supported in Year 3 by the same student since she did not have any ethical issues during the four hours of her final practical assessment during which she had to act out a blood transfusion scenario with her external supervisor. However, this student also mentions examples of giving treatment earlier and knowing that it might not be ideal. Thus, Student D3 acknowledges the following:

> *They tell me, do not do this during an exam obviously...if it is an assessment you need to give it on time. But it is a bit weird, because in the exam you cannot do it and in real life you can.... this might be a dilemma... because it makes more sense that in real life you do what is right and not in the exam, because the exam is planned and not realistic, but in real life you should do what is right because it is realistic"*

The preceding quote highlights the notion that students might not be aware of the ethics involved in nursing practice, but once prompted to reflect further about it, they are able to identify such examples and would refer to these as possible dilemmas. This could also suggest that students do not have enough practice in discussing and reflecting on nursing ethics throughout their education.

The majority of decision-making associated with ethics is the decision between right, wrong, good, and bad. Although these concepts have a different meaning, students refer to the terms interchangeably. The concept of good was more common in first year, whilst doing what is right was more common in third year. Most students understand ethics as deciding between right and wrong. In fact, Student I describes: *"I think I define ethics as deciding between right and wrong".* However, this decision becomes very complex as described by Student F3: *"In a sense what I understand as being good, doesn't mean that others understand the same".* This highlights a belief in relativism about what is good, with very subjective perspectives. Student H3 also expresses the difficulty in always doing good, whilst Student I3 highlights the challenges in making good decisions, referring to organisational regulations that are not congruent with what the student views as the patient's best interest:

> *Knowing what is good and bad and doing the right decision by using your ethics and the ethics that you learnt.*
>
> (Student I1)

> *I do not think that we need to find excuses and loopholes to do what is best for the patient. There is no need for so much hassle to do the right decision" [referring to anointment of the sick to extend visiting hours].*
>
> (Student I3)

> *For me ethics is what is right? I imagine…because it is quite vast as a term.*
>
> (Student D3)

> *…principles that help you realise what is good and bad, in work, with patients and other colleagues…it is something that a human being does. Principles to realise what is right and wrong.*
>
> (Student A2)

You will not always do what is good, we are human after all. I do not know...you get angry or something...if something like this happened I take two seconds to calm down.
(Student H3)

Further complexity was also highlighted by Student A1. She sustains that she might think that she is working ethically but she would not be: *"I would like to follow ethics when I know, because sometimes I think that I am doing the right thing but I would not be…but I do think that I am an ethical person…I think sometimes I prefer doing what is right and breaking the law than the other way round".* This is emphasised also in Year 3, when the same student sustains that she might not know that she is doing something unethical. Lack of feedback and follow up throughout her nursing studies can contribute to the lack of insight on progress made.

Students seemed to mention ethics linked to lack of clarity but at the same time define ethics as a decision between two polarities, that are good/bad, right/wrong. This tension might be a result of biases related to needing to simplify aspects of our care that we do not fully understand. When students were asked how they would know what is right from wrong, students refer to upbringing, inherent character traits, relationships, role models, education, and practice as highlighted in previous sections of this chapter.

5.9 Conclusion qualitative data

Students associate a negative perspective at the place of work with nurses that act ethically, because the general belief is that ethical nurses are few, and usually work on their own and are fighting against the majority. This is also reflected through the relationships between nurses, students, and relatives. There is minimal reference to other disciplines in healthcare, with some reference to medical doctors in relation to nurses being equal to doctors. Moreover, there is also reference to nurses that obey blindly doctor's orders or students who wish to be medical students, and thus do not give their utmost during the nursing degree, which in turn influences the attitudes of those around them. This identified a gap in both theoretical and practical education relating to the relationships with other

healthcare professionals and the ethical decisions that might need to be taken as part of a healthcare team. This can also reflect the organisational structures within local healthcare environments.

Longitudinally evident qualitative data is an exemption towards every day unethical issues that happen in practice and possible regression in practice over a period of time. Students provide examples of leaving a curtain open, giving medication at the incorrect time, laughing at a patient who lost control of their bowel...as issues that are not 'life and death' and things that everyone does, and thus are not major. This supports the idea that there is a perceived hierarchy of ethical issues or how wrong/unethical a decision/action can be.

Over the span of three years, most students had increasingly negative views regarding ethics and nursing practice. Student D and J had the most positive comments during their interviews. They also commented on having excellent role models and mentors throughout their nursing practice that can influence such perspectives. Furthermore, as students progress in their degree programme, they become more independent in their practice, and thus feel that they are increasingly able to make good decisions. However, this is fraught with challenges from both a practical and organisational perspective, but mostly through the need to maintain good relationships with others in the practical setting. Ultimately, this leads to a belief that students will need to follow whatever is accepted as the norm on the setting that they will work in.

In terms of curriculum, most students did not relate to the principles of bioethics model or dilemma ethics, but rather understanding ethics from a perspective of values, behaviours, patient rights and maintaining relationships. What students recalled are the delivery method of ethics lectures and lectures that were not related to ethics but other topics that provided a contextual element to ethics. Furthermore, students seem to have a basic level of knowledge about ethics but are unable or not confident enough to communicate this knowledge and utilise this in decision-making. How this ethical knowledge is applied in practice is also very unclear, and what the role of ethics is in practice is still very ambiguous even by the third year of study.

Students also felt powerless along the three years of practice when faced with unethical practices. There is no discussion with clinicians or lecturers because they do not

feel that this will bring about any change. Students do not speak up and lack the confidence to discuss ethical issues. From the interviews carried out, it is evident that students get extremely frustrated when they are told by nurse clinicians that they only work ethically and according to the books because they are still students, and this will change when they graduate. This notion creates a lot of uncertainty for students about what their role will be once they graduate.

Along the three years, students felt that placements had the most significant role in their learning of ethics. Nonetheless, students often express ethical examples from lectures and theoretical sessions, but unethical examples from practice. As they progress through their course, students have become increasingly aware of ethical issues by giving examples of their own experiences, even though some students highlight that they did not really encounter any ethical issues even in their third year of studies. Some students also had to simulate ethical dilemmas because during a morning of work the supervisor could not assess the ethical domain. Students identified a gap regarding the lack of knowledge by university mentors and supervisors regarding ethics, even though this is one of the assessment of competence domains in all placements. Reflection was identified as one of the ways in which students support their learning in practice, however reflection does not often inform consecutive action.

5.10 Quantitative data

The Year 1 cohort, to whom the surveys were distributed, consisted of a total of 98 students; 27 of which are male and 71 of which are female. The mean age is that of 21, with a range of 18-45. Student nationalities were mostly Maltese (n=94), with 1 student from Nigeria, 1 student from Ethiopia and 2 British nationals. In Year 3, the cohort consisted of a total of 89 students, 24 of which were male and 65 female. The mean age is that of 23 with a range of 21-47. Most students were Maltese (n=86), with 1 student from Nigeria, 1 from Ethiopia and 1 British national. The demographic variables of survey respondents can be found in Table 5.3.

Table 5.9

Demographic Characteristics of Survey Respondents

Characteristics	**Year 1**	**Year 3**	**Mean Values**	
Age	18-28	20-47	19	22
Gender				
Male	7	8	19%	21%
Female	28	31	77%	80%
Trans* Female	1	0	3%	
Trans* Male	0	0		
Gender non-binary	0	0		
Self-defined				
Nationality				
Maltese	35	37	97%	95%
British	1	0	3%	
Nigerian	0	1		3%
Australian	0	1		3%
Race				
White Caucasian	35	37	97%	95%
Multiple ethnicity/other	0	0		
Pacific/Asian	1	1	3%	3%
Hispanic	0	0		
Black/African American	0	1		3%
Employment				
Previous work experience	21	23	58%	59%
Previous healthcare work experience	1	2	3%.	5%
No previous work experiences	14	14	39%	36%
Marital Status				
Married	0	0		
Widowed	0	0		
Divorced	0	1		
Separated	0	0		
In a domestic partnership or civil union	4	1	11%	3%
Single but cohabiting with a significant other	2	5	6%.	13%
Single, never married	30	32	83%	82%
Language				
English as a primary language	10	12	28%	31%
English not a primary language	26	27	72%.	70%

The DIT2 measures the moral development of participants using N2 and Pscores (postconventional). The measurements are distributed into three main schemas of moral reasoning: (1) The personal interest schema; (2) the maintaining norms schema; and (3) the postconventional schema (p-score). The postconventional schema score correlates to the highest level of moral reasoning.

Only level of education had an impact on N2 scores as a developmental index as shown in table 5.5. None of the demographic variables had any significant impact on moral reasoning and development (Table 5.4).

Table 5.10

Demographic Variables vs. Developmental Scores

	Year 1		**Year 3**	
	N2	**P score**	**N2**	**P score**
Age				
Pearson correlation	0.19	0.17	0.01	0.1
Sig-2	0.26	0.33	0.94	0.56
Gender				
F score	1.29	0.72	2.11	3.36
Sig-2	0.29	0.49	0.61	0.1
Language				
T score	0.36	0.42	-0.12	-0.08
Sig-2	0.72	0.68	0.91	0.93
SE	3.70	3.41	4.73	5.54
Nationality				
Two-sided *p*	0.92	0.66	0.84	0.94
Education	Not analysed same education level			
Previous work experience				
Two-sided *p*	0.90	0.79	0.21	0.30
Relationship status				
F score	0.42	0.97	0.49	0.63
Sig-2	0.66	0.39	9.69	0.60

The main outcome of the DIT2 are developmental and phase indices. The DIT N2 scores of Junior high students average in the 20s, senior high 30s, college students 40s and students graduating from professional school programs in the 50s, with philosophy and political science doctoral students scoring the highest, in the 60s. In heterogenous samples, level of formal education accounts to 50% of the variance in DIT scores. The average scores for students in this research study are in the 20s, thus indicating that students are at a lower level of scores than freshman students, who are approximately 18 years old. This is a lower level than that expected from undergraduate students and is similar to vocational students as showin in Figure 3.4. Mean scores for DIT indices for college students can be found in Figure 5.5. One of the possible reasons for these overall scores is that most participants did not select English as their first language (72% = Year 1; 69% = Year 3). From the research identified

and the DIT2 guide, students who select this option are likely to achieve lower scores on the DIT.

Figure 5.5

DIT2 Means and Standard Deviations for Schema Score and N2 Scores (Dong, 2009)

	Summary Scores					
Educational	N2 Score			Type Indicator		
Level	Mean	Std. Deviation	N	Mean	Std. Deviation	N
Freshman	33.42	15.25	10319	4.57	1.89	10320
Sophomore	34.60	15.65	3542	4.68	1.90	3541
Junior	34.65	15.52	6909	4.69	1.86	6907
Senior	36.01	15.42	12204	4.79	1.84	12202

	Schema Scores								
Educational	Personal Interest (Stage 2/3)			Maintain Norms (Stage 4)			Post Conventional (P score)		
Level	Mean	Std. Deviation	N	Mean	Std. Deviation	N	Mean	Std. Deviation	N
Freshman	26.52	12.27	10327	34.29	13.60	10327	34.11	14.99	10327
Sophomore	25.71	12.28	3542	34.28	13.74	3542	35.23	15.35	3542
Junior	24.88	12.43	6913	35.49	13.89	6913	34.91	15.28	6913
Senior	23.67	12.27	12207	35.71	14.13	12207	35.97	15.27	12207

Personal interest schema scores represent the proportion of items selected that appeal to Stage 2 and 3 considerations of Kohlberg's theory. Stage 2 focuses on direct advantages to the participant themselves and on the fairness of simple exchanges of favour. Stage 3 considerations focus on the good or evil intentions of parties, concerns for maintaining friendships and good relationships and maintaining approval. The personal interest score for this cohort of students was the highest out of all three schemas with 39.24 (SD 10.77) in Year 1 and 36.13 (SD 13.83) in Year 3.

The maintaining norms schema represents Stage 4 considerations, focusing on maintaining the existing legal system, existing roles, and formal organisational structures. In this research study, this score decreased between Year 1 and Year 3 from 29.75 (SD 9.60) to 24.96 (SD 9.40). This change is statistically significant as at a *p*-value of 0.03. This indicates

that student progress in their education shifts away from conventional moral reasoning, contributing to a positive developmental change.

The postconventional schema, which represents a higher level of moral reasoning represented items that appealed to Stage 5 and 6 considerations. These considerations focus on organising a society by appealing to consensus, producing procedures, and insisting on due process, as well as safeguarding minimal basic rights. Furthermore, Stage 6 considerations focus of organising social arrangements and relationships in terms of intuitively appealing ideals. In this research study, students score at 21.96 (SD 9.05) in Year 1 and 26.93 (SD 15.55) in Year 3. Year 3 scores have a large SD. Although there is an increase in postconventional scores, this was not statistically significant.

The N2 scores consist of two aspects. The degree to which postconventional items are prioritised and the degree to which personal interest items receive lower ratings than the postconventional items. When comparing Year 1 and Year 3 scores using a paired samples test, there was a statistically significant improvement in moral reasoning, approximately p=0.037, which indicates that students have developed improved moral reasoning abilities along the three-year programme.

Figure 5.6

Mean Scores Paired Samples t-test DIT2 Year 1 vs. Year 3

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	N2 score Y1 (N2 score) - N2 score Y3 (N2 score)	-5.70572	15.76754	2.62792	-11.04068	-.37075	-2.171	35	.037

Paired Samples Test

		Paired Differences							Significance	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper	t	df	One-Sided p	Two-Sided p
Pair 1	Personal Interest Score Y1 - Personal Interest Score Y3	3.29167	17.37501	2.89584	-2.58719	9.17053	1.137	35	.132	.263
Pair 2	Maintainig Norms Y1 - Maintaining Norma Y3	5.30556	14.01595	2.33599	.56324	10.04787	2.271	35	.015	.029
Pair 3	P score Y1 - P score Y3	-4.48611	15.69326	2.61554	-9.79595	.82372	-1.715	35	.048	.095

Table 5.11

Development and Phase Indices Year 1 Compared to Year 3

Developmental Indices	**Year 1**	**Year 3**	**Year 1 vs. Year 3 paired sample t-test**
N2 scores	18.57 (SD 9.83)	24.52 (SD 13.43)	**p=0.04**
Postconventional score	21.96 (SD 9.05)	26.39 (SD 15.55)	p=0.10
Maintaining Norms score	29.75 (SD 9.60)	24.96 (SD 9.40)	**p=0.03**
Personal Interest score	39.24 (SD 10.77)	36.13 (SD 13.83)	p=0.26
Phase Indices vs N2 scores			
Utiliser score	Uscore: 0.13 (SD 0.14) Pearson correlation: 0.13 Sig-2: 0.502	Uscore 0.12 (SD 0.13) Pearson correlation:0.22 Sig-2: 0.23	
Consolidation transition (2 or 1 CONSTRAN)	SE: 10.11 F: 0.14 Sig-2: 0.89	SE:2.15 F: 1.27 Sig: 0.27	p=0.32
Typenew	F: 1.68 Sig: 0.18	F:19.84 Sig**: <0.05**	**p=0.002**

The second aspect of developmental measures are phase indices which provide a fine grade way of examining effects of development and the impact of educational interventions (Thoma & Rest, 1999). The consolidation transition (CONSTRAN) is a measure that identifies students who showed evidence of discrimination among two or more schema-typed items and others who clearly distinguished between the three schema-typed items. Those students that did not discriminate between schemas showed developmental disequilibrium or transition, with no evidence of schema preference. The type of indicator further specifies profiles in terms of consolidation of transitional phases by distinguishing between seven different types, taken from Yeap (1999) and Babeau (2002):

- Type 1: predominant in personal interests schema and consolidated
- Type 2: predominant in personal interests schema, but transitional
- Type 3: predominant in maintaining norms schema, but transitional; personal interests secondary schema
- Type 4: predominant in maintaining norms schema and consolidated
- Type 5: predominant in maintaining norms schema and transitional postconventional secondary schema
- Type 6: predominant in postconventional schema, but transitional; and
- Type 7: predominant in postconventional schema and consolidated.

Typenew scores were significant when correlated with N2 scores in third year. This indicates that students significantly moved to transitional profiles. It is expected that development progresses across the life span and one might expect a person to move from consolidated profiles to transitional profiles with corresponding shifts in schema preference. In third year, most students (n=22) chose the type 2 schema, which is predominant in personal interest and transitional. Type 6 (n=10) schema followed the type 2 schema relating to postconventional but transitional schema.

Further to this, the DIT2 looks at experimental indices, such as the human liberal (HUMLIB) outlook score, the number of cannot decide choices (NUMCD) and religious orthodoxy (CANCER10). Although the religious orthodoxy score (CANCER10) score was almost significant with a p-value of 0.06 between Year 1 and Year 3. None of these experimental indices showed any statistically significant values when comparing with N2 and Pscores. Furthermore, there was no statistical significance (two-sided p) in these scores when comparing first year to third year results. These results are show in Table 5.12.

Table 5.12

Experimental Indices Year 1 vs. Year 3 N2 scores

Experimental Indices	**Year 1 N2 score**	**Year 1 Pscore**	**Year 3 N2 score**	**Year 3 Pscore**	**Year 1 vs. Year 3** **paired sample t-test**
HUMLIB					
F score	1.24	1.33	0.21	0.55	p=0.57
Sig	0.31	0.28	0.96	0.74	
Tukey	0.29	0.12	N/A	0.75	
CANCER10					
F score	1.22	0.86	1.76	0.97	p=0.06
Sig	0.33	0.56	0.15	0.45	
Tukey	N/A	N/A	N/A	N/A	
NUMCD					
F score	0.21	0.64	0.39	0.78	p=0.70
Sig	0.93	0.64	0.86	0.57	
Tukey	0.91	0.73	0.93	0.73	

Overall, the results of the quantitative findings indicate that there was significant moral development in student nurses between first year and third year of studies. However, most students are guided by personal interests when reasoning morally. Possible reasons for this result could be an outcome of most students not selecting English as their first

language, as well as being faced with scenarios within the study that were not based on nursing examples and thus nursing students might not have been able to relate to. This is further explored in Chapter 6. There was no influence of demographic factors in moral reasoning abilities. There was also a significant increase in transitional scores between first and third year, which indicates that students are developing their moral reasoning skills as they progress through their education.

5.11 Quantitative and qualitative data congruencies and discrepancies

The following section presents the findings of congruencies and discrepancies between the qualitative and quantitative data. This is also summarised in Table 5.13.

Only education was deemed to positively influence students' development. This was also highlighted by students and this development could be assessed longitudinally based on student replies. During the third year of studies, there was an increased link between values and nursing practice, compared to first year which were more focused on personal life. However, the extent to which education influences moral development is lower than international means and is based on personal interests. However, during the interviews students often mentioned moral reasoning based on conventional and postconventional thinking, such as patient rights, organisational and professional norms, human vulnerability, relationships with others, values, and virtues. There is congruency in transitional perspectives towards ethics because students do not relate to rigid structures in decision-making and refer to the further development once they graduate. The majority of transitional scores were either in personal interests or postconventional moral reasoning, which is at a discrepancy with interview findings because students often referred to a more complex understanding of nursing practice.

Gender did not statistically influence development, however, this needs to be interpreted with caution in view of the majority of participants being female. During interviews there were no evident differences in development or replies by female or male participants. Students' current relationship status did not influence student development, however relationships in nursing are deemed to be one of the most important factors that can influence development, and good relationships also represent moral agents. Furthermore,

upbringing and family relationships are considered to positively influence moral development.

Employment was not significantly related to moral development. Students did not mention previous employment experiences as a possible influence on their development. However, there is a discrepancy because students mention their practical experience on placement as being the most influential on their development. This can indicate that students relate ethics to the nursing role and professional employment not to other jobs that do not relate to nursing. Furthermore, these past experiences in other roles might not be considered as relevant employment for nursing. At this stage students might not see nursing as employment and thus do not associate practice placements with work.

In this research study, no significant differences in scores were identified between the students who selected English as a first language, and those who did not. However, any DIT2 calculated means have excluded students who do not select English as a first language. During the interviews most students opted for a Maltese interview, thus signifying a preference towards the Maltese language. No difference was noted in specific answers to questions during interviews. However, on occasion, the researcher had to translate questions in English to prompt further answers.

A discrepancy noted is that, during interviews, students often referred to dilemmas and ambiguity in ethical decision-making. However, in the DIT2 most students made a decision regarding their preferred course of action. There was no statistical difference in the number of cannot decide choices between first and third year, which shows that there was no significant development in their assertiveness when making decisions. Dilemmas in interviews remained constant between the first year and third year of studies, although the nature of dilemmas shifts between first and third year. There seems to be congruency between the qualitative and quantitative data in relation to liberal views and religious perspectives. These were not deemed to significantly influence moral development, even as perceived by students.

Table 5.13

QUAN + QUAL Data Matrix

Criteria	**DIT2 Scores**	**Student Responses Interviews Year 1**	**Student Responses Interviews Year 2**	**Students Responses Interviews Year 3**
Age and Education	Significant development between Year 1 and Year 3 (p=0.04). Scores lower than mean expected mean scores.	*Congruency:* Students age increased and their education also. Both experiences with time and education are linked to development, with emphasis on practical experiences and knowledge		
Gender	No significant differences in gender and N2/Pscores of Year 1 and Year 3	*Congruency:* Both male and female students replied similarly to questions asked. Gender did not play a role in understanding or applying ethics		
Employment	No significant difference in N2/P scores of Year 1 and 3	*Congruency:* No reference in interviews to previous employment and ethical development or understanding *Discrepancy:* Students relate ethics to nursing role, which is professional employment, however at this stage might not be considered as employment or relates more to identity rather than work		
Relationships	No significant difference in N2/Pscores of Year 1 and Year 3	*Congruency:* Students did not refer to personal relationships as influencing development. *Discrepancy:* Mention professional relationships and family upbringing		
Language	No significant difference between English and non-English as first language. DIT2 scores might be lower for the latter.	*Congruency*: No differences in language, students talked in English based on character not the questions asked or topic. However, most opted for Maltese language interviews congruent with possible lower scores in DIT		
N2 scores	Significant improvement between Year 1 and Year 3, scores lower than mean scores.	*Congruency:* Students perceive that they have developed in terms of ethics, the process of how this development happens is not well articulated. The level of development is described as very significant.		

Criteria	DIT2 Scores	Student Responses Interviews Year 1	Student Responses Interviews Year 2	Students Responses Interviews Year 3
Postconventional scores	Lower scores compared to DIT2 mean scores. No significant change between Year 1 and Year 3.	*Congruency:* Several uncertainties with regards to decision-making and understanding of ethics. Conflicting views often present. *Discrepancy:* However, higher order of ethical thinking in relation to personhood, vulnerability, and values in relation to nursing practice in third year and general life in first year.		
Maintaining Norms	Statistically significant negative relationship between Year 1 and Year 3 (p=0.03).	*Congruency:* One student mentioned maintaining social norms as an understanding of ethics and further students mentioned organisational norms		
Personal Interests	Highest ranked score in Year 1 and Year 3.	*Congruency:* Themes within the qualitative data can be related to concern with personal interests such as maintaining relationships and being concerned with repercussions of actions on themselves *Discrepancy:* All students very often referred to caring for others and selflessness		
Consolidation transition/typenew	Significantly higher scores (p=0.05) in Year 3. Students in transitional phases.	*Congruency*: Refuting rigid structures for ethical decision-making and relating to multiple approaches to ethics *Discrepancy:* Majority of scores relating to personal interests, interviews showed a further understanding in nursing practice		
Number of cannot decide choices	No significant difference between Year 1 and Year 3 NUMCD choices and NUMCD with N2/Pscores.	*Congruency:* No difference in dilemmas of decision-making between the three years of study *Discrepancy*: Several students referred to ethical dilemmas, difficulty in decision-making or never making ethical decisions.		

