A FRAMEWORK TO ENHANCE ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

by

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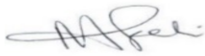
DECLARATION

I, Moliehi Rosemary Mpeli, declare that "**A FRAMEWORK TO ENHANCE ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA**" is my work, and that to the best of my knowledge, this work has not been submitted before for any other degree at any other institution, and that all the sources that I have used or quoted have been indicated appropriately and acknowledged.



12 December 2022

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A FRAMEWORK TO ENHANCE ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

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ABSTRACT

Nursing ethics is the basis of nursing practices, and is aimed at improving the well-being of patients and their families, society, and the nursing profession. However, nursing ethics education and practice have always been under scrutiny globally, due to prevailing unethical practices perpetrated by some nurses. In South Africa, some of the investigations into these practices have resulted in disciplinary hearings by the South African Nursing Council (SANC). It is against this background that the aim of the study is to describe the status of nursing ethics and consequently develop a framework for enhancing ethics education and practice within the nursing profession in South Africa. Higher education institutions and the public health care services sector in Free State Province provided the study's context and reference point.

A convergence mixed-methods approach was used, in terms of which relevant literature and pertinent documents were reviewed, a survey was undertaken for exploring the ethics knowledge of the Com-serves; while unstructured interviews were also conducted with ethics educators and Com-serves. Inferences from these diverse data sources portrayed the status of nursing ethics and gave insight into the trajectories that may be pursued to enhance ethics in nursing and, therefore, ethical patient care.

The study results revealed that nursing ethics is constrained by factors such as misinterpretation of broad SANC directives, resulting in discordant nursing ethics and professional practice, as well as limited ethics content in education. The results further reveal poor ethical reflection amongst healthcare professionals. For instance, while the Com-serves reported unethical practices and attitudes by senior nurses and medical practitioners, they lacked the courage to report similar unethical behaviour towards

patients. It was further revealed that there exists a narrow understanding of ethical and legal frameworks among the Com-serves. As pronounced in the conceptualisation of nursing ethics, the use of personal values was also prevalent.

Therefore, the study recommends an ethical framework that considers internal and external guidance of morality as the basis for preparations in nursing ethics education to enhance the nurses' encounter with their clients. Such a framework should recognise nursing ethics from the philosophical view of ethics as a binding responsibility focusing primarily on a patient as the vulnerable and suffering 'other'. The framework should also integrate the application of ethical and legal frameworks in nursing activities for achieving human dignity as a normative standard described by the patient.

Key words

Nursing ethics; status of nursing ethics; enhancing nursing ethics.

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DEDICATION

In memory of my parents,
Mathapelo Celestina and Keizer Emmanuel Chakalane,
for ingraining the value of probity in my upbringing.

You were my philosophers from birth. Reciprocally, I have grown up to be more thoughtful, diligent, and reflective.

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LIST OF ABBREVIATIONS

DoH	Department of Health
ICN	International Council of Nurses
NQF	National Qualifications Framework
SANC	South African Nursing Council
SAQA	South African Qualifications Authority

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The chapter presents an overview of the entire study, with the phenomena of interest presented and discussed further in the subsequent chapters. Existing literature on nursing ethics education and practice, as well as the related issues are presented and discussed as the background to the research problem. Thereafter, the research problem *per se* is discussed in the context of the identified gaps in nursing ethics. The approach to the research problem is discussed and explained further in the context of the theoretical framework. The study's purpose and objectives are then discussed as research variables continuing from the background of research (Babbie 2020:36). Meanwhile, other composite parts of the chapter relate to the research methodology that was followed, as well as the study's significance and scope.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

The background of the research problem is presented and discussed in terms of the mounting concerns regarding nursing ethics education; reviews regarding the code of ethics; and the nursing ethics challenges.

1.2.1 The mounting concerns regarding nursing ethics education

In 2018, the South African Nursing Council (SANC) undertook a disciplinary hearing in which 17 cases were heard, and disciplinary decisions were made (SANC 2018:18-19). Most cases were related to unethical practices such as neglect and abuse of patients by those expected to have undergone nursing ethics training. The preponderance of discipline cases is not an emerging problem, as nursing ethics education and practice status has always been under scrutiny, even from student nurses themselves. Therefore, there have been constant changes regarding nursing ethics. For instance, in their study with nursing students, Vynckier, Gastmans, Cannaerts and Dierckx de Casterle (2015:304) highlight that ethics courses fail to fulfil nursing's primary objectives regarding

ethics education. This disquiet regarding ethics coheres with other authors' concerns about nurses' inability to analyse ethical problems, reason their judgments, and act ethically without conforming to rules (Tsuruwaka 2018:156; Dierckx de Casterle, Izumi, Godfrey & Denhaerynck 2008:548). The report that prompted the strategic plan for nursing education and practice of 2012/13-2016/2017 by the South African SANC (2018:24) relates to the concerns that professional nurses raised regarding the unethical face of the nursing profession to the public. Despite all the challenges presented, limited studies in South Africa have evaluated the state of ethics education and nurses' ethical competencies in clinical practice.

The study by White, Phakoe and Rispel (2015:3) is one of the few that analysed nurses' perspectives regarding the Nurses' Code of Ethics and Nurses' Pledge. The afore-cited authors' study revealed an above average awareness level of the International Council of Nurses' (ICNs') Code of Ethics and Nurses' Pledge of Service amongst nurses. However, White et al (2015:4) identified some contradictions between nurses' actual knowledge and their practical application of such knowledge: A high percentage of the participants (96%) were aware of upholding the patients' rights. At the same time, 85% of the participants believed that nursing homosexuals is against their personal ethical frameworks (White et al 2015:5). It may be assumed presumed that the ethical principles stated in codes of ethics are abstract concepts lacking in practical location. Therefore, there is a potential risk of succumbing to rules without reflection and deliberation.

In their study on nurses' opinions regarding their current ethical practices and strategies for enhancing ethical practice, White et al (2015:5) found and confirmed that most nurses felt a need to improve ethical education and practice at the nursing colleges or universities. The current study attests to the sparseness of ethical discernment within the nursing profession in South Africa. The desire to improve ethics among nurses in clinical practice signifies a declaration to the colleges and universities regarding the foundational significance of ethical competence in the profession. The concerns with improvements and efforts to strengthen ethical competence necessitate a strategic evaluation of nursing ethics education and practice from those conducting ethics training; as well as those in the practical realm of care in nursing. Although the Code of Ethics exonerates the face of nursing from public scrutiny, there is a need to train nurses in ethical competence and move beyond the professional codes of ethics that have always informed nursing.

1.2.2 Reviews regarding the Code of Ethics

There have always been challenges regarding the codes of ethics in nursing as a prescribed ethical framework. For example, Esterhuizen (1996:26) indicates that the Code of Ethics does not substantiate on practising nurses' and midwives' moral decision-making. Furthermore, the Code of Ethics is viewed as presenting an ideal morality accompanied by non-strategic sanctions for the individual's internal moral development. Reiterating the limited power of the codes of ethics, Mathibe-Neke (2020:53) argues that the Code of Ethics as stipulated in the set SANC standards does not equip nurses with the desired moral norms, ethical principles, and legal perspectives relative to health care. Gallagher and Wainwright (2005:22) point out that patients endure disgraceful treatment despite the regulating bodies' continuing efforts to revise and produce the desired Code of Ethics. The SANC’s 2016 statistical report on disciplinary hearings demonstrates that some nurses were reported for misdemeanours such as poor nursing care, medication-related errors, fraud/forgery/theft, assault of patients and colleagues, including sexual assault (SANC 2016).

The prevalence of disciplinary hearings in spite of the Code of Ethics guidance, suggests that it would be appropriate for the SANC and its policies to scrutinise for the existing ethics education and practice guidelines in South Africa. In 2010, the New Zealand Nurses’ Organization agreed that the Nurses’ Code of Ethics was not a sufficient framework for teaching nursing ethics (Song 2018:14). From the current study’s perspectives, the latter state of affairs suggests that micro- and macro-level curricula ought to be continuously renegotiated with rules and strategies that are aligned to contemporary ethical issues in nursing education and practice.

