Nursing ethics education in undergraduate nursing programs in South Africa and Namibia:

A critical appraisal

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DECLARATION

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OPSOMMING

Die geskiedenis en ontwikkeling van verpleegetiek dui op versorging as die kernwaarde van verpleegkunde. Sedert die vroegste tye sien die gedragskodes wat deur samelewings ontwikkel word, na kwesbare lede van die gemeenskap om. Die waardestelsel van verpleegkunde in Suid-Afrika en Namibië kan teruggevoer word tot die Christen-sendelinge wat uit Engeland en Europa gekom het. Florence Nightingale word as die stigter van moderne verpleegkunde beskou en het ’n stewige etiese grondslag vir verpleegkunde gelê. Verpleegetiek onderrig het verskeie doelwitte, waaronder bevordering van die etiese insigte van verpleegkundigies en beskerming van pasiënte. Etiek onderrrig word daagliks gekonfronteer deur menige uitdagings met volgehoue pogings om hierdie uitdagings deur innovering aan te spreek. Oor die geskiedenis heen het die verpleegberoep op morele uitdagings gereageer deur etiekkodes met rigsnoere vir die verpleegpraktyk op te stel. Mettertyd het die etiek van versorging veld gewen as ’n belangrike benadering tot verpleegpraktyk. Die waardes en verpligtinge wat in die etiekkodes van sommige lande sowel as dié van die Internasionale Raad vir Verpleegkundiges vervat is, toon bepaalde gemeenskaplike beginsels en oortuigings. Hierdie etiekkodes beskryf verpleegkundiges se plig jeens pasiënte, die verpleegberoep, die samelewing, hul medewerkers én hulself as individuele verpleërs. Verpleegkundiges behoort sekere vereiste karaktereienskappe te ontwikkel. Veral Aristoteles se gedagtes oor intellektuele deugde en praktiese insig kan verpleegetiekopvoeders van ’n lewensvatbare benadering tot onderrig en leer op hul vakgebied voorsien. Tog bied hoëronderwysinstellings in Suid-Afrika en Namibië oënskynlik wisselende mates van voorgraadse verpleegetiekonderrig. Hierdie gebrek aan standaardisering maak dit moeilik om die werklike gehalte van verpleegetiekonderrig te bepaal. Die verpleegetiekopvoeders in Suid-Afrika en Namibië wat vir hierdie studie geraadpleeg is, maak melding van uitdagings met betrekking tot die onderrig- en leeromgewing, verpleegpraktisyns, studente en opvoeders, die

reguleringsowerhede sowel as politieke en regskwessies. Die opvoeders het ook voorstelle gemaak oor hoe hierdie uitdagings hanteer kan word. Die doeltreffende internalisering van verpleegwaardes vereis toewyding van verpleegopvoeders, -studente en -praktisyns sowel as belanghebbendes buite hoëronderwysinstellings. ’n Kritiese beoordeling van verpleegetiekonderrig in Suid-Afrika en Namibië dui op bepaalde tekorte wat regulerings- en bestuursaspekte van verpleegonderrig betref, en ook verskeie uitdagings met betrekking tot verpleegonderrig oor die algemeen en verpleegetiekonderrig in die besonder. Die verbetering van verpleegetiekonderrig vereis spesialisering deur verpleegetiekopvoeders, die standaardisering van etiekonderrig, en innoverende onderrig- en leerstrategieë, onder meer die inskerping van praktiese insig by verpleegstudente. Gesondheidsorgfasiliteite moet opgeknap word en verpleegpraktisyns en -opvoeders moet verpleegstudente doeltreffend ondersteun. Ook bestuurs- en reguleringsaspekte moet verbeter word. Die uitdagings wat in hierdie studie na vore kom, kan die hoof gebied word deur beter samewerking tussen hoëronderwysinstellings, verpleegrade en diensverskaffers. Intussen bly verpleegetiekopvoeders vol hoop dat verpleegetiekonderrig in Suid-Afrika en Namibië verbeter kan word.

SUMMARY

The history and evolution of nursing ethics situate caring as a central value of nursing. Since ancient times, codes of conduct, developed by societies, have protected the vulnerable. The value system of nursing in South Africa and Namibia is derived from Christian missionaries who hailed from England and Europe. Florence Nightingale is recognised as the founder of modern nursing and established a firm ethical foundation for nursing. Nursing ethics education has various aims, i.e. promotion of ethical insight of nurses and protection of patients. Ethics education is confronted daily with many challenges with continuous efforts to address these challenges through innovations. Throughout its history, the nursing profession has responded to moral challenges by developing ethical codes with guiding principles for nursing practice. An ethic of care gained ground as an important approach in nursing practice. The values and obligations proclaimed in the codes of ethics of some countries and the International Council of Nurses reveal shared values and beliefs in nursing. These codes of ethics describe the obligation of nurses towards patients, the nursing profession, society, co-workers and themselves as individual nurses. Nurses ought to develop certain required character traits. Aristotle's ideas on intellectual virtues and practical wisdom specifically may provide nursing ethics educators with a viable approach in the teaching-learning of nursing ethics. The status of nursing ethics education in South Africa and Namibia revealed variability in most aspects of undergraduate nursing ethics education in institutions of higher education. This lack of standardisation complicates assessment of the quality of nursing ethics education. Nursing ethics educators in South Africa and Namibia identified challenges regarding the teaching-learning environment, practising nurses, students and educators as well as challenges related to the regulatory authorities and political and legislative framework. Suggestions to address these challenges were also offered by the nursing ethics educators. The effective internalisation of nursing values requires the efforts of nursing educators, students, practising nurses as well as stakeholders beyond institutions of higher learning. A critical assessment of nursing ethics education in

South Africa and Namibia highlighted certain deficiencies in relation to regulatory and managerial aspects in nursing education and various issues related to nursing education generally and nursing ethics education specifically. Improving nursing ethics education needs nursing ethics educator specialisation, standardisation of ethics education and innovative teaching-learning strategies, including the inculcation of practical wisdom in nursing students. Health care facilities need upgrading, and practising nurses and educators must support nursing students effectively. Managerial and regulatory aspects need improvement. The challenges identified in this study can be resolved by improved collaboration amongst institutions of higher learning, nursing councils and service providers. Nursing ethics educators remain hopeful that nursing ethics education has the potential to be significantly improved both in South Africa and Namibia.

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GENERAL INTRODUCTION AND PROBLEM STATEMENT

The nursing profession originated from a societal need to care for people who were injured, sick or vulnerable. Society has had expectations from care-givers since ancient times. These expectations were founded on care for the sick, the promotion of wellbeing and alleviation of suffering. Throughout the ages these expectations of care-givers by society have not changed.

> *Nursing has been called the oldest of the arts and the youngest of the professions. As such, it has gone through many stages and has been an integral part of societal movements.*
>
> Donahue, 1996: 2)

Florence Nightingale founded modern nursing in the mid-19th century and established the ethical foundation of nursing by introducing nursing values and norms as part of nursing education. The study of nursing values and norms is included in current undergraduate nursing education programs and nursing ethics education is still seen as relevant and necessary in such programs.

The study of codes of ethics in countries around the world confirms that nurses should be certain about the ethical norms and values of the nursing profession. Contemporary codes of ethics studied describe ethical expectations of nurses that not only relate to patients, but also to colleagues, the nursing profession and society at large. Caring remains the core value in nursing ethics and nursing practice.

Political decision-makers and leaders in South Africa and Namibia have heard the concerns of the public about the shortcomings in the health care systems in both countries and acknowledged that the provision of health care is challenged and that these challenges should be addressed. In South Africa, a Nursing Summit, held in April 2011, scrutinized all the issues that can take the nursing profession forward in its endeavours to improve effective health care. Relevant to this study is the analysis of undergraduate nursing education generally and the implementation of the recommendations related to

undergraduate nursing education. For the purpose of this study undergraduate nursing education refers to both nursing degree programs at university and nursing diploma programs (pre-registration programs) at affiliated nursing colleges. In South Africa diploma nursing programs are offered at colleges affiliated to universities, while in Namibia both nursing degree and nursing diploma programs are offered at the national university.

In Namibia, the President of the Republic of Namibia appointed a Commission of Inquiry into the nursing profession, including undergraduate nursing education, in September 2012. This commission will report on the challenges and potential solutions to the President for further action. Many of the challenges described in this dissertation correspond to the challenges outlined in the report of the Nursing Summit of 2011 in South Africa. The challenges in Namibia, in the process of being identified by the Commission of Inquiry, are not expected to be different from those reported in this dissertation.

1. Background, problem statement and objectives of the study

The public in both South Africa and Namibia still need and expect nurse practitioners to practice nursing ethically. The provision of ethical care by nurses, which ensures effective health care of patients, is often challenged by discordance between societal, regulatory, organizational and personal requirements. Indecision about the challenges in health care and the provision of ethical nursing care result in poor health care to patients, which impacts negatively on disease profiles and developmental health goals of both South Africa and Namibia.

The regulation of nursing education by the South African Nursing Council (SANC) and the Nursing Council of Namibia (NCN), in the two countries, provides broad frameworks for nursing education. These frameworks grant institutions of higher learning a great deal of autonomy in the development of nursing curricula. The SANC and the NCN must nevertheless approve those institutions which offer education to nurses, including their clinical facilities and nursing curricula, before nursing education can commence.

Institutional autonomy means that undergraduate nursing programs are not standardized and nursing students receive a wide variety of different nursing content at different institutions. Nursing ethics education is still seen as a minor component and less important module, despite the challenges in nursing attitudes and the conduct of practicing nurses. Health care facilities approved by the regulatory authorities do not fulfill the requirements for quality nursing education. These facilities, in both South Africa and Namibia, are often in a state of disarray and dilapidation without the necessary equipment and supplies to provide effective care or education.

Some managers in institutions of higher learning find it hard to understand the unique requirements of undergraduate nursing education which are prescribed by regulatory authorities with regard to both theoretical and practical nursing education. Hours of clinical practice, special time tables for nursing students and assessment modalities for nurses all contribute to the challenges faced by nursing educators in institutions of higher learning. Nursing ethics educators are challenged by high student numbers, worsening student attitude, poor discipline and irresponsible conduct of students and the current over emphasis on students' rights. Academic expectations in institutions of higher learning, such as involvement in research and community service, differ from those that educators were accustomed to in the hospital school system, and exacerbate the challenges in nursing education, because teaching-learning is not the only focus of nurse educators.

The training and education of student nurses contains prescribed clinical requirements and clinical skills are imperative for quality nursing care. Educational institutions rely on clinical facilities that are conducive to the education of students and practicing professionals who can guide and support students while in training. Professional nurses are often not role modeling the values and norms which are expected from them by the nursing profession in clinical practice settings. The organizational culture in state facilities in both South Africa and Namibia where nursing students receive clinical nursing

education is not conducive to socializing nursing students into the nursing profession. Uncaring nurses and poor care has become the norm and there are few disciplinary consequences for nurses who behave badly.

The objectives for this study are:

- Describing the status of undergraduate nursing ethics education in selected institutions in South Africa and Namibia
- Describing the challenges in nursing ethics education in selected institutions in South Africa and Namibia
- Critically appraise nursing ethics education in selected institutions in South Africa and Namibia
- Explore Aristotle's *phronesis* as an approach in nursing ethics education

The challenges in nursing ethics education is appraised specifically, within the framework of nursing education generally. In both South Africa and Namibia, the standard of nursing care is consistently under question by the public and reports of unethical behavior of nurses are reported in the media. The question arises as to whether nursing ethics education provides nursing students with the necessary competencies to practice nursing as professionals. No data exists in South Africa or Namibia on the status of, and challenges in, nursing ethics education. Contemporary health care is challenged by many factors, such as unsatisfactory disease profiles and mortality rates, new diseases, increasing resistance to medicines that increase difficulties in treatment modalities, access to facilities and social problems such as poverty and drug abuse. Nurses, as forerunners in the primary care of patients, are sometimes overwhelmed by the service demands of patients and the availability of resources. All these factors have eroded the culture of care that the nursing profession holds so dear. It is, therefore, imperative that

nursing ethics education is critically appraised to determine the status and challenges and those recommendations are formulated to improve nursing ethics education in both South Africa and Namibia.

This dissertation also explores a further approach in the caring process of nursing practice and nursing ethics education. This approach is founded on Aristotle's notion of the intellectual virtues and specifically the virtue of practical wisdom. The goal of nursing is to promote patient *eudaimonia,* i.e. the wellbeing and happiness of patients, and is therefore an appropriate approach in nursing practice and nursing ethics education. Attainment of practical wisdom, also called clinical wisdom (Uhrenfeldt & Hall, 2007), by nursing students will provide them with the competencies to integrate the nursing sciences with the art of nursing. Practical wisdom is an approach in nursing ethics education that relies on an open, tolerant and collaborative teaching-learning environment, where learning is seen as a process, where students and educators deliberate on what is good and right in life and nursing practice specifically. Nursing students are then placed in the position of having the ability to use practical wisdom as an approach in their care of patients.

2. Methodological aspects

The empirical data in this study were gathered by a survey as well as individual interviews. A literature study was also conducted on Aristotle's concept of practical wisdom and how it is used in nursing ethics education.

3. The empirical component of the study

A survey to respondents determined the status of nursing ethics education and the challenges in nursing ethics education through administering questionnaires to respondents. The empirical component of the study obtains data about the current educational practices with regard to nursing ethics education in South Africa and Namibia. Without obtaining the current status of and challenges in nursing ethics

education in South Africa and Namibia a critique of nursing ethics education in the two countries could not be done. The status of nursing ethics education includes data on nursing ethics educators and the presentation of nursing ethics education in undergraduate nursing programs with the aim to determine both the structural and functional aspects in nursing ethics education in South Africa and Namibia. Questionnaire data is strengthened by data from individual interviews with respondents on the challenges in nursing ethics education, how respondents think these challenges can be addressed, and the teaching-learning of values to students in South Africa and Namibia. No data exists in South Africa and Namibia on the presentation of undergraduate nursing ethics educations or the challenges that nursing ethics educators experience in nursing ethics education. This study attempts to provide new information on structural and functional aspects of undergraduate nursing ethics education in both countries. Data obtained from respondents in participating institution can indicate the efforts put into and importance of ethics education at these institutions. Individual interviews with nursing ethics educators provide insight in the day-to-day challenges that nursing ethics educators experience in undergraduate nursing ethics education in both countries. The information gathered in this study forms baseline data about undergraduate nursing ethics in South Africa and Namibia and can stimulate further research in this area. Data regarding the status of nursing ethics education is presented in Chapter Four of the dissertation. The individual interview data delivered several challenges and views on addressing these challenges, including how values can be taught to nursing students and this is discussed in Chapter Five of this dissertation.

Respondents who participated in this study were identified from tertiary institutions approved by the South African Nursing Council to offer undergraduate nursing education. Institutions, whose contact details were available on the web pages of their institutions, were identified and approached electronically. The head of nursing schools were requested to identify nursing ethics educators who are currently teaching nursing ethics and those who previously taught nursing ethics education. These

respondents are referred to as experienced nursing ethics educators throughout this study. The identified educators were requested to complete the questionnaire. The same respondents were interviewed and provided additional information on the challenges in nursing ethics education. Only one institution in Namibia offers undergraduate nursing education and experienced ethics educators from this institution participated in the study.

4. Structure of the dissertation

Chapter one presents an overview on the history of nursing ethics and chapter two present a literature review of nursing ethics education and ethical codes of nursing. Chapter three offers Aristotle's ideas of the intellectual virtues generally and practical wisdom (or phronesis) specifically. Chapters four and five deal with the empirical research components of the dissertation and present the status of nursing ethics education in South Africa and Namibia and the challenges in nursing ethics education in the two countries. Chapter six contains a critical appraisal of nursing ethics education in South Africa and Namibia, while chapter seven proposes some recommendations of the identified challenges. Chapter eight concludes this dissertation.

Chapter One presents a historical overview of the evolution of nursing ethics from ancient to modern times. Various categories of caregivers performed tasks that supported the wellbeing of others. In ancient times it was mainly mothers within family units who provided such care, but later care was also provided by the shaman (medicine man), the priest-physicians and their practical attendants. Ancient civilizations (±2000–80 bce) formalised the care of others by developing codes of conduct, such as the Code of Hammurabi, created in 2250 bce, that protected the vulnerable in ancient societies (Donahue, 1996). In ancient civilisations caregivers were expected to provide care according to the values set by societies (Searle, 1988). Christianity, (since the first century AD) contributed to the value system of caregivers in Europe and England, the Americas and Africa, because Christian missionaries moved from

Europe and England to other parts of the world. The value system in nursing in South Africa and Namibia is derived from these values, established by the missionaries. Florence Nightingale founded modern nursing in the mid-19th century and established the ethical foundation of modern nursing by including nursing ethics into the earliest education of nurses (Searle, 1988). Florence Nightingale exemplifies a belief construct of compassion and duty fulfilment upon which her choices were based (Stanley & Sherratt, 2010). Nursing, as well as other professions, was challenged by the scientific advances of modern times and responded, inter alia, by developing codes of ethics and guiding principles for nurse practitioners (Viens, 1989). Throughout the ages, caring remained the core value in nursing practice and an ethic of care gained ground as an approach in nursing practice. Concluding remarks are included.

Chapter two firstly contains a literature review on nursing ethics education presenting the aims of nursing ethics education, the required content, challenges and innovations in nursing ethics education. Secondly, it presents an analysis of codes of ethics of some countries in the world, including the ethical code of The International Council of Nurses (ICN). Some countries use the ethical code of the ICN as the ethical code of choice in their countries. Studying the codes of ethics of some countries in the world reveals and identifies the following shared ethical obligations of nurses towards patients:

- respect for persons and respect for the rights of patients;
- fair and compassionate treatment and care;
- the avoidance of harm to patients; ensuring access to information and the facilitation of informed decision-making and consent;
- the protection of patient information and the establishment of a trusting relationship;
- the provision of care according to patient need and patient culture;

- the maintenance of desirable standards of nursing practice/quality nursing care and professional competence;
- Collaboration and cooperation with all involved in health care and
- Keeping clear and accurate records of all nursing actions and the awareness of accountability for professional practice.

The shared ethical obligation of nurses towards national and global society is identified as working towards health for all by collaboration with all partners (nationally and internationally) and towards coordinated services for the promotion of health. Nurses are also expected to participate in national and international conferences and conventions, establish systems for quality nursing care and actively address social problems that affect the population's health.

Practising nurses have an ethical obligation towards the nursing profession and towards themselves as individual nurses. Most codes of ethics identify these ethical duties of the nurse as requiring the nurse to uphold the tradition and collective efforts of the nursing profession and to take pride in being a nurse by displaying acceptable behavior.

The analysis of codes of ethics identifies the desirable personal character traits of the professional nurse practitioner which include, inter alia, having *a* virtuous character, manifesting integrity, transparency, kindness and compassion. Commentary remarks on relevant issues are included.

The conceptual component of this dissertation is presented in *Chapter Three* as part of the background to the study. This includes a description of Aristotle's ideas on moral virtues and his explanations of the intellectual virtues generally and practical wisdom more specifically. Practical wisdom (phronesis) as an approach to nursing ethics education is also presented as it relates to nursing and nursing education in contemporary literature.

Chapter Four discusses the empirical study on the status of nursing ethics education in participating institutions in South Africa and Namibia. Together with chapter five, reflecting on the qualitative data on the challenges in nursing ethics education, it forms the essence of the dissertation. Chapter Four presents the quantitative data on the status of nursing ethics education as obtained from the questionnaire. This status report presents biographical data of respondents related to age, gender, general teaching experience in nursing education and teaching experience in nursing ethics. The offering of nursing ethics in undergraduate nursing education programs is presented in terms of level of offering (degree or diploma level); whether content is offered as a separate module or integrated into other modules; the academic year in which nursing ethics content is offered, the amount of time (hours) allocated per week, whether ethics education is presented as a semester, year or other mode of offering, whether a clinical component is attached to nursing ethics modules and the content offered to students in nursing ethics education at participating institutions. Also presented in this chapter are the views of respondents on the importance of changing the teaching-learning methods in nursing ethics education, how these changes can be introduced and how difficult this change might be.

Chapter Five firstly presents qualitative data on the views of experienced nursing ethics educators at participating institutions on the challenges in nursing ethics education, how these challenges can be addressed and how nursing ethics education can facilitate the internalization of nursing values in nursing students. Three themes are discussed according to the analysis of the transcribed interview data and from the answers to open ended questions of the questionnaire survey. Theme one relates to challenges in the teaching-learning environment, theme two presents the challenges related to nurse educators, nursing students and practicing professional nurses, while theme three discusses challenges relating to regulatory authorities, political and legislative issues. For the purpose of this dissertation practicing nurses refer to those professional nurses who guide students in the clinical environment where students are placed during their training.

Secondly, this chapter also presents the views of nursing ethics educators at participating institutions on how the identified challenges can be addressed. With regard to this, theme one contains suggestions on improvement in the teaching- learning environment and theme two suggests changes from outside the teaching-learning environment.

Thirdly, the views of respondents on how nursing values can be internalized by teaching-learning of nursing ethics echo the challenges in nursing ethics education at participating institutions and are mentioned briefly in this chapter. With regard to this aspect, namely the internalization of nursing values, suggestions relating to the responsibility of nursing educators, professional nurses and students are described. Contributions by other stakeholders such as the Ministry of Education, the regulatory authorities and decision-makers in the health care delivery system, to the effective socialization of student nurses in the nursing profession, are also included. This chapter further adds some positive and negative feelings that were noted by the researcher during the analysis of the transcribed interviews and the field notes, which indicates that nursing ethics educators are sometimes disheartened by the circumstances in which they operate, but are also excited about going forward and creating new opportunities to nursing students in the teaching-learning of nursing ethics.

Chapter Six contains a discussion and critical assessment of the challenges in both theoretical and practical nursing ethics education at participating institutions in South Africa and Namibia. Issues that are referred to are the regulatory issues in nursing education; various aspects in the offering of nursing ethics education modules in institutions of higher learning; specialization in nursing ethics; aspects related to the theoretical and clinical teaching-learning environment and teaching-learning methods in nursing ethics education. A commentary on relevant issues is included.

Chapter Seven generates some ideas on improving nursing ethics education at participating institutions in South Africa and Namibia. Decision-makers and stakeholders should focus on improvement in regulatory and administrative aspects of nursing education which influences nursing ethics education. Specialization of nursing ethics educators is necessary to produce competent ethics educators. The standardization of nursing ethics education removes the uncertainty about offering of nursing ethics education and can assist in the monitoring of nursing ethics education. The quality of nursing ethics education can be improved by innovative teaching-learning methods and upgrading of ethical skills of practising nurses as well as the clinical facilities where students are placed. Practical wisdom as an approach in teaching-learning of nursing ethics enables educators to create an educational environment that assists students to learn at a pace that allows for reflection, critical thinking and deliberation without fear that wrong answers equate to failure. Practical wisdom also seeks an ethic of responsibility and the flourishing of others, which is an ethic so dearly needed in South Africa and Namibia.

The final chapter of this dissertation is *Chapter Eight* which summarizes the main findings of the study and the recommendations derived from the study. The limitations of the study are identified and further research generated by the study is mentioned. It is concluded that the challenges identified by the study can be met and improvements in nursing education generally and nursing ethics education specifically are possible when all stakeholders work together to effect the improvements needed in South Africa and Namibia.

5. Contribution to nursing ethics education in South Africa and Namibia

The proposals in this dissertation, discussed in chapter seven of the dissertation, are based on both the empirical data and the conceptual component of this study. It is proposed that the regulatory aspects of nursing education generally should involve more collaboration between the Nursing Councils in South Africa and Namibia with the nursing professions in the two countries. Decision-making about nursing

education should be a more collaborative exercise between regulatory authorities, tertiary institutions offering undergraduate nursing education and health care service providers. Managers of tertiary educational institutions and in schools/faculties of nursing should practice a bottom-up approach to ensure grass root support and the cooperation of academics. Nursing leaders need to voice the challenges that are prevalent in the nursing profession and in nursing education. Without strong leadership the nursing profession cannot go forward.

Nursing ethics education at participating institutions can improve when nursing ethics educators become experts in the teaching-learning of nursing ethics. Opportunities for specialization in nursing ethics are critical.

The nursing profession and regulatory authorities must consider the standardization of nursing ethics education in South Africa. Such standardization is necessary to eliminate variability in nursing ethics education. Namibia is not challenged to the same extent as South Africa in this regard, because only one institution in Namibia currently offers undergraduate professional nursing education.

Innovations in teaching-learning methods, as well as innovations in the assessment of students, are imperative to improve the quality of nursing ethics education. Inter-professional education requires consideration and should be implemented. Clinical facilities need upgrading and supplies and equipment should be available for effective teaching-learning. Unethical behavior and poor role modeling by practicing nurses should be addressed in the employment situation to facilitate effective socialization of nursing students. Students should receive clear guidance from educators regarding teaching-learning expectations as well as expected conduct. Irresponsible behavior of students needs remedial action and punitive measures where indicated.

To effectively facilitate the teaching-learning of nursing ethics, practical wisdom as an approach in nursing practice and nursing ethics education should be considered. In nursing practice, practical

wisdom enables the nurse practitioners to seek and ensure *eudaimonia* (human good and human wellbeing) for patients considering all the relevant particulars of the situation within which the patient and nurse find themselves. With practical wisdom the true art of nursing, and not only nursing science, is practiced by the nurse. In facilitating practical wisdom in nursing education generally, and nursing ethics education specifically, the nursing educators combine the science and art of nursing in such a way that the teaching-learning is focused on meeting the needs of patients. Facilitation of practical wisdom in nursing ethics education may enhance the competencies of nurses in seeking to address the needs of patients more holistically. Virtue ethics offers an understanding that nurses need to require character traits that display a moral orientation promoting the good for patients, families and the society at large.

CHAPTER ONE

THE EVOLUTION OF NURSING ETHICS – AN OVERVIEW

1.1 Introduction

The word ethics refers to "the concepts involved in practical reasoning: good, right, duty, obligation, virtue, freedom, rationality, choice" (Blackburn, 1996, p.126), or to "the moral principles used by an individual or group that provides a framework for behavior" (Liddell & Cooper, 2012: 14), while applied ethics refer to "the subject that applies ethics to actual practical problems" (Blackburn, 1996, p.126). Nursing ethics refers to "knowledge of morality in nursing that goes beyond simply knowing the ethical codes [of nursing], it includes all voluntary actions that are deliberate and subject to the judgment of right and wrong" (Carper, 1878 in Epstein & Carlin, 2012). Nursing ethics, as applied ethics, is therefore concerned with the norms and values that guide the practical actions of nurse practitioners in nursing practice.

Nursing originated from the human need for care and the ability to be concerned and to care for others (Searle, 1988). Caring remained the central value of nursing throughout the ages of its existence. Caring in primitive societies took place within family units by mothers, but also outside family units by other categories of caregivers such as the medicine man/shaman, the priest-physician and practical attendants who mostly performed nursing tasks (Donahue, 1996). Primitive societies established expectations from caregivers as is evidenced by the imposition of penalties by society on caregivers for the transgression of conduct not meeting the expectation of society (Searle, 1988).

In ancient civilizations (±20000 – 80BC) care giving was formalised by codes of conduct prescribed by societies to caregivers in an effort to protect the vulnerable (Searle, 1988). Nurses and midwives were held in high esteem in some ancient societies and were placed under the guardianship of goddesses. This ensured orderly practice and the protection of the recipients of care (Searle, 1988). In other ancient

societies, codes of conduct for caregivers were related to religious beliefs but the purpose of these codes was still protection of those who received care from others (Donahue, 1996).

The advent of Christianity (AD 1 – 1499) contributed to the ideas of love, caring and service to others. In monasteries nuns and monks cared for the sick and the infirm and the first hospitals (houses of deacons) were established (Donahue, 1996). Christianity contributed a belief construct and a value system still evident in nursing in Southern Africa because of the Christian missionaries who rendered health care services and established a value construct of care and compassion (Van Dyk,1997).

Florence Nightingale revolutionized nursing as an organized form of care giving in 1854 (Donahue, 1996), but the value system of nursing did not change. The traditional value of care which gave rise to the existence of nursing remains the central value of nursing in modern times (Pera & Van Tonder, 2005).

Scientific advances in medicine and nursing created a need for the development of ethical codes of conduct in fulfilling the expectations of society and providing professions with unifying mechanisms and guiding principles (Viens, 1989). Moral behavior remains a critical requirement of professional practice but moral decision making becomes more complex in the light of scientific progress and diverse societies (Beauchamp & Childress, 2009).

The evolutionary literature review that follows focuses exclusively on the evolution of nursing ethics throughout the different historical periods. Florence Nightingale's contribution to nursing ethics and nursing ethics education is also offered underneath.

1.2 The evolution of nursing ethics - from primitive to modern times

Care-giving amongst the primitive people (before 45000 BC)

Donahue (1996) states that simple medical and nursing procedures were prehuman in their origin as humans observed how animals attempted to care for their own by the licking of wounds and eating of plants in the event of ailments. Primitive man rationalized ailments as the work of evil spirits due to the inability to assign causation.

Many healing practices therefore attempted to ward off these spirits by rites, rituals and spells and concocting and administering substances that would drive demons from the suffering human body (Donahue, 1996).

Amongst the primitive people, mothers and wives were the caregivers in societies. Care was provided firstly to next-of- kin, but as knowledge and skills of care-givers developed, care also took place beyond family units. The mostly feminine activity of caring is distinguished from the activities of the mostly male "*medicine man/shaman/witch doctors* ", who performed both benevolent and malicious rituals and spells by either invoking good spirits to drive off evil spirits, or to bring evil onto others with the assistance of evil spirits (Donahue, 1996). This dual function of the medicine man evolved into practices that had religious tones, and the medicine man became a "holy "person, who then became the "priest-physician". Another class of practitioner developed together with the *"medicine man"*. These were practical attendants who performed what can be recognized as nursing tasks, because they applied treatments, dressed wounds, alleviated fevers and discovered and utilized herbs in their healing practices. Care-givers in primitive societies were powerful, prestigious and respected persons who were believed to receive their power from the supernatural (Donahue, 1996). Nursing as a motherly, caring and feminist activity took root in primitive society.

Primitive societies, not unlike modern societies, had to deal with considerable uncertainty, and therefore needed to operate within societal rules and reciprocal expectations to ensure the survival of the group. Inevitably, the roles and conduct of care-givers were founded alongside these expectations (Searle, 1988). According to Searle (1988) primitive societies established ethical expectations of nurses because midwives in primitive societies had to observe rules of conduct and were "penalized" for non-observance of these rules. Primitive societies therefore established the earliest forms of ethical codes for the healing professions.

Ancient civilizations (±2000 – 80BC)

The foundation of control and regulation of the nursing profession, as a part of the healing professions of the time, was laid by the ancient civilizations situated in the Cradle of Civilization (Egypt and the Middle East region) and the civilizations north of the Mediterranean (Greece and Rome) around 2250 BC (Donahue, 1996).

Sumerian and Babylonian civilizations left evidence of the first writings confirming legal agreements and regulatory systems in various healing disciplines. The Code of Hammurabi, created from older laws and customs, by the sixth king of Babylonia in 2250 BC, was the first humanitarian law that protected the vulnerable and defenseless members in ancient civilizations (Donahue, 1996). This code contained reprimands for those who practiced medicine (Van Niekerk, 2011) and penalties for failure of treatment and the fee structures for medical interventions. Pictorial evidence from Babylonia depicts nursing as being supportive and assistive in nature (Donahue, 1996).

The high regard society had for nurses and midwives in Egyptian society is illustrated by the placing of mother and children under the observance of the goddesses, *Neklibet*, *Uziot* and *Ubastet*, and the societal expectation that nurses and midwives should observe the wishes of these goddesses (Searle, 1988). Practicing under the auspices of the goddesses ensured an orderly system of practice and

protection of mother and children, which indicates that these practices had a benevolent purpose (Searle, 1988).

Members of Hebrew society did not believe in many deities or magic and superstition, but worshipped one God, who was seen as the source of health and the punisher of sins through disease (Dolan, Fitzpatrick, & Hermann, 1983). The Hebrew Mosaic Health Code prescribed strict health practices and a caring code of ethics and sanctions were believed to come from God (Dolan, et al, 1983). Documented evidence exists that displays the nurse-midwife as an independent decision-maker and skillful practitioner, delivering babies and refusing to participate in infanticide (Dolan, et al, 1983).

There is however also further evidence (Dolan, et al, 1983) that another class of slave nurse existed in this time, who was dependent on, and subservient to, the physician. Slave nurses were buried alive when the client died, to enable the provision of care in the afterlife. Slave nurses rendered custodial care to sick persons and received little reward or appreciation for the services rendered. Caring for others was, however, the focus of both the independent and slave nurse practitioner in Hebrew society (Dolan, et al, 1983).

There is evidence that training schools for midwives existed in Egypt, but it was mostly the Greek and Roman societies, north of the Mediterranean who contributed extensively to the intellectual foundation of the healing disciplines (Dolan, et al, 1983).

Hippocrates (460-377 BC) from Greek society and the Hippocratic Oath established ethical principles of conduct for medicine (Moodley, 2011) which is still relevant today in both medicine and nursing. Beneficence, non-maleficence, loyalty, trust and confidentiality are some of the principles that are proclaimed in the Hippocratic Oath (Beauchamp & Childress, 2009).

In other ancient societies such as the Americas, Asia and India, nursing was influenced by cultural attitudes towards sickness and health, and nursing mostly remained a feminine activity (Dolan, et al, 1983). In some of these societies nurses had a low status, while in others they were respected healers who cooperated with other care givers to the benefit of their societies (Dolan, et al, 1983).

1 – 500 AD – Spiritual leadership and the evolution of nursing ethics

The teachings and example of Christ had a significant influence on the philosophy of nursing during this time. Altruism as an existing belief construct (already practiced by Buddhists for many centuries) was given further motive, i.e. to devote one's earthly life to serve others because it will be rewarded in the hereafter (Donahue, 1996).

According to Donahue, Christian idealism was to forever have a deep and significant impact on the practice of nursing because "a spiritual meaning became deeply attached to the care of the sick and the suffering" (Donahue, 1996: 75).

Early Christians founded the first organized hospitals (first called houses of deacons) because of their beliefs of respect for human dignity, mercy, love and charity (Searle, 1988). The ill and infirm were nursed by deaconesses, widows and Roman matrons and these nurses, because of their high moral standing and charitable beliefs, uplifted the image of nursing (Searle, 1988). The establishment of special hospitals for persons with unique needs, such as the mentally ill and the retarded is evidence of the belief construct of persons who cared for the vulnerable persons in society (Donahue, 1996). The compassionate and caring approach of believers in caring for others during this time, contributed to the caring ethic of nursing, still evident in nursing practice of contemporary societies around the world.

Early and Late Middle ages: 500 – 1500 AD

Care givers during the Middle Ages were mostly nuns and monks in monasteries who provided refuge and care to most of the poor and oppressed populace in communities around the Mediterranean (Donahue, 1996). The establishment of nursing orders by St. Francis of Assisi (1182-1226AD), as well as the patron saints of nursing e.g., St. Elizabeth of Hungary (1207-1231), confirms that nursing values were supported by religious values during the early and late middle Ages (Donahue, 1996). According to Searle (1988), the character of nursing was influenced extensively by the Christian religion which brought the values of charity, concern and dedication to nursing. Midwives as private practitioners and text writers contributed significantly to the development of the midwifery profession during this time. There is evidence that midwives were regulated by the church and were held accountable for their actions by courts of law (Searle, 1988).

It seems that nurses and midwives, being important and appreciated social developers, contributed to the dawn of modern times which became evident by the intellectual, industrial, political and economic revolution which gave birth to the Era of the Renaissance and the Reformation (Dolan, et al (1983).

The Renaissance and the Reformation (1400 – 1700 AD)

According to Dolan, et al (1983), the intellectual revolution, which started in the late fifteenth century, caused a renewed appreciation of the need to educate nurses. The advancement in science, generally, and in medical science particularly, only influenced the development of a scientific basis for nursing science in later centuries (1800 onwards) (Searle, 1988). The teachings that took place during this period were founded on a sound philosophy of holistic care (Searle, 1988). Noteworthy, regarding the ethos of nursing, were the discovery of the new world and the transfer of a value and belief system of care, compassion and dedication, by religious orders and missionaries to the new colonies (Dolan, et al, 1983). Health care services rendered to the poor people in the colony of the Cape of Good Hope (1665) who

were not servants of the Dutch East India Company, were mostly “acts of Christian charity” (Searle, 1970: 59). This belief construct still forms part of the ethical foundation of nursing in most commonwealth countries, including South Africa and Namibia, today.

1.3 Florence Nightingale (1820-1910) and organized Nursing

The review of Florence Nightingale’s historical contribution to nursing will in what follows specifically note her contribution to the ethics of nursing and nursing education. Florence grapple with the calling to become a care-giver of others since her childhood (Strachey, 1918). Against the social constraints on women in Victorian England, Florence Nightingale showed character traits different from her sisters and the expectations from Victorian women of her social class (Strachey, 1918). She was often hard-headed, focused and driven towards her life’s goals, but she was also compassionate, committed and quire introspective (Strachey, 1918). Her contribution during the Crimean war to alleviate the misery of the wounded and sick at Scutari is proof of her exemplary leadership and managerial skills, but her actions was motivated by real compassion and commitment. Her approach to caring laid the foundation for modern nursing and reformed nursing from a service mostly provided by religious orders to a secular service provided by women representative of both the lower and higher social classes in England from 1857 onwards (Donahue, 1996). When all odds were against what she envisioned for the improvement of the horrendous conditions in the Crimea, she never lost hope, she believed that she could make a change and used her own financial resources, and her political connections to advocate for whatever was needed to better the conditions of those who need her assistance at Scutari (Strachey, 1918). The character traits Nightingale displayed and motivational force which drove her to serve others during her work at Scutari and throughout her life are still advocated in nursing today.

Florence Nightingale arrived in England from Scutari in 1856 in “a shattered stat of health” (Strachey, 1918: 163). She did however not heed to the advice of the doctors or her family that she should rest,

she believed that there was a job to be done and while laying sick, she wrote and dictate letters with suggestions how the training of medical officers, the administration of army systems and the regulation of hospital procedures can be improved (Strachey, 1918). Through Nightingale's continuous efforts a Royal Commission to report on the health of the army were established which eventually after a lot of in-fighting and Nightingale's, behind the scenes efforts, publish a report with recommendations (actually exclusively those of Nightingale) (Strachey, 1918). Eventually the army barracks and hospitals were properly ventilated, clean water was provided, policy regarding these was developed and the army medical department was completely re-organized (Strachey, 1918). Recreation facilities were established contributing to the health of the soldiers (Strachey, 1918) confirming Florence Nightingale view of the promotion of holistic health. Nightingale laid the foundation of modern system of medical work in the army (Strachey, 1918), she campaigned to train soldiers and army doctors (Attewell, 1998).

In 1860 when she founded the Nightingale Training School for Nurses at St. Thomas Hospital, she became the founder of modern Nursing (Strachey, 1918). The accolade of the "founder of modern nursing" is not bestowed on Nightingale because she was the first person to established a nursing school, many schools of nursing existed by 1860, but she brought to the fore an approach of caring for those in training and a system of training not known before (Attewell, 1998). The probationers (students) of nursing were each allocated their own room for study showing her concern (Attewell, 1998). Nightingale was not involved directly with the nursing school at St. Thomas, but she often sent letters to students containing practical and moral advice regarding nursing (Attewell, 1998). Her continuous contribution to improving the Nightingale training system allowed for the system to transfer to countries all over the world because of the Nightingale nurses who migrate to other continents (Attewell, 1998). She insisted on practical nursing skills and support to students by a "home sister" (Attewell, 1998: 162), who could support learning, as well as moral development of students (Attewell,

1998). Educational methods according to Nightingale, need to be practical and purposeful (Attewell, 1998). These views are still valid in contemporary teaching-learning of nursing students.

Florence Nightingale demystified the approach to health care from an ancient art, riddled with superstition, to a modern and relevant art, characterized by her belief in service to humanity (Donahue, 1996). As the founder of modern nursing her contribution to the nursing profession reflected courage, dedication, compassion, discipline and perseverance, which still today are values; hold dearly by the nursing profession.

Florence Nightingale's philosophy of life laid a sound foundation for ethical nursing practice. Her concern for patients and the suffering of others was the motivation behind her life's work. This concern is evident in her Notes on Nursing, written in 1859:

"Oh, mothers of families! You who say this, do you know that one in every seven infants in the civilized land of England perishes before it is one year old? That, in London, two in every five dies before they are five years old? And, in the other greater cities of England, nearly one out of two? The life duration of tender babies" (as some Saturn, turned analytic chemist say)," is the most delicate test" of sanitary conditions. Is all this premature suffering and death necessary?"

(Notes on Nursing What It Is and What It Is Not, 1859)

Nightingale established secular nursing training schools and uplifted the social status of women who were subsequently allowed to be educated. She introduced "The Nightingale Pledge" in 1893 as the first code of ethics for nurses (Numminen, Leino-Kalpi, van der Arend & Katajisto, 2011). She firmly established most of the components of modern nursing i.e. clinical nursing practice, nursing management, nursing education and nursing research (Donahue, 1996). According to Searle (1988) the training provided in the Nightingale School of nursing included training on nursing ethics.

Florence Nightingale delineated her philosophy of nursing by believing that the focus of nursing is to care for the sick (by an educated nurse), that the nurse must care for the person and not the disease (client orientation), she had a holistic approach to the care of patients and emphasized that the nurse collaborates with others while nursing patients (Donahue, 1996). These concepts are still relevant in nursing philosophy and nursing ethics today.

Nightingale's approach to nursing remains the foundation of contemporary ethical nursing practice. She established nursing as a reputable profession guided by moral principles and believed that the aim of nursing is to focus on the wellbeing of patients (Hoyt, 2010), which strongly reminds of Aristotle's conception of ensuring "eudaimonia" or human flourishing, as an important consideration in taking moral decisions. Nurses are still obliged today to ensure the well-being of patients. A further contribution to current nursing ethics identified by both Hoyt (2010) and Sellman (1997) is Nightingale's requirement of virtuous character traits i.e. perseverance, diligence, truthfulness, sobriety, reasonableness, amongst others, the nurse must possess. Existing ethical codes of nursing (cf. chapter 3) identify similar desirable character traits of nurses.

Nightingale firmly believed that persons who entered nursing require virtuous character traits, which was a novel expectation for the time because most nurses were not of good character and from lower, less sophisticated social standing (Searle, 1988). Nightingale's writings contain multiple indications that a good nurse "uses both her brain and her heart" (Wagner & Whaite, 2010: 231) and that both actions and attitudes of the nurse have positive results in the caring relationship with patients (Wagner & Whaite, 2010).

Hunt (2001) sees Florence Nightingale not only as the founder of nursing skills and knowledge, but as the founder of spiritual nursing. Nightingale saw menial, but also skilled nursing tasks of love and devotion as religious acts enabling a connection with a higher presence that provides humans with their

finest moments in life (Hunt, 2001). Fulfillment of spiritual needs of patients continues to be important in ethical nursing practice and care of the human spirit. Becker (2009) views the teaching-learning of spirituality in nursing as challenging, but a trend that nursing schools should not ignore considering nursing's goal ensuring holistic wellbeing of patients.

The 20th Century onwards

The first half of the twentieth century is marked by significant advances in physics, medicine and other scientific disciplines (Donahue, 1996).

These advances influenced not only the provision of health care, but stimulated debates on the education of health professionals, ideas about professional status requirements and the influences of advancements on the requirements of ethical conduct of professionals (Dolan, et al, 1983). In America, Abraham Flexner developed criteria that distinguished professionals from other persons. One such criterion referred to the observance of an ethical code, which is still a criterion of professionalism today (Dolan, et al, 1983).

The atrocities committed during World War II in the fourth decade of the 20th century influenced ethical perceptions of people worldwide when these atrocities were made public through public inquests as well as the media (Benedict & Georges, 2009). Noteworthy are the medical experiments of Nazi doctors (Moodley, 2011), and the involvement of nurses in the euthanasia program under the Nazi regime (Benedict & Georges, 2009). Mistakes of the past, as well as developments, both technological and medical, create new awareness and expectations from nurses to interact more thoughtfully with regard to ethical practice and ethical decision making (Benedict & Georges, 2009).

Occurrences in the 20th century are evident of societal progress and developments worldwide and many disciplines, including nursing, had to respond and keep up with the scientific, technological and social progress in society. In South Africa, the content in nursing education in the early years of the 20th century was mostly curative (Searle, 1970), this changed in the later decades of the previous century when preventive and promotive approaches to health and health care were developed (Searle, 1970).

From the mid 1950's, nurse theorists developed theories of nursing in an attempt to explain the nature of nursing in a logical and scientific manner (George, 1995). While caring remains the central value of nursing, a more scientific process to provide nursing care is developed whereby professional nurses can initiate a nursing regimen according to the needs of a patient. While a variety of nursing theories exist today, the person, as the recipient of nursing care, remains one of the four core concepts in the Meta paradigm of nursing (George, 1995).

Progress in the sciences generally, and in medical science particularly (i.e. genetic engineering, use of advance technology in health care), create ethical challenges and issues that complicates ethical decision making for care-givers. The extensive powers of doctors created by advancement in the medical sciences, requires careful moral consideration in the application of these advanced possibilities (Van Niekerk, 1997). For the nurse practicing in the 21st century, the intemperate powers of physicians in the application of modern medical interventions requires moral awareness of another kind. As patient advocates nurses need moral discernment in considering what is just to patients in a particular context and need to voice concerns when patients are exposed to the unbridled powers of physicians. The advocacy role of nurse practitioners in questioning medical decisions on ethical cases and seeking clarification and advice to protect patients and public morals are extremely relevant in contemporary health care.

Ethical perspectives are also influenced by globalization and a global ethics that becomes a reality because of universal connectivity. Despite difference of opinion on what might be right or wrong or good versus bad, clinical nursing intervention still focuses on the care provided to humans in need of care.

1.4 Conclusion

From primitive to modern times the fundamental value nursing focuses on is the care of others. From ancient times nursing conduct had to meet the expectations of societies within which nursing was practiced. With the advent of modern times, nursing became more organized and the need for an educated nurse became more evident. Florence Nightingale is seen as the founder of modern nursing and the values she prescribed is still relevant in nursing today. Nursing practice and nursing ethics is challenged by development in medicine and medical technology. Care remains the focus in the relationship between nurses and patients and an ethic of care is becoming more relevant in the evolution of nursing ethics.

Content on the caring ethos of nursing should form part of nursing ethics education and the aim of nursing ethics education is to prepare nursing students to conform to the ethical expectations in the code of nursing ethics. Nurses should have an understanding of caring and should internalize caring attributes which should be visible in the caring of patients and communities. Student nurses should be assisted to internalize the norms and values inherent to nursing and should understand that nursing as a profession is practiced within a code of ethics, which evolved through the ages, and which still forms the ethical foundation on which caring practice is based. The next chapter explores the values, norms and obligations of nurses as found in ethical codes of nursing in countries of the world.

CHAPTER TWO

NURSING ETHICS EDUCATION AND ETHICAL CODES OF NURSING – A LITERATURE REVIEW

2.1 Introduction

The history of nursing ethics (cf. chapter one) confirms moral values are important in nursing practice and therefore are included in nursing ethics education. Florence Nightingale included ethics in initial nursing training for nurses (Searle, 1988) and has expected nurses to have sober personal characteristics (Donahue, 1996). Currently a revival of moral education is experienced generally, because of deviant conduct in modern societies and nursing ethics and nursing ethics education is a well research discipline (Koh, 2012).

Moral education is determined by the societal context in which it takes place and nursing ethics education should rely on scientific research in ethics which should be incorporated into nursing ethics curricula (Toliušienė & Peičius, 2007). In Namibia, nursing ethics education at the University of Namibia is supported by a core module in ethics for all undergraduate students focusing on a universal non-religious principled approach to conduct. A similar secular principled approach to moral education is also utilized in Botswana and Nigeria (Koh, 2012).

Nursing ethics education is important in nursing education programs because it affords students the opportunity to learn about themselves and grow as persons and to explore the relation between their personal and professional self (Doane, Pauly, Brown & McPherson, 2004). The caring ethos of nursing in education and nursing practice may assist in constraining an uncontrolled application of medical interventions (Choe, Song & Kang, 2013) which is caused by current scientific advances in medicine and the resultant extension of the powers of physicians (Van Niekerk, 1997). Nurses have ethical responsibilities in the workplace and students view ethics education as relevant in preparing them for clinical practice (Kalaitzidis & Schnitz, 2012). Nursing ethics education alleviates the vulnerability of students in enabling them to judge between good and bad practices and/or role models (Begley, 2006),

but also assist nurses' to appropriately interact with their patients (Burkemper, DuBois, Lavin, Meyer & McSweeney, 2007). Ethical decision-making and improvement in ethical behavior (Choe et al, 2013), enhance the confidence in nurses of their ability to take ethical decisions and moral actions, assist nurses to seek resources when it is needed, assist them to define their own ethical values and differentiate ethical challenges from other nursing problems (Grady, Danis, Soeken, O'Donnell, Taylor, Farrar & Ulrich, 2008). Nursing ethics education also develop nurses' abilities to be self-aware, to critique context and to name ethical issues, learn about the self as a moral agent and "to give voice to that self in everyday nursing practice" (Doane et al, 2004: 248) and to develop both skills and knowledge that support ethical nursing practice (Doane et al, 2004)

The need to include nursing ethics in nursing education programs is widely accepted (Begley, 2006; Burkemper et al, 2007; Godbold & Lees, 2013), but the attainable outcomes remains controversial and the optimal way to deliver ethics education remains contentious (Godbold & Lees, 2013).