Criteria	DIT2 Scores	Student Responses Interviews Year 1	Student Responses Interviews Year 2	Students Responses Interviews Year 3
Human Liberalism	No significant difference between Year 1 and Year 3	*Congruency:* Liberalism perspective referred to by three students, no significant differences between year of study		
Religious orthodoxy	No significant difference between Year 1 and Year 3	*Congruency:* Students did not relate to religious views or justifications for ethical reasoning		

5.12 Overall findings from quantitative and qualitative results

The main conclusion that is congruent between the quantitative and qualitative data is that students have ethically developed between Year 1 and Year 3. This is substantiated by the increasing ability to give examples of ethics in Year 3 and the statistically significant developmental scores between Year 1 and Year 3 N2 scores. The overall scores compared to other literature, indicate that students still have lower scores when compared to students at the same levels in other countries. There seems to be a discrepancy between the student scores and their interview replies. During the qualitative data students have shown an understanding of ethics, especially in relation to nursing practice. The DIT2 provided scenarios relating to life experiences, and thus students might have found it difficult to relate to such scenarios. Furthermore, most students did not select English as their first language, which as a result, reflected in lower DIT2 scores. This is further discussed in the next chapter. The predominant examples of ethics provided by students are related to nursing practice, even though most of these examples are negative. Students perceive that they learn ethics from relationships, emotions, knowledge, intuition and experiences in education. However, students also comment on lack of ethical knowledge and awareness in nursing practice. Students are able to verbalise their thoughts about their understanding of ethics mostly through examples from nursing practice. Students perceive ethics to be based on values, patient rights and vulnerability rather than theories or principles.

Drawing upon the qualitative data, students might not be fully aware of how they develop during their education, both how formal and informal aspects of the curriculum contribute to their development. Ethics is viewed as a complex and ambiguous subject or conversely an inherent trait that one does not need to develop. The process of learning ethics is multifaceted and dynamic in nature. Several factors can determine how ethics education is developed and if it is retained in nursing practice. However, students lack the self-confidence and ability to talk about ethical issues with role models in practice and education. Through these results students provided their perspective on ethics and discussed the most relatable and effective way to learn ethics. Through this data, one can start to understand what matters to students and how educators can develop curricula that are student-focused. The next chapter discusses the research study's results in an attempt to correlate the different themes and aspects of data gathered.

Chapter 6: Discussion of the findings

The following chapter critically discusses the results of the research findings and its possible implications. These findings are discussed in relation to pre-existing research and any discrepancies and congruencies in the findings are also explored. The first section of this chapter explores the longitudinal development perspective and a discussion of the discrepancies in the main findings of this research study. This is followed by a subsequent discussion of the identified themes using a mixed methods approach derived from both strands of data collection methods.

6.1 Ethical development

Throughout this research study, the main aim has been to understand and explore the ethical development of student nurses during a three-year program. The overall results from the quantitative data indicate that student nurses in Malta have improved scores of moral reasoning and judgement between their first and third year ($p=0.04$). The findings also indicate that there was also a statistically significant improvement ($p=0.03$) in Stage 3 and 4 scores (maintaining norms), statistically insignificant increases in postconventional score ($p=0.10$) and a statistically insignificant decrease in personal interest score between Year 1 and Year 3 ($p=0.26$). This is a similar finding to several other studies identified in the literature that delved into ethical development (Auvinen et al., 2004; Duckett et al., 1997; Felton & Parsons, 1987; Kim et al., 2004; Krawczyk, 1997; Mustapha & Seybert, 1989; Nolan & Markert, 2002). Park et al. (2012) did not find any correlation between academic year and moral reasoning ability, albeit identifying a positive relationship between academic year and moral sensitivity. The authors attributed this change to limitations in formal education and socio-cultural changes. Bužgová and Sikorová (2013) did not identify any significant longitudinal improvement, and students obtained lower Moral Judgement Test C-index scores as their age increased. In this research study, age has had no significant correlation with moral development. Moreover, the authors also found a higher proportion of development scores in individuals exiting the program. They also commented on the lower scores obtained by nursing students compared to midwifery students and medical students in the Czech Republic. Felton and Parsons (1987) compared the moral development of students in undergraduate and postgraduate education. Students in postgraduate education had higher

scores of moral development, thus indicating that education has an impact on moral development.

In this research study the mean scores from the quantitative data are still very low for students undergoing professional training with the N2 score for Year 1 and Year 3 being 18.57 and 24.52 respectively. A cross-sectional study carried out by Camilleri (2011) as part fulfilment of a dissertation in Malta indicated that students have scores relating to personal interest and conventional moral thinking (mean Pscore 23.57). The Year 3 scores in this research study are higher than those identified in 2011 (mean Pscore 26.39). Since 2011, the curriculum has changed significantly with the program now delivered as a three-year degree. This might indicate that the changes in curriculum had a slightly positive impact on student ethical development. Camilleri (2011), further assessed the relationship between moral development and intellectual student scores and determined that higher intellectual ability is directly related to increased moral development. In this study, Year 3 students obtained a mean score similar to adolescents that are undergoing vocational studies, in the US and lower than the mean Pscores (44.6) identified for nurses (Dong, 2009; Rest & Narvaez, 1994). From the studies included in the literature review of this thesis, only Mustapha and Seybert (1989) and Sivberg (1998) indicated that nursing students had a mean Pscores in the 20's. However, these studies were carried out significantly long ago and nursing curricula have changed since then.

A multinational meta-analysis by De Casterlé et al. (2008) regarding nurses' responses to ethical dilemmas established that nurses adopt a conventional approach to ethical reasoning. This means that nurses relied on beliefs and conventions rather than critically seeking the best guidelines. These results indicate certain discrepancies when compared to the results obtained in this research study, since most nursing students score the highest in the personal interest schemas followed by the maintaining norms moral schema which relates to Stage 3 and 4 of Kohlberg's moral development stages. This implies that nursing students in Malta have lower scores that that reported in this meta-analysis. However, the participants in this research study are students and the meta-analysis included graduated nurses. De Casterlé et al. (2008), argued that this level of ethical decision-making is not adequate for the postmodern world because nursing care needs to go beyond the application of knowledge and skills, and should push towards the integration of creativity and critical reflection, whilst supporting a postconventional moral approach to decision-making.

In relation to ethical development, the above uncovers a missing link between the cogition of ethics and ethical behaviour in practice. The process of how students can move from understanding ethics to applying ethics in practice is not clear for students, as student B mentions in their second year of studies "*I never had that connection between lectures and what I do. Maybe something that is missing is that there are actually people who help us make this connection"*.

One finding from the interviews conducted, infers that students could not define ethics or claimed that they never apply ethics in their practice or daily life situations. Students view ethics as a complex and ambiguous subject and distance themselves from ethics since they do not feel equipped with the neccessary tools to integrate ethical principles into their nursing practice. This could be because of the association of ethics with abstract dilemmas rather than day to day ethical issues that can be resolved without complex thought. However, a discrepancy was observed in the interviews where students refer to conventional and postconventional moral thinking as societal norms, human vulnerability, patient rights and justice. It is important to note that students who participated in the interviews chose to do to so willingly, and thus bias is a possibility. Nevertheless, all the students who participated in this research study discussed more complex ethical dilemmas in Year 3 compared to Year 1 of studies which is in line with the quantitative findings that indicate an increase in moral development from course entry to exit stage. This demonstrates that students are sensitive to ethical situations around them and are aware of their potential implications in clinical practice This is similar to studies by Baykara et al. (2015), Callister et al. (2009), Park et al. (2012) and Ranjbar et al. (2017) who argue that nursing students can recognise ethical dilemmas in clinical practice and use reflection and critical thinking to analyse their own involvement and actions.

With the significant improvement in moral development evident in both quantitative and qualitative data, there is still a gap in relation to the insight of students regarding how ethical reasoning leads to ethical behaviour. This is evident in the interviews because most often students describe ethical behaviour as a definition or explanation of the meaning of ethics. This is also attributed to students perceiving ethical behaviour as naturalistic or intuitive in nature (Garrigan et al., 2018; Haidt & Bjorklund, 2008; Kahneman, 2013). Students believe that one is inherently ethical, and their character has intuitive abilities that

inform ethical practice. This means that some students do not believe that they need to learn ethics because it is a subconscious action that does not require active thought. The naturalistic adoption of ethics as part of our own character is a repeated notion along the three years of undergraduate study. The reason for such a belief might stem from the lack of understanding of the meaning of ethics and its development. However, some students in the same interview mention that they are trying to learn a value or trying to improve their own personal development, and this indicates that although ethics is viewed as intuitive, it is not innately present from birth, but it is constructed through daily socio-cultural interactions. This lends itself to social domain theoretical perspectives (Haidt, 2013; Smetana & Turiel, 2006; Turiel, 2001).

No differences were identified in relation to gender and moral development. This can be related to the evolution of society and historical shifts in binary views of gender, even though most participants identified with the male or female gender. Adolescents are increasingly aware of the different identification of genders and these perspectives have become normalised in society. Thus, a possible implication is that with the increased equality of different genders within society, the differences in moral development are not evident. In previous research findings Auvinen et al. (2004), Baykara et al. (2015), Geddes et al. (2009), as well as Lacobucci et al. (2013), did not find any difference in gender and moral development abilities. De Casterlé et al. (1997), Duckett et al. (1997), Latif (2009) and Mustapha and Seybert (1989) found that females have a higher level of moral reasoning. The findings in this research study need to be interpreted with caution in view of the majority of participants being female.

6.2 Discrepancy between DIT scores and qualitative data

The next section discusses possible reasons for the discrepancy between the DIT scores and the qualitative data in this research study. In the quantitative data students base their moral judgements on their own personal interests. However, in the interview data, students often referred to ethical principles such as human rights, personhood and vulnerability, which go beyond consideration of personal interests. The first reason is based on the mean values of the DIT2 on another generation of nurses and professionals, which might be very different than the current populations. A possible explanation for this discrepnacy might be because

students might have a low level of moral reasoning ability and understanding of ethics at the start of their degree, students in the interview might be basing their replies on what they perceive as the appropriate answer or they differentiate between their professional self and personal self in ethics and thus the survey data is relating to their personal self and not nursing. In the DIT, lower mean scores are possible in participants who have English as a second language and this could be a possible explanation for the low N2 scores in this research study. However, in Malta nursing students are bilingual, and the vast majority of our education is delivered in English throughout mainstream education. Furthermore, English is the language of instruction and communication at tertiary level. Hence, language was not deemed to be a significant reason for explaining these discrepancies.

Kim et al. (2004) postulated that lower scores for students can also stem from the increased exposure to ethical conflicts in new nursing contexts. In this research study, students often referred to exposure to ethical conflicts in practice. Furthermore, they also mentioned feelings of fear and feeling unprepared to work as an autonomous nurse at the end of their studies. The findings of this research study indicate that students perceive education in Malta as very didactic, with a significant focus on knowledge acquisition. This can lead to students who do not think critically and who are not aware of the moral realm of development in higher education. Didactic learning is still a limitation to university undergraduate education as well, which is constrained by a rigid curriculum that needs to cover specific content related to biological, technical, and medical concepts, most of which are necessary competencies to become a nurse. In their grounded theory study, Ranjbar et al. (2017) found that Iranian nurses have a high level of moral development correlating to the development of a professional identity. The nature of the DIT2 provides scenarios that are not related to nursing practice whilst during the interviews most students mentioned examples of ethics from nursing practice. One way of interpreting this phenomenon can be that students separate their professional identity as a professional ethical nurse and personal ethical individual. This is further discussed in section 5.4.

The low scores in this study prompted a search for studies within other disciplines that might explain or relate to this finding. A study by Ferrucci et al. (2020), utilising the DIT1 short form to explore moral decision-making in journalists, identified much lower scores for journalists compared to 13 years ago. However, when comparing the scores in this research study, the scores still have a mean of 40 which can signify a trend for decreasing moral

reasoning abilities in society. The cultural differences in moral reasoning was also explored in the study by Phillips et al. (2020), where they compared the moral reasoning skills of veterinary students in Turkey and Australia and they did not find any significant differences between universities. Larin et al. (2009) found significant differences in moral development scores between western cultures and the UAE. Malta is a republic country that has a public and democratic system closely related to western countries, and thus these findings might not necessarily explain the lower scores obtained.

6.2.1 A new generation of nurses

A possible explanation for the lower DIT scores and interview replies is that this is one of the first studies that explores and evaluates nurses who are digital natives. The participants who have been involved in this study are some of the first Generation Z nurses to commence higher education and start working in practice. This generation has also been labelled as the generation of digital natives because of their upbringing within a technologically advancing world. No recent nursing studies that utilised the DIT to measure moral development in this generation could be identified. Generation Z students are exposed to vast amounts of information and ideas compared to other generations through the availability and accessibility of the world wide web. This generation has a unique combination of attitudes, beliefs, social norms and behaviours and educators need to understand how these learners think so as to guide student nurses accordingly. Chicca and Shellenbarger (2018) identified that Generation Z are high consumers of technology, pragmatic, underdeveloped in terms of social and relationship skills; cautious yet concerned with emotional, physical, and financial safety; individualistic with an increased risk for isolation and mental health disorders, open-minded, diverse and participants in sedentary activism. These attributes are linked to the findings of this research study because the quantitative results indicate that students base their moral judgements on personal interests whilst in the qualitative data the concept of fluidity and individualistic relativism to moral decisions has been often referred to. In this research study one student states that ethics is open to interpretation, supporting a fluid view of ethical perspectives. A study identifying values and work ethic in Generation Z nurses attributed a safe and healthy environment, economic benefits, respect for nurses as professionals, respect for diversity and an opportunity to expand abilities as the values that are most important to this generation of nurses. In terms of work ethics, Generation Z nurses value honesty, integrity, upholding

patient rights and dignity, as well as accountability for decisions and collaboration with other healthcare professionals (Hoskins et al., 2018; Kim et al., 2021). This is comparable to this research study, in which students value relationships with others, patient rights and diversity.

6.2.2 Previous development

The discrepancy in moral development stages and the lower DIT2 scores might indicate that nursing students do not reach high levels of development during their education, but this might be exponentially increased when they start working in practice. This can also indicate that students enter University education with poor ethical reasoning abilities, suggesting that students might not be ethically well-prepared for university education. Results from qualitative data show that students perceived this mainly because they relate the learning of ethics to experiential knowledge and practical placements and some students believe that they will learn more once they are working autonomously and must make their own decisions. One student mentions that once she is allocated a patient to care for, she will be able to understand her role better when compared to being allocated random tasks throughout the day. Students gradually make their way to becoming professionals and the undergraduate years are the initial stages of this development. However, educational entities might be neglecting the students' developmental process unless a comprehensive and integrative curriculum for ethics is developed. Park et al. (2003), Robichaux et al. (2022) and Gastmans (2002) support the implementation of comprehensive and integrated curricula with the inclusion of different ethical approaches using a multimodal approach. The ICN (2021) also emphasises the importance of giving students the opportunity to make ethical decisions throughout their educational experience. This is also evident because students felt that their final practical placement, during which they were given further responsibility and were subjected to decision-making scenarios, exponentially contributed to their learning.

Students perceive ethics as an 'on-and-off switch' or a document you refer to when you do not know what the right decision is. They do not question the process of making these decisions in practice and lack awareness of how their environment and those around them influence their reasoning and decision-making skills (Lacobucci et al., 2013; Liaschenko & Peter, 2016). This can be linked to the educational approach employed within universities, with the focus on dilemma ethics and principlism. These approaches neglect the emotional, social, and cognitive aspects of moral development. Peter and Liaschenko (2003) argue that

holistic nursing care is viewed as a morally excellent practice, however this can deny the moral worth of daily tasks that nurses do. Clarkeburn (2002), further suggested a skill-based approach to ethics education in life sciences courses. Individuals who are unable to engage in holistic care in organisational or social contexts can be marginalised because they do not reach the moral ideal. Most often, students faced dilemmas and frustration because of their perceived inability to participate in overall patient care or doing the right thing. Cameron et al. (2001) and Park et al. (2003) identified the conflict of the right thing to do as one of the most common concerns for student nurses, where students are aware of the right action to be taken and had to do otherwise in view of hospital policies, peer-pressure and feeling caught between the ideal and practiced behaviour. By incorporating ethics into conversations that are directly related to the tasks that students do, contributes towards the development of their self-esteem and self-efficacy. This might contribute to the correlation of ethics in both personal and professional domains.

6.2.3 Interview replies

Another possible explanation for the discrepancies in findings are the replies to interviews. Students could change their responses to what they perceive the researcher would like to hear. Furthermore, during the interviews with students there are inconsistencies in thought, long pauses, and indecisiveness. This, in itself, can indicate that students are reflecting on the questions being asked and need to deliberate before answering. However, it can also reflect decreased reasoning abilities and challenges in communicating ethical concepts. The challenges in verbalising their thoughts should have been abolished in the quantitative data, since there is no need for communication. However, the scores are still lower than expected means. The interviews provided students with the opportunity to articulate their thoughts and as the students mention, this was very often not an opportunity that they had throughout their education. In fact, all students commented on their minimal exposure to discussions and reflective exercises in relation to ethics and this can lead to the latter. Thus, altough students struggle to verbalise the ethical concepts that they wish to convey, they are able to provide examples drawing from practice or hypothetical examples.

It is important to note that the first phase of data collection occurred prior to the COVID-19 pandemic and the second phase of data collection during the COVID-19 pandemic. Without a doubt, this situation had an impact on the way nursing education was

delivered with less face-to-face interaction and left an impact on practical placements for students. However, only one student passed a comment regarding her training during the pandemic. This was a positive comment about the impact of the pandemic on her appreciation of her family and the positive aspects of her life.

The other possible explanation for the discrepancies in findings is the students' professional and personal identity. This is discussed in the upcoming section with fostering an ethical character. The upcoming sections will delve into further discussion regarding the themes identified and how these can relate to the research questions of this study. Furthermore, an attempt to link education to nursing practice is made.

6.3 Fostering a moral character

The theme of character was a predominant aspect observed in the results of this research. Values, beliefs, attitude, emotions, and behaviour were all discussed in relation to moral character. These sub-themes lend themselves to a virtues-based approach to ethics. The virtue ethics approach is characterised by human qualities such as character traits and attitudes that are desirable to have. From a virtue ethics perspective, questions about the character of an individual precede any form of moral action (Armstrong, 2006; Gastmans, 2002; Sellman, 2011). Some of the terms labelled as *values* by students can be interpreted as virtues such as honesty and compassion. However, students did not label these as virtues. Surprisingly, values were more predominant in the first year of studies. A reason for this could be that as the students progress in their nursing degree they are associating ethics with the nursing profession and with the technical aspects of the nursing degree. Students felt that the values they adopt in nursing correspond to their own personal values. However, one student mentioned that the values they adopt at home might not translate at work, a perception which changed in third year, possibly linking to the assimilation of the nursing identity and group norms within the profession. Another student further mentions the challenge of being virtuous all the time, described by the student as "doing what is right". The challenges identified by students are also arguments brought about in the literature towards virtue ethics. Louden (1992) argued that only evaluating character without looking at the actions of individuals is a failing in virtue ethics. This argument stems from the need to explain why individuals with good character can still demonstrate harmful behaviours.

However, virtue ethics is still regarded as a relevant and useful approach because looking only at action without identifying a link between character, moral sensitivity and other influences that can inform behaviour can reduce complex and multifaceted issues to a single perspective. Moreover, virtues make it possible for one to adopt the correct stance and do the right thing in different situations in life, moving away from context-specific actions since no context will ever be identical. Gastmans (2002) and McLean (2012), suggested that the integral character of ethics education should be interdependent on rational, affective and contextual factors. The authors further referred to cognitive, affective, and motivating factors that can inform good moral action. Students in this research study perceived such aspects to be very important in their development relating to themes of relationships, role models, professional issues, and character.

The values that one adopts vary, with some values stemming from bioethical principles (justice) and others from behaviour informing values (care). From the findings, most students agree that values are subjective and individualistic in nature. This led students to believe that there is no absolute right or absolute wrong, but that the right and wrong decision is subjective and depends on the individual. This idea merits further analysis, as one is unable to question the morality of a decision or context unless they are questioning their own ideas. The idea that yourself and your character determine what is right and wrong is concerning because this shifts the focus of students from a societal to an individualistic perspective of ethics. This can also be supported with the DIT2 results, in which students scored the highest in personal interest schemas.

The values that are mentioned in this research study are empathy and compassion, respect, care, honesty, equality, loyalty, and selflessness. Several of the latter values have also been referred to in studies performed by Cannaerts et al. (2014), Lacobucci et al. (2013) and Park et al. (2003). These values are taken to be synonymous with nursing practice and form an integral part of nursing curricula, pertaining to a level of understanding and retention of knowledge from theoretical sessions. This is hypothetical since students do not directly relate these values to theoretical education. These values are aspects required to maintain a good nurse-patient relationship. Interestingly, between Year 1 and Year 3 of studies, language shifts from helping to caring for, possibly referring to an increasingly active role in patient care.

Students often describe empathy as a way of understanding others, listening, and imagining that patients are family members. However, the nature of relationships between family members and the professional relationship between nurses and patients are very different in nature. This is only mentioned by one student, who said that he is more ethical with his relatives than with strangers he meets in practice. In this research study students believe that they learn values through their upbringing, with only one student referring to religion. Most of the students interviewed live with their parents, and this is common practice in Malta because students do not need to move out to study because most educational establishments are within close proximity. The minimal reference to religion also relates to the increasing secularisation of the Maltese society. Students in the study of Nolan and Merkert (2001) believed that parenting, upbringing, and education have a key role in developing the individual's ability to make moral judgements. This might imply that individuals who do not have a good upbringing struggle to make moral judgements, however, Rest (1982) argued that moral development continues through adulthood, and this is also evident in the statistically significant development of students between their first year and final year of studies.

Several authors have argued in favour of adopting a virtue-based approach to nursing ethics (Armstrong, 2007; Sellmann, 2009; Gastmans, 2002). This approach is grounded in the work of Aristotle (1984) suggesting that virtues are dispositions that can be developed by habit. When implementing a virtue-ethics approach, character can be described as representing one's virtues. This approach is referred to by students in this study as an emphasis on character and one's behaviours based on the values identified. A values-based approach to nursing curricula should support a journey of self-discovery in nursing education through care, compassion, courage, and theoretical/practice learning. A curriculum based on virtues and values suggested in the literature emphasises self-awareness pertaining to professional values and awareness of the values of others. However, McLean (2012) argue that this approach led to students developing their identity as a nurse but at the same time perceive ethical practice as something that cannot be learned. Nonetheless, this research study presumes that awareness translates to ethical behaviour. This is also mentioned by some students, who believe that more self-awareness and reflection on practice will help them develop ethically. The nature of reflection is described by students as a process of exploring actions taken without the possibility of changing them in the future, which indicates a lack of critical understanding of reflection to bring about change. Kyle (2008) and Edlund-Sjoberg &

Thorell-Ekstran (2001) supported the use of reflection and group discussions for the teaching of ethics. However, McCarthy et al. (2016) mentioned that reflection on malpractice or unprofessional behaviour can cause students distress and negatively impact their development of professional attitudes. The authors advocate for a clear policy that is available to all stakeholders involved in student education regarding decision-making processes in a response to ethical concerns.

In relation to character, good character is associated with an ethical nurse. However, one student believes that to be of good character you need to work alone. With some students further mentioning that nurses of *good character* are few and far between. Conversly, students who have had positive role models and commented on their positive experiences in clinical practice view nurses with good character as the predominant population of nurses. The students who commented on such positive experiences in the interviews seemed certain that they want to be nurses from their first year of study, possibly indicating an early acceptance of nursing identity. Ranjbar et al. (2017) stated that accepting the professional nursing identity is associated with greater commitment toward nursing and this identity can transfer between the professional and personal life. However, other students mention that ethics will *automatically happen* once they start working as nurses in practice. This is disassociating the self as a student and the self as a graduated nurse which contributes to the belief that these are very separate worlds.