1.2.3 The nursing ethics challenges

Gallagher and Wainwright (2005:22) aver that nurses' conduct towards patients has deteriorated, despite the compulsory nature of ethics training in the institutions of nursing education. In South Africa, the Strategic Plan for Nursing Education, Training, and Practice of 2012/13-2016/17 highlights the deteriorating standards of nursing care, characterised by unethical conduct and poor nurse-patient relationships (DoH 2013:24). As such, Hye-A, Sung-Hee and Su-Jeong (2017:646) acknowledge the need for continuous measures for developing innovative content, structure, and instructional

methods for nursing ethics educational programmes. The 2014 appointment of a Chief Nursing Officer in South Africa heralded the strengthening of ethics training and practice (DoH 2011:24). To date, no identifiable studies have analysed the efficacy of these efforts in the improvement of content, teaching, and learning strategies for ethics education and practice by the nursing institutions in South Africa.

Furthermore, little is known about the extent of knowledge of ethics by nurses who have just completed their nursing programmes, or are in community service practice (Com-serves). These practitioners may still have fresh perspectives regarding ethics education. The above-cited concerns, in conjunction with the nurses' increasing unethical conduct and its attendant neglect and abuse of patients, provided the impetus for this study's commencement. Therefore, the question is: *Which is an appropriate ethical framework that the nursing education institutions may employ in enhancing clinical nursing ethics?*

Clinical nursing colloquies globally and in South Africa continuously search for strategies to augment the nursing ethical standard because incapacities may collectively impact the patient's care and the nursing profession (Grob, Leng & Gallagher 2012:39). This state of affairs assigns the nursing ethics educators to search for the ethical frameworks that may be compatible with nursing education and practice to help the nursing students develop the required ethical skills pertinent to patient care (Tsuruwaka 2018:156). Hence, an evaluation of ethical competence in nursing education and practice could contribute to betterment of the structure and position of nursing ethics education and practice.

1.3 RESEARCH PROBLEM

A research problem refers to some identifiable difficulty within a situation or phenomenon of interest, which the researcher intends to resolve by means of evidence-based mechanisms (Polit & Beck 2017:69).

The researcher has vast nursing ethics experience in the clinical and academic fields. The researcher is also adequately exposed to the field of local and international bioethics at higher education institutions. From the health sciences perspective, this stance of professional advancement in bioethics and ethics has influenced the researcher's view of nurses' ethical practices. Furthermore, the researcher's interest and experience in nursing ethics was improved and expanded through her protracted involvement in the

moderation of professional practice and ethos examination papers from diverse local nursing education institutions and some neighbouring countries. Additionally, the researcher is involved in developing the micro-curriculum for ethics at a higher education institution.

The researcher's nursing ethics experience derives from the midwifery students' clinical accompaniment in which she has been engaged for more than 20 years. The highlights of these experiences emanate from the students' reflection reports regarding their ethical competence and practising professional nurses' conduct. The range of accumulated experiences inspired the researcher's questioning of the formal acquisition dictate of ethical competence by the nursing education institutions.

In South Africa, the nursing education institution develops the curriculum under the directive of the SANC, which sets standards for education in nursing and develops competencies relevant to nursing ethics education (SANC 2016). However, Iacobucci, Daly, Lindell and Griffin (2012:480) believe that implementing these guidelines is subject to individual institutions' interpretation, resulting in the variability of ethics education from one institution to another. As stipulated in the new nursing qualifications for inclusion in the National Qualifications Framework (NQF), the current guidelines for ethics education have different exit level outcomes for different categories of nurses. As such, there is a strong likelihood of different institutional learning content.

For example, the Bachelor of Nursing and Midwifery Qualification Framework emphasises proficiency in identifying and addressing ethical and legal issues, as accrued from critical reflection concerning the appropriateness of various ethical prescripts (and legal) systems of the nursing and midwifery practise within a legal context (SANC 2014a). Thus, there is an expectation that one will:

- Develop advocacy mechanisms to enhance individual, group, and community regarding health care and legal provision.
- Frequent practice to demonstrate precise understanding and interpretation of South African legislation concerning requirements for nursing and health care, including a primary health care approach.

- Abide by Ethical codes, including professional accountability, responsibility, and standards for nursing and midwifery practice, and ensuring consistency with the declared spirit and intent.

According to the Qualification Framework leading to the Diploma in Nursing (staff nurse), it is expected that the diplomates should be able to render nursing care within legal and ethical frameworks (SANC 2013a). However, there is limited research concerning education institutions' translation of the SANC guidelines in respect of instilling ethical competence. Therefore, it is essential to determine how Free State Province's nursing education institutions have developed the curriculum and learning materials for nursing ethics based on these SANC guidelines.

In translating these SANC guidelines into the ethics curriculum and study material, the researcher hypothesised that most nursing education institutions could possibly use traditional ethical frameworks consisting of various nursing practice aspects. Although these may be different from one institution to another, these aspects, among others, include the nature and parameters of nursing practices (e.g., philosophy of nursing, history of nursing, caring ethos, and nursing as a profession) (Jooste 2010:80). Other institutions may dwell on aspect such as: theories of nursing and their paradigms; professional, ethical practice (nursing values, nursing pledge ethical challenges and dilemmas and moral decision-making); legal rights and responsibilities (e.g., Batho-Pele, Patients' right charter advocacy and informed consent); professional regulation; professional competencies; as well as the professional and legal aspects (Jooste 2010:80). The question then, premises on whether or not these approaches contribute to the desired goal of ethical competence development. The researcher's experiences in translating the SANC guidelines into the micro-curriculum (in the light of being uninvolved in the development of the nursing programme's macro-curriculum) raised some difficulties and inconsistencies for alignment with the internal morality of nursing.

Despite the supposed fertile ground for ethical engagement, Melody Emmett's *Sunday Times* article of 26 September 2017, demonstrated the extent of the increasing litigations in South Africa (Emmett 2017:online). A range of other contemporary issues continue to affect the nursing practice (Cornford & Klecun-Dabrowska 2001:165), and poor nurse-patient relationships (DoH 2013:24) have become regular occurrences. Meanwhile, the SANC's continuing disciplinary hearings show poor nursing care, fraud/forgery/theft,

assault of patients and colleagues, including sexual assault (SANC 2016). Consequent to these concerns and attendant numerous efforts to improve nursing ethics, the researcher then embarked on acquiring detailed understanding of nursing ethics in Free State Province's nursing institutions, the results of which could inform on possible national trends.

1.4 PURPOSE OF THE STUDY

The purpose of this study was to explore and describe the state of nursing ethics education and practice in South Africa and develops a framework to enhance ethical practice in nursing.

1.4.1 Research objectives

The objectives of the study are:

- To review nursing education institutions' nursing ethics documents.
- To explore and describe nurse educators' perceptions concerning the ethics content taught to students.
- To explore the teaching strategies used by education institutions to develop students' ethics competence.
- To explore and describe the newly qualified nurses' ethics knowledge regarding community service.
- To describe the newly qualified nurses' perceptions on community service regarding ethics knowledge and application in clinical practice.
- To develop a framework to enhance ethics education and ethical practice within the nursing profession in South Africa.

1.4.2 Research questions

- Which ethics content is portrayed by the nursing ethis documents of the nursing education institutions in the Free State?
- What are the perceptions of educators regarding the ethics content taught to students?

- Which teaching strategies do institutions of nursing education use to develop students' ethics competence?
- To what extent do the newly qualified nurses in community service know about nursing ethics?
- What are the perceptions of the newly qualified nurses on community service regarding ethics knowledge and its application in clinical practice?
- Which framework may be considered for enhancing the ethical practice within the contemporary moral world of nursing in South Africa?