Begley (2006) differentiates between teaching-learning *ethics* and teaching-learning *virtue*. Teaching-learning ethics facilitates theoretical wisdom for understanding ethical frameworks and concepts while teaching-learning virtue facilitates moral development, practical wisdom and excellence of character that enables sound moral judgments. The latter, according to Begley (2006) can be taught, but places great emphasis on the role of the educator because it is about the influencing the hearts and minds of students, which requires a dynamic and sensitive approach in the teaching-learning process (Begley, 2006). Although no teaching-learning of ethics can close the gap between knowing what is right and doing it (Pellegrino, 1989 in Begley, 2006), nursing ethics educators cannot only facilitate ethical theories and moral rules in teaching-learning, this renounces the responsibility of educators to attempt to inspire moral development in students (Pellegrino, 1989 in Begley, 2006). Pellegrino's notion is supported by Bray, O'Brien, Kirton, Zubairu & Christiansen (2013) who believe ambiguity exists between

the possibility to facilitate teaching-learning of compassionate care to patients and attaining the personal attribute of compassion. The former might be possible while the latter poses challenges to nursing ethics education (Bray et al, 2013).

2.2 The aims of nursing ethics education

Nursing ethics education primarily aims to enhance the quality of nursing care by protecting patients' interests and achieving responsible decision-making by nurses, but also upholds the reputation of the nursing profession and informs students on ethical principles that will assist to act with the expected decorum (Ujvarine, 2008). Accountability for nursing decisions and actions under all circumstances remains a professional requirement and the transmission of ethical values to nursing students through the teaching-learning process is imperative (Quinn, 1990; Pera & Van Tonder, 2005).

Development of persons is the general aim of education and therefore moral development of nurses is the goal of nursing ethics education (Skisland, Bjørnstad & Söderhamn, 2011). Vanlaere & Gastman (2007) believe nursing ethics educations' two-fold goal is to provide nurses with tools to reflect critically as well as create a pedagogical context that cultivate and teach a caring attitude. Critical thinking abilities is important in nursing practice and student nurses need education that facilitates higher reasoning skills to be competent and skillful, but also compassionate practitioners (Berndt, 2010). Lynch, Hart & Costa (2013) believe that tertiary education focus less on developing students' capacity to act on their values, but nevertheless emphasize competencies to raise ethical awareness and developing skills in analysis and reasoning.

Nursing ethics education attempts to facilitate moral insight and ethical sensitivity in all nursing care situation, but especially in circumstances when patients are most vulnerable, i.e. in end of life settings (Begley, Glackin & Henry, 2010). Nursing ethics education cannot only facilitate knowledge of ethics, but need to facilitate practical wisdom that requires good moral actions, therefore nursing students need to

be introduced to more than theoretical knowledge but "be nurtured in such a way that they become good nurses within the context of their practice" (Begley et al, 2010: 516).

In the technologically–mediated nursing environment nursing ethics education sensitize nurses to prevent the uncritical use of technology which may influence nurses as moral agents, as well as the perceptions of nurses of the patient and patient care (O'Keefe-McCarthy, 2009). According to Church and Ekberg (2013) new technologies in reproductive health specifically pose pertinent challenges to consumers of health care and midwives, therefore student midwives must be prepared to face these challenges specific to their field of specialization. New ethical challenges in nursing practice require practicing nurses to be competent ethical decision makers who focus on the ethical dimensions of nursing care (Choe et al, 2013; Choe, Park & Yoo, 2014). Van Niekerk (1997) argues that the advancement of medicine often provide physicians with unchecked powers in medical decisions. Nursing ethics education should aim to equip nurses to question medical decisions in ethical cases, to ask for further investigations and to intervene to protect patients in fulfilling nursing advocacy (Searle, 2005).

Ethical challenges are address both within the multi-disciplinary team context and the one-on-one relationship between patient and nurse. Skisland et al (2011) expect nursing ethics education to enable nurses to examine ethical problems, make and justify ethical decisions, address patients' problems independently when necessary, but also function within a multidisciplinary team.

Allmark (2005) motivates the teaching-learning of nursing ethics as enabling nurses to differentiate the types of problems encountered in practical situation; develop necessary skills to address philosophical questions in practical problems and assist in developing soundness of ethical beliefs and values. Developing of students' moral judgment and ethical decision making skills is also important aims of nursing ethics education (Burkemper et al, 2007).

Nursing students must be taught to be critical thinkers who contribute to quality needs-based nursing by both lifelong learning and professional development (Martyn, Terwijn, Kek & Huijser, 2013). Critical thinking involves both cognitive skills and affective dispositions which nurses need to solve contemporary challenges in the changing clinical nursing situation (Kong, Qin, Znou, Mou & Gao, 2013). Clinical competence includes clinical reasoning skills and ethical comportment in patient care (Nielsen, Noone, Voss & Mathews, 2013). Nurses need ethical reasoning skills to enable them to understand, participate and influence a complex health system (Nolan & Markert, 2002). Nursing ethics education prepares nurses to recognize and act on various ethical issues, not only to know nursing values in ethical codes, but to judge every deliberate action with regard to right and wrong (Epstein & Carlin, 2012). Nurses need to label ethical issues in the practical ethical dimensions and link these to the pedagogy of the classroom (Epstein & Carlin, 2012).

The aims of nursing ethics education creates development of nursing ethics education teaching-learning content and outcomes and determines the teaching learning methods in nursing education programs.

2.3 Ethics education content

The content of nursing ethics education is not confined to the ethics of the nursing profession, but need to address the nature of nursing (Ujvarine, 2008) as well as the theoretical base that supports and structures nursing interventions, i.e. the inclusion of nursing theories into nursing curricula (Nilsson & Silén, 2010). Inclusion of content on nurse patient relationship, nursing as a caring relationship, the professional role of the nurse, nursing as a multidimensional response to needs and nursing as a way of living are important aspects to cover in nursing ethics education (Nilsson & Silén, 2010). Culture and culture care as a prerequisite for competent ethical nursing care (Lancellotti, 2008), require content on culture care in nursing.

Ethical principles i.e. respect for autonomy, beneficence and justice, and deriving moral values impact greatly on nursing and the provision of ethical nursing care (Skisland et al, 2011), ethical codes provides ethical standards (Leach & Oakland, 2007) and a point of reference in nursing practice (Dobrowolska, Wrońska, Fidecki & Wysokiński, 2007) and is therefore important content in nursing ethics education. Principle-based ethics, virtue ethics, caring ethics and feminist ethics all have a place in nursing ethics education (Kalaitzidis & Schnitz, 2012). Moral theories and ethical principles (Epstein & Carlin, 2012) which frame ethical decision making in nursing practice (Lynch et al, 2013) is required content in nursing ethics education. The nursing ethics educator who creates and sustains programs in ethics and nursing ethics education in nursing curricula, need to stay involved in clinical ethics consultations (Wocial, Bledsoe, Helft & Everett, 2010), this ensures relevance of nursing ethics education in nursing programs.

Considering the sources prescribed in nursing ethics in South Africa and Namibia, it becomes clear that nursing ethics education in these countries still follow a conceptual model of integrating various aspects relevant to nursing practice (Quinn, 1990) in nursing ethics education. These aspects include traditional ethical nursing aspects i.e. norms and values in nursing; clinical ethical aspects i.e. ethical dilemmas, ethical decision making and standards of care; rights of patients; rights and duties of nurses and professional practice aspects i.e. nursing laws and regulations and aspects of safe nursing practice (Searle, 2005; Pera & Van Tonder; 2005; Jooste (ed), 2010; Mulaudzi, Mokoena, & Troskie, 2010; Geyer (ed), 2013).

2.4 Teaching–learning approaches and methods in nursing ethics education

The orientation and approach to nursing ethics education are determined by the social, political and economic milieu ensuring relevance to the nursing context in which nursing is practiced (Kalaitzidis & Schnitz, 2012). Relevance of nursing ethics education is also influenced by in-country peer regulation of the nursing profession that create nursing values in the establishing of ethical standards of practice

(Kalaitzidis & Schnitz, 2012). Nursing ethics education is important and therefore should not be an elective, but mandatory subject in nursing programs (Choe et al, 2013) supporting the milieu in which nursing is practices.

According to Grady et al (2008) many controversies exist regarding the content to be taught and structure of nursing ethics education, but that skills-based approaches are preferable over abstract theory teaching-learning in solving everyday ethical challenges. Begley (2006) alludes to Aristotle's practical approach to ethics and suggest that nursing ethics education need to extend teaching-learning ethics beyond pure theoretical ethics, but ground teaching-learning virtue in everyday nursing practice and the provision of exemplary role models and clinical educators.

The complexities in multifaceted nursing practice require educative approaches that foster and sustain skilled ethical comportment, reconciling students' personal and professional lives, integrate rational thinking and subjective experiences (Doane et al, 2004). Narrative approaches, relying on relevant life stories, are helpful to explore the personal and professional contexts of students in ethically challenging situations (Doane et al, 2004). Case studies, step-by-step ethical decision-making and professional codes are used to elicit classroom discussions in teaching-learning nursing ethics (Epstein & Carlin, 2012; Kalaitzidis & Schnitz, 2012).

Teaching-learning approaches and methods that facilitate critical reflection, examining, verifying, assimilating or rejecting what is being taught is required in ethics education (Begley, 2006) and Interdisciplinary teaching-learning to learn about ethics from other health care professions (Grady et al, 2008) may assist in reflecting on ethical nursing practice.

Excellence in nursing education is ensured within a framework which contains excellence in three aspects i.e. scholarship, leadership and teaching practice, within a teaching philosophy of an ethic of caring (Sawatsky, Enns, Ashcroft, Davis & Harder, 2009).

Methods that will develop ethical argumentation is imperative in nursing ethics education, it is not sufficient to know moral values or think that good nursing relies on performance of nursing interventions because nursing practice also requires good moral judgment (Bužgová & Sikorová, 2013). Teaching-learning methods can include class discussions, lectures, case studies, small group discussions, dramatizations and demonstrations (Ujvarine, 2008).

Nursing ethics education is however not without challenges, which are highlighted in the following section.

2.5 Challenges in nursing ethics education

Nursing ethics education is challenged to provide all the content relevant to assist student understand the context within which nursing is practice. Some content should explain the health care organization, structure and policies framing ethical duties of nurses (Doane et al, 2004). Inclusion of all these content may challenge nursing ethics education because it may overload nursing ethics courses. Inability to integrate contextual aspects may hamper the preparation of students to practice within the required context, if teaching-learning approaches and methods not facilitate successful integration of theory with contextual expectations, it creates shortcomings for successful learning for students.

New technologies create new ethical challenges which students face in clinical practice situations (Church & Ekberg, 2013). Rapid advancement of medical technologies and social change create knowledge gaps in the nursing field (Ramos, Pires de Pires, Brehmer, Gelbcke, Schmoeller & Lorenzetti, 2013) because curriculum changes do not keep up with these changes. When nursing ethics education not responds timeously to these challenges students may experience moral distress while practicing nursing (Lawrence, 2011). Nursing ethics education requires provision of opportunities for students to reflect on their feelings and perspectives on ethical issues (Church and Ekberg, 2013), to diminish moral stress and clarify students' experiences of ethical challenges in nursing practice. If large students'

numbers in ethical courses prevent individual guidance of students, it frustrates both students and educators.

New and unfamiliar ethical challenges create the need for value clarification (Lynch et al, 2013) during nursing ethics education. The facilitation of value clarification is difficult when student numbers inhibit one-on-one contact or at least small group sessions in the classroom or practice setting.

While simulated clinical practice has advantages, over usage of simulated clinical experience for nursing students remove students from real-life experience and the patients and challenges the human and therefore the ethical aspect of nursing (Berndt, 2010). Nursing ethics education offered in ways that are often isolated in the nursing program and by educators without specific ethics training results in ethics education becoming invisible and distant from the knowledge and experience with which it should be interacting (Ramos et al, 2013).

The most effective teaching-learning methods in nursing ethics education are not sufficiently researched while innovative teaching-learning methods are needed in nursing ethics education (Campbell, Chin, & Voo, 2007). Innovation in teaching-learning methods generally can however not jeopardise the standards in nursing education. Delivering nursing courses by the internet may, for instance, pose its own ethical concerns and educators should develop ethical standards to which educators and students need to conform in eLearning (Fulton & Kellinger, 2004).

Complex interests of health care providers and patients and conflicting expectation of role players in the health care situation makes it difficult to teach bioethics (Choe et al, 2014), therefore new teaching-learning methods, such as multidisciplinary teaching-learning, is to be researched and practiced in nursing ethics education.

Selecting nursing students lacking the personal attribute of compassion and seek nursing education because of other reasons such as job security and career opportunities rather than a desire to nurse, challenges the core value of compassion in care of patients and challenge teaching-learning of this value to students (Bray et al, 2013).

According to Fowler & Davis (2013) nursing education are riddled with its own ethical dilemmas, both person and system related, which need further scrutiny through research. The moral milieu in which nursing education takes place influence the virtues and excellences of students, therefore nurse educators need to examine and address the moral issues in the nursing ethics education milieu that influence students negatively while in training (Fowler & Davis, 2013).

2.6 Innovations in nursing ethics education

Nielsen et al (2013) believe the changing health care environment requires a well-planned, more integrative learning experience for students. Five elements i.e. case-based, concepts-based, focus-directed client care, intervention skill based, and integrative experience, challenge students to blend prior learning within new contexts and integrate relevant concepts with clinical learning activities (Nielsen et al, 2013).

Inclusion of preceptors in the ongoing education on ethical issues identified by students and educators (Epstein & Carlin, 2012) facilitate teaching-learning, because preceptors are conversant with the practical ethical challenges and can clarify the contextual issues influencing the ethical decision making process.

Case based seminars assist especially the younger students to clarify their values (Lynch et al, 2013). Value clarification is especially challenging for students who are confronted with new challenges in the health care settings and need innovative teaching learning methods that guide students through unfamiliar perspectives until some clarification is reached (Lynch et al, 2013).

Web-based ethics programs is used in engineering, business and health care and provides students with the opportunity to study at their own pace and avoiding pressure from peers who may expect certain moral responses (Godbold & Lees, 2013). *e*Learning, however, has its own ethical challenges which need attention in the educational setting (Fulton & Kellinger, 2004).

Nursing ethics educators need to venture beyond simple lectures and create opportunity for students to debate and argue ethical issues (Choe et al, 2014). Action learning requires student nurses to visit clinical units, listen to discussions about ethical issues, select a case on which they then develop and present possible solutions to the challenges identified. (Choe et al, 2014). Cross-examination debate requires students to prepare arguments for and against selected ethical topics and in class lots are drawn on who will argue for or against the issue (Choe et al, 2014). Both these innovative methods enhance students' adaptability in clinical practice and foster interaction and effective learning (Choe et al, 2014).

Capturing the interest of students requires nurse educators to be creative and imaginative, especially in abstract nursing notions, such as critical thinking and decision making. Board games may be a teaching-learning method that encourages students to collaborate with colleagues, interact and negotiate with team members for beneficial health outcomes and learn to respect and learn from others (Stanley & Latimer, 2011).

Studying existing health related fictional stories by authors (such as Tolstoy's "Death of Ivan Lynch"), assist nurses to gain insight and in-depth understanding of persons' personal experiences (Begley et al. 2010).

Despite the challenges faced by nursing ethics educators in tertiary institutions, the autonomy of nursing educators in teaching-learning in the lecture room (or clinical setting) makes it possible for nursing ethics educators to be innovative and creative in the teaching-learning environment.

2.7 Ethical codes in nursing

An ethical code represents the norms and values to be practiced by professionals as the evolutionary process of respective professions (Viens, 1989) developed it. Throughout the ages, ethical expectations by care practitioners have been part of the traditions of societies, and acceptable behavior has always been guided by traditional rules within these societies. Some societies had rules that advocated due care to those who are more vulnerable. Strict ethical conduct was, for instance, expected from midwives in caring for mothers during childbirth and is evidence of the first ethical code for a specific category of nurse (Searle, 1988).

The oldest preserved codes of conduct, or rules of law, containing prescriptions of behavior attempting to prevent harm to care recipients, are found in Hammurabi's Code of Law (Dolan et al., 1983; Donahue, 1996). With the advent of modern nursing, under the leadership of Florence Nightingale, ethical expectations were formalised by the inclusion of ethics training into the educational programs of nurses (Searle 1988).

The Hippocratic Oath by Hippocrates, known as the Father of Medicine, exists from the fifth century bce and is still used, sometimes in adapted versions, by some institutions today. In 1893, a nurse educator, Lystra Gretter (Gretter 1893) from the old Harper Hospital in Detroit, Michigan, composed the Nightingale Pledge, which contains elements of the Hippocratic Oath, and reads as follows:

> *I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the*

practice of my calling. With loyalty will I endeavor to aid the physician, in his work, and devote myself to the welfare of those committed to my care.

(Gretter, 1893)

The last decades of the nineteenth century marked the establishment of nursing associations in the twentieth century, which paved the way for the establishment of various national nurses' organisations in America, Britain, continental Europe and various Commonwealth countries. These organisations played a significant role in the setting of professional nursing standards, which enhance ethical nursing practice. The development of nursing's code of ethics was very much influenced by the challenges encountered in the practice of nursing, and the evolution of written codes has both guided and mirrored nursing's journey towards professionalism (Viens, 1989).

The International Council of Nurses (ICN), which was established in 1899, is the oldest international professional organisation (Donahue, 1996), and promotes international cooperation between nursing associations worldwide. The ICN developed an ethical code for nurses, which guides many regional and national nurses' organisations in developing ethical codes for their respective organisations. Nursing organisations in the Scandinavian countries, Sweden and Denmark, refer practicing nurses to access and uphold the ethical norms and values as declared by the ICN's code of ethics (Danish Nurses' Organisation, n.d.; The Swedish Society of Nursing, n.d.).

The following section explores the current content of ethical codes of selected countries in most of the regions of the world, confirming societal expectations of nursing conduct by nurses in these countries. The candidate attempted to select ethical codes, which was available in English on the World Wide Web, representing all the continents and regions of the world. These include South and North America, Britain, Europe, Eastern Europe, Asia, Middle East, Africa (Northern, Eastern, Western and Southern regions) and Australasia. In selecting the codes it was considered that regions such as North America has

a variety of codes, therefore the Code of the American Nursing Association was selected. Similarly the European Council of Nursing Regulator's code was selected as representing European nursing codes. The total number of codes studied was 15, including the ICN Code of Ethics. The candidate reviewed these codes with the aim of identifying common norms and values that denote ethical practice in nursing, and comments on the particularities within these codes under the identified similar norms, values and obligations.

The purpose of ethical codes is not only to declare the fundamental norms and values to which nurses should be committed, but also to assist in ethical decision-making in nursing practice. Ethical codes also assist care recipients to identify the conduct they can expect nurses to uphold. Ethical codes not only guide nurses' actions but are also used by individual nurse practitioners as reference tools to reflect and judge their own and other practitioners' conduct (Heymans, Van der Arend, & Gastmans, 2007; Aitamaa, Leino-Kilpi, Puukka, & Suhonen, 2010).

The codes identify the core values and norms that denote ethical nursing practice and should guide the teaching-learning of students in nursing ethics in undergraduate nursing programs within educational institutions.

The ICN as an international nurses' organisation plays a significant role in its relationship with nursing and other health-related organisations globally. The ICN aims to serve both the public and the nursing community by involvement in nursing education, health policies and all matters that enhance the health status of humankind (International Council of Nurses, 2006). The ICN involves itself in projects that clarify and enhance the challenges unique to the discipline of nursing, such as the diagnosing of nursing problems and the development of processes for the provision of nursing care. (International Council of Nurses, 2006). The ICN (International Council of Nurses, (2006) has also set standards of responsibilities for nurse practitioners in the ICN Code of Ethics and identifies four principle elements as standards of

ethical conduct towards which nurses have ethical duties, namely people, practice, the profession and co-workers.

2.8 Obligations of nurses in selected ethical codes of nursing

A study of the selected ethical codes identifies common values in nursing which create the obligations of nurses towards patients, the society (international and national), the profession and the self. The studied codes also identify the expected character traits of nurses.

Table 2.1: Common and particular nursing values creating nursing obligations.

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
Obligations to the patients	*Respect for persons and respect for the rights of patients* Promotion of environment of right protection *Respect for religion and culture of patients* Provision of needed, effective and timeous services and care to patients and right to refuse care Protection against abuse, torture and forms of violence Meeting patients' needs and best interest and voluntary care. Respect for patient autonomy Respect for patients' rights as research subjects Right to complain about poor care	**Nursing and Midwifery Council of Nigeria** *As provided for in the country's constitution.* **Nursing and Midwifery Council of Ghana** *Care also to patients' relatives; emergency care in or outside the work setting; to consult with relatives or specialists;* *Nurse accessibility when on duty and arrangements for access when not on duty and consent witnessed by either relatives or legal guardians of patients.* **Health Professions Council of Namibia** *seeking a second opinion without*	Respect for the **autonomy** of patients as an bioethical principle is covered in the ethical codes of nursing Reference to the rights of patients according to a national instrument of human rights The obligation extended to patients' relatives is evidence of an African, communal approach in care. The duty of the nurse to arrange accessibility to care even when the nurse is not on duty is unique and indicates a unique societal expectation of the nurse The right of patients will not be prejudiced on the basis of the choices that patients make.

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
		prejudicing their future treatment; Research participants' compensation for any material loss or costs incurred; protection against victimisation or intimidation in reporting of misconduct; upon request information about the chemical composition and effects of substances used for treatment.	Including compensation in loss during research. Patients' rights protected even when patient complaint. The right of the patient to request information on chemical composition is unique
		Canadian Nurses Association *consent by the person/guardian also valid for mentally challenged; physical privacy, minimum intrusions into lives and least restrictive measures in community health interventions to be advocated for; continued care; to provide informed consent as a research subject and access to their own records;*	Specific mentioning of categories of vulnerable patients, i.e. mentally challenged,
		Australian Nursing and Midwifery Council *Assessment of patient and substitute decision makers' capacity to make decisions. The development of risk*	Specific mentioning of surrogate decision makers as well as management of risks, indicating that patients' rights are dependent on effective management.

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
		management processes	
		Nursing and Midwifery Council, United Kingdom *Safe use of complementary or alternative therapies*	Mentioning of duties in relation to alternative therapies is indicative of a particularity in the scope of practice of nurses in this part of the world
		European Council of Nursing Regulators *Consideration of advance directive and care should continue if harm is foreseen in absence of care.*	Consideration of advance directive is indicative of an expectation relevant in developed countries
		Canadian Nurses Association,; European Council of Nursing Regulators *Effective management of patients pain*	Unique requirement viewing suffering of pain as an infringement of patients' right
		South African Nursing Council Protection of vulnerable patients by: *Correct identification of patients;* *Safe application of diagnostic and therapeutic interventions;* *Accurate and complete recording of*	Unique mentioning of some clinical measures to protect patents' rights, including recordkeeping

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
		observations and care provided to patients; *written declaration of any conscientious objection by nurse forwarded to employer*	Mentioning of advance written objections to protect continuous care to patients
		Japanese Nursing Association *Collaboration with health and welfare personnel*	The importance of a team approach in ensuring patient care
		Medical Association Argentina *Use of indicated, quality guaranteed and proven products*	Specific reference to utilization of approved products in protection of patients' rights
		National Nurses Association of Kenya *Protect custody of client property or monies, no involvement in sexual harassment of patients, or the public or colleagues, by nurses*.	Specific mentioning of patients property and prohibition of sexual conduct in protecting patients' rights

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	Avoid harm to patients Primary obligation of nurses Assessment of risks, removal of risks, and ensuring safety Avoid negligence, malpractice and inform supervisors of risks Care only with consent from patients Nurse competence, practicing within nursing limits, keeping nursing knowledge and skills updated, identify incompetent colleagues and withdrawal when incompetent Safe emergency care Sufficient resource, safe use of equipment Patient advocacy and reporting violations and risk situations Use of technology and scientific advances in safe manner		**Beneficence** and **non-maleficence** as ethical principles is covered in ethical codes of nursing as avoidance of harm to patients All studied codes include values of harm avoidance which indicate a common understanding of this primary obligation of the nurse

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	Desirable standard of nursing practice/quality nursing care Nurses are obligated to provide quality nursing care to patients Establish, maintain and improve nursing standards	**American Nurses Association** *Conditions of employment must be conducive to the provision of quality care* **Nursing and Midwifery Council of Ghana** *Inform authorities of problems prohibiting working within ethical code or acceptable standards of care* **Japanese Nursing Association** *Implementation of nursing standards in practice, management, education and research* **Australian Nursing and Midwifery Council; Nursing Council of Hong Kong** *Quality measure by accessibility, availability, acceptability and safety*	A specific requirement in facilitating standards of care Mentioning the involvement of management in standard assurance A unique comprehensive requirement in ensuring standards in nursing A qualification of the meaning of standards and quality care
	Fair and nonprejudicial treatment and care Provision of equal, non-discriminatory and unprejudiced care to patients No influence of personal or social		**Justice/Fairness** as an ethical principle is covered in all codes of nursing. Reference to fairness is mostly related the relationship between nurse and patients and does not address public health ethics per se

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	attributes of patients in care	**Nursing and Midwifery Council of Nigeria; Japanese Nursing Association** *No acceptance of bribes/gifts for preferential treatment* **The National Nurses Association of Kenya** *Mentioning avoidance of direct and indirect discrimination* **Canadian Nurses Association** *Fair decisions in resource allocation* *Refrain from judging, labelling, stigmatization and humiliation of patients* **Australian Nursing and Midwifery Council** *Complaints by patients should not prejudice care* **Nursing and Midwifery Council, United Kingdom** *Nurse awareness of own personal beliefs not to prejudice care*	Each of the mentioned particular provisions provides a unique reference to how nurses should consider fairness in caring for patients

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
		Health Professions Council of Namibia *Compensation for use of indigenous knowledge* **The South African Nursing Council** *Awareness of ethical challenges in care prioritization*	
	Treatment with compassion, sympathy and empathy Gentle, compassionate, kind-hearted, sensitive sympathetic, empathetic and committed care	**Health Professions Council of Namibia** *Seeking and creating opportunity to translate feelings into action* **Canadian Nurses Association** *Support to dignified and peaceful death and support to bereaved family* **Code of ethics Nursing in Egypt** *Care to patients must be merciful*	Nurses cannot only feel, but these values should be visible in caring nursing actions Unique mentioning of care of the dying and bereaved family Islamic tradition require the Muslim nurse to extend the mercy of Allah to patients
	Access to information, informed decision-making and consent Provision of accurate, honest, understandable information on condition, treatment, care, and prognosis in enabling informed	**Australian Nursing and Midwifery Council** *Affording patients opportunity to verify meaning and implications of provided information. Facilitation of the role of family members, partners and others in decision making*	An extended duty of the nurse to allow patient to consult and ask questions and to provide answers

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	decisions by patients	**Nursing and Midwifery Council, United Kingdom** *Access to relevant and evidence-based information*	Addition of requirement to the information provided to patients
		Health Professions Council of Namibia *Provision of information that patients ask; not withhold information; access to medical records; right to withdraw from research without any adverse results*	A further requirement to information to patients and clarifying patient's right to own records. Importance of information and consent in research mentioned
		The Nursing Council of Hong Kong *Information according to the needs and capacity of patients; information to patients is an ethical requirement*	Criteria related to provision of information as well as the rationale behind information provision
		Nursing and Midwifery Council of Nigeria *Information to patients is a legal requirement*	A rationale for the provision of information
		Medical Association Argentina *Information is given because patients are autonomous persons*	A rationale for the provision of information

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
		Nursing and Midwifery Council of Ghana *Supervisors should be consulted when patients incapable of signing consent*	Specific duty of the nurse related to incapable patients
	Protection of patient information and trusting relationship Honouring of patient information and confidentiality because it creates trust between nurse and patient. Nurse manage patient records safely and with integrity Discretional information sharing and explanation when and how information will be shared Relationship with patients is a privilege and should be protected Breaching of patient information is only allowed by consent of patient, overriding moral obligations or according to legal guidelines of the nursing profession	**Nursing and Midwifery Council of United Kingdom** *Cooperate with media in protection of patient information* **Canadian Nurses Association** *No abuse of photo's or technology to intrude in patient privacy* **Health Professions Council of Namibia; Nursing and Midwifery Council of Ghana** *No abuse of privileged relationship by sexual relationships or financial exploitation of patients, their family or friends or property of patients*	Mentioning of specific duty of nurse in relation to the media, not found in other codes studied Unique requirement not found in other codes studied Avoidance of specific actions in protecting the privileged relationship between nurse and patient

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	Provide care according to patient need and patient culture Care should be provided according to the need of patients and other consideration should not influence the care of patients Care provision also considers patients religion, culture, patient's view and values, and spirituality	**South African Nursing Council** *Care should not be unduly influenced by financial or material rewards* **Australian Nursing and Midwifery Council** *Nursing actions must mitigate harmful cultural practices*	Mentioning of specific considerations that should not influence care provision A further obligation in provision of cultural care to patients
	Professional competence Nurses practice with knowledge skills and proper attitude Maintain competence Practice based on scientific evidence Limit functions to qualifications and scope of practice Keep up with advances in nursing	**European Council of Regulators** *Delegation only when to competent person* *Report serious incompetence to managers, regulatory authorities* **Nursing and Midwifery Council, United Kingdom** *Development of students' competence before delegation* **Nursing and Midwifery Council Ghana** *Assessing of own knowledge and skills before engaging in emergencies* *Sharing of knowledge and skills with*	Extended duty of the nurse considering delegation and reporting of incompetence A further obligation to engage in training of students before delegating tasks Mentioning of specific situation in relation to competence

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
		other members of health team **South African Nursing Council** *Engaging in effective ethical decision making*	An obligation to share with others in enhancing competence of team Mentioning of a specific competence in practice
	Collaboration and cooperation with all involved in health care Quality teamwork to enhance interest of patients Collaborate with patients, families, communities, groups, the public and other health team members Dialogue with others	**Nursing and Midwifery Council of Ghana** *Collaboration facilitate the patients contribution to their health care* **Nursing and Midwifery Council, United Kingdom** *Listening to people, responding to concerns and preferences, consulting and taking advice from colleagues*	Rationale mentioned for collaboration Inclusion of explanation of practicing collaboration
	Keeping clear and accurate records (ffound in most, but not all the codes) Records must be clear, accurate, up-to-date and legible Record all procedures and discussions Recording as soon as event occurred Records kept securely	**Nursing and Midwifery Council, United Kingdom** *Not tampering with original records and measure to attribute electronic records to writer*	Addition of specific requirements in relation to recordkeeping

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	Accountability for professional practice Accountable for individual acts and omissions, unless under supervision Accountable for safe practice, judgments, actions and risks taken Accountability related to activities in education and training	**American Nurses Association** *Accountability for tasks delegated to others* **South African Nursing Council** *Accountability for functions performed beyond scope of nursing practice* **Nursing and Midwifery Council of Ghana** *Accountable despite advice and direction from others*	Mentioning of accountability of delegator implying supervision of tasks by others Practicing beyond nursing scope of practice not a defense for not being accountable Accountability is not obsolete on ground of others' directions, it is a personal choice to act or omit
Obligations to society (nationally and globally)	Participate in international and national conventions and conferences Implement universal initiatives and instruments when signatory Fulfil in societies needs and goal of health for all Safe accessible, acceptable health services to society Collaborate with partners and public administrators	**International Council of Nurses** *Sharing duty with society to initiate and support health and social needs especially needs of vulnerable groups; sustain and protect environment from depletion, pollution, degradation and destruction* **American Nurses Association** *Involvement in shaping social policy*	Expectation of reciprocal duties of nurses and society and inclusion of duties related to the environment Expectation of a high level of involvement by nurses

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	Share responsibility in raising health consciousness in communities Involvement in prevention of social problems effecting health	**Australian Nursing and Midwifery Council; Health Professions Council of Namibia; Nursing Council of Hong Kong** *Effective management and use of resources*	A important expectation and indication that resources belong to society
		Australian Nursing and Midwifery Council; Medical Association Argentina; Health Professions Council of Namibia; Japanese Nursing Association *Valuing ecological, sustainable environment; No exploitation of natural resources; legal disposal of health waste*	Extended duty of nurses in relation to environment ,natural resources and waste management as obligation to broader society
		Canadian Nurses Association *Effective management of disasters and disease outbreaks;* *Support society to question status qua and good faith whistle-blowing*	Reference to specific health care situation related to society's health Expectation that nurses should have awareness and support a just society
		Health Professions Council of Namibia *Obtain authorisation for research in society, understandable feedback and results to research participants*	Acknowledgement of societies input in knowledge creation and reciprocal duty of nurses to respect this

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
Obligations to the profession	High standard of professional conduct and practice Respect for fellow professionals Activities uplift social status, integrity, enhance public confidence in nurses and not bring profession in disrepute Dress decently, not consume alcohol excessively, not take prohibited drugs, act with dignity and decorum Not favor relatives, practice nepotism, not abuse positions of authority, Not allow commercial consideration influence care judgments Engage in development of profession, students and own competence. Perform nursing research in knowledge creation Maintain professional relations, share knowledge and respect fellow professionals. Not injure the	**International Council of Nurses** *Create and maintain safe. equitable, social and economic working conditions with nursing organizations* **Health Professions Council of Namibia** *Prevent other professionals to practice illegally; respond to complaints and criticism promptly and constructively*	Good working conditions are necessary for nurses to function optimally Extended expectation to prevent others to harm the reputation of the profession and to take action when nursing is criticized Most studied codes have similar expectations of nurses in relation to the nursing profession at large

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	reputation of other professionals Be good employees, inform employers of skill deficits and balance professional and employee rights Support regulatory bodies in their legal functions Practice nursing within nursing laws and ethical codes		
Obligations to the self	Self-knowledge about values, beliefs, strengths, limitations and how this influence care Be proud, have self-respect, honor themselves, recognize self-worth and value own identity Protect own physical and mental health, integrity and safety Object conscientiously to participate in unacceptable religious and cultural treatments Avoidance of actions that risks self,		The rationale behind taking care of the self is to enable the nurse, as a professional person, to provide quality care to patients , as well as protect the self from negligent practice and harm to the self (Searle, 2004)

Major common values identified	Examples of common values	Particular values in specific codes	Commentary
	others and may cause impairment Development of acceptable personal qualities		
Personal character traits of the professional nurse practitioner	High standard of integrity, be Honest, transparent, courteous, resourceful, supportive, ethical, rational, efficient, critical, dedicated, cautious, diligent, sober, reasonable, committed, competent, kind, tolerant and respectful Not be corrupt, not steal, fight, be abusive or use privileged positions for their own ends	**Canadian Nurses Association** *Support good faith whistle-blowing*	Nurses are expected to be courageous and support prevention of corrupt practices

(Code of Ethics in Egypt (n.d.); American Nurses Association, 2001; Medical Association Argentina, 2001; Japanese Nursing Association. 2003; European Council of Nursing Regulators, 2004; South African Nursing Council, 2004; Nursing and Midwifery Council of Nigeria, 2005; Australian Nursing and Midwifery Council, 2006; International Council of Nurses, 2006; Nursing and Midwifery Council of Ghana, 2007; Canadian Nurses Association, 2008; Nursing and Midwifery Council, United Kingdom, 2008; National Nurses Association of Kenya, 2009; Health Professions Council of Namibia, 2010 & The Nursing Council of Hong Kong, 2010)

Comparative commentary

The most extensive provision in all the studied ethical codes relates to the rights of patients and the reciprocal obligation of nurses towards their patients. The obligation of nurses towards patients is covered comprehensively in most studied codes.

The main and general focus of all the studied codes is the respect for persons, protection of the patients' rights and the promotion of health according to patient needs, including respect for patients' culture. Nurses are obligated to respect patients autonomy, their rights as research subjects; the right to complain about poor care and protection against abuse, torture and violence. Obligation to the patients includes service delivery and care and promotion of an environment of protection and care.

The Nursing and Midwifery Council of Nigeria (2005) draw on their country's Constitution to protect rights of others, the Nursing and Midwifery Council of Ghana (2007) includes obligations of nurses to the patients' family and expects of nurses to arrange access to services even when the nurse is not on duty. These specific obligations are indicative of specific needs for service delivery in developing countries where mainly nurses provide health care in remote areas. Special rights of patients is found in the Canadian Nurses Association's (2008) code, the Health Professions Council of Namibia (2010) and the Medical Association Argentina (2001) that provide details on the rights of special vulnerable categories of patients (Canada); the right of patients to receive details on chemical composition of medicine and right irrespective of patient complaints (Namibia) and the use of proven, guaranteed products of quality (Argentina).

Risk management procedures and confirmation of the capacity of surrogate decision makers are included in patient rights by the Australian Nursing and Midwifery Council (2006). Significant details of right protection is found in the ethical code of The Nursing and Midwifery Council, United Kingdom (2008) providing for safe use of alternative and complementary therapies while the European Council of

Nursing Regulators (2004) protect the rights of patients in the consideration of advance directives. These obligations of nurses reveal a developed health care system and the prevalent approach in addressing ethical issues in these societies.

The Japanese Nursing Association (2003) expects nurses to collaborate effectively with other to protect patients. Both the Canadian Nurses Association (2008) and the European Council of Nursing Regulators (2004) mention effective pain management of patients as a right of patients. Of the studied codes it only these two codes that mention pain management specifically as a nursing obligation.

The National Nurses Association of Kenya (2009) include the protection of patients' properties, monies and protection against sexual harassment as a right of patients. Evidently, the countries whose codes were studied provide for the protection of general human rights and the special rights of patients as specified in the codes.

Countries in more developed societies (Canada, United Kingdom, Europe) includes provision addressing the issues related to the advance health care environment within which they function. The ethical codes of countries in Africa include provisions relevant to the communal approach in African societies and inclusion of family and community expectation in the codes. A further right of patients found in all studied ethical codes is the protection from harm to patients. Harm avoidance (non-maleficence) and doing good (beneficence) are two ethical principles that form part of the traditional moral framework in health care and bioethics.

Patients have the right to receive care of desirable standards and nurses are obliged to observe and establish standards of quality. The requirement for quality nursing care is provided in all studied codes. The American Nurses Association (2001) expect work conditions to enable nurses to provide quality care, while the Nursing and Midwifery Council of Ghana (2007) expect nurses to inform authorities of challenges prohibiting quality care. The Japanese Nursing Association (2003) extend practice standards

to standard in education, management and research while the Australian Nursing and Midwifery Council (2006) and the Nursing Council of Hong Kong (2010) specify quality measures of accessibility, availability acceptability and safety.

Values regarding the rights of patients found in all studied codes further includes the right to fair and non-prejudicial treatment; compassionate, sympathetic and empathetic treatment; access to information and the right to informed decision making and consent; protection of patient information and trusting relationships; ensuring professional competence; collaboration and cooperation with others and accountability for professional practice.

With regard to the right of patients mentioned in the previous paragraph, the following unique provisions need mentioning. Fairness means that nurses cannot accept bribes/gifts for preferential treatment of patients (Nursing and Midwifery Council of Nigeria, 2005; Japanese Nursing Association, 2003). Nurses are required to know their own belief systems to prevent prejudices (Nursing and Midwifery Council, United Kingdom, 2008); complaints by patients must not prejudice care (Australian Nursing and Midwifery Council, 2006) and the fair decisions about resource allocation (Canadian Nurses Association, 2008). The Health Professions Council of Namibia (2010) views the compensation for use of person's indigenous knowledge as fair, which may indicate that communities are accessed for research about indigenous health knowledge.

Specific provisions with regard to compassionate, sympathetic and empathetic care to patients are creating opportunities to translate patients' feelings into actions (Health Professions Council of Namibia, 2010), support for dying patients and the bereaved family (Canadian Nurses Association, 2006) and merciful care to patients (Code of ethics of Egypt, n.d.). These provisions indicate that feeling should be translated to caring actions by nurses and that Islam requires the Islamic nurse to extend the mercy of Allah to patients.

Seven of the studied codes provide reasons why patients have the right to information, informed decision-making and consent and how this right must be protected. Reasons are patient autonomy (Medical Association of Argentina, 2001), legal requirement (nursing and Midwifery Council of Nigeria, 2005) and ethical requirement (Nursing Council of Hong Kong, 2010). Nurses are obliged to create opportunity for clarification of information by patients and facilitate the role of family members/surrogate decision makers (Australian Nursing and Midwifery Council, 2006); access to relevant and evidence based information (Nursing and Midwifery Council, United Kingdom, 2008); to consult supervisors when patients capacity are compromised (Nursing and Midwifery Council of Ghana, 2007) and provision of information that patients ask, not withholding information, ensuring access to patient records and respecting withdrawal from research (Health Professions Council of Namibia, 2010).

The creation of trust by confidentiality is observed in all studied codes and some codes described the following different measures in protecting this right of patients:

- cooperation with the media (Nursing and Midwifery Council, United Kingdom, 2008);
- no abuse of photo's or technology to intrude into patients privacy (Canadian Nurses Association, 2008) and
- no financial or sexual exploitation of patients, their family or friends (Health Professions Council of Namibia, 2010; Nursing and Midwifery Council of Ghana, 2007),

Specific provisions with regard to the obligation of nurses to maintain professional competence are reporting of incompetent colleagues and delegation to competent persons (European Council of Nurses, 2004; Nursing and Midwifery Council, United Kingdom, 2008); assessment of own knowledge before interventions in emergencies and sharing knowledge within the health team (Nursing and Midwifery Council of Ghana, 2007) and engaging in effective ethical decision making (South African Nursing Council, 2004).

The Nursing and Midwifery Council of Ghana (2007) specify the patients as important collaborators in their care while the Nursing and Midwifery Council, United Kingdom (2008) require nurses to take consult and take advice from colleagues, to listen to people and respond to concerns and preferences. These unique provisions relates to the nurses obligation to collaboration and cooperation with others.

Recordkeeping as a measure to ensure patients' rights is found in most, but not all ethical codes. The Nursing and Midwifery Council, United Kingdom (2008) prohibits the tampering with original records and measure to attribute electronic records to the writer of such records. Recordkeeping might be seen as a legal requirement and might therefor be included in nursing legislation.

Accountability for professional practice is a general nursing obligation. Delegated tasks remain the accountability of the delegator (American Nurses Association, 2001); nurses are accountable for tasks performed beyond their scope of practice (South African Nursing Council, 2004) and accountability remains despite the advice and direction from others (Nursing and Midwifery Council of Ghana, 2007). From these general and specific provisions it is evident that nurses are accountable for their decisions and actions and need to act after careful and insightful professional judgment.

The nurses obligation to society, both nationally and internationally, found in most of the codes studied involves international participation in conventions, conferences, with partners and initiatives, provide care according to societal needs, prevent social problems and raising health awareness in communities. The International Council of Nurses (2006) specify protection of the environment, sharing duty with society for their health and social needs, especially vulnerable groups as an obligation nurses have. The American Nurses Association (2001) requires nurses to be involved in social policy while the management of resources is seen as an important obligation of nurses (Australian Nursing Midwifery Council, 2006; Medical Association Argentina, 2001; Health Professions Council of Namibia, 2010; Japanese Nursing Association, 2003). The Canadian Nurses Association (2008) specifies involvement in

disaster management and disease outbreaks and support in good faith whistle-blowing while the Healht professional Council of Namibia (2010) requires consent for societal research and the right to feedback to society in research participation.

Ethical codes also include provision regarding obligations of nurses towards the nursing profession. Generally these provisions relate to high standards of professional conduct, respect for fellow professionals and maintain professional relationships, engagement in developing the nursing profession and display actions that uplift the image of the nursing profession. The International Council of Nurses (2006) specifically require nurses to collaborate with nursing organizations to better the work life of nurses while the Health Professions Council of Namibia (2010) require prompt response to complaints and criticism and to prevent illegal practice of other professionals.

Ethical codes also include obligations to the self. Searle (2004) view these obligations as enabling the nurse to provide quality care to patients and to protect oneself to negligent practice that may be harmful to oneself. These obligations include self-knowledge about values, strengths and limitations, protection of own health holistically, avoidance of actions that risks oneself, others and may cause impairment, conscientious objection to involvement in unacceptable practices, honor won worth and self-respect and develop acceptable personal qualities.

Personal character traits mentioned in most of the codes studied are virtues needed to fulfill one's day to day duty in caring for vulnerable persons and to serve society in meaningful ways. Nurses are expected to grow into moral persons who are courageous and prevent corrupt practices in health care.

The provisions in both the Ethical guidelines of Namibia and the Draft Charter of Nursing Practice of South Africa compared well with the provisions in the other studied codes. The Ethical guidelines of Namibia contain content relevant to all health professionals in Namibia because it was developed by the Health Professions Council of Namibia. Many provisions in this document address aspect related to

private practice mostly relevant to physicians, dentists and physiotherapists. The aspects related to patient care are however relevant to all health providers, including nurses. The Draft Charter of Nursing Practice of the South African Nursing Council contains only provisions for nurses. Noteworthy of the South African document is the description of clinical measure in the protection of the rights of patients, i.e. correct identification of patients and safe application of diagnostic therapeutic interventions.

Further general comments

While the development of ethical codes by countries show some divergence in authorship and format, the values and norms, which form the framework of ethical nursing practice in many different countries, including Namibia and South Africa, converge remarkably in content and expectation.

Regulatory bodies (nursing councils) in some countries develop ethical guidelines/standards/codes to which members of the nursing profession, but also other health professionals, must subscribe, the Guidelines for Health Professionals of Namibia is an example, while in other countries codes are developed by nursing associations/organisations. Nursing organisations in regions also collectively develop ethical codes for countries within the region, such as the Code of Ethics and Conduct for European Nursing, developed by the European Council of Nursing Regulators (European Council of Regulators, 2004).

Not all countries develop their own ethical codes. Some nursing organisations in Scandinavian counties rely on the International Council of Nurses' Code of Ethics in their expectations of ethical conduct by nurses, as is evident in the following statement by the Swedish Society of Nursing: "The Swedish Society of Nursing (SSF) promotes: …awareness of ICN's Code of Ethics for Nurses …" (The Swedish Society of Nursing, n.d.)

Ethical codes that are presented in understandable, simplistic statements with explanatory notes are easily accessible, while longer narratives are probably not as user-friendly. Narratives describes the ethical norms and does not necessarily guide users of these codes in a direct manner, therefore codes that provide direct assignment of what is expected (i.e. you must…), is more specific than long descriptions or statements that address nurses collectively (i.e. Nurses respect…). Ethical behavior is a personal choice and therefore statements in ethical codes that address the practitioner in singular form and personal tone seem to have more urgency and strength. These direct statements leave little doubt about expected norms and behaviors and do not allow the individual practitioner to distance him/herself from the stated expectation.

Ethical codes address the expectations of the societies within which nurses function (Nursing and Midwifery Council of Ghana, 2007; National Nurses Association of Kenya, 2009). Generally, the approach in the ethical codes of African countries seem to be more communal by extending the duties of nurses to the extended family members/relatives of patients, this expectation is also included in the codes in South Africa and Namibia, where care to communities is important in the provision of primary health care by the nurse. South Africa's Charter is still a working document, but reflects contemporary expectations, while the Ethical Guidelines of Namibia is a recent document addressing contemporary expectations of the health professionals in Namibia. The approach in an ethical code in Europe seems more individualistic in nature and view the obligation of nurses to have professional indemnity as ethical (European Council of Nursing Regulators, 2004), with no such provision in the other ethical codes studied.

Not all the ethical codes studied included record keeping as an ethical requirement. This requirement might be included in the legal regulation/rules of professions in different countries and nursing organisations might view the keeping of records as a requirement to observe nursing laws.

The obligation of nurses towards society confirms the importance of good health in the development of societies. It also confirms that countries worldwide do not function in isolation in seeking quality healthcare services. Countries and their healthcare providers, including nurses, should be committed to promote health of communities and society and acknowledge the interdependence between role players nationally and globally in the promotion of health and prevention of disease. The inclusion of obligations of nurses to the broader society, also the global society, within ethical codes, confirms the nursing profession's responsiveness to current expectations and the current perception that people are global citizens who should understand that human actions (or omissions) have global consequences.

With regard to the obligations of nurses towards, patients, families, communities and societies at large, as found in ethical codes, it becomes clear that nursing ethics education is an important component in nursing education. The teaching-learning of nursing values, nursing obligations, ethical decision making and problem-solving in practical nursing situations utilize ethical codes to explicate expected conduct in nursing. Numminen, van der Arend & Keino-Kilpi (2008) confirm the importance of ethical codes in nursing education and state that the teaching-learning of ethical codes have a positive influence on students' behavior. Nursing ethics educators use ethical codes as justification and disciplinary measure in evaluating students' assignments in ethics (Numminen, van der Arend & Keino-Kilpi, 2008).