In view of the above the general student belief is that one can be ethical without knowledge of the right terminology or concepts. Drawing upon cognitive-based theories regarding moral development it can be argued that the degree or level of ethical development without reasoning and cognition is limited. Thus, although students believe that they are ethical in practice, they frequently mention the need to know and learn more about ethics. All students highlighted that nursing helped them mature or build their own character.

A perceived unethical behaviour that students commented on is individuals who only work for renumeration and only doing what is necessary. This was related to the way one communicates, how patient they are, their respect towards diversity as well as how they are actively trying to bring about change in practice. Bringing about change is referred to in the second and third year of study possibly relating to an increased exposure to clinical settings. This indicates that students are observing practice that they believe needs changing. The

qualities that the students mention require nurses to be courageous and assertive when faced with unethical or unsafe practices. Most examples are derived from the behaviour they observe in other nurses. However, when students described their own behaviour, they commented on their inability to change practice due to systems in place that do not allow this because of a perceived sense of powerlessness. In their article proposing a values-based curriculum, McLean (2012) referred to *the nerve* as a central aspect of nursing curricula. This concept refers to the courage required to overcome barriers in patient safety. Furthermore, this value is based on self-belief and personal efficacy. Benner et al. (2008) referred to this idea as moral agency that describes one's ability to act upon or influence a situation. Within the literature discussed, several authors referred to standing up for what is right as an important virtue in nursing practice (Benner, 1997; Callister et al., 2009; Day, 2007; Numminen et al., 2017). This is often referred to as moral courage, where an individual stands up for their beliefs irrispective of the personal repercussions (Koskinen et al., 2021; Pajakoski et al., 2021). The findings reveal that students often commented on their wish to speak up and advocate for patient rights. This is similar to the study by Park et al. (2003) and Edlund and Ekstran (2001), where most students choose passivity when faced with unethical practice. As a result, this leads to students expressing guilt about their inaction or passive attitude. This signifies that students are conciously aware of what is happening around them in terms of ethics and can identify ethical or unethical behaviour but do not have the means or support to bring about change. Most students believe that once they graduate, they will have more power and courage to act as patient advocates. It is interesting to note that students view nurses in practice as passive. In their concept analysis, Numminen et al. (2017) identified experience, overcoming fear, conscience, and ethical sensitivity as antecedents to moral courage. Fear and inexperience also featured in the findings of this research study as a challenge to advocacy for ethical practice (Numminen et al. 2017).

Throughout the three years student felt that they are in an inferior position compared to all healthcare employees. They also commented on how they rarely advocate or speak up for patient rights or when unethical practice is observed. This contrasts with the study by Lacobucci et al. (2013), where they quantitatively measured the ethical confidence of nursing students. In their study, nursing students had moderate self-esteem levels and felt that it is important to confront health care providers who have questionable or inappropriate practice, which was not a finding in this research study. However, this can be attributed to the cultural differences between both countries, that are the US and Malta. Reporting or whistleblowing

in Malta is frowned upon, which is also highlighted by students who comment on the passivity of other nurses when faced with unethical practices. Students are afraid of the implications that this will have on their marks and the relationship with their mentors. Some students believe that once they graduate this powerlessness will decrease. However, other students believe that even after graduation they will still be at the bottom of the hierarchy, and they will not be heard. This belief might stem from students' lack of confidence to communicate ethical issues, their concern for self-interest and the lack of awareness of avenues for reporting. The inability to speak up results in feelings of guilt and frustration among students. This means that students are intuitively aware that their lack of action can have consequences on the patient, however this action is not translating into practice. Similarly, in their randomised control trail, Hsiang-Chu et al. (2022) identified lack of confidence in their ability to communicate about difficult ethical situations.

As mentioned above, a behaviour associated with unethical nurses stemmed from the perceived motivation for working as a nurse. The findings reveal that students commented on nurses who only do what is necessary and only work for renumeration. This can be interpreted as nurses who do not find satisfaction in their work as a nurse. This is, in fact, distinguished from nurses who want to make a difference in the lives of the people they meet and act ethically because they want to do so.

Fostering an ethical character is perceived by students to relate to virtues and values. This can be supported through self-awareness and reflection. However, students do not have adequate awareness on how self-awareness and reflection can bring about change in practice. Ethical characters are also understood to be inherent and guide ethical decision-making without much thought or deliberation. Nurses who are deemed to be ethical are those who do not only do what is necessary and have the right motivations for their actions. Furthermore, individuals that act as patient advocates and speak up for patient rights are perceived to be ethical.

6.4 Emotions and ethical decision-making

The influence of emotion in decision-making for nurses is evident from the research findings. Positive feelings were associated with a good decision, whilst guilt and stress were

associated with wrong decisions or unethical practice. This might indicate that the absence of stressful situations is a result of ethical practice, however this could also be a result of lack of sensitivity to ethical issues. McCarthy et al. (2018) reviewed the reflective writings of student nurses in relation to ethical concerns. Concerns about guilt were often referred to as a conscience and a motivator for working ethically. The recurrent reference to emotion indicates that students are not able to make moral judgements without an emotional dimension to these decisions. The awareness of an emotional domain may suggest sensitivity and perception towards morality that can facilitate good nursing practice (Scott, 2000). Emotions such as frustration, hopelessness and fear inhibited students from engaging in discussion about ethical issues or participating in ethical decision-making. This highlights the need to cultivate emotional faculties in nurses as these emotions act as a trigger, thus enabling nurses to notice what is ethically right or wrong in clinical practice through improved ethical sensitivity.

There is evidence of burnout even within the student population with students viewing nursing as taking over their lives and having very little time to do anything else with 12-hour shifts and studying. These students still received an education during the COVID-19 pandemic but none of the interviewed students perceived this as a reason for their burnout. However, the constant changes and pressure to make up for missing hours of placement and study could have contributed to this stress. Most references in this research study are related to negative emotions such as stress, anger, hurt, frustration, and fear. These emotions are similar to those identified in the systematic review by Sasso et al. (2016). The reasons behind such emotions in this review stem from inequalities in healthcare, relationships with mentors and individual characteristics.

The predominant feeling of fear featured mostly during their third year of studies in relation to autonomous practice. Students are concerned that because there is a shortage of staff in the local healthcare setting, they will need to make independent ethical decisions that might be wrong. This feeling of fear is also related to students believing that they will not continue to work as they ‘should’ in practice. This phenomenon can be linked to moral stress or distress, which can be defined as knowing the right thing to do but being unable to follow your moral beliefs or the right course of action due to external and internal constraints, as well as a difficulty in finding a venue where one can express his concerns (Jameton, 2013; Kopala & Burkhart, 2005; McCarthy & Gastmans, 2015). Epstein et al. (2019) have also

described moral distress as actively doing something that is ethically wrong and being unable to change that situation.

McCarthy and Gastmans (2015), highlighted the need to develop a narrative that highlights further the work the nurses do and their resistance to institutional constraints using ethical competencies and skills. Johnstone and Hutchinson (2015) supported this perspective that further attention needs to be given to the quality of moral decision-making and moral conduct of nurses rather than the distress as a result of decision-making in healthcare. However, the presence of this distress cannot be ignored. The negative approach that students portrayed in this research study can be linked to the narrative that the educational and practice settings provide. A reason for this can be attributed to the lack of requirements and ongoing training of nursing staff after graduation.

However, students did mention some strategies that help them mitigate moral stress through the relationships that they have with their peers. Working with other students in the clinical area allowed students to discuss issues in real-time with someone who can understand their perspective because they are in the same situation and have similar goals in their nursing career. However, peers that do not want to pursue a nursing career or are perceived to have a lack of motivation towards nursing had a negative influence on students. Ranjbar et al. (2017) mentioned that peer-supported learning plays a significant role in the moral reconstruction and acceptance of the nursing identity in view of their group participatory engagement.

Affective domains in ethical decision-making can act as a trigger for sensitivity to ethical issues. These emotions also change the way students react to ethical issues. An emphasis on acknowledging these emotions and working through them through training in emotional intelligence can shift the narrative from negatively lingering onto a negative emotion and adapting this to a learning opportunity. Students also comment on burnout because of studying and long practical hours. This echoes the situation in clinical practice and suggests a need for further emotional support and self-care for students and nurses in practice.

6.5 The educational environment

Ethical development was significantly influenced by student relationships with their mentors, nurses in practice, lecturers, other students, patients and relatives. Kim et al. (2004) and Ranjbar et al. (2017) similarly identified these interactions as having an impact on moral development. However, patients and relatives were not mentioned in this study. Ranjbar et al. (2017) also identified the practice setting as having a considerable effect on nursing students' understanding of the profession through the practice and socialisation related to the profession.

Student nurses believe that they learn most from experience and clinical practice. Interestingly, most of the memorable experiences derived from practice are negative experiences. Even though these are the most memorable, students that have had a positive outlook on nursing have also commented on positive role models. Role models can project their frustrations or positive outlooks towards their practice with students, and these perceptions translate deeply into student worldviews. Even though students believe that practice areas are the place in which they learn, they tend to provide examples from assignments or case scenarios provided in class. Furthermore, when students were asked how they would know something is right or wrong in practice, they commented on the lectures and sessions that they had in university. These sessions are not ethics lectures, but other lectures regarding palliative care and clinical skills. The provision of a context in these lectures is what differentiates between learning about ethics and learning how to be ethical. Similar to their own development, students might not understand or realise the impact that certain lectures can have on their development and adopt a passive approach to lecture content (Ranjbar et al., 2017). Students do not believe that lectures regarding ethical theories are beneficial for their learning, however they acknowledge the need to know and understand ethics better. In a study by Dinç and Görgülü (2002), students perceived theories as useful for their learning, namely utilitarianism, the four-principles approach and deontology. Educators also view theory and ethical principles as a requirement to develop ethical knowledge prior to practicing. Students also feel increasingly confident when equipped with frameworks or decision-making models, whilst ethical theories informed systematic reflection on ethical issues (Cannaerts et al., 2014; Kim et al., 2004; Park et al., 2003).

During interviews students refer to ethical issues in society such as euthanasia and abortion however these are not mentioned frequently. The issues that students are concerned about, or issues that cause distress, are based on day-to-day nursing care, showing that students are reflecting and thinking about everyday nursing practice but not their role as a nurse in society. Although it is argued that students should be more active members in society, the only group that they are concerned about is that of their own profession. This interview finding can correlate with the personal interest schema of the DIT2.

In this research study, students seem to lack confidence to reconcile the dilemmas that they face in practice and perceive most ethical issues as a dilemma. This is related to the idea that ethics is an ambiguous and complex subject. A study by Callister et al. (2009) identified the lack of confidence of students when it came to take an ethical stand. The latter can indicate that a dilemma-based approach to ethics education can cause further distress and further strengthen the negative idea that ethics is based on unsolvable problems. However, ethical development occurs because students engage with moral situations (Ranjbar et al., 2017, Auvinen et al., 2004). In practice, challenging situations proved to be a learning opportunity for students since resolving such issues led to students developing their decision-making abilities (Auvinen et al., 2004; Baxter & Boblin, 2007; Ranjbar et al., 2017). One student mentioned how discussions with her mentor contributed to this process. This could also explain why students, most often, provided examples that are difficult to resolve.

Quantitatively, there was no significant difference in moral development between students who are or were employed and those who are studying full-time, findings that are similar to those obtained in the study by Auvinen et al. (2004). During the interviews, only one student mentioned that previous jobs did not provide the same fulfilment as nursing. Another student sustains the distinctiveness of nursing as a profession compared to computing or office jobs and highlights that nursing is more difficult and complex. A possible reason why students do not believe that previous employment makes a difference is because they are distinguishing between ethics in their personal life and professional ethics. Due to this, they do not find relevance in the ethical competencies that they might have achieved in previous employment. Although students do not refer to previous employment, they specifically highlight that they learn ethics through the experiences that they encounter.

One of the dichotomies of ethics education between the theoretical/practical and student perceptions is that ethics is placed in a compartment, most probably to simplify the topic and make it understandable for students. Nevertheless, students perceive ethics in relation to the relationships they have and the values they uphold. Thus, at an educational level, domains are created that need to be ticked off and competencies that need to be completed, but students may believe that ethics is based on other aspects that are constantly present as part of their character or the relationships they foster.

The educational environment in which students learn ethics greatly influences their development. Students perceive practice settings as the area where they learn the most. However, there is also a passive adoption of examples and scenarios from theoretical practice. Students acknowledge a need to understand ethics better, however, believe they that they make ethical decisions irrespective of their knowledge. Students prefer ethical decision-making models compared to theories, although they are not sure what these models are. However, students associate dilemmas and unsolvable ethical issues as a negative learning experience. Other than theoretical and practical learning, students also refer to experiential learning, as well as the content and pedagogical approaches to learning.

6.5.1 Experiential learning

Experiential learning has been correlated with both negative and positive learning experiences. One student comments on the negative experiences of role models, with these role models emphasising that she will learn from experience rather than providing an explanation. The student struggled to relate to this notion and questioned why she should learn from experience when she can learn something now. This can be explained by generational perspectives and differences between nurses working in practice, where current students look for advancement in their careers both educationally and financially. However, experiential learning is also viewed as one on the most powerful ways that students can learn in practice, and it is linked to the ability to make decisions, which suggests a need to provide better tools for mentors and nursing students on how one can learn from experience such as through reflection and self-awareness, as previously mentioned. McLean (2012) mentioned that experiential learning promotes contextual knowledge and skill acquisition through an integrated approach. Students relate to both experiences within nursing and outside of nursing that promote their ethical development as well as development of their opinions and

perspectives. Experiential references are more common in the first and second years of studies.

6.5.2 Context

In relation to context, students further commented on role models in education who attempt to justify unethical practice. Students refer to nurses justifying unethical practice in view of time, lack of resources or not providing any justification at all. These justifications created uncertainty and feelings of helplessness. However, students mention occasions in which these justifications are relevant, and students tolerate unethical behaviour in view of role models justifications relating to limitations such as time or burnout. Thus, the context in which these justifications are provided and the kind of justifications can merit unethical practice. Furthermore, as students progress in their training, the examples of ethics that they provide are associated with perceived complex issues and not day-to-day nursing issues. Ethical issues distributed into minor or major life and death issues, with life and death issues being deemed as more important and thus students attributed these decisions as being mostly done by medical professionals (Park et al., 2003). This suggests that day-to-day ethical issues do not have the same repercussions as life and death issues and thus are not prioritised. One student further commented on minor unethical behaviours in third year which were deemed to be major issues in her first year of studies. This can support the idea that unethical behaviours, that are repeatedly observed, start becoming standardised, leading to a cultural normalisation of unethical practices. Hence, ethics can seem to be relative to several environmental factors, peer influences and contextual situations. This creates a huge challenge since learning what moral judgements are relative to, is more complex that learning for example, a simple fundamental rule.

Gastmans (2002), suggested a contextual ethics education approach in which the relational, cultural, social, political, institutional, and religious links the nurse has, with other aspects from a specific context, are considered for decision-making. The authors referred to scenarios with interdisciplinary teams within healthcare institutions as deeply involved in ethical problems. Interestingly in this study there is minimal reference to inter-professional practice. For nursing students, the contexts that they work in centre around themselves and other nurses. It is expected that as nurses start to work autonomously in practice, this inter-dependence between professionals in care provision will become increasingly clear. This

suggests a lack of emphasis in education, especially practice settings on interdisciplinary care. The influence of context and institutional expectations and pressures on ethical practice are also mentioned in this research study.

6.5.3 Content and educational pedagogy

Research indicates that students perceive ethics lectures as dull and demotivating (Cannaerts et al., 2014). This is similar to the findings of this research study, in which students feel that ethics lectures are very difficult and unengaging. There is ample reference to further small group discussion, case scenarios based on practice and models that will help in decision-making. Overall, students prefer a problem-based approach with active involvement (Auvinen et al., 2004; Callister et al., 2009; Cannaerts et al., 2014; Ranjbar et al., 2017). Having said this, they acknowledge the limitation of this approach since the class is large, an aspect that this is also highlighted in the study by Park et al. (2012). Students prefer models rather than a theory, with models focusing on decisions that they will be making as students, not hypothetical situations that they will face in the future (Cameron et al., 2001). The use of models is also supported by Park et al. (2003), however the use of models provided a rationale for decision-making but not necessarily an action-oriented resolution. In a values-based curriculum model, McLean (2012) suggested seminar groups, where students reflect on their own practice and experiences and further explore these experiences from a theoretical perspective. Cannaerts et al. (2014) advised caution in relation to case studies and the need for these case studies to be detailed and allowing sufficient time for discussion and development after the case study. A limitation of case studies is that they present a very specific context with limited parametres and do not represent the wider concepts of ethics in relation to other scenarios.

In this research study, there is reference to aspects of principle-based approaches, with one student particularly heavily relying on such an approach for decision-making. It is interesting to note that the student that relied on such models has a medical background. However, there are also a lot of references in the interviews referring to examples involving care, empathy, values and relationship-based approaches. This contrasts with Cannaerts et al. (2014) who mentioned that ethics courses have very little focus on care ethics, virtues and nurse-patient relationships. The same is relevant to the current curriculum in Malta with no

specific mention of ethical approaches other than principlist or normative ethics. However, it is evident that students believe that other approaches are distinctly relevant to nursing practice and are exposed to different perspectives, even though they are unable to define them.

None of the students mentioned virtue and some struggled to understand what a value is, with a lot of uncertainty when discussing values. This can be indicative of a knowledge gap regarding virtue ethics-based approaches in the current nursing curriculum. The emphasis on bioethics and principlism in nursing education is well documented in the literature with students also commenting on these principles relating to ethics. However, this approach does not take into consideration holistic care, focusing mainly on beginning of life and end of life issues, with little consideration of the lived experiences in between.

Auvinen et al. (2004) and Duckett et al. (1997) concluded that the curriculum design or teaching methods utilised are not significantly important in moral development. However, an environment that promotes students' critical thinking will influence moral development (Auvinen et al., 2004; Duckett et al., 1997; Park et al., 2012; Ranjbar et al., 2017). This is congruent with the findings in this research study. Students mention a range of approaches to ethics education, however the difference is that they mentioned several approaches that they deem to be more interesting and engaging. This environment needs to support constructive learning and increase nursing students' thinking abilities, contrasting to the environment that students currently learn in which is an auditorium that allows very limited creativity and discussion in class. Park et al. (2012) and Cameron et al. (2001) stated that although group discussions are deemed as an effective teaching method, the quality of discussion, self-reflection and the competency of the facilitator will influence the outcome of these discussions.

Students in this research study also comment on the mode of the lecture delivery, they find it very difficult to endure hours of lectures. Students value efficiency and productivity from the hours they spend in lectures, thus they need to be worth their time. One student also comments on lecturer attitude, where the student describes that the sessions were interesting because the lecturer enjoyed teaching them (Cannaerts et al., 2014). This contrasts with the unethical behaviour of other lecturers who cancel sessions or leave early from the lecture. This highlights the need for educational entities to reflect on their own ethical behaviour, not

just that which is found in clinical practice. Self-directed learning, including reflection, was deemed as an effective method of learning ethics. According to students, reflection encourages self-awareness in clinical practice and improved ethical decision-making abilities. This observation is also supported by Ranjbar et al. (2017), who claimed that thinking about a decision is a key characteristic in an advanced phase of moral development of nursing students. On the other hand, Cannaerts et al. (2014) sustained that students view reflective attitudes and increased awareness as activities that create a lot of uncertainty. This contrasts with the findings of this research study.

In practice, role models and lecturers at university, whose attitudes and behaviours are not perceived as being ethical, may push nursing students towards being better than these individuals, resulting in improved ethical behaviour. However, being exposed to an aura of pessimism and negative criticism from these individuals when commenting on the nursing profession was very demotivating for nursing students and seems to leave a greater impact when compared to being exposed to positive behaviours. Baxter and Boblin (2007) further argued that inconsistencies between faculties in dealing or excusing dishonest behaviour, makes it increasingly difficult for students to understand what is right and wrong.

Only two students refer to the code of ethics for nurses, with a very vague idea about what the code of ethics means. Others refer to laws and regulations, without clear differentiation between the diverse aspects. Only one student in their third year of studies mentioned that she started to understand the code of ethics further because she started to link the content of the code of ethics to her nursing practice. Numminen et al. (2009) looked at the perceptions of nursing students regarding codes of ethics and agreed that codes contribute to the development of professional identity, which has been linked to enhanced moral development. Linking the theoretical components to practice has been mentioned by several students and most of them identify this as a gap in their learning, that is the inability to connect practice to the lectures. This might explain why students identify clinical procedure examples such as infection control and medication administration as an ethical or unethical example. This is because they are attempting to link what they learn to their own practice which is not abstract but a tangible skill that can be objectively observed. Park et al. (2003) identified the discrepancies between theoretical lectures and practice as an ethical problem experienced by students. This is an evident circumstance that causes stress for students; differences between theoretical lectures and what is observed in practice. These differences

might be related to the lack of justification for actions provided by role models or that the theoretical setting is not relating to real-life situations. In both instances, students are unable to mitigate these discrepancies and this leads to feelings of frustration and uncertainty.

According to some students, the curriculum further emphasises knowledge and competencies as students reach their third year. This was also explained by one student who wanted to spend more time near his patients in third year, but since it was an exam, he believed he would do better if he focused on documentation. His examiner commented that he spent too much time with files and folders, and this led to a misunderstanding of what was expected out of a student in their third year of studies. This emphasis on knowledge does not only stem from university lectures but also from the clinical field. The association of being a good nurse because you are very knowledgeable and intelligent seems to be predominant as a perspective of third-year students, with a heavy focus on academic achievement. The high value placed on knowledge in clinical practice might be linked to the experience of education for role models in practice. Looking back at previous clinical exams, the structure of these exams differed from real-life practice, with a rigid structure and at times involving a whole practical setting preparing for a student exam in a rigid and pre-planned system. A remnant of this system could still be present in the clinical areas since not all clinical educators are trained on current educational pedagogy.

Students did not solely rely on experiences in practice for learning, but also learnt from the theoretical lectures. Lectures that were cancelled at the last minute and the lack of student involvement in class, created an unsupportive environment for learning and perceived unethical practice. The instructional method utilised by lecturers in relation to ethics is pivotal in facilitating understanding. Some students highlight that they did not understand anything about ethical principles. They attribute this to the instructional method and lack of direction towards further learning resources. Furthermore, the relevance to context and everyday nursing issues contributes to the understanding of ethics in a comprehensive and applicable way. One student identifies the unclear link between what is taught in theory and its application in the practice area as a limitation of current ethics education methods. Cannaerts et al. (2014) argued that a combination of theory and practice is an effective way of teaching ethics. However, if a connection between theory and practice is not clear, education in ethics is not very useful.

There is a need to support students with overcoming these difficulties during nurse training and support ethical deliberation in their current practice. Furthermore, there is a need to provide an understanding of negative perspectives on nursing by student and the general public perspectives, such as the long hours and perpetual burnout of nursing staff, but instead provide factual information about staffing levels and how these situations can be mitigated. This cohort of students have witnessed, and are part of an unprecedented time in healthcare, that is the COVID-19 pandemic. Although there is minimal reference to the pandemic itself within the data collected, the impact of training and working during such a global event is evident from the motifs expressed in the interviews when students recall feeling tired, being fed up at the place of work and a general negativity surrounding healthcare professions.

6.5.4 Complexity and ambiguity of ethics in education

There seems to be consistent ambiguity in students' perceptions, with conflicting statements often being presented in the same interview. This is also evident in the quantitative data because students mostly related to transitional profiles of development. Although this might be considered as deliberation, there is still an evident lack of basic understanding of ethics and ethical principles in undergraduate students, as perceived by students themselves, with most students commenting that they would like to understand ethics better.