1.5 SIGNIFICANCE OF THE STUDY

There is ambiguity regarding questions on *what, how,* and *by whom* in respect of the development of ethics competencies in nursing. This trend has led to different approaches, and the patients, families, and societies at the receiving end may only experience the effects. This predicament is the basis for this research, in terms of which nursing ethics educators and Com-serves as nurses with immediate knowledge of ethics training provide their insight regarding the state of nursing ethics in South Africa. The findings of this study could clarify uncertainties regarding the *what* and the *how* of nursing ethics. It is envisaged that the study will contribute towards contextual knowledge, given the long tradition of reliance on rules. It is also anticipated that the disseminated evidence-based results and proposed recommendations will impact positively on the nursing practice curriculum.

1.6 DEFINITION OF KEY TERMS/CONCEPTS

The definition of the below-mentioned key terms is intended to provide clarity and elimination of any ambiguities regarding the denotative, connotative, contextual, and practice-related application or usage of these terms (Biddle & Schafft 2015:333).

1.6.1 Framework

A framework is a set of ideas or beliefs from which something is developed as the basis for decision-making concerning the structure of a particular system (*Oxford Advanced Dictionary* 2009, sv “framework”). In this study, a framework outlines interlinked entities that support the nursing ethics approach for nursing education and practice.

1.6.2 Nursing ethics

The concept of nursing ethics bears an earlier interpretation and current revision in the wake of bioethics. According to Robb (1913:8), nursing ethics is concerned with moral virtues, moral duties, and services to others. As such, it is defined as ideals, customs, and habits of performing one's duty with skills and moral perfection in others' service (Post 2004:900). On the other hand, Van der Wal and Pera (2018:10) describe nursing ethics as a philosophical school of thought concerned with specific moral and ethical problems occurring in the practice of nursing care.

1.6.3 Nursing ethics education

Nursing ethics education is a nursing practice that is engulfed in moral complexities and provides a core basis for addressing questions concerning ethics in the patient-provider relationship (Hoskins, Grady & Ulrich 2018:1). Furthermore, nursing ethics education refers to the teaching and learning of ethics in nursing curricula, with the intermediate goal of enabling one to examine personal commitment and values concerning patients' care (Hoskins et al 2018:1). This training and learning involve engaging in ethical reflection, developing moral reasoning and judgment, and using ethics to reflect on broader issues with policy and research implications on the moral foundations of practice (Post 2004:1900).

1.6.4 Ethical practice

According to Holt and Convey (2012:54), ethical practice in nursing is linked to decision-making. One has to be morally aware and recognise situations with ethical elements and problems before making a decision. This recognition entails:

- moral perception
- moral sensitivity
- capacity to appreciate the significance of an ethical situation from the perspective of another individual

In this study, the exact definitions were expanded to include the nurses' ability to act and assert/defend moral decisions.

1.6.5 Nursing profession

The Nursing Act (Act No. 33 of 2005) describes nursing as a "caring profession practised by a person registered under section 31, which supports, cares for and treats a healthcare user to achieve or maintain health and where this is not possible, cares for a healthcare user so that he or she lives in comfort and with dignity until death" (South Africa 2005). On the other hand, Post (2004:1899) views the nursing profession as a composite part of pre-determined criteria aimed at improving the practice of nursing, which includes accepted evaluation procedures for ensuring that nurses can practise effectively, and in safety.

1.7 CONCEPTUAL PARAMETERS/GROUNDING OF THE RESEARCH

Essentially, concepts are abstract ideas or philosophically constructed principles that serve as 'building block' of various theories (Ruel, Wagner & Gillespie 2016:36; Birks & Mills 2014:19). The epitome of allocating a conceptual grounding in a study is founded on the idea that a theory-driven perspective creates a rigorous structuring of ideas that project a tentative and systematic view of the phenomenon of interest to the researcher (Streubert & Carpenter 2011:11). While the pragmatic research paradigm and its assumptions influenced this study's initial conception and investigative course, the conceptual parameters allocated a degree of structure and coherence of the information obtained from different sources as ideas regarding nursing ethics.

The purpose of this study was to explore and describe the state of nursing ethics education and practice in South Africa and develops a framework to enhance ethical practice in nursing. Accordingly, nursing ethics constituted the pivotal domain or parameter in this investigation/inquiry. The latter coheres with the perspective by Creswell and Plano Clark (2011:280), that a theoretical or conceptual grounding of the study is described as lenses or standpoints taken by the researcher in providing direction for many phases of the research project. Particularly in sections 2.3, 2.6.1, 2.7.1, and section 2.11.1 most importantly, ethics in nursing is presented in its entire complementarity with the principle of accountability (to both the profession and health care service users).

Given the above, the concept, 'ethics of responsibility' is adopted in this study to critically analyse the macro- and micro-curriculum content and the perspectives of the potential participants. Gracia (2010:62) acknowledges that the ethics of responsibility acknowledges the strengths and weaknesses of various worldviews. The rationale for the study's orientation to the 'ethics of responsibility' emanates from the fact that the concept or principle (as derived from the larger domain of nursing ethics and its composite elements) underpins nursing care's goal and, therefore, the essence of nursing ethics. Lavoie, De Koninck and Blondeau (2006:230) contend that a sense of responsibility towards others is inextricable from the concept of care and is, therefore, fundamental to nursing ethics. According to Levinas (1989:132), the other person's suffering requires a sensible narrative that compels one to interpret and act responsibly beyond the ordinary dictates of the universalism of values. Gracia (2010:62) also confirms that the 'ethics of responsibility' emphasises the vulnerability of others, which is the basis for the ethical response.

The notion of the 'ethics of responsibility' was coined by Max Weber (1864-1920) and presented a counter-tradition of ethics of convictions and obligation proposed by Kant (Starr 1999:407). The ethics of responsibility acknowledges the commitment to values and the value conflicts that are context-specific in moral endeavours (Starr 1999:407). Therefore, the ethics of responsibility calls for dialogical and interpretative strategies that galvanise desired responses (Gracia 2010:62) contrary to obligated action as mandated by the Code of Ethics. Within the ethics of responsibility, dialogue, and interpretation, provide an analysis of rational values and the conflict brought about by contextual issues and experiences of stakeholders (Starr 1999:408) for finding good care.

1.8 RESEARCH DESIGNS AND METHODS

The entirety of the research design and methods adopted in this research study is presented in more details in Chapter 3. However, the ensuing sub-sections outline a synopsis of the essential aspects, including the research paradigm and approach.

1.8.1 Research paradigm

Overall, a research paradigm or perspective depicts a continuum of beliefs, value systems, moral attributes, philosophical assumptions or principles, scientific norms and standards; as well as abstract ideas in terms of which researchers define or construct the view of the world (natural phenomena), human interactions, and everyday experiences (Polit & Beck 2017:738). Meanwhile, Creswell and Creswell (2018:5), specifies on the effect or capacity of the research paradigm to provide a degree of coherence to the basic set of beliefs that influence the particular researcher's approach to scientific inquiry. Meanwhile, Polit and Beck (2017:738) and Mertens (2015:3) view the research paradigm reflects as collection of philosophical assumptions that underpin a scientific inclination or orientation regarding methodological approaches and interpretation concerning the nature of reality.

The current study opted for the pragmatist research paradigm, as elements of different taxonomies were adopted, namely: positivism on the one hand, and interpretivism on the other (Kivunja & Kuyini 2017:27). Biesta (2010:112) acknowledges that the importance of pragmatism lies in its focus and attention to pluralistic approaches in deriving knowledge about the problem. As Creswell and Creswell (2018:10-11) attest, pragmatism provides a philosophical basis for research whose research question seeks wide-ranging design and data collection methods and analysis. Furthermore, pragmatism is not committed to one system of reality because the truth is what works practically at a specific time and space (Creswell 2013:28). Indeed, Cohen, Manion and Morrison (2018:36) affirm that there are exclusive and multiple versions of the truth and reality, which may be subjective, objective, and occasionally scientific or humanistic. Moreover, the truth changes over time and space when other ideas emerge (Given 2008:679). Therefore, one needs to consider contextual factors and circumstances in addressing specific concerns at a specific point in time.