Doane, Pauly, Brown & McPherson (2004) acknowledge that the teaching-learning of principles, theories and ethical decision making are not sufficient to address the multi-layered moral challenges in contemporary nursing practice. The nature of nursing (and health care practice generally) requires an appreciation of virtues which address the motive/s of actions (Beachamp & Childress, 2009). Application and specification of rules may provide justification for right actions, but present little on the feeling, or disposition of the actor, this makes morality "a cold and uninspiring practice" (Beachamp & Childress, 2009: 30), and therefore moral character is a necessary requirement in the judgment of virtuous acts.

Virtue ethics addresses an important requirement in moral theory, that of the distinction between obligation and moral character as requirements for virtuous acts. Virtue ethics therefore adds a valuable and indispensable dimension to traditional moral theory.

2.9 Virtue ethics

According to Beauchamp & Childress, 2009), moral excellence draws on both right actions and right motive/s in determining virtuous actions. An act might be right, but without proper motive such act is not virtuous, a virtuous act requires both proper motive (emotion and desire) and right action (Beachamp & Childress, 2009). Professionals, including nurses, should cultivate the traditional virtues derived from the primary goal of nursing, which is the virtue of caring referring to the "care for, emotional commitment to and deep willingness to act on behalf of persons with whom one has a significant relationship" (Beauchamp & Childress, 2009: 36). Nursing practice focuses on meeting the needs of vulnerable persons within the special nurse-patient relationship (Tong, 1998) and according to Van Niekerk (2011) nurses are less oriented towards curing, but more focused on caring and promoting the total wellbeing of patients.

With the advent of 20th century feminism which attempted to rectify the biases of male superiority and provide a voice for women's experiences in life, including how women approach decisions, gave birth to the theory of an "ethic of care". An ethic of care seems appropriate for the nursing profession which is still viewed as a female dominated profession and fits the relational and caring character of nursing.

The ethic of care needs some explication as it historically contains the central moral value of the nursing profession and gained ground as an ethical framework in contemporary nursing practice and education. An ethic of care will briefly be presented as a contemporary framework in the ethics of nursing.

2.10 The ethic of care

The idea of an ethic of care evolved from Gilligan's critique of Kohlberg is cognitive developmental moral theory, which was based on research with boys. Gilligan argued that girls approach moral challenges differently from boys and that girls are more concerned about protecting relationships, while boys focus more on justice and rights as a basis for conflict resolution (Pera & Van Tonder, 2005). The ongoing debate on whether and ethic of care is substantive enough to be considered moral theory is beyond the scope of this study, which will rather focus on what an ethic of care entails and how such an ethic of care might be practiced in nursing. It is however important to explore the meaning of the concepts of "care" and "caring" in order to describe an ethic of care in nursing practice.

The concepts of care and caring

According to Griffen (1983), caring is an innate attribute of all human beings, and a primary mode of being which is important in human relationships. Caring is also seen as a requirement for human existence, because this inborn attribute allows things to matter to humans and therefore determines the interest humans have in things. The interest allows motivation and an awareness of and feelings about the self and others. Caring is therefore "a structural feature of human growth and development" (Griffen, 1983: 289).

Beauchamp and Childress (2009: 36), define caring as "to care for, emotional commitment to and a willingness to act on behalf of others with whom one has a significant relationship", supporting the importance of relational responsibilities between persons.

Nursing literature often uses care and caring synonymously. Sometimes care (as a verb) may refer to a procedure or action that not necessarily includes feelings (e.g. compassion, empathy). Care might also refer to feelings and emotions. Caring behavior not only requires both action and feelings, but has the further requirement that the action and feelings should intentionally benefit the person to whom the

caring behavior is directed. Caring therefore excludes all forms of malice, neglect or harm to others (Pera & Van Tonder, 2005). This means that caring persons are seen as moral agents who continuously strive to advance the wellbeing of others and who take appropriate, altruistic action to attain and oversee that wellbeing.

The concept of care may present itself on two levels, according to Edwards (2011). These levels are ontological, and psychological. Ontological care differentiates two further levels, namely biological and conscious-levels. The biological level refers to the behavior of organisms (including humans), showing what they really care about without intentionally or consciously engaging in these and can also be seen as basic needs, such as seeking food, shelter, warmth and the such as. Conscious-level ontological care becomes evident in the actions humans take based on those things they value, or care for, and are related to our identity as persons. This action or doing mode of caring is also identified by Van der Wal (in Pera & van Tonder, 2005). A further mode of caring identified by him refers to feelings and emotions and can be seen as qualitative indicators of caring i.e. the motivational force of caring, the attitude while caring, self-extension of the caregiver and doing what is needed in the right manner and the right time.

Psychological care, according to Edwards (2011) refers to an orientation within persons from which morality might be viewed and practiced. Psychological care may operate from an obligation-based or responsibility-based orientation. An obligation-based orientation involves determining what obligation one has in a situation and responding to such an obligation accordingly. This means that one considers care distantly and more objectively.

A responsibility-based orientation denotes an 'a priori' responsibility towards others in their misfortune and therefore one responds by helping because the responsibility to care already exists. This responsibility based orientation resonates with an ethic of care because of the existing relational element that motivates the care of others.

An ethic of care

Acceptable conduct in an ethic of care is not motivated by considerations of utility, universal moral duties or social contract, but rather by the particular needs and an active concern for others within a relational context.

Tong (1998) argues that an ethic of care approaches morality contextually, considering human connectedness and communal relationships in the private realm and stresses the role of emotions in constituting good character, all pointing to a more feminine/feminist approach to ethics. An ethic of care is contrasted against an ethic of justice which is masculine, stresses the role of abstract reasoning in performing right action mostly in the public realm, considering individual rights in an approach of human separateness.

The cornerstone of an ethic of care is its relational nature and interpersonal connectedness. Moral conduct is based on the awareness of human interdependence and interpersonal responsibility and not by being impartial or distant. An ethic of care accepts that humans have obligations within relationships and that the vulnerability of others motivates caring emotions and actions towards others (Nortvedt, Hem & Skirbekk, 2011).

In an ethic of care moral consciousness is acquired by interactive patterns of conduct, perceptions and interpretation. It is about being open to others and an awareness of the relational self. Moral responsibility is defined by relationships and is not motivated by rules (Parton, 2003).

An ethic of care requires of moral agents a different approach in moral judgment and moral actions. Moral actions are not motivated nor enacted on grounds of universally applied principles but by a genuine feeling and concern for others within a particular relationship. This approach is now described as an ethic of care, but is also the ethic of nursing since the inception of nursing.

Practicing nursing within an "ethic of care"

Van Niekerk (2011) argues that an ethic of care suits nursing practice because nursing focuses not mainly on cure, such as medicine, but is concerned about the total wellbeing of patients. Nursing practice is about being available to patients throughout the span of their illness, in continuous contact and not fleetingly such as the contact doctors often have with patients. Nurses concern themselves with the whole person and all the needs that a person has.

Searle & Pera (1995) explore five fundamental caring values in nursing practice, namely commitment, compassion, conscience, confidence and competence. Commitment requires an acceptance of one's responsibility in life, while realizing that life is not only joyful, but also full of suffering and hardship. The nurse becomes part of others joy as well as their suffering. Compassion requires the nurse to immerse him/herself in all the conditions of being human. Compassion is seen in kindness, nearness and a genuine desire to do what is right for others. It is more that sympathy or empathy. Conscience is the authority that guides our moral decisions and behaviors. Nurses are guided and act according to prescribed moral and legal standards which evolved over many years of the existence of nursing. Confidence denotes the trusting relationship between the nurse and the patient where the nurse is committed to respect human life, promote human wellbeing and protect the confidential information of the patient. Competence is an imperative in nursing practice. Without the necessary knowledge and skills caring is not possible because the patient is exposed to harm which is the opposite of the caring intention of nursing practice (Searle & Pera, 1995).

Edwards (2011) sees caring practices by nursing as respecting the autonomy of patients, promoting patient well-being, act fairly and not harming patients and practicing those values featuring in nursing ethical codes. These principles should however not be practiced as abstract, universal duties, but should be considered by nurses within the relational context of nursing practice where the total need of

patients is the continuous focus of the nurse practitioner and where the responsibility towards the patient takes place within the special nurse-patient relationship.

Practicing within an ethic of care means that the nurse appreciation emotions and relations within the interpersonal relationships in nursing, as indicators of best practice. Best caring practice is therefore not informed by abstract reasoning but by considering the position, reality and experience of patients and how the nurse can serve the interests of the patient (Robertson & Walter, 2007).

An ethic of care in nursing practice requires nurses to do more than their duty, it requires more than conscientiousness to be caring and skillful, it requires a kindness that is motivated by a genuine understanding of the position and vulnerability of patients. It requires an awareness of the relational context within which nurses and patients find themselves, a determination to do what is good and best for the patient with the needed concern and feeling for the patient (Tong, 1998).

Nursing ethics education need to facilitate the development of nurses as "moral agents within the contextual and relational influences shaping them" (Doane, et al, 2004: 250). Educator competence, the organization and effectiveness of nursing ethics education are areas in nursing education that need further exploration (Numminen, et al., 2011). Teaching-learning methods cannot remain narrow and conventional (Numminen, et al., 2011) but need to explore more appropriate teaching-learning methods in the facilitation of ethical competencies in nursing students. Facilitating the ethical abilities of nurses in nursing ethics education is even more important considering the progress in medical sciences which provides physicians with possibilities in clinical practice that require caution and critical assessment in decision making. Van Niekerk (1997) views determining the limits of competencies of physicians as one of the most important ethical questions in medicine today and considers Aristotle's practical wisdom as appropriate to justify ethical acts in the light of all the possibilities modern medicine offers (Van Niekerk (1997). Aristotle's conception of practical wisdom may be an appropriate approach in the teaching and

learning of nursing ethics to students, because the aim of nursing is to promote the total well-being of patients, establish good communication with patients considering the immediate (contextual) need/s of the patient. Nurses as care providers and patient advocates are always at the bedside of patients and probably the most appropriate health team member to curb the paternalistic approach that physicians may take in clinical and moral decisions regarding patient care. Justification for moral action cannot rely solely on the observance of rules, whether these rules are derived from ethical codes or traditional ethical approaches, for instance fulfilling on one's duties. The current context of postmodern health care practice requires persons of moral character who can temper all the advance possibilities of care in medicine.

Nursing ethics education should attempt to develop, a virtuous nurse who, according to Aristotle avoid and guard against extreme actions, not to be excessive or deficient in moral judgment and actions. Nurses can, and need to, play an important role in the face of the moral questions that modern medicine pose in clinical decisions.

The following chapter describes Aristotle's virtue ethics and specifically the classical conception of practical wisdom and reviews current literature of practical wisdom in nursing ethics education and nursing practice.

CHAPTER THREE

ARISTOTLE'S CLASSICAL CONCEPTION OF PRACTICAL WISDOM (PHRONESIS)

3.1 Introduction

The previous chapter examined various codes of nursing ethics as guiding rules in nursing practice and education and virtue ethics as a further dimension and valuable requirement in moral theory. An ethic of care was explicated as a theoretical framework related to virtue ethics and a significant construction in nursing ethics. This chapter will explore Aristotle's virtue based approach to ethics.

According to Aristotle[1], moral virtues are different from intellectual virtues as moral virtues are states of character that are about people's desires, choices and conduct (1105b & 1111b) while intellectual virtues explore the manner in which people arrive at their desires, choices and actions (1138b). A moral person is recognised by choices and actions that are produced by virtues that originate from the mean between the extremes of excess and deficiency (1106b). Using one's intellectual virtues enables one to seek the truth in meaningful ways. Aristotle's idea of intellectual virtues includes the virtues of scientific knowledge, art, intuitive reason, philosophic wisdom and practical wisdom (1139b – 1143a).

Aristotle's conception of ethical conduct is significant in the explication of determining moral praiseworthy acts in life. In nursing practice misconduct or malpractice are often determined by either deficient or excessive nursing practice (Jooste, 2010). In practicing bedside nursing care, ethical versus unethical conduct are more often determined by the ethical codes of nursing which respond to the demands within a society (cf. chapter two). Ethical theories are utilized in ethical decision making in morally challenging situations and are included in the curricula of undergraduate nursing ethics education in some participating institutions (cf. chapter four). For the purpose of this study Aristotle's

[1] *The Nicomachean Ethics. The works of Aristotle.* trans. D Ross, (1993) Oxford: Oxford University Press.

conception of practical wisdom is described as a required construct in nursing ethics and will be considered as an approach in the teaching-learning of nursing ethics.

The following two sections are brief descriptions of Aristotle's concepts of both moral and intellectual virtues. Practical wisdom as a particular intellectual virtue and the way this virtue might be utilised in teaching-learning will be described more fully in the last sections of this chapter.

3.2 A general account of Aristotle's moral virtues

According to Aristotle (1103a-1109a), inquiry into moral virtues has no meaning unless it assists people to become virtuous; therefore, how people ought to act, needs examining because actions determine character. Man is not born virtuous, but acquires moral virtues by habit. Habit means that we exercise and learn how to do by doing. With reference to good character, persons become virtuous by doing virtuous acts. A virtuous person is not only recognised by the performance of virtuous acts, but also by fulfilling certain conditions in the performance of virtuous acts. People firstly need to have knowledge, secondly, they should choose good acts for their own sake (and not for other reasons), and lastly, the actions must come from "a firm and unchangeable character" (1105a). Virtuous acts cannot be divorced from the virtuous person. Virtuous acts are therefore only virtuous if they are performed by a person with a virtuous character. The assumptions of "good conduct" should, however, be presented cautiously, as good conduct is not exact and may be determined by particular situations (1104a). Generally, virtuous acts are produced by finding the mean between excess and defect (1108b). Right actions are therefore neither extreme nor defective, but moderate in nature, and are acquired by repetition (1104b). With regard to the virtue of courage, the coward who flees from everything, exemplifies the deficient, while the man who fears nothing seems rash and exemplifies the excess; therefore, good moral conduct with regard to the virtue of courage, attempts to find moderation between rash and cowardly acts. Persons then need to consider their own tendencies and move away

from the two extremes of deficiency and excess, and seek the mean (1103b-1109b). There can be no mean for those excesses (e.g. adultery) or defects (e.g. envy), which are bad in themselves. What one ought to do, or ought to abstain from, is connected to pleasure and pain, because people consider their actions by the rule of pleasure or pain. Moral excellence is doing what is best with regard to pleasure and pain, and vicious acts involve doing what is not good with regard to pleasure and pain. The moral person is able to choose well with regard to pleasure and pain in considering good conduct, while the bad person does not choose well with regard to pleasure and pain in considering what to do, and choosing well is the ability to find the mean, i.e. to avoid either excess or deficiency. For example, it is possible with regard to truth to describe the mean as truthful. The exaggeration (excess) might be boastfulness, while the deficiency with regard to truth might be called mock modesty. It is however more difficult to describe the mean with regard to certain dispositions such as honour. A person who desires honour might be called ambitious and the person who falls short of the desire is called unambitious, but the mean is difficult to describe, because what will a person that is neither ambitious nor unambitious be called? In addition, the state of the mean, as opposed to the extreme or deficiency is relative. Aristotle exemplifies this relativity by explaining that a coward (morally deficient person) might see a brave man (the mean) as rash (the excess), while a rash man might think the brave man to be a coward, but the biggest inconsistency lies between the two extremes, being the excess and the deficiency. Both excess and deficiency lie further from each other than from the mean, exemplified by the opposition between cowardice and rashness, both being further apart from each other than each is from the mean, i.e. braveness. People may also be more opposed to either an extreme or a deficiency, depending on the particular "thing"[2] itself and our own natural inclination towards the "thing" (1115a-1126b) People may be more opposed to cowardice (the deficiency) than to rashness (the excess) with regard to courage, for instance, or more opposed to self-indulgence (the excess) than to insensibility

[2] The "things" to which Aristotle refers are those moral concepts, i.e. courage, truth, anger, etc. which he used to explain his position on how good moral conduct is chosen as moderate actions, as opposed to the extremes of excess and deficiency (1115a – 1126b)

(the deficiency), with regard to temperance. This, according to Aristotle, is because people judge either the excess or the deficiency to be nearer to the mean, with regard to the particular "thing". Also, the extreme which is further from people's natural tendencies, is described as more contrary to the mean, for example, people have a natural tendency to pleasure and may easily self-indulge, therefore self-indulgence is described as more contrary to the virtue of temperance than propriety, to which people are not naturally drawn. Moral virtue then requires that someone desires and acts in moderation, as opposed to the vices of excess or deficiency. It is however difficult to find moderation in desires and actions, and not everyone succeeds in doing this. To be good people we need to consider our own tendencies, make an effort to depart from those erroneous extremes to which we are most inclined, and move toward the opposite extreme, whereby the moderate might be reached (1109b). Because of our perceptions of things, it is furthermore difficult in particular cases to determine which actions are blameworthy and which are praiseworthy. Actions by people, such as other things, are perceived by the senses, and judgments are therefore determined not by reason, but by perception (1110a).

3.3 Aristotle's account of the intellectual virtues

The reason for exploring intellectual virtue, according to Aristotle (1138b), is to determine the ways in which someone may seek the truth. It is not enough to know the mean as opposed to the extremes (having moral virtue), but it is also important to explore how people arrive at the truth, i.e. by the intellectual. Virtuous conduct is therefore determined by actions that are based on the right reasons and the right desires.

Aristotle differentiated between two parts of the human soul: one part that grasps the rational principle and one that grasps the non-rational (1138b). The part of the soul which grasps the rational principle further distinguishes between contemplative things whose originative causes are either invariable or variable. The invariable is constant and never changes while the variable can change. Invariable things

are called the scientific/contemplative, i.e. they cannot be deliberated, whereas variable things, because they can change, are called the calculative (1139a). The rational capacity of humans grasps both invariable things (which are scientific facts) and variable things (which can change and on which humans can deliberate). The aim of both the contemplative and deliberative parts of the soul is seeking the truth, but while the virtue of the contemplative is only secured in the truth, the deliberative needs both the truth and the right desire.

Three parts of the soul control action and truth, namely sensation, reason and desire. Human conduct is determined by reason and desire, unlike lower animals, which may sense, but their actions are not driven by reason or reasoned desire (1139b). Human actions are therefore purposive and are based on both reason and desire. Good human actions require good reasoning and the right desire as well as a good character. The opposite is true for evil/bad human actions. These actions are based on bad reasoning, desire and character.

In securing the truth, humans rely on the intellectual virtues of scientific knowledge, art, intuitive reason, philosophic wisdom and practical wisdom. Scientific knowledge is invariable, unchangeable, universal, necessary and therefore eternal. It is demonstrative and based on principles, which are derived from intuitive reason (1139b). Art relates to the variable and is the knowledge to make things, based on reasoning. The origin of art lies with the maker, not in the thing itself, nor in science (1140a). Philosophic wisdom refers to general wisdom, not wisdom of a particular kind, but wisdom based on knowledge of both intuitive reason (grasping initial principles) and scientific knowledge (1140a).

Practical wisdom is the virtue of knowing what contributes to the good life generally, for oneself and for others, based on the ability to deliberate well. Deliberation is not about the invariable, because that cannot change, nor is it related to the knowledge of making things, but it is about the capacity to reason and act with regard to the things that are good or bad for man. A practically wise person is able to

determine, through deliberating, which actions are needed to ensure a good result in a particular situation (1140a). Deliberation relates to those things, which are variable, but with regard to the virtue of practical wisdom, deliberation focuses on the judgment about what is good or bad for man, and does not refer to scientific knowledge, which is about the invariable, or art, which is about making things. Practical wisdom is about forming an opinion about what is good and bad in life, and mistakes in judgments about life cannot be judged the same way as acknowledgment of mistakes in the making of things (art). While it might be praiseworthy for the maker of a thing to be critical about the outcome of his or her work, it cannot be praiseworthy to err about judgments related to the good and bad in life. Practical wisdom is gained by experience. In deliberating, the practically wise person not only takes cognisance of the universals, but moreover also of the particulars within a situation, and this is the reason why this type of knowledge is practical in nature. Deliberation is not inquiry into scientific knowledge, neither is it skill, such as making a thing. Excellence in deliberation refers to correct thinking and reasoning that bring about true understanding. Understanding means the ability to judge soundly what others say about those things with which practical wisdom concerns itself, i.e. the things that are "just and noble and good for man" (1143b). Sound judgment refers to the ability to differentiate correctly which actions are fair, best and suitable in a specific situation. It is however, not enough to know what is good for man, or to understand what brings about this good, or even to act in the correct way, i.e. to have practical wisdom. Practical wisdom also requires that actions derive from the right motivation, which attains fruition from a moral character. Practical wisdom therefore enables someone not only to know when to do the right thing to the right person, but also to know the right time and to have the right reasons for acting (1144a, 1144b).

3.4 Contemporary views on phronesis in nursing and in education

Practical wisdom is a combination of practical knowledge, sound judgment and thoughtful actions Fish & Coles (1998 cited in Goodfellow, 2002), and therefore is the ability to learn by using ideas, intuition and focus on the context, to see beyond the obvious and to gather understanding through interactions (Goodfellow, 2002). Flaming (2001) argues that intuition in the phronetic sense, i.e in the sense of applying both intelligence and wisdom, does not refer to unreasoned knowledge, but to educated perception or educated emotion. Flaming (2001) and McKie, Baguley, Guthrie, Jackson, Kirkpatrick, Laing, O'Brien, Taylor & Wimpenny (2012) believe that phronesis can expand the knowledge base of nursing practice because nursing's *telos* (goal) is ensuring the patients *eudaimonia*, i.e. to assist patients to achieve their own personal and holistic flourishing or happiness.

> *A nurse using phronesis deliberates about the ethically correct nursing actions (praxis) in a particular situation. These particulars are used to moderate the generalities of the situation, not vice versa. For example, research is needed to understand the generalities of a disease process or an emotional reaction to death, but the "phronetic" nurse will then deliberate how to use the findings in the particular situation* (Flaming, 2001: 255).

As a kind of knowledge, phronesis requires moral agency, judgment ability and focus on relationships with insightfulness of real particulars in a situation while mediating the particulars with universal principles. Phronesis requires the ability to identify and apply the relevant principles, norms and values within a particular context, without expecting the application of these action guides to be the same in all situations. Practical wisdom needs the moral person to apply action guides in seeking what is good for the self and others by deliberating with the self and others, within a particular situation. Practical wisdom is not merely the objective application of rules and principles, it is mindful interaction between acceptable values and norms and the question/s in a particular situation. According to Van Niekerk &

Nortjé (2011: 13, 14) deliberation, as a tool of practical wisdom, is "the careful weighing up of the claim of the norms against the requirement of the situation – bearing in mind, especially, the consequences our deeds will have". Considering the values and norms prescribed in the ethical codes of nursing and application of these values in nursing practice, the nurse needs to identify the applicable norm/s, but not blindly apply the norms to all nursing situations. It is important for the nurse to consider the requirements of the specific situation in the application of the rule. This means that rules are not blueprints for nursing actions, but are guides that are balanced against the specifics in a particular context. Moreover as a virtuous nurse due consideration should be given to the motive of decisions and actions, the state of mind that motivates a chosen action. Both right motive and right action is required in a virtuous act. For example, confidentiality of patient information as an important obligation to patients might not be appropriate if the situation requires breaching of patient information in an effort to protect a third party. Breaching of confidentiality might be justified because of the requirement of the situation (for instance notifying a partner who might be infected with HIV). The reason of informing the partner should however be a genuine desire to deliver the good. Breaching confidentiality does however not nullify the general obligation of nurses to observe confidentiality of patient information.

While both techne and phronesis are required in nursing practice, phronesis is not primarily focused on a means–end rationality, but is a lived, open, responsive, relational and allowing process in nursing practice (Benner, 2000). Woods (1999) cites Nussbaum (1986) and supports the idea that addressing moral problems in nursing requires personal involvement and intuition of nurses. Nurses' experiences contain rich reflective interpretation and practical wisdom, which contribute to learning when it is shared with others in nursing practice (Woods, 1999). In his explication of Aristotle's phronesis, Trowbridge (2005) views the *phronimos* (the person with practical wisdom) as someone with the ability to practice moral excellence by recognising the best choice and course of action in a specific situation. Morally excellent choice and action are attained by deliberation of that which is "the best humanly

attainable good" (Trowbridge, 2005: 25). The nature of phronesis, as a kind of knowledge, is characterised by its variability, particularity and perceptiveness, which are attained by a process of deliberation (Kessels & Korthagen, 1996). As perceptive knowledge, practical wisdom uses rules as guides, exhibiting responsiveness to the real world and developing resourcefulness through experience (Kessels & Korthagen, 1996).

When practical wisdom is the aim of nursing ethics education, teaching-learning strategies and methodologies cannot focus on which actions are right (or wrong) in nursing practice, but rather to be, or to become, ethical nurses who are able to determine which nursing actions contribute to the thriving of patients (Sellman, 2009). In a particular context it might be more beneficial not to resuscitate a patient, honouring the patient's wishes, than to save a life which is a fundamental value in the nursing profession. Woods (1999) believes that nursing ethics educators ought to facilitate the teaching-learning that enables students to challenge traditional approaches in moral decision-making, to keep nursing ethics relevant, contextual and relational. Challenging the system within which nursing care takes place may also be necessary even if idealistic (Woods, 1999). Being a good nurse requires the application of theoretical knowledge in facilitating sound judgment and appropriate actions, and teaching-learning facilitates the development of moral character (Begley, 2006). Nursing ethics educators assist students to firstly determine their unreflective and natural inclination/desire about a situation, and then reflect on what they are expected to do in the specific situation, this process might facilitate practical wisdom beyond attainment of knowledge alone. Practical wisdom assist students to solve ethical problems relevant to a particular issue they identify (Gibbs, Costley, Armsby & Trakakis 2007). Wivestad (2008) describes education as a venture of which the outcomes cannot always be calculated. It is a process where love, trust and openness are required (Gibbs et al., 2007; Wivestad, 2008). McPherson (2005), in his discussion of Dreyfus' account of the seven stages of learning, argues that attainment of practical wisdom, as the seventh stage of learning going beyond expertise and mastery (stages five and six

respectively), is the ability of learners (and educators) to understand relevant features of particular situations or people, shown in practices and morally skilled perceptions (McPherson, 2005). Learning practical wisdom requires both intra- and interpersonal human processes in an effort to live well with and accepting one another, to maintain just relationships, to shape situations and to allow situations to shape us. It pervades all learning and binds together both justice and reason and requires learners (and educators) to recognise, share and incorporate moral virtues by accepting the responsibility to do so (Goodfellow, 2002; McPherson, 2005). According to Van Niekerk (2008), phronesis is one of three central concepts in an ethic of responsibility. An ethic of responsibility allows moral judgments and decisions, using a variety of approaches and sources (personal and societal) that are relevant in a particular situation. People accept responsibility and accountability for the integrity of moral decisions and actions and attempt to reach such decisions by applying considered moral approaches through a process of deliberation (Van Niekerk, 2008).

The phronetic agent (Carnevale, 2007) is a person who creatively understands the meaningful particularities of a situation, unconstrained by previous prescriptions. This agent has the ability to "perceive how contextual particularities help to determine the forms of conduct that can be considered good under specific circumstances" (Carnevale, 2007: 576). Kristjánsson (2005) argues that Aristotle's conception of phronesis is not restricting the *phronimos* in relying on universal moral truths or rationality in seeking situational answers. In the practice of nursing, practical wisdom refers to the process of moral reasoning that enables nurses to establish the "good" of a particular situation (Connor, 2004). Reference to the particulars in situations is not a particularistic approach in determining the good, and therefore educators utilize all necessary teaching-learning methods and relevant theory (moral, psychological or educational) in teaching-learning (Kristjánsson, 2005).

Ethics is about what people ought to do; teaching ethics is about educators influencing both the hearts and the minds of learners. Nursing ethics education relies on exemplary nursing practitioners and clinical teachers (Begley, 2006). Role modelling in nursing goes beyond modelling expected behavior; it entails nurse educator openness for discussion and critical reflection on ethical judgments and actions. This means that the educator/mentor and the student deliberate all aspects, including the motivation, for decisions (Begley, 2006).

For Higgins (2001), education is not so much about facilitating the learner to do something well (Aristotle's conception of *techne*), but about educators who facilitate the realisation of the good of a particular idea. This requires not only using flexible teaching-learning strategies and methodologies, but also developing practical wisdom about the aims of teaching-learning (Higgins, 2001). Phronesis assist educators to find the right time, place and way to educate (Wivestad, 2008).

Phronesis, according to McKie et al. (2012), is a practical knowledge, which offers to nursing education a complementary approach in the teaching-learning of nursing students and the development of nursing curricula by nurse educators. Practical wisdom enables nurse practitioners to reflect upon the nature of nursing and nursing practice situations without having a specific goal in mind, but by an approach that focuses on the "significant dynamic of reflexivity within a particular context and emphasising change, contingency, uniqueness and participation" (McKie et al., 2012: 258).

Differing views exist on whether virtues can be taught or whether education produces moral conduct. Pellegrino (1989 cited in Begley, 2006) argues that no education can with certainty close the gap between knowing about what is right and doing it, while Begley (2006: 259) makes an important inference that if practical wisdom is meant to be a type of knowledge, then certainly practical wisdom can be taught.

McKie et al. (2012) identify the scientific, planned and systematic system of nursing program organisation, the traditional distinction between academic support and pastoral support to students and the fragmentation of students' learning experiences as aspects which might be addressed adequately when a wisdom approach is used in nursing ethics education (McKie et al., 2012).

Teaching-learning practical wisdom assist students to access their perceptions about nursing actions. Awareness of their perceptions is related to their emotions and therefore teaching-learning attempts to influence students' emotions and their ethical awareness (Begley, 2006). As a teaching-learning method, readings about people's life stories or case studies can present students with dilemmas in particular situations. By asking the right questions, educators can assist students to move from awareness to giving meaningful attention and then to recognition of what is happening to particular people in specific contexts and what the right actions ought to be in such situations (Begley, 2006). Nursing ethics educators focus their teaching-learning on assisting students to grow and cultivate wisdom by guiding students to recognise tacit knowledge, question assumptions, frame results of possible decisions and actions in a wider context and to assist students to reflect and voice not only what they think, but also what they feel (McKie et al., 2012).

3.5 Commentary

It is clear from Aristotle's writing in the Nicomachean ethics that while episteme is about the unchangeable, variable and universal things, and phronesis is about the changeable and the variable within a specific context, the wise person does not deliberate from a vacuum, but may utilise universal principles in reasoning about the good in life. In addition, creating things (techne) is based on the reasoning of the creator. A high premium is placed on practical wisdom in Aristotle's writings about intellectual virtues. While experiential scientific knowledge might be proved fallacious, it still embodies scientific knowledge. When art is critiqued, it still stays art, but a person who makes mistakes in

deliberating about the good of life, or about what would constitute good actions in particular situations, cannot be called wise.

Routine nursing tasks are driven by scientific knowledge, and creative nursing intervention might be analogous to art. While both routine tasks and creative efforts are commendable in nursing practice, the practically wise nurse cannot be restricted to these actions. Routine nursing practice creates the danger that individual assessment of the needs of patient might be overlooked. Practical wisdom requires assessment and reflection on the particular context of the nursing care situation, considering the context of the patient (holistically), constantly communicating with the patient (or family, community, society), allowing the situation to unfold, being open, but conscious of nursing values and ethical principles applicable to the context, and being able to judge and justify professionally what is right and reasonable in the situation. Practical wisdom requires of nurse practitioners to safely push the boundaries of conventional nursing practice with collaborative consideration of what may bring about the good for patients.

Teaching-learning strategies and methodologies that enable students to come into contact with meaningful moral situations where students can reflect on their intuition about a situation assist in deliberating about their initial thoughts and how these thoughts compare to those of patients, educators and fellow students. Educators guide students to seek answers beyond their initial responses. This requires of educators to ask meaningful questions to allow students to reflect on the context and the moral requirements of the context. Learning outcomes for such teaching-learning is not primarily about the internalisation or describing of moral values, but about the process in which the student engages. Assessment of student progress is not necessarily about the best outcome or answer to a problematic, or even an ordinary nursing care situation but about the students' ability to be open and

responsive to others, to form relationships, communicate well and the ability to perceive what is the best course of action in the particular situation.

The approach of practical wisdom in nursing ethics education might be challenged by the fragmented structure in undergraduate nursing programs, large student numbers and resistance from nursing ethics educators who are more comfortable with conventional teaching-learning methods and conventional student assessment methods.

Practical wisdom requires constant student–educator engagement focusing on the facilitation of practical wisdom. Practical wisdom is acquired by experience and habitation, therefore the integration of this approach in all modules of the undergraduate nursing programs will be imperative for its success. Educators are responsible for the development of curricula in their respective specialties/modules and have little say about the learning outcomes and teaching-learning methods in other modules, which may impede the implementation of practical wisdom as an approach in nursing programs.

The facilitation of practical wisdom in teaching-learning in undergraduate nursing ethics education in participating institutions will be assessed in Chapter 6 of the study. The next chapter will present and appraise the current status of nursing ethics education in South Africa and Namibia based on the empirical information obtained in this study.

CHAPTER FOUR

THE STATUS OF UNDERGRADUATE NURSING ETHICS EDUCATION IN SOUTH AFRICA AND NAMIBIA

4.1 Introduction

Ethical nursing practice requires a person who has acquired the character traits and virtues of a caring person. A moral person, according to Aristotle, considers the context within which decisions are taken, engages in deliberation and chooses rationally to act neither deficiently nor excessively, but moderately in moral actions. Determining the status of undergraduate nursing ethics education in South Africa and Namibia can provide some insight of the efforts by educational institutions and ethics educators in preparing student nurses to attain moral and intellectual competencies in nursing ethics.

Nursing as a profession exists because the need exists for others to be cared for in circumstances where they are unable to care for themselves. The central focus of nursing is to care. A basic principle that guides the practice of caregivers generally is that a human being in suffering is sacred (Searle, 2004). This principle is specifically inherent in the tradition of the nursing profession. The philosophy of nursing is founded on values of caring such as compassion, commitment, conscience, confidence and competence (Searle, 1995). It is therefore imperative that undergraduate nursing students be introduced to the belief system inherent in the nursing profession generally and that nursing ethics education specifically prepares student nurses to face the many ethical challenges in nursing practice by not only applying the principles and values on which nursing is founded, but also to practice nursing with care and forethought.

Adding to the philosophical foundation of nursing, the healthcare demands of society and legal prescription by regulatory authorities also dictate the educational needs of nurses and guide curriculum development by tertiary institutions offering undergraduate nursing ethics education. The legislature is responsible for ensuring the greater public good through promulgation of statutes and the common law

processes (Searle, et al, 2009). Tertiary educational institutions take cognisance of such prescriptions and developments and respond by developing relevant curricula in institutions of higher learning. The goals of nursing ethics education facilitate attainment of the ethical competencies that satisfy the healthcare service demands and also create opportunities for the individual nurse to internalise the virtues valued by the nursing profession. Botes (1999) argues that nurses are required to possess certain character traits or virtues to sustain moral conduct. Nursing ethics education needs rational interaction for moral sensitivity by application of teaching-learning strategies that assist students to be aware of moral requirements and base nursing actions on such awareness (Botes, 1999). It is argued that the virtues necessary to ensure moral conduct be emphasised and integrated in all nursing content (Tschudin, 2010). There is more to nursing ethics education than simply teaching the application of ethical principles and moral rules to nursing practice. Ethics education for nurses need to move beyond western principlism to an ethic of care that takes cognisance of the context within which nursing takes place (Tschudin 2010).

Nursing ethics education is expected to keep up with both national and international developments relevant to the practice of nursing because Namibian and South African nurses seek employment opportunities in other countries for a variety of reasons (Oosthuizen & Ehlers 2007). Professional migration as an element of globalisation often exposes the migrating nurse to developed healthcare systems with advanced medical technologies and bioethical problems unknown to Namibian and South African nurses. Nursing ethics education requires facilitation of competencies that enable nurses to practice in different cultural environments and be sensitive to belief constructs that differ from their own (Pera & Van Tonder, 2005). Migration of nurses to overseas countries also depletes the healthcare services of experienced mentors to guide newly qualified nurses in clinical practice settings and creates a void in the transference of nursing's traditional value system (Jooste 2010).

An assessment of the current status of nursing ethics education in South Africa and Namibia could shed light on the current concerns about nursing education in South Africa (Republic of South Africa, 2011) and Namibia. The assessment of the current status of undergraduate nursing ethics education in South Africa and Namibia was conducted by an open- and close-ended questionnaire addressing experienced nursing ethics educators in identified South African and Namibian educational institutions offering accredited undergraduate nursing education programs.

The following objective of this study is addressed in this chapter:

- Describing the status of undergraduate nursing ethics education in selected institutions in South Africa and Namibia

4.2 Methodology

Information regarding the status of nursing ethics education was obtained through a survey of institutions in South Africa and Namibia offering undergraduate nursing education programs. A survey could provide a broad overview of how nursing ethics education is offered and managed in undergraduate nursing education programs and allowed for comparison of nursing ethics education between participating institutions in South Africa and Namibia. The survey could however not provide in depth information on the challenges in nursing ethics education and therefore the survey questionnaire was followed by individual face-to-face interviews of respondents who completed the survey questionnaire. The individual interviews explored the challenges in nursing ethics education and issues which was not fully explored by the questionnaires. The face-to-face interviews also provide for triangulation of data obtained and contributed to the reliability of the data.

The heads of nursing schools were requested to identify nursing ethics educators who are currently teaching nursing ethics and those who previously taught nursing ethics education at their institutions.

Educators who teach nursing ethics presently or in the past would be best suited to provide information on the status and challenges in nursing ethics education in South Africa and Namibia. Educators who never taught nursing ethics would not be able to provide the information related to nursing ethics education and were excluded from the study. The nursing ethics educators identified by heads of nursing schools were included in the study and are referred to as experienced nursing ethics educators throughout this study. Not all the universities contacted provided contact information of ethics educators and after numerous electronic and telephonic contact, the candidate accepted that those institutions will not be part of the study. The details provided by the heads of nursing schools enabled the researcher to contact the respondents to request whether they were willing to receive the questionnaire that contained all the necessary information for respondents to make an informed decision about their participant in the study. Completion of the questionnaire implied consent of respondents to participate in the study and all these educators were included in the study. All distributed questionnaire were received back from the respondents. The researcher fulfilled all the ethical obligations set forward by the ethical committee of the University of Stellenbosch upon application of ethical clearance for the study. All respondents provided voluntary informed consent. Confidentiality of data was assured in the event of publication. The questionnaire was developed and submitted to the main supervisor of the study and was discussed with an experience nursing educator in Namibia for content and construct validity. The questionnaire was also piloted by two of the respondents. Minor changes were effected after the piloting of the questionnaire and these two respondents were excluded from the main study as well as the interviews.

The final questionnaire consisting of closed and open-ended questions was e-mailed to the identified ethics educators in tertiary educational institutions in South Africa and Namibia in August 2009 and all questionnaires were received back by January 2010. The candidate conducted the face-to face interviews during November 2010. The individual interviews explored the current challenges in nursing

ethics education (cf. chapter five). The use of both the survey and individual interviews is referred to as methodological triangulation by Burns & Grove (2005). Triangulation of data enabled the doctoral candidate to obtain more comprehensive knowledge and information on nursing ethics education in South Africa and Namibia (Farquhar, Ewing & Booth, 2011). The data collected by the questionnaire relevant to the status of undergraduate nursing ethics education in South Africa and Namibia will be presented in this chapter. The data gathered regarding the challenges in nursing ethics education, the way these challenges can be addressed and the way nursing ethics education can facilitate the internalisation of nursing values in students through the questionnaire and individual interviews will be presented in Chapter 5.

Close-ended questions in the questionnaire gathered data on:

- biographical data of respondents;
- the level and structure of ethics education modules at institutions;
- the attachment of a clinical component in nursing ethics education; and
- the change in teaching-learning strategies and methodologies at institutions.

Open-ended questions in the questionnaire gathered data on:

- educator selection in teaching nursing ethics;
- curriculum content;
- clinical guidance of students in nursing ethics education; and
- teaching-learning methodologies in nursing ethics education.

The development of the questionnaire was guided by the researcher's teaching experience on the teaching-learning of nursing ethics education and the current challenges in nursing ethics education and an extensive literature review.

4.3 Population and sample

There are 13 Universities approved by the South African Nursing Council (SANC) to offer undergraduate nursing education in South Africa. They are located within seven of the nine provinces in South Africa. Nine universities whose contact details were available on their respective webpages were contacted and the deans/heads were requested to identify current and past nursing ethics educators to participate in the study, as well as to provide information on the nursing colleges affiliated to them. Various efforts were made telephonically and electronically to elicit participation in the study in South Africa. Nursing colleges required permission from provincial managers to participate in the study. After various efforts to obtain access to provincial managers, for obtaining consent for colleges to participate in the study, it became evident that the process of obtaining consent from provincial managers would be a significant challenge to data collection. Finally, the researcher had to be satisfied with a convenience sample of six of 13 universities (46%) and one affiliated nursing college in six regions in South Africa who participated in the study, together with the only institution in Namibia (see table 4.1) In Namibia, the information and questionnaire were forwarded to the identified nursing ethics educators at the tertiary institution offering undergraduate nursing education. Two respondents from the Windhoek campus and one respondent from the Oshakati campus participated in the study. A total of 14 respondents completed the questionnaire. Throughout this study those educators identified by nursing heads of tertiary institutions with the necessary experience in nursing ethics education, are referred to as experienced nursing ethics educators.

Table 4.1: Participating institutions and respondents in South Africa and Namibia

Institution	Number of Respondents Questionnaire	Respondent number – interviews (cf. chapter five)
South Africa		
A (University)	1	R1
B (College)	2	R2
C (University)	1	R3
D (University)	2	R4
E (University)	1	R5
F (University	2	R6
G (University)	2	R7
Namibia		
H (University)	3	R8, R9, R10
Total : 8	14	10

Complete information regarding the study, including the consent process and the questionnaire was attached to the request for participation. Respondents completed the questionnaire voluntarily and returned it to the researcher. The returned questionnaire was taken as implied consent from respondents to participate in the study. Fourteen respondents from seven institutions in South Africa and one institution from Namibia were purposively sampled and participated in the study.

4.4 Data analysis

The data gathered by the close-ended questions in the questionnaire was captured using a Microsoft Excel spread sheet and analysed by a statistician using Statistica, version 9 for descriptive statistics for discrete data. Histograms were selected to illustrate the current status of nursing and nursing ethics education in South Africa and Namibia. The respondents' answers to the open ended questions was summarized and analysed qualitatively together with the transcribed data of the individual interviews. The data on the challenges in nursing ethics education, as viewed by respondents during the individual interviews, will be described in Chapter 5.

4.5 Results of questionnaire data

The information provided by respondents emerged from three sections of the questionnaire, namely demographic data of respondents; the current status of theoretical and practical nursing ethics education and value education.

4.5.1 Biographical data of respondents

Respondents provided data on their age, gender, experience in nursing education and their experience in nursing ethics education. This data is presented in the figures that follow.

4.5.1.1 Age of respondents

Of the 14 respondents who completed the questionnaire, 11 were in the range 50–59 years. There was one respondent in each of the other age groups.

Table 4.2: Age of respondents

Age	Number of respondents	%
30-39	1	7.1429
40-49	1	7.1429
50-59	11	78.5714
60+	1	7.1429
Total	14	100

4.5.1.2 Gender of respondents

All the respondents in the study were female.

4.5.1.3 Nursing education teaching experience of respondents

Eight of the respondents had more than 20 years' teaching experience in nursing education. Of the other participants, three had between 15 and 19 years' teaching experience, one had between 10 and 14 years' teaching experience, while two of respondents had less than five years' teaching experience.

Table 4.3: Teaching experience of respondents

Years teaching experience in nursing education	Number of respondents	%
<5	2	14.2857
10-14	1	07.1429
15-19	3	21.4286
20+	8	57.1429
Total	14	100

4.5.1.4 Nursing ethics teaching experience of respondents

Of the respondents, five had less than 5 years' experience in the teaching of nursing ethics, while a further five respondents had between five and ten years' experience in teaching nursing ethics. This means that ten respondents had 10 years' or less experience in teaching nursing ethics. Of the respondents, two had between 16 and 20 years' teaching experience in nursing ethics, while another two had 21 years' or more teaching experience in nursing ethics.

Table 4.4: Experience in teaching nursing ethics

Years teaching experience in nursing ethics education	Number of respondents	%
<5	5	35.7143
5-10	5	35.7143
16-20	2	14.2857
21+	2	14.2857
Total	14	100

Commentary on biographical data of respondents

Most of the respondents (12/14) were 50 years or older and eleven respondents have more than 15 years' experience in nursing education, while four of the respondents have 16 years and more experience in nursing ethics education. It is difficult to conclude any significance regarding the influence of age of respondents and their experience in nursing education or nursing ethics education experience, especially in the small sample in this study. Nevertheless, respondents 'experience in nursing education generally may have advantage also for nursing ethics education, because it is expected that experience and skills attainment in teaching-learning correspond.

The views of younger nursing educators are not well represented in the sample as only one of the sample was aged between 30-39 years. This may not represent the age of educators at the population level.

All 14 respondents who participated in the study were female. In South Africa, the male representation in the nursing profession for 2009 was 17 115, while there were 204 702 females. Male representation in the nursing profession is therefore 7,7% (SANC web page). In Namibia, there are 1 287 male nurses and 7 081 female nurses, i.e. male representation in Namibia is 15% (personal communication with the Nursing Council of Namibia). It is a limitation of the study that only female respondents participated in the study, because male ethics educators might have contributed different perspectives on nursing

ethics education in South Africa and Namibia. The exclusively female participation in the study poses the question why male nursing educators are not involved in ethics education in participating institutions and why this is the case? On the other hand the exclusive participation of female respondents may be due to the small cohort of respondents who participated in the study.

While eleven respondents at participating institutions had more than 15 years' experience in nursing education, only four respondents have been teaching nursing ethics for more than 16 years. Respondents indicated that the teaching of nursing ethics is not always voluntary and that it is sometimes part of other modules, which are assigned to lecturers. The difference between nursing teaching experience generally and teaching nursing ethics experience specifically might also indicate that educators prefer to teach nursing ethics or are assigned nursing ethics training after they have accumulated some teaching experience in nursing. Further research is however necessary to verify this assumption.

4.5.2 The level and structure of nursing ethics education courses

Data on the level and structure of ethics education courses include information on whether nursing ethics is offered separately or integrated; as semester or year modules; the time spent per week on nursing ethics education; in which academic year nursing ethics is offered and the attachment of a clinical component to nursing ethics education.

4.5.2.1 Offering of nursing ethics in undergraduate nursing education programs

Of the training institutions surveyed, six indicated that their institutions offer nursing ethics education at degree level, one offered diploma undergraduate nursing ethics education, while one offered both degree and diploma nursing ethics education in their undergraduate nursing education programs.

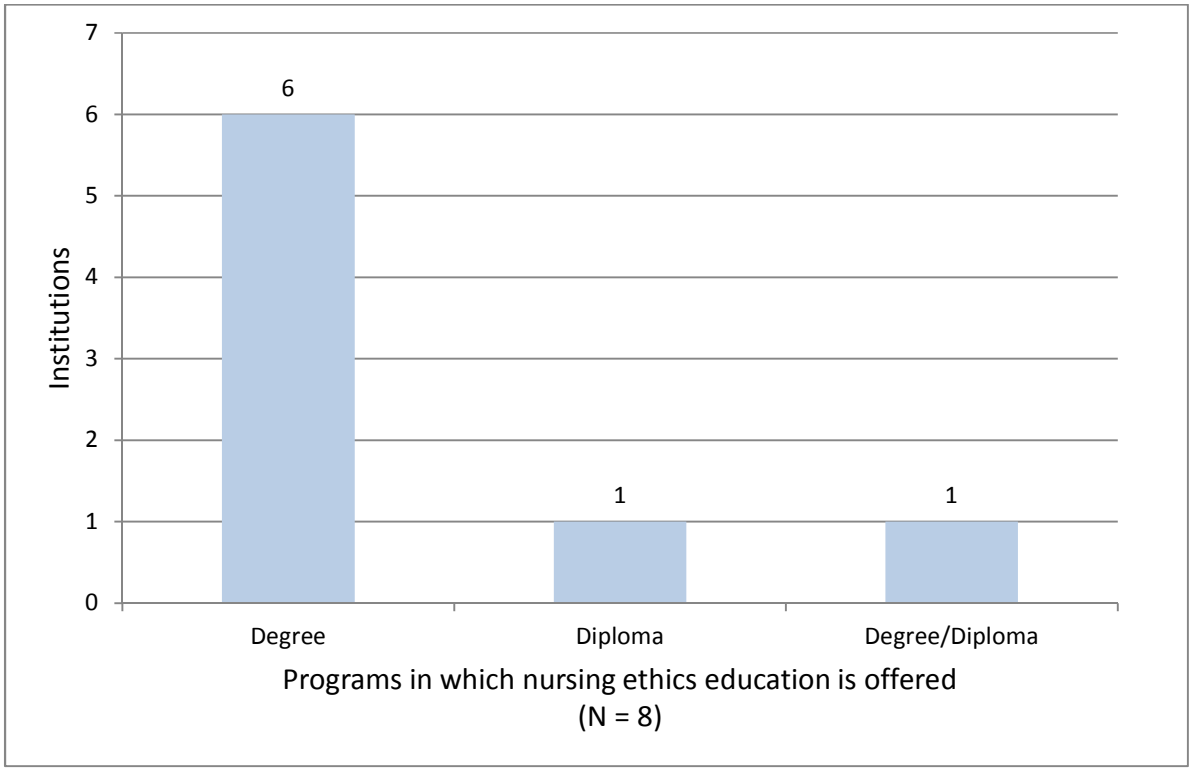

Figure 4.1 Programs in which nursing ethics education is offered

4.5.2.2 Separate or integrated mode of offering

Five respondents indicated that nursing ethics education is offered as a separate module at their institutions. Nine respondents indicated that nursing ethics education is not offered as a separate module, which means that nursing ethics content is integrated throughout the undergraduate nursing program.