In relation to ethical issues, most students either do not believe that they encountered any ethical issues, which suggests that there is a lack of sensitivity to ethical issues or they encounter ethical issues but they did not know what the morally correct choice was. On the other hand, some students express that most issues are not ethical because they are easily resolved and do not require much deliberation. Such variation in student perceptions might be linked to the previously mentioned fluidity of ethics, whereby students believe that ethics is *open to interpretation* or that it depends on the individual; they are likely to face challenges in knowing with is right and what they ought to do.

This complexity is more commonly mentioned during their third year of studies, indicating that with increased knowledge and development, students find it more difficult to make ethical decisions. This can be positively attributed to students becoming increasingly

aware and experiencing the complexity of clinical decisions first-hand, as well as becoming more autonomous in their own nursing practice. Students face dilemmas regarding the motivation behind certain unethical decisions. Some of the examples that students express are deemed to be straight forwards decisions, such as omitting medication but signing that it was administered. However, when this scenario is shifted from paper to a clinical setting, several factors, including emotions and relationships, predominate student thinking and the decision of what is ethical is not so obvious and straightforward. Sudents mention that they would give medication at a time other than that prescribed if it is the norm of the clinical setting and their mentor supports this. Students question the realities around them when unethical behaviour is accepted by the masses and the peers around them.

Students feel that their final placement is very ethically challenging because as one student mentioned "*it makes more sense that in real life you do what is right and not in the exam…in real life you should do what is right because it is realistic"*. This dissociation between clinical and theoretical practice is evident in this sentence. A reason for this might not only be because of the presence of this dichotomy but because this dichotomy has been promoted and discussed for years in nursing practice. Although ethics is associated with grey areas, seemingly on a scale, students understand ethics as differentiating between the polarities of right and wrong, good, and bad. However, for students, what is good is very subjective, individualistic, and fluid. This can be linked to lack of ongoing and effective feedback that can support students in critically reflecting about their own practice.

6.6 Challenges to ethics education

From the discussion above, the environment that students learn in is very challenging both in the theoretical and in the practical setting. The huge classes and engagement of lecture delivery has an important role to play in learning ethics, because this in itself can be viewed as an ethical issue. Students support the use of active learning pedagogies in ethics as well as other subjects.

Furthermore, students refer to their perceived self-efficacy and their taking much longer to complete tasks as a barrier to acting in an ethical manner. Students mention that in healthcare there is a lot of emphasis placed on efficiency and, as students, being efficient is

considered to be a postive quality. However, at times, this efficiency gets in the way of ethical and safe practice, because in order to be efficient, students have to cut corners and have less time to think about their practice. This perceived lack of time and the requirement to be fast are also presented as justifications for acting unethically both by role models and students. This is especially relevant to students in their third year of studies, whereby students often get feedback about the need to be faster in the care they provide. This need to hurry can be associated with staffing problems, burnout and long working hours that create a very challenging clinical environment, and this can be linked to moral distress and patient safety issues.

6.7 Relationships in practical and theoretical education

One of the most referenced themes within this research study is that of relationships. The main focus for student nurses is the relationship that they have with other nurses and mentors. Furthermore, good nurse-patient and relative relationships are deemed to represent ethical behaviour. The following sections discuss the findings of this research study and the role that relationships have in developing student ethical development.

6.7.1 Nurse-student relationships

In practice and theory, positive and good role models in practice and theory are key to student development (Borhani et al., 2017). These relationships foster a safe environment that is open to discussion. This is supported by ample literature, all of which stated that much of ethical learning takes place alongside formal teaching (Cameron et al., 2001; Cannaerts et al., 2014; McLean, 2012; Sellman, 2009). Positive relationships are based on open communication channels, positive reinforcement and creating a sense of belonging in this relationship. Mentors who strive for change and support students in decision-making are deemed to be excellent role models. Some students also refer to their mentors being pressured by their peers. One student further comments that her mentor was subject to humour and peer pressure regarding her practice when she was with the student. There seems to be an assumption made that the longer a role model practices, the less ethical they become. There is almost an expectation that if you work for a number of years the nurse will not adhere to regulations or safe practices. Reflecting on my own experiences as a mentor, such comments

were also often mentioned by students where they questioned the researchers practice and the reasons why one would still work *by the book* after a number of years. This might relate to students wanting to work in line with regulations, yet they seem to accept that by time this will regress. This further supports the idea that to retain ethical practice after graduation, the environment that you work in has to support such development. Moreover, education regarding ethics moves beyond the undergraduate student years. Students further mention that nurses who work well do not work in a group because they will inevitably assimilate bad practices that the setting upholds, supporting the idea that the environment one works in isolates those nurses who strive for good practice. Although supportive environments have been deemed to highly influence ethical decision-making, none of the research studies mentioned this isolation and loneliness that practitioners might experience as a result of ethical decision-making. The peer-pressure that students perceive mentors to be subjected to, needs to be further researched. This is because this might further neccesitate support to mentors in clinical practice. Furthermore, it is undeniable that nurses rely on others in the team to meet nursing goals and it is very difficult to work in isolation as a nurse without jeopardising patient care. Related to this, Gastmans (2002) also suggested shifting the conversation to a healthcare ethics approach, where ethical issues in relation to the different roles within the healthcare team, not only nurse-patient relationships are discussed. This approach can be adopted to focus on ethical issues that might arise between nurses themselves in clinical practice, not necessarily relating to direct patient care.

Further research suggested that students experienced ethical dilemmas when other nurses, who are role models or mentors took unsafe shortcuts in patient care (Baxter & Boblin, 2006; Numminen & Leino-Kilpi, 2007). This resulted in students feeling caught in between patients and nurses. Students wanted to resolve their ethical conflict in a way that led to happiness (well-being, excellence, self-actualisation), meaning (seeing their life as part of a bigger, purposeful picture), and integrity (living up to their best values). In this research study, students often mentioned examples of knowing what the ethical or safe way to carry out a task but were advised or observed otherwise in practice.

There is a need to support students who have experienced difficulties and dilemmas in clinical practice such as being exposed to long hours of work and perpetual burnout experienced by the supervising nursing staff. Most often, the findings reveal that students felt like they are a burden to practicing nurses whose main objective is that of working

efficiently, thus creating a stressful environment. Students believe that they are at the bottom of the hierarchy of healthcare and this notion seems to persist with some students believing that once they graduate this power imbalance will remain present. This inequality further underscores this hierarchy in the clinical areas. The language that role models use in practice can also emphasise the lack of power that students have. Peter and Liaschenko (2003) argue that moral understanding cannot be disassociated from the social role and related hierarchies and that such organisational mechanisms define moral responsibility.

During the interviews carried out in this study, students also comment that feeling part of a team or working in settings that have good teamwork created a more supportive environment. Creating such a setting has a similar value to that of having a good role model. Another student found difficulty in building a relationship with their mentor because of the generational differences and the differing perspectives on contemporary issues such as teenage pregnancies, abortion, LGBTIQ rights (Lesbian, gay, bisexual, transgender, intersex and queer) and similar issues. Role models and students might lack insight into the different worldviews of other generations and simply dismiss other generations as being inferior compared to their own. Opening a good channel of communication can be an effective approach in mitigating these differences and creating a culture of understanding.

Currently, in practice, role models are responsible for giving students a grade as part of their practical assessments. When students discuss situations in which they felt distressed, or when they faced ethical dilemmas in practice, they do not seek guidance from their role models because they are afraid of how this will influence their marks. There is a power imbalance between students and mentors in clinical practice that is detrimental to student learning and sustaining a positive relationship. Unless mentors directly ask students for an opinion, students will not question or discuss dilemmas that they have in practice. However, students view their relationship with mentors as a very important aspect of their learning. Thus, although this relationship is vital to a positive learning environment, it might be hindered by organisational structures of providing a grade. Some students comment on the lack of ethical awareness by other nurses in practical settings. This is evidenced by students because clinical supervisors isolated one example from a morning of work or tried to simulate an ethical scenario in the clinical setting because of the perceived absence of any ethical issues in care. This can suggests that ethical sensitivity and awareness is limited with clinical

nurses involved in the assessment and mentoring of nursing students, possibly also stemming from the training that nurses have been previously exposed to.

In the current system all students are allocated to a link lecturer who follows up their practice and theoretical progress in the course. Students feel that they were able to discuss ethical issues with link lecturers, but they did not engage in such an endeavour as they felt that their concerns were never addressed, and no action is usually taken to amend the issue. This can be true because unless the students formally write a complaint it can be quite challenging to follow up. This means that students do not refer to link lecturers in relation to ethical or moral development. However, one student mentions that her link lecturer prompted her to discuss ethics with her clinical mentor. This suggests that further training is required for link lecturers regarding ethical domains in practice and a system for highlighting complaints or patient safety issues anonymously that students and mentors are aware of. However, there is a question of which should be the entity that addresses such concerns. Currently in Malta, any complaints about an organisation are dealt by the organisation itself, thus being at risk of biased forms of troubleshooting. The introduction of a patient council can act as a mitigator between both educational and healthcare provision entities in order to promote patient safety.

A review by Cannaerts et al. (2014) regarding ethics education assessed the perceptions of educators and students. One of the findings mentions that students who reflected on practice, discussed conflicting viewpoints, and performed self-examination felt more vulnerable and thus resulted in uncertainty about practice. This highlights the need for a safe environment with educators that are adequately equipped to supervise and have such discussions (Baxter & Boblin, 2007; Clarkeburn, 2002). In this research study, students do not view the practical setting as a safe environment and regard link lecturers as an avenue that will bear no results nor promote any improvement. Cameron et al. (2001), Cannaerts et al. (2014) and Kim et al. (2004) suggested that students should have the opportunity to discuss anonymous cases in a private setting within a democratic climate, so as to provide a feeling of security. Ranjbar et al. (2017) also found that nursing students' moral development was significantly influenced by their educators, mentors, clinical practitioners, and their peers. In this research study, students often referred to relationships with their mentors, nurses in practice and peers as having an impact on their development, both positively and negatively. Students also emphasised their relationships with patients and how they developed morally

through experiential learning. The reference to university lecturers is often passive in nature, with students mentioning lectures and the theoretical setting, when prompted on how they would differentiate between what is right and wrong in clinical practice. This is a similar finding to the one observed by Ranjbar et al. (2017), wherein passive acceptance of lecture content was observed.

The notion that students will exhibit an innate understanding of ethics upon graduating could be paralleled by what role models, such as clinical supervisors, believe when it comes to ethical development, namely that the understanding and application of ethics is instinctive and present from the start. Baxter and Boblin (2007) suggested that individuals who have not been challenged in their moral reasoning are unlikely to develop further. The authors further maintained that, based on Kohlberg's theory, students can be in a stage of moral development based on their own personal interests rather than the needs of others and these individuals are highly likely to be influenced by authoritative figures, as also mentioned in this research study. Students in this level of development who have not been challenged by supervisors, lecturers or clinicians may ultimately lead to unethical behaviour. It is interesting to note that students rarely identify their own unethical behaviours but refer to the unethical behaviour of others around them or a potential unethical action that they might take. This might be because they do not wish to disclose this information or because they have not been challenged enough in terms of their ethical behaviour and are thus unaware of it. Students also mention that when ethically difficult situations arise, the clinician is involved in the decision-making process and the student stands aside, with one student further mentioning that most ethical decisions are made by medical professionals, not nurses.

In their third year of studies, students' final practice placement was an experience that really propelled their personal and professional development. However, this placement also brought with it some of the most frustrating dilemmas and challenges. One of the common themes that emerged was the dichotomy between what they do in their final placements and what they will do once they are nurses. Students mentioning that several nurses in practice tell them that they will not continue to work and be as they are once they graduate. This creates feeling of uncertainty regarding their role and identity once they are a nurse and challenges students to think about why there is this difference. This led to one student questioning whether all that he learnt at university was a fallacy, even though university

education is based on research. Another student questioned why good practice is employed during their assessment but not in real life.

Role models in practice and lecturers at university, whose attitudes and behaviours are not perceived as being ethical, pushes nursing students towards being better than such individuals and avoiding the same behaviours, possibly resulting in improved ethical behaviour. However, negativity from individuals that are perceived to be unethical, regarding the nursing profession was very demotivating and seems to leave greater impact when compared to positive behaviours by other role models.

Nurse-student relationships are deemed to be very important for students in their development. Belonging to a team, peer-support for mentors, mentors who practice ethically and safely, mentors who challenge student behaviours and treat students as equals left a positive impact on students. The emphasis on determining what links theory and practice, rather than how they differ can support students in understanding how these two domains of nursing can better relate to each other.

6.7.2 Relationships of nurses with patients and relatives

Fostering good relationships with patients and relatives was a motivator for nursing students in improving their own nursing practice. The ability to build good therapeutic relationships is considered a defining characteristic of good role models. When patients and relatives show gratitude and respect towards nurses, students feel valued in the profession. They mention that patient and relatives who are disrespectful and do not value the nursing profession make it very difficult to care for them. This indicates that the nurses' own experiences of patient care and the relationships that patients have with them, will influence their ethical behaviour.

The aforementioned relationships are often subject to ethical concerns in view of the inadvertent disclosure of information. The limited living area in Malta means that relatives live very close to each other, thus allowing easy access to family members in need. However, at times, relatives tend to take over patient care and hinder the decision-making abilities of the patients themselves, a trend which is often viewed as unethical by student nurses. One student clearly differentiates between family relationships and professional relationships.

Other students claim they cared for their patients as if they were their own relatives thus ensuring that they provided high quality care.

6.7.3 Personhood

The following theme describes one of the identified discrepancies between interviews and quantitative survey data. Survey data indicates that students make moral judgements based on personal interests. However, the interview questions make several references to personhood, vulnerability, holistic care, dignity, and patient rights. This correlated to postconventional ways of thinking through the reference of extrinsic ethical principles that can guide moral reasoning. A possible methodological reason for this difference is the purposive nature of the interview recruitment and the small sample size of survey participants.

Students believe that objectifying the person and looking at the patient as a number, bed or an object is unethical. They contrast this with treating a patient with dignity and refer to the need to look at patients as human beings who are vulnerable. One student further highlights that expressing showing emotion towards the patient shows an understanding of ethics. These perspectives are evident during all three years of study. Students further note that vulnerability and dignity may be overlooked because care becomes part of a routine, resulting in such issues being taken for granted.

Most students view patients as being vulnerable and sometimes even pitied these patients. This pity can be automatically associated with patients having a poorer quality of life, a factor which can influence moral decision-making. In this study, students believe that recognising vulnerability and weakness leads to responsible ethical action. However, they do not mention the need to empower patients to help them break through their vulnerability but rather adopt a passive attitude towards this helplessness. However, students in this research study show that they can relate and are sensitive to the vulnerability of those that they care for and that their focus centres on caring for the person and not the disease. Most nursing students work in hospital or clinic settings and do not have a lot of exposure to social settings in which individuals who are vulnerable can integrate into normal life routines. Although educational content focuses on the social perspectives of care, this might not be evident in the practice setting. Students directly refer to patient’s rights as a directly relating to patient

safety and person-centred care. These concepts of vulnerability and patient rights are central principles in bioethics and thus can be associated with post-conventional moral reasoning. However, this information featuring in interviews can be a regurgitation of information that students have during lectures.

Students focus on the relationships based on four main pillars, that are (a) nurses which includes mentors and academics; (b) patients; (c) relatives; and (d) the students themselves. These are interrelated with each other and the dynamics within these relationships will influence ethical decision-making of all parties involved. Students emphasise the impact of relationships on the well-being of others through teamwork, a sense of belonging and good communication. In turn, these relationships in turn are social experiences that students value and have a significant influence on their ethical development.

6.8 Role of the nurse and identity

The formation of an identity in the nursing profession leads to a decrease is moral stress and improved moral development (Haghighat et al., 2020; Lacobucci et al., 2013; Ranjbar et al., 2017). Nevertheless, how nursing derived its identitiy in Malta is still a subject that is not included in nursing curricula. During the three years, students gradually increased their actualisation of a nursing identity, with their final practice placement being a pivotal experience in the assimilation of such a role. In their research, Lacobucci et al. (2013) argued that nursing students who assimilate professional nursing values such as privacy, confidentiality and respect, noted an improvement in their perceived confidence in ethical decision-making and self-esteem. Moreover, in this research study students highly valued respect, confidentiality, and privacy, which might indicate that students are in the process of developing their professional identity. Thus, developing a professional identity can be directly correlated with moral development.

Students sustain the belief that nursing contributed to their development and personal growth, suggesting an assimilation of values to their non-professional life but not vice versa. Although not mentioned as a direct link to ethics, students mention that nursing encouraged open mindedness regarding the diseases that one can have and encouraged students to appreciate life and one's vulnerabilities. This belief is predominant in the second and third

year of studies when students are increasingly exposed to clinical practice. This indicates that students are reflecting on their own practice and their worldview is changing because of the nursing degree they embarked on.

There are also discrepancies of what students perceive to be the role of a nurse. One student mentions the distress caused by being unable to improve a patient's condition. Nurses are viewed as heroes, angels and life-savers and this situation might have clashed with the mainstream stereotypical view of nurses. The stereotypical and subservient position of nurses demoralised students, with one student mentioning that society does not know what the actual role of nurses is. In practice, this also translates to autonomy and hierarchical inferiority compared to other health professions. Students are unaware of the reasons why nursing is viewed as such and how this has been shaped by history. However, one student highlights that this perception motivated her to prove to people the true value of nursing in healthcare and society by working ethically.

The decision to join nursing is also viewed as a moral one, because joining nursing is correlated with good character (Ranjbar et al., 2017). This can justify unethical practice, because one would already believe that they are good simply by becoming a nurse. Thus, one might be unethical in practice, but their self-perception is that they are still good because they are nurses irrelevant of what they do. The idea that becoming a nurse automatically means one is doing something morally superior to other professions can be detrimental to nursing practice because nurses are not viewed as professionals but as following a vocation and this decreases their rights at the place of work. If students are unable to figure out who they are and what their values are, as well as gain their identity as a nurse, they can be subject to moral distress.

This assimilation of identity identified by Ranjbar et al. (2017) is similar to findings observed in this research study suggest that assimilating a nursing identity promoted development, with students referring to feeling like a nurse at the end of their studies. There is also reference to previous years of study with nursing principles being assimilated into their own personal identity outside the place of work with reference to nursing influencing their attitudes and moral behaviour outside of work. This internalisation of nursing values and morality was also found in the study by Ranjbar et al. (2017). However, one student in his third year of studies reflects on how, in nursing, it is easy to do something wrong and hide it,

which renders a very negative perception towards nursing. It is worth noting that this student does not want to be a nurse but pursued the course to later start a medical degree. The lack of assimilation of identity by this student can be linked to the fact that he is not committed to working as a nursing professional after finishing the course. This can provide an insight into another perspective towards development. A possible reason for the lower moral DIT development scores signifying personal interest based moral reasoning, is that students develop the ability to rationalise unethical practice and think of ways in which this can be hidden in their own practice. Other students have observed this behaviour in role models in practice with nurses covering up errors in relation to patient care. Ethical decision-making is related to the development of professional identity through the reconciliation between the personal and professional self, the realisation of nursing role expectation in different contexts and reflecting on one's own preparedness and confidence in resolving dilemmas. In this research study, two students commented that research interviews regarding ethics was a reflective exercise that promoted the level of self-awareness regarding ethics.

6.9 Conclusion

This chapter provided a discussion in an attempt to understand the discrepancies and congruencies in this research study. Overall, this research study indicates that nursing students have not adequately developed their moral competencies by the end of their third year of studies. This is shown by the quantitative findings and the perceived development by students themselves. It is suggested that most nurses in practice, faculty and students do not have adequate training to facilitate the learning of ethics. However, even though students do not believe they need further training regarding ethics, they are able to make ethical decisions beyond just their own personal interests and this is evident from the qualitative data. Although students progress in their ethical development along their undergraduate years, there are contexts and situations that can facilitate regression without consistent training regarding ethics. This indicates that there is a need for ethical competencies and ethical reasoning to be placed at the forefront of nursing education beyond the undergraduate years. A shift in educational pedagogy beyond dilemma ethics and principles is clearly expressed by students. Fostering critical reflection on solvable day-to-day ethical issues and increasing student awareness about the factors that can affect ethical decision-making such as social,

affective and contextual domains, supports students in having insightful and informed ethical development.

The experiences that students have shared in this research are unique and have provided an insight into the students' worldviews regarding ethics. With the growing complexity of healthcare and the increased demands placed on the nursing profession, ethical dilemmas are on the increase. Nursing students should be encouraged to think critically about their environment and to be empowered to speak up when confronted with unethical practice, as well as implement ethical decision-making in practice. However, it is not only the educational institutions that need to change, however also the healthcare organisations in which the students practice.

Chapter 7: Conclusion

The study of moral development still needs further academic involvement from several disciplines. Its relevance to current times is undisputable with global threats, cultural disputes, inequality, and the rapid technological advancements. Nurses who are prepared and confident to participate and positively contribute to the improvement of society at large through sound moral judgement and actions is pivotal in upcoming curricular changes.

7.1 Aim and research questions

The aim of this research study was to explore and evaluate the ethical development of nursing students during an undergraduate programme:

i. How and to what extent do students develop ethically over an undergraduate nursing programme?
ii. How does education influence ethical student development?

7.2 Significance of study

This is the first research study to longitudinally follow up nursing students within the University of Malta. This is also the first research study that delves into the ethical development of nurses in Malta. Furthermore, this is the first study that sought student perceptions of ethics education. It is also the first research study that used a mixed methods approach to provide a deeper understanding of student development. Globally, in English, no research studies that combined mixed methods on the same student cohort for a longitudinal period was identified. Furthermore, research on student ethical development and understanding of ethics was last identified 10 years ago. Thus, this research study provides new insight in relation to ethics education of a new generation of nursing students. This research study presents a clear audit trail of literature retrieval, as well as a detailed description of the methodology and methods utilised for this research study. Furthermore, this research study has given a voice to nursing students, who are key stakeholders in education. Their development from the beginning to the end of their studies provides a unique insight

into their experiences and worldview, not only for ethics but also for higher education. This is hoped to equip academics in nursing education with a better understanding of student development and inform evidence-based curricular changes.

The discrepancy between interview questions and DIT2 results could not be found in any other research study. Globally, studies that have explored nursing students' ethical development using the DIT2 were carried out in 2012. In 2022, the DIT2 was used with nursing students in South Korea to assess the impact of an educational intervention. The DIT2 may not reflect the moral reasoning of nursing students since this was developed to address the adolescent populations in general. Furthermore, the sample size included in the quantitative data is quite small and thus the interpretation of this data should be done with caution. The following sections will discuss the research questions in relation to the findings, implications and reccommendations of this research study.

7.3 The extent of ethical development during an undergraduate programme

A summary of the perceived and quantitatively measured and qualitatively explored ethical development is presented. The implications of this development and reccommendations for education and practice is provided.

7.3.1 Findings related to student longitudinal development

Overall, the quantitative data reveals that students develop ethically during an undergraduate programme. However, this development is based on personal interests schema from the beginning of their programme and remains in this schema in their third year of studies. However, the score significantly increased over three years. The discussion of this chapter provides several reasons for this finding. This finding does not fully support the findings of the interviews since students have shown awareness of ethical principles beyond their own personal interests. Students believe that they have developed ethically during their undergraduate programme. This is in congruency with the qualitative change in student replies between Year 1 and Year 3 of studies, which supports the longitudinal development scores of the quantitative data.

7.3.2 Implications for student's longitudinal development

Further training regarding ethics in primary, secondary and post-secondary education can improve students ability to identify, assess and evaluate ethical issues. This is similar to reccommendations and findings by O'Flaherty and Gleeson (2014). Having further education prior to entering a professional university programme can improve student development through higher moral schemas. Throughout their programme, a consistent input of ethics education can ensure that students have consistent and incremental developmental changes over time. This training should go beyond the undergraduate years and continue throughout the careers of nurses. This will also ensure that nurses are aware and sensitive to emerging areas of ethical issues in healthcare.