Given the peculiar difficulties in studying nursing ethics, pragmatism was espoused in this study because it is not bound by, or confined to only one philosophical approach or research methodology, but considers different taxonomies' strengths and weaknesses to develop an effective reformed initiative (Creswell 2014:11; Bourgeois 2010:238). According to Biddle and Schafft (2015:321), assumptions that most commonly constitute the philosophical foundation of research are: ontology (the nature of reality), epistemology

(the construction of knowledge), methodology (grounded on methods and strategies for obtaining knowledge), and axiology (concerned with the nature and role of values).

1.8.1.1 Ontological assumptions

The ontological assumption in pragmatism identifies reality as fluid and open to multiple interpretations (Creswell & Poth 2018:25). According to Mertens (2010:36), pragmatists believe that although there may be a single reality, people see it differently; as such, each individual will have a unique interpretation of the same reality. In concurrence, Creswell and Creswell (2018:11) mention that different inter-subjective social life issues influence the open interpretations ontology. In this research study, the ontological assumption is that the nature of knowledge concerning nursing ethics is pragmatically derived from the lived experiences of those whose daily lives are impacted on actual practices in nursing ethics education.

1.8.1.2 Epistemological assumptions

According to Given (2008:674), epistemology pursues the transformative or critical trajectory because of the fluidity of ontology. As Kivunja and Kuyini (2017:35) attest, pragmatism advocates relational epidemiology by determining *what* is deemed appropriate to that particular study. This study aims to obtain information about the state of nursing ethics in South Africa and consequently develop a framework for enhancing ethics. Therefore, the epistemological assumption in this study is that practical knowledge is generated and obtained from the perspectives of those with direct experience of the phenomenon being investigated (i.e., nursing ethics). Furthermore, such knowledge is generated through their own words, and in the context of their own naturalistic or ecological surroundings to which they are familiar.

1.8.1.3 Methodological assumptions

According to Cohen et al (2018:36) and Polit and Beck (2017:10), the methodological assumptions are concerned with *how* best evidence may be obtained, which necessitated both inductive and deductive approaches to be adopted in this study. For Zimmermann (2018:938) and Forester (2012:6) methodological assumptions are conducive in relation to the various methods utilised by the researcher to obtain useful information that

advances the resolution of the stated research problem and its attendant research aim and objectives. In nursing ethics education and practice and structures of domination these constructs require deliberative communication for a better understating (Forester 2012:6). Four purposes of this study, the researcher's methodological assumptions are fully expressed in various levels of detail in section 3.3 and section 3.4 of Chapter 3.

1.8.1.4 Axiological assumptions

In essence, axiological assumptions are premised on the normative values and ethical standards espoused by the researcher during the course of the study, particularly in relation to the empirical phase of data collection from the participants (Biddle & Schafft 2015:322). As Mertens (2010:36) attests, axiology subscribes to those behavioural practices considered worthy in a particular activity to bring desired goals to a specific context. In the case of this study, the researcher's declared axiological assumptions were prominent in two principal areas, namely: her compliance with the institutions and organisations that are directly affected by the study, as well as compliance with ethical protocols and conduct in relation to her interaction with the research participants as the most valuable primary data sources.

1.8.2 Research design and approach

The research design is premised on the overall strategies and planning mechanisms adopted by the researcher to manage the various processes and stages of the research process as whole (Creswell & Poth 2018:35; Forester 2012:8). Accordingly, a pragmatic (mixed-methods) approach was adopted, which informed the concomitantly adopted parallel convergent design as well. According to Creswell and Creswell (2018:240), the parallel convergent design involves collecting and analysing independent strands of qualitative and quantitative data and comparing the results for confirmation, corroboration or disapproval. Additionally, the parallel convergent design aims at unifying the complementary information from these research approaches to answer the study's fundamental questions (Mertens 2015:4).

1.8.2.1 Research methods

The choice of method is dependent on the type of information one wants to generate. It is in this regard that the study has encapsulated four sets of data, including the quantitative and qualitative research designs. This adopted quadrupled process of research methods was concurrent, in which case, both the quantitative and qualitative forms of data were collected and analysed as part of a single (convergent) process for answering the research questions (Creswell & Creswell 2018:16).

1.9 ETHICAL CONSIDERATIONS

The ethical considerations observed in this study are discussed fully in Chapter 3. Ethical considerations in research refer to the principles and rules that inform or direct the researcher's approach and conduct in terms of safeguarding the interests of the research participants during the process of research (Dhai 2019:45). Thus, researchers ought to be knowledgeable and be able to apply these ethical principles and legal requirements as expected in a particular field of research. Before the research process commenced, the researcher obtained the following:

- Ethical clearance certificate (ERC Reference # HSHDC/962/2020) from the UNISA Health Studies Higher Degrees Ethics Review Committee (NHREC Registration # REC-012714-039) was granted to the researcher as permission to conduct the study (Annexure A).
- Permission to conduct the study from the Free State Department of Health and Free State Department of Health, School of Nursing (Annexure C and Annexure D).
- Permission to conduct the research study at the private institutions of higher education in the Free State (Annexure E).

Before collecting the data, all the research participants voluntarily gave consent after comprehending the purpose of the research and its process (examples of these are provided in Annexure G and Annexure K).

1.10 SCOPE OF THE STUDY

The present study is confined to only the public and private nursing education institutions accredited by the Higher Education Council (HEC) and the SANC, as well as the public health care service institutions within Free State Province, South Africa. This province has twenty-four public hospitals in five districts where the new nursing graduates work as community service practitioners. However, it must be understood that although private nursing education institutions form part of the study, there is no community service practice for the newly graduated nursing students. Thus, only public institutions were involved in the collection of data from the Com-serves, who were from both the urban and rural districts of Free State Province.

1.11 STRUCTURE OF THE STUDY

The study comprises eight chapters as indicated below:

- Chapter 1 provides a brief description of the background to the research problem. Also discussed are the purpose, objectives, research methodology, and scope of the study.
- Chapter 2 presents the literature review and details the conceptual underpinning of the study.
- Chapter 3 details the study's research design and methods in its broadest context, and includes both the qualitative and quantitative data collection and analysis aspects.
- Chapter 4 presents the interpretation of the quantitative results.
- Chapter 5 presents the presentation and interpretation of the qualitative results.
- Chapter 6 presents the qualitative and quantitative data integration (convergence) and discussion thereof as part of the mixed methods approach.
- Chapter 7 details the process and development of a framework to enhance nursing ethics.
- Chapter 8 presents the conclusions, limitations, recommendations, and proposed framework to enhance ethics education and practice in South Africa.

1.12 SUMMARY

The general outline of the study was presented in this chapter, including the background to the research problem and the purpose and objectives of the study. The significance of the research, the theoretical grounding, and scope of the study were also briefly overviewed. The ensuing chapter presents and discusses the pertinent literature reviewed and multiple scholarship and viewpoints in respect of nursing ethics education.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the researcher discusses the original narrative of nursing ethics with specific reference to its training and practice. The idea is to synthesise credible sources of national and international and information literature that may highlight trends and models consistent with nursing ethics. Polit and Beck (2017:87-88) indicate that the literature review helps researchers in gaining insight into evidence and comprehends contributions, possible controversies, and gaps regarding the study topic. Discussions are based on ethical frameworks being followed in acquiring clinical ethical skills amongst nurses. The discussions on ethical frameworks reflect on the successes, challenges, gaps, and consequently, the contribution of this study to the body of knowledge. Furthermore, the literature discourse deals with the theoretical framework of the study.

2.2 SOURCES CONSULTED FOR LITERATURE REVIEW

The study's literature was obtained from the indexes of periodicals and books from academic libraries at the University of South Africa and the University of Free. These indexes include published and unpublished university postgraduate theses/dissertations, reports, and official government documents, including statutes and articles. The following search engines were also used: Public Medline; SCOPUS; Elton B Stephens' company research database (EBSCO host); Cumulative index of nursing and allied health literature (CINAHL); Science Direct; and Google scholar. Keywords utilised by the researcher for searching were 'nursing ethics', 'nursing morality', 'nursing ethos', 'professional practice AND ethos', 'nursing AND etiquette', 'nursing AND professionalism', 'nursing conduct', 'ethics for health professionals', 'ethics of care', and 'moral philosophy AND nursing'.