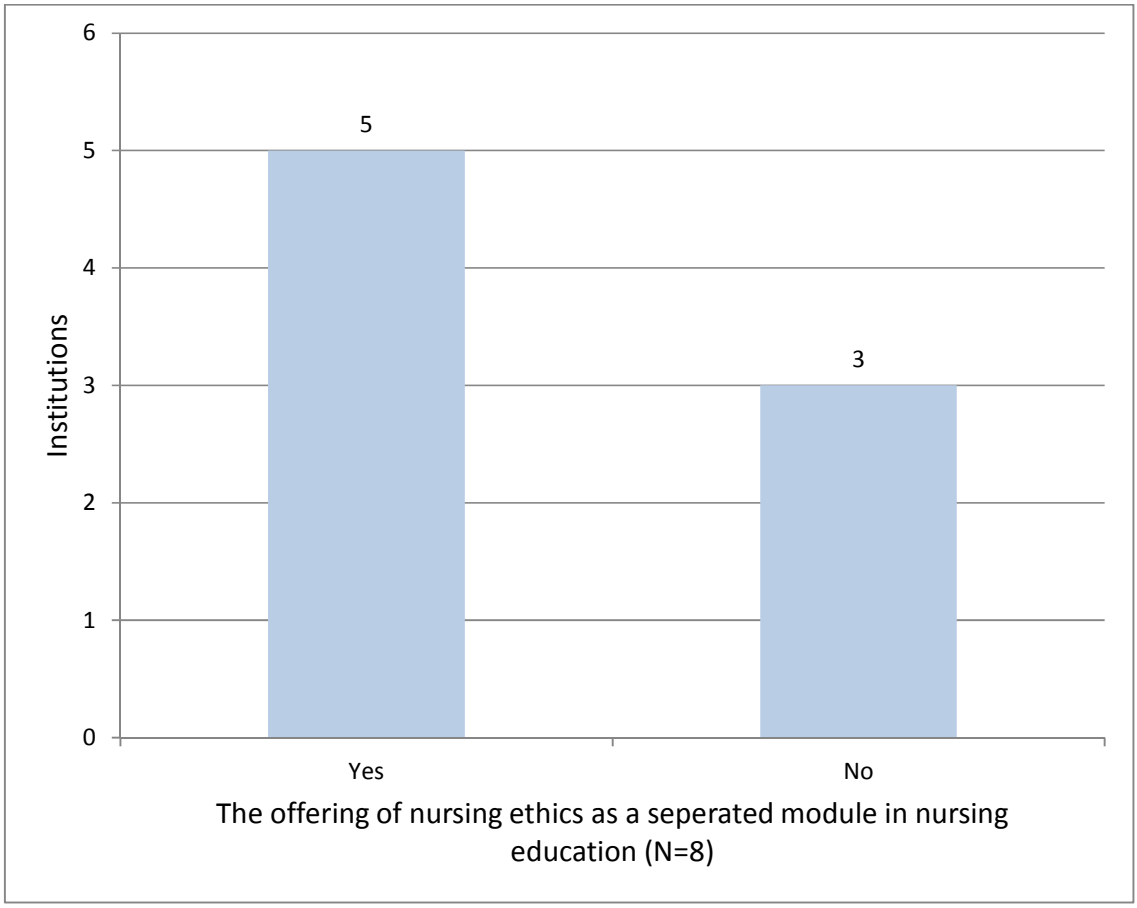

Figure 4.2 **Separated mode of offering of nursing ethics education modules**

4.5.2.3 Semester, year or other mode of offering

Two institutions offer nursing ethics education as a semester module, while three institutions offer a year module. Five institutions offer nursing ethics education by other means, specifying integration in a variety of courses, such as Nursing Management, Psychiatry, Midwifery Science, General Nursing Science or that it is generally incorporated throughout the undergraduate nursing program.

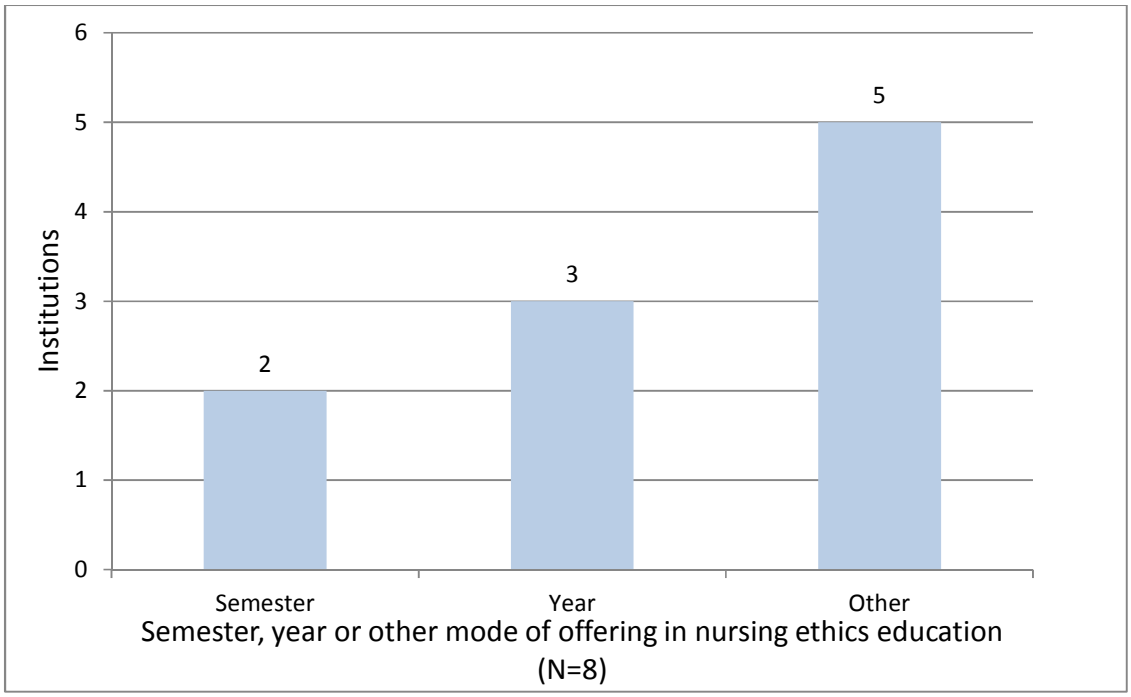

Figure 4.3 Semester, year or other mode of offering of nursing ethics education modules

4.5.2.4 Time allocated per week to nursing ethics education

The hours per week allotted to nursing ethics education are indicated as two hours per week by two institutions or four hours per week by three institutions. Those institutions allotting other hours per week were five and respondents from these institutions specified the following about nursing ethics education:

- it is included in the program where appropriate;
- it is included in all modules, but students do one term, in other words three hours per week for seven weeks;
- two hours per week for three weeks are allotted to complete a case study;
- twenty hours spread throughout the first study year and reinforced (integrated) throughout the four-year undergraduate program;
- four hours in total during the Nursing Management module, four hours in the first academic year. Nursing ethics is assessed in General Nursing Science, and all the courses in the second, third and four study years (integrated); and
- one respondent was not sure of the allotted hours per week.

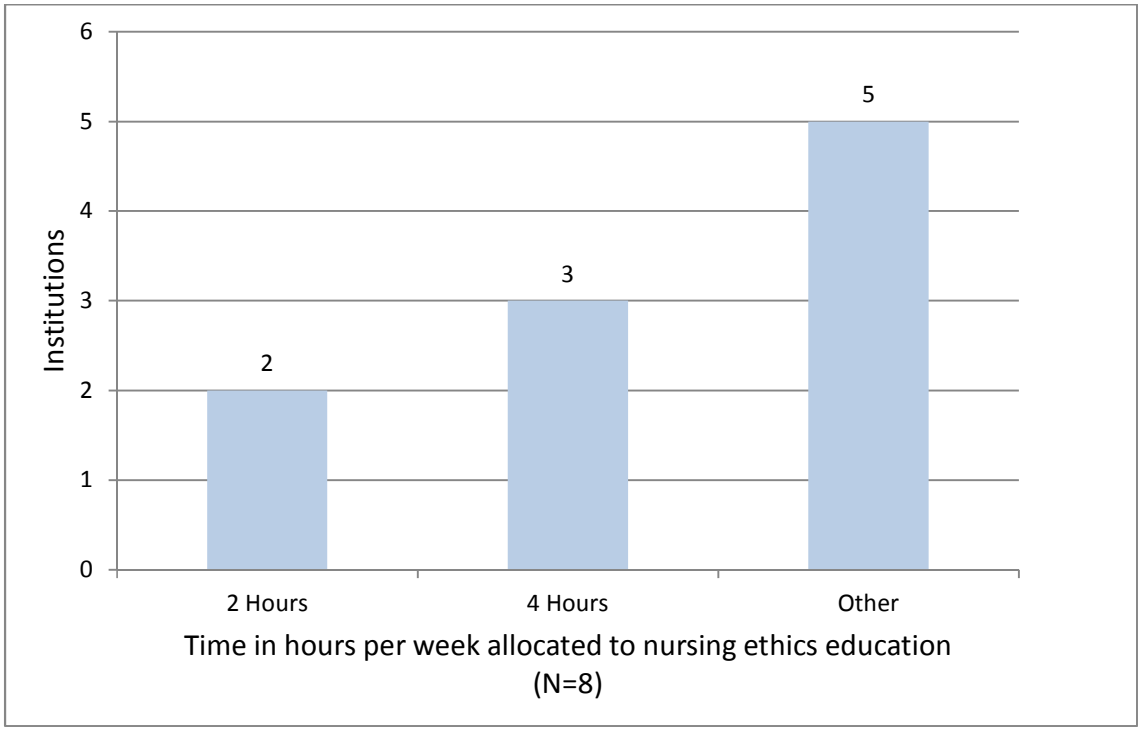

Figure 4.4 Allocation of time per week to nursing ethics education

4.5.2.5 Academic year in which nursing ethics is offered

One institution offers nursing ethics in year one, two and three of the undergraduate nursing program, while two institutions offer nursing ethics education in year four of the program. Five institutions indicated that nursing ethics education is offered in an integrated way.

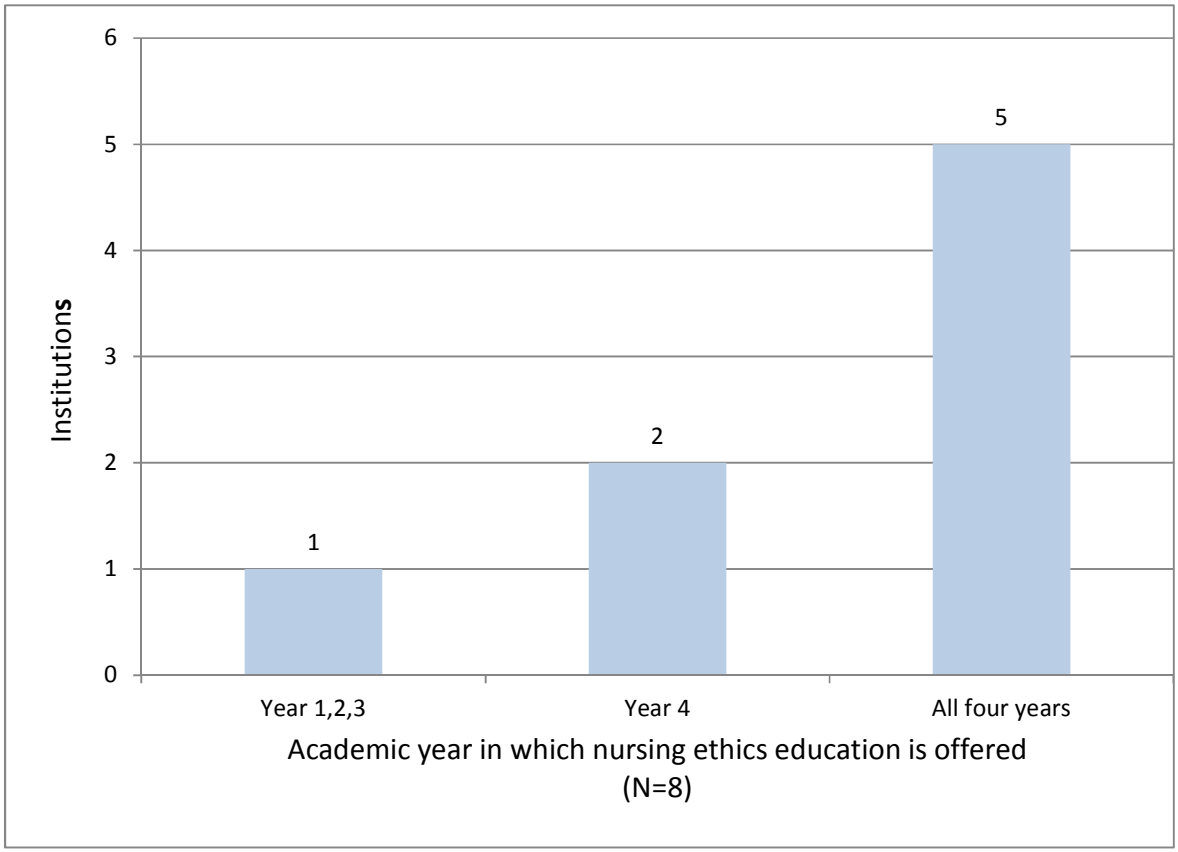

Figure 4.5 Academic year in which nursing ethics education is offered

4.5.2.6 Attachment of clinical practice component in nursing ethics education

Three institutions have an attached clinical component for nursing ethics while five institutions do not have an attached clinical component to nursing ethics education modules.

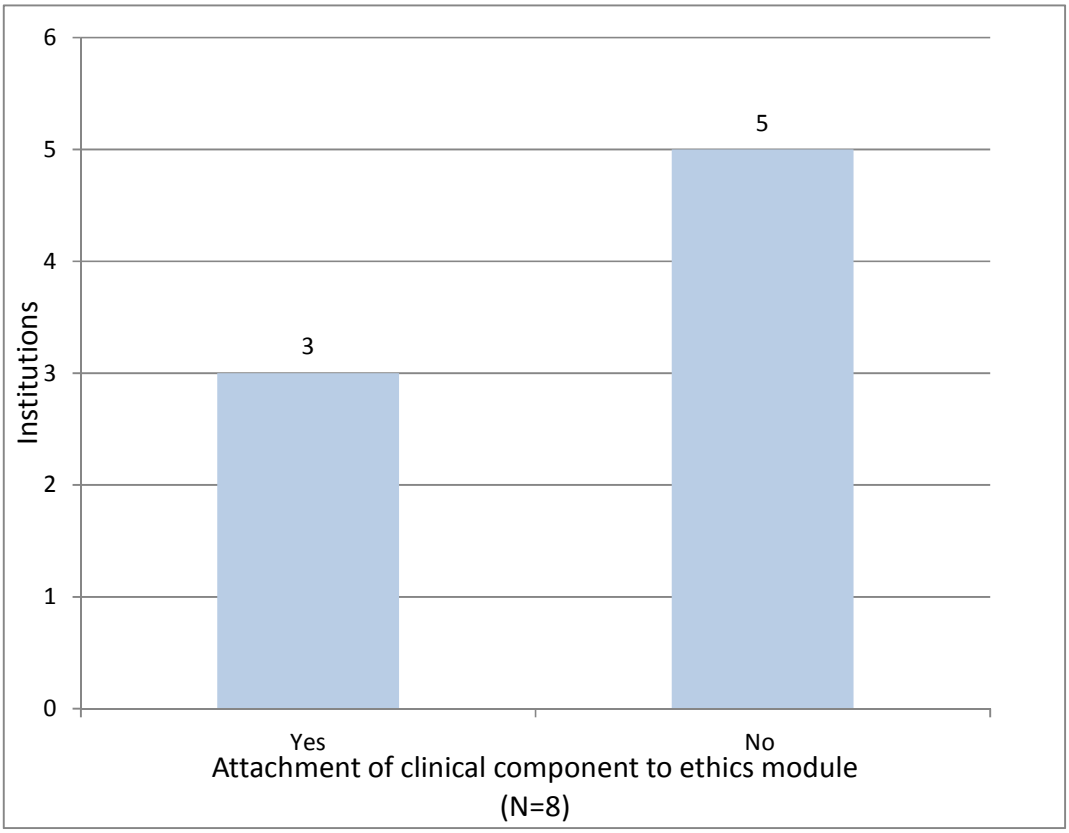

Figure 4.6 Attachment of clinical practice component in nursing ethics education

4.5.3 Change in teaching-learning methods at institutions

Respondents indicated whether it is important that teaching-learning strategies and methodologies in nursing ethics education change and how difficult this change might be. Respondents also indicated ways in which teaching-learning strategies and methodologies and other factors could change in nursing ethics education.

4.5.3.1 Importance of changing teaching-learning methods in nursing ethics education

Of the respondents, seven indicated that it is vitally important that the teaching-learning methods in nursing ethics education change. Of the other respondents, three thought it was very important, while a further three indicated it was fairly important to change the teaching-learning methods in nursing ethics education. One respondent did not indicate the importance of changing teaching-learning methods.

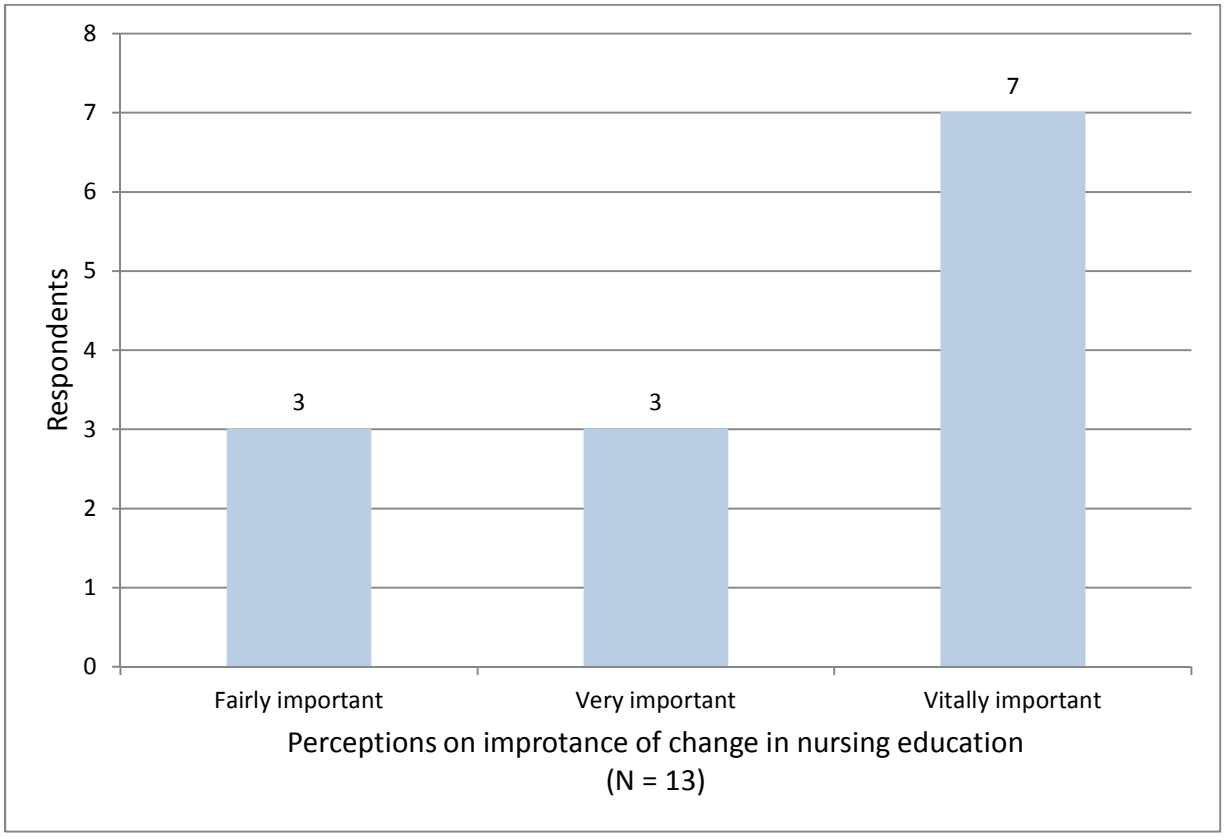

Figure 4.7 **Perceptions on importance of changing teaching-learning methods in nursing ethics education**

4.5.3.2 Possibility of changing teaching-learning methods in nursing ethics education

One respondent thought it might be very difficult to change teaching-learning strategies in nursing ethics education. Conversely, three respondents indicated that it might be difficult, while six thought it might be slightly difficult. Of the respondents, two respondents were of the opinion that there might be no difficulty in changing teaching-learning methods in nursing ethics education. Two respondents did not answer this question.

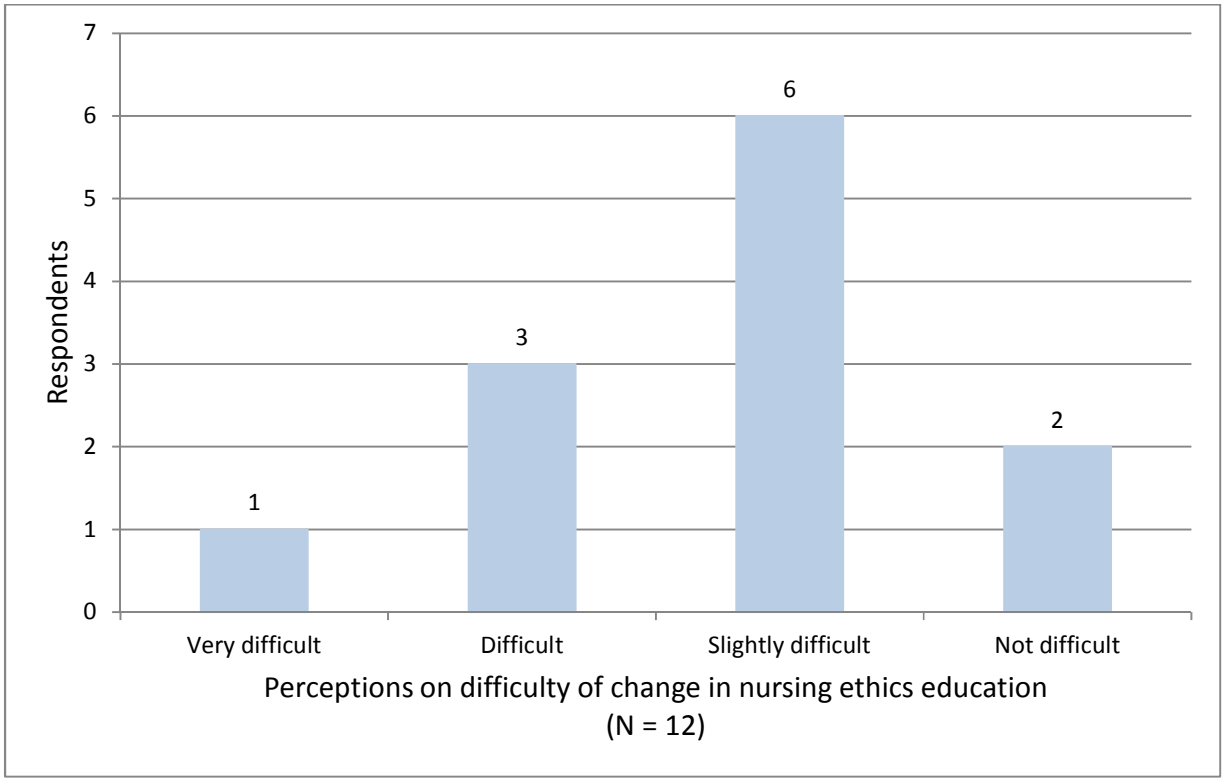

Figure 4.8 Perceptions on difficulty of changing teaching-learning methods in nursing ethics education

While respondents agreed that it is important to change teaching-learning strategies in nursing ethics education, ten respondents also indicated that it might be difficult to change the teaching-learning

strategies if other priorities in the curriculum are considered. One respondent indicated that it might not be teaching-learning strategy/methodology, but the content and practice that need to change. This respondent argued that students want to make a difference, but they are challenged in clinical settings if they want to do anything positive. The respondent reasoned that the solution might lie in nursing educators supporting students to cope in negative clinical settings.

The following quotes illustrate this:

> *"They [students] want to make a difference, but in practice they are shot down and hammered if they do anything positive."*

> *"We [educators] have to teach the kids how to cope with all the negative stuff they see and how to cope with saying NO and how to deal with all the pressure from these older 'bad' nurses."*

4.5.3.3 Ways in which teaching-learning strategies in nursing education could change

Respondents indicated that teaching-learning methods above could not improve nursing ethics education, but mentioned other factors, as will be discussed below.

(a) Teaching-learning methods

Suggestions made by respondents regarding teaching-learning methods included:

- highlighting to the neophyte the importance of internalisation of ethical behaviors;
- case scenarios/studies to guide students to recognise the ethics involved in cases;
- more emphasis to be placed on ethics;
- more incorporation/integration in all courses, as indicated by the following response:

"I do not think that teaching ethics as a separate course is useful as it becomes removed from the real situation that it affects";

- a practical basis for better understanding of the theory; and
- up-to-date reading material and updating of ethics sources.

(b) The environment

Change can be effective if all persons involved in the nursing education process are also involved in and agree on the change.. Respondents also indicated that it might be good to provide in-service training to health facility staff members in applying ethics in the workplace. The challenges facing nursing educators in health facilities will be discussed in the next chapter.

(c) The educator

Respondents suggested that nursing ethics educators should change their mind set and should be good role models. Nursing ethics educators also need support in further training at a higher level as indicated by the following response:

"*Develop a course for lecturers (on higher level), let all get a more or less similar idea what ethics is about and how to practice it, to empower lecturers and give them confidence in the teaching thereof."*

Commentary on level and structure of course, clinical attachment and change in teaching-learning methods

The drive to introduce university education to nurses started in the early 1960s in America (Searle, 1988). Undergraduate nursing education joined mainstream tertiary education in the mid-sixties of the 20th century in South Africa, when nursing degrees were offered at universities. In South Africa and Namibia, nursing colleges, affiliated to universities in their respective provinces in the mid-eighties of the 20th century. In Namibia, nursing education was transferred from the nursing college to the university in 1986 (Van Dyk, 1997). This development in nursing education brought nursing education to a comparable standard with other professional education at tertiary level. Nursing education still takes place in nursing colleges because of the severe shortage of nurses in both South Africa and Namibia, and the inability of the more expensive university education system to provide for the needs of nurses. In Namibia, undergraduate nursing students can obtain either a nursing degree or diploma at tertiary level. Diploma-level education enables sub-professional nurses and persons who do not meet university-degree entry requirements, to obtain a professional qualification. Degree-level training provides nurses with the opportunity to further their career to master's and doctoral level, which enhances nursing leadership and specialisation in the nursing profession.

The respondents who indicated that nursing ethics education is offered as a separate module in their undergraduate nursing program represented five institutions, while the respondents who indicated that nursing ethics education is offered in an integrated manner represented three other institutions. Evidently, institutions are autonomous and may structure their undergraduate nursing programs in various ways. Presenting nursing ethics content in a separate module has the advantage of ensuring the completion and assessment of definite ethics learning outcomes while integration of ethics content in other course outcomes might prevent the prioritisation of ethics content. On the other hand, if integration of nursing ethics content is done and assessed properly it might contribute significantly to the integrated learning and growth of students. It may be ideal to offer nursing ethics content in both integrated and as separate modules in the undergraduate nursing programs. As separate modules an

introductory module in the first year of study has the advantage that students are introduced to the norms and values of nursing as well as the important legal provisions of nursing practice. In the final study year a separate module may consolidate ethics content by preparing the student to practice as a professional person after registration with the registering authority. It is preferred to integrate nursing ethics content throughout the other years of study in all nursing modules. The advantage of integration of ethics content throughout the undergraduate program is sustaining the ethical expectation and to develop the students holistically.

Offering nursing ethics as either a semester or year course is usually indicative of the time allocated in presenting ethics content to students. A semester course is usually a half-year course while a year course runs over a full academic year. It is, however, true that the allotted hours per week determine the time spent on the presentation of nursing ethics content. Therefore, a semester and a year course may have the same number of allotted hours over an academic year if the semester course is allotted four hours per week and the year course is allotted two hours per week. More significant is the overall hours allotted to the presentation of nursing ethics education in the undergraduate nursing programs at institutions. A variety of contact hours exist in offering nursing ethics content to students at participating institutions. The indication that nursing ethics is integrated where appropriate, that it is reinforced throughout the program or presented within selected courses in the program, might not be as important as the ability of nursing ethics educators to confirm that students are presented with and assessed on specific nursing ethics learning outcomes that enable nurses to manage the ethical challenges in nursing practice. Considering the many challenges facing nurses today and the many complaints by the public about the behavior of nurses, it is important that nursing ethics education be allotted not only a significant number of hours in undergraduate nursing ethics education, but also that nursing ethics learning outcomes be assessed. Students who do not meet the learning outcomes may

need more time to master not only the cognitive, but also the affective competencies required in nursing practice.

Institutions offering nursing ethics education as separate modules indicated that it is offered in the fourth year only, or the first, second and third study years, or the first to the fourth years of study. Those institutions which integrate nursing ethics education throughout the program indicated all four study years or a combination of more than one study year in integrating the nursing ethics content. Presenting nursing ethics content in the first study year has the advantage that it lays the ethical foundation and creates the expectation of ethical conduct and competencies for nursing practice early in undergraduate nursing ethics education. Presenting nursing ethics in the fourth study year has the advantage that students are more mature, have experience of the challenges they faced in clinical practice and they might therefore be able to integrate ethical theory and practice more appropriately. More important, however, is the continuous assessment of ethical competencies attained by nursing students. An integrated approach in nursing ethics education might provide the opportunity to assess nursing ethics competencies throughout the program, and if ethical competencies are regarded as just as important as the attainment of cognitive or psycho-motor competencies.

Five institutions (5/8) offering undergraduate nursing ethics education do not have an attached clinical component for nursing ethics education. The institutions which do, indicated that it is integrated throughout the program or in selected courses in the program. According to Markie (1994), the teaching and assessment of values are problematic because the assessment of normative content is more difficult than the assessment of non-normative content. The assessment of normative values does not necessarily guarantee virtuous practice (Moodley, 2007). While the teaching and assessment of ethical competencies remain challenging it is imperative that ethical learning outcomes are valued as much as other competencies in nursing education. Undergraduate nursing programs are generally offered over a

minimum period of four and a maximum of six academic years. This provides ample time to guide, assess and support students in the attainment of ethical competencies before registration as professional practitioners. Nursing ethics educators should, however, be prepared to develop and assess appropriate ethical learning outcomes, guide students sufficiently and be brave enough not to promote students who do not display the expected ethical competencies. It will be easier for nursing ethics educators to manage, and for students to attain ethical competencies, when nursing ethics courses have an attached clinical component for the teaching-learning and assessment of nursing ethics competencies.

All respondents indicated that it is important to change teaching-learning strategies in nursing ethics education. This result indicated that respondents realised that new and innovative teaching-learning strategies should be initiated to improve the teaching-learning of nursing ethics to students. When nursing students practice in clinical settings that require internalisation of values that are fundamentally different from their own values, students experience conflict and stress. Nurse educators should recognise and manage the existence of different traditions and values of students and address this challenge by assisting students to develop an acceptable ethic of care (Caldwell, Lu & Harding, 2010). Curriculum outlines in undergraduate nursing programs of institutions participating in this study indicated that nursing ethics is still a minor course, allotted minimal time. Attainment of ethical competencies depends on appropriate and sufficient contact between student and educator. Guiding students to attain ethical competencies, such as ethical sensitivity and the character traits expected from a caring person, nursing ethics education should focus on rational interaction to attain moral sensitivity (Botes, 1999). Teaching-learning strategies therefore consider the development of learning outcomes that create and convey to students expectations of ethical competencies, it further assess ethical competencies and institute rehabilitative educational sessions for those students who face challenges in attaining the necessary competencies. While it might be difficult to assure that

professionals are virtuous practitioners, nursing educators cannot ignore the attainment of ethical competencies just because it is more challenging to assess normative learning outcomes. Educational institutions must be able to validate the attainment of cognitive, psycho-motor and affective competencies by students. Such competencies are necessary to obtain a qualification with which students can enter the market place. The validation of competencies covers both the theoretical and practical components of nursing ethics education. This is even more important for professional qualifications, such as nursing, whose practices influence the lives of people significantly. Teaching-learning methods should therefore address the attainment of ethical competencies and must take a rightful place in the development of undergraduate nursing curricula.

Attainment of ethical competencies can however not only be the responsibility of educational institutions; they also need to be a collective effort between educational institutions and the health facilities in which clinical practice takes place. Nursing educators representing educational institutions that validate the attainment of competencies by students should initiate cooperative agreements with professional nurses in clinical practice environments. These cooperative agreements should include:

- clear guidelines of the expectations on the attainment of ethical competencies by students;
- strategies/methodologies in attaining these competencies;
- the assessment of these competencies;
- the rehabilitative measure that will be taken in non-attainment of the competencies; and
- the roles and functions of educators and clinical supervisors regarding student support.

Some respondents indicated that there might be no difficulty in changing teaching-learning methods in nursing ethics education. For most nurse educators at tertiary educational institutions, it is possible to

change teaching-learning methods in the presentation of nursing ethics education in classroom and clinical settings. These changes are however not without their challenges. The challenges facing nursing ethics educators in both theoretical and clinical ethics education will be discussed in the next chapter.

4.5.4 Nursing ethics educator selection

Respondents indicated the following reasons for teaching nursing ethics:

- own choice /voluntary;
- interested in and/or knowledge of the subject;
- ethics is integrated into subjects that they are teaching;
- staff delegation/selection to teach ethics; and
- requested to teach ethics after completion of a doctoral degree which covered the teaching-learning of ethics and professional practice.

4.5.5 Clinical guidance of students

Respondents indicated persons responsible for clinical guidance and strategies and methodologies used in clinical guidance of students.

4.5.5.1 Persons responsible for clinical guidance

Respondents indicated that the following persons are responsible for the clinical guidance of students regarding nursing ethics education:

- clinical supervisors;

- lecturers/accompaniers from the university and the health facility (responsible for the different year groups);
- facilitators responsible for class (theory) also do clinical facilitation; and
- clinical tutors.

The clinical guidance of students is not dependent on whether nursing ethics has an attached clinical component, because some respondents indicated that students are guided in clinical practice irrespective of the non-attachment of a clinical component.

4.5.5.2 Clinical guidance in health facilities

Respondents indicated the ways in which nursing ethics is facilitated in clinical practice settings by educators, clinical facilitators and students.

(a) Educator/Supervisor/Facilitator support

Guidance in clinical settings takes place in a variety of ways, as indicated by respondents. Those responsible for clinical guidance in health facilities use the following methods to guide students:

- orientation of students to clinical units with regard to ethics and etiquette; and
- on-the-spot teaching and discussions of situations the students encounter to enable them to make correct ethical decisions, as indicated by the following response:

  "The responsible lecturer visits students in the health facility and questions students on theory application to what they are busy with and explains application of the theory within the situation/patients they are attending to";

- role modelling by facilitators;

- reinforcement and emphasis during clinical accompaniment throughout the program;
- demonstration of required clinical procedures; and
- guidance solely dependent on the lecturer who teaches the subject.

One respondent also indicated that nursing ethics is not included in practice, but discussions and reflective sessions are included with the students (in class).

(b) Student responsibility

One institution places some responsibility for clinical learning on the students themselves. At this institution, students are provided with the South African Nursing Council's regulation on ethical conduct and guidelines on communication and ethical conduct within the institution at which the students practice.

4.5.6 Teaching-learning methods in nursing ethics education

Respondents indicate using the following teaching-learning strategies and methodologies in their teaching-learning. One participant did not indicate teaching –learning strategies and methodologies.

Table 4.5: Teaching-learning strategies and methodologies in nursing ethics education (N=13)

Teaching-learning strategies and methodologies	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13
Problem based learning	✓												
Case-based scenarios		✓				✓			✓	✓			✓
Teachable moment/On the spot teaching		✓							✓				
Projects			✓										
Lectures			✓	✓	✓							✓	✓
Group/Class discussions			✓	✓							✓	✓	
Questioning and correcting			✓										
Debate				✓	✓								
Case studies				✓	✓	✓		✓					
Value clarification						✓							
Reflective reports						✓							
Demonstrations						✓							
Discussions from news and newspapers							✓						
Internet searches											✓		
Power point presentations											✓		
Role plays												✓	
Individual assignments												✓	✓
Group assignments													✓
Group work													✓
Observations												✓	

4.5.6.1 Theoretical nursing ethics education (classroom)

Respondents indicated a variety of teaching-learning methods in the teaching-learning of theoretical nursing ethics education. These included lecturing, case scenarios/studies, individual/group assignments, group discussions, class discussions, role plays, panel discussions, internet searches, DVDs, CDs, Power Point presentations, debates, projects, reflective reports, examples from news/newspapers, practical examples during clinical placements and problem based learning.

4.5.6.2 Clinical nursing ethics education

Clinical teaching-learning methods are indicated as observation, on-the-spot teaching, case scenarios/studies, reflective sessions, teachable moments, problem-based learning, questioning, demonstrations and correcting during procedure evaluations and group discussions, which is evident from the following response:

> *"I [educator] ask about situations and let the students tell me how they handled it, then as a group this is discussed and ideas regarding how to handle such situations are offered, also helps to point out ethical issues to the students, they do not always pick these up themselves".*

Commentary on educator selection, clinical guidance of students and teaching-learning strategies and methodologies

It is commendable that some nursing ethics educators teach nursing ethics to students based on special skills, knowledge and specialist training in the discipline of nursing ethics. Nursing ethics educators who have special training and/or skills/knowledge in nursing ethics, and those who have a special interest and who volunteer to teach nursing ethics might enhance the teaching-learning of nursing ethics compared to educators who teach nursing ethics as a delegated task or who need to manage nursing ethics content integrated into a another subject. Motivation to involve oneself in the teaching-learning

of ethics might be significantly enhanced when one is interested in nursing ethics and has specialist training. Life missions of effective people [educators] draw upon personal values and personal commitment which are unique to each individual (Covey, 2004). Personal choice to be involved in teaching-learning of nursing ethics may therefore enhance effective ethics education.

Clinical guidance of students seems to be a shared responsibility between educators from training institutions and staff members from the health facilities where students are allocated for clinical practice. Students are supported in a variety of ways and clinical guidance takes place whether or not nursing ethics education has a clinical attachment component. This is especially relevant when nursing ethics is presented integrated into other nursing subjects in the program.

Clinical guidance seems to be a challenging issue in nursing ethics education. The challenges in nursing ethics education will be discussed in detail in Chapter 5 of the study.

A commendable variety of teaching-learning strategies and methodologies is used in the teaching-learning of nursing ethics. Endeavours of problem-based learning is evident in methodologies such as reflective reports, case scenarios/studies, discussions, debates, internet searches and group discussions of problems encountered in clinical areas or in news reports/newspapers. The facilitation of the attainment of the needed competencies in nursing ethics is however a real challenge. The challenges with regard to teaching-learning methods will be discussed in detail in Chapter 5 of the study**.**

Nursing educators have significant autonomy with regard to the selection of teaching-learning methods used in the teaching-learning of nursing ethics, in both the classroom and clinical settings. The challenge to facilitate the attainment of competencies in nursing ethics education however depends not only on change in teaching-learning methods, but also on other factors. The environment, within which theoretical, and especially clinical, teaching-learning take place, is often compromised. All persons involved in the teaching-learning of students should receive training with regard to nursing ethics and

should enhance their performances in the teaching-learning of nursing ethics and in role modelling the norms and values of nursing. The challenges in nursing ethics education is discussed in detail in Chapter 5 of the study.

4.5.7 Nursing ethics curriculum content

Respondents provided information on the nursing ethics content at their respective institutions. The content offered at institutions one to five is covered in different study years, in different study modules, and is offered as separate modules.

Table 4.6: Content in separate modules of nursing ethics education at institutions

Institutions	1	2	3	4	5
Year one	History and theories of nursing; Professional practice; Ethical concepts & conduct; Therapeutic working relations; Professional indemnity; Patient and nurses' rights; Professional rules and regulations	Nursing history *Definitions:* nursing; nursing science; philosophical core concepts; responsibility and accountability *Nursing ethics:* terms, ethical codes, personal values; Batho Pele *Relationships:* patients; doctors; profession; employer; colleagues; public Human rights: patients; nurse; employer; Nursing functions *Legal issues:* malpractice; litigation; negligence; assault; defamation Rules; regulations and scope of practice; Professional associations and trade	Integrated in General nursing science 1		

Institutions	**1**	**2**	**3**	**4**	**5**
		unions			
Year two	*Professional community care:* community rights and trends in community	*Teaching-learning in nursing:* principles; clinical teaching; resources in teaching; role and duties of nurse as educator and learner	Integrated in General Nursing Science 2		
Year three	*Nursing Ethics:* theories; dilemmas; Professional accountability; Scope of practice	*Nursing management:* principles; leading and directing; control; Nursing research: process and ethics *Nursing as profession:* statutory control; characteristics; ethics and ethical standards; clinical ethics (dilemmas end decision making); personal and professional values *Current issues in nursing:* Batho Pele; affirmative action; xenophobia; HIV/AIDS; brain drain	Integrated in General Nursing Science 3		
Year four	*Professional Practice:* professionalism and accountability;		*Professional practice*: public's right to safe care; patients' rights;	*Professional foundations:* current issues; dilemmas;	*Philosophy of nursing:* western worldviews, Indian philosophy,

Institutions	**1**	**2**	**3**	**4**	**5**
	legislation and guidelines (in Mental Health, Midwifery, Primary Health Care)		human rights; right to strike' functions of nurse; interpersonal skills, trust and respect *Ethics in health:* ethical aspects; ethical codes; dilemmas; recordkeeping, integrity and confidentiality *Cultural issues in health care:* transcultural ethics; principles; holistic care *Nursing Management:* philosophy and mission of unit; legislation, policies; regulations in unit; personnel management; communication, coordination and supervision; risks and hazards; quality improvement; conflict and disaster management;	professional criteria; pledges of service; professionalism *Professional organizations*: duties; trade unionism versus association *Professional regulation:* principles, composition and functions regulatory body *Professional accountability:* pre-conditions; reasonableness; duties; legislation; informed consent; conditional authorization, secrecy; strike action; patient's rights *Ethical decision making:* principle; approaches; patient versus nurses' rights; current ethical problems	Chinese word view; African thoughts; nursing philosophy; nursing as caring profession *Nursing theories:* Nightingale; Orem; Leininger *Culture care:* cultural competence; obstacles; knowledge and skills of nurse *Professional relations:* importance; rights and duties; development; maintenance; interpersonal relations *Ethical problems in nursing:* core concepts and codes; intrinsic values; ethical concepts; moral challenges; approaches; phases in moral decision making

Institutions	**1**	**2**	**3**	**4**	**5**
			leadership; grievance and discipline in unit	*Health care services:* analysis; HIV/AIDS policy/strategy	*Human rights in nursing:* human and patients' rights; Bill of rights; patient Charter; HIV/AIDS Charter; rights and duties of nurses *Legal foundation of nursing:* concepts; sources of law; professional regulation; scope of practice International conventions *Role modeling in nursing:* concept; being role model; roles and functions of nurse *Duties of nurse practitioner:* selected concepts; selected duties; to live with care and justice

Commentary on nursing ethics content offered as separate modules

Institution one offers nursing ethics education as separate modules throughout the four years of education. It however seems that ethics education is integrated in community health nursing in year two of the program. Institution two (the participating nursing college) offers nursing ethics in years one, two and three of the undergraduate program and do not have any ethics training in the final study year. Institution three integrates ethics education in general nursing science in the first three years and offers a module on ethics education in the final years including content of nursing management. Institutions four and five each offer a module on nursing ethics in the final study year. The content in these five institutions covers most of the expected content for nursing ethics education. Institutions one has an introductory module in year one and a module covering professional practice issues in different subjects of the final study year, which is commendable because it provides ethics education early in education and emphasize professional issues before students start with their professional lives. Institution two has a very comprehensive curriculum for the first three study years, and includes both teaching-learning and management content in ethics education, which is commendable. The ethics content of institution three is presented only in the fourth year and addresses the important ethics content as well as nursing management. The first three study year integrate ethical and legal aspects in General Nursing Science and the challenge with this approach might be that students may struggle to grasp the importance of ethical issues without specific accompanying theoretical teaching-learning outcomes, especially if the educator does not emphasize ethical and legal aspects during teaching-learning. The content offered by institution five seems more elaborate compared to institution four, but both these institutions offer content on ethics and professional practice in the final study year. The challenge with only offering ethics content in the final study year is however that students might be unprepared for ethical challenges during the first three years of study. All five institutions offer human rights content which is important in ensuring the rights of patients, the access to health care and provision of ethical nursing

care (Mayers, 2007). Institution one includes the Batho Pele principles that ensure acceptable service provision according to the rights of patients and institution four includes The Patient Charter as a document ensuring the rights of patients in service delivery. The rights and duties of nurses are covered in the content of all five institutions who offer separate modules on nursing ethics.

Respondents from institutions six to eight indicated that nursing ethics content is integrated throughout their undergraduate program. The integration takes place within certain courses and in different study years.

Table 4.7: Integrated nursing ethics content at institutions

Institutions	6	7	8
	Fundamental Nursing Science: ethics of nursing science; ethical decision making; moral dilemmas; Role and duties of nurse towards patients, colleagues, profession, employer, fellow human beings and him/herself *Community Health Nursing:* Batho Pele; Human rights; theoretical models for health behavior; economical, ethical, cultural influences on service delivery; ethical influences in community health; ethical dilemmas; ethical decision making; concepts in culture care; cultural assessment principles; providing cultural congruent care; dimensions model in providing culture care *Management, Ethics and Professional Practice:* ethical concepts; personal and nursing values in nursing care; patient advocacy; moral basis of nursing according to models; traditional ethical theories; View and role of the International Council of Nurses; Human Rights Charter; Batho Pele; informed	*General Nursing Science:* ethical-legal implications in specialized care settings (assessment, management, evaluation); ethical-legal principles in implementation of care plan congruent with patient's health status; ethical-legal implications in preparing patient for surgery (physically and emotionally)	*Introduction to professional practice and psycho-social and spiritual needs of patients:* conceptual framework and concepts in nursing; ethical and legislative frame of reference; nursing as profession; comprehensive health care; scientific approach in nursing; nursing process and documentation; role and function of nurse; professional accountability; stress, anxiety, adaptation; the individual, health, holism; therapeutic communication; cultural diversity; life cycle; needs of elderly; needs of dying patient, family, relatives. Professional organizations *General Nursing Science:* Ethical, legal (including scope of practice) in nursing care of illnesses according to body systems *Family planning and genetics:* social, cultural, religious, legal factors in contraceptive use *Practical parameters of midwifery:* scope of practice, role and functions of midwife;

Institutions	6	7	8
	consent; Nursing unit philosophy, vision, mission; communication; coordination; transcultural issues; nursing legislation; key elements of law (abortions); professional duties and liability; risks in nursing unit; quality assurance in unit; statutory control; Searle's model (legal and ethical parameters in nursing); recording in nursing practice; nursing actions in emergencies; leadership; labour relations; role modeling *Psychiatric Nursing Science:* ethical framework in psychiatric nursing and application thereof; counseling of persons with special needs (abused, raped, HIV/AIDS, substance abuse); intercultural communication strategies; delivering appropriate mental health care in culturally diverse society; ethical and legal care in mental health nursing *Nursing research process:* critical thinking abilities; communication, presentation skills in writing and speech; ethical consequences of nurse scientist; ethical elements of research report		regulations of conditions of practice of midwife; Medicine and Related Substance Control legislation *Contemporary nursing practice:* ethical aspects; rights of nurse; Geneva Convention; labour relations; private nurse entrepreneur; contemporary issues; leadership and globalization *Unit management:* philosophy and objective of unit; financial liability; quality improvement; personnel management; decision making and problem solving; harmony and personnel motivation; career and personal management *Cultural practices and social-cultural risk factors in midwifery:* family development approach; contemporary family health problems and culture; family pathology and role of community nurse; culture and healing; identification of social-cultural risk factors in midwifery; management of social-cultural risk factors in pregnancy, labor and puerperium

Commentary on integrated nursing ethics content at institutions

Institution six integrate nursing ethics content into different subject modules throughout the four study years, content at this institutions is integrated in Fundamental nursing science; Community Nursing Science; Unit management (including Ethics and Professional Practice); Psychiatric Nursing and Nursing Research. Integrating ethics content in specific subjects might challenge students to generalize some content to other practice situation, for example the offering of human rights in Community Health Science, while human rights are applicable in all nursing situations. This approach also challenges the educator because it needs explicit explanations of the general application of human rights, while a community health nursing educator might not be an expert in human rights. The Human Rights Charter is offered in another subjects in institution six, it might be difficult to coordinate the offering of content in different subjects to ensure effective teaching-learning by students. The same critique is valid for other content like cultural issues, ethical dilemmas and nursing duties, which are relevant in all nursing care settings. It might make more sense to have content on human rights (or other generally applicable ethical aspects) and apply this to different practice situations. Rights of nurses are not visible in the ethics content of institution six, but nursing duties are covered, according to Pera and Van Tonder (2011) it is not always possible to distinguish between the rights of nurses and their duties, therefore human rights of nurses might be presented as duties. The ethics content offered in the different subjects however covers the important ethical content expected in undergraduate ethics education.