7.4 What do students understand by ethics and ethical development?

The following section attempts to summarise the findings and implications of this research study in relation to student perceptions of ethics and ethical development. This is a sub-question on how and to what extent students ethically develop during their undergraduate education.

7.4.1 Findings related to students understanding of ethics and ethical development

This research study indicates that nursing students associate ethics with the role of nursing and professional identity. This can be linked to the process of becoming a nurse during undergraduate education. Student understanding of ethics is based on several approaches to ethics, namely character and humanity. Ethics related to character is based on values, attitude, beliefs, emotions and behaviour. For humanity, ethics is perceived as patient rights, dignity, vulnerability and holistic care. This supports findings in the literature review where students do not only relate to a limited approach towards bioethics. Students are concerned with day to day issues that are affecting them as students. However, students perceive ethics to be a complex and ambiguous subject with minimal problem solving. There is also an understanding of ethics in relation to clinical procedures in nursing practice and organisational and professional laws and regulations. A further reference to the relationships

of nurses with patients, relatives, students, and other nurses is considered to be an ethical domain.

1.1.1 Implications related to students understanding of ethics and ethical development

In relation to the findings above, this research study informs curriculum development in Malta through the inclusion of an integrated curriculum that includes; virtue-ethics, values, care-ethics, social theory, and a broad understanding of bioethics beyond the four principles. Students relate to ethics and moral development beyond fundamental principles and decision-making. Their perceptions of nursing ethics in relation to care and personhood, upholding values such as honesty and loyalty and equality in the provision of care to vulnerable populations merits discussion and inclusion in decision-making models and curricula. Adopting a wide-range of approaches and models in education supports students in developing conscious awareness and sensitivity to ethical issues in nursing practice.

7.5 Student learning of ethics and influences on learning

This section will summarises the findings of this research study in relation to ethics education and practice. This section presentes the different ways in which students believe that they learn ethics and what influences this development. This is a sub-question of how ethics education influences student ethical development.

7.5.1 Findings related to learning and influences on learning

The findings of this research study reveals that nursing students mostly learn through practical placements and passively assimilate knowledge from ethics mainly based on lecture content. There is significant focus on the relationships of students with mentors in practice, lecturers and other students. Students also believe that reflection and experience contribute to their learning. However, throughout this study, tudents have verbalised several negative experiences in practice that lead to emotions such as sadness, frustration, anger, fear, and frustration, amongst many others. This is also linked to the relationships that students

experience in clinical practice. Students further comment on the challenges they face when learning and trying to apply ethics in practice. Students perceive a lack of ability and confidence to speak up about ethical concerns and pressures to work efficiently in a way that might compromise safe patient care.

7.5.2 Implications for ethics education

These findings suggests a strategy to assist students in navigating relationships in practice and decreasing the power imbalance between students and the rest of the healthcare team. This strategy needs to include stakeholders in healthcare such as faculty, students, patients, and healthcare organisations. This can be achieved by removing the power of clinical mentor to give a grade for students but look towards assessing competencies based on a pass or fail, provide training to clinical mentors and students on maintaining relationships in the clinical area, providing a framework for faculty members to anonymously report abuse of power by both students and mentors.

In this research study, students often referred to negative, or sometimes even upsetting clinical situations that they had to either suppress or cope with on their own. Thus, strategies to deal with moral distress for students is suggested. This can be achieved through peer-mentoring and training for link lecturers in identifying moral distress in students. A safe and anonymous method for whistleblowing regarding ethical issues needs to be identified to mitigate this distress. Students and nurses need to have a person or somewhere that they can go to when confronted with such situations. Healthcare organisations are morally obliged to investigate and take action on reports in an unbiased manner such as through patient councils, organisations and employee associations.

The above suggestion also supports the need to create a supportive environment in nursing education through active involvement of students in ethical decision making and critical reflection. Students are not bystanders in care provision but provide vital input to the healthcare team and patient care. Ample time to practice ethical decision-making based on real and relevant clinical scenarios is hoped to equip students with the necessary skills and assertiveness to lead ethical decision making in the future. Critical reflection on their own

nursing practice can further address the gap between theoretical constructs and ethical practice.

Considering the mostly negative comments and emotions associated with ethics and ethical decision-making and the focus on unethical practice it is suggested that education should think about adopting a positive approach to ethics rather than soley a dilemma based approach. When students are only aware of ethics as a result of dilemmas, they felt like it is too complex to understand and ethics is only useful when you are unsure about a decision. This could overshadow the impact of everyday ethical decisions involved in nursing practice. A positive approach can be one of the measures that promotes job satisfaction within the nursing population and in turn positively influence students practice experiences.

Students perceived patients as being vulnerable and possibly dependent on nurses. A stronger patient voice in nursing education, including patient experiences of unethical and ethical practice and the outcome on patient care can provide insight to a different perspective on how healthcare is experienced. Involving key stakeholders in education, beyond lecturers, mentors and healthcare organisations can provide insight into the impact of ethical nursing practice on patient care, looking beyond the necessary technical skills.

In this research study, most students are afraid to speak up, voice their concerns and take an increasingly active role in practice. Furthermore, nursing education should aim to provide the tools and required for students to be active participants in care and society through increased confidence when communicating their views. This can be achieved through debates, argumentation, critical thinking and positive reinforcement. Curricula that include issues that are currently challenging society, including climate change, equality, peace, immigration and poverty will hopefully empower nursing students to participate in social activism and speak up about these challenges that will noticeably leave an impact on their nursing practice.

With the practice area being deemed to have the highest impact on student development, further training, and education regarding ethics to mentors and nurses in practice is required. This needs to move beyond publishing guidelines on ethical problems or codes of ethics and focus on effective supervision and discussion in practice. This education is an ongoing process due to the desensitisation to moral issues over time. Furthermore,

healthcare organisations and universities need to be consistent in the expectations of student behaviour both in lectures and in practice. Further discussion of ethical issues needs to be carried out at faculty level as well with all lecturers.

7.6 New insights from this research study

This research study identifies perceived determinants of students' ethical development along their three-year programme. This research study suggests that dilemma ethics or a problem-based approaches without an answer are not sufficient in ethics education. Nursing students value ethics education that adopts a virtue, value and social approach based on context relevant to day-to-day nursing issues. Furthermore, students view ethics as a complex and ambiguous area of nursing without clear guidance and adequate support in decision-making. This is associated with the perceived lack of awareness and education regarding ethical issues by stakeholders in education such as mentors, clinical educators, and lecturers. The lack of awareness of ethics in clinical and educational organisations inhibits students from reflecting and practicing ethical decision-making. This research study also reveals that navigating the affective and social domain with regards to ethics needs to be included in ethics education. Students believe that their ethical practice and decision-making abilities will regress with time after they leave higher education. Theoretical and practical education are considered to be two very distinct branches of education with minimal continuity, this is also evident between nursing student practice and nursing practice after graduation. A further finding relates to the hierarchical nature of nursing in Malta, with nursing perceived to be inferior to other professions and thus not involved in ethical decision-making.

7.6.1 Summary of main findings

Thus, emerging from this research study, the section below highlights the main findings in relation to student ethical development in undergraduate education:

i) Students understand ethics as a multi-faceted subject referring to emotions, character, virtues, attitudes, social ethics, bioethical principles, and day-to-day nursing issues.
ii) Students do not refer to interdisciplinary issues within healthcare teams with the focus mainly on the nursing profession

iii) Student do not have opportunities in decision-making, reflection, and self-awareness in a safe environment for discussion
iv) Students identify contextual factors and relationships as having the highest significant influence on their ethical decisions.
v) Students find the link between theoretical ethical sessions to practical and contextual situations to be unclear
vi) Students believe that healthcare organisations do not create environments and workplaces that promote positive ethical climates (empowering mentors and role models in practice/education), with continued ethics education
vii) Nursing undergraduate education has a longitudinal positive impact on student's moral development and their knowledge about ethics

Drawing on the above findings, therefore, the main finding of this research study leans towards an integrated student-centred nursing curriculum based on a multifaceted approach along the whole programme that supports positive ethical education environments and opportunities for decision-making in practice.

7.7 Limitations and strengths

Every research study has its limitations, and this study is no exception. In view of the timeframe required to collect longitudinal research over a whole educational programme, a pilot study was not employed prior to data collection. However, to mitigate this impact, an already validated tool was utilised for quantitative data collection and qualitative interview questions were tested with colleagues within the healthcare setting for feedback and legibility.

Furthermore, questions were professionally translated to Maltese. Participants involved in this study contributed to this research through purposive sampling, and thus the results of the interview could be biased towards individuals with an interest in nursing ethics. In view of the specific characteristics of the population, this was the most reliable method for recruiting participants. However, the lack of knowledge in the interviews is still evidently suggesting that even though some students are interested in ethics this might not reflect in

their development. Some of the students recruited for this study also participated after being recommended to do so by their friends.

The number of surveys collected was quite low, even though several attempts at collecting data were made. As a researcher you cannot coerce students into participating and ethically cannot provide renumeration or gifts in exchange for survey participation. To improve the validity and reliability of the quantitative research the full version of the survey was used. Thus, although a smaller portion of surveys had been collected than initially planned, the surveys collected have high validity scores.

Due to the COVID-19 pandemic, the mid-phase of quantitative data collection had to be removed. The initial plan was to carry out a survey during all the three years of the undergraduate programme. However, this decision was made on the basis that development happens at a gradual level and thus the surveys of second years would hypothetically indicate limited development in view of the short timeframe.

Another possibility to improve this research study would have been to provide an identification number to students and individually follow up progress. The quantitative aspect of this research study aimed at looking at the overall student development. However, using an identifier could have provided further insight into individual student development and provided feedback regarding DIT scores to individual students should they wish, fostering an opportunity for feedback through this research study.

The pre-existing differences and experiences encountered in Year 1 and Year 3 of studies can provide alternative results. This limitation was mitigated by the inclusion of a qualitative stand in data collection. The sample of this study was nursing students in Malta, who are part of a specific culture and thus translating these results to the general global nursing student population needs to be done with caution.

This research study was carried out at the only University, in Malta which is responsible for the education of the majority of nurses working in Malta. Thus, although the number of participants is small, it is informing the majority of the nursing population in Malta. Furthermore, the same cohort of students was followed along their three years of study decreasing added variables that might influence the results of this research study.

Development is understood to happen in small increments over a long period of time, thus a longitudinal approach is the most suited method for identifying changes in development.

This research study provided a medium for students to express their view on their own education and sought to understand their honest perspectives. This research study utilised a mixed methods approach with a theoretical framework that does not dismiss opposing views and thus made sure that conflicting perceptions were not disregarded. A pluralistic and open-minded approach to this research area was utilised throughout the research study, which decreased research bias. The utilisation of a mixedmethods approach provided an opportunity for converging different data collected. Longitudinal resaerch is subject to attrition issues however no students dropped out of interviewing during the whole three years and quantitative survey numbers were almost identical between first and third year. Utilising a longitudinal approach allowed the researcher to understand student development over a period of time and explored patterns or events and behaviour as students move through their educational journey. Empirically researching ethics, morality and development will contribute to the development of knowledge in nursing. This area of research interest has not been recently researched among nursing student populations. There are no research studies that considered the cultural context of Malta.

7.8 Recommendations for the development ethics education

The first recommendation derived from the results of this research study consists of developing an integrated ethics curriculum that includes ethics in wider social issues beyond the hospitalised patients, values and virtues, ethics of care, everyday bioethical issues that go beyond life and death, or else ethical dilemmas and ethical issues that have a direct influence on patient well-being. During nursing ethics, the discussion regarding vulnerability and care needs to shift towards a more empowering narrative in which vulnerability is recognised as part of the human condition. Decision-making models need to consider the context and affective domains for students and adequate opportunities for practicing ethical decision-making needs to be provided.

Curricula should identify ethical issues that are relevant to nursing students who are currently in practice and avoid including only hypothetical situations that are unrealistic.

Critical reflection should be formally integrated into assessment methods of practical placements to help encourage self-awareness and improve decision-making abilities based on past experiences in different contexts. Ethics study-units should not be stand-alone but constantly integrated into all study-units within nursing education. The lived experiences of those directly experiencing unethical practice is suggested, to provide a closer link between stakeholders involved in care by offering formal instruction through story telling.

The interrelationship and distinctiveness of law and ethics needs to be further emphasised. Further resources for ethical decision-making and nursing ethics need to be made available for students. Education needs to pedagogically shift from simply using a knowledge-transfer approach to encouraging more critical thinking and self-directed learning.

Furthermore, nursing education and practice needs to look at the profession in an increasingly positive and professional manner. The use of media to promote and update what it means to be a nurse can be useful in shifting public opinion about nursing. This can also be achieved by adopting positive small group discussions with students that do not only look at issues within a system and profession but also look at the positive outcomes of such systems and the positive role of nursing in healthcare. Using strategies that can increase the confidence of nurses in practice, such as training regarding communicating ideas and leadership competencies can push the role of nurses from a more passive one to that of an actively evolving and actively involved profession. Education should shift from dilemma based approaches that never provide answers to ethical issues to an approach that looks at different contextual situations that can be answered using a variety of ethical principles and approaches.

The second recommendation is the training and education of key stakeholders in student education such as lecturers, clinical instructors, clinical mentors, and healthcare organisation managers in ethical decision-making. There needs to be an increased awareness of the constant presence of ethics within healthcare and a clear understanding of the role that nurses have in clinical ethics. Role models need to have adequate knowledge to support and guide students in ethical decision-making, with the opportunity to have discussions and challenge student assumptions. Role models themselves need the support of educational entities. The collaboration between educational entities and healthcare organisations needs to be further improved to create an environment of teamwork and support within both settings.

In practice, ethics education needs to move beyond completing a set of criteria but a clear understanding of what these criteria mean and how they can assessed in practice, needs to be implemented.

The third recommendation is the development of a support system for students and clinicians. A system that provides opportunity for nurses and students to voice their concerns regarding ethical or unethical practices which are tackled in an anonymous and blame-free culture, this will directly improve patient safety outcomes. A system that values the input of the nursing profession and strives towards progress will encourage nurses to have an active role in bringing about change. Students would benefit from having peer support groups and have a buddy system in which first-year students are allocated with a third-year student for preceptorship. This system will help students in developing their identity as nurses and will provide opportunities to discuss with peers regarding professional nursing issues in an informal manner. Individual student supervision will promote discussion and critical thinking, this can be achieved through the current link-lecturing system in place at UM.

Fostering ethical climates in healthcare and educational entities, that supports professional and personal development can help nurses in developing rather than regressing in their own practice. This will inadvertently affect students' practical education and encourage students to belong to a team rather than being at the bottom of the hierarchy. The silent voices of nurses need to be heard and this can be achieved through further qualitative research and having nurses in leadership roles that are involved in ethically sensitive issues. The relationship between healthcare teams and their role in ethical decision-making needs to be further clarified and the nursing specific perspectives to these issues clearly highlighted. Nurses have specific responsibilities, expertise and perspectives that provide further understanding of a context. Healthcare organisations require a clinical ethics committee that can provide ethics advice to healthcare professionals which should be made up of different members of the multidisciplinary team. Lack of staffing and burnout are key issues that can influence ethical decision making and thus the management of people within settings and strategies aimed at improving staffing levels should be considered. These do not only include financial packages but values-based organisational systems that promote development and change. Thus the summary of the reccomendations from this dissertation are:

(i) An integrated and multifaceted nursing ethics curriculum

(ii) The moral obligation to train stakeholders in education

(iii) Developing a student support system for dealing with moral distress and ethical concerns

(iv) Fostering ethical climates in healthcare and educational entities

(v) Adopting a positivist approach to ethics education

7.9 Directions for future research

Although this study attempts to understand student development along a three-year programme in Malta, further studies are required to corroborate the findings of this research using larger sample sizes and integrating other nursing schools in different countries. A further approach to systematically understand educator and mentor perspectives regarding the subject can further extrapolate the findings of this research study. The impact of the clinical environment and ethical climates on mentors in practice and how that can influence student moral development needs to be further analysed. One of the hypotheses from this research study is that there would be incremental development once students start to practice autonomously and thus a follow-up study of the participants can provide a clearer understanding of nurse development, since this progression does not stop after they leave university. Further research with nursing students using the DIT2 should also consider using intermediate concept measures, which allows the researcher to measure development in specific contextual settings. This would incorporate dilemmas relevant to the nursing profession. Intermediate concept measures do not measure moral schemas but focus on contextual norms that are specific to that context (Bebeau & Thoma, 1999; Thoma et al., 2013).

The impact of living on a small island nation, culture, and upbringing on nursing students, including the perceptions of society towards nurses in Malta can contribute to student education. Students hold perceptions on what patients want from them and what society thinks being a nurse means. However, this is not based on factual information or research. A frequently debated argument within the circles of Maltese society is the *laissez-faire* attitude of Mediterranean countries and the impact of micro-politics within such societies. All of these socio-political aspects can correlate not only to nurse ethical development but the ethical development of the Maltese population as well. Research on how

organisations and educational entities can foster ethical climates can further inform leadership to bring about positive change.

In this research study students mention several examples of ethical dilemmas or perceived ethical and unethical practices. An observational study that identifies real-life cases from clinical settings can further inform scenarios that are realistic to the Maltese context. These observations can inform field work activities relating to nursing practice with the involvement of key stakeholders for student education namely: lecturers, mentors, clinicians, patients, and students. Observational studies will further link moral reasoning with clinical behaviour. With students placing such an importance on the development and maintenance of such relationships and the impact of the clinical setting, such interventions can attempt to target this missing connection. The involvement of other professionals is also desirable, considering the minimal reference to these professions in this research study.

Overall, research in nursing ethics education should focus on the areas identified by students as having the most considerable impact such as the practice settings, relationships, and values in practice. There is a myriad of research regarding models, ethical approaches, and theories but minimal focus on the complexity of the practice setting. A major gap identified by students is the disassociation or dichotomy of theory and practice settings. The integration between theoretical and practical aspects of nursing curricula needs to be developed further to provide students with relevant ethics education that is not detached from day-to-day nursing practice. Nursing students understand moral development relating to actual people in social contexts that is not only based on knowledge but also on experiences and practice in everyday life.

Through this study an understanding of the cognitive, affective, and social aspects of moral development have been addressed. Furthermore, further insight regarding the progress of moral development and influencing factors was explored. However, these findings and recommendations if implemented do not guarantee moral behaviour from student nurses due to the complexity of human behaviour. However, it is hoped that they will drastically decrease moral distress, provide and avenue for ethical discussions and centre education around student needs.

7.10 Conclusion

Ethics education needs to leave room for emotions and feelings along with reason, driven by a paradigm of care that is not opposed to ethical principles but precedes them. Nursing students value a multifaceted perspective towards ethics that integrates several aspects of nursing education: practice, theory, experience, and context. From this research study, it can be determined that nursing students develop their moral reasoning abilities throughout their programme of studies and higher education directly correlates with this development. Students become increasingly aware of ethical issues as they progress in their program and strive to be ethical. However, students lack the vocabulary and knowledge to provide cognitive arguments that support their ethical behaviour, other than referring to practical examples. Students are not well supported throughout their education in navigating and communicating the ethical comportment of their practice. Ethical development is not sustained without consistent active engagement in education even after graduating. The recommendations presented in this research study are intended to provide a way forward for ethics education in Maltese nursing students.

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Appendix 1

Participant Recruitment Email

The perceptions of ethics and ethical development of undergraduate student nurses

Dear Student,

Well done on your enrolment to the Nursing degree course! My name is Adrienne and I am currently enrolled in a PhD programme in Nursing, at Swansea University, Wales and I am conducting a study to fulfil the requirements of this programme.

The study concerns exploring the perceptions of students with regards to ethics and exploring the ethical development that occurs along the years. It involves a maximum one hour interview annually, the beginning of your first and second year and at the end of your third year, as well as two surveys at the beginning of the scholastic year, which will not take more than two hours each year. You can complete the surveys by clicking the link provided below (Link surveys). You can choose to participate either in online surveys, interviews, or both.

I am looking for degree students commencing their first year of study with the University of Malta. I would be very grateful if you would be willing to take part in my study. If you are interested, please contact me at the address below to participate in the interviews. If you do so, you will have the opportunity to find out more about the study before coming to any decision and will be under no obligation to take part.

My study is supervised by Dr. Gideon Calder and Dr. Hugh Upton, and they can be contacted on [redacted] and [redacted]. The use of email to recruit participants has been approved by the Research Ethics committees at the University of Malta and Swansea University.

Thank you very much for your time. Looking forward to your replies.

Adrienne Grech
Senior Staff Nurse
Orthopaedic Ward 3

Appendix 2

Quantitative Survey-Demographics

First letter of your first name, day and month of birth (in numbers ddmm), first letter of last name (Ex:A0901G)

_____

What is your age?

_____

What is your Gender?

- Male
- Female
- Trans* Male
- Trans* Female
- Gender Non-Binary
- Self-Defined (Please State) _____

What is your nationality?

_____

Year of Study?

- Bachelor of Science Nursing 1st Year
- Bachelor of Science Nursing 2nd Year
- Bachelor of Science Nursing 3rd Year

Is English your primary language?

- Yes
- No

What race/ethnicity best describes you?

- Asian/Pacific Islander

- Black or African American
- Hispanic
- White/Caucasian
- Multiple Ethnicity/ Other (Please Specify)

  _____

Which of the following best describes your current relationship status?

- Married
- Widowed
- Divorced
- Separated
- In a domestic partnership or civil union
- Single, but cohabiting with a significant other
- Single, never married

Do you have any previous work experience? If yes, please specify.

_____

_____

_____

Appendix 3

Interview Questions

Semi-structured Interview Questions Year 1- English

1. What especially drew you to nursing?
2. What do you understand by ethics?
3. How do you anticipate that you will learn about ethics, on the course?
4. Are there any values or approaches which are particularly important to you?
5. Do you think that your nursing practice will reflect your personal values? If so, how? If not, why not?
6. Do you find that you apply ethics to situations in your everyday life? If so, can you provide examples?
7. Do you think that nursing will help you learn how to be more ethical as an individual in life? If so, how?

Semi-structured Interview Questions Year 1- Malti (Maltese)

1. X'ħajrek tagħżel nursing?
2. X'tifhem bl-etika?
3. Kif taħseb li se titgħallem dwar l-etika fil-kors?
4. Hemm xi valuri jew metodi li huma importanti għalik?
5. Taħseb li l-prattika tan-nursing se tirrifletti l-valuri personali tiegħek? Jekk iva, kif? Jekk le, għaliex le?
6. Jirnexxielek tapplika l-etika f'sitwazzjonijiet fil-ħajja ta' kuljum? Jekk iva, tista' tipprovdi xi eżempji?
7. Taħseb li n-nursing se jgħinek titgħallem tkun individwu iktar etiku fil-ħajja? Jekk iva, kif?

Semi-structured Interview Questions Year 2- English

1. What kind of nurse do you want to become?
2. What do you understand by ethics?
3. How are you learning about ethics, on the course?

4. Are there any particular values or approaches which are helpful to you in nursing practice?
5. Does ethics help you in nursing practice? If so, can you give examples? If not, why not?
6. Do you think nursing reflects your personal values? If so, why? If not, why not?
7. Do you find that you apply ethics in your own nursing practice? Can you give examples?
8. Is nursing helping you learn how to be more ethical, as an individual, in life? If so, how?
9. Can you provide examples from clinical situations, when you have acted ethically?