The search yielded a lot of literature, which led to the need for the researcher to screen the sources for relevancy and appropriateness, as asserted by Polit and Beck (2017:90-91). Based on the significant results to the phenomenon of interest in this study, the literature review discussions will follow this arrangement:

- Understanding of nursing ethics
- Professionalism and professional practice
- The role of nursing regulatory bodies: re-ethical education and practice
- Current ethical frameworks in South Africa
- What is ethics, and what is morality
- Current challenges facing nursing ethics
- Contemporary views regarding nursing ethics

2.3 UNDERSTANDING OF NURSING ETHICS

Nursing ethics is considered a field that is evolving, which makes it difficult to comprehend, especially when it is viewed as an entity in its own right; that is outside the biomedical discourses that shaped it, such as medical ethics and bioethics (Varcoe, Doane, Pauly, Rodney, Storch, Mahoney, McPherson, Brown & Starzomski 2004:317; Melia 1994:7). On the other hand, Baker (2020:98) considers nursing ethics complex and challenging to define due to various interpretations. Furthermore, Baker (2020:98) ascribes different nursing ethics' interpretations to the overall developments within professions and healthcare systems. The diverse definitions are attributed to the improvements in healthcare ethics and bioethics as broader and all-encompassing branches; furthermore, these continuously widen the scope of nursing ethics (Fowler 2020:online; Post 2004:1898). Johnstone (2017:19) corroborates that nursing ethics' field has been widening from the first publication of the concept in 1889, while Liascenko and Peter (2004:489) suggest that the changing conceptualisation of nursing, first as a calling, profession, and then practice, contributed to the dynamics of nursing ethics education and application.

With the emergence of the concept of nursing as a profession, nursing became an independent scientific profession with responsibilities mandating complex roles. In South Africa, the professional status was fully achieved with the Nursing Act (Act No. 45 of 1944) (South Africa 1944). As Vasuthevan (2015:56) attests, the professional nursing position is based on solidarity's professionalism, accountability proficiency upholding of Code of ethics, and safeguarding the public's welfare. Based on this status, the characteristics of nursing as a profession dominated the discussions amongst nurses, and significance was the discourse around professionalism and professional practice.

As Baker (2020:98) attests, the difficulty defining nursing ethics will continue unless nurses become clear about nursing actions' boundaries and goals. Nursing ethics' ultimate goal is to promote the patients' well-being through service delivery of good nursing care (Johnstone 2017:19). Therefore, the understanding of cultivating the moral character and humane disposition of advancing humanity's good, coupled with a sense of civic duty, are activities that have been geared toward that goal (Johnstone 2017:19). Johnstone's interpretation concurs with Robb's (1913:8) description that nursing ethics is concerned with moral duties, moral virtues, and services to others.

However, with the contemporary nursing issues, nurses should articulate clearly the ethical issues in nursing care contexts and the provision of robust reasons and sound justifications for their decisions and actions (Johnstone 2017:19). Accordingly, Epstein and Carlin (2012:897) and Carper (1978:20) define nursing ethics as the knowledge of morality beyond expressive codes of ethics in which voluntary reflective actions are judged against right and wrong. Developing these skills requires a deep understanding of morality and ethics. As Melia (1994:9-10) attests, nursing ethics may not rely on the problematic sense of advocacy, as it resembles benevolent paternalism and continues the moral uncertainties presented by early notions of nursing ethics.

2.3.1 Nursing ethics in the 19th century

Society has always been concerned with the ethics of those who have influence and wield power; thus, ethics has been necessary since Florence Nightingale's times (Lippitt 1966:1); however, there was no formal ethics training (Burkhardt & Nathaniel 2014:131). Nonetheless, Lippitt (1966:2) identified that Nightingale's dynamic leadership, described as being passionate, intellect, conscience, and philosophical spirit, were responsible for the entanglement of nursing ethics with administrative and leadership ethics. The struggles of management and leadership influenced the interpretation of nursing ethics, and as such, numerous organisational practices were labelled unethical (Lippitt 1966:2).

For example, nurses smoking within the institutions' premises was seen as being unethical. It would be worth determining how the nurses in community service (Com-serves) and nursing educators interpret nursing ethics. According to Fowler (2016:S9), the early nursing ethics literature depicts nursing practice under citizenship and the

democratic ideal. Within the realm of ideal citizens, nurses voluntarily benefit the exemplary citizens of society's health demands, which came with surrogate decision-making capacity from medicine (Fowler 2016:S9). As there was no formal training, student nurses were expected to be sober, honest, truthful, and trustworthy based on religious orders (Burkhardt & Nathaniel 2014:131). Therefore, early nursing ethics' constituent was a virtuous woman, emphasising a character and its manifestation (Fowler 2016:S9). Concurring with that position, the nurses' characteristics, virtues, and correct manners were rules and norms ascribed to individual nurses in those days (Kangasniemi, Pakkanen & Korhonen 2015:1752).

The narratives of virtues expressed courage, cheerfulness, and friendliness (Östman, Näsman, Eriksson & Nyström 2019:28), to the point where nurses' ethical stand was equal to nursing etiquette (Fowler 2016:S9). Indeed, nursing ethics and etiquette were embroiled together in normalising nursing practice. Perry (1906:451) highlighted that etiquette becomes part of ethics because it is concerned with 'minor' morals that are expressed through look, voice, speech, walk, and touch. In that regard, ethics is the larger and deeper subject, the well-trained nurse cannot avoid the ethical virtues of obedience, truthfulness, trustworthiness, neatness, punctuality, economy, and quietness as accompanying nursing gifts (Perry 1906:451). In this manner, submissiveness, dependency, and reliance on others were highly valued, and these are the features that have undermined nurses' ethical stance. The question is whether nurses may deem etiquette as ethics or not.

According to Burkhardt and Nathaniel (2014:132), the Code of Ethics suggested in the United States of America in 1921 contained obedience, trustworthiness, loyalty, and professional etiquette. As Johnstone (1993:40) attests, etiquette and the prescribing behaviours of obedience, self-sacrifice submission, self-restraint and silence became archetypal of a good woman until after World War II. At this level of practice, Codes of Ethics bearing virtues were used to regulate and guide nurses (Fowler 2016:S9). However, professional secrecy was the most stringent ethical norm which became persistent as a prominent legal and moral aspect of nursing practice, even though the bioethics emergence coupled confidentiality with privacy (Fowler 2016:S9; Bhengu 2015:126). The insistence on etiquette is still evident in the current nursing education curriculum. It is further emphasised by Safdar and Aqeel (2019:405) in affirming that grooming and etiquette are essential elements of professional practice. An efficient and

empathetic nurse is a positive image in alleviating the patients' miseries (Safdar & Aqeel 2019:405). If etiquette is so befitting in defining nursing ethics, it may be weighed whether it may solely assist in moral reasoning.

One of the critical aspects of nursing ethics was the Nightingale's Pledge, adopted from the Hippocratic Oath of physicians by Lystra Gretter in 1893 (Black 2020:63; Fowler 2016:S9). According to Black (2020:63), the pledge functioned as the nursing's first Code of Ethics and became the basis of the current Code of Ethics. The Nightingale's pledge still holds a significant value even today when there is a formalised code of ethics. Accordingly, Stellenberg (2015:181) corroborates that the pledge is a fundamental ethical element of nurses preparing for the services. The Nightingale's Pledge, commonly recited at nursing graduation ceremonies, is like a personalised promise that nurses undertake for upholding the core values and principles of nursing (White et al 2015:3). However, it has been identified that nurses do preach these but practice differently (White et al 2015:4).

2.4 PROFESSIONALISM AND PROFESSIONAL PRACTICE

Professionalism translates from the term profession. Black (2020:59) describes the domain as a signifying occupation that requires specialised knowledge and intensive academic preparation. Naidoo (2016:166) expands the definition by suggesting that intensive training is acquired in higher education. Moreover, the profession is self-regulating and is governed by a particular code of ethics (Naidoo 2016:166). Professionalism is a broad term used to describe aims, qualities, and behavioural conduct that characterise professionalism (Black 2020:59; Naidoo 2016:166). While Jooste (2010:9-10) views professionalism as a method of fulfilling all the responsibilities enshrined in the scope of practice. On the other hand, Vasuthevan (2015:56) views professionalism as a never-ending process of growth that assimilates to professional identity through a variety of influences and experiences.