Institution seven integrates nursing ethics content in General Nursing Science and focus on the ethical-legal principles in different care settings and nursing tasks. The only content seems to be ethical legal implications in specialized care setting, preparation for surgery and application of ethical principles. It is however not clear which ethical principles are covered. It is therefore difficult to assess ethics education content at institution seven.

Institution eight integrates nursing ethics content throughout the undergraduate program with content on professional practice and holistic needs fulfillment of patients; scope of nursing practice; ethical and social/cultural issues in family planning; unit management and ethical/social/cultural issues in midwifery practice. The curriculum and content of institution eight is well developed and comprehensive compared to the other two institutions who integrate ethics content in the undergraduate program. The rights of nurses are covered as a contemporary aspect in nursing practice, which is commendable. The introductory content on professional practice covers the basic issues in ethical nursing practice. The presentation of ethics content in other subjects progresses from basic ethical considerations to more specialized content relevant in specific specialized practice situations, like midwifery practice and unit management.

General commentary on nursing ethics content at all institutions

The content of nursing ethics education as provided to the researcher by eight participating institutions' respondents is evidence of a nursing education system that is highly autonomous at institutional level. The content provided by respondents at participating institutions did not always indicate the details of the teaching-learning outcomes or the micro-curriculum. Whether micro-curricula exist at participating institutions remains unclear. Some institutions are clearly more advanced in the development and presentation of nursing curricula. Generally, the nursing ethics content offered to nursing students seems to cover nursing philosophy, nursing norms and values and nursing regulatory and legislative aspects either in the separate modules or integrated in other modules. Not all institutions cover cultural care in nursing practice, while it is deemed important content in nursing ethics education (Lancelotti, 2008) Ethics content is also offered in subjects where ethical issues are particularly relevant, such as health service or unit management, community health nursing, midwifery, psychiatric nursing and nursing research. Views on the content required in nursing ethics education, include the nature of

nursing (Ujvarine, 2008) and nursing theories, the nurse patient relationship, caring relationship and the professional role of the nurse (Nilsson & Silen, 2008). Relationship content is visible in the content of two institutions, but relationships might be implied in the rights of patients or the role of the professional person, for instance in the care of a dying patient. Nursing theories are offered by two institutions, while ethical theories are covered by most participating institutions, it is not always clear whether only the more traditional theories are covered or whether a combination of approaches is presented to students. Kulaitzidis & Schnits (2012) believe principle based ethics, virtue ethics, caring ethics and feminist ethics are appropriate for nursing ethics education. The ethical principles autonomy, beneficence/non-maleficence and justice (Skisland et al, 2011) as well as ethical codes and ethical standards (Dobrowolska et al, 2007; Leach & Oakland, 2007) are needed in nursing ethics education. Most participating institutions cover content on the ethical and legal framework in nursing care. The Batho Pele principle of care is covered by three participating institutions in South Africa, but it might be covered with other caring/service values at the other institutions. The history of nursing, except for one participating institution, is not covered in nursing ethics education content but might be offered by other subjects for instance General Nursing Science. While history is important, this might be content that will suffer exclusion considering the pressure of time and credit requirements of the recent Qualifications Authorities in both South Africa and Namibia. Most participating institutions offer content on ethical decision-making and ethical dilemmas, but the decision making models are not necessarily covered, even though this might be a helpful tool for nurses in ethical decision making (Chloe et al, 2013). Advocacy, assertiveness and critical thinking which are vital skills needed in addressing dilemmas in nursing care are not given due attention in the content presented by participating institutions. The participating institutions integrating ethics throughout the curriculum covers the ethical-legal implications of different nursing management situations (i.e. patients with complex health issues; implementing a care plan; preparation of a patient for surgery) throughout the different study

years. The African value of Ubuntu is not visible in the provided content of participating institutions, but it might be covered as a moral value in nursing.

Some of the institutions who participated in the study also offer other healthcare professional training at their institutions, but none indicated during the face-to-face interviews that nursing students are trained together with other healthcare professionals regarding health care ethics, which is particularly relevant in ethics education. One respondent of an institution mentioned that a bioethics module was previously offered to the nursing students by the law faculty at their institution, but was discontinued. Provided content information and the differences in offering mode (integrated or separate content) of nursing ethics education at participating institutions inhibits the comparison of content at participating institutions. It seems, however that nursing students are presented with content that cover the aspects of the ethical, legal and professional framework of nursing. Retrospectively it might have been better to illicit information on nursing ethics content by not providing an open ended question to respondents on nursing ethics content, but a close ended question based on the literature.

4.6 Conclusion

Data collected by means of the questionnaire in determining the current status of undergraduate nursing ethics education in South Africa and Namibia confirmed that participating institutions of higher learning have significant autonomy in decisions on the offering of nursing ethics education within undergraduate nursing programs. This was evident in the variety of nursing ethics content offered, the different modes of offering as evidenced by differing time allocations to nursing ethics education, the integration of ethics content throughout the curriculum against offering nursing ethics as a separate module and the offering of nursing ethics over the whole spectrum of academic years in the undergraduate nursing programs.

Responses from the open-ended questions indicated that not all nursing ethics educators are specialists in ethics or that they volunteered to teach nursing ethics out of an inclination towards nursing ethics. Some educators were either delegated the responsibility or were teaching nursing ethics because it was integrated into a module, which such an educator was teaching.

Nursing ethics educators attempt to use a variety of teaching-learning strategies and methodologies in facilitating problem-based learning and student participation, but are faced with a variety of challenges in both the classroom and clinical practice settings. These challenges will be discussed in more detail in the next chapter of the study.

CHAPTER FIVE

THE CHALLENGES IN UNDERGRADUATE NURSING ETHICS EDUCATION

5.1 Introduction

Historically, since the inclusion of ethics in nursing education by Florence Nightingale, nursing ethics education was considered within the context of Christian values. After World War II, the teaching of nursing ethics became more secular, and since the 1970s, the rapid expansion of scientific knowledge in health care required ethics education of an applied nature, which prompted specialisation and advanced ethical knowledge and skills to which nursing ethics education responded (Dolan, 1983). Currently, nursing ethics educators in Africa are challenged to create a nursing ethics curriculum that is founded on African values and beliefs (Mogale, 2012).

The aim of nursing ethics education is a controversial topic in current literature. Some scholars believe that ethics education cannot internalise values, but rather aim at providing students with effective moral problem-solving skills and the ability to analyse moral problems and outcomes (Clarkeburn, 2002; Klugman & Stump, 2006). Another viewpoint is that ethics education cannot only focus on moral decision-making, but also take into account how ethics education advances good clinical practice (Chaloner, 2007), while Görgülü and Dinç (2007) believe that nursing ethics education aim to produce morally accountable nurses who are skilled in detecting and responding to ethical issues. Vanlaere and Gastmans (2007) mention the twofold goal of nursing ethics education as the accomplishment of critical reflection and cultivating a caring attitude. Caldwell, Lu and Harding, (2010) report that the aim of nursing ethics education is set by registration authorities. According to Lin, Lu, Chung and Yang (2010), these uncertainties challenge nursing ethics education because they challenge decisions by educators about the most effective nursing ethics curriculum and teaching-learning strategies and methodologies.

Research in nursing ethics is challenged by the lack of consensus about the goals and content of nursing ethics education (Kesselheim & Joffe, 2008; King & Wood, 2011). More discussion and research are therefore necessary about these goals, as well as about the development and testing of a normatively grounded conceptual model for teaching-learning in nursing ethics education and the issues in nursing ethics generally (Grady, Danis, Soeken, O'Donnell, Taylor, Farrar & Ulrich 2008).

According to Van Dyk (1997), the challenges for the nursing profession in the twenty-first century are the interpretation and application of nursing's philosophy and ethical norms, assertive cooperation, collaboration and networking to ensure development in the nursing profession, good management, fostering of contemporary nursing knowledge and skills, and the strengthening role of modelling in the health field. All of these challenges have been shown to still be relevant today, as perceived by experienced ethics educators in this study.

The changing nursing environment, caused by advanced medical technologies, higher awareness of human rights, diverse cultures, belief systems, values and ethical dilemmas requires practicing nurses to make moral judgments and decisions. It further requires a solid educational preparation of the neophyte nurse, but also continuous education of professional nurses on ethical issues in nursing (Caldwell, Lu & Harding, 2010; Chaloner, 2007; Ito, Ota & Matsuda, 2011; Monteiro, Barbosa, Barroso, Vieira & Pinheiro, 2008). The continuous support and education of nursing managers and nursing leaders by both employers and educational institutions is an acute challenge to improve the quality of nursing services to societies (Musa, Harun-Or-Rashid & Sakamoto, 2011; Jooste & Kilpert, 2002). Reid, Dahlgren, Petocz & Dahlgren, (2008) report that nursing students indicate that clinical nursing exposure is the most valuable learning opportunity.

Van Niekerk (2003) supports Pellegrino's view that more ethics education (theory on ethics) does not solve the problems of unethical conduct in practice. Van Niekerk (2003) expands the approaches of both Hegel, who believed that thoughts and ideas influence people's reality and will therefore influence lifeway and action (theory determine practice) , while Marx believed peoples 'perceptions and actions are derived from their material existence (practice to theory). Van Niekerk (2003) believes the relationship between theory and practice is not as unilateral as either Hegel or Marx forwarded, but that the interaction between theory and practice is complementary. Ethics education can increase moral awareness, but this cannot guarantee moral conduct. Complementary to education is taking measures to create an ethical environment in which people can function morally. It is however not enough to create a culture by setting rules according to which persons need to function; persons need to understand that moral character plays an overarching role in ethical actions. The responsibility to choose those actions that benefit others befalls the individual person (Van Niekerk, 2003; Van Niekerk, 2008), and stems from a virtuous character.

The notion of individual responsibility, or the absence thereof, in praiseworthy conduct is also demonstrated by the dichotomy between persons' knowledge, attitude and behavior. Adequate knowledge of HIV/AIDS or knowledge of risks in injecting drugs users is not preventing risky practices in which children engage. (Trudgeon & Evans, 2010; Thanavanhi, Md. Harun-Or-Rashid, Kasuya, & Sakamoto, 2013). Bridging the gap between theory (knowledge) and practice (actions) needs measures of self-regulation i.e. control of immediate needs, mobilization of thoughts, feelings and conduct (Chaves, Bento, Ferreira & Duarte, 2013). While nursing ethics education cannot guarantee moral conduct or the prevention of unethical practice of nurses, nursing ethics education need to endeavor to create ethical sensitivity (Botes, 1999) and teaching-learning methods need to guide students to critically reflect on and question individual assumptions that can lead to the change of conduct (Savaya & Gardner, 2012). According to Hatlevik (2011) reflective skills of nursing students depend on relevant

professional knowledge and experiences in nursing practice. Therefore, the teaching-learning methods that nursing ethics educators employ need to assist students to find coherence between theory and practice in nursing education (Hatlevik, 2011).

When the clinical practice setting is not desirable, nursing ethics education is severely challenged because poor role modelling of professional nurses, poor nursing management and poor patient care negate the object of ethical nursing practice and nursing ethics educational efforts and hinder professional identity formation by students (Reid et al., 2008).

Woods (2005: 15) believes the challenge for development of appropriate nursing ethics education lies in curricula, strategies and methodologies, which focus on the real context within which nursing is practiced, i.e. an applied ethics. Critical thinking skills are a necessary nursing ethics education outcome and an innovative teaching-learning strategy is necessary to attain this (Epstein, 2011). However, nursing ethics education in South Africa and Namibia is often challenged by high student numbers in nursing institutions, which make small group and one-on-one teaching-learning difficult. Nursing ethics education is also challenged by gender issues, because some healthcare systems are still characterised by male-oriented and paternalistic approaches to ethical decision-making, which exclude female nurses from moral decision-making, even though nursing ethics educators facilitate the teaching-learning of moral decision-making. (Sorta-Bilajac, Baždarić, Zagrović, Jančić, Brozović, Ċengić, Corluka & Agich, 2011) Multidisciplinary education for healthcare providers is not realised in South Africa and Namibia, while it is necessary for enhancing teamwork and understanding of the different professional roles (Hutchinson, Haynes, Parker, Dennis, McLin & Welldaregay, 2006). Authoritarian relationships between nurse educators and nursing students also challenge nursing ethics education and undermine the attainment of critical thinking and self-directed competencies by students needed in the healthcare situation (Monteiro, 2008).

Nursing education is furthermore challenged by the expectations of governments, who in turn need to fulfil the Millennium Development Goals (MDG) of South Africa and Namibia. Three of the eight MDGs are directly related to health care, while the rest are indirectly related to health and wellness of the people (Republic of South Africa, 2006; Republic of Namibia. 2008a).

Nursing ethics education is challenged to facilitate the teaching-learning of affective skills by nurses enabling them to deal with demands technically and emotionally, which is fundamental in the delivery of quality healthcare services to meet the Millennium Development Goals. In South Africa, new abortion legislation demands that nursing ethics education must respond to the need to prepare practicing nurses to face the challenges prevalent in abortion care (Harries, Stinson & Orner, 2009). Furthermore, globalisation of the nursing workforce and nurse migration require nursing education to facilitate teaching-learning for an international labour market, while at the same time it has to be sensitive to the diverse cultural beliefs of foreign nursing students accessing nursing education at local tertiary institutions (Singleton & Krause, 2009; Caldwell, Lu, & Harding, 2010; Ito, Ota & Matsuda, 2011).

The following objective of this study is addressed in this chapter:

- Describing the challenges in nursing ethics education in selected institutions in South Africa and Namibia

5.2 Methodology and sampling

The challenges in nursing ethics education at participating institutions were identified firstly by open-ended questions in the questionnaire and secondly with the follow-up semi-structured individual face-to-face_interviews. All respondents who completed the questionnaire were approached for individual interviews to enrich the data received by means of the questionnaire.

Four respondents in South Africa could not be interviewed, one respondent retired, one was on sabbatical leave and the other two were not available during the researcher's visit to South Africa. The number of respondents who were interviewed was 10, seven of the 10 respondents represented seven institutions in South Africa while three respondents represented one institution in Namibia. Nine of the interviews were in English and only one interview was conducted in Afrikaans according to the preference of the respondent. All face-to-face interviews were tape-recorded and transcribed verbatim within a month after the interviews were conducted by a professional transcriber who is involved in the transcribing of disciplinary hearings of the Nursing Council of Namibia. During the interviews researcher biased were minimized by asking three broad research questions on the challenges in nursing ethics education, how these challenges can be addressed. The researcher attempted not to ask leading questions but only probed when responses were not clear to the researcher.

The content on the voice recorder was transferred by the researcher to a personal computer that can only be accessed by a personal password to protect confidentiality of respondent information. The researcher erased all names of respondents from the transcribed interviews and reported on research data not mentioning the names of respondents but numbering the institutions represented by respondents. This ensures anonymity of respondents. All transcribed data is locked away in a secure cupboard and will be destroyed when the study is completed. Electronic data will be erased from the computer upon completion of the study.

In the questionnaire, open-ended questions covered the challenges in nursing ethics education, namely the challenges in theoretical nursing ethics education, the challenges in clinical guidance of students in nursing ethics education and the challenges in the teaching-learning of nursing values in nursing ethics education. Respondents were also required to indicate how these challenges could be addressed. During the follow-up individual, semi-structured interviews, the respondents were asked their views on the

challenges in nursing ethics education at their institution, how these challenges could be addressed and how nursing ethics education could facilitate the internalisation of nursing values in students. The questions were forwarded electronically to participants before the interviews to enable them to think about their responses beforehand and to enhance the richness of data. Semi-structured interviews were appropriate to obtain information on the challenges in nursing ethics education because in the first phase of the empirical component of the study, the questionnaire obtained both biographical data from the respondents as well as data about the status of undergraduate nursing ethics education in the two countries (Babbie & Mouton, 2001; Burns & Grove, 2005). In the second phase, the semi-structured interviews enriched the data obtained by means of the questionnaires and obtained data on the challenges in nursing ethics education as viewed by the participants. The researcher also kept field notes, which are included where appropriate in this chapter. All responses in the questionnaire with regard to the challenges in nursing ethics education were summarised and analysed by means of the transcribed interviews. Data obtained through both the questionnaire and the semi-structured interviews will be presented in this chapter.

5.3 Data analysis

In an attempt to understand and organise the information provided by the participants during the interviews, the transcriptions were thoroughly studied and organised into themes and subthemes, known as thematic content analysis of research data. Tesch's method for qualitative analysis was utilized in this study (Tallerico, 1991; Tesch, 1991) whereby transcribed data was studied and organized in major themes and sub themes. The data was analysed manually by the researcher. Initially, the researcher read the transcribed data more than once and identified repetitive views of participants, which were manually coded on the transcribed data sheets (Burns & Grove, 2005). The initial codes were grouped into subthemes and thereafter the main themes were identified. The responses on the

questionnaires as well as the field notes of the researcher were included in the coding of themes and subthemes while analysing the data on the challenges in nursing ethics education, addressing these challenges and the data on the facilitation of the internalisation of nursing values in nursing ethics education.

Trustworthiness

Trustworthiness of the research results was ensured during this study by the following principles:

Principle	Criterion	Measures taken in this study
Credibility: Ensuring compatibility between respondent reality and the truths attributed to them	**Data triangulation**: Refers to the collection of data from different sources to examine how different individuals experience a specific event.	Data were collected from 10 experienced nursing ethics educators from eight different institutions of higher education in South Africa and Namibia.
	Methodological triangulation: Refers to the use of two or more research methods in a study.	Data were collected from 14 participants through a questionnaire. Ten of those participants were interviewed individually afterwards.
	Referential adequacy: Includes the materials available in documenting the research findings.	All interviews were tape-recorded and transcribed. Notes were taken by the researcher during the interviews.
	Member checks: Refers to the checking of data and data interpretations with participants.	Questionnaire data were clarified with participants during the individual interviews.
Transferability: Ensures the generalisability of findings to a target group	**Thick descriptions:** Reporting and describing contextual data sufficiently and in detail **Purposive sampling:** Selecting locations and participants specifically and with purpose	Analysed data are reported in detail in this chapter of the study. Experienced nursing ethics educators were selected as participants to this study.
Dependability: Provides evidence that the study results will be similar when repeated in a similar context	**Inquiry audit:** Examination of the study products, its internal coherence and the fact that it is supported by the data	An independent coder analysed the transcriptions and this was compared with the analysis done by the researcher. Study supervision is done by a main and co-supervisor of the study.

Principle	Criterion	Measures taken in this study
Confirmability: Provides evidence that the research results can be traced back to its original sources	**Audit trail:** Review of the data and data processes of the study	Review is done by main and co-supervisors of the study.

(Babbie & Mouton, 2001; Burns & Grove, 2005)

5.4 The views of nursing ethics educators on the challenges in nursing ethics education

Based on questionnaire and interview data, the following three themes indicate the challenges as identified by the nurse ethics educators:

Theme one: Challenges within the theoretical and clinical teaching-learning environments

Theme two: Challenges related to nurse educators, nursing students and practicing professional nurses. Practising professional nurses refer to those professional nurses involved in clinical guidance of students at participating institutions)

Theme three: Challenges beyond the teaching-learning environment, but which influence nursing ethics education

Theme one: Challenges within the theoretical and clinical teaching-learning environments

a) With regard to the theoretical teaching-learning environment, participants identified the following challenges:

- nursing ethics content and curricula;
- teaching-learning strategies and methodologies;
- tertiary education system and academic workload;
- large student numbers;
- student selection;
- student discipline; and
- teaching-learning of nursing values.

b) With regard to the clinical teaching-learning environment, participants identified the following challenges:

- integration of theory and practice;
- differences between the theoretical and clinical teaching-learning environment;
- policies; and
- support for nursing students.

Challenges related to theme one:

a) Challenges within the theoretical teaching-learning environments

Content and curricula

Respondents mentioned that ethics education is not always viewed as an important subject and is not given the same weight as other subjects in undergraduate nursing programs, especially those subjects with a clinical component. Students view ethics education as less important because it is not allocated a practical component. Some fundamental shortcomings in ethics education content is that it may lack depth and ethics educators are challenges in the assessment of ethics because it requires educators to not be prejudices and be objective. Respondents also think that the grading of affective skills of students is more difficult than grading of technical skills.

Respondents made the following comments:

> *Nursing subjects such as fundamentals of nursing and anatomy and physiology are weighted heavily…the nursing ethics component is minimum. Ethics is an underrated subject all way round; it's one of those Cinderella subjects. (R2)*

Maybe if there is a practical component or periods allocated to ethics then students would also regard that as important the same way they look at other nursing subject with a practical.(R10)

How are you going to fail somebody? She's, for example, she's got all the technical skills but has bad ethic[s]? (R1)

Die dosente moet gesensitiseer word en ek dink … dis baie maklik om vinnig en haastig en vooroordele te hê en dit is, ek dink nie maklik om dit ['n etiese werkstuk vir studente] te assesseer nie. [the lecturers must be sensitized and I think …. It is very easy and hasty to have prejudices and it is, I think not easy to assess it [an ethical assignment of students]. (R4)

Respondents recognize that students have difficulty in understanding the abstract concepts in ethics education and applying these practical situations. Students find ethics content difficult to understand, complicating the application of theory to practice. It is a challenging subject because of its own veiled nature. Supporting comments by respondents were:

The content sometimes it's nebulous and abstract. (R2)

Many times they [students] do not understand, they can't apply it, so for me … that is the challenge. (R9)

Respondents think curricula content does not necessarily keep up with the changes in the practical situations, or are not addressing those challenges nurses are facing at the bedside of patients. Respondents also mention that there is a lack of common understanding between nurses, including students, on the interpretation of nursing values. Diverse interpretations of nursing values by educators and students challenge the teaching-learning environment. Respondents mentioned the following:

I was asking my post-graduate groups, how many of you had to do with euthanasia and those things, and it's very few, but lot of other ethical dilemmas such as I'm having a TB patient and I haven't got medicine for this person, now what? (R6)

There's a whole diversity among your colleagues, among your students … who think differently on what is an appropriate value … the interpretations are all different … are we teaching the same things? (R7)

Respondents view ethics as a foundational subject which is required to be integrated throughout the curriculum. Ethics should be connected with all subjects throughout the undergraduate nursing program. Proper linkage is necessary for the creation of a strong ethical foundation in nursing and increase awareness of ethics. Comments by respondents were:

So that's a major challenge … to have that strong ethical foundation and as well to … throughout the curriculum sustain … your awareness of ethics … should be throughout the program … so somewhere in the program second year, third year … it should be linked. (R5)

The isolation of the subject, not being integrated into all other nursing subjects. (R10)

Proper liaison and communication between ethics lecturers and clinical professional nurses who guide students are necessary about curricula content and teaching-learning expectations of students. Educators might not liaise with managers and professional nurses in the clinical teaching-learning facilities and those supervisors do not know which nursing ethics content is covered in the classroom by nursing ethics educators. One respondent stated:

And then, to what extent does … the managers, the practitioners in practice know what's happening in the curricula. (R10)

Teaching-learning strategies and methodologies

Respondents confirmed the challenge making ethics education valid and true for students. Little of what is taught in theory is visibly transferred to clinical practice settings by students. A respondent remained uncertain on the best role modelling strategies to transfer values to students in advancing the best interest of patients. Respondents observed the following:

> *The biggest challenge of ethics is to make it real for the students. (R9)*

> *En dit is moeilik om dit [hoe ek as verpleegkundige moet optree … vir die beste vir my pasiënt] van eerstejaarsvlak af tuis te bring. [And it is difficult to instil it from first year level [how I as a nurse should act ... for the interest of my patients] (R4)*

Tertiary education system and academic workload

A concern of respondents is the tertiary educational system with its own structure standards that challenges non promotion of students who lack affective skills. University advancement rules regulate the promotion of students according to pass or fail grades while educators may observe students not attaining the values needed in nursing. A respondent commented:

> *One of these challenges is that we've got to … work within a university system that has marks and processes by which you pass or fail a degree … we struggle to stop that student [a student not having the affective skills] from just promoting to the next year. (R8)*

Nursing educators are challenged to attain and maintain the level of research and publications required by tertiary educational institutions and teaching-learning demands of students. These demands force educators not to be available in clinical settings for students all the time. Respondents remarked:

We don't have time because of the contact load and so much that we're doing, for us to write articles … and put it in a journal. (R3)

Want, ek weet nie, ek kan nie daar wees vir die hele tyd nie. [Because, I do not know, I cannot be there the whole time] (R4)

Large student numbers

Large numbers of students make it difficult to provide individualised teaching-learning, which is important in nursing ethics education and which is needed when students encounter ethical dilemmas in clinical practice. Clinical accompaniment by nurse educators then focuses more on assessment than on real support to individual students. A respondent stated:

Another challenge is our large numbers. We're taking three hundred students a year … so I struggle … in the clinical setting to spend time with each individual student … the time spent is focused around assessment rather than actual accompaniment … I think one-on-one time is so crucial to develop both the student's skills, but also their ethical values. (R2)

Student selection

Nursing ethics educators view it as impossible to select the best candidates for the nursing profession because of the numbers of applications, the academic system and time constraints in the application and selection process. One respondent mentioned:

It is only three of us and I think to do 5 000 tests or exams would be a … mammoth task. (R2)

Student discipline

Flexibility of rules, inconsistency in the management of undisciplined students and lack of discipline contribute to unethical and more unruly conduct by students. Sometimes the educator feels the victim because management only looks and hears the side of the student. The following observations were made:

> *The rules I'm referring to are disciplinary rules … the rules are saying, no, the student is being like this or the student is a final-year student, let's do this to the student. (R8)*

> *…even when they [students] are guilty in the same issue then we will see one student will be considered the other way than the other, the other student will be considered in a different way. (R1)*

> *When the student is not being punished for unethical behavior, the student usually become unruly or says that it was the lecturer, that it was his or her fault, again nothing could be done to the student. (R8)*

Teaching-learning of nursing values

Respondents view value education in nursing as difficult because of the diverse South African and Namibian societies. Different value systems, faiths and cultures in society challenge the teaching-learning of nursing values, especially when the language of students do not have the words to describe concepts accurately. Respondents noted:

> *I am not sure whether it is possible to teach students a generic value system as there are fundamental clashes and conflicts between faiths and value systems … These conflicts need to be resolved. (R2)*

To get the understanding what values are – over cultural borders, because some values (the words) do not exist in all languages, e.g. caring in English – in Afrikaans there is no word with the precise meaning. What about Sotho, Xhosa, etc? (R1)

Other challenging issues

South African textbooks lack real-life scenarios on ethical issues, which could be used by educators. Textbooks might not be used by educators the way it should be used and that textbooks are not written by those educators who teach ethics, which might be a shortcoming.

b) Challenges related to the clinical teaching-learning environment

Integration of theory and practice

Respondents observed the gap that exists between theory and practice regarding ethical expectations of students. Student actions in the clinical areas do not imitate what they are taught in the classroom. The following comments were made:

It's one thing talking about situations in the classroom, but it's another thing actually what gets done in the facilities. (R6)

So, there's a big gap for me between the class and the clinical area. (R10)

Differences between the theoretical and clinical teaching-learning environments

The circumstances in clinical settings are not supporting effective teaching-learning of students. Lack of supplies and equipment, the poor clinical standards of practice, and the huge patient numbers within the facilities, all have a negative impact on the teaching-learning of students. Professional nurses are not role modelling appropriate caring behavior to students and have a lower level of awareness and knowledge of ethics than students themselves.

Respondents mentioned:

> *….hulle [studente] moet 'n bed opmaak en daar's nie beddegoed nie, daar's nie waslappe nie; daar's nie seep nie … [they [students] must make beds, and there is no linen, there is no washcloths, there is no soap …..] (R4)*

> *The things that are going on [in facilities], it actually makes you wonder what's happening to nursing, because standards are dropping. (R6)*

> *With the number of patients that people are seeing, it becomes such as a sausage factory and I think that then even if we do give them all the theory, it gets lost in the hundred patients you're seeing in the clinic. (R2)*

> *We teach it here [ethics in the classroom] and we take it very seriously, but when I'm in the wards and in the hospital, I wonder if people realise the enormity of the ethical issues that they are dealing with … they [registered nurses] just do what they're doing and they don't realise the enormity of what they're doing and what could happen.(R2)*

> *Students are sometimes on a higher level about awareness of ethics than those in practice. (R3)*

Policies

Employing authorities develop policies about ethical issues that refute the approach to ethical decision-making and the application of ethical principles as they are presented to students in the classroom. The dichotomy between what is taught to students and the requirements by employing authorities are confusing to students and not supporting effective teaching-learning. A comment made was:

> *There's certain rules that, for example if a patient has HIV and AIDS, they don't resuscitate. (R1)*

Support to nursing students

Respondents view support to nursing students as an important element in effective teaching-learning. In the events where students are not supported and properly supervised either because of poor planning by the authorities or because of the attitude and/or abilities of professional nurses or nurse educators, effective teaching-learning suffers. Examples of the above from the interviews were:

> *Like this clinic's been opened, staffed and [the staff] are not having enough time to spend with the students. (R7)*

> *I think the major reason [for non-compliance with ethical conduct by students] is the lack of supervision in the clinical area; whether it be by the hospital staff or whether it be by the teaching staff and the lack of role modelling. (R10)*

Summary of findings in theme one: Challenges within the theoretical and clinical teaching-learning environments

a) Challenges within the theoretical teaching-learning environments

Ethics teaching is not allocated the same value as other subjects and inadequate curricular time is available at participating institutions. The assessment of ethics is problematic. Educators themselves regard ethics content as nebulous and abstract and the interpretation of nursing values is diverse. Theoretical content may be inappropriate to address practical challenges in clinical context. Ethics teaching is not sustained throughout the program and is not integrated with the other subjects and poor liaison exists between educators and clinical supervisors. Ethical conduct in clinical practice does not mirror what is taught in the classroom and educators remains uncertain of the most effective teaching-learning method/s to transfer nursing values. Academic demands of educators leaves less time for more effective ethics teaching-learning and large student numbers diminish the quality of teaching-learning.

The reasons for students choosing nursing as a career is dubious and selection procedures remain challenging. Student discipline is a problem. Diverse values and semantics of indigenous language challenge the teaching-learning of values. South African nursing ethics textbooks do not provide scenarios to use in teaching-learning ethics.

b) Challenges in clinical teaching-learning environment

Students find it difficult to integrate theory with practice. Disjunction between theory taught and ethics in clinical setting jeopardizes ethical practice. Policies challenge the application of nursing values and students are not supported sufficiently in clinical practice settings.

Theme two: Challenges related to nursing ethics educators, nursing students and practicing professional nurses

The following challenges were identified by participants in this study with respect to:

1. Nursing ethics educators
   - (i) their knowledge and skills of the nursing ethics educators; and
   - (ii) their lack of experience

2. Nursing students
   - (i) their reasons for entering nursing and subsequent disillusionment;
   - (ii) attitudes of students;
   - (iii) understanding the importance of nursing ethics;
   - (iv) students' background, culture and values; and
   - (v) self-knowledge or awareness.

3. Practicing professional nurses involved in student guidance

   (i) role modelling and attitudes;

   (ii) knowledge and assertiveness; and

   (iii) culture and value system.

1. Challenges related to nursing ethics educators

(i) Knowledge and skills of nursing ethics educators

Compared to other areas of nursing specialization, respondents believe nursing ethics educators are treated differently and inconsistently. Nursing ethics is not always a course of choice for nurse educators. Little opportunity exists for nurse educators to specialise in nursing ethics or to advance their knowledge of nursing ethics. Nursing ethics educators might also be required to teach nursing ethics without a real interest in or little background knowledge of nursing ethics. Specialisation in nursing ethics at a certain level (usually a master's level) is also not required when nurse educators are appointed and nurse educators are not trained in an education system where nursing ethics is enhanced. Respondents made the following comments:

> *Not everybody is keen to teach ethos, maybe they don't feel comfortable with the subject or maybe their attitude towards it is different …not many people specialise in ethics in nursing education. It's just put into the curriculum and with the staffing, if they're given the choice to teach it, they will not choose it. (R2)*

> *The South African Nursing Council requires you to have the basic qualification as well as a higher qualification like a master's degree in that area [area of specialisation] but when it comes to ethics …there is not a prerequisite that you should have done. (R6)*

But there are minimal or no chances for the lecturer to go out on workshops on pressing issues for the teaching of ethical issues. (R8)

Lecturers are not prepared in a program where this [ethics] is enhanced. (R5)

The lack of ethics educators' knowledge and skills of other cultures and their values challenge the effective teaching-learning of values to students. Lack of awareness and knowledge of different values inhibits the effective facilitation of teaching-learning of values to students. Prejudices and biases of the educator may hamper educator objectivity and it is sometimes difficult to overcome own prejudices. Respondents observed the following:

We know too little about other cultures' real values and we don't discuss it. (R3)

Want jou eie emosionele gevoelens speel tog ook 'n geweldige rol om te kyk en om werklik die student te evalueer en weet dis vir my altyd, dis vreeslik maklik om voor … bietjie bevooroordeel te wees teenoor sommige studente. Ek dink nie dit is 'n grap of dis maklik. Ek dink dit is ongeloof fyn kuns om jouself te distansieer en regtigwaar objektief te kyk na hoe jou studente die situasie hanteer. [Because one's own emotional feelings also play a big role to look and evaluate the student and it is always for me, it's easy to be ……. a little prejudiced to some students. I do not think it is a joke or it is easy. I think it is an unbelievable fine art to distance oneself and to look objectively at how your students manage the situation] (R4)

(ii) Lack of experience

New nursing educators need support and guidance from more experienced educators. Nurse educators are expected to teach, while they do not always have the necessary teaching experience. Induction and mentorship of such educators are needed. A respondent mentioned the following:

They're bringing in people with no teaching experience and this is why the induction and the mentorship should be improved. (R5)

2. Challenges with regard to nursing students

Respondents believe nursing students enter nursing for the wrong reasons; do not understand the importance of nursing ethics education during their training and lack self-awareness and self-knowledge. The background and culture of students challenge nursing ethics education and students often display negative attitudes towards their studies and patients.

(i) Reasons for entering nursing and disillusionment

Respondents believe aspirant nurses are not well informed on what nursing really entails or selected to study nursing for the wrong reasons. Nursing is often entered for job or financial security, family pressure or the opportunity to enter university and not because it is a vocation. Students are disillusioned about nursing after their exposure to clinical practice settings. The following comments validate the above:

…the nurses that's coming into nursing is coming for the job and not for the vocation and sometimes it is not their first choice. (R2)

They've [first-year students] gone to the old age home, they then work in the hospitals then they realise this is not … and you talk to them and they say, well nursing wasn't exactly their first choice. The pressure from the family … it wasn't quite what they wanted to do, but they don't want to give up their chance to university. (R1)

(ii) Attitudes of students

Respondents view the attitude of some students as worrisome and having a negative influence on the image of nursing. Educators feel unable to rectify poor attitudes of students despite measures taken by them. Some students have poor attitudes towards their studies and patients. They are absent from classes and clinical practice, where poor role modelling by professional nurses is copied. Students often practice the opposite of what they had been taught in the classroom. Some students are not responsible and do not think that respect for others is important. Nurse educators feel they have no control over this. Lack of pride, care, mindfulness and a lack of proper work ethic are characteristic of conduct exhibited by some nursing students. Respondents reported the following about students' attitudes:

> *We have a student who was ducking and diving … we sent him to student counselling here, but he's still ducking and diving. (R1)*

> *We teach them basic concepts of accountability and responsibility for the employer, the patient, the functions, the obligations and the regulations of our practice and the ethical codes of practice, but these are not taken seriously. (R2)*

> *There is no caring, no empathy … they are judgmental towards their patients. (R6)*

> *Even in small things like pride in the uniform, you don't see that culture even in students starting now. (R10)*

(iii) Understanding the importance of nursing ethics

A respondent believes students do not take ethics education seriously and lack understanding of the importance of ethics in protecting themselves and patients, despite the educators' best efforts of

instilling this important aspect in students. Students do nursing ethics just to get through the examinations. A respondent reported the following:

> *They [students] don't always seem to get the whole enormity of it [nursing ethics] … they wished they'd listened better and understood better and took more care … you [educator] giving them these things you know should be danger zones … some people will hear, some people won't. (R2)*

(iv) Students' background, culture and values

Backgrounds, cultures and values of nursing students, including foreign students, and those of nurse educators, and the values inherent in nursing challenge nursing ethics education differ and nursing ethics educators do not always have knowledge of other cultures. Differences in value systems create value conflict because of the diverse opinions on what is appropriate in nursing. Persons from different cultures and backgrounds may also interpret words differently. Examples of the above argumentations are:

> *The students will probably get into a nice discussion [on the topic of stealing] because some will say yes, some would say no …so it seems to me that there's also a kind of a background issue and stealing is but one simple thing, what about the more complex things. (R2)*

> *It's completely different. Their values are different. When we do value clarification exercises, you must see what happens …they, so you see the difference in their value system. (R3)*

> *I had some students from Taiwan and China and they actually had an issue with our western ways … they came to me and afterwards and say this isn't very clear to us can you explain it … So this is a challenge that we know too little about other cultures' real values and we don't discuss it.(R7)*

(v) Self-knowledge or awareness

Respondents believe some nursing students do not have the necessary self-awareness or self-knowledge and do not reflect on their own practice. Some students do not determine what is needed for self-growth and do not know their own values. A respondent mentioned the following:

> *That's a major thing, critical reflection, on their own practice and how they could improve or change their thoughts because I don't think … sometimes the students know their own ethic, where they stand on their own ethics. (R6)*

3. Challenges with regard to practicing professional nurses involved in student guidance

Respondents believe that the professional nurses in the clinical settings have negative attitudes and do not role model the values of nursing. Practicing professional nurses also lack knowledge, are not assertive and their culture and value system challenges nursing ethics education.

(i) Role modelling and attitudes

Poor role modelling by professional nurse practitioners severely challenges nursing ethics education in clinical practice environments and prevents the internalization of good nursing values in students. Students do not receive the example for ethical behavior from professional nurses when exposed to clinical learning environments. Clinical practice environments are important with regard to nursing ethics, and a conducive learning environment is non-existent in most of the clinical facilities where students are allocated. Registered professional nurses do not assume any responsibility for students, do not manage the clinical unit effectively, show disrespect towards educators and patients, have uncaring attitudes, use their cell phones while nursing patients and practice nepotism in caring for patients. Respondents regard the input of practicing professional nurses in clinical areas as very important in the teaching-learning of students. The following comments demonstrate these views:

I think that one of the big challenges that we have is the lack of appropriate and good role models in the clinical situation. … we (educators] only have so much input to the students in terms of what we teach them in the classroom, but what really often is internalised is what they see in the clinical setting and we struggle with good role models in the clinical setting. (R5)

You will find that the person [professional nurse] … is busy answering a cell phone …where the person was supposed to have been helping a patient … they come late, they're absent without leave. (R6)

High absenteeism in the workplace. All is absent from top down …payday, you won't find people… (R2)

If he's a friend, he'll do the utmost, but if the person does not know the patient, then something else is being done. Because I know the person, because he is the family of my colleague or this is my colleague, I'll do the utmost … so, people come in comradeship. (R8)

(ii) Knowledge and assertiveness

Teaching-learning is challenged in the clinical setting because professional nurses often do not display the needed skills and character traits presented in the classroom as a requirement for professional practice. Professional nurses in clinical settings lack assertiveness while practising and do not have enough knowledge to provide safe nursing care. They do not see themselves as independent practitioners and often do not assume their responsibility. That might be because they do not feel competent enough in their practice or are burnt out. They also lack understanding of the extent of their wrongful actions. The following statements validate these views of respondents:

They've got a little bit of knowledge, but they haven't got enough to actually keep them safe practitioners. (R3)

They haven't got the courage to actually state their perceptions or views in a specific situation … they don't' see themselves as independent practitioners. (R5)

Professional nurses don't want to take responsibility … for example being in charge of the unit … as if they're standing back in certain situations … so that could be because they haven't got the knowledge. (R9)

(iii) Culture and value system

The multicultural societies of South Africa and Namibia challenge the teaching-learning environment. Diverse value systems of professional nurses, nurse educators and students contribute to culturally incongruent care of patients, but it also challenges the existing value system of nursing. While it might be easy to practice a cultural value in a customary cultural setting, that same value might pose a challenge within a multicultural context. Diverse values are also a source of conflict between people. Respondents made the following comments:

I was asking myself, but if a certain culture group believes in Ubuntu, why isn't it visible? Can it be something that I accept it is in my culture, but it's difficult to do it in a trans-culture thing? And the same goes for the westernised values.(R3)

A clash of value systems that is happening in our society is very much multicultural … I think there are a lot of clashes between what one person holds as being appropriate nursing values and what other people hold as being appropriate nursing values.(R2)

A further challenge identified

Another surprising challenge identified by a participant was the high expectation the public have of nurses, unlike the expectation they have of other persons. A respondent mentioned the following:

The public expect too much from the nurses … unlike what they expect from office workers, clerks or people working in the days or teachers … (R8)

Summary finding in theme two: Challenges related to nursing ethics educators, nursing students and practicing professional nurses

1. **Nursing ethics educators**

Nursing ethics educators are not specialized in ethics education and are allocated to teach without real interest in the subject. A lack of knowledge of other cultures exists and may lead to prejudice towards students. There is lack of mentorship and induction when educators are inexperienced.

2. **Nursing students**

Some students enter nursing either for financial benefit, job security or because of family pressure and then are disillusioned after exposure to clinical practice. Student attitude is poor and ethics is not deemed important. Diverse background and values of students and of nursing educators creates value conflict and challenges ethical decision-making of students. Lack of self-knowledge and self-awareness challenges the moral growth of students.

3. **Practicing professional nurses**

Role modelling and attitude of practising nurses are poor and they do not assume responsibility for teaching-learning of students. Lack of assertiveness and poor knowledge and abilities jeopardize ethical nursing care. Diverse cultural values and backgrounds challenge culturally congruent care to patients and the multicultural nursing context is a source of value conflict.

A further challenge identified is the high societal expectation of nurses.

Theme three: Challenges beyond the teaching-learning environment

Respondents also identified challenges from outside the teaching-learning environments that influence nursing ethics education.

(i) Politics and legislation

One respondent believes employment of nurses in South Africa is based on politics and affirmative action, which allow mostly African nurses and few nurses from other races into nursing. The respondent relates the unethical conduct of nurses to the culture of these nurses, their socialisation process, and their focus on money rather than on caring for patients. A respondent mentioned the following:

> *The employment of our nurses is based on politics and affirmative action and you'll notice in the classroom … it's mostly people from the African culture and very few of other races … it seems they're only pocketing on one area and that is why these people come in just for the money … there's no caring, no empathy … they're judgmental towards their patients … I think it's got to do with where these nurses are coming from … their socialisation process, their different norms and values … (R2)*

It is also problematic for teaching-learning of students and for practicing professions when laws and policies override ethical values in the nursing profession. The legislator follows western trends and legalizes abortion, while many South Africans are against it. Legislative prescriptions are forced upon nurses and complicate nursing ethics education because of the differing opinions that are found in the teaching-learning environment and the dichotomy between performing abortions and valuing of human life as a traditional nursing value. A respondent mentioned the following:

Things like for instance the legalisation of abortion, euthanasia all these things that is coming in unwanted by … the majority of people are against it. Yet, *it's being forced on us. Forced on us as nurses and make the clashes become increasingly a problem. (R7)*

(ii) The nursing profession

A lack of coherent understanding and declaration by members of the nursing profession of acceptable nursing values and differences of opinions on ethical issues create uncertainties for nurses. The nursing profession does not collectively clarify the values nurses subscribe to, which are necessary in a multicultural society where there are diverse ideas, beliefs, opinions and values. Respondents stated the following:

The profession of nursing should spell out what we see as our values … I don't think that's very clear. (R5)

We don't know what the group decided on, the professional group then where do you go? … there are so many opinions … (R3)

A further concern is the shift to trade unionism because it brought about a change in the value system in nursing which is now viewed more as a job than as a profession with the emphasis on satisfying individual rights, mostly related to money. A respondent indicated:

[W]e changed from having a purely professional association to a professional association combined with a trade union some years back and … and I think a lot of that sort of approach to nursing had changed how people view it; it's not so much as an honest profession anymore, but as a, as a job and I want my rights and I want my, my salary and, and, and so on and that kind of approach I think has changed nursing. (R2)

(iii) The regulatory authority

Respondents believe the absence of good relationship between regulatory authorities and members of the nursing profession is not serving the profession well. Regulatory authorities do not consult the members of the profession before implementation of new educational programs. Very little communication is forthcoming and Councils are not accessible to answer uncertainties. Nurses are also not clear on what nursing ethics really is, because the South African Nursing Council does not emphasise it enough. The following views of respondents validate the above:

> *[P]eople are making unilateral decisions … from the top … The South African Nursing Council because there … is very little communication with them, with what is happening … what are they implementing, like in a situation now where they're saying we no longer going to do the four-year program and they going to institute another program; it will be … something like that. But there's nobody you can … consult. (R2)*

> *I think the fact that we, that, if you ask anybody, what is nursing ethics, you get different answers and I think that is because it is not emphasised enough from our main authority body, the South African Nursing Council (R6)*

(iv) Organisational culture and employer discipline

A poor culture has developed within the healthcare facilities and extends to the matrons and managers. Respondents view the poor ethical culture in health care facilities as influencing the negative attitude of students who observe these situations when placed in clinical setting. Managers condone unacceptable conduct and protect their colleagues who misbehave. Employer discipline is not addressing these challenges effectively. Respondents mentioned the following:

The organisational culture in the hospitals is so pathetic … no whistle blowing … secrecy … buddy-buddy … no accountability and the matrons are the biggest culprits because they turn a blind eye. (R2)

I mean, you never hear of them, you know, they come late, they're absent without leave, … but students I think see that and, and they just think that, so maybe a little bit more, even if it's just, you know, your employers' discipline that should be more strict on this kind of … stuff. (R6)

Summary finding in theme three: Challenges beyond the teaching-learning environment

One respondent believes that affirmative action excludes some other races from entering nursing. Legalized abortions challenge traditional nursing values in South Africa. There is no collective clarification of nursing values by the profession in diverse society. Trade unionism and emphasis on individual rights and financial gain change the value system in nursing. There is lack of communication and consultation by the Nursing Councils on educational issues. The Councils place insufficient emphasis on nursing ethics. Nursing managers allow development of poor ethical behavior in health care facilities and employer discipline does not address unethical conduct effectively.

5.5 Views of nursing ethics educators on addressing challenges in nursing ethics education

Based on the questionnaire and interview data, the following two ideas indicate how the challenges in nursing ethics education as identified by the nursing ethics educators could be addressed:

- Initiative and change in the theoretical and practical teaching-learning environments
- Change from beyond the teaching-learning environments

Other relevant comments and feelings of participants will also be presented in this section.

Initiative and change in the theoretical and practical teaching-learning environments

In addressing the identified challenges, the following suggestions were made by the nursing ethics educators:

- values and approaches within the educational institutions be improved;
- improved selection procedures;
- improvement in teaching-learning strategies and methodologies;
- responsibilities of the nurse educators be emphasised;
- student support be enhanced; and
- broader involvement in strengthening ethics is required.

Change from beyond the teaching-learning environments

The participants also identified changes that fall outside the domain of their institutions. The following suggestions were made by the nursing ethics educators:

- More independent nursing education system;
- Value clarification in society and the nursing profession is required; and
- Improved professional discipline.

5.5.1 Initiative and change in the theoretical and practical teaching-learning environments

Respondents believe it is helpful when a selected philosophy underpins teaching-learning at an institution. New and innovative teaching-learning methods are needed and collaboration with other educational institutions strengthens new teaching-learning strategies. Student discipline and selection procedures of nursing candidates need improvement. Professional nurse practitioners need education

on nursing ethics, students need better support in the teaching-learning environments and nursing ethics educators have the responsibility to liaise broadly to improve their own skills and knowledge.