Semi-structured Interview Questions Year 2- Malti (Maltese)

1. X'tip ta nurse tixtieq li tkun?
2. X'tifhem bl-etika?
3. Kif qed titgħallem dwar l-etika fil-kors?
4. Hemm xi valuri jew metodi li huma ta' importanza għalik fil-prattika tannursing?
5. L-etika tgħinek fil-prattika tan-nursing? Jekk iva, tista' tagħti xi eżempji? Jekk le, għaliex le?
6. Taħseb li n-nursing jirrifletti l-valuri personali tiegħek? Jekk iva, għaliex? Jekk le, għaliex le?
7. Jirnexxielek tapplika l-etika fil-prattika tiegħek tan-nursing? Tista' tagħti xi eżempji?
8. In-nursing qiegħed jgħinek titgħallem kif tkun individwu iktar etiku fil-ħajja? Jekk iva, kif?
9. Tista tipprovdi eżempji minn sitwazzjonijiet kliniċi, meta ġibt ruħek b'mod etiku?

Semi-Structured Interview Questions Year 3-English

1. What kind of nurse do you want to become?
2. What do you understand by ethics?
3. How did you learn about ethics, during the course?
4. Were there any particular values or approaches which were helpful to you in nursing practice?
5. Did ethics help you in nursing practice?
6. Do you think nursing reflects your personal values? If so, why? If not, why not?
7. Do you find that you apply ethics to nursing practice? If so, can you give examples? If not, why not?

8. Is nursing helping you learn how to be more ethical, as an individual, in life? If so, how?
9. Can you provide examples from clinical situations, when you have acted ethically?

Semi-structured Interview Questions Year 3- Malti (Maltese)

1. X'tip ta' infermiera tixtieq tkun?
2. X’tifhem bl-etika?
3. Kif tgħallimt dwar l-etika matul il-kors?
4. Kien hemm xi valuri jew metodi partikolari li kienu ta’ għajnuna għalik filprattika tan nursing?
5. L-etika għenitek fil-prattika tan-nursing?
6. Taħseb li n-nursing jirrifletti l-valuri personali tiegħek? Jekk iva, għaliex? Jekk le, għaliex le?
7. Jirnexxielek tapplika l-etika fil-prattika tan-nursingetiku? Jekk iva, tista’ tagħti xi eżempji? Jekk le, għaliex le?
8. In-nursing qiegħed jgħinek titgħallem kif tkun individwu iktar etiku fil-ħajja? Jekk iva, kif?
9. Tista' tipprovdi eżempji minn sitwazzjonijiet kliniċi, meta ġibt ruħek b'mod etiku?

Appendix 4

Translator Authentication

18th July, 2018

To whom it may concern,

This is to confirm that I, Ms Janice Mifsud holding ID no am a qualified translator awarded by the University of Malta in 2013.

Hereby I confirm that translations included in Ms Adrienne Grech's, ID no thesis who is reading a PhD degree in Nursing were solely done by me.

Thanks and regards,

[redacted]

Ms Janice Mifsud

[redacted]

Appendix 5

Ethical Approvals

[redacted]

15:54
Details
SA

Many thanks Adrienne.

Please see my query below in green. Subject to you amending that particular element from the PIS (which I do not need to see, I am happy that you will do that), and subject to you obtaining permission from Veronica Grech on an annual basis to contact the students then formal approval for your study is now granted. I wish you well with your research.

Best wishes,

[redacted]

Angela Smith
Lecturer in Health Care Law and Ethics | Darlithydd mewn Cyfraith Gofal Iechyd a Moeseg

[redacted]

Yesterday
Details
VG

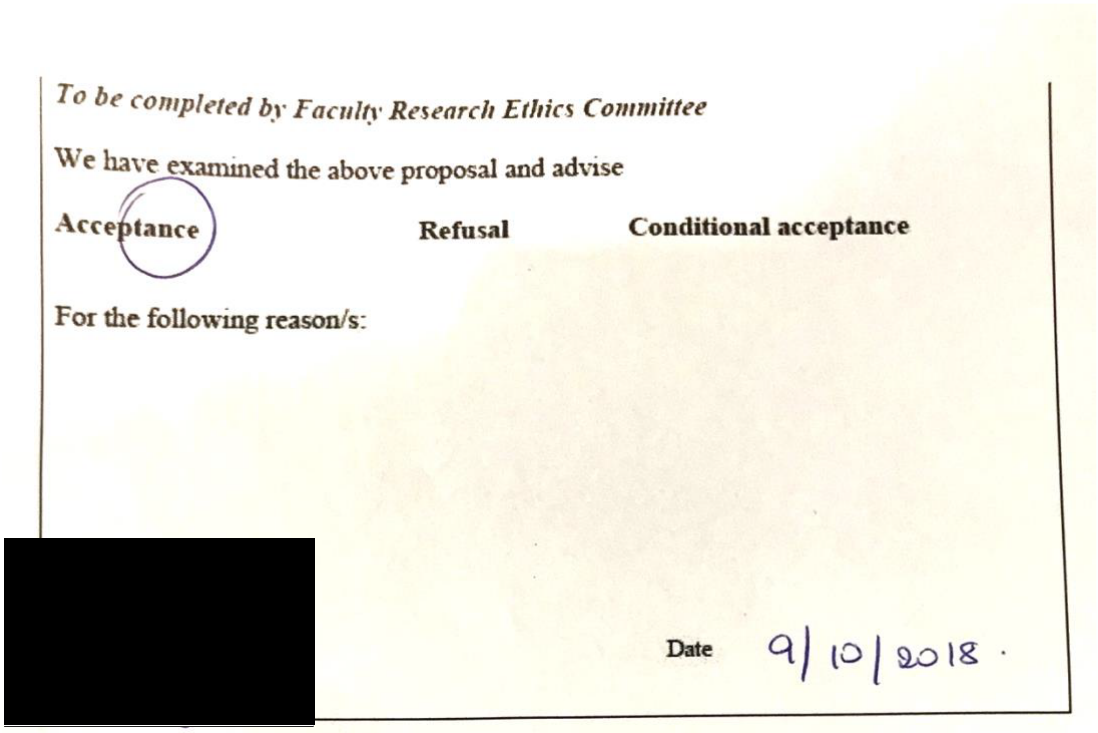
Dear Ms Grech

After discussing with our Data Protection Officer please note that we will be able to send an email to the first year nursing students on your behalf on condition that you provide us with the research ethics approval of both the University of Malta and the University of Swansea. The students would have been asked to indicate whether they wished to receive surveys and your email will only be sent to those who would have agreed to receive student surveys.

You would need to send me the text of the email to be sent to students, explaining your research project and asking them to contact you if they wish to participate.

regards
Veronica Grech

Veronica Grech
Registrar
University of Malta



To be completed by Faculty Research Ethics Committee

We have examined the above proposal and advise

Acceptance **Refusal** **Conditional acceptance**

For the following reason/s:

[redacted]

Date 9/10/2018.

Roberta Sammut 04 June 2018 at 13:39

Re: PhD study-UoM Nursing Students Details

To: Adrienne Grech, Cc: MARIA CASSAR

Dear Adrienne,

I provide permission to access students for your study on 'perceptions of ethics and ethical development of degree nursing students'.

Please note you also need to seek permission from the Registrar, Ms. Veronica Grech.

Please liaise with the course coordinator for the B.Sc. Nursing programme to arrange data collection.

Kind Regards
Roberta

Dr. Roberta Sammut
Dean Faculty of Health Sciences
University of Malta

Associate Editor International Journal of Nursing Studies

Tel: +356 2340 1851/1831

Appendix 6

Participant Information Sheets

Understanding of ethics and ethical development of undergraduate student nurses (Survey)

You are being invited to take part in some research. Before you decide whether or not to participate, it is important for you to understand why the research is being conducted and what it will involve. Please read the following information carefully.

What is the purpose of the research?

We are conducting research with regards to exploring nursing students' perceptions of ethics and the development of ethics longitudinally throughout a three-year degree programme. Participants in this study include students enrolled with the University of Malta on a nursing degree progamme in 2018, students who are repeating their first year of study are not eligible to participate. The purpose of the study is to longitudinally explore student perceptions with regards to ethics and ethical development, as well as longitudinally measure and assess their ethical development over a three-year degree programme at the University of Malta. It is hoped that this research study will provide an increasingly comprehensive understanding of the ethical development of nursing. Your participation in this study will take approximately one hour for each interview annually over three years.

Who is carrying out the research?

The data are being collected by Adrienne Grech at the College of Human and Health Sciences at Swansea University, being supervised by Dr. Gideon Calder and Dr. Hugh Upton. The research has been approved by the College of Human and Health Sciences Research Ethics Committee.

What happens if I agree to take part?

We will be asking you to take part in two surveys of approximately a total of two hours each year, for the duration of your degree. We will ask you to complete online a Moral Sensitivity Questionnaire (MSQ) including some background information such as your level of education, your age and sex. The MSQ will measure moral sensitivity in nursing practice.

The second survey is the Defining Issues Test, which measures moral judgement development. These surveys will be held online at the beginning of the first and second year and at the end of the third year. Additionally, we will ask for some background information including your level of education, your age and sex. Filling in and submitting the survey constitutes giving consent.

Are there any risks associated with taking part?

The research has been approved by the College of Human and Health Sciences Research Ethics Committee. There are no significant risks associated with participation. Should you feel and distress whilst participating in this research study please do not hesitate to contact the researcher on the details below or the University of Malta Counselling services on 23402235 or via email on http://www.um.edu.mt/contact/counselling

Data Protection and Confidentiality

Your data will be processed in accordance with the Data Protection Act 2018 and the General Data Protection Regulation 2016 (GDPR). All information collected about you will be kept strictly confidential. Your data will only be viewed by the researcher/research team.

All electronic data will be stored on a password-protected computer file on the researcher's personal laptop. All paper records will be stored in a locked filing cabinet at the researcher's private residence. Your consent information will be kept separately from your responses to minimise risk in the event of a data breach.

Please note that the data we will collect for our study will be made anonymous, this will take place once the survey is submitted, thus it will not be possible to identify and remove your data at a later date, should you decide to withdraw from the study. Please note that if data is being collected online, once the data has been submitted online you will be unable to withdraw your information. Therefore, if at the end of this research you decide to have your data withdrawn, please let us know before you leave.

The lead researcher will take responsibility for data destruction and all collected identifiable data will be destroyed on completion of the study and once the PhD has been attained.

Conducting research overseas

The researchers will abide by local data protection laws when collecting personal data.

What will happen to the information I provide?

An analysis of the information will form part of our report at the end of the study and may be presented to interested parties and published in scientific journals and related media. *Note that all information presented in any reports or publications will be anonymous and unidentifiable*. As a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify, and where applicable ask for the data concerning you to be erased.

Is participation voluntary and what if I wish to later withdraw?

Your participation is entirely voluntary – you do not have to participate if you do not want to. If you decide to participate, but later wish to withdraw from the study, then you are free to withdraw at any time, without giving a reason and without penalty and prejudice.

Data Protection Privacy Notice

The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data and can be contacted at the Vice Chancellors Office.

Your personal data will be processed for the purposes outlined in this information sheet. The legal basis that we will rely on to process your personal data will be processing is necessary for the performance of a task carried out in the public interest. This public interest justification is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

The legal basis that we will rely on to process special categories of data will be processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

How long will your information be held?

We will hold any personal data and special categories of data for no longer than is necessary, once the study has been completed and the PhD granted, data will be deleted. Information

will be kept for five years after completion of PhD to allow adequate time for publishing of research.

What are your rights?

You have a right to access your personal information, to object to the processing of your personal information, to rectify, to erase, to restrict and to port your personal information. Please visit the University Data Protection webpages for further information in relation to your rights.

Any requests or objections should be made in writing to the University Data Protection Officer:-

University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email: dataprotection@swansea.ac.uk

How to make a complaint

If you are unhappy with the way in which your personal data has been processed you may in the first instance contact the University Data Protection Officer using the contact details above.

If you remain dissatisfied then you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: -

Information Commissioner's Office,
Wycliffe House,
Water Lane,
Wilmslow,
Cheshire,
SK9 5AF

www.ico.org.uk

What if I have other questions?

If you have further questions about this study, please do not hesitate to contact us:

Adrienne Grech
College of Human and Health Sciences
Swansea University
[redacted]

Dr Gideon Calder
College of Human and Health Sciences
Swansea University
[redacted]

Participant Infromation-Interviews

Understanding of ethics and ethical development of undergraduate student nurses (Interviews)

You are being invited to take part in some research. Before you decide whether or not to participate, it is important for you to understand why the research is being conducted and what it will involve. Please read the following information carefully.

What is the purpose of the research?

We are conducting research with regards to exploring nursing students' perceptions of ethics and the development of ethics longitudinally throughout a three-year degree programme. Participants in this study include students enrolled with the University of Malta on a nursing degree progamme in 2018, students who are repeating their first year of study are not eligible to participate. The purpose of the study is to longitudinally explore student perceptions with regards to ethics and ethical development, as well as longitudinally measure and assess their ethical development over a three-year degree programme at the University of Malta. It is hoped that this research study will provide an increasingly comprehensive understanding of the ethical development of nursing. Your participation in this study will take approximately one hour for each interview annually over three years.

Who is carrying out the research?

The data are being collected by Adrienne Grech at the College of Human and Health Sciences at Swansea University, being supervised by Dr. Gideon Calder and Dr.Hugh Upton. The research has been approved by the College of Human and Health Sciences Research Ethics Committee.

What happens if I agree to take part?

We will be asking you to take part in an interview of approximately one hour each year, for the duration of your degree, at the beginning of the first and second year and at the end of the third year. This interview will be held with myself Adrienne at the Faculty of Health Sciences. My role will be to interview you and ask open questions about your views on ethics and nursing, with no wrong or right answer, I am simply interested in your views. The interviews will be video recorded with only the researcher having access and supervisory team having access to them upon request.

Are there any risks associated with taking part?

The research has been approved by the College of Human and Health Sciences Research Ethics Committee. There are no significant risks associated with participation. . Should you feel any distress whilst participating in this research study please do not hesitate to contact the researcher on the details below or the University of Malta Counselling services on 23402235 or via email on
http://www.um.edu.mt/contact/counselling

Data Protection and Confidentiality

Your data will be processed in accordance with the Data Protection Act 2018 and the General Data Protection Regulation 2016 (GDPR). All information collected about you will be kept strictly confidential. Your data will only be viewed by the researcher/research team. Interviews in Maltese will be shared with a translator to change the text to English.

All electronic data will be stored on a password-protected computer file on the researcher's personal laptop. All paper records will be stored in a locked filing cabinet at the researcher's private residence. Your consent information will be kept separately from your responses to minimise risk in the event of a data breach.

Please note that the data we will collect for our study will be made anonymous, this will take place at the end of the three years, thus it will not be possible to identify and remove your data at a later date, should you decide to withdraw from the study. Therefore, if at the end of this research you decide to have your data withdrawn, please let us know before you leave.

The lead researcher will take responsibility for data destruction and all collected identifiable data will be destroyed on completion of the study and once the PhD has be attained.

Conducting research overseas

The researchers will abide by local data protection laws when collecting personal data.

What will happen to the information I provide?

An analysis of the information will form part of our report at the end of the study and may be presented to interested parties and published in scientific journals and related media. *Note that all information presented in any reports or publications will be anonymous and unidentifiable*. As a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify, and where applicable ask for the data concerning you to be erased.

Is participation voluntary and what if I wish to later withdraw?

Your participation is entirely voluntary – you do not have to participate if you do not want to. If you decide to participate, but later wish to withdraw from the study, then you are free to withdraw at any time, without giving a reason and without penalty and prejudice.

Data Protection Privacy Notice

The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data and can be contacted at the Vice Chancellors Office.

Your personal data will be processed for the purposes outlined in this information sheet. Standard ethical procedures will involve you providing your consent to participate in this study by completing the consent form that has been provided to you.

The legal basis that we will rely on to process your personal data will be processing is necessary for the performance of a task carried out in the public interest. This public interest justification is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

The legal basis that we will rely on to process special categories of data will be processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

How long will your information be held?

We will hold any personal data and special categories of data for no longer than is necessary, once the study has been completed and the PhD granted, data will be deleted. Information will be kept for five years after completion of PhD to allow adequate time for publishing of research.

What are your rights?

You have a right to access your personal information, to object to the processing of your personal information, to rectify, to erase, to restrict and to port your personal information. Please visit the University Data Protection webpages for further information in relation to your rights.

Any requests or objections should be made in writing to the University Data Protection Officer:-

University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email: dataprotection@swansea.ac.uk

How to make a complaint

If you are unhappy with the way in which your personal data has been processed you may in the first instance contact the University Data Protection Officer using the contact details above.

If you remain dissatisfied then you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: -

Information Commissioner's Office,
Wycliffe House,
Water Lane,
Wilmslow,
Cheshire,
SK9 5AF
www.ico.org.uk

What if I have other questions?

If you have further questions about this study, please do not hesitate to contact us:

Adrienne Grech
College of Human and Health Sciences
Swansea University
[redacted]

Dr Gideon Calder
College of Human and Health Sciences
Swansea University
[redacted]

Consent interviews

Research team: Adrienne Grech

	Participant initial
1. I (the participant) confirm that I have read and understand the information sheet for the above study (v dated) and have had the support and opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reasons.	
3. I am aware that all my details are confidential and identifiable data will not be published. I agree to the use of a study number assigned to my details.	
4. I agree that the researcher will ask me some questions about my views.	
5. I agree to the use of anonymised data and quotes in any relevant publications.	
6. I agree for interviews to be video recorded.	
7. I consent to take part in the above study and have reached this decision without coercion or undue pressure.	

Print name of participant Signature Date

Print name of researcher Signature Date

This study is being conducted by Swansea University, College of Human and Health Science.

When complete: Original copy for participant, one copy to be retained by researcher

Appendix 7

Debriefing Sheets

Perceptions of ethics and ethical development of undergraduate nursing students (Interviews)

Thank you very much for participating in this study. The purpose of this research study is not only for us to collect data, but also for you to explore your thoughts about ethics and how they develop during your degree programme. It gives you an opportunity to see how research works and to learn how data is collected. This research study will potentially identify issues with ethics education and positively influence students' ethical awareness about nursing practice.

You have participated in interviews along the years, these were carried out to link what you perceive ethics to be and what you perceive as development and its relationship the defining issues test scores and moral sensitivity scores. There is really no right or wrong answer in this research study, the aim is to explore relationships between different aspects of ethical development and your views on ethics.

This research study has been conducted over a period of three years, from the beginning of your degree to the end. Having you as a consistent participant for the duration of the study was vital, your participation has been greatly appreciated.

This study has been granted clearance according to the recommended principles of Swansea University Ethics Committee and the University of Malta Research Ethics Committee. If you have any complaints, concerns, or questions about this research, please feel free to contact, the researcher, Adrienne at [redacted] or phone number [redacted] or the research supervisor on [redacted].

Should you feel and distress in relation to participating in this research study please do not hesitate to contact the researcher on the details below or the University of Malta Counselling services on 23402235 or via email on http://www.um.edu.mt/contact/counselling

If you would like to learn more about this experiment and its results, please contact Adrienne Grech at the phone number or email above. In addition, you might want to read the following articles available at University of Malta Library.

Thoma, S., & Dong, Y. (2014). The defining issues test of moral judgment development. Behavioral Development Bulletin, 19(3), 55-61.

Lützen, K., Dahlqvist, V., Eriksson, S., & Norberg, A. (2006). Developing the Concept of Moral Sensitivity in Health Care Practice. Nursing Ethics, 13(2), 187-196.

Thanks for helping us with this research, wishing you all the best for your new career!

Perceptions of ethics and ethical development of undergraduate nursing students (Surveys)

Thank you very much for participating in this study. The purpose of this research study is not only for us to collect data, but also for you to explore your thoughts about ethics and how they develop during your degree programme. It gives you an opportunity to see how research works and to learn how data is collected. This research study will potentially identify issues with ethics education and positively influence students' ethical awareness about nursing practice.

One of the scales that you completed is known as the Defining Issues Test which give numerical ratings on the assessment of the understanding and interpretation of moral issues. It is designed to assess development of adolescents or adults. In this study we combined this with demographic data (such as; gender and age) and moral sensitivity scores to attempt to develop a comprehensive study looking at your ethical development along the years.

This research study has been conducted over a period of three years, from the beginning of your degree to the end. Having you as a consistent participant for the duration of the study was vital, your participation has been greatly appreciated.

This study has been granted clearance according to the recommended principles of

Swansea University Ethics Committee and the University of Malta Research Ethics Committee. If you have any complaints, concerns, or questions about this research, please feel free to contact, the researcher, Adrienne at [redacted] or phone number [redacted] or the research supervisor on [redacted].

Should you feel and distress in relation to participating in this research study please do not hesitate to contact the researcher on the details below or the University of Malta Counselling services on 23402235 or via email on http://www.um.edu.mt/contact/counselling

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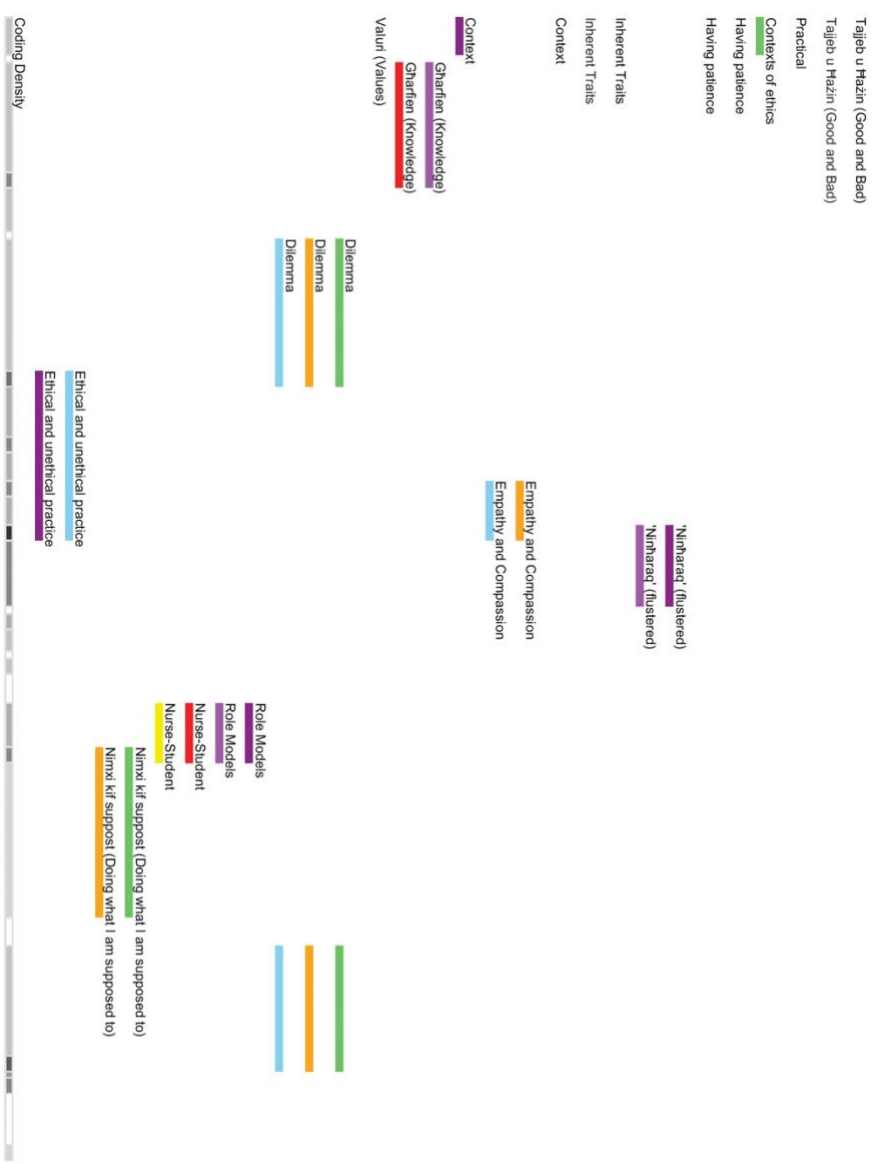
Thanks for helping us with this research, wishing you all the best for your new career!