According to Black (2020:59), professionalism is marked by three attributes: (1) nursing education, in which one develops a cognitive framework to understand the nursing profession; (2) acquisition of professional values through experience in shaping the professional identity; and (3) development of the standard of practice and psychomotor competencies. According to Volp (2006:4-5), the importance of professionalism is the

nurse-patient relationship. It is such relations that patients, families, and communities expect nurses to demonstrate extensive knowledge, professional attitudes, interpersonal skills, accountability, effective communication, empathy, and courtesy (Sivamalai 2008:938; Volp 2006:4-5). Reiterating the same notion Mathibe-Neke (2020:53) affirms that nursing professionalism must ensure safe and effective care; therefore, there must be an expansion of knowledge in preparing nurses. As Jooste (2010:52-53) highlighted, in functioning within the scope of practice, one must be aware of evident best practices with a moral basis.

Professional morality depends on a contract that commits to service and adheres to values and standards as well as responsibility, accountability accountable, and committing to professional advancement (Jooste 2010:52-53). According to Bhengu (2015:126), the domains defined within the framework of professionalism include: (1) professional, ethical and legal practice; (2) clinical practice; (3) personal, professional, and quality of care; (4) leadership and management; and (5) research. The five domains, sometimes called the scope of professional practice, demonstrate that nursing ethics is just one aspect of professionalism. Within the ethics domain, the Code of Ethics and advocacy become standard obligatory professional training, as these infer trust and commitment to act in the patient's best interest (Kotzé 2015:276; Vasuthevan & Geyer 2015:277). The question is whether these domains may, without doubt, assure effective, ethical care to society, as expected.

There has been a concern that the five domains' amalgamation make the framework for professional practice too complex to understand (Poitras, Chouinard, Fortin & Gallagher 2016:2-3). According to Poitras et al (2016:2-3), the regulatory bodies and the scientific literature's professional practice description use different concepts and heterogeneous vocabulary. These prevent a clear understanding of what is entailed in nursing professional practice. In that regard, some scientific literature insinuates professional practice as practice standards, performance standards, or nursing deontological values based on specific clinical contexts of practice (Poitras et al 2016:3). In contrast, others refer to it as the profession's legislative framework (Poitras et al 2016:3), which may let people concentrate on legal issues about nursing.

Within the domain of being a profession, there is an aspect of self-regulation, which Vasuthevan (2015:52) indicates that it is founded on the understanding that the

government formally regulates the occupational group's activities. Under the government's auspices, a regulatory body of professional peers is established under the notion of professionalism (Healy 2016:1-2; Vasuthevan 2015:52). Healy (2016:1-2) points out that self-regulation entails professional peers establishing and monitoring the entry into and exit from the profession by determining the occupation's education standards and the professionals' ethical conduct at collective and individual levels. There are various self-regulation models (Vasuthevan 2015:53). In South Africa, the promulgation of nursing professional status was with the Nursing Act (Act No. 45 of 1944), followed by the revised Nursing Act (Act No. 33 of 2005) (Vasuthevan 2015:53).

These acts are considered to afford the scope of practice clear boundaries of what nurses may and may not do (Vasuthevan 2015:53). Professional practices regulation aims at protecting the public and establish practice standards (Healy 2016:1-2; Vasuthevan 2015:53). The ICN’s principles provide the best-practices models for instituting the regulatory bodies (Vasuthevan 2015:53). The SANC is the regulatory body established by legislation to oversee the practices of all nurses registered in South Africa (Ricks & Van Rooyen 2015:3-4). In regulating the nursing profession, the Nursing Act (Act No. 33 of 2005) was decreed by the Parliament of the Republic of South Africa, and SANC conferred with powers has a role in nurses' ethical education and practice in South Africa (South Africa 2005). As such, the legislation mandates ethical training and practice for the public interest and not for individual nurses' development.

2.5 ROLE OF NURSING REGULATORY BODY: RE-ETHICAL EDUCATION AND PRACTICE

As the reliable underwriter of the nurses' proficiencies and conduct, SANC ensures the public's expectation of safe services and protection from harmful or unacceptable nursing practices (Vasuthevan 2015:53; South Africa 2005:Nursing Act (Act No. 33 of 2005)). In Chapter 2 of the Nursing Act (Act No. 33 of 2005), nurses' training, education, practice, research and registration are discussed. Relative to ethics, SANC is authorised to protect the public, learners, and research participants against professionals' routines. In guarding against the potential activities that may have harmful effects, SANC is set to regulate education and training and nurses’ clinical practice.

2.5.1 Education and training of nurses

Based on Section 42 of Act (No. 33 of 2005), SANC is obligated to protect public and learner rights. The learner is expected to receive the education and training that will permit registration and practice as a professional nurse from the accredited nursing education and training institution and programmes (South Africa 2005). From these grounds, the public can be assured that those serving them have received a high-quality education that meets competency standards and compassionate and ethically based nursing care (Act. 33 of 2005) (South Africa 2005). In fulfilling its directive, SANC conducts inspects and investigates nursing education institutions, nursing education programmes, and health establishments in order to make sure that nurses are familiar with and comply with the rules, and standards of the Nursing Act (Act No. 33 of 2005) (South Africa 2005). The Regulation R.173 of 2013 details the requirements of being accredited, specifications that the nursing education and training and criteria to abide by (SANC 2013b).

Consequently, SANC does the auditing, monitoring, and evaluation in checking compliance. The question relating to this study is whether these prescribed requirements are precise enough for nursing ethics educators to establish the macro- and micro-curriculum. Are there diverse approaches to ethics education, are these perspectives contributing toward ethics competence amongst nurses?

Nonetheless, Grady, Danis, Soeken, O'Donnell, Taylor, Farrar and Ulrich (2008:4) stipulates the challenges of being in the knowledge of whether the students thought of themselves as confident and competent in dealing with ethical issues after undergoing ethics training. The results of prescribed requirements and ethics education initiated may only be evaluated by the face the profession portrays in the country. SANC registers the nurses and guides the practice.

2.5.2 Registration and practice of nurses

The Nursing Act (Act No. 33 of 2005) decreed SANC to determine the following activities based on the self-regulation agreement. First is nurses' scope for practice and the difficulties of their profession to work under such conditions. SANC has the powers to admit into the profession and train and stipulate how its members' discipline and dismissal for failure to sustain responsibilities will be undertaken. As a hallmark of being a

professional body, SANC has to state the acts and omissions to take steps against a person registered and the requirements for nurses to remain competent in their practices (South Africa 2005).

Section 30(1) gives the professional nurse scope of practice and registration by illustrating the required competencies and capability in assuming such responsibilities with accountability. To be eligible for registration with SANC, Section 31(5)(b) requests from the individual nurse a certificate of good character and standing. The requested submission may be challenging as giving evidence of good dispositions may be viewed differently, depending on understanding morality, ethics, virtue ethics, and nursing ethics. Besides the expectation of possessing a good character, the Code of Ethics must be upheld by those registered and other SANC regulations. For example, the Regulation R.767 of 1 October 2014 stipulates the acts or omissions pertaining to the Council may take disciplinary steps toward the members (SANC 2014b).

2.6 CURRENT ETHICAL FRAMEWORKS IN SOUTH AFRICA

The macro- and micro-curriculum for ethics translates from SANC's guidelines as a regulating body for the nursing education institutions for ethics education. The country has private, public nursing education institutions, and their nursing ethics approaches may differ. An idea of institutional autonomy always determines nurses' ethical framework in many educational institutions. Another aspect is the use of core or fundamental terminology in describing the importance and the number of credits allocated for nursing ethics. These aspects influence how higher learning institutions deliberate regarding nursing ethics curricula. According to Iacobucci et al (2012:481), there are diverse and voluminous contents for ethics education, which may differ from one nursing institution to another. Different curriculums among the nursing education institution are likely to affect many in South Africa.