Values and approaches within participating institutions

According to one of the respondents, it is helpful if departments of nursing have a specific philosophy or theory on which nursing education is based. The respondent mentioned that this is successful if everyone supports this approach:

> *Your department must be viewed with a specific theory or philosophy that incorporates these values or critical thinking or … it must link, it must link with that. Even your pledge … everything must link with that so that you can internalise it, … if you've got this, it's an underlying philosophy that it's linked to and all your subjects refer back to, you know; and it's another major challenge because everyone must buy into it. (R5)*

Networking and collaboration with other institutions strengthens the teaching-learning at institutions. A respondent believes the international partnerships established by their institution introduced a new teaching-learning method which strengthens value teaching through the simulated patient approach. The respondent mentioned the following:

> *That idea comes from a partnership that we had with Holland University and they do a lot of that [live simulated patients] in the Netherlands … (R7)*

Nursing ethics educators believe that student discipline is important in addressing some of the challenges that institutions have to face. Training institutions should collaborate with regard to student discipline with the managers of institutions where students are placed for clinical practice. Clinical facilities must develop and enforce policies on dress code and the use of cell phones in clinical facilities, not only for students but also for their staff members. Fairness within departments is important and a

remedial approach should be taken in student discipline. The following comments by respondents demonstrate these views:

> *In every unit or department the disciplinary procedures should be the same and the, the … the committees, or the disciplinary committees or units … or units should also look on the side from the lecturer's (R8)*

> *The Minister or the institutions, they need for instance to put down a dress code; what is expected and what is not expected to be on, on, on duty and let the rules be applied. (R8)*

> *The ward or a clinic or something, she must have policies regarding the usage [cell phones] thereof and how it can be tackled for people to … It's a management issue. (R6)*

> *Your employers' discipline that should be more strict on this kind of … misbehaving … (R10)*

Improved selection procedures

Nursing ethics educators believe that improved selection procedures are necessary to attract the right candidates to enter nursing.

Questionnaires, an examination or interviews could be used in the selection of nursing students for nursing education and are required to be done by the educational institutions themselves.

Improvement in teaching-learning strategies and methodologies

The nursing ethics educators taking part in the research believed that teaching-learning strategies and methodologies play an important part in addressing the challenges in nursing ethics education. Induction to nursing ethics for the neophytes in nursing education programs is important and the expectation of ethical behavior from students should be a collective approach of all nursing educators and professional nurses in the health services, not only of individual nursing ethics educators. It is also

important to facilitate the teaching-learning of service to others in nursing educational programs. A formal, written and signed agreement between student and institution that clarifies ethical expectations and student disciplinary procedures is an option in strengthening ethical behavior of students. Respondents commented as follows:

> *Etiek binne verpleegkunde is iets wat jy in hulle eerste jaar moet aanwakker en dan voel ek baie sterk daaroor dat hy moet in elke jaargroep deurgetrek word binne elke vakgebied.[Ethics in nursing is something you must start in their first year and I feel strongly that it must then be integrated in every year and in every discipline]. (R4)*

> *Put the expectations in terms of ethical and professional conduct in writing to the students. …let them sign a contract with … with the, with the school of nursing. (R5)*

> *It's everybody's responsibility to enforce ethical behaviors to the same level. (R9)*

Respondents believe the role practising professional nurses play in teaching-learning of students is important and that in-service education can enhance ethical knowledge and skills. Awareness by practising professionals of the importance of ethics in clinical healthcare facilities including the importance of good role modelling and the supervision of students during clinical practice, are necessary. More clinical supervisors are needed to guide students in clinical practice. Respondents observed the following:

> *Some ungraded courses for them [older nurses] would be good; some in-service training … (R3)*

> *There is a need … communication on making the clinical people aware of their responsibility … we do need to up our numbers of clinical supervisors so we have a smaller student–supervisor ratio (R9)*

Continuous and in-depth evaluation and monitoring of nursing ethics content within nursing education programs are necessary, as well as ensuring the integration of ethics into all other nursing subjects or modules, but it be a module that is presented on its own. Nursing ethics content be increased in the curricula at nursing colleges. Nursing laws, regulations and policies are important content, but it should not be the main emphasis in nursing ethics education. It is also important that nursing educators have the same idea about nursing values and that they know which of these values is important in nursing. A practical component for ethics is necessary, but it need not be formally evaluated. It is important that clinical teaching be meaningful, structured and outcomes-based. Assertiveness training be included in nursing curricula to enable students to articulate conscientious objections when necessary in nursing practice. Respondents shared the following comments:

> *I suppose we have to know about Acts and regulations and, and policies that also guide you, but that shouldn't be the main emphasis.* (R1)

> *… determine what is nursing values … one would see respect as very important; the other one would say justice … (R2)*

> *Students should do, go to the clinical setting for so many hours, but with a specific objective or outcome; either under guidance of a facilitator or not, it depends on how you want to deal with it, but it must be a meaningful something. (R5)*

Respondents identified the need for more innovative teaching-learning strategies. Multidisciplinary teaching-learning and exposure to disciplinary hearing can be arranged. Technology could be used more effectively in nursing ethics education and peer group teaching could also be explored. Respondents shared the following ideas:

…'n generiese module te ontwikkel, waarbinne ons etiese aspek toe aangespreek het;_ken die wêreld van gesondheid, nou sit hierdie multidissiplinêre groep studente daar en hulle deel gevalle binne verskillende dissiplines met mekaar. [… to develop a generic module, within which ethical aspects were addressed, now these multidisciplinary students sit and share cases in different disciplines with each other]. (R4)

… to attend disciplinary hearings. To attend and to see what happens, the consequences. Even if it is through a mock disciplinary hearing… (R5)

… this more emphasis on simulated situations, both in theory and practice and we are thinking of video recording these things and having one or two students doing a procedure or a whatever the scenario would be, and then afterwards let the whole class look at the same thing on the computers and then let them decide was, for instance, the practical things done, the ethics appropriate (R7)

Peer group … again, maybe in a simulated way where one person acts as a patient or you get somebody from outside to be the patient, one person handling it as the nurse, taking it up on video and then discuss it; debriefing and say what was good, what could have been better, what can you do in practice about that … we've got computers; putting scenarios on the computers, let students reflect again on that, make a discussion on that. Role play and drama, the literature says that can help … (R7)

Most of the teaching-learning methods mentioned by participants in the previous chapter of this study are believed to be important in the teaching-learning of nursing students. These methods include case studies, role play and dramatizations by students, class debates and discussions, reflective sessions and using teachable moments when in contact with students.

Proper planning of teaching-learning strategies and methodologies is necessary to overcome the time constraints in nursing ethics education, and critical thinking be facilitated in nursing ethics education. The following are comments of the respondents:

> *Students should have more access or given case studies in which they can analyse, evaluate, but I also think they should critically reflect, and I think that's a major thing, critical reflection, on their own practice and how they could improve or adapt or change their thoughts … (R3)*

Responsibilities of nurse educators

Nursing ethics educators believe that nurse educators have certain responsibilities in addressing the challenges in nursing ethics education. Nursing educators seek opportunities for exchange and collaboration with other institutions on ethics education and in-service training and opportunities for specialisation in nursing ethics to keep abreast with the latest in nursing ethics education. Research and publications are needed in different dimensions of ethics, such as social ethics and people behavior. Nurse educators should be involved in the training and upgrading of professional nurses in the healthcare services and specifically train student preceptors in student mentoring, but also present colleagues in the educational institutions with relevant content on nursing ethics. Respondents shared the following:

> *Research can also being done what could be or in the, in the, in the different dimensions of ethics; something from social ethics and why are people behaving. (R3)*

> *Ek dink dit begin by die … dosente. So, ek dink mens se verantwoordelikheid raak vir my al hoe, al hoe dringender op die dosente … op dosentevlak meer kursusse sou moet begin aanbied om hulle te sensitiseer. [I think it starts with the …..educators. So, I thing one's responsibility*

becomes for me more urgent on the educators …. on educator level more courses should be presented to sensitize them]. (R4)

Nurse educators should also have personal qualities that facilitate the teaching-learning of nursing values. The educators should be aware of their own values and be objective in assessing students. They should be able to learn from students and apologise to students when applicable and they must be committed and involved and guide students in clinical practice. Above all, they should have a passion for nursing ethics, and be a role model to others. Respondents had the following views:

Ek dink dis ("n) ongelooflike fyn kuns om jouself te distansieer en regtigwaar objektief te kyk na hoe jou studente die situasie hanteer. [[I think it is (a) unbelievably fine art to distance yourself and truly look objectively at how your students manage the situation] …'n toegewyde dosent wees wat die etiek deurtrek na al die jaargroepe toe … [… be a committed educator that integrate ethics in all the year groups]. (R4)

The role modelling in the, in the wards or by the lecturer is important … (R9)

The nursing ethics educators in the research group also believed that inexperienced educators should be assisted and mentored, and that nurse educators can expect students to use the cognitive knowledge they receive in education and to apply it in practice. Respondents commented as follows:

An induction program, I would like that for the lecturers … bringing in people with no teaching experience and this is why the induction and the mentorship should be impressed. (R2)

So, ek verwag van hulle om sekere kognitiewe kennis te gebruik en te implementeer in die praktyk … [So, I expect from them to use certain cognitive knowledge and to implement it in practice …] (R4)

Student support

Nursing ethics educators see support to students as very important in addressing the challenges in nursing ethics education. Collaboration with staff members in the clinical practice areas is necessary.. Nurse educators should monitor student absenteeism and take remedial or disciplinary steps to enforce ethical conduct of students. Helplines, student counsellors and student representative councils should be used, or can be established where needed. Nurse educators should identify unsafe circumstances and arrange for the protection of students in the teaching-learning environments. Respondents shared the following comments:

> *I feel helplines for the students, because really, they're left to their own devices … student counsellor and have a post for that … (R1)*

> *… student representative council to play an active role and they can be the change agent for fostering care because they could have like a career day, you've been initiated, have a seminar on caring … (R8)*

> *… he [student] got branded on it … so that's why she prefers not to put them in the, in the gynae ward, … for their own safety (R1)*

Broader involvement in strengthening ethics

More efforts should be made to create and raise awareness of ethics in practicing healthcare professionals. Various methods could be used to provide opportunities for nurses to share their experiences in nursing practice. Strengthening nursing leadership and collaboration with stakeholders, secondary schools, parents and the broader societies where students come from should also be sought. On the other hand, nursing leaders should also listen to what society expects from nurses. Respondents shared the following comments:

One must think about associations or, or journal groups or coming together once a month and just discuss things; how do you experience ethics within the practical setting. I'm, ja, okay, this is another dream I had or still have, I'm not sure, is to maybe through computer, start a, a … what do they call it, pin board, chat board or something like that because that makes us all accessible and we can chat on that on ethics. (R3)

This management course, this is one of the things that we want to implement … specifically this professional practice, ethics values part. (R5)

… to be having discussions and also session or visiting, visiting parents, visiting pastors coming in and re-emphasising what the public are expecting from nurses or how nurses can, can be looked at in the society and, and then there are those who can identify and internalise what is expected socially that is also expected in the profession. (R8)

We need also a platform with the different stakeholders like the Ministry of Basic Education …. up to secondary school, to talk about that [ethics] because unethical behaviors are not only in the profession … the novice [come] from secondary schools … the parents can also be given input or be made aware what they have to … understand their role in enforcing also discipline … there is a need to have a point where the adults can come together. (R8)

Summary findings on initiative and change in the theoretical and practical teaching-learning environments

A specific philosophy on which nursing education is founded is helpful in nursing ethics education. Innovation in teaching-learning methodologies, international partnerships, multidisciplinary teaching-learning, and use of electronic teaching-learning opportunities will strengthen nursing ethics education. Student and staff discipline need improvement and enforcement of discipline be a collective effort by

educational institutions and health care services. Student selection procedures must be improved. Induction to nursing ethics is needed for neophyte nurses and both nursing educators and practising nurses should role model good ethical conduct. A written contract between students and educational institutions may strengthen student behavior. Nursing ethics educations needs strengthening in educational programs, ethics must have a practical component and must be assessed. Improved clinical supervision of students is necessary, clinical teaching-learning must be outcome based and assertiveness training must be added to nursing ethics education. Nurse educators assume responsibility to improve nursing ethics education and awareness of ethics by practising nurses.

5.5.2 Change from beyond the teaching-learning environments

Factors beyond the teaching-learning environment may contribute to the improvement of nursing ethics education in South Africa and Namibia.

More independent nursing education system

A nursing ethics educator questioned the wisdom of having nursing education in the mainstream tertiary education system. The view was that, if nursing education can be more independent, as it was within the hospital school system, the challenges in nursing education might be easier to resolve. A respondent shared the following comment:

> *… perhaps we're even … on the wrong road in putting undergraduates, and this is a controversial one, but, but having undergraduate nursing so at the university … because the university is so controlled how things are done. If we, we had a more independent organisation you'd have more freedom to look at, at those sorts of things. (R7)*

Value clarification in society and the nursing profession

Certainty about which values are important in society and the profession, and how these values are practiced in the profession are necessary to prevent unfavourable influences on societal and nursing values. According to one participant, society should guard against other western influences and clarify our own societal values. It is also important for the nursing profession at large to determine what the value system of nursing is as this is necessary to address the different perceptions of values of nurses in South Africa and Namibia. The following comments were raised by respondents:

> *… stop copying America and Europe and start thinking for ourselves and valuing what we've valued … (R7)*

> *… the profession of nursing should first spell out what do we see as our, our values … (R5)*

Improved professional discipline

A respondent thinks action by regulatory authorities may be necessary to discipline student nurses. Formal professional discipline could strengthen ethical behavior of students and it sometimes might be necessary for regulatory bodies to penalise students. A respondent commented the following:

> *… a reprimand or whatever, I think the Nursing Council should become more prominent in, in disciplining students. (R8)*

Summary findings on change from beyond the teaching-learning environments

Mainstream tertiary education for nursing might not have been a wise decision. Society should clarify its own values and not be influenced by other society's value systems. The nursing profession address the different value perceptions by nurses in clarifying nursing's own value system. Professional discipline must be improved, including the discipline of students.

5.6 Nursing ethics educators' views on the internalisation of nursing values

In coding the views of the nursing ethics educators on the internalisation of nursing values, it became apparent that the participants repeated many of the issues regarding challenges in nursing ethics education.

The following two aspects indicate additional views on how nursing ethics education can facilitate the internalisation of nursing values in student nurses.

- The responsibility of educators, professional nurses and students
- Further initiatives by stakeholders in nursing education

The responsibility of educators, professional nurses and students

Nursing ethics educators in the study group mentioned the following additional suggestions in facilitation of the internalisation of nursing values in nursing ethics education:

- improved personal and professional qualities of nurse educators;
- empowerment of nurses in clinical practice settings; and
- improved student responsibility

Further initiatives by stakeholders in nursing education

Nursing ethics educators believe that the following stakeholders may contribute to improved conditions that will facilitate the internalisation of nursing values in nursing ethics education:

- the Ministry of Basic Education;
- decision-makers in the healthcare delivery system; and
- the regulatory authorities.

5.6.1 The responsibility of educators, professional nurses and students

Internalization of nursing values can be enhanced if nurse educators improve their own skills and are creative and innovative in nursing ethics education. Practicing nurses must be empowered to be good role models and the responsibility of students to conform to nursing's traditional values must be enforced during training.

Improved personal and professional qualities of nurse educators

Educators should know which difficulties students have in the internalisation of nursing values. Ethical sensitivity by lecturers is important in setting an example for students, and respect for students' faiths and cultures needs consideration, for instance in expecting students to partake in activities or in the scheduling of tests. A respondent made the following comment:

> *As you are unique, the other person is unique and you must respect the decision that the other person takes, because a person would say no or yes, for example to partake in a specific treatment or to partake in, for example, activities, for … a test. The test could be on a Jewish holiday, so our university would advise that we don't schedule our things on that specific day. (R7)*

Nursing ethics educators should be creative in teaching-learning to assist students in internalising nursing values. Informal contact with students is important and one-on-one and small group interactions are valuable. Educators find ways to make students realise the value of service to others. Creative ways of assessing the internalisations of values may be helpful, such as panel examinations, using socialisation models, and self- and peer group appraisal of professional growth (Cullen & Harris, 2009). Respondents shared the following comments:

… this one-on-one situation or the one with the small group is where those kind of things really happens … (R6)

… if you want to assess what, how it [internalisation] was done. Sit with that model for the internalisation of ethics … (R5)

They monitor themselves with their overall development and growth, but also specifically in this professional practice ethics values part … self-evaluation, that's right, but we also want to do peer evaluations, but we are starting now with this kind of self-evaluation through the performance appraisal system. (R1)

The attitude and approach of nursing ethics educators contributes to effective teaching-learning of students and interest in students convey care and understanding which enhance caring values of students. Educators must have a positive approach, talk positively about nursing to build the image of nursing and ensure that students attend to the ethical aspects of nursing in all case presentations. A student mentoring system could also be helpful so that senior students who exhibit good ethical behavior could mentor junior students. A respondents stated the following:

… a mentoring system where, for instance, second-year students would mentor first-years … choose those students who seem to exhibit the role modelling behavior and … being on time, punctuality, not exposing patients, those that have those characteristics … (R10)

Empowerment of nurses in clinical practice settings

Educators and managers in health care facilities have a responsibility towards practising nurses and should support attainment of skills in guiding and managing nursing students and address the challenges in nursing units. Professional nurses in the health services ought to be good role models to students to

facilitate internalisation of nursing values and nursing managers be empowered by their employers to act against nurses who act unethically. Respondents suggested the following:

> *Empower the administrators so that they feel and know they can fire nurses who are guilty of unethical behavior. (R2)*

Improved student responsibility

One participant believes that it is the responsibility of the students to internalise the values of nursing after they had come to understand it, and that it be enforced in some way. This respondent said:

> *I think if they understand what it means it, it, they should be able to decide whether they want to make that part of their life, but it should be enforced in such a way that they don't have an option. (R8)*

Summary findings on the responsibility of educators, professional nurses and students

Educators are required to have a positive approach towards nursing, be culturally sensitive and respect students' faiths and cultures. Creative teaching-learning, including assessment, methodologies may assist students to internalize nursing values. Student mentoring is also important. Practicing professional nurses should be good role models and employers should empower nursing managers to address unethical conduct of nurses in the health care services. Students themselves should assume responsibility to internalize nursing values.

5.6.2 Further initiatives by stakeholders in nursing education

Collaboration with secondary educational institution may create a culture of discipline before students enter institutions of higher learning. Decision-makers in the health care system and regulatory authorities should also consider issues that may hamper ethical nursing practice.

Ministry of Basic Education

Broader societal collaboration is necessary to enhance values in societies. It is important that the Ministry of Basic Education be involved in discussion with educational institutions about behavioral aspects because value education can start earlier, in secondary schools already. A respondent shared the following comment:

> *…with the different stakeholders like the Ministry of Education, Basic Education, educational … up to secondary school, to talk about that because unethical behaviors are not only in the, in the profession because the professions do or are … with the novice from the high, secondary schools and this, usually the students keep on behaving the way they used to … (R8)*

Decision-makers in the healthcare delivery system

The provision of bursaries by health care authorities to students may be a wrong incentive to enter nursing. The bursary system for nursing student should be stopped because some students enter nursing only for the money and not because they really want to serve the public. Decisions to import foreign health care professionals create ethical and legal challenges in health care settings. Foreign healthcare practitioners should be orientated to and evaluated on the laws and ethics of the respective countries in which they practice. A respondent commented the following:

Orientation and evaluation of foreign health personnel on Namibian laws… (R8)

The regulatory authorities

Nursing Councils can enhance the ethical foundation of nursing by taking their roles and functions more seriously. Internalisation of nursing values could be supported by a functional professional disciplinary system, and they reckoned the regulatory authorities of nursing should remove unprofessional persons from the nursing register and make their names known to the public. The following comment was made by a respondent:

Change them [South African Nursing Council] … get their system sorted out so that they can take people off the role again … they should make "criminals'" names public. (R2)

Other relevant comments and feelings of participants

The nursing ethics educators mentioned that confidentiality regarding students' personal information is an important value that the educators themselves practice while supporting students in the teaching-learning environment. It was also mentioned that professional nurses practicing in private hospitals could be better role models for students than professional nurses in state facilities could where students are placed for clinical practice. Further observations made by the respondents were that nursing ethics education is a complex issue, that assessment of good ethics is difficult, and that some students really go "the extra mile" during clinical practice. During the interviews, the participants expressed some negative feelings. They felt that they did not have answers for the challenges they face, and in some instances, they appeared desperate about this. Some still suffered from guilt feelings about the past and the wrongdoings during the apartheid years. In some instances, participants reported being very cautious because students may be very sensitive about certain issues. A certain measure of sadness about the conditions in current nursing and nursing education was also apparent, while some feelings of alienation

were also observed when a participant recounted that professional nurses do not appreciate any form of criticism from educators when confronted with their wrongdoings. Another participant displayed positive feelings and excitement about the multidisciplinary module on ethical issues at their institution. Some comments by respondents are as follows:

> *I don't know how it [ethical values] could be developed. I don't have any sense as to how it could be done. (R6)*

> *Alles wat in die verlede verkeerd was, is jou skuld want jy sit in hierdie vergadering. [Everything that was wrong in the past, are your fault because you sit in this meeting]. (R4)*

> *And I'm quite sad about that; I've seen it. (R7)*

> *Ek is eintlik baie opgewonde daaroor. Ek het gevoel ek wil self daai module deurloop want dit gaan, dit gaan vir my sinvol wees. [I am actually very excited about it. I felt I wanted to do that module myself because it will make sense to me] (R4)*

Summary findings on further initiatives by stakeholders in nursing education

Ministry of Basic Education should liaise with participating institutions about value education that should start in secondary schools. Bursaries to nursing students should be stopped to allow persons to enter nursing for the right reasons. Foreign practitioners should be orientated and evaluated before allowing them to practice. A functional disciplinary system may improve internalization of values. Unethical nurses should be removed through discipline and their names must be published publicly. Educators admit nursing ethics education remains a complex issue. Respondents have both negative and positive feelings about nursing ethics education in South Africa and Namibia.

Concluding commentary

The views of experienced ethics educators identified manifold issues in nursing ethics education that contribute to the challenges that are faced in the teaching-learning environment as well as the health care facilities in South Africa and Namibia. Challenges in the teaching-learning of nursing ethics as provided d by respondents indicates that factors in both the classroom and practical setting influence effective teaching-learning of nursing ethics. Participating ethics educators believe institutional environments, their workload, poor student attitudes, student numbers, students' reasons for entering nursing and selection procedures and the difficulty to instil nursing values in students challenge nursing ethics education. Institutional environments and student numbers also hamper more effective teaching -learning strategies and methodologies. Students struggle to overcome the theory-practice gap and educators and practicing professional nurses are challenged in proper support to students in clinical settings. Some nursing ethics educators believe their knowledge and skills and lack of experience hamper effective nursing ethics education, while professional nurses in clinical settings also lack knowledge, have poor attitudes and are not good role models for students. Different values systems of students and educators complicates teaching-learning of ethics. Beyond the teaching-learning environment and the challenges related to nursing ethics educators, students and professional nurses in clinical settings, nursing ethics education is also challenged by inaccessible regulatory authorities and by law makers who do not consider the influence of legislation on nursing practice. The nursing profession at large also lack coherent declaration of nursing values, while the culture of care has deteriorated in health care facilities.

The empirical data show that improvement in the teaching learning of nursing ethics and the ethical conduct of all categories of nurses need collaboration between educational institutions, health care institutions, regulatory authorities and political decision makers. The empirical data in this study

represent the views of nursing ethics educators in educational institutions in six provinces in South Africa and the one educational institution in Namibia offering undergraduate nursing education. The data present primary information on nursing ethics education and pave the way for further research regarding some issues identified by the empirical data in this chapter.

CHAPTER SIX

NURSING ETHICS EDUCATION IN SOUTH AFRICA AND NAMIBIA – A CRITICAL APPRAISAL

6.1 Introduction

The decentralisation of healthcare services in South Africa and Namibia increases accessibility, especially in rural areas, and nurses are primarily tasked with the delivery and management of these services in the most remote and marginalised areas of both countries. Both Namibia and South Africa have high burdens of disease, such as Tuberculosis, HIV/AIDS and Malaria, and are facing challenges in improving the health outcomes to which they are committed (Republic of Namibia, 2008; Republic of South Africa, 2011). The training and utilisation of nursing professionals as a health resource, to improve the health outcomes for South Africans, is imperative because nurses are the "backbone, and indeed the engine of the healthcare delivery system" (Republic of South Africa, 2011: 7). This statement is equally true about nursing professionals in Namibia.

Nursing education programs should prepare nurses to fulfil service delivery demands within the ethical and legal framework of the nursing profession. Nursing ethics education particularly bears the responsibility to provide quality teaching-learning, and Woods (2005) rightfully asks whether nursing ethics education is delivering the goods. Ethical conduct is the showpiece by which good governance and the image of service delivery agents are judged (Edwards, 2007). The nursing profession has reason to be concerned about the ethical conduct of many nurses, especially those in public health care facilities. Nursing ethics education and accountability has become even more important for public (and private) nurses.

The empirical component of this study (cf. Chapters four and five) has shown that South Africa and Namibia share most challenges in nursing ethics education, as viewed by experienced nursing ethics educators in both countries. As a former protectorate of South Africa, the undergraduate nursing

education program in Namibia mirrors the South African model. It is therefore possible to jointly appraise nursing ethics education in both countries, but some aspects may need some specific country reference. The following main issues, as derived from the empirical component of the study, will be highlighted in assessing nursing ethics education in participating institutions in South Africa and Namibia:

- Theoretical and clinical nursing ethics education
- Nursing ethics educators, nursing students and practicing professional nurses
- The role of external stakeholders in nursing ethics education

6.2 Theoretical and clinical nursing ethics education

Arguments on whether ethics education has any effect on improved patient care (Gross, 2001) or will prevent moral lapses by health professionals (Benatar, 2003), or how ethics should be taught and what content such courses should have (Bolin, 2006; Brigley, 2006; McCullough, 2002) are subjects that are well documented and defended in the literature. According to Aristotle, practical wisdom is a type of knowledge, and knowledge can be facilitated in education. Moral education however does not guarantee moral persons, just as scientific education not necessarily guarantees an exemplary scientist.

Moral education does not guarantee moral conduct, but the alternative i.e. absence of ethics education is unthinkable. At the least, inclusion of ethics education into undergraduate nursing programs can provide proof to educational institutions that ethics education was provided to student nurses. This might especially be important when regulatory authorities (or courts of law) need to determine whether nurses acted reasonably. In disciplinary hearings (or court cases) a third person (witness) will have to provide evidence that certain content was covered in educational programs in determining reasonability. It is impossible to confirm the offering of moral education if same is not included into the

curriculum. Moreover, if no moral education is provided to nurses it will leave a big void in the preparation of professionals whose existence is founded on a moral need, i.e. to care for the vulnerable. Nursing ethics educators need to believe that they do contribute to the moral growth of students during nursing ethics education. Wouter Basson's defense during his disciplinary enquiry by the Health Professions Council of South Africa, of unawareness of and no training in medical ethics (City Press, 2013) emphasizes the necessity to prepare health care providers in ethics. While it is true that affective skills are more difficult to assess or to confirm the attainment of such skills, the alternative, not offering moral education to nurses, is not an option. The best nursing ethics educators can do is to consider and address the challenges influencing moral education of students.

The following aspects in theoretical and clinical nursing ethics education, as identified by respondents in the empirical component of this study, are considered and judged in the light of contemporary literature and the context within which nursing ethics education takes place currently in participating institutions.

A more independent nursing education system

The view that nursing education might better resolve its challenges in a hospital nursing school system might have merit, but transition to a new system is never expected to be without its growing pains. Transition might have its challenges (Hutchinson et al., 2011) but the nursing profession should not lose sight of the advantages of being part of the mainstream educational system in South Africa and Namibia (Van Dyk, 1997).

The current cadre of nursing ethics educators remembers the previous education system well. Before nursing was incorporated into mainstream tertiary education, most nursing education took place in the hospital school system. Control of nursing education in the hospital school system rested with the nursing service managers and senior nursing staff within the hospital schools. Monitoring and control of clinical teaching-learning was more effective within the hospital school system, because the number of

students within each hospital school was small and nursing students were provincial employees and were obligated to their employers. Many previous trained nurses as well as current nursing ethics educators vouch that the ethical culture within the hospital school system was much better compared to the system followed today, because the expectancies from students as employees differed and supervision of small numbers of students was more effective. Namibia joined the tertiary education system in 1986, and started to offer an undergraduate nursing degree in 2008. The hospital school system was abolished in 1985 in South Africa and Namibia. It is doubtful whether nursing education can re-introduce the hospital school education system. Nursing has moved forward since the mid 1980's and rightfully owns a place within the tertiary education system. Being part of the mainstream tertiary education system contributed to the development of nursing as a science through research and collaborative opportunities, which will be difficult in a hospital school system. Students are no longer provincial employees but have supernumerary student status and enter tertiary institutions by fulfilling similar entry requirements as other students, buttressing entry standards for nursing programs. Contrary to views that students enter nursing for the money, supernumerary status of students may attract students who choose nursing as a career and for the right reasons. Introducing the hospital school system will not rid nursing ethics education of its current challenges. The solution rather lies in better collaboration between educational institutions and all stakeholders involved in nursing education, improved marketing strategies for nursing programs and improved selection procedures for nursing candidates.

Difficulties in satisfying academic requirements and institutional policies

Since nursing education shifted to mainstream tertiary education, nursing educators have had to fulfil the requirements of academic teaching at tertiary institutions. While these expectations of academic research and community service are commendable, and nursing academics have to fulfil these

requirements, there is little understanding from management at tertiary educational institutions that nursing education requires more than lecturing in a theoretical educational situation. Clinical guidance of students is labour-intensive, and quality teaching-learning is not possible with limited human resources. High student numbers aggravate the challenge of the shortage of nursing educators and clinical supervisors. Clinical guidance requires a lower student-educator ratio, but often institutional decision makers do not understand the context and requirements of clinical teaching-learning in nursing and institutional policies (e.g. workload and student-educator ratios).

Variations in offering mode, hours per week and academic year of nursing ethics education

When nursing education joined the mainstream of tertiary education in the mid-1980s, nursing schools, departments or faculties at institutions of higher learning received a high degree of autonomy over the development and presentation of nursing curricula. The regulatory authorities, the South African Nursing Council (SANC) and the Nursing Council of Namibia (NCN), provide broad frameworks for the education of nurses within different nursing qualifications, and the respective national qualifications authorities provide a framework at different levels for tertiary qualifications. Educational nursing directives by the SANC (Republic of South Africa, 1985) and NCN (Republic of Namibia. 2008b) prescribe the minimum requirements for teaching-learning of nursing ethics, and these are generally followed during curriculum development and teaching-learning activities at institutions. Both the SANC and the NCN educational directives for undergraduate nursing programs support nursing ethics as a minor and not major subject in undergraduate nursing programs. Provisions with regard to minimal hours of instruction (Republic of South Africa, 1985; Republic of Namibia, 2008b) make it difficult for ethics educators to defend higher amounts of credit allocation to nursing ethics in undergraduate nursing programs, despite the views of participants that nursing ethics education should be a major subject.

Lack of standardisation in undergraduate nursing education programs of participating institutions within South Africa contributes to the uncertainty of the quality of nursing ethics education. Standard setting is a requirement for quality assurance (Booyens, 2001) and will be helpful in creating a common, and less questionable, approach in the teaching-learning of nursing ethics at participating institutions in South Africa. Namibia is not challenged in the same way as South Africa in this regard, because professional undergraduate nursing education is currently offered at only one institution. Tertiary institutions pride themselves on being autonomous and capable of developing appropriate curricula, but for nursing ethics education this means great variation in curriculum content, the allocation of hours per week, the academic year in which ethics education is offered and whether nursing ethics is offered as a separate module or integrated throughout the programs at participating institutions. Complicating the matter of standardisation further is the offering of nursing education at nursing colleges in South Africa, as well as the education of different categories of nurses in both South Africa and Namibia. Nursing colleges in South Africa are affiliated to universities which assist in quality assurance measures, but colleges function as governmental institutions and are ultimately accountable to provincial heads. This two pronged approach may contribute to difficulties in satisfying affiliated university relations as well as provincial expectations by nursing colleges. Although assessment of enrolled nursing education was not evaluated in this study, it is worthy to mention that the education of different categories of nurses may further challenge nursing education as it becomes increasingly more difficult to determine the scope of practice of the enrolled nurse and the registered nurse practitioners. In practice enrolled nurses are expected to take over many duties of registered nurses because of staff shortages, and training institutions are faced with difficulties when curricula needs to be developed for the training of enrolled nurses, because the expectation is to develop curricula for the service needs of respective countries. It therefore does not make much sense to train different categories of nurses, while the expectation for service delivery in both South Africa and Namibia requires comprehensive nursing care which is required

to be delivered in both urban and rural settings. Training of different categories of nurses expose both registered and enrolled nurses to precarious ethical situations because registered nurses are not always able to supervise enrolled nurses effectible because of work overload and enrolled nurses are often required to perform tasks of professional nurses, which heighten the risks for these enrolled nurses. The current regulatory system is unfair to both registered and enrolled nurses.

The broad frameworks in regulating nursing education, is not helpful in setting a standard for quality nursing education generally, and nursing ethics education, specifically. A comprehensive and national nursing education and training policy framework should be developed in South Africa as was identified during the provincial consultations by the organising committee of the National Nursing Summit in South Africa in 2011 (Republic of South Africa, 2011).

Offering nursing ethics as part of other modules or integrated throughout the program

Some participating tertiary institutions combine nursing ethics education with other module content. Nursing ethics education might for instance be part of a module of either nursing management or general nursing science. While integration of nursing ethics throughout an undergraduate nursing program, i.e. incorporated in all modules, may be commendable, having nursing ethics content as part of another module might lessen the importance with which nursing ethics could be viewed. It is also uncertain how well nursing ethics education content is integrated throughout the curriculum at participating institutions that integrate nursing ethics into the undergraduate program. Nursing ethics content and assessment might be discounted when educators have a need to prioritise or when cognitive and psychomotor skills take precedence over the attainment of ethical competencies. Furthermore, it is problematic for effective teaching-learning when ethics content is integrated within different subjects with subject specificity and no general theoretical content explains the applicable

ethical principles beforehand. If nursing educators require students to develop skills to reason logically and systematically, then the development of curricula should also fulfil the requirement of logic.

The neophyte nurse needs some introduction into the ethos of the nursing profession, therefore it would be ideal to offer an introductory module in the first study year in undergraduate nursing programs. In subsequent study years the values and norms and the affective competencies need to be integrated in all modules of the undergraduate nursing program to sustain nursing ethics education. In the last study year students need consolidation of ethical knowledge and skills by a further modular course in preparation to become a professional nurse after completion of their education.

Attachment of a clinical component

Nursing modules are allocated with a clinical component when clinical nursing skills, mostly psychomotor skills, form part of such modules. The exception to this is psychiatric nursing. It is not surprising that most participating institutions do not attach a clinical component to nursing ethics education. Both Markie (1994) and Moodley (2007) indicate the difficulties in the assessment and guaranteeing of normative competencies in ethics education (Markie, 1994; Moodley, 2007). To ensure meaningful teaching-learning in clinical setting, educators and clinical supervisors must supervise students because it is doubtful whether clinical practice time is used meaningfully by students in the attainment of the necessary clinical and ethical competencies. The provision to students of concrete outcomes for theoretical teaching-learning is also required for clinical teaching-learning settings. When concrete outcomes are not provided to students for clinical teaching-learning, nursing ethics educators fail in their teaching-learning of nursing ethics. Nursing ethics educators cannot trust that students will learn affective competencies without the necessary concrete expectations and effective guidance from clinical educators. Tertiary institutions guarantee competencies when qualifications are awarded to students and should at least have some evidence that ethical competencies were assessed and

confirmed adequately before awarding qualifications according to which nurses will be registered as professional persons.

Nursing ethics education content

Considering the current prescribed sources available in South Africa and Namibia for nursing ethics education, most of the expected ethics content is offered the participating institutions. Research ethics might be taught in research modules and this content was not available to the researcher.

The rights of patients and the rights and duties of nurses are covered in most of participating institutions content. According to London & Baldwin-Ragaven (2008) South Africa is a world leader considering the requirement by the regulatory authorities of health professionals of inclusion of human rights content in health professional curricula. The rights of patients and the corresponding duties of nurses form an important part of nursing accountability and any refusal of care by nurses should be carefully considered by nurse practitioners (Maze2005). It is commendable that participating institutions included human rights content in nursing curricula.

A core value in nursing is patient advocacy. Protection of patients and safeguarding the interest of patients lie at the heart of the nursing profession. It is disappointing that core functions of the nurse as patient advocate and team member are not sufficiently strengthened by appropriate content within nursing curricula. Notably absent from nursing ethics content presented at the participating educational institutions are teaching-learning content related to assertiveness, which is an essential quality of the nurse advocate. Reality-based ethics education requires that nurses need assertiveness skills to fulfil their advocacy role in clinical practice. Only one institution (cf. chapter four) provided evidence of inclusion of African thoughts in the final study year in undergraduate nursing ethics education. More effort should be made to incorporate clear explication of the concept of “Ubuntu” as an African approach to morality in the content of undergraduate nursing ethics education.

The content on moral decision-making in health care focuses mainly on ethical principles, but the nurse's role in moral decision-making or a bioethical decision-making process as a usable tool in objective moral decision-making could not be identified in the content of most participating institutions.

Nursing ethics content is incorporated in Nursing Management, Mental Health/Psychiatry as well as Nursing Research modules at some participating institutions. No content on good governance or prevention of corruption was identified in nursing ethics content. Nurses are involved in many operational decisions on healthcare service delivery, involving tenders, contracts and procurement. It is therefore important that nurses be educated on the dangers and consequences of corruption (Prinsloo & Beukes, 2005). It might be that content on good governance is covered in nursing management modules at participating institutions.

Respondents in the study identified reluctance on the side of practicing nurses in clinical settings to be involved in education of students as a major challenge in nursing ethics education (cf. chapter five). It is therefore important that clinical teaching as an ethical duty of the professional nurse be emphasised in nursing ethics education content. Content on clinical teaching was observed only at one participating institution, but it might be that clinical teaching is covered in nursing management modules at participating institutions.

Student selection and bursaries

While selection procedures in developed countries focus on alleviation of the attrition of student nurses (Scott, 2010; McLaughlin et al., 2007), student selection challenges in South Africa and Namibia, as indicated in this study, focus on identification of students who are most suitable to enter the nursing profession and decentralisation of student selection. Respondents indicated that nursing applicants cannot be interviewed due to high application numbers. Interviewing student nurse applicants is practiced in other countries (Wilson, Chur-Hansen, Donnelly & Turnbull, 2008; Roberts, 2010) and local

nursing schools should attempt to institute this practice. High student numbers should not deter local nursing schools from interviewing prospective nursing students because initial academic admission scores can be used to select manageable interviewee numbers. Innovative selection procedures are needed to ensure suitable student candidates, and closer contact with applicants is needed during the application and selection process.

The perception that government's affirmative action policy challenges nursing ethics education and selection procedures should be understood against the background of the poor clinical environment in state healthcare facilities, because these issues trigger the search for reasons for poor service delivery in healthcare facilities in South Africa and Namibia. The perception that affirmative action challenges quality service delivery and professionalism is well recorded in both scientific and popular media (Heinecken & Van der Waag-Cowling, 2009). Affirmative action remains a contentious issue. Forty years after initiating affirmative action in the United States of America, researchers still investigate initiation of affirmative action and people's perception thereof (Haley & Sidanius, 2006; Olu Oyinlade, 2013). Questions also remain whether affirmative action really levels the playing field for those intended to benefit from it (Harris, 2009). It seems more studies are needed to establish the results of affirmative action policies, especially in higher education in both South Africa and Namibia, but it has been proven that diverse student bodies in higher education have definite advantages for institutions (Featherman, 2010).

It is common practice in South Africa and Namibia for the respective governments to provide nursing students with bursaries or student loans. This practice is not only important to alleviate the shortage of nurses, but it is important as a process of restorative justice for those people who were previously not able to access institutions of higher learning. Withholding bursaries from nursing students will not be helpful in addressing the challenges in nursing ethics education. More appropriate selection procedures

of nursing candidates might be a more acceptable way to address some of the challenges nurse educators face in the teaching-learning situation.

Lack of innovations in teaching-learning strategies and methodologies

Despite the high degree of autonomy of nursing ethics educators, few innovative teaching-learning strategies are visible in nursing ethics education in South Africa and Namibia.

Nursing ethics educators still rely mostly on conventional teaching-learning strategies and methodologies. While conventional methods may have a place related to specific content, current expectations in teaching-learning cannot be met by lectures, power point presentations, classroom discussions, role–play exercises and reflective sessions only. Nursing ethics educators need to explore new and innovative teaching-learning strategies and methodologies to facilitate effective teaching-learning in nursing ethics education (Epstein, 2011; Groh et al., n.d.; Leppa & Terry, 2004).

With regard to the formal assessment of nursing ethics content, the challenge lies with assessing and confirming the attainment of nursing values by nursing students after teaching-learning contact or experience. It remains difficult for nursing ethics educators to confirm this attainment of values by formal means, which might be the reason why nursing ethics is not formally assessed by nursing ethics educators. Both Markie (1994) and Moodley (2007) agree that teaching-learning and the assessment of values are problematic. Including affective outcomes in curricula means that educators need to assess these outcomes the same way non-normative outcomes are assessed (Markie, 1994), and confirmation that practitioners will practice as virtuous practitioners or that they have internalised values, remains difficult (Moodley, 2007).

Innovative teaching-learning strategies should be student-centred and should integrate theory with practice (Holaday & Buckley, 2008), it needs to be problem-based and should enhance critical thinking in

students (Lin et al., 2010; Marchigiano, Eduljee & Harvey, 2010; Kyle, 2008). Teaching-learning strategies and methodologies should be outcomes-based and situation-specific (Grealish & Smale, 2011; Lenburg et al., 2011) and have innovative assessment strategies such as objectively structured clinical examinations (Baid, 2011). It should also include student self-assessment opportunities (Mader, 2009).

Farrel, Shafiei and Salmon (2010) developed a model for training nurses interacting with clients with challenging behaviors because the authors agree that values and attitudes of nurses influence nurse–patient interaction. Training for effective nurse–patient interaction requires not only skills acquisition, but should also include, what the authors call SOS, i.e. an awareness of **s**elf, **o**ther, and **s**etting. The interaction between nurse educator and student in nursing ethics education is no different. Nurse educators should also be aware of their own values and attitudes, the values and attitudes of students, and the setting within which education is taking place, while facilitating learning and while assessing nursing ethics assignments.

Woods (2005) is concerned that the teaching-learning of nursing ethics is misplaced when it does not address practical nursing challenges faced by nurses daily, while Chaloner (2007) thinks nurse practitioners are misguided when they think of ethics as distant concepts that have no practical effect on everyday practice. Nursing ethics education needs to apply abstract theory to practical nursing situations (Woods, 2005). This research study aims to assess nursing ethics education in South Africa and Namibia critically because of the firm belief that nursing ethics education should facilitate practical wisdom explicated by Aristotle, as presented in Chapter three of this study. This means that nursing students should be enabled by the teaching-learning process to practice nursing contextually and to address the ethical challenges, which are faced daily, in the most appropriate and ethically sound manner within the specific situation. Ethics should therefore be integrated, horizontally and vertically, into education because of the constant interaction between what is taught and current ethical issues

(Campbell, Chin & Voo, 2007). According to Holaday & Buckley (2008), nursing education is severely challenged by a complex and constantly changing healthcare environment while compressed and taxing curricula within shortened timeframes add to this challenge. Nurse practitioners need a variety of ethical knowledge and skills to practice effectively (O'Brien Steinfels, n.d.; Waite & Calamaro, 2010). Globalisation and internationalisation of the nursing workforce add to the challenges of providing relevant nursing content in nursing education programs (Caldwell, Lu & Harding, 2010). Examples of innovative teaching-learning methods are the hybrid, inquiry-based learning framework described by Holaday and Buckley (2008) and the COPA Model (Competency Outcomes and Performance Assessment Model) as described by Lenburg, Abdur-Rahman, Spencer, Boyer & Klein (2011).

Considering the teaching-learning strategies and methodologies indicated by respondents in this study (cf. chapter four), innovation is needed in presenting ethics content to students. Only one respondent indicated that internet searches are used as a teaching-learning methods, while –learning can be used effectively in nursing ethics education. Case-based and problem based learning used by some respondents is commendable because it creates opportunity for critical thinking by students.

Innovations in nursing education should also consider collaboration and partnerships in clinical placements of students (Grealish & Smale, 2011; Newton & Cross, 2011). New and non-traditional teaching-learning strategies and methodologies that enhance teaching-learning in clinical placement settings are camp nursing (Vogt, Chavez & Schaffner, 2011) and school-based community projects (Bassi, n.d.), which are forms of service-learning that attempt to integrate community service with education. Service learning also enriches student experiences, enhances civic responsibility and at the same time delivers a service to communities (Groh et al.,n.d.). Service learning is an innovative strategy to facilitate acceptance by nursing students of the service motive of nursing. Epstein (2011) proposes therapeutic landscaping as a new teaching-learning strategy that could provide nursing students with the

opportunity to reflect on ethical concepts in their everyday nursing practice. This strategy however needs a supporting, guiding, trusting and accepting atmosphere to enable students to be creative, intuitive and transformative in the integration of ethical knowledge into nursing practice (Epstein, 2011). This will require the nursing ethics educator to be positive and approachable in the teaching-learning of students. To ensure practical competencies, students need practical exposure and opportunities to practice the ethical competencies required (Wocial, 2008). Competencies need not be practiced only in clinical practice settings, but could also be attained in simulated settings, including online exercises (Guhde, 2010), computer-based simulations and videos, which all provide a safe environment until competencies have been attained (Chen, 2011). Few of the above mentioned teaching learning strategies and methodologies are applied by ethics educators at participating institutions.

In some participating institutions in Namibia and South Africa, the problem-based approach, which is imperative when facilitating critical thinking and reasoning skills in nursing students, is severely hampered by the large student numbers in the classroom and clinical practice situations. During the interviews for this study, nursing ethics educators vented their extreme frustrations with the unconducive teaching-learning environments in South Africa and Namibia. Many concerns these educators have fallen outside their jurisdiction and make them feel powerless. Various challenges that are faced by nursing ethics educators are created to satisfy other needs, but not the need for quality nurse education. An example of this is the intake of high numbers of nursing students into undergraduate programs. Some nursing schools or faculties are constantly pressurised to take in more nursing students to address the needs of the respective countries. Quality nursing education is also compromised in the clinical settings because of the constant competition for clinical sites, which need to be shared with other students (Davis & Davis, 2010). The high number of students is not a new challenge and the choice to exchange quantity for quality is still the Achilles heel of nursing education today (Searle, 1988).

Multidisciplinary healthcare teaching-learning

No evidence exists that multidisciplinary teaching-learning exists in participating institutions. Multidisciplinary healthcare teaching-learning may contribute significantly to the understanding of healthcare practitioners' roles and functions and the way members of the health team can collaborate in providing healthcare to patients (Oandasan & Reeves, 2005). Nursing ethics educators should play proactive roles in the recommendation and establishment of multidisciplinary healthcare teaching-learning for nursing students. Multidisciplinary team teaching-learning across the healthcare disciplines will attune nurses (and other members of the health team) to their relational roles in ethical decision-making and caring for patients (Sorta-Bilajac et al., 2011; Stone, Haas, Harmer-Beem & Baker, 2004; Wright & Brajtman, 2011). Multidisciplinary teaching-learning strategies in nursing ethics education enhance understanding of professional roles, promote teamwork in health care (Sorta-Bilajac, Baždarić, Zagrović, Jančić, Brozović, Ċengić, Corluka & Agich, 2011) and enhance the credibility of nursing curricula (Hutchinson, Haynes, Parker, Dennis, McLin, & Welldaregay, 2006).

Facilitation of practical wisdom as an approach to teaching-learning

Teaching-learning strategies and methodologies currently do not sufficiently facilitate practical wisdom in nursing students. Practical wisdom (phronesis), also sometimes referred to in the literature as clinical wisdom (Uhrenfeldt & Hall, 2007), is a nursing skill that can enhance the care nurses provide to their patients and therefore it comprises a competency which nursing ethics educators should facilitate in nursing students (Chan, 2005; Edmondson & Pearce, 2006; Jenkins & Thomas, 2005; Leathard & Cook, 2009). Teaching-learning outcomes, as received from participating institutions, mostly describe the attainment of theoretical knowledge relevant to the philosophy, ethics and legal dimensions of nursing. Teaching-learning outcomes that are not measureable are criticised by some educators as unattainable and not worthy of inclusion in curricula. Affective skills are seen as immeasurable and are therefore

mostly not included in nursing curricula. When teaching-learning outcomes focus on attainment of the development of cognitive skills only, students are not afforded the opportunity to engage in a process where their own emotions, feelings and motivations are explored. Overemphasising the attainment of outcomes also denies students the opportunity to engage in a process where educators can assess how students manage and engage in the process itself. As an intellectual virtue, practical wisdom enables the acquiring of character traits acceptable in nursing. Despite the views that moral conduct cannot be ensure by moral education, nursing ethics educators can, at the least, create a teaching-learning environment that support moral growth.