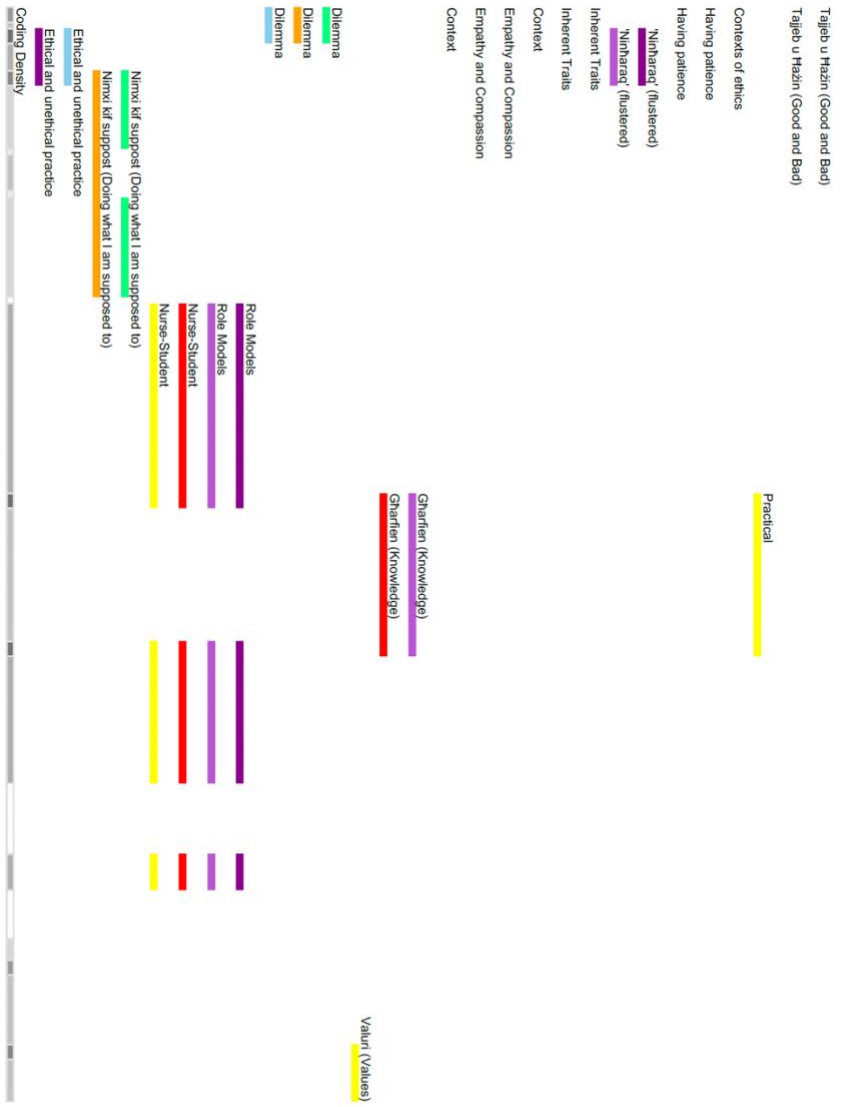
Appendix 8-Interview excerpt with bilingual coding

INTERVIEW 2	
X'Tip ta nurse tixtieq li tkun?	Jien nixtieq li... s'issa mill- l esperjenza li kelli fis swali li kont nahseb iktar nixtieq inkun medical nurse..issa medical huwa aktar l acute, l admissions. Ghax mill l esperjenza li kelli hemmek ikollok x'taghmel, busy pero fl-istess hin mhux busy essegerat bhall ma nahseb li jkun l emergenza...ghadni ma kontx hemmimma din hija l perception tieghi. Ghallura ghandek x'taghmel ghax ma rridx dik ix haga li noqghod bilqieghda wara nofsinhar u ma naghmel xej. Ghalija narah hela ta hin. Ghallura fl acute medical setting ghandek qisek il-hin kollu xi haga gejja imma hux essegerat u jien dejjem irrid li jkolli xi haga x'naghmel.
Kieku kellek timmaginak nurse fil medical admissions unit, x'tip ta nurse tixtieq tkun...bhala kwalitajiet.	Trid tkun nurse li taghmel xoghlok tajjeb. Iggifiri trid tkun kompetenti ghax fl-istess hin trid tghaggel naqra biex tlahhaq imma fl-istess hin trid taghmel xoghol sew ghax hafna drabi ma narawiex dik ghax meta tghaggel tispicca taghazel... ee triq fil-qosor. Iggifiri tkun kompetenti u anke li tghaggel iggibha bl-esperjenza. Li tkun pacenzjuza ghax specjalment fil medical admissions ikun hemm hafna anzjani habba li jbghatu bil-problemi tan nifs u hekk ghallura xi kultant tkun iktar difficli biex tfemhom ghallura ma tistax taqbizlek. Allura anke il moghod ta kif titkellem, iggifiri trid pacenzja...tkun kompetenti emmm.....
Meta tghidli li meta tghaggel ma jsirux affarijiet sew, tista tispjega iktar?	Ghax taghzel l way out...tipo ezempju se tqabbad IV, tara mandekx toqod timsah l cannula jew taghti flush u taqbad u tqabbad solution, u nitkellmu kollox gieli rajt dawn l-affarijiet. Iggifiri jew per ezempju biex tipprepara l medicina specjalment bil-lejl, taqbad u tipprepara ta kulhadd f'salt mhux xi hag ali suppost taghmel. Inti qatt ma titghallem hekk, mela ghalxiex imbghad once li tiggradwa ma tibqax tamilhom dawk l affarijiet. Hemm hafna...anke em documentation, tikkupja min ta qablek. Tara hafna affarijiet li tigi mghallma fuqhom u imbghad ma jsirx hekk. Mela ghalfejn qeghdin nitghallmu hekk biex taghmel moghod iehor? I mean documentation anke jekk l pazzjent ilu, ma tistax tikkupja min ta qabel l mean forsi l affarijiet inbidlu. U infection control...specjalment ikun hemm isolation rooms (Commented and asked about facial expression). Ghax ma jzommux maghha, tipo tkun qieghed titghallem u taghmel zball nifimha, ghax ovjament kulhadd jaghmel zball..qalulek u tghallimt. Imma li taf u ma tamilx hekk, I mean tidhol b'apron u gloves u ghax se taghmel xi haga zghira...ma tilbisomx ghax u ija mhux dik biss se naghmel.
Ghall-min qieghda tirreferi meta tghid huma?	Health care professionals, il-maggoranza li nista nitkellem fuqhom jien qishom nurses u tobba ghax dawk l-iktar li qisni nara.
Kif thossok inti f'dawn is-sitwazzjonijiet?	Nirrabja naqra...isasa jien nghidlek il-verita ghadni ma gradwajtx...u ma nixtieqax li wara li niggradwa naqa f'dik il-vizzju, anke issa noqghod vera attenta. Imma nirrabja ghax anke ma titfax dell sabih fuq in-nurses u fuq it-tobba u kull min jahdem hemm. Mhux professjonali...u hasra ghax l affarijiet li taghmel jaf taghmel hsara.
Tista tahseb f'xi kwalitajiet ohrajn li inti bhala nurse kif tixtieq tkun?	Compassionate, li tipprova tifhem lil dak li jkun. Iggifiri jekk jiftah qalbu mieghek, mhemmx alfejn toqod tghidlu ghandek ragun u ija issa forsi tkun ahjar, ma tridx tuza statements hekk ghax forsi ghalih billi tghidlu se tkun ahjar mhux se tghinu. So ahjar tisma u toqghod kwieta. Jew inkella qisek taqbel maghhom ghax xi kultant li tghidilhom issa jaddilek mhux qieghda tghinhom ghax xi kultant lanqas iridu jisimaw hekk ghax jghidulek li kif qed ihossuwhom issa...allura tismaghhom u taqbel maghhom ezempju tghidilhom vera difficli...hekk
X'tifhem bl-etika?	Kif wiehed jara li ghandu igib ruhu, iggifiri qishu mhux regoli....mhux regioli ghax mumiex regoli. Principji li jghinuk taraf x'inhu tajjeb u hazin, kemm jekk huwa f kull xoghol, ma pazzjent u kollegi ohra..erm xi haga li jamilha bniedem...mhux bhall ligi li jikontrolla l gvern..xi haga li jamilha l bniedem..principji biex jaraf 'inhu tajjeb u hazin
Bhala individwu jew	Jista jkun it-tnejn ghax bhala individwu jien nahsibha moghod.u inti tahsibha

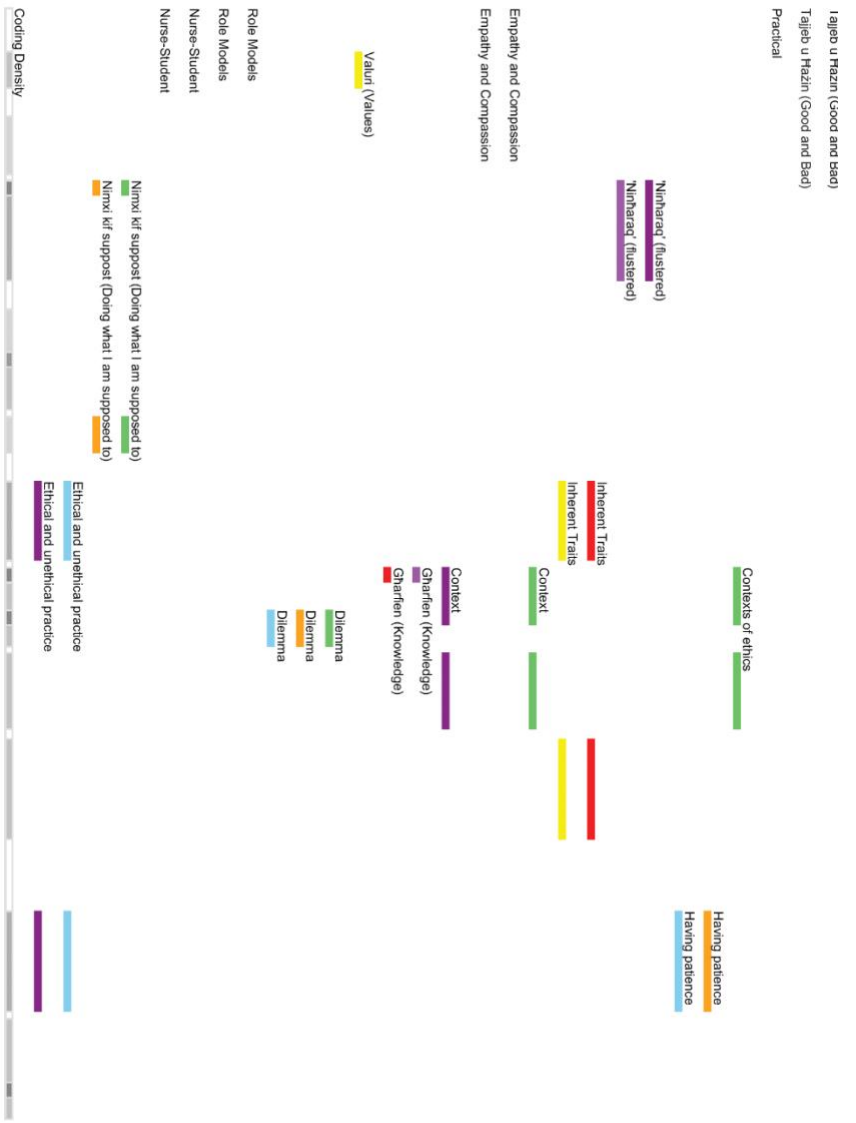
kolletivament?	moghod iehor. Mhux bhall ligi qieghda miktuba iswed u abjed...naraha li l etika tvarja ghax mhux kulhadd ghandu l istess perspettiva ta l affarijiet.
Kif qieghda titghallem dwar l-etika fil course?	Fl-ewwel sena kellna ftit, nghidlek il verita ma tantx nara li tista titghallimha jew jenfasizzaw fuq l-etika...vera ftit. Li tista taghmel tfittex ghalik. Issa jien l iktar li nara li tkun f xi sala u tiltaqa ma xi kaz u qisek tghid kieku din kif irrid namilha hekk jew hekk, u tfittex fuqha. Imma bhala taghlim huwa minimu hafna . Qisek min jeddek trid taghmel, tinqalalek xi haga u tghid din kif se namilha u tmur tfittec fuqha. Bhala etika ma tantx nahseb esperjenzajt...nghid ethical issues kbar hafna..bhall jien naf xi medical procedures u hekk. Imma imbghad ovjament hemm minor issues li dejjem tarhom fl-ethics
Tista ttini xi ezempju?	Ezempju, ghax qisni naf kif ghadha tkun l way so ma tantx infittex. Imma ezempju emm... medicina, ezempju kien hemm sala partikolari kellhom igibu mill-pharmacy u iddum biex tigi sakemm ma tmurx ghaliha u kien baqa xi wahda, u kellhom bzonn xewg pazzjenti l istess medicina, ghallura inti kif se tiddecidi lil min se tatiha ghax imbghad jispicca tikteb ta xi hadd not available u l-iehor tiffirma li tajtha...u jien min minnhom ghandu id dritt li jehodha, kif se tiddecidi ezempju..dik wahda. Emm, confidentiality...ezempju dik ma tridx tifftex fuqha jekk taf li parti mill l-etika, qieghda go sala u tkun taf x'qieghed jigri go sala ohra fuq pazzjent iehor u orrajt kieku isemmi l kaz biss nifimha ghax ma inti qieghda turi xejn imma kif naf x jismu u kollox fuqu..u anke il moghod ta kif titkellem qisna qeghdin il-bahar hekk vera casual kif titkellem fuq l affarijiet jew ghax nara hafna hekk...privacy ukoll... tkun qieghda tahsel lil xi hadd u tghidlu issa nkomplik ta u thallih nofsu hemm gharwiex...kieku jien jaghmlu hekk lili nidejjaq nghid mela jiena mhux importanti daqs l ohrajn biex hallewni hawn. U l iktar li ninharaq ghax huma affarijiet bazici, u mhux ghax tmur kontra l kurrent imma persli l kurrent huwa hafna iktar minnek hija difficli biex igib bidla. Imma hemmek tkun ix-xewqa...
Kurrent akbar minnek x jigiri?	Ghax il-maggoranza jaghmlu hekk inti trid liiggib il bidla u qisek wahdek ma tant tista taghmel affarijiet.
Qieghedk narak ftit irrabjata...	Ija ghax anke l fatt li titfa vera dell ikrah fuq il-professjonalita, idejjaqni hafna
U kif tikkopja maghha xi haga hekk?	Nghid nara x'naghmel jien...jien se nkun qieghda naghmel xoghol sewwa. Nghid at least jekk tibda minnek haddiehor jghid ara dik ezempju tajjeb forsi jaghmlu bhalek. Trid tkun soda biex ma timxix ma l-ohrajn. Jiena gieli anke jghiduli, inkun qieghda nipprepara l antibiotics kif suppost, ovjament ghadni nibda ndum naqra biex namilhom. Kien hemm min gieli qalli allahares meta tiggradwa tibqa taghmel hekk ta ghax ta bil-lejl qatt ma tlestijhom l-affarijiet u jiena nghidilhom orrajt.
U kif thossok meta jghidulek hekk?	Nirrabja hux ghax hekk suppost imorru l affarijiet...u kont qieghda nghidlek l ezempji...tal-medicina, privacy nara hafna, confidentiality u ijwaaa informed consent...ghax se taghmel l operation...gieli anqas nahseb ikunu jafu ghalxeix dehlin. Iva vera l irwol tat tobba li jispjegawlhom ezatti x se jaghmlu u hekk imma imbghad inti meta tkun qieghda taghmel ezempju cehcklist ghandek l opportunita li tara li fehem sew x'se jaghmel u forsi twiegeb xi mistoqijiet. Li ma naqbilx..imma forsi hija just l idea tieghi li taghmel c checklist ezatti qabel jinzlu ghat-theatre. Issa ma nafx hux suppost hekk tamilha jew le imma kif ghandha bzonn inizzluh malajr malajr...u tmur anqas tilhaq kwazi issaqi l mistoqijiet kolloha...kollox iva iva, i mean kieku jkollok cans tamilha ftit qabel ikollok cans tiklarifika xi affarijiet u hekk. Xi kultant il pazzjenti narawhom qishom oggetti taghna, namlu hekk hekk u hekk..qishu oggett narah iktar milli bniedem. Li jien nghid jekk inpoggi lili nnifsi fil-pozijoni tieghu dak li nkun ma nkunx irid min jaghmilli hekk, qishu jistamani inqas minnu ghax qieghda l isptar.
Gieli titkellem ma xi	Il-hbieb l iktar li nghid, ma nies kbar ma tantx nitkellimom l affarijiet. Ghax qishu



hadd fuq dawn l affarijiet li tiltaqa maghhom?	kulhadd jaf x'inhu l faults fis sitema imma hadd ma jipprova jirranghom. Imma l iktar ma shabi nitkellem, tal course. Emm...ghax xi kultant anke nkun fuq s sala u nara dawn l affarijiet nhossni nisthi...nghid iva mama mia dawn hekk namluwhom l affarijiet. Jien nippreferi naghmel iktar bilmoghod u naghmel l affarijiet sew milli nghaggel biex inlesti kollox. Ghax vera jien nammeti s'issa mill placements li kelli mhux daqshekk hazin. Imma ghax naghmel l affarijit bilmoghod u sew, jien nipprefei naghmel hekk milli noqod naggel u ma naghmilx kollox preciz. Jista jkun ghax jien ftit perfezzjonista u nkun irrid kollox sew.Allura nhossni nisthi anke min nies u profesjonijiet ohra, jghidu kif taghmel l affarijiet hekk, mhux moghod.
U thoss li hafna nies jghidulek trid taggel iktar?	Ija nsibha ta spiss, u nghid ma jimpurtax ghax nghid bl esperjenza tasal li tghaggel naqra iktar u tibqa tamilhom sew. Imma ahjar nitghallem sew. Ghax din anke kif jghidulek ejja ghamel hekk halli tghaggel imbghad fl ahhar tal course, fl-ahhar tal palcement jippretendu li taghmel kollox by the book ha tghaddi? Jew se tigi mghallem sew mill nbidu inkella taghmel xejn.
U dawn kellek placements bil-mentor?	Ija mhux kollha bil mentor, Ifhem issib mentors tajbin hafna. Ezempju nitkellem fuq l ewwel mentor li kelli. Nahseb ghalija l ewwel wiehed baqa l iktar wiehed li tghallimt fih. Ghax hafna mentors ikunu passivi...orrajt forsi vera ma jridu joqodu mieghek il hin kollu imma fil verita hekk hemm bzonn isir ghax jekk inti taghmel xi haga hazina jghidulek li mhux hekk trid taghmel, mela hekk. Mela ihalluk tazaq wahdek. I mean vera li kollox, imma ehe jekk huwa mentor xogholu huwa li jara inti x'qieghda taghmel halli jekk qiegheda thallat antibiotic hazin, ghamilt washing u mamiltu kif suppost, jghidlek, jigbidlek l attenzjoni gha xhadd ma jigbidlek l attenzjoni fuq l affarijiet, imbghad tasal l ahhar sena.. u kulhadd inti kif ma tafx dawn l affarijiet? Inti suppost taf taghmel dawn l affarijiet. Jew jistennew hafna knowledge, issa inti k knowledge tista ggibha milli tistudja, tfittex inti. Pero nahseb l iktar importanti huma dawk l affarijiet li jghidulek huma stess fil palcement jekk qieghed taghmel washing, ghallura ghalfejn ma jispjegawlekx fuq ambultion, dawk l affarijietl li jgidulek iktar tibqa tiftakar
U fit-teorija titghallmu fuqhom dawk l affarijiet?	Washing suppost kellna lesson u anqas kellna lesson, jew ghax tigi cancelled u hadd ma jerga jamilha. Iggifiri titghallem imma fil prattika dejjem ikun hemm izjed dettalji u titghallem iktar. Pero biex tkun iktar feasible trid mentors iktar jinvovlu ruhom.
Iggifiir jekk qieghda nifhem sew, l esperjenza tieghek keient fejn il-mentors ma tantx jinolvu ruhom?	Ehe ezatt, I mean u iktar u iktar la dhalt ghalijha inti, taf ghalxiex diehel. Dan mhux qbadt lilek u ghedltek ghoqod mentor, le la taf ghaliex diehel trid tghin lil l istuidenti kem jista jkun. U trid tigi mill l istudent ukoll li turi interess, jekk hemm oppportunita biex titghallem tmur tara imma tghinek li dejjem ikollok xi hadd jara x'inti taghmel.
So inti you lean fuq il mentor fil prattika?	Iva ghax inkun irrid li nara x'qiegheda naghmel jiena u jispjegali.
U fl-etika mal mentors thoss li kellek opportunita titghallem?	Insomma ma tantx...ma tantx. Qatt ma kellna discussion jew qishu qatt ma staqsewni din x'taghmel? Allura qishom they disregard them.
Hemm xi valuri jew principji ta l etika li huma importanti ghalik fin-nursing?	Iva li taghmel kemm jista jkun il-gid u dak li hu tajjeb ghall pazzjent u li tirispetta id decizjonijiet tieghu. Ezempju anke medicina li ma jridx jehodha, taf kemm il darba jirrifjuta li jehodom l pazzjent, staqsi ghaliex ma jridx jehodom forsi hemm raguni waraja, qieghda tamillu xi side effect jew hekk...imbghad tipo tipprova tikonvincih, jekk jibqa jghid le imbghad naghmel patient refused medication. Imma mhux just ma trid tehodom..ok tehodomx u daqshekk. Tipprova taghmel il-gid kemm jista jkun ghalhekk inti tipprova tikkonvincih jehodohom imma jekk ma jridx imbghad trid tirispetta id decizjoni tal pazzjent. Dawk nahseb, li tisma lil



	pazzjent, tirispetta d decizjonijiet tigehu u tipprova taghmel il gid kemm jista jkun.
U tuzhom hafna dawn inti?	Ijwa u nhobb hafna nitkellem maghhom u hekk, forsi jkollom xi haga noqghod nismaghhom u hekk specjalment l anzjani iktar hekk..
U xi jzommok motivat li tibqa fin-nursing?	Ghax anke il-moghod ta kif in nies iharsu lejn nursing qishu jarawh bhala ix haga li mhux ta valur kwazi, hdejn professjonijet ohra. Dik ittini hafna hekk...nghid mela le jien irrid naghmel l affarijeit kif suppost halli jarfu kemm hu xi haga importanti. Imma haddiehor meta jara l affarijiet kemm mhux isiru kif suppost...nursing station balla nruses man nursing station qisna qeghdin...uu minn jigi anke jarak hekk balla nies tal-misthija qisha. I mean inti studjajt u gradwajt ball kull course iehor mhux imbghad titazzen, trid tahdem biex turi lil haddiehor li dan huwa job u professjoni bhall l ohrajn
So din izommok motivata?	Ija li jaghmlu hafna ghall gid tal pazzjent...imma imbghad trid turiha. Jien togobni hafna u jien ukoll ghalhekk biddilt l course, li tahdem hafna mal patient u ghandek cans issir tafu xi haga sabiha u anke titkellem maghhom dik togobni. Certu challanges bhall dawn jaqtawli naqra qalbi imma nibqa nipprova. L importanti li if you fall you get back up.
U iltqajt ma xi nies li jahsbuha bhalek fil prattika?	Ija ikun hemm min jaghmel mhux xi hafna...imma ikun hemm min jaghmel l affarijiet bl ezatt u kif suppost. Imma fil-minoranza.
L-etika tghinek fil prattika tan nursing?	Ehe ezempju jien ghalija dawn li semmejt kolha ethically driven, ezempju confidentiality, privacy, li taghmel l gid. Dawn huma kollha ethically drive, li tismaghhom, li tirispetta id dinjita taghhom..ma tantx tahseb fuqhom dak il hin imma huma kollha etika ghalija.
U kif tghallimt li dawn huma ethical concepts?	Ftit minnhom qisek titghallimom milll ftit lezzjonijiet. Ohrajn ghax kif ghedtlek qabel...qisek tohloq principji ghalik ta x'inhu tajjeb u hazin ghallura naf x'inhuma l affarijiet tajbin li rrid naghme f healthcare. LI qisni nitghallem billi nfittex, ghalkemm ma keliex hafna meta tigi f dilemma ta x'ghandek taghmel. Ezempju..mhux ghax jidhlu nurses fiha imma transplants u min jiehu l organs u hekk. CPR, kif jiddecidi tabib u mhux l patient jew realtives...affarijiet hekk ghadni qatt ma rajt daqshekk. Forsi anke ghax is settings li kont fihom ma tantx hemm ethical issues
Tahseb li nnursing jirifletti l valura personali tieghek?	Iva nahseb iva. Il fatt li tkun per ezempju, pacenzjuza, taraf bejn li hija misthija u nurse li hija hekk iktar outgoing. Dawk jidhlu, tihdol hafna l karattru. Forsi kunfidenza, tkun taf taghmel xogho sew imma ma tkunx daqshekk kunfidenti. Haddiehor jista jklun li jaghmel xoghol inqas sew, imma peresli ikollu l kunfidenza tidher iktar. So nahsebjidhol l karattru u l valuri tal persuna.
U l valuri tieghek pesonali japplikaw?	Iva, forsi li kieku jkolli ftit aktar kunfidenza tghin. Imma ehe..nahseb li iva
In-nursing qieghed jghinek tkun individwu aktar etiku fil hajja?	Eee.....Ija ta. Forsi mhux daqshekk naraha..imma l-pacenzja. Titghallem tghid ok ha nikkalma meta xi hadd jibda jirrabjak jew jinnervjak.Ghax mal pazzjent ma tistax tirrabja. Jekk inti id dar tirvilla meta xi hadd jghidlek xi haga mal pazzjent ma tistax, jekk ikollu dementia...gieli qaluli xi haga u tghid ma tghid xejn, u tmur d dar u jghidulek xi haga u tmu mar rih, ma taghtix kas xi jkunu qalulek.
U thoss li mis-sena l ohrajn l hawn din inbidlet?	Jien nhossni li kont enrvuza hafna, meta jghiduli xi haga jew xi hadd idum biex jifhem, taqbizli. L-istess nursing ma tistax jekk xi hadd ma fehemx, trid tispjegalu bi kliem ehfef. Qabel kont isaqsuni xi haga darbtejn..."ijwa ergajt staqsetjni". Issa aktar nerga nghidilhom, ma natix kas mhux bhall qabel. U nahseb timmatura naqra ukoll, li immaturajt naqra iktar u jkollok iktar insight ta l affarijiet....bhall



Appendix 9

Codebook preliminary and final thematic framework

Codes\\Thematic Framework

Name	Description	Files	References
Character		30	416
'Iġġib ruħek' (Attitude) (Implying how one thinks about behaviour)		6	9
'Jaqtawli qalbi' (lose hope)		3	5
'kont tibqa imbellha' (flabbergasted)	Or stupefied	4	4
'Ma tantx jimpurtani' (I do not really care)		2	3
Being Kind	Be Nice changed to Being Kind	3	8
Disappointed in myself		1	1
Resilience		1	1
Selfish		2	2
Sod (Strong)	Developing a shell and being strong as a nurse	3	5
Behaviour (Implying action)		30	217

Name	Description	Files	References
'Mhux se nindaħal' (Will not get involved)		8	10
Accepting gifts		3	5
Bidla (Change)	Bringing about change	5	9
Communication		16	28
Għajnuna(Helping)		23	70
Having patience	Remain calm	13	23
Independenti	Students feeling like they are independent in their nursing practice	8	14
Limiti		2	4
Ma nitkellimx (Will not speak up)		4	5
Naf x'qiegħda nagħmel (I know what I am doing)		4	4
Respecting diversity		1	2
Tafda lilek innifsek (trusting yourself)		3	3
Tagħmel differenza (making a difference)		10	17

Name	Description	Files	References
Tagħmel għax tixtieq (doing because you want)		9	13
Tagħmel li hemm bżonn biss (Doing only what is neccessary)		3	4
Tiġi x-xogħol għall-flus (working for renumeration only)		3	4
Beliefs		25	84
'Tikber bħala persuna' (developing as a person)		11	13
Bilanċ (Balance)		1	1
Demoralising		4	4
Inherent Traits	Individuality? Personal character traits? Could these traits also refer to virtues?	20	51
Religion		3	3
Trobbija (Upbringing)		19	33
Inutli (useless)		3	4
Napprezza l-ħajja (Appreciating life)		6	11
Emotions		16	50

Name	Description	Files	References
'Ninħaraq' (flustered)		1	3
'Weġġajt' (hurt)		1	1
Anger		3	3
Biża (Fear)		7	12
Feeling guilty	Feeling guilty because they did not act ethically or observed unethical behaviour	3	8
Frustrated		5	6
Overwhelmed		4	4
Sad		3	3
Stressed	Referring to nursing degree programme	4	9
Valuri (Values)		21	55
Caring		13	26
Empathy and Compassion		21	52
Equality	Discriminazzjoni (discrimination)	5	14
Honest		9	18
Loyalty		3	6
Respect		20	35
Selfless		4	4

Name	Description	Files	References
Complexity and ambiguity	Diffiċli (Diifficult), Ambiguity in ethics. This code includes experts where students are indecisive about their actions or opinions or have claimed that ethics is very complex or difficult to understand	28	183
Dilemma	Students speak of dilemmas or grey areas	21	63
Tagħmel deċiżjoni (Decision making)	Making the right decision, undecided about a decision	21	73
Education and Practice	Added practice since they are very interrelated	30	631
Theoretical	Theoretical Knowledge or the act of knowing or understanding What students understand by ethics Gharfien	30	232
Code of ethics	Rules or regulations relating to nursing practice	3	11
Liġi (law) u regoli (Regulations)	Liġi (law) changed to laws	14	23
Normi tas-soċjeta (social norms)		4	5
Political perspective	Reference to liberalism	1	1
Principju tal-bioetika	Four principles of Beauchamp and Childress	14	30
Practice	Reference to placements, wards, health care settings	29	399
Context		7	19
konsegwenzi (Weighing consequences)	Consequentialist approach to ethics	6	7

Name	Description	Files	References
Nimxi kif suppost (Doing what I am supposed to)		10	37
___Procedures		19	63
Anointment of the sick (Griżma tal-morda)		1	3
Confidentiality		6	9
Consent		8	14
Dying patient		2	3
Infection control		8	12
Medication related		8	11
Presence		7	7
Privacy		3	4
Right thing to do		7	16
Esperjenzi (Experience)	Tacit knowledge, knowledge gained from life or nursing experiences. Refernce to learning from experience	20	36
Tagħmel l-aħjar (Doing what is best)		16	42
Tajjeb u Ħażin (Right and wrong)	This is also referring to good and bad. Students seemed to use these terms	26	81

Name	Description	Files	References
	interchangeably		
Tapplika l-etika (applying ethics)		11	14
Time constraints		13	27
Tirrifletti (reflection)		7	12
Humanity	Referring to the human side of caring for patients	29	93
Dinjita (Dignity)	Dignity is worth of being treated as a human being	13	32
Drittijiet tal-pazzjent (Patient rights)		15	30
Beneficcju ghall-pazzjent (benefit of the patient)	Change to Beneficence?	9	17
Patient safety		4	4
Pazzjent jiġi l-ewwel (Patient Comes first)	Patient centered care	13	21
Holistic care		5	7
Vulnerabbli (vulnerability)		14	24
Professional Issues	Professjoni (Profession) Why students think that nurses work ethically or not in relation to professional issues	14	26
Professional Identity		7	9
Role of nurse	Double meaning: Outside view of nursing Students feeling like they are now a	11	17

Name	Description	Files	References
	nurse		
Role models and Relationships	Was relazzjonijiet changed to dinamika ma haddiehor Dinamika ma' ħaddieħor (Team dynamics) Dynamics with others	25	75
Nurse-patient		16	28
Nurse-Relatives		12	19
Nurse-Student		28	138
Student-Student		7	17

Codes\\Thematic Framework\\Final Framework

Name	Description	Files	References
Character		30	407
'Iġġib ruħek' (Attitude)	Implying how one thinks about behaviour	6	9
'Jaqtawli qalbi' (lose hope)		3	5
'kont tibqa imbellha' (flabbergasted)	Astonished reaction and shocked	4	4
'Ma tantx jimpurtani' (I do not really care)		2	3
Being Kind	Be Nice changed to Being Kind	3	8
Disappointed in myself		1	1

Name	Description	Files	References
Resilience		1	1
Selfish		2	2
Sod (Strong)	Developing a shell and being strong as a nurse, referring to strength of character	3	5
Behaviour	Implying action	30	212
'Mhux se nindaħal' (Will not get involved)	Passive behaviour	8	10
Bidla (Change)	Bringing about change	5	9
Communication		16	28
Għajnuna (Helping)		23	71
Having patience	Remain calm and taking your time, not rushed	13	23
Independenti (Independent)	Students feeling like they are independent in their nursing practice	8	14
Limiti (boundaries)	Boundaries between work and personal life	2	4
Ma nitkellimx	Will not speak up, will not talk	4	5
Naf x'qiegħda nagħmel	I know what I am doing, competent	4	4
Tafda lilek innifsek	trusting yourself	3	3
Tagħmel differenza	making a difference	11	18
Tagħmel għax tixtieq (doing because you want)	Motivations for behaviour and actions (non-monetary)	9	13

Name	Description	Files	References
Tagħmel li hemm bżonn biss (Doing only what is necessary)	Motivations to do only what you are duty bound and neccessary, basic only nothing else	3	4
Tiġi x-xogħol għall-flus (working for renumeration only)	Motivation to work for money only	3	4
Beliefs		25	80
'Tikber bħala persuna' (developing as a person)		11	13
Bilanċ (Balance)		1	1
Demoralising		4	4
Inherent Traits	Individuality, traits that an individual is born with	20	51
Religion		3	3
Trobbija (Upbringing)		19	33
Napprezza l-ħajja (Appreciating life)		6	11
Emotions		16	50
'Ninħaraq' (flustered)		1	3
'Weġġajt' (hurt)		1	1
Anger		3	3

Name	Description	Files	References
Biża (Fear)		7	12
Feeling guilty	Feeling guilty because they did not act ethically or observed unethical behaviour	3	8
Frustrated		5	6
Overwhelmed		4	4
Sad		3	3
Stressed	Referring to nursing degree programme	4	9
Valuri (Values)		21	55
Caring		13	26
Empathy and Compassion		21	52
Equality	Diskriminazzjoni (discrimination)	6	16
Honesty		9	18
Loyalty		3	6
Respect		20	35
Selflessness		4	4
Complexity and ambiguity	Diffiċli (Diifficult) Ambiguity in ethics? This code includes experts where students are indecisive about their actions or opinions or have claimed that ethics is very complex or difficult to understand	28	188
Dilemma	Students speak of dilemmas or grey areas	22	68

Name	Description	Files	References
Tagħmel deċiżjoni (Decision making)	Making the right decision, undecided about a decision	21	73
Education and Practice	Added practice since they are very interrelated	7	8
Għarfien (Knowledge)	Knowledge or the act of knowing or understanding? What students understand by ethics? How students understand ethics?	7	8
Challenges	Perceived challenges to ethical practice	13	28
Time constraints		13	28
Experiential		22	49
Esperjenzi (experience)		20	36
Normi tas-soċjeta (social norms)		4	5
Practical		26	119
Context		7	18
konsegwenzi (Weighing consequences)	Consequentialist approach to ethics	6	7
Practice		14	41
Presence		7	7
Tapplika l-etika (applying ethics)		12	16
Procedures		19	58

Name	Description	Files	References
Anointment of the sick (Griżma tal-morda)		1	3
Confidentiality		6	9
Consent		8	14
Dying patient		2	3
Infection control		8	12
Medication related		8	11
Privacy		3	4
Tajjeb u Ħażin (Good and Bad)	This is also referring to right and wrong. Students seemed to use these terms interchangeably	26	81
Theoretical		28	172
Code of ethics		3	11
Liġi (law) u regoli (Regulations)	Liġi (law) changed to laws and regulations	13	23
Political perspective		1	1
Principju tal-bioetika		14	30
Tirrifletti (reflection)		10	16
Humanity	Should this be patient rights? Patient Centered Care	29	93
Dinjita (Dignity)	Dignity is worth of being treated as a human being	13	32

Name	Description	Files	References
Drittijiet tal-pazzjent (Patient rights)	? Change to patient entered approach	15	30
Beneficcju ghall-pazzjent (benefit of the patient)	Beneficience	9	17
Patient safety		4	4
Pazzjent jiġi l-ewwel (Patient Comes first)	Patient centered care	13	21
Holistic care		5	7
Vulnerabbli (vulnerability)		14	24
Professional Issues	Professjoni (Profession) Why students think that nurses work ethically or not in relation to professional issues	14	26
Professional Identity	Feeling like a nurse or becoming a nurse	7	9
Role of nurse	Public perception of the nursing role and student perception of the nursing role	11	17
Role models and Relationships	Was relazzjonijiet changed to dinamika ma ħaddiehor Dinamika ma' ħaddieħor (Team dynamics) Dynamics with others	25	75
Nurse-patient		16	28
Nurse-Relatives	Nurses and mentor relationships with relatives of patients	12	19
Nurse-Student	Nurses in practice and mentor relationships with students	29	141
Student-Student	Peers In course	7	17

Appendix 10

Sample memo note-NVIVO

Year 1

"*Hemmek naħseb tiġi face to face with reality (referring to placements) - There you come face to face with reality"*
" nipprova inkun fejn inkun inkun a better person- I try to be a better persona wherever I am"
"inħossni inutli, speċi ngħid jien min jien biex jien ngħid li mhux hekk suppost... I feel useless, I kind of say who I am to say that that is not what is supposed to be done"

Student feels powerless when faced with what she perceives to be unethical practice. She feels useless and irrelevant to question this kind of practice when someone is her senior. This is iterated by a lot of students, especially in 2nd and 3rd year. There seems to be an observation of unethical practice, but a sense that nothing can be done about it, especially when a student. This is derived on the need to have good relationships with those working with you and mentors giving a mark to students for their practice.

The student specifically mentions that she feels that she is more ethical at work and requires less effort. She states that it is probably because people at home are less vulnerable as individuals. She associates ethics with decisions that are uncertain or that do not have a clear outcome. She observes different nurses in practice with some coming to work because they want to and others coming to work just for the pay. She says that character and background will influence your work and values. She did not find lectures very useful; she mentions that in practice there should be more focus on ethics. However later she mentions that in lectures there is more time to discuss ethical issues compared to practice and believes that as of yet, she has not faced ethical issues in practice. However, the examples she is relating to portray a different story as seen below:

"Naħseb l-iktar ħaġa li tirrelata ma ethics hija meta jkun hemm xi ħadd jittrata l- pazzjent ħazin u bħala studenta ma tantx hemm x'tagħmel, jekk hemm xi hadd ta livell għola minni għax ma tistax tmur tgħidlu mhux hekk titratthom il-pazzjenti" - I think what relates most to

ethics is when someone treats a patient badly and as a student there is nothing you can do, if there is someone who is at a higher level than yourself you cannot go and tell them that that is not the way to treat patients"

Year 2

The student mentions that she wants to be a good nurse in terms of skills. The skills that she mentions are technical skills such as NGT and catheters. She seems to have more insight that ethical issues happen in practice with more examples provided. There is evidence that the student reflects on her own practice after her shift and identifies ethical issues in such instance, however she labels them as difficult decisions or unanswerable questions.

In year 1 and year 2 the student mentions boundaries and protecting oneself. This was not observed with any other participants. She feels that ethics is confusing.

"Iktar milli isma dan huwa is-sylabbus u daqshekk fullstop. Ma tantx tagħmel sens at this point- Rather than listen this is the sylabbus and that is it fullstop, it does not make sense at this point" This sentence highlights a shift from discussion based to trying to fit in as much knowledge as possible in the curriculum

Several students mention discussions with other classmates to deal with ethical dilemmas and having discussions to vent out what was observed in practice which seems to be very helpful for the student.

In this interview the student seems hurt by certain aspects of care and indifference in the clinical area. This instance seems that it would have been a good opportunity for her to learn how to deal with the loss of a patient, but the observations she made was of nurses who acted indifferent to a situation and she is concerned that she will become indifferent to the death of a person.

Honestament weġġajt daqs li kieku qal fuq relative tiegħi...għax qisek ilek tieħu ħsieb il pazzjent ġurnata sħiħa u speċi you couldn't care less jekk dal patient jibqgħax ħaj- honestly I

was hurt, as if he said it about my own relative...because you are taking care of this patient all day and you couldn't care less if this patient remains alive"

"issirx hekk...issirx hekk". Anqas jekk inkun xbajt mix-xogħol...jekk xbajt nitlaq mhux noqgħod nikkumidja -" I say to myself do not become like this...do not become like this. If I am fed up from work, I would leave not" (nikkumidja? translation?)
The student seems to be struggling with the concept of not helping actively, but allowing a patient to die. There seems to be subject to insensitivity from nurses in practice who are not explaining this at that moment in time and she is really struggling with this. She cannot understand why such a decision was taken and does not agree with it.

Għedtilhom *"x'jiġifiri jekk patient huwa not for CPR x'jiġri? Qaluli, xejn tħalliħ imut... X'jiġifiri? Ma niflahiex! Jekk taf li patient se jmut xorta I try my best- I asked "what happens if the patient is not for CPR? they said nothing you let him die...what do you mean?! I cannot stand it! If you know that the patient will die, I will still try my best".* Student feels like she cannot give an opinion about this because she does not have enough knowledge and cannot question the signature of a doctor, but it is clearly that this is really bothering her. She says that she will give an opinion once she graduates. This ties with the theme of powerlessness as a student.

Meta nibda nara li speċi m'hemmx compassion tbeżżani... nibda ngħid "possibli wara għoxrin sena f'dan ix-xogħol hekk se nispiċċa? tipo I don't care and couldn't care less-*When I see that there is no compassion, I get scared...I start thinking "is it possible that after 20 years in this work I will end up like this?"*

In this paragraph student feels like most people who have been working for a long time have lost their sense of compassion and care. However, she mentions that she cannot feel too much for patients, there needs to be some control over her emotions. Here the student is associating ethics with the values of compassion and care. In practice the student feels that she does not conciously apply ethics.
Nahseb mhux willingly...knowingly? Ha nuża...imma mhux qed nuża...tagħmel sense? - ***I think not willingly...knowingly? I use it .... but I am not using it...does it make sense?***

She mentions that she does not use ethics, but at the same time she believes she does not have enough knowledge about it. This is an indication that the transference of ethical knowledge to practice is a huge gap. Students struggle to identify what is ethics and how to apply it. THe knowledge that they have, they are not sure how they got it. Some say nurturing and others say lectures and practice. Students that rely on values as an explanation of ethics tend to focus on character and upbringing.

Year 3

In year 3 the student went through some life changing situations in which her family members experienced illness. She mentions that at times it was very difficult to cope with her studies and felt like se was duty bound to support her family, as well as the patients she meets at work. Her final assessment was a source of stress she said "bdejt ngħid ma niflahx iktar...u vera bdejt insibha diffiċli - *I started saying that I cannot take it anymore... and I was really finding it difficult*. "

The student mentions the job satisfaction when patients thank you and appreciate the work that you do. Throughout the interview she mentions the influence of the environment and the feelings/moods that others project. She seems susceptible to such projections and mentions that this influences how much she would be looking forward to going into work. She continues to explain that she thinks that people might act this way because they take what they do for granted and this translates to patient care. She goes on to further state that:

*"Imbgħad tibda tara minn perspettiva l-bogħod tibda tgħid għalfejn sirna daqshekk inhumane? - Then you start looking at things from a faraway perspective and you start asking yourself why we have become so inhumane?" T*his is a very strong assumption, the student in general could have a pessimistic attitude and how she views the world can lead to focusing on such negative aspects. Furthermore, she strongly believes that "Realistikament... u nibqa ngħid l-istess ħaga sakemm immut. Ħafna nies qegħdin fix-xogħol għall-flus mhux għax genwinament iħobbu ix-xogħol. - *Realistically...and I will say the same until I die, a lot of people are in the job for money not because they genuinely like the job"* She mentions that she observes people that are not "għall-qalbhom" -translation from the heart?

Her perception of ethics seems to shift toward a more patient centered approach, she does not mention safeguarding herself anymore but mentions that you must see what the patient needs from their perspective, not from her own.

When it comes to observing ethics in practice, The student feels that she cannot recall when she saw ethics being applied in practice but said that she is able to pinpoint missing aspects of ethical care. An emphasis on wanting to spend time near the patient and listening to them is very evident, which is a shift from 2nd year and the emphasis on practical skills. When it comes to applying theory to practice, the student does not think that she applies any theories, but she applies the examples that were provided in lectures. She said that ethics has helped her give more priority to the patient themselves rather than what needs to be done.

She says that now she feels like it is easier to do things the right way because she genuinely wants to, not because of marks or because that is what she learnt. This shows a sense of ownership of her own practice. This year the student felt like she wanted to learn how to do things the right way so that it becomes easier once she graduates to do what is right. There is a development in what
The student understands Nursing to be, (she has shifted her perception to understand the importance of nursing as a profession): *"il fatt li qisni sirt nara l-importanza tan-nursing bħala xogħol dik għenitni ħafna- The fact that I started appreciating the importance of nursing as a job helped me a lot"* This major shift happened during her final placement, like most students she feels like this placement was pivotal in her learning, This could also have a role in developing an identity as a nurse.

"Qisek f'daqqa wahda tawk id dinjita li m'ghadekx tifla ta 5 snin, trid tgħallimni u turini kollox. Fl-istess ħin għandi idea ta x'irrid nagħmel u ma nagħmilx. Dik id-dinjita timmotivani ħafna, li nara li qegħdin jistmawni bħala nurse mhux studenta". Suddenly I was given my dignity, I am not a 5-year-old girl having to teach me and show me everything. At the same time, I have an idea of what I need to do and not do. This dignity motivates me a lot, that I am treated as a nurse not as a student"

The student mentions that she has often been told in practice that she does everything as should be because she is still a student and she questions why this is. She was told *"intom għax għadkom tibdew tagħmlu kollox kif suppost- It is because you are just starting out that*

you do everything as you should" she seems to be placing a lot of effort in doing things the right way and not only for her final exam but beyond that. However, her perception is that to continue doing things right, she will make a lot of enemies, end up working alone and being laughed at. This peer pressure results from various comments such as the ones beforehand and the fact that she does not observe a lot of people working as they should. She uses the term **fear** to explain this dilemma, which is a very strong emotion to have considering that this is just the start of her career as a nurse. **This idea that you must fight against a current to work well. (note own assumption here, you have experienced this many times).** She also mentions how this behavior is observed between nurses who graduated, such as her mentors in practice. She also says that she feels pressured to work unethically because of time and the constant pressure to go faster. When this happens, she feels very frustrated and disappointed in herself.

"Tinkwetani naqra e... għax nixtieq li nibqa nagħmel l-affarijiet sew għall ġid tal-pazzjent u fl-istess ħin naf li biex tagħmel l-affarijiet sew se tagħmel l-għedewwa eventwalment. -This worries me...because I wish to continue doing things right and for the patient's wellbeing but at the same time, I know that to do things right I will eventually make a lot of enemies"

The student mentions that she would suggest further self-reflective interviews like this, because she said that this interview helped her identify her progress in this area and in education we do not focus on improvement. She further mentions that she believes that there isn't enough awareness about ethics, it is not a priority in practice.