Giving a global view, Saxén (2018:33) indicates that most nursing ethics' guidebooks include topics such as values of organisation, leadership, guidelines of care in ethics, moral distress, identifying issues of ethics, patients' uniqueness and equality, patient records, and intercultural interaction. The argument is whether these nursing ethics' topics may promote the acquisition of ethical competence or the habits of inquiry and render the nursing goal from the patient's perspective (Melia 1994:9; Henderson

1978:128). In this regard, Johnstone (2017:19) claims that a growing body of literature reveals that nurses cannot meet the expected ethical conduct standards. In meeting ethical standards, which Gallagher (2006:229) describes and calls for ethical competence. Gallagher (2006:230) avers that ethical competence is characterised by ethical knowledge, the ability to observe the presentation of a situation presents a moral problem, critical reflection, and bring about ethical behaviour that should remain consistent. On this ground, one of this study's objectives is to evaluate whether the current ethical framework is likely to help students acquire ethical competence. It is necessary to ascertain the ethical frameworks nurses' training institutions use. Furthermore, this study's results will reveal the participants' views regarding their nursing ethics education and practice confidence.

The current framework demonstrates that nursing ethics education is a compulsory core module for a specific qualification (SANC 2014a:1). The SANC directives for Bachelor's degree in nursing and midwifery qualification framework illustrate that nursing ethics has eight credits with 80 notional hours. The exit level outcomes relating to ethics state that the student should be able to address and identify legal and ethical matters pertaining to how different ethical value (and legal) systems should be reflected to the nursing and midwifery practice within the legal framework. These exit outcomes have the following are the assessment criteria:

- Individual, groups, and community rights receive protection from advocacy activities with respect to providing law and health care provision.
- The application of nursing practice should be consistent to clearly reflect, understand and interpretation of the South Africa nursing and health care legislation requirements, including a primary health care approach.
- Interpretation of professional accountability and responsibility, practice standards of nursing and midwifery and ethic codes are applied and interpreted in line with their spirit and intent.

The exit outcomes and the associated assessment criteria may have implications when translated into the curriculum. As the exit outcomes and allocated credits explained, nursing ethics is an unavoidable nursing training aspect with few training hours. In that regard, nursing ethics educators tend to have ambiguous messages. The guidelines predominantly prescribe that ethics education should entail the scope of professional

practice, advocacy, ethical codes, and practice standards that constitute competent nursing care. For that reason, there is a continuation of the professionalism tradition, which is mainly marked by rules with limited ethics orientation.

Various curriculum approaches include introducing ethics to the first-year students and integrating the modules' objectives from the second year onwards. The challenges faced by nursing ethics education are caused by competing and diverse epistemologies and curriculum' models (Allmark 1995:19). According to Van der Merwe (2010:6), professional practice and ethos cover factors influencing nursing practice, nursing philosophy, nursing history, caring ethos, and nursing as a profession. Based on the nurses ' training institution's preference, the caring ethos may consist of suitable ethical values, including caring compassion, advocacy, and care ethics. Simultaneously, the human rights, SANC regulations, and institutional policies form part of the legislative requirements. Thus, there is a use of various books and grey literature from SANC that nursing ethics educators must acquaint with in their practice.

Pellegrino (2010:94) criticises ethics within the notion of professionalism and equates it to indirect ethics that influence behaviour as an eternal factor. Salloch (2016:online) argues that the broad knowledge within auspices of professionalism does not significantly extend the skills essential for moral reasoning. Dierckx de Casterle et al (2008:542), attest on the approaches which are unable to encourage self-reflection and guidance toward being ethically competent. The limitations of ethics within the symbol of professionalism in nursing ethics education and practice are also cited by Illingworth (2004:35), who posit that ethics in this category become a component of fitness for practice. The question is whether this process sufficiently prepares one to be ethically competent. Therefore, nursing education institutions and clinical practice should decide on nursing ethics if they lament moral competence within the profession.

In regulating the professional nursing practice, SANC is mandated to ensure that the professional conduct and practice standards are maintained within the ambit of laws applied in South Africa. In so doing, SANC established the current ethical framework for nursing practice, which is evidenced by the SANC code of ethics for nursing practitioners in South Africa under the Nursing Act's provisions 2005. The principles of respect for human dignity and life emanate from the South African Bill of human rights. Besides the code, nursing is regulated by the regulations and scope of practice with regards to the

acts or omissions in which the Council may take disciplinary steps against a practitioner. These regulatory measures are necessary for trust within the society, although their authority remain controversial for nursing education and practice (White et al 2015:6).

2.6.1 The Code of Ethics for nurses

The Code of Ethics is a notated public document presenting proof of evident responsibilities and obligations that the practitioners provide in their service to the public (Black 2020:65). The premise for developing a code of ethics is thought to emanate from philosopher Thomas Hobbes (1588-1679) by Epstein and Turner (2015:1). Hobbes (1950:103) in Epstein and Turner (2015:1) alludes that humanity is at danger of being in constant wars against each other because of lust for power, especially when it is left solely in its survival mode tendencies. Correspondingly, Hobbes (1950) believed that desires such as freedom from fear of death and enjoyment of prosperity are also shared by people (Rae 2018:49). On that account, human beings may achieve universal good as a basis for ethics through solid leadership and accepted social contract (Rae 2018:49; Hobbes 1950 in Epstein & Turner 2015:1). The social contract entails justifying viewpoints or values that must appeal to an agreement amongst suitable, rational, and free persons (Rae 2018:49).

Similarly, in being a nurse, additional obligations and virtues pertinent to a profession are incorporated for survival and human flourishing (Epstein & Turner 2015:2). Within the notion of the social contract, one accepted into nursing submit to the profession and defers to the group by abiding by the standardised set of moral rules. The nursing code of ethics is described as one of the criteria for the professional status of nursing and midwifery in South Africa (Vasuthevan 2013:56). It serves as conduct that outlines nurses' duties towards the patients (Vasuthevan 2013:56). The Code of Ethics as the SANC’s directive that acknowledges the professional members’ responsibilities and privileges towards a larger society. Furthermore, it guides professional members and become a declaration to the public (Pera & Van Tonder 2018:9), affirm that it forms part of nursing ethics education and practice.

Although ethical guidance in nursing was recognised early, the ICN’s Code of ethics became formal in 1953 (Black 2020:155). Furthermore, it spelt the rights and responsibilities of nurses related to people, practice, society, co-workers, and the

profession (Black 2020:55). According to Epstein and Turner (2015:2), nursing practices before this code were guided by Gretter's Nightingale Pledge, akin to medicine's Hippocratic Oath. The Nightingale Pledge reflected the virtues such as fidelity, loyalty, purity, and trustworthiness as cornerstones of good nursing (Black 2020:65; Burkhardt & Nathaniel 2014:51). The good characters in the pledge may still have a voice in nursing ethos.

The Codes of Ethics are sets of standards and guidelines based on shared ideas of what is good and right by defining professionalism and best practices (Pera & Van Tonder 2018:9; Stellenberg 2015:172). Reiterating, Searle, Human and Mogotlane (2009:267) describe the nurses' Code of Ethics as a tool to unify diverse nurses by spelling out nurses' parameters of responsibilities towards society. Fowler (2016:S9) indicates that codes of ethics are legally binding interpretive standards and are non-negotiable descriptions of nurses' obligation to the community.

The purpose of the code of ethics for nurses is to assist practitioners and healthcare users in identifying the ethical standards endorsed by profession as a reference point for ethical decision-making (SANC, under the Nursing Act (Act No. 33 of 2005). However, Snelling (2016:229) indicates that the purpose of the code of ethics is multifaceted. It may represent the managerial and disciplinary agenda, becoming an ambiguous document that effectively loses its intended aspect (Snelling 2016:229). Indeed, Johnstone (2016:106) indicates a need to differentiate between a code of ethics and conduct. Accordingly, codes of professional conduct are prescriptive and duty-centred, and ethical codes are aspirational and have professional virtues or values that detail an ideal nurse (Johnstone 2016:106). In that regard, Snelling (2016:229), posits that ethical codes involve emotion, a characteristic that could be difficult to enforce and presents the risk of investigation and sanction. According to Snelling (2016:229), there should be a distinction between the code of ethics and conduct. It is, therefore, crucial to understand how nursing ethics educators and Com-serves deal with issues surrounding the SANC code of ethics for nursing practitioners.

Commenting on the codes of ethics, Pellegrino (2010:95) indicates that they stifle individual capabilities as they prioritise conformity to rigid rules. There are arguments about whether there is a need to enforce the codes of conduct or search for ethical competency (Meine & Dunn 2013:150). Similarly, Dierckx de Casterle et al (2008:548)

suggest that ethics education should encourage self-reflection and guidance towards being ethically competent. Bertolami (2004:415-416) avers that courses on ethics should allow students to devise personal synthesis by borrowing from many disparate sources and coming up with what works for them while realising compatibility with the profession's aspirations.

2.6.2 Ethos

In the Aristotelian sense, ethos is the internal value of the virtues that characterise an individual and further aspire her/him to be the best (Macintyre 1985:xviii). Ethos stems from Aristotle's Rhetoric, which is the faculty of persuasion exemplified by three modes: (1) ethos as a character for the persuader's credibility; (2) pathos concerned with emotional appeal; and (3) logos that have to do with logical reasoning (McCormack 2014:131). As a persuader's credibility, ethos aims at convincing the audience to believe that they share their values (McCormack 2014:136). Reiterating the same notion, Baumlin and Meyer (2018:3) explain that ethos deals with trust, expertise, and charismatic authority that individuals exhibit to their target audience. Ethos is, therefore, defined as a perceived measure of credibility believed to be present in a group of persons (Maklin 1982:67).

In nursing, ethos and caring are described together to demonstrate the reality of the ethical aspect of nursing. According to Van der Merwe (2010:6) and Muller (2009:20-21), nursing ethos is entrenched on the basis of nursing and philosophy, which obliges the characteristics of professionalism that involves virtues, fundamental rights, and nurses' competencies. Ethos in nursing includes ethical theories such as care ethics, virtue and *Ubuntu*, as these are consistent with care. As Östman et al (2019:28) attest, ethos consists of a fusion the external and internal aspect of ethics, exemplified by habits that demonstrate how a group does things. According to Östman et al (2019:28), ethos is the external values’ fusion, directions, norms, and rules and the internal side of personal human values and dispositions. Ethos, being a disposition, provides a sense of peace, which gives human beings warmth, courage, joy and an inner force (Östman et al 2019:27). For this reason, nurses are expected to possess and develop these dispositions in caring for the vulnerable. Therefore, the individuals are trusted and acknowledged based on their noble character and the moral rules of the profession.

Although nurses are expected to have a fusion of character and laws, Östman et al (2019:29) raised a concern that ethics' internal and external sides are likely to be separated. And in most incidences, the external side of ethos, characterised by rules, becomes more prominent. Ethics becomes an occasional practice and not an everyday activity (Östman et al 2019:28). Östman et al (2019:29) further indicate that focusing mainly on external ethics alone is not up to the task, as ethics become proceduralism. Baumlin and Meyer (2018:3) describe ethos as a character that has the personhood and persona − the self's expressive self-identity and its social presentation. In the social presentation, the rules aspect of ethics becomes evident to secure societal trust. Thus, as a regulatory body for nursing education, the SANC has a special responsibility in reinforcing the internal element of ethos. Nursing as a profession has to deepen the understanding and practice of ethos, especially the internal part of ethics, which requires some teaching approaches and in-depth knowledge of ethics and morality.

2.7 IS THERE A DIFFERENCE BETWEEN ETHICS AND MORALITY?

It is essential to expound on morality and ethics because they form the moral ground for many disciplines, including nursing education and clinical practice. As a discipline, nursing focuses on morality and ethics as the core of their training (SANC 2020:1). As Zigon (2009:253) attests, individuals or groups that focus on morality are motivated by a commitment to defend others' rights, declare the responsibility to take care, and lavish science's benefits on those in need. Zigon (2009:253) states that such a determination may run the risk of confusion if the interpretation and evaluation of morality, especially in specialised practices, are not precise (Zigon 2009:253). Accordingly, Zigon (2009:254) warns that the diverse, fragmentary, and contradictory claims of moral and ethical dimensions in the social world may impede attempts to do good or act responsibly.

Although ethics and morality are used interchangeably, morality is much broader than ethics (Tangwa 2011:93). Fassin (2012:1) asserts that the concepts are used variously, even amongst philosophers. While others refer to these concepts indistinctly without attaching importance to differentiation, others use them to assume a hierarchy between the two (2) terms (Fassin 2012:4). Chowdhury (2016:16) believes that accurate descriptions of ideas are fundamental to ethical advancement in the profession.

2.7.1 Ethics

Ethics is part of philosophy that deals with questions about the right versus the wrong conduct, what constitutes a good or bad life, and the justificatory basis for such matters (Deigh 2010:1). Like morality, the meaning of ethics has always been ambiguous. According to Hodges (1955:311), when people describe ethics based on how philosophers determine ethics' significance, confusion comes about.

2.7.1.1 Definition of ethics

Pera and Van Tonder (2018:5) posit that ethics as an exemplary behavioural study that deals with the essence of being a person and the practices or beliefs of a particular group of individuals. UNESCO (2008:8) defines ethics as an intellectual analysis of the human dimension of morality, intended to explore the nature of moral experience, universality, and complexity of this experience. Accordingly, Butts and Rich (2008:106) describe ethics as a branch of philosophy concerned with scientific understanding and ideal behaviour, commendable to the well-being of and relationship among sentient beings. Armstrong (2015:143), from the perspective of professional practice, describes ethics as well-founded propositions that prescribe what ought to be done in terms of right and wrong in executing one's obligations.

Rae (2018:14) posits that ethics determines and discovers right and wrong through reasoning and justification. While Doherty and Purtilo (2016:18) describe it as a how morality is reflected as well as systematic study, which follows a gold standards question, what do human dignity and respect demand? According to Zigon (2009:256), ethics is a conscious act that a person instils in oneself to be morally appropriate and acceptable in the social circle and amongst peers (Zigon 2009:256). Foucault (2000:319) defines ethics as a conscious practice of freedom. Within the realm of being ethical, individuals are expected to establish a relationship that they ought to have with themselves, to be a moral subject (Foucault 2000:319). Levinas sharpens the definition of ethics by seeing ethics as no longer a simple moralism of rules that decree what is virtuous (Marcus 2008:278).

Accordingly, Levinas calls it the first awakening of an ‘I’ responsible for the other; a person's accession to the ‘I’ summoned and elected to responsibility for the other (Marcus 2008:278). In this study, ethics is a conscious scientific process that an individual

undertakes at liberty to understand, analyse, and demonstrate morality concerning oneself and other beings, a responsibility that one is called to towards the other. This scientific process is naturally categorised into metaethics, normative ethics, and descriptive ethics (Pera & Van Tonder 2018:10; Rae 2018:14; Doherty & Purtilo 2016:18).

2.7.1.2 Categories of ethics

2.7.1.2.1 Descriptive ethics

Descriptive ethics reveals the facts about moral beliefs (Sugarman & Sulmasy 2010:4). Descriptive ethics involves investigating and describing people's actual ethical conduct, opinions, and reasoning (Pera & Van Tonder 2018:10). Although it reveals the real world of behaviour through empirical inquiry, the descriptive findings have to be evaluated, judged, and engaged by normative ethics. Thus, descriptive ethics is not a formal branch of ethics, as it merely states the facts about a person or a group (Pera & Van Tonder 2018:10). For example, studies about nurses' understanding regarding autonomy, advocacy, codes of ethics, vulnerability, and challenges regarding euthanasia practices or abortion may never stand for normative ethics studies; instead, these provide facts that need normative engagement. Nonetheless, nursing literature on nursing ethics is mostly on descriptive ethics. As Sugarman and Sulmasy (2010:4) attest, such studies do