Some conventional teaching-learning strategies and methodologies therefore limit teaching-learning, the development of critical thinking and the attainment of practical wisdom by students. Practical wisdom as an aim of teaching-learning in nursing ethics education might enable students and educators to assess and deliberate on those means that bring about *eudemonia* for patients. The focus therefore extends beyond the physical needs of patients and encompasses the social, emotional, psychological aspects, i.e. the holistic good for patients. Practical wisdom as a virtue also require nursing ethics education to assist students to attain the required character traits to practice nursing effectively. This will require not only ensuring that the gap between ethics teaching-learning and ethical practice narrow (the ideal must become the reality), but that tertiary institutions and clinical facilities provides and environment and develop a culture that support and enforce ethical conduct (Van Niekerk, 2003).

The facilitation of practical wisdom in nursing students will need a new mind-set and creative effort from nursing ethics educators. Many nursing ethics educators still rely on conventional teaching-learning strategies and methodologies, and the approach in nursing education is still focused mostly on the accumulation of scientific knowledge and psychomotor skills where applicable. Practical wisdom requires the nurses to have the ability to maintain an open mind and to reflect on what is particular in

the situation. A practical wise practitioner considers need fulfilment of patients in collaboration with the patients and where necessary with the patients' family or others in the patients' support structure. Educators and students are not so much focused on the achievement of a predetermined outcome, but are living the process of teaching-learning with an acute awareness of thoughts, intuition, scientific knowledge and constantly reflecting and deliberating on significant contextual requirements, occurrences and thoughts. Teaching-learning outcomes are not focused on the attainment of end results, but focus on how well the process of 'becoming' is lived. Practical wisdom as a teaching-learning approach requires both students and the educator to be involved in the process. Educator and student learn from each other. The educator is conscious of how to nudge students into those areas of learning that need support. At the same time, the educator is acutely aware of the direction of his or her own thoughts. Practical wisdom as an approach in teaching-learning is not totally unstructured, but it is rather open, responsive, collaborative and relational. While individual nursing ethics educators may utilise practical wisdom as an approach in nursing ethics education, the approach will yield better results if practiced by all educators in an undergraduate nursing program.

The internalization of nursing values

According to Dogan, Tschudin, Hot & Özkan (2009) ethics is not taught to nurses, but is learned by nurses. Nursing ethics education should therefore facilitate undergraduate and life-long learning opportunities for nurses (Dogan et al, 2009). The challenge for ethics education is to find teaching-learning methods that enable nursing students to learn the norms and values expected in ethical nursing practice. On-going research in both nursing and medical ethics education show that educators belief that ethics education contributes to ethical knowledge and skills, the reasoning skills of practitioners and the management of ethical challenges in practical situations (Asai, Kishino, Fukui & Masano, 1998; Knoppers & Chadwick, 2005).

Education can improve students' ethical reasoning skills (Nathan, 2013) and many variables such as beliefs, culture and aspects of theology influence the moral reasoning of students. Wocial (2008) identified that nurses are often morally concerned about aspects in nursing care, but still choose not to take action on these concerns. Considering the view of Nathan (2012) that culture may influence moral reasoning of nurses it might be that the prevailing subservient and unassertive culture in nursing in South Africa and Namibia hamper nurses to act according to the moral requirements in nursing situations. The requirement to address subservient and unassertiveness of nurses support the need to address these aspects in nursing ethics education. Also, appropriate moral reasoning abilities do not necessarily guarantee appropriate moral action. Moral actions require moral maturity which need moral sensitivity (alertness), moral judgment (reasoning) and moral motivation (commitment), which culminate in moral action (Liddell & Cooper, 2012). Moral education should therefore address all four mentioned components, but the question still remains whether moral education can ensure moral maturity of students. It remains problematic to assert that moral education can ensure moral maturity and the change in moral character of students, especially in higher education where students' character and most beliefs are formed when entering higher education.

Planning nursing ethics content effectively and exposure to a variety of teaching learning methodologies is necessary to facilitate the internalization of nursing values in nursing students (Park, Kjervik, Crandell & Oermann, 2012). Innovations in and rethinking the current approaches in the teaching-learning of nursing ethics are imperative in addressing the challenges in nursing ethics education and providing nurses with ethical knowledge and skills.

Studies show that there are positive relations between ethics education and moral skills of nurses. Students exposed to group discussions, critical reflective practices (Lawrence, 2011) and decision-making elements scored higher on the Defining Issues Test (a test scoring moral judgment) than those

students not exposed to moral education (Krawczyk, 1997). A study by Grady, Danis, Soeken, O'Donnell, Taylor, Farrar & Ulrich (2008) states that nursing ethics education assists nurses to differentiate between ethical and other problems in nursing practice; defines own beliefs and values and assist in developing and using tools and skills in addressing these problems. Ethics education also instils confidence in nurses to take decisions, use appropriate resources and to act upon their moral judgments (Grady et al, 2008).

The attempt by nursing departments to base their teaching-learning on a conceptual model is a viable attempt to socialise student nurses in the value system of nursing. A conceptual model defines the outcomes and interests of nursing ethics education (Kesselheim & Joffe, 2008), and a goal of nursing ethics education is teaching core nursing values (Klugman & Stump, 2006). To reach this goal it is important for nursing ethics educators and the nursing profession in South Africa and Namibia respectively to have a similar understanding and collective consensus about the core nursing values to be presented in nursing ethics education. Mogale (2012) is extremely relevant in the argument that African scholars should not shy away from creating African knowledge generally and in developing nursing knowledge specifically through scholarly endeavours. This is extremely important for nursing ethics in South Africa and Namibia, because the teaching-learning of nursing ethics is essentially western in its approach and clarifying nursing values within the African context is a timeous challenge for nursing scholars. Caldwell et al. (2010) further argue that nursing ethics educators need to examine the inherent ethnocentric approaches in the teaching-learning of nursing ethics and should attempt to make nursing ethics education more inclusive in the face of globalisation and nurse migration. Ethical sensitivity comprises the ability to perceive the ethical implications of a situation, to recognise morally relevant facts and to understand networks and implications of actions (Clarkeburn, 2002). These are important skills for both nursing students and nursing ethics educators.

Woods (2005) argues, *inter alia*, that nursing ethics educators need to rethink the underlying philosophy of nursing ethics education and bridge the theory–practice gap by focusing on 'real-world' situations from nursing practice. Teaching-learning strategies and methodologies need to take into account the life-world of students and facilitate sharing of students' views and ideas in deliberations on ethical issues (Chaloner, 2007). According to Clarkeburn (2002), ethics education should develop moral skills in students. Course or module design should consider student needs, readiness and experience, timing of the ethics course or module to students in the program, the duration of the ethics module to facilitate skills development and the appropriate teaching-learning methodologies to nurture and develop students' personal moral agency. Curriculum development, review, and planning of nursing ethics education require student input and cooperation between educator and student (Paris & Combs, 2006). Students associate preferred study units with professional skills improvement (Birks, Cant, Al-Motlaq & Jones, n.d.), therefore, nursing ethics education should focus on practical relevance for students in nursing ethics education. According to Phillips & Vinten (2010), innovative teaching-learning strategies require self-directed learning, considerations of social and cultural factors influencing the learning environment, and role modelling which allows students' self-expression and exploration.

Searle et al. (2009) argue that ethical practice by nurses is an individual choice and individual responsibility, and choice forms part of all the great religions of the world. It is therefore reasonable to expect that individuals, including nursing students, should internalise the core values of the nursing profession.

In the following section the aspects identified by respondents related to educators, students and practicing nurses involved in the teaching-learning in undergraduate nursing education will be appraised.

6.3 Nursing ethics educators, nursing students and practicing professional nurses

Investment in the development of human resources within health care institutions ensures the necessary skills for effective health care delivery (Booyens, 2001). Nursing ethics educators, nursing students and practicing professional nurses represent the human resources within the educational and service delivery domain of health care provision. Human assets remain the most important resource in the delivery of health care (Muller, 2009) and skills development of and support to staff members contribute to quality education and service delivery.

6.3.1 Nursing ethics educators

In the teaching-learning environment nursing educators play a critical role in the success of educating nursing students. Regarding nursing ethics education it is important that ethics educators are specialists in nursing ethics and defend the importance of nursing ethics education.

Specialization and experience in nursing ethics education

Shortage of qualified nursing ethics educators is a reality (Wocial, 2008) and Lin et al. (2010) argue that expert teachers are better equipped than unqualified educators to facilitate higher cognitive learning in students. More than half (57%) of the respondents in this study (cf. chapter four) had more than 20 years' teaching experience in nursing education, but 72% of these respondents had less than 10 years' teaching experience in nursing ethics education, and 36% of this same cohort had less than five years' experience in teaching nursing ethics. Most respondents indicated that they are involved in nursing ethics education because nursing ethics is integrated in the modules they are teaching or they had been delegated to teach nursing ethics, which leaves the impression that nursing ethics is not a popular module to teach. The lack of opportunity to specialise in ethics may contribute to the reluctance of

educators to teach nursing ethics and this may hamper building a core of specialist nursing ethics educators.

Inexperienced nurse educators often feel unequipped to teach nursing ethics and do not get guidance from more experienced ethics educators on how to teach ethics when entering nursing education settings. (Davis et al., 2010). According to Professor Laetitia Rispel, in her address at the National Nursing Summit in South Africa in 2011, support to nursing students requires a sufficient number of well-trained nurse educators in both the theoretical and clinical nursing areas (Republic of South Africa, 2011). Specialized training in ethics is also not required in the tertiary institution in Namibia for teaching-learning of nursing ethics, unlike specialized qualifications in other specializations, like Intensive Care Nursing or Operating Room Science,

Specialization in ethics at post-graduate level is possible at a few tertiary institutions as applied ethics modules, and these might not always be accessible to full-time employed nursing ethics educators. Lack of specialised training in ethics contributes to nursing educators' unwillingness to be involved in nursing ethics teaching-learning because the empirical data (cf. chapter four and five) shows that educators do not perceive themselves as competent ethics educators. Specialization in nursing ethics education, producing experts in the ethics discipline, will improve the quality of nursing ethics education (Lin, Lu, Chung & Yang, 2010). Without further ethics education, ethics educators may lack awareness and understanding of cultural and other factors that influence student learning (Davis, Davis & Williams, 2010).

It is worrying that experienced nursing ethics educators identified the lack of training and specialised knowledge in ethics as a challenge in nursing ethics educators, because the knowledge and skills of nurse educators will certainly influence the quality of ethics education. Lin et al. (2010) claim that expert teachers, who receive proper training in nursing ethics, will have the ability to elicit higher cognitive

functions in students. Nursing ethics is often not included in programs because of the shortage or lack of nursing ethics teachers (Lin et al., 2010). The unavailability of postgraduate nursing ethics education programs at tertiary institutions in South Africa and Namibia, unlike other clinical specialisations programs, is a real problem. Further training in ethics is available at overseas institutions, but this might not be accessible for local nurse educators. Nursing ethics educators could attempt further ethics training online, but perhaps educators in South Africa and Namibia have not yet established a culture of on-line education. Continuous as well as in-service education with regard to ethics is however necessary to ensure ethical practice and quality care to patients (Donovan & Redman, 1996–2002). Davis et al, (2010) concur that nursing education is challenged by the shortage of nurse educators (and clinical nurse specialists) formally trained in transcultural nursing. The view that nurse educators should remain generalists, as discussed above, also hamper the specialization of nursing educators in nursing ethics and is not helpful in motivating the need for specialization in ethics education.

The generalist view of nursing creates the expectation that nursing educators should be involved in all nursing fields and stay abreast in all aspects of nursing, thus often defeating the requirement that some educators should become specialists in certain nursing fields to provide high-quality teaching-learning. Nursing educators at tertiary institutions should not be treated differently from other educators (in medicine, the arts, the sciences, etc.) by nursing leaders, tertiary institution decision-makers or nursing councils in respect of specialist versus generalist expectations. Such unreasonable expectations hamper specialisation and skills of nursing educators and consequently the quality of nursing education.

Differing cultures and value systems

The generation gap between current nursing educators and nursing students became evident during the individual interviews with experienced ethics educators (cf. chapter five). Caldwell, Lu & Harding (2010) acknowledge the difficulties in nursing education related to cultural values and practices and mention

the ethnocentric western philosophical approach in nursing's value system as a challenging issue for nursing education. It is difficult for nurse educators to uphold the ethical values and standards prescribed in educational programs while at the same time accommodating a vastly different cultural identity of students. However, nurse educators need to acknowledge their own biases, prejudices and ethnocentric approaches because of the globalisation and internationalisation of the nursing workforce (Caldwell et al., 2010).

Diverse cultural values and practices challenge healthcare delivery generally because of language differences and misinterpretation of patient needs (Oosthuizen, 2002; Singleton & Krause, 2009) and nursing ethics education specifically (Waite & Calamaro, 2010; Caldwell et al., 2010; Campbell et al., 2007).

Nursing values presented to students are still conventional, mostly western-based nursing values. It is a shortcoming that nursing ethics educators in South Africa and Namibia have not yet addressed. Only one institution includes content on African and eastern worldviews. While the understanding of African values might not be so different from western values it will be more acceptable if these values are described within the context of the African world view of communalism and Ubuntu (Mogale, 2012).

Nurses in South Africa and Namibia are challenged by their own cultural biases and perceptions cultivated in an extremely unequal and unjust past. It will take time for people to overcome these biases and prejudices. For nurses it should not be too difficult, because the race of a patient is in most instances not a consideration when a patient is in need of assistance and care. Inclusion of cultural issues in undergraduate nursing programs became especially necessary because of the multicultural societies in which nurses practice and the cultural differences involved in ethical dilemmas (Yarbrough & Klotz, 2007). Cultural competence, which includes cultural awareness and cultural sensitive nursing actions, is a requirement for ethical nursing practice (Pera & Van Tonder, 2005). This sensitivity is also

needed from educators in respecting the beliefs of students and seeking encounters with students to learn and reflect on issues which may create conflict and need reflection in the teaching-learning setting. Some nursing ethics handbooks started including "Ubuntu" as a value in nursing ethics (Pera & Van Tonder, 2005; Jooste (ed), 2010 & Mulaidzi et al, 2010).

Although no indicator of race was included in the biographical data of respondents in the questionnaire of this study, the perceptions of respondents of the challenges in nursing ethics education during the interviews highlighted the differences in backgrounds of students, professional nurses and educators as a significant challenge in nursing ethics education. In South Africa, none of the experienced ethics educators were Africans and in Namibia only one ethics educator was an African. Davis et al. (2010) believe that educators who understand student demographics might be more competent in the management of challenges faced by students. No evidence exists that indicates race or culture of nursing ethics educators as significant determinants in the teaching-learning of nursing ethics. This is therefore an area in nursing ethics education that needs further investigation.

Educator responsibilities

Some respondents in this study (cf. chapter five), were quite introspective and critical about their own ability to teach nursing ethics and doubted whether the approach and content of their courses really address the need for nursing ethics education. This should be appreciated and should stimulate more collective discussion and decision on what is appropriate for South Africa and Namibia with regard to nursing ethics education.

More worrying was the comment by an experienced nursing ethics educator that the public have overly high expectations of nurses compared to their expectations of office workers, clerks, day workers or even teachers. Health care workers, including nurses, deal with life and death issues and enter into a special relationship of trust with patients and therefore the public do have higher expectations of these

professionals (Searle et al, 2009). It is not expected that an experienced nursing ethics educator who is involved in the teaching-learning of nursing students does not understand that the public's expectations of health care workers, including nurses, are different from the expectations they have of office workers and others.

Nursing ethics educators do not respond timeously to the demands of educational needs of practicing nurses. Challenges are often identified, such as the challenges practicing nurses encountered with the promulgated abortion legislation in South Africa, but little is done to strengthen the knowledge and capacity of those nurses confronted with the challenges. Updating of knowledge should not always be seen as an in-service education obligation which should be fulfilled by employers. Tertiary institutions need to collaborate with stakeholders in line ministries and industry to develop and present appropriate content to practicing nurses as soon as the need for such education arises. Academics should not shy away from their responsibility to contribute the newest evidence based information to practicing nurses and to incorporate this content into undergraduate and post-graduate nursing programs.

Collaboration and exchange between scholars in Africa are needed for creating relevant nursing knowledge. Such collaborative agreements and projects already exist between nursing schools in the Southern African region and beyond, and are essential in facing the realities in nursing practice today (Uys & Middleton, 2011). Nursing ethics educators should seize these opportunities to share ideas and conduct research together with their counterparts on the teaching-learning of nursing values at their institutions (Davis et al, 2010).

Most responsibilities, as well as personal character traits of the nursing ethics educator as indicated by the participants in this study, are relevant for all nursing educators. Modelling good character and care begins in schools of nursing (Wolf, 2012). Institutions of higher learning require educators to perform

research, and ethics educators in South Africa and Namibia should take up the challenge to perform relevant nursing ethics research (Klopper, 2007).

Support to students is a requirement in the teaching-learning process. When student support is holistic it includes both humanistic as well as academic support to students (Bartram, 2009). It is important for institutions to clarify their approach to student support, to assess the necessary support needed by students and to create infrastructure for student support (Jacklin & Le Riche, 2009; Van Schalkwyk, 2010; Williamson, Callaghan, Whittlesea & Heath, 2010). Technology is helpful in providing academic support to students (Diziol, Walker, Rummel & Koedinger, 2010). Peer-to-peer student mentoring not only supports students, but also enhances leadership skills in students (Power, Miles, Peruzzi & Voerman, 2011).

Nursing ethics educators should get involved in the teaching-learning of their peers. Teaching of others is an ethical requirement in nursing (Searle, Human & Mogotlane, 2009). Using the World Wide Web and creating online discussion opportunities are all possibilities in sharing knowledge with others (Beard, 2003; Sandars, 2006). Donovan & Redman (2002) report that registered nurses in their study identified the need for in-service education and continuing education on nursing ethics. Personal and professional growth of practicing professionals can be enhanced by continuing education, especially for those professionals in societies which transits from a traditional religious value system to a more secular, scientific and proactive value system (Sartorio & Zoboli, 2010)

Nursing ethics educators rely on professional nurses to supervise and guide students while in clinical practice settings because it is impossible for nursing educators to accompany students constantly. Absence of proper communication and structured collaboration between nursing ethics educators and professional nurses in healthcare facilities where students are allocated jeopardises the teaching-learning of students. Agreements with professional nurses, as well as in-service training for those who

guide students are an essential aspect of quality teaching-learning of students. The above issues were all identified as challenges in nursing education in South Africa during the provincial meeting before the National Nursing Summit in South Africa in 2011 (Republic of South Africa, 2011).

6.3.2 Nursing students

Nursing students rely on the guidance of both nursing educators and clinical supervisors for effective learning. Students themselves should be committed and take responsibility for their studies, personal and professional growth.

Student attitude

Current nurse educators complain about the attitudes of the candidates that enter nursing and which require from nursing ethics educators an intensified effort to assist young students to internalise nursing values, especially where students come from different cultures and backgrounds (Davis & Davis, 2010). Cognitive, psychomotor and affective learning outcomes are influenced negatively by the poor attitudes and commitment of students reported by respondents in this study and contributes to frustration and burnout for nurse educators. The frustration for nurse educators is exacerbated by the modern human rights culture in society that sometimes contributes to undisciplined student behavior. Brady (2012) believes the neoliberal education at universities in the United Kingdom has contributed to 'moral loss' during the past 15 years and while consensus exist that 'moral reconstruction' is necessary, there is little agreement on how this can be achieved. Moral loss is also experience by nurse educators at participating institutions. A contributing factor to this moral loss, which resonates with experience at the University of Namibia, is the focus of students on degree attainment with lesser attention on learning (Brady, 2012). While human rights remains an important issue in contemporary and especially new democratic and independent countries like South Africa and Namibia, human rights cannot be

conceptualized without taking into account the reciprocal obligations all rights create (Pera & Van Tonder, 2005). The provision of health care in societies is based on human rights (McQuoid-Mason & Dhai, 2011) and health care practitioners have professional rights (Pera & Van Tonder, 2005), but these rights are claimed based on reciprocal duties.

It is not unreasonable to expect nursing students to be serious about and involved in attaining the necessary ethical competencies and to display and maintain ethical conduct while in training and in their professional lives. Moral conduct ultimately remains an individual responsibility whereby the individual nurse is required to consider applicable contextual norms and values and apply this with virtuous intention (Van Niekerk & Nortje, 2013)

Student attitude cannot be seen in isolation without considering the factors contributing to the difficulties that nursing students might experience. Other challenges mentioned in this study, such as real interest in being a nurse, disillusionment, poor clinical environment and inadequate role models are all factors that might contribute to absenteeism, poor values exhibition and disrespect as mentioned by respondents. The transitional state of both the South African and Namibian societies, from colonial rule to independence, has bearing on people's perceptions and lived experiences. Transition within tertiary educational institutions has its own unique challenges and influences on educators, administrators and students within these institutions. The institutions are sometimes slow in developing protocols for disciplining disruptive or undisciplined students (Davis et al, 2010). Nursing ethics educators need to support students whose behavior is wrong or irresponsible. Fundamental to a learner-centered approach in nursing education are remedial interventions to assist students becoming responsible persons and caring for the students (Robertson, 2005).

Higher education institutions cannot ignore their responsibility to contribute to a moral civil society, especially seeing that graduates might be societal leaders. Therefore tertiary institutions generally have

an obligation to society to contribute to the moral growth of students (Keçi, Bulduk, Oruç & Celik, 2011) and need to take steps to restrict unacceptable conduct by students through policy development and enforcement of reasonable disciplinary measures.

Reasons for entering nursing

Own interest will guide students in selecting a future career and study program. This might be especially true in countries like South Africa and Namibia where job opportunities are scare and job security is an important issue. It is not surprising that nurse candidates' choose nursing as a career, because nursing offer job security and options to improve one's future. According to Reid et al. (2008), students sometimes do not have a clear idea about the profession they prefer to enter, while other student applicants might be transferred from other educational programs for different institutional reasons, and enter nursing school without having an interest in nursing (Eddins, Hu & Liu, n.d.). A study performed in Queensland, Australia indicated that self-interest plays a role in deciding to enter nursing as a profession, and job security, job availability and financial interest are indicated as important factors in this choice (Eley, Eley & Roger-Clark, 2008). The views of respondents that student nurses enter nursing in South Africa and Namibia for reasons of money, job security or due to family pressure are not surprising, considering that both South Africa and Namibia have high unemployment rates, 23.9% (Government of the Republic of Namibia, 2008c) and 51,2% (Statistics South Africa, 2011) respectively. Disillusionment of students (and practicing nurses) is a common feature in the nursing profession where practicing nurses often yearn to care for patients effectively, but the practical environment puts a damper on this desire and leave nurses frustrated and eventually drive them from the nursing profession (West, 2004: 346; Reid et al., 2008: 9; Ooshuizen & Ehlers, 2007).

Student discipline

Some respondents in this study expressed the view that enhanced student discipline might address poor student attitudes and irresponsible student behavior (cf. chapter five). Some of the respondents were discouraged and did not know what to do about poor student attitudes and also doubted whether increased discipline will rectify the situation at participating institutions. Punitive measures are not the answer to inculcating the required nursing values in students. Nursing ethics educators should rather play a significant role in setting ethical expectations to which nursing students should abide. In addition, they should create remedial strategies for unacceptable student behavior. Absence of a formal agreement with students about the required ethical behavior leaves students isolated in the teaching-learning experience and does not provide educators with backing to address challenges encountered with students. While student discipline might have a place it should not be the first line of action when students misbehave. A reactive approach is not conducive to educator–student relationships, and information on expected nursing conduct sets the stage for meaningful engagement with students during teaching-learning contact. It is also very difficult for nursing ethics educators to expect students to display acceptable conduct while the example they observe in clinical practice settings are the opposite. Van Niekerk (2003) views the environment where people practice as an important determinant of moral conduct. Student discipline cannot be the only measure to take in rectifying unacceptable student conduct.

The views of nursing ethics educators on the need to enforce student discipline in educational institutions resonated with popular views that the human rights culture prevalent in South Africa and Namibia needs countermeasures of responsibility and accountability. Teaching-learning content presented by the institutions that participated in this study (cf. Chapter four) indicated that professional accountability is seen as important, and teaching on this is included in nursing curricula. Nursing

legislation provides for professional disciplinary measures and nursing students are not exempted from this discipline. Disciplinary hearings follow the judicial procedures in courts of law and are open to the public (Searle, 2005). Educational institutions also have policies on student discipline on dishonesty and plagiarism, but other negative behavior by students should be managed by individual departments. It is not helpful when policies exist, but are not enforced by managers or educators. At tertiary institutions educators also view their role as primarily the teaching-learning of students and often do not want to be involved in policing students who misbehaves or claim that disciplinary measures are too time consuming (personal observation). Keçeci et al. (2011) propose that aspects of internal control in departments be communicated to students online and on notice boards, and that out-of-class student conduct could be assessed and incorporated within formal assessment procedures. Monteiro et al. (2008) believe it is necessary to involve parents in the teaching-learning process of nursing ethics.

Integration of theory and practice

The expectation exists that students should practice the way they are taught in the classroom. The effective integration of theory and practice is however defied by the discrepancy between teaching-learning in classroom, which represent the ideal, and poor clinical practice standards. In both Namibia and South Africa it might not be culturally acceptable for a younger person to disapprove the conduct of older persons. This situation confuses students and contributes to ineffective integration of theory and practice and consequently the internalization of nursing values.

6.3.3 Practicing professional nurses

Practicing professional nurses are important stakeholders in teaching-learning of students in the clinical environment. Effective teaching-learning cannot take place without clinical supervision and support of practicing professional nurses.

Role modelling and attitudes of practicing professional nurses

Human Rights Watch reports (CMAJ, 2011) that healthcare workers abuse maternity patients in South African healthcare facilities with the resultant effect that pregnant women avoid delivering their babies in healthcare facilities. It is unacceptable that the abuse of patients' rights by practicing professional nurses causes inaccessibility to health care for patients. As patient advocates and promoters of health nurses have an ethical obligation to protect the rights of patients which include ensuring accessibility to health care. It is unacceptable that the conduct of practicing nurses defeats the objects object of nursing, i.e. care of those who need care. The poor attitudes, inadequate role modelling and poor knowledge and skills of ethics of professional nurses in clinical practice situations defies ethics teaching-learning of nursing students. Poor attitudes and poor role modelling might be the result of the prevailing poor conditions as well as diverse cultural beliefs and practices within the healthcare delivery system in both South Africa and Namibia.

Proper role modelling, by both educators and clinical nurse practitioners, is imperative in the socialisation of nursing students into the nursing profession (Lin et al., 2010). Poor role modelling by supervisors are observed by students and negates positive socialization of students.

Pillay (2010) reports ethical-legal knowledge deficiency as one of the largest skills gaps in nursing managers in South Africa. It is reported that a lack of supervision in facilities, poor training in professionalism, staff shortages, high workloads, low staff morale and long working hours are contributing factors to this type of unethical behavior of nurses (and doctors) (Vivian, Keikelame & Irlam, 2011) Abuse of patient however remains unacceptable ethical conduct, notwithstanding circumstances in the health care delivery system.

Assertiveness and cultural perspectives

Traditional perceptions within the health professions often leave nurses feeling powerless and unassertive, compared to physicians (Woods, 2005) and in Namibia and South Africa, these feelings of inferiority by nurses may be worsened, especially in the case of older nurses, by culturally defined gender perceptions or as a result of feelings of inferiority created during the apartheid rule.

Vivian et al. (2011) reported the following on the abuse of patients in an institution in South Africa:

- nurses and midwives are the main perpetrators in the abuse of patients;
- abuse is acceptable in some cultures, for example, elderly women are allowed to be physically and verbally abusive;
- healthcare providers (59% of medical students in the reported study) in most instances do not intervene when patients are abused by other professionals; and
- nurses think that patients are 'inferior, ignorant or bad' and therefore deserve to be abused (Vivian et al., 2011: 1285).

Laabs (2011) reports that moral integrity of practicing nurses is often conceded because of environmental pressures and the expectations of colleagues. The poor environment within which practicing nurses and students have to deliver nursing services is recorded in this study, (cf. chapter four and five) and contributes to the decline of the moral integrity of nurses. Practicing professional nurses cannot single-handedly carry the burden for the dire state in health care facilities and poor service delivery. It appears that improvement of ethical conduct by professionals within the healthcare services need an extraordinary and comprehensive effort from role players in the healthcare service sector, educational institutions, regulating authorities as well as nursing organisations.

6.4 The role of external stakeholders in nursing ethics education

Respondents in this study (cf. chapter five) indicated that some challenges in nursing education generally, and nursing ethics education specifically, are created by factors outside the tertiary educational institutions. These challenges are more difficult to address than those directly related to the theoretical teaching-learning environment.

Clinical health care facilities

The current situation in clinical facilities where students are allocated for their clinical teaching-learning experiences is the single most dispiriting factor expressed by the participants of this study. Within the new education system, the clinical facilities fall outside the jurisdiction of the educational institutions and it remains a major challenge to nurse educators to effect change in the clinical facilities. Yet, for nursing, the most important and significant teaching-learning environment is the nursing unit where practical nursing takes place (Reid et al., 2008), and students are confronted with a dilemma when the clinical environment is incongruent with classroom teaching-learning (Vivian & Keikelame, 2011). The aim of nursing ethics education is to produce morally accountable nurse practitioners who can render quality nursing care to those in need of care (Görgülü & Dinç, 2007). When the nursing units are not provided with the necessary equipment and supplies, it has the propensity to make quality nursing care impossible. This situation is worsened by the poor role modelling of professional nurse practitioners in the nursing units. It is impossible for nursing students to practice what was taught in the classroom when the standards of nursing care are poor and the necessary supplies or equipment are not available or when there is no proper role model to follow. Despite the best efforts of nurse educators to apply appropriate teaching-learning strategies or to guide students in nursing units, the theory–practice gap will not be bridged when the clinical environment is not supportive of such education (Valizadeh, Abedi & Fathi-Azar, 2008). The inability of students to apply theoretical knowledge in clinical practice

situations and the view that professional nurses often do not support students in the clinical learning environments are sources of frustration to nurse educators (Paris & Combs, 2006). This is especially true when the nurse educator knows that the content was covered in the classroom and that teaching-learning of peers and students are part of the ethical obligations of professional nurses (Searle, 2005).

The South African audit on nursing education and training institutions as reported at the National Nursing Summit in South Africa in 2011, identified the following challenges in delivering the annual output targets of different categories of nurses:

- shortages of infrastructure and resources, including simulation facilities;
- inaccessibility of clinical facilities for practical placement (due to lack of transport for students and distances between institutions and clinical facilities);
- inadequate numbers of educators to accompany students in facilities; and
- shortages of accommodation for nursing students.

(Republic of South Africa, 2011)

The above factors aggravate the challenges that nursing ethics educators face at educational institutions because the inadequacies and shortages of the required infrastructure and resources increase the dichotomy between the ideal to which nursing ethics educators aspire and the real situation at institutions and clinical facilities. When these challenges are not addressed timeously and effectively they contribute to burnout and the laissez-faire attitudes of nurses.

Deficient organisational culture and employer discipline

Weak role modelling, poor attitudes, incompetency and lack of continuous professional development of professional nurses are not restricted to professional practitioners in nursing units, but extend to matrons, managers and decision-makers within the whole healthcare delivery system. Nursing managers condone unacceptable conduct and protect their colleagues who misbehave. This unethical conduct of managers and leaders in the health care services do not facilitate positive socialization of the neophytes in nursing, but enforce negative attitudes and unethical conduct. According to personal encounters with post graduate students, tribalism is rife in many healthcare facilities in Namibia. Participants in this study have expressed the view that employers and managers in South African health care facilities do not address misbehaving workers effectively (cf. chapter five), which leads to an organisational culture of tolerance in terms of unethical, incompetent and sometimes criminal healthcare worker behavior. Neophytes who enter a healthcare system find themselves torn between the right and reasonable ideal presented in theoretical teaching-learning and the horrors in clinical practice environments. These deficiencies render quality teaching-learning impossible.

Nursing managers at unit level do not take up the responsibilities for effective management of nursing units, although this is the lawful and ethical duty of the unit manager (Searle, Human & Mogotlane, 2009). Shortages of medicine, equipment and supplies, results from unit managers not organising and monitoring resources in nursing units, leaving practising nurses without the means to render care. Staff shortages and addressing the shortages of resources generally were key issues identified in the provincial consultations before the National Nursing Summit of 2011, and need urgent attention from decision-makers (Republic of South Africa, 2011).

Bureaucracy and economic factors challenge leadership and management in nursing (Bondas, 2010). Clinical leadership is important in the creation of an environment where nurses are able to care

effectively for patients (Stanley, 2010; Germain & Cummings, 2010; Mortlock, 2011) and to facilitate guidance of students in clinical practice settings. Challenging environments should not prevent practising nurses from speaking out in eliciting the support from superiors in establishing improved nursing care settings. It is a moral duty of all nursing professionals, including nursing educators, to voice their needs in improving the care of patients. Assertiveness training of nurses remains imperative to obtain quality nursing care environments in South Africa and Namibia.

It is understandable that nursing ethics educators perceive the organisational culture in healthcare facilities as undesirable, considering the many reports about the uncaring conduct of healthcare providers and the complaints by healthcare providers about their unsupportive environment. According to Pillay (2010), poor management undermines healthcare delivery and nursing managers have key responsibilities to improve the healthcare environment and to satisfy the aspirations and value systems of nurses, but also to achieve the Millennium Development Goals and to improve South Africa's Human Development Index (Pillay, 2010). Poor working conditions in health facilities, including the insensitive management of staff needs, are contributing factors in nurses' decisions to migrate to other countries, increasing the plight of staff shortages (Oosthuizen & Ehlers, 2007). It is inconceivable how healthcare delivery can improve and nursing students can be socialised effectively when nursing managers are themselves guilty of misconduct or do not sufficiently address unethical conduct by or the ill-discipline of nursing personnel in the healthcare services.

The regulatory authorities

The South African Nursing Council (SANC) developed a draft Charter of Nursing Practice in 2004 (South African Nursing Council, 2004), containing guiding ethical principles for nurses. The Health Professions Council in Namibia (HPCNA) has Ethical Guidelines for the Health Professionals in Namibia (Health Professions Council of Namibia, 2010). These documents are available on the websites of both the

regulatory authorities, but it is not clear how members of the nursing profession are informed about the drafting or publication of these documents. Nurses use other nurses as a resource to solve ethical problems in practice but, while ethical codes may guide nurses in preventing unethical conduct, such codes do not assist nurses in judging and dealing with ethical issues (Musa et al., 2011). It is important for nurses to have a collective understanding of the ethical issues relevant in nursing practice, and the ethical values underpinning nursing are necessary and should be explored by members of the nursing profession (Monteiro et al., 2008). There appears to be no consensus on many ethical issues in nursing ethics education. Consensus on the ethical values of nursing, and the ethical knowledge to be included in nursing ethics education is necessary (Görgülü & Dinç (2007) and Kesselheim & Joffe (2008). Clarkeburn (2002) believes that the identification of appropriate values is the first step in any value education, and therefore nursing ethics education will be challenged if consensus about the inherent values in nursing by the members of the nursing profession in South Africa and Namibia is lacking. A case was already made above for the way both the SANC and the NCN prescribe minimal requirements with regard to nursing ethics in their curricular regulatory requirements in undergraduate nursing educational programs.

The participants in this study were not wrong in their expectations of the role the regulatory authorities, the SANC and the NCN need to play in improving clinical facilities. The Nursing Councils need to engage with governments to address the poor conditions within the healthcare facilities where students receive their clinical education. The SANC and the NCN approve not only nursing curricula, but also the institutions within which clinical nursing practice takes place. The Democratic Nurses Organisation of South Africa (DENOSA) and the Namibia Nursing Association (NNA) focus on enhancing the interests of members of the nursing profession and should advocate for improved clinical facilities to enhance the working conditions of practising nurses.

South Africa and Namibia, as young democracies, are challenged not to overregulate nursing education nationally, but to maintain national standards that guarantee the delivery of health resources to ensure quality service delivery to the public. Nursing ethics education to students should be provided within national and institutional regulatory frameworks, which should enhance, and not challenge, the teaching-learning of nursing ethics to students.

While the primary objective of the professional regulatory authorities, the SANC and the NCN, is protection of the public, the influence that these bodies have on members of the nursing profession should not be underestimated. This became evident from the empirical data, namely that nursing ethics educators view the nursing councils as insufficiently involved in the challenges in nursing generally and nursing education specifically (cf. chapter five). The councils approve nursing education and nursing schools, but are silent about the poor conditions of clinical healthcare facilities within which students receive their education. The councils also have a top-down approach and do not communicate effectively with their stakeholders on educational matters before decision-making. Nursing councils need to be more visible and need to listen to the needs and challenges faced by members of the profession (Republic of South Africa, 2011). Despite the high incidence of unprofessional conduct and the public outcry about uncaring nurses, the councils and most tertiary participating institutions still view ethics as a minor module, and in Namibia, the nursing council does little to assist practising nurses to fulfil continuous professional development requirements.

Leadership in the nursing profession

Respondents identified that the Nursing Councils and decision makers in the nursing profession do not communicate effectively with nurses on grass root level. Unionism created an image of nursing opposing the traditional values of patient service and measure of personal promoting patient interest. The nursing profession in both South Africa and Namibia had to adapt to the political and societal changes of

the post-apartheid era. Restructuring of healthcare services and changes in nursing organisations require nursing leadership who can advocate for the preservation of the core values and responsibilities of nursing and the importance of the contribution of nursing to healthcare service delivery. Provincial consultation information presented at the 2011 National Nursing Summit in South Africa identified the creation of the nursing services component at a senior strategic decision-making level as a key issue for the nursing profession (Republic of South Africa, 2011). Nursing leaders will have to provide sufficient and relevant information that will take the nursing profession forward for the improvement of the health of the public. Strong leadership from national level to the level of healthcare units is imperative in the provision of service, care and creating an ethical professional culture (Bondas, 2010; Klopper, 2007; Mortlock, 2011). This strong nursing leadership was not always forthcoming, according to respondents in this study, and in both South Africa and Namibia nurses found themselves in precarious situations where the demand for quality health care could not always be met. Effective leaders base decision with the end in mind (Covey, 2004), therefore the improvement of bedside nursing and effective provision of care in communities should be the goal of nursing decisions. Justice cannot be done to patients if decisions about health resource distribution are not balanced with the ethical principles on which health care practice is based (Pera & Van Tonder, 2005)

The advent of trade unionism in both South Africa and Namibia influenced nursing in many ways. Nurses are divided on the morality of strike actions, which has become a right of nurses after 1990 in Namibia and 1994 in South Africa (Ehlers, 2000). Strike action by nurses did not prove to be helpful for nurses, because nursing leadership did not use the opportunity during strike action to advance the plight of nurses, but were silent, resulting in the media focusing more on the suffering of patients than on the plight of nurses (Ehlers, 2000). According to Klopper (2007), nursing leadership seems to be a problem in Africa, and nurse leaders play an important role in the lives of nurses and in enhancing quality nursing

care. Strong leadership is needed to facilitate reforms, and leadership structures are necessary to establish leadership skills (Kloppers, 2007).

The influence of politics, legislation and societal values

Respondents indicated that political decisions (allocation of bursaries, student numbers) and health legislation are not considering the interest of the nursing profession, but advances political requirements. The general decline of the value system in society directly influences the nursing profession, because students come from these societies. Unilateral political decisions related to abortion legislation in South Africa eroded the image of nurses as carers, because practicing nurses were not prepared to be involved in abortions, while the law provided women the right to this choice. The value system evident within organisations or professions is often a reflection of the value system of the society within which such an organisation or profession functions. The nursing profession in South Africa and Namibia is no different. The current human rights culture, unionism, the drive for economic welfare, the focus on materialism, the unusual individualism in urban African societies and the acculturation of traditional African values are all factors that influence the nursing profession at large. These values erode the values of caring, compassion, collaboration and sharing which form the core of the value system of nursing and threatens the maintenance of a healthy nursing philosophy. According to Dr Stella Anyangwa, the World Health Organisation (WHO) country representative of South Africa (Republic of South Africa, 2011), a global survey by the WHO on nursing and midwifery education has shown the need for more global standards for nursing and midwifery education, while the cultural norms and values of each country should be recognised and incorporated.

Politicians require human resources in nursing to reach the Millennium Development Goals (MDGs).

They determine the number of nursing students to be educated at tertiary institutions. The requirement of human resources in nursing does not consider the influence of high student numbers on the quality of nursing education generally and nursing ethics education specifically.

Controversial policies and legislation, such as the abortion law in South Africa, challenge the value systems of some practicing nurses and creates a challenging ethical climate in the healthcare service that contributes to moral distress in nurses (Pauly, Varcoe, Storch & Newton, 2009).

Lack of communication between all stakeholders in the healthcare delivery system creates challenges that often need resolution through crisis interventions. Politicians and decision-makers from the health service sector often do not collaborate sufficiently with other sectors, such as tertiary educational institutions, consequently national health outcomes do not address the targets or goals set by governments (Republic of South Africa, 2011).

According to Campbell et al. (2007), ethics education is challenged by the following factors:

- recruitment and selection of suitable candidates;
- large numbers of students in training;
- the time spent in education to attempt changing a person's habitual way of treating others;
- poor role models in clinical practice;
- progressive student cynicism and disillusionment;
- a culture of under valuing ethics;
- a lack of institutional support and resource constraints in participating institutions; and
- agreement of an accepted and fitting belief and value system within the profession.

The above factors in medical ethics education identified by Campbell et al (2007) are significant as these confirm most of the challenges identified by the respondents in this study (cf. chapter five). These

challenges confirm that ethics education for health care workers, specifically physicians and nurses, is burdened by similar obstacles.

The legislator in South Africa aggravates the conflicts for nurses in healthcare delivery by legislating issues such as abortion, contributing to feelings of guilt, stress and burnout in some nurses who have little choice but to be involved in legal abortions (Natan & Melitz, 2010; Harries et al., 2009). Nursing ethics educators should prepare students for addressing conflict situations in the clinical practice settings and coping with these.

Concluding remarks

The individual interviews with experienced nursing ethics educators in South Africa and Namibia (cf. chapter five) provided the opportunity to determine their views on the challenges faced in nursing ethics education at tertiary educational institutions.

There was little difference_between the different institutions taking part in this study regarding the challenges nursing ethics educators face. A concern which most participating institutions share is how day-to-day theoretical and clinical teaching-learning can be organised to facilitate learning and still fulfil the academic requirements of research and community service. The unique nature of nursing education as well as high student numbers (at some institutions) challenges the quality of nursing education generally. Nursing ethics educators also see the differences in background, culture and values of educators, students and professional nurses in healthcare facilities as a tremendous challenge, which has a significant influence on nursing ethics education.

It was however heartening to realise that nursing ethics educators are hopeful that the challenges in nursing ethics education can be addressed and that educators can and will play an important role in the overall improvement of healthcare service delivery in both South Africa and Namibia.

The next chapter will consider what is necessary to improve nursing ethics education in South Africa and Namibia and will propose recommendations in this regard.

CHAPTER SEVEN

NURSING ETHICS EDUCATION – QUO VADIS?

7.1 Introduction

The study of various national codes of ethics as presented in Chapter two of this study has shown that the nursing profession worldwide shares a common value system. It is clear that with regard to nursing ethics, nurses should be aware of the values and norms that guide professional nursing practice. The socialization of students to this value system is challenged in both the education and clinical practice settings. This chapter will propose some ideas on how nursing ethics education can be improved at institutions in South Africa and Namibia that participated in this study.

7.2 Recommendations

Considering the empirical information obtained in this study the following recommendations are proposed to improve nursing ethics education at participating institutions in South Africa and Namibia.

7.2.1 Improving regulatory, managerial and leadership collaboration

Considering the views of respondents (cf. Chapter five) about the poor liaison from Nursing Councils to nurses as well as poor management on different levels of service provision, improved intersectoral collaboration is needed between governments, the education sector, the professional regulatory authorities (SANC and NCN) and the professional associations and organizations that represent nurses. The African Health Professions Regulatory Collaborative (ARC), initiated in 2011, as a partnership between the United States Center for Disease Control (CDC), Emory University in Georgia (United States of America), the Commonwealth Secretariat and the East, Central and Southern African College of Nursing (ECSACON) endorses collaboration between, what they called the quad, i.e. the health sector, the regulatory authorities, the education sector and the nursing associations/organizations within

partnership countries (McCarthy, & Riley, 2012). Creation of agreed systems and national standards in nursing education ensures cooperation on all levels and eliminates uncertainties about nursing educational standards n institutions of higher learning. An effort must be made to follow a bottom-up approach in political and managerial decision-making to ensure relevance and grass root support. Nursing education generally can be effective if all stakeholders provide input, work together and are committed to address the mismatch between professional competencies and the population's health priorities (Republic of South Africa, 2011). Nursing leadership should live up to their task of communicating the challenges in nursing practice and nursing education. Without the voices of the nursing leadership the challenges faced by nurse practitioners and nursing educators will remain (Klopper, 2007; Mortlock, 2011). Germain & Cummings (2010) observe:

> *"Effective nursing leadership is essential to the creation of practice environments that support nurses' ability to perform"*

(Germain, & Cummings, 2010: 436)

The regulation of education and training of nurses is one of the major functions of the Nursing Councils in South Africa and Namibia (Republic of Namibia, 2004; Republic of South Africa, 2005). The Councils should collaborate with educational institutions with regard to nursing education and should be more active in addressing the shortcomings in clinical facilities where nursing education takes place. The ultimate duty of approval of acceptable standards in facilities for nursing education lies with the Nursing Councils of both countries, and Councils need to live up to this expectation despite the political and/or relational discomfort such pressures might cause.

Improved collaboration and communication between Councils and grass root nursing practitioners can be attained by establishing provincial/regional offices that can serve the health and educational sectors within the provinces/regions in South Africa and Namibia.

Prevention of ethical problems in the health care services, such as physical maltreatment of patients, breaches of confidentiality and privacy and disrespectful conduct towards patients, should be addressed by both national and institutional policies and quality management processes (Erdil, & Korkmaz, 2009). Students who observe unethical conduct by doctors, nurses and other health care personnel towards patients are confronted with a theory-practice dichotomy which obstructs the internalization of nursing values.

Noting the concerns of respondents about the perception of importance ethics education by Nursing Councils, the Councils need to consider whether nursing ethics should remain a minor subject within the prescribed nursing education directives from Councils. It may also be helpful to develop national guidelines in nursing ethics to ensure relevance and remove uncertainty about the quality of nursing ethics education at individual educational institutions. Councils should make an effort to disseminate developed guidelines and should assist with in-service education to train practicing nurses on the guidelines. Continuous professional development (CPD) of nurses is an obligation set by law and Councils cannot develop directives that make individual nursing practitioners solely responsible to attain the set CPD units. The means to attain CPD units should be a collaborative exercise by Councils, national and private health care institutions, educational institutions as well as nursing associations/organizations. With improved collaboration and cooperation with regard to CPD between the different sectors the educational needs of professionals may be fulfilled and service delivery to the public improved.

A further relevant issue mentioned by respondents relates to leadership and decision-making by nursing leaders that benefits the profession as a whole. The leadership of nursing, representing the profession on Nursing Councils and nursing associations/organizations, should consider whether the quality of care and the image of the nursing profession cannot be improved by upgrading all enrolled nursing

categories to professionals and educate and register only one category of nurse, the professional person. Alternatively, the shortage of professional nurses as well as in service training of these nurses should be addressed in order to facilitate the effective supervision of enrolled categories of nurses at the bedside.

The responsibility to provide nursing education that responds to the disease profiles and development goals in South Africa and Namibia applies to all the different sectors involved in the creation of systems that can ensure quality nursing education and nursing care. Attempts to improve nursing ethics education does not so much lie with the place where nurses are trained, the hospital school system or mainstream tertiary education, but in the effective intersectoral collaboration and collective standard setting in ethics education and processes monitoring these standards.

The ability of nursing leaders in all these different sectors to collaborate effectively will determine the outcome of nursing education and health care delivery in South Africa and Namibia.

7.2.2 Refining nursing ethics education

The directives regarding undergraduate nursing programs by the Nursing Councils in South Africa and Namibia provide institutions of higher education with a high degree of autonomy on the structuring and modes of presentation of nursing modules (Republic of Namibia, 2008b; Republic of South Africa, 1985). This study has shown high variance in the way nursing ethics education is offered to nursing students at participating institutions, which makes it difficult to determine the standard of nursing ethics education, especially at the institutions in South Africa. The following aspects in nursing ethics education need to change at participating institutions to refine nursing ethics education:

Standardization in the offering of nursing ethics in nursing programs

Standardization of nursing education generally and nursing ethics education specifically is a necessity in South Africa. Namibia is not challenged in the same way as South Africa regarding this matter, because only one institution in Namibia provides undergraduate professional nursing education. Standardization of nursing ethics content can both improve the quality of and enhance the monitoring of nursing ethics education. A national and approved framework stipulating the requirements of nursing ethics education and what competencies nursing students should attain will remove ambiguities' and may consolidate the foundation on which nursing should be practiced. Such a framework will need to address content deficiencies in nursing ethics curricula such as assertiveness training and promotion of advocacy roles. Teaching spirituality and nursing values based on an African worldview is an important gap that must be addressed.

Research in ethics education is also constrained because of the lack of consensus about ethics content, the appropriate context for ethics education and the discrepancies in the methods of teaching ethics (Kesselheim, & Joffe, 2008). The need for a more comprehensive, transformative and national framework for nursing education was identified as a strategy to improve nursing education in South Africa (Republic of South Africa, 2011).

Development of affective skills

Caring conduct, evident in the affective skills of nurse practitioners encompasses both the cognitive and psychomotor skills of nurses. Caring is recognized by patients primarily when nurses respect and show compassion towards patients, but caring conduct also means that nurses are knowledgeable and skillful practitioners. Nursing education has the responsibility to provide nurses with cognitive, psychomotor and affective competencies necessary to be caring practitioners.

"Nursing programs are the first filters of character for the profession, and modelling good nursing care begins in schools of nursing"

(Wolf, Z.R.,2012: 16)

As a pivotal partner in national and global sustainability, institutions of higher learning generally, and nursing education specifically, should aim to develop nursing students holistically by promoting environmental awareness, social responsibility and sound economic stewardship in all educational programs (Shephard, 2008). Affective skills, therefore, are imperative in nursing ethics education to enable students to contribute to sustainable development in South Africa and Namibia.

Selection of candidates for nursing programs and provision of bursaries/loans to students

Participating institutions must devise selection criteria and create selection committees in nursing schools/faculties. Candidates for nursing cannot be selected only by institutional criteria, but nursing educators and faculty management should have procedures and processes in place to select candidates who enter nursing for the right reasons. Interviews should be held with pre-selected candidates and aptitude testing can be done to improve nursing candidate selection. It is also possible that the moral integrity of nursing candidates can be tested by an Integrity Scale test, which may indicate candidates' aptitude to act according to the required moral principles (Millier & Schlenker, 2011).

The provision of bursaries or loans to nursing students should remain. This is not only necessary to rectify past injustices, but to acknowledge the contribution that nursing students deliver to patients while performing clinical duties. Accommodation in nursing hostels is also needed. Shared accommodation in nursing hostels may contribute to more effective socialization and shared values within the nursing profession.

Specialization in nursing ethics

One of the six principles to reform nursing education in South Africa, according to Professor Laetitia Rispel, is the provision of sufficiently well trained nurse educators (Republic of South Africa, 2011).

Nursing ethics education needs educators trained and experienced in nursing ethics to facilitate higher cognitive functions in nursing students. Lin, et al. (2010) claim that expert educators are better able to stimulate higher cognitive functions in students, therefore expert ethics educators are needed because teaching ethics requires specific skills, such as facilitation of reflection, which is a complex and multi-dimensional activity (Epstein, 2011). In preparing students for moral challenges in clinical practice, nursing ethics educators must improve their own skills and ethical knowledge and gain the expertise to facilitate discussions and reflection of the perceived "difficult" topics covered in nursing ethics education (Becker, 2009). Görgülü, & Dinç (2007) write:

"Teaching ethics requires first and foremost the knowledge and skills of teachers of ethics"

(Görgülü, & Dinç, 2007: 750)

Post-graduate nursing programs should, therefore, develop courses that provide opportunities for nursing educators to specialize in nursing ethics education and attainment of skills to facilitate the discussion of difficult topics. When specialization in nursing ethics is possible some of the challenge of inexperienced nursing ethics educators and the random selection of ethics educators will be addressed. Education on different worldviews is important for ethics educators. Cultural awareness, which include knowing one's own beliefs and how it differs from others beliefs, is a prerequisite to cultural competence (Pera & Van Tonder, 2005). Nursing ethics educators who may come into contact with students from different cultures and facilitate the cultural knowledge of students need to have specialized knowledge in this important area of nursing ethics.

An issue related to specialization in nursing ethics is the perception of managers in participating institutions of higher education (Universities and Colleges) that nursing educators should be generalists. This perception often creates expectations that nurse educators should involve themselves in a variety of areas in nursing education, leaving less time to focus on growth and becoming an expert in nursing ethics. Nursing faculty and nursing college management should understand that specialisation in any area of nursing education requires continuous development of expertise in such an area. Nursing ethics educators should not be expected to be involved in other areas of nursing education, because this hampers the sustainability of expertise in ethical knowledge and skills.

Some respondents in this study believe that there is discord between the cultural background of nursing ethics educators and nursing students, which challenges nursing ethics education. The magnitude of this challenge is difficult to determine because sufficient information is not available on the cultural backgrounds of ethics educators in the many other universities or colleges in South Africa. While Davis et al. (2010) claim that challenges faced by students might be more competently managed by educators who understand the demographics of students, further research is needed in both South Africa and Namibia on the culture of nursing ethics educators as determinants in improving nursing ethics education.

Improving theoretical and clinical nursing ethics education

This study has shown that nursing ethics educators at participating institutions are under a great deal of pressure to fulfill their academic educational requirements, conduct research and be involved in community service. The former system of nursing education at nursing colleges and in nursing hospital schools did not have the same academic requirements and provided ample time for nursing educators to guide students in clinical practice settings. If nursing education wants to fill its rightful place in the tertiary education system, understanding of the position of the academic nursing educator is necessary,

and expectations with regard to clinical guidance of students should be realistic. Nursing educators generally and nursing ethics educators specifically should plan and organize clinical guidance of students. Clinical partnership between students, educators and clinical preceptors, who are responsible for clinical guidance of students at the bedside of patients, is essential in teaching-learning in clinical practice settings (Newton, Cross, White, Ockerby, & Billett, 2011). Appointment of clinical preceptors/educators who can guide students in practice is long overdue in South Africa and Namibia.

Manageable student numbers is an issue which participating institutions need to consider. According to Searle, (1988) the 'Achilles heel' of nursing education is to focus on quantity and not quality. High student numbers challenges the quality of nursing education generally and has a long term negative impact on the value system of nursing as educators and clinical supervisors becomes disheartened and tired.

National guidelines should prescribe the ethical competencies nursing students should attain and ethics educators in institutions of higher learning should plan, coordinate and initiate clinical opportunities for students, in collaboration with clinical preceptors. Nursing Councils must decide whether it is viable to require specific clinical competencies with regard to nursing ethics. Institutions will then have to decide whether a clinical component should be attached to nursing ethics education. Clinical experience of students should be goal directed and must provide students with the opportunity to attain the identified core competencies in nursing ethics. Nursing ethics educators should collaborate with professional nurses in clinical practice facilities and provide information on nursing curricula and the goals for clinical practice of students. Effective collaboration and communication between participating institutions of higher learning and health care facilities where students are placed is essential for quality nursing ethics education.

Urgent attention must be given to upgrade health care facilities, especially those where nursing students are placed. The quality of nursing ethics education is severely constrained when the health facilities do not have sufficient equipment, supplies or effective maintenance. Addressing all the challenges of relevant teaching platforms, i.e. health care facilities, supervision and management, is essential to improve nursing education (Republic of South Africa, 2011).

Attention must be given to upgrading of skills of practicing professional nurses. Information obtained from the respondents in this study has shown that many practicing nurses, who they come into contact with, are not role models to nursing students. Continuous professional development is a legal requirement in both South Africa and Namibia (Republic of Namibia, 2004; Republic of South Africa, 2007). Nursing ethics educators should develop continuous professional development courses for ethics education, register these with their respective Nursing Councils and be active in upgrading the ethical skills of practicing nurses. Nursing managers should set an example and not cover up for transgressing nurses under their supervision. A national system of performance assessment of health care workers should be initiated. Salary increments should be provided according to such performance assessment. Disciplinary policies should be enacted and enforced in institutions of higher learning as well as health care organization. A national monitoring and evaluation system needs to be developed and initiated for both the health care and nursing education sectors to ensure continuity of reforms and proof of goal attainment.

Ethics education content

Participating institutions need to assess and consider the inclusion of patient advocacy and assertiveness, moral decision making processes and team membership content into ethics curricula. Professional nurses function as a multidisciplinary team member and in societies where cultural aspects may influence the standing of women specifically, Assertiveness training is required in nursing ethics

education (Timmins & McCabe, 2005). Gender, age and education play a role in assertiveness, according to a study by Onyeizugbo (2003), and more research is needed to determine why nurses in South Africa and Namibia may be perceived to be unassertive. it is however important that students are prepared to conduct themselves assertively to advocate for patients' rights (Pera & Van Tonder, 2011).

It is also important for participating institutions to liaise with other health care professional educators (e.g. medical doctors, pharmacist social workers) for opportunity of inter professional education. Interprofessional education can broaden the perspective of nursing students and all students can gain understanding of the role and function of other health care professionals.

Good governance and prevention of corruption are important content that are required in nursing ethics education. .Higher education must play a role in preparing leaders for ethical and responsible practices in relevant public sectors (Prinsloo & Beukes, 2005).

If clinical teaching as a duty of the professional nurse is not covered in Management modules, it should be included in nursing ethics education. Clinical teaching remains an important duty of practicing professional nurses contributing to the education of students (Booyens, 2001).

Content of Ubuntu as an African worldview and ethic is required in all undergraduate nursing ethics education. Ubuntu supports many current nursing values and it is important to present the ethic of Ubuntu to nursing students in South Africa and Namibia. Morality in Ubuntu presupposes harmony, a state of balance between people and their environment, and restoring imbalances in relationships between people (Mkize, 2009). Ubuntu also prioritises the fulfilment of duties towards others and the natural environment in ensuring social equilibrium (Mkize, 2009). Human beings are seen as holistic beings not separating body from mind because all living creatures in the cosmos mutually share divine energy (Mkize, 2009). The glory of being human is to know righteousness and the foundation of the ethic of Ubuntu is found in the concepts of justice, respect, caring and empathy, which creates harmony

(balance) in the world (Mkize, 2009) Morality is an indispensable part of personhood and a moral person's actions ensure and maintain social justice, respectfulness, truthfulness and empathy towards others (Mkize, 2009). Ubuntu is African humanism espousing the virtues of respect, dignity, solidarity, compassion, giving arms, care, consideration, patience, kindness, warmth and understanding (Pera & Van Tonder, 2011). Ubuntu therefore seems to support the caring ethos and values of nursing and should be included in the undergraduate ethics curricula of nursing students. It is important to present the caring values of nursing to nursing students in the context of traditional African thoughts and beliefs.

Innovation in teaching-learning methods

Nursing ethics educators at participating institutions need to think afresh about the teaching-learning methods in nursing ethics education. While educators are confronted with packaged instructional programs, they should not lose sight of the needs of students to connect with the teaching-learning content and the learning process (Mader, 2009). Educators need to recognize that students learn differently and need to utilize different teaching-learning methods to accommodate different learning styles of students (Hoffmann & McGuire, 2009).

Mogodi, Jooste & Botes, (2003) propose that nursing ethics educators rethink teaching-learning methods, the assessment of nursing values and introduction of value clarification into nursing curricula because current methods do not facilitate the internalization of nursing values by students effectively. The teaching-learning of nursing values should, however, be sustained throughout all the years of education/training because research has shown that values of students change positively as their studies progress (Lin, Wang, Yarbrough, Alfred, & Martin, 2010).

Professional education should prepare nursing students for life-long learning; therefore, students need to be active participants in their own learning process. Holaday & Buckley, (2008) propose an Inquiry-based learning (IBL) method where students design their own clinical learning outcomes based on their

own needs and the course outcomes, while the nurse educator assists students to monitor their own knowledge and modify clinical outcomes as needed. When students are placed with real patients in the clinical setting, students identify and perform case studies which are then explored together with educators. Educators focus on facilitation of critical thinking, analytical and problem-solving skills in students (Holaday & Buckley, 2008).

Critical thinking is a required skill for nursing students and nursing ethics education must facilitate critical thinking skills. Problem-based learning (PBL) must be considered as an approach in nursing ethics education because problem-based learning facilitates student activity, enhances student motivation and the ability to distinguish relevant ethical factors (Lin et al. 2010). Undergraduate nursing programs should gradually incorporate outcomes that facilitate the attainment of critical thinking in nursing students, from the first to the last years of study. Critical thinking should be practiced in all modules of the undergraduate nursing programs. McMullen & McMullen (2009) observe:

> *"The development of critical thinking skills should be viewed as a process, as with the development of any skill, these new skills require practice"*

(McMullen & McMullen, 2009: 311)

Nursing ethics educators at participating institutions need to identify methods that can transform theoretical knowledge to practical knowledge. Integrative teaching-learning methods require ethics educators to focus intentionally on integrative learning (Epstein, 2011). Noone (2009) suggests designing integrated learning outcomes based on what she calls three apprenticeships, i.e. cognitive, skills based, and professional/ethical apprenticeships. Designing integrative learning outcomes considers intellectual and academic nursing knowledge (cognitive); clinical know-how and clinical skills; and ethical and social responsibilities of the nurse. Specific nursing content (e.g. sexually transmitted diseases) is offered to nursing students by covering all three nursing apprenticeships (Noone, 2009). Epstein (2011)

describes the utilization of therapeutic landscaping as a teaching-learning method when students are guided to understand the relationship between social and physical environments of their patients and to integrate these with their ethical knowledge. Integrating cognitive, psychomotor and ethical knowledge and also transforming theoretical knowledge to practical skills is important in nursing ethics education and nursing ethics educators should guide students by developing questions that assist students to identify, question, reflect, judge, and integrate ethical concepts in clinical practice.

> **"***Transformative learning requires an environment that encourages and rewards intellectual openness. The instructor must strike a careful balance between support and challenge"*

(McGonigal, 2005: 1, 2)

Facilitating effective learning in students also needs a balance between critical thinking and creativity (Belluigi, 2009). Creativity is necessary in nursing ethics education because it incorporates abstract learning outcomes such as reflecting, generating ideas and solving problems having a range of divergent solutions (Belluigi, 2009). Student-centred teaching-learning is needed to facilitate creativity and nursing ethics educators must create an environment where students are supported to understand their own views, where these views come from and whether these preconceptions should be replaced by other possible views (Belluigi, 2009). Another innovative form of ethical learning through creativity mentioned by Milligan, & Woodley, (2009) is allowing students to write a short evocative account on a carefully selected hypothetical situation that focuses on the human condition in suffering, guided by educator's expectations of interpretation, appreciation, appraisal and transformation. This approach assists students to creatively engage with their own understanding and insight into sickness experience of others (Milligan & Woodley 2009).

Lizzio & Wilson, (2004) recommend teaching-learning designs that accommodate differences in student learning. A peer-based action learning system, including action based, project based and peer group

learning is an innovative design that is grounded in a process whereby students plan and implement solutions to problems through peer interaction where the learning process utilizes peer experience in structured roles in an attempt to develop student capabilities (Lizzio & Wilson, 2004). More innovative teaching-learning methods in clinical experience of students should also be explored. Service learning, work-based or practice-based learning refers to real life learning situations where learning opportunities for students are created. Camp nursing is an example of an innovative service learning method where nursing students can elect to apply for employment as a medical staff member at a camp for persons with a specific illness. Pre-camp induction and specific assignments to manage the camping patients were provided and educators and physicians were available to supervise the students (Vogt,et al. 2011).

Problem-based learning (PBL) is known to develop student critical thinking skills, creativity and student centred learning. In the participating institution of this study, problem based-learning is not used as a whole-curriculum approach, probably because institutions of higher learning in both South Africa and Namibia are constrained regarding human resources. The principles of problem-based learning can, however, be used to facilitate learning in suitable and selected contexts in nursing ethics education (Taylor & Miflin, 2008).

Nursing ethics educators should seriously consider creating opportunities for inter professional education (IPE) (Oandasan & Reeves, 2005). Interdisciplinary, also called multidisciplinary education creates an opportunity for categories of professionals to learn from each other, to collaborate to improve the quality of care of patients and to gain understanding of each other's roles in patient care and ethical decision making (Wright & Brajtman, 2011; Sorta-Bilajac et al. 2011; Stone et al. 2004; Wright & Brajtman, 2011). Edward & Preece, (1999) report that their endeavors' in what they called shared teaching, assisted health care professionals to appreciate the ethical views and approaches to patients of other professions. Shared teaching is a teaching-learning_method that facilitates learning in

small groups or seminars of students from different professions. It is an inter-professional teaching-learning method.

A further innovative, but not new, teaching-learning method is team teaching that involves two or more educators with complementary technical and personal abilities, working together to ensure that outcomes in the teaching-learning process are improved. Team teaching is especially useful in the teaching-learning of sensitive content, as in nursing ethics education (Kerridge, Kyle & Marks-Maran, 2009). Educators plan, present and evaluate the teaching-learning together. While team teaching might be viewed as resource intensive, research has shown that students found team teaching time saving and that learning is faster and more effective because of the involvement of more educators in the educational process (Kerridge et al. 2009).

Nursing educators at the participating institutions did not indicate the use of internet technologies as an educational method. E-learning and web-based learning are methods that need to be explored by nursing ethics educators because they support the learner-centred approach, provide opportunity for student paced learning and enhance learning when students are able to revisit e-learning materials (Ruiz, Mintzer & Leipzig, 2006). E-learning can be used together with conventional educational methods (Hsu, 2011). Hsu (2011) calls this educational method blended learning. Blended learning involves providing students with a practical problematic scenario which is discussed in the classroom. Web-based discussions between students then follow and web-based videos are available for students to explore further knowledge. This creates a meaningful way of involving students in actively constructing knowledge and meaning and move away from just assimilating knowledge in ethics education. A further possibility of e-learning is creation of international internet collaboration and creation of forums that reflect on nursing practice. Students and educators can discuss and compare the management of ethical dilemmas within different countries and different cultural contexts (Leppa & Terry, 2004).

Kneebone, Bello, Nestel, Mooney, Codling, Yadollahi, Tierney, Wolcockson& Darzi, (2008) describe a highly technological method where health care students are evaluated in a simulated setting by using wireless technology. Students are observed on computers through webcam technology. Remote observation and assessment alleviate student anxiety and provide opportunity for educators to provide electronic feedback to students within a specified period.

Nursing ethics educators should consider more novel assessment methods in the light of the belief that assessment of internalization of values by students is challenging. Grading as a contingent reward may hamper internal motivation of students, despite the fact that grading may have other gains (Mader, 2009). Therefore nursing ethics educators should devise other forms of assessment in nursing ethics education. Self-assessment by students may assist in self-growth, it challenges students' prior assumptions and can enhance student learning because self-assessment allows students to assist in compilation of assessment criteria which enhance interaction with learning content. Self-assessment by students as a co-operative activity between students and educators empowers both students and educators (Leach, 2010). Nulty, (2010) believes peer and self-assessment by students have both proven and potential advantages and should be part of higher education assessment culture and introduced in the early stages of programs. Peer and self-assessment prepare students for continuous learning, they support exchange of ideas, values, multiple perspectives and insights; assist in creation of and participation in a community of critical scholarly inquiry (Nulty, 2010). Assessment feedback can be done in new ways by involving students to provide timeous formative feedback to each other in a variety of innovative ways. Colour-coded quizzes, student conferences and structured criteria-specific templates posted on blogs are possibilities in peer assessment. These templates and comments provide opportunity to give specific feedback to students to improve and can also be accessed by other students who utilize the blogs (Fluckiger, Tixier y Vigil, Pasco & Danielson, 2010).

Another teaching-learning self-assessment method is the writing of portfolios. Portfolios can be a tool for promoting and supporting personal professional learning in higher education. Authenticity of the learning process can be ensured by developing a rubric to assess learning authenticity and students are informed about learning expectations and nursing ethics educators must clarify all concepts relevant to the learning expectation (Trevitt & Stocks, 2011).

Participating institutions of higher education are responsible and accountable for the learning by students within respective institutions because institutions certify completion of education programs. Educators are the guardians of facilitating the teaching-learning process and should balance their own scholarly inputs and student-centered methods to optimize teaching-learning and should be aware that assessment of learning plays a pivotal role in effective teaching-learning and the certification of mastering competencies in educational programs (Cullen& Harris, 2009).The Competency Outcomes and Performance Assessment Model (COPA) described by Lenburg and others, is one example of a method that can enhance effective learning of identified core competencies and standardized methods to validate these competencies in actual practice (Lenburg, et al. 2011). The COPA model identifies the following eight core competencies by which teaching-learning of affective, cognitive and psychomotor skills of students can be facilitated and assessed

- *Assessment and intervention* which includes gathering of patient information, evaluating the information and planning intervention , considering patient safety;
- *Communication* focus on all factors in the communication process and includes oral, written and computing communication skills to all involved in the caring process;
- *Critical thinking* throughout the interactive process with patients and others, includes integration of theory into practice, problem solving skills, scientific inquiry and research process;

- *Human Caring Relationships* includes ethics, cultural aspects, cooperation, interpersonal skills and teamwork, client advocacy and relationship-based care;
- *Management* focuses on all factors and steps of the management process, human and material resources, performance appraisal and quality assurance;
- *Leadership* considers collaboration, coalition building, assertiveness, creativity, management skills and professional accountability;
- *Teaching* includes health promotion to all patients and significant others, support to patients and others, coaching, mentoring, precepting , instructing and teaching; and
- *Knowledge Integration* considers systems thinking, integrating health care and related discipline knowledge, integrative nursing judgment and population and individual-specific care and evidence-based practice.

(Lenburg et al. 2011)

Contemporary innovations in educational methods focus on the higher levels of the Revised Taxonomy of the Cognitive Process Dimensions of Bloom (Krathwohl, 2002). Nursing ethics educators should facilitate outcomes on the levels of analysis, evaluation and creativity in relation to cognitive skills. For the affective dimension nursing ethics educators should assist students to clarify what they value, how these values are organized and prioritized and help students understand how their own value system is evident in their conduct. In the teaching-learning process nursing ethics educators should reveal their expectation by providing students with comprehensive descriptions of competency expectations and assessment rubrics that makes it possible for both student and educators to evaluate student progress (Krathwohl, 2002).

Nursing ethics educators at participating institutions should provide students and professional nurses in clinical practice settings with clear expectations of learning outcomes and competencies. Both students and professional nurses should be orientated towards teaching-learning expectations and educators should monitor the teaching-learning process.

Student support and mentoring of students with learning difficulties should be structured. Students should be provided with expectations of conduct, for instance by signing a contract with nursing departments. Students who do not conform to expected behavior should be supported by remedial programs during their studies. Nursing ethics educators should create behavioral expectations and be fair, but firm with students who are irresponsible and do not conform to expectations.

Initiating Practical wisdom as an approach to teaching- learning of nursing ethics

The challenges in nursing ethics education as mentioned by the respondents in this study require a rethinking of teaching-learning strategies and methodologies in ethics education in undergraduate nursing ethics education programs. Efforts to facilitate moral growth of students and attainment of the necessary virtues in becoming caring nurses need to be the primary focus of nursing ethics education. To achieve practical wisdom, nursing ethics educators need to be involved in creation of an environment (both in the classroom and clinical settings) where the values of nursing are practiced. This might be a mammoth task, but small steps need to be taken to restore the value system of care so fundamental to nursing practice. Uhrenfeldt & Hall (2007) and McKie et al, (2012) view practical wisdom as an approach that can assist in reflective practice of educators and nursing students and an appropriate strategy for ethics education.

Practical wisdom, which can be seen as the wisdom to take counsel and the capacity for moral insight, should be an approach applied throughout an undergraduate nursing education program. It is gained by experience (Kessels & Korthagen, 1996), and should, therefore, be introduced as an approach from the

first to final study years of students to gain maximum time to inculcate the relevant skills in them. Nursing ethics education should attempt to assist nursing students understand that it is not enough to apply the science of nursing rigorously, but that nurses should have the desire, as moral agents, to provide patients with consensual care that heals, and address patient needs, holistically. Consensual care is based on a process of deliberation where nurses use their nursing knowledge, reflect critically on this knowledge and the needs and situation of the patient, while engaging the patient and others involved in patient care. Practical wisdom is not practiced when reasoning is limited to the professional, but deliberation should embrace all persons involved in the care situation. These persons contribute their knowledge, past experiences and own capabilities as well as their personal characteristics to the deliberating process (Edmondson & Pearce, 2006). The process of deliberation is an iterative process, recognized by tolerance and patience. Nurses with practical wisdom acknowledge patient wishes as important and never ridicule patient choice as trivial or inappropriate. Practical wisdom as an approach in nursing education is not mainly focused on the application of rules and justification of actions, but focuses more on the process of learning; positively examining attempts to solve problems and address needs, not expecting solutions to be perfect and final, but solutions should be commendable and advance the good of patients. Actions of the wise nurse are driven by honest desire for the good, emerging from a moral character.

Current application of the scientific nursing process attempts to address nursing needs holistically, but the needs assessment as the departure point of this process, is more often than not, based on the nursing diagnoses, which is derived in the first instance, from the medical diagnosis of patients. The nursing process is also used primarily by nurses to plan and initiate a care plan for patients, while practical wisdom as an approach should focus on deliberation and relationships between caregivers, patients and significant others (such as parents in the case of children, family members, or other practitioners).

In practical wisdom the focus of the nursing process needs to assist patients to accept those situations which cannot be changed, and to identify and attain the optimal result in the healing process, to enable patients to live the best possible lives in their particular circumstances. It is more about the nurse practitioners' moral sensitivity, the motivation to ensure the best for patients and to act responsibly, while interacting with patients (Uhrenfeldt & Hall, 2007). Practical wisdom as an approach in nursing education should, therefore, not in the first instance focus on those issues that cannot be changed (the illness, the disease) and the scientific process to address those issues, but rather on what will be good for the patient, what can be done to ensure *eudaimonia* for the patient. The good life for patients suffering from ill health will mean that the illness/disease should be cured if possible, but the healing process extends beyond cure, it also encompasses the life world of the patient and how the patient passes through/lives the situation. Nurses should focus on the particular situation of the patient and combine the practical knowledge of all involved and sound judgment. This approach needs some creativity, thinking "outside the box" and deliberating notions relevant in the context (Goodfellow, 2002).

In a personal interview with James Giordano (2010), on the event of his 90th birthday, Professor Edmund D. Pellegrino said that the teaching-learning of the humanities and liberal arts (which he see as those arts that free the minds of humans from the tyranny of other minds) is just as important as the teaching-learning of the sciences, and the teaching-learning of the arts require critical thinking (Giordano, 2010).

The challenge for nursing ethics education is, therefore, to facilitate skills that enable nursing students to see the difference between moral excellence and moral mediocrity, and to select the best choice of action in a specific situation (Trowbridge, 2005). Nursing ethics educators should assist student nurses to identify the variables influencing particular nursing care situations, reflect on and seek different

perceptions on these variables from others involved in creating solutions and new perceptions that fit the current situation.

Nursing ethics education should sustain throughout the undergraduate nursing programs an approach that seeks and confirms the origin of good ethical decisions and to challenge those circumstances that inhibit choices that facilitate flourishing of patients (Woods, 1999; Sellman, 2009). Humans, as the moral agents of their choices and actions, cannot be separated from those choices and actions (Pellegrino in Giordano, 2010) and therefore nursing ethics educators should develop teaching-learning methods which enable nursing students to become aware of and understand the motivation for their choices and actions.

Practical wisdom as an approach in nursing ethics education will require:

- Nursing ethics educators attaining practical wisdom themselves and by deliberations determine the aims of nursing ethics education and develop the appropriate teaching-learning methods to facilitate practical wisdom in students (Higgins, 2001; Wivestad, 2008). Nursing educators should themselves display virtuous character traits inspiring students to follow their modeling. As a type of knowledge, practical wisdom can be taught (Begley, 2006) and, therefore, nursing ethics educators should find creative teaching-learning methods to facilitate practical wisdom;

    - A special teaching-learning environment where both nursing educator and nursing students are able to create intra and interpersonal relationships necessary to seek understanding of the human condition (of the self and patients), to accept and share perceptions, feelings and taking responsibility for the teaching-learning process (Goodfellow, 2002; McPherson, 2005). Both nursing ethics educators and clinical educators should be role models who facilitate the effective teaching-learning of students;

- Teaching-learning methods that enable the fusing of cognitive, psychomotor and affective skills together as the pathway to developing the moral character of nursing students and the facilitation of sound moral judgment (Begley, 2006);

- Nursing ethics educators who understand that practical wisdom is attained through a process of learning and that students' unreflective and natural responses is the starting point in deliberation and critical reflection with students on their own perceptions and moral choices;

- Living with the uncertainties in life and also in the teaching-learning process. Seeking the truth is an iterative process and nursing ethics educators should create the opportunities for students to repeat and reflect on choices and decisions (Wivestad, 2008);

- Creation of teaching-learning methods that facilitate critical thinking, using a variety of sources (theory, human and own creative ideas) (Van Niekerk,2008) and considering the relevant and particular features of an situation in deciding what is the "good" in any particular situation and a particular idea (McPherson, 2005; Carnevale, 2007);

- Nursing ethics educators will have to lead institutions of higher learning in thinking about this approach. Phronesis is practical knowledge (McKie et al. 2012), and nursing educators should reflect on the nature of nursing in contemporary society and how nursing education can advance to be more relevant, less fragmented and fulfil its social obligation;

- A culture and environment within institutions of higher learning as well as clinical facilities where ethical practices will become the norm and persons accept responsibility for ethical conduct (Van Niekerk, 2003), and

- An environment where unacceptable character traits and unethical conduct are sanctioned and not supported.

Nursing ethics educators should develop teaching-learning outcomes that focus on the process of learning by students. Traditional teaching-learning outcomes focus mostly on knowledge attainment and not the learning process itself. The following examples attempt to illustrate the difference between a traditional learning outcome and an outcome facilitating practical wisdom in relation to moral decision-making, using a hypothetical scenario containing a moral problem in nursing practice:

Hypothetical Scenario

Patient X is 53 years old, blind, a diabetic and diagnosed with chronic renal failure. Mr. X has suffered two cardiac arrests and was successfully resuscitated on both occasions. Patient X is in your care and is now requesting you not to resuscitate him again in the event of a further cardiac arrest.

Traditional learning outcome:

- Apply a moral decision-making process in solving the moral problem you face from the request of Patient X.

Outcomes facilitating practical wisdom

The following outcomes are attained by discussions between students and educators, peers, patients, patients' family and colleagues during the teaching-learning process.

- Explicate the possible feelings of Patient X when he requested you not to resuscitate him again.
- Explicate your initial and first response to Patient X's request
    - ✶ What did you think about when Patient X asked you not to resuscitate him again?
    - ✶ Did you think that Patient X has a right to ask this from you?
    - ✶ Do you see Patient X's request as reasonable? Why? Why not?
- Identify those persons who might be influenced by Patient X's request

- Describe how the identified persons might be influenced
- Justify who you think should be involved in the moral decision that needs consideration.
- Evaluate your answers to the above against the answers of other students and examine the different perspectives of other students on this matter.
- Create a possible solution or possible solutions to Patient X's request. Justify your possible solution/s?

The above process of teaching-learning assists students to develop moral imagination and skills while perceiving the immediate situation, the importance of relations in the situation and universal principles applicable in the situation (Benner, 2000).

The above outcomes can be used in a class or small group discussion, as an assignment whereby the assessment rubric of the educators assesses the critical thinking, honest and open responses of the student and not so much the correctness of the management of the problem. The same types of outcomes can also be provided to students in the management of real life case studies. Assessment rubrics develop grading that allocates sufficient weight to student responses in the learning process against right answers (if right answers are necessary, for instance in management of a clinical problem).

Nursing ethics educators should:

- Ask appropriate questions to assist students to move forward in the learning process, ideally from moral awareness (knowing own beliefs) to moral sensitivity (accepting own and others beliefs and respecting both;
- Assist students to understand their own perceptions and where they come from (What is your view about this? Why do you view it in this way?);

- Assist students to see the context, (what is really happening in this situation? Why do you think this is happening?);
- Nudge students to voice their thoughts (What do you think about this situation?)
- Support students to voice their feelings (How do you feel about this situation?)
- Allow students to reflect on their existing knowledge about a nursing care situation (What do you know about this situation?)
- Allow students to create possible solutions to the situation (What do you think can be done in this situation?) and
- Facilitate consideration by the student of their personal moral growth (Will your choice be difficult or not and why?)

Where the interactive process between educator and students is challenged by high student numbers, ethics educators can create and provide students with outcomes that guide students in writing of portfolios; to perform peer and self-assessment exercises and to interact individually with challenges in the clinical management of patients. Students can be assisted to use the same interactive process when they are deliberating with patients and others in addressing patients' holistic needs.

Practical wisdom as an approach in nursing ethics education requires both nursing ethics educators and nursing students to seek the good for themselves and for patients. The goal of nursing is to ensure human well-being and the focus of nursing education should be to enable nursing students to assist patients to live their lives to the fullest.

> *Biotechnology cannot substitute for moral and ethical reflection. That is why I believe that Aristotle, Aquinas or Augustine will not ….should not fade from our view….I think that the*

> *proverbial big questions are still the same as they were 3000 years ago. Human nature does not change.*
>
> (Pellegrino in Giordano, 2010: 19)

It will be wise to use practical wisdom as an approach in nursing ethics education, because contemporary sciences and technologies may evolve, but human nature will stay the same and to provide nursing students with practical wisdom enables them to stay true to the goal of nursing, i.e. to actively seek and promote the well-being of others. Practical wisdom as an approach also supports an ethic of care which is perceived as a suitable ethic for nursing (Moodley, 2011). An ethic of care and practical wisdom are alike, because both are relational and interactive in nature.

7.3 Concluding remarks

Nursing educators generally and nursing ethics educators specifically need to champion the education of nursing ethics in undergraduate nursing programs. Affective skills are the foundation of nursing practice and the assessment of affective competencies are neglected in nursing ethics education. Nursing leaders and managers in all sectors, (practice, regulatory, educational, political), should collaborate in preventing the erosion of nursing values. Attention must be given to the identified challenges in the health care sectors of both Namibia and South Africa that contributes to the loss of the caring nature of nursing. To attain a caring cadre of nurses, strong leadership in nursing is imperative who can voice the concern of nurses to decision makers and who practicing nurses will respect and listen to. Nursing ethics educators need to consider innovative educational methods in the education of nursing ethics and specialization in nursing ethics should be considered as important as specialization in clinical areas of nursing practice.

CHAPTER EIGHT

CONCLUSION

8.1 Introduction

Nursing ethics refers to the norms and values that guide the conduct of nurses in the course of the execution of their professional duties. Expectations of ethical behavior by nurses have existed since ancient times and caring has remained the core value in nursing practice. Since the Common Era the Christian faith contributed significantly to the value system of nursing as it is known today. Florence Nightingale (1820-1910) who has been credited as the founder of modern nursing and nursing education has cemented the value system association with nursing and has contributed significantly to the image of nursing and the establishment of nursing as a profession.

Most disciplines, including nursing, were and still are challenged by societal change and the nursing profession has attempted to respond to this in meaningful ways. During the mid-twentieth century nursing leaders in the United States of America developed nursing theories that reinforced nursing as a professional discipline. During the last decades of the twentieth century and the new millennium a new awareness of the true nature of nursing and an ethic of care for nursing was explored.

The evolution of nursing and consequent challenges has contributed to the development and maintenance of codes of ethics that proclaim the norms and values to which nurse practitioners should abide. The International Council of Nurses has contributed significantly to the universal perception of nursing and how nurses perceive themselves and their practice. The study of codes of ethics from various countries in the world has shown that the nursing profession universally subscribes to similar norms and values that are adopted and proclaimed within countries. These norms and values in codes of ethics form an integral part of nursing ethics education and are viewed as important content in such curricula.

South Africa held a Nursing Summit in 2011 with the aim to reconstruct and revitalize the nursing profession and to provide a long and healthy life for all South Africans. Before this summit consultation took place with members of the nursing profession in all the provinces of South Africa, the summit adopted a Nursing Compact whereby the Minister of Health and the Department of Health in South Africa agreed to facilitate the reconstruction of the nursing profession, including nursing education. Most of the challenges identified by respondents of this study are confirmed in the Report of the Nursing Summit of 2011 (Republic of South Africa, 2011).

In Namibia, in July 2012 the President Honorable Hifikepunye Pohamba, called for a commission of Inquiry into the nursing profession, including nursing education. The Report of the Presidential Commission of Inquiry was issued in January 2013 and has reported, inter alia, that more effective disciplinary measures for unethical conduct by nurses are needed and that clinical instructors must be recruited to mentor students in clinical facilities (Report of the Presidential Commission of Inquiry, 2013) This enquiry will hopefully result in decisions that can address the challenges in the nursing profession and nursing education in Namibia.

8.2 The main findings of the study

Public complaints about uncaring nurses and challenges within institutions of higher learning and clinical facilities where students receive education have indicated that nursing education generally and nursing ethics education specifically face challenges in both South Africa and Namibia. Empirical investigation into the status of nursing ethics education at participating institutions in both countries has shown many variations in the offering, content and clinical education of nursing students. The change from a hospital school education system to mainstream tertiary education in nursing education has its own challenges and is currently not addressed sufficiently in both South Africa and Namibia.

Some nursing ethics educators at participating institutions feel uncertain about teaching nursing ethics and find transferring nursing values to students a real challenge. A need for specialization in nursing ethics exists. Not enough attention is given to assertiveness training and African values are not incorporated into nursing values in a meaningful way. Interdisciplinary teaching-learning is not practiced resulting in many missed opportunities for nurses. Nursing ethics training is compulsory in undergraduate nursing education and is a continuous professional development requirement; yet nursing ethics is marginalized in undergraduate nursing education programs. Many challenges faced in the health care services in South Africa and Namibia relate to poor ethical conduct by professional and sub professional nurses, yet nursing ethics education remains a small component of undergraduate nursing education. Some students enter nursing for the wrong reasons and current student selection methods do not opt to identify the most suitable nursing applicants, but consider affirmative action and numbers as some criteria. Diverse values of students and educators, assessment of internalization of nursing values and overcoming the theory-practice gap challenge nursing ethics education. Poor role modeling by practicing nurses, the lack of supplies and equipment in nursing units, poor standards of care to patients and ineffective supervision and guidance of students hampers effective teaching-learning of students in clinical facilities. Nursing managers condone undisciplined behavior of nurses or participate themselves in unethical conduct causing an unacceptable organizational culture of indiscipline. Trade unionism changed the view of nursing from a profession to a job with a culture of "wanting", instead of service to others. The regulatory authorities of nursing (Councils) maintain a top down approach of decision making and do not communicate sufficiently on grass roots level with practicing nurses. Poor collaboration between nursing councils, institutions of higher learning and service providers hampers the standard of education and progress in the profession. Nursing ethics educators have to rethink the teaching-learning strategies and methodologies in the facilitation of ethics

education to nursing students. It might be worthwhile to explore practical wisdom as an approach that can facilitating ethical competencies in nursing students.

8.3 Recommendations from the study to participating institutions and stakeholders

It is clear from this study that improvements in nursing ethics education and nursing education generally, are needed at participating institutions. The South African Nursing Council and the Nursing Council of Namibia should consider whether nursing ethics should continue to remain a minor subject in undergraduate nursing programs. It is also recommended that the presentation of nursing ethics and the content of nursing ethics education should be more standardized in South Africa. The variability in nursing ethics education curricula at participating institutions might make it more difficult to monitor and ensure the quality of nursing ethics education at these institutions in South Africa. Namibia, with only one institution offering undergraduate nursing education, is not currently challenged to the same extent as South Africa in this regard, but should consider standardization if undergraduate nursing training changes in the future.

Institutions of higher learning must be innovative in the teaching-learning process and should take full responsibility for the quality of undergraduate nursing education, including support of nursing ethics educators who wish to specialize in nursing ethics. Improving clinical teaching-learning requires closer collaboration between the Nursing Councils in the two countries with respective service providers where students are allocated, as well as with the institutions of higher learning. Nursing councils should monitor and enforce compliance regarding the standards of care. Planning, organization and monitoring of clinical teaching-learning in facilities are necessary to ensure effective nursing education. Nurse educators at participating institutions should monitor clinical nursing practice and expectations from students should be clearly communicated to nurses who guide students. Irresponsibility of students should be managed in a firm, but fair manner. Nursing managers and decision-makers in health care

facilities should create a culture of responsibility and compliance with both the legal and ethical expectations of the nursing profession. Nursing practitioners who are poor role models to students or who place patient safety at risk should be dealt with.

In both South Africa and Namibia, the delivery of health care relies heavily on practicing nurses in both urban and rural health care facilities. It is important that political decision makers, regulating authorities and institutions of higher learning collaborate with regard to nursing education in strengthening the education of nurses. Nursing educators should realize the importance of preparing nursing students to face challenging situations in practice. Nursing ethics educators must find innovative ways to facilitate wisdom in nursing and to assist students to realize that the goal of nursing has not changed, that caring for others is still the central value in nursing practice.

8.4 Impact of this study

This study has yielded unique information on the challenges in nursing ethics education at participating institutions in South Africa and Namibia because no empirical research in this field has been conducted in these countries before. Empirical knowledge on the status and challenges in nursing ethics education in these institutions creates opportunity to address these challenges and improve undergraduate nursing ethics education at these institutions. This study also proposes a new approach in nursing ethics education based on Aristotle's conception of practical wisdom. This approach in nursing ethics education has the potential to introduce innovative teaching-learning methods that may enhance the teaching-learning process as well as the internalization of nursing values in nursing students. Information obtained in this study also provides opportunity for further research in nursing education, nursing ethics education and nursing generally.

The findings of this study will be disseminated to participating institutions and to the South African Nursing Council and the Nursing Council of Namibia. The chapters of the dissertation will also be

reworked into articles to be published in peer reviewed academic journals, to enhance the availability of the findings. The current ethics curriculum will be reviewed and the recommendations will be implemented to enhance the quality of undergraduate nursing ethics education in Namibia.

8.5 Limitations of the study

After various unsuccessful attempts to get ethics educators from nursing colleges and other universities involved as participants in the study, the researcher had to be satisfied with participants from universities and only one nursing college in South Africa. The Information obtained in the study is therefore not representative of nursing ethics education in South Africa. Non-participating tertiary institutions offering undergraduate nursing programs, including nursing colleges might have unique challenges in nursing ethics education which might not be fully addressed in this study. Participation of nursing colleges might also have provided a broader and more diverse perspective of nursing values to the study. Some participants who completed the questionnaire were not available for individual interviews, but the researcher is of the opinion that this did not influence the validity of the data because data saturation was achieved with the interviews conducted with available participants.

Retrospectively it might have been more beneficial to include closed, and not open-ended, questions on the ethics content offered at participating institutions and teaching-learning methodologies used by nursing ethics education. The data received on content and teaching-learning methodologies did not allow a satisfactory comparison of the content and methodologies offered and used at participating institutions.

All the respondents in this study were female while male nursing ethics educators could have provided a different and unique perspective on nursing ethics education in the countries.

8.6 Future research

This study creates opportunity for various further research studies in nursing education and nursing generally. Some proposals for further research are to:

- Determine the goals of nursing ethics education and the content necessary to achieve the goals;
- Determine the general variability in nursing ethics education in South Africa;
- Determine the influence of differing cultural beliefs between educators and students on nursing ethics education ;
- Develop a synergized African nursing value system based on “Ubuntu”;
- Propose innovative student selection procedures in institutions of higher learning;
- Determine obstacles to good standards of patient care;
- Determine reasons for poor role modeling of practicing nurses in health facilities;
- Propose a stakeholder collaboration model to improve nursing education;
- Describe the perceptions of practicing nurses have of their profession, and
- Describe perceptions on the unassertiveness of nurses.

8.7 Conclusion

None of the challenges in nursing ethics education is so overwhelming that it cannot be addressed. It requires commitment from all the relevant role players in government and in institutions of higher learning. Nursing ethics educators should consider the recommendations in this dissertation as well as

the recommendations from the Nursing Compact in South Africa and the Commission of Inquiry in Namibia.

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ADDENDUM 1: QUESTIONNAIRE

Dear Participant,

Thank you in advance for completing this questionnaire.

The questionnaire consists of the following sections.

Section A: Demographical information

Section B: Undergraduate professional nursing ethics education

Section C: Teaching-learning strategies.

Section D: Teaching-learning of nursing values (value education)

Please complete the questionnaire electronically, and return it to edevilliers@unam.na

Indicate your response with a [X] where applicable, and type in the further responses beneath each question. This allows you to use as much space as you need to answer the questions at hand.

This questionnaire could take 30 minutes to complete.

Section A. <u>Demographical information</u>

1. Please indicate your age range

   [ ] 20 –29 years

   [ ] 30 – 39 years

   [ ] 40 – 49 years

   [ ] 50 – 59 years

   [ ] 60 and older

2. Please indicate your gender

   [ ] Female

   [ ] Male

3. How many years of teaching experience do you have in nursing education?

   [ ] less than 5 years

   [ ] 5 –9 years

   [ ] 10 – 14 years

   [ ] 15 – 19 years

   [ ] 20 years and more

4. How many of the above years teaching experience is/was experience in nursing ethics education?

[ ] less than 5 years

[ ] 5 – 10 years

[ ] 11 – 15 years

[ ] 16 – 20 years

[ ] 21 years and more

5. On what basis were you selected to teach nursing ethics to undergraduate nursing students?

……

……

Section B: <u>Undergraduate professional nursing ethics education</u>

6. In what undergraduate nursing program/s are nursing ethics offered in your institution?

[ ] diploma

[ ] degree

[ ] other, please specify …

7. Is nursing ethics content offered to students as a separate module in the nursing program at your institution?

[ ] Yes

[ ] No

8. If yes, can you attach the current nursing ethics micro curriculum of the offered module to this questionnaire?

9. If no, what nursing ethics content is covered in the undergraduate nursing program at your institution? *If it is possible to attach a full micro curriculum of your undergraduate nursing program, such will be sufficient.*

……
……..

10. Is nursing ethics content offered as?

[ ] a semester module (half year module)

[ ] a year module (over full academic year)

[ ] other, please specify

11. How many theoretical hours are allotted per week to nursing ethics education?

[ ] 2 hours

[ ] 4 hours

[ ] other, please specify…

12. In which academic year/s are the nursing ethics content/module offered in the undergraduate nursing program of your institution?

[ ] 1

[ ] 2

[ ] 3

[ ] 4

13. What are the current challenges/difficulties/problems in THEORETICAL nursing ethics education at the undergraduate level of nursing education?

……
……
……

14. How can these challenges (re THEORETICAL ethics education) be addressed?

……
……
……

15. Does nursing ethics education have an attached clinical practice component?

[ ] Yes

[ ] No

16. If nursing ethics education has an attached clinical component, please elaborate on what content is covered during clinical practice guidance?

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17. What are the current challenges/difficulties/problems regarding the CLINICAL GUIDANCE of students regarding nursing ethics education?

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18. How can these challenges (re CLINICAL GUIDANCE) be addressed?

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19. Please indicate the moral dilemmas which nurse practitioners mostly face in clinical nursing practice situations, according to your experience.

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Section C: **<u>Nursing ethics teaching-learning strategies and methods</u>**

20. Which teaching-learning strategies and methods do you currently use in facilitating THEORETICAL nursing ethics education?

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21. Which teaching-learning strategies and methods do you currently use during CLINICAL guidance of students in nursing ethics education, if clinical guidance takes place?

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22. How important do you think it is that teaching-learning strategies and methods in nursing ethics education change?

1	2	3	4
Not important	Fairly important	Very important	Vitally important

23. If it is important to change teaching-learning strategies and methods in nursing ethics education, how possible will change be if other priorities in the curriculum are considered?

On the scale below please indicate how difficult change may be.

1	2	3	4
Very difficult	Difficult	Slightly difficult	No difficulty

24. If change in teaching-learning strategies and methods in nursing ethics education is important, how do you think it should change?

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……
……

25. If the teaching-learning strategies and methods in nursing ethics education need not change, why do you think it need not change?

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……

Section D: **Teaching-learning of nursing values**

26. Do you think it is possible for nurse educators to facilitate the internalization of nursing values in nursing students?

[ ] Yes

[ ] No

27. If it is possible to facilitate the internalization of nursing values in nursing students, how can this be done?

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28. What challenges do nurse ethics educators face in facilitating the internalization of nursing values in nursing students?

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29. How can these challenges be addressed?

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30. If it is not possible to facilitate the internalization of nursing values in nursing students, what do you think are the reason/s for this?

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……

Thank you very much for your participation and contribution in completion of this questionnaire.

ADDENDUM 2: SEMI-STRUCTURED INTERVIEW GUIDE

The semi-structured interviews will aim to compliment and enrich the data obtained by the questionnaire and to explore the current status and challenges in nursing ethics education. Individual interviews will be conducted with participants who have completed the questionnaire.

The candidate aims to cover the following themes during the individual interviews, but the completed questionnaire will primarily guide the individual interviews.

Theme 1

The view of respondents on the challenges in nursing ethics education in South Africa and Namibia.

Theme 2

The view of respondents to address the identified challenges in nursing ethics education in South Africa and Namibia.

Theme 3

The view of respondents on the contribution (if any) that nursing ethics education can make to facilitate the internalization of nursing values and affective skills in student nurses.

ADDENDUM 3: INDEPENDENT CODER LETTER

Faculty of Health Sciences

School of Nursing and Public Health

To: Ms J E De Villiers

From: Prof LF Small

Date: 18th July 2012

Re: Comments of the data analysis that was done for the doctoral dissertation of Ms JE de Villiers

I have read through the narratives and have used mainly Tesch's steps in analyzing the data. The data were based on the narratives acquired from three questions posed to the participants.

My approach was mainly to identify patterns (sub- themes). After this identification, I juxta-positioned these patterns next to the already derived themes submitted by Ms J E De Villiers. In general, I have found my patterns to be in agreement with her themes

I thank you

Prof LF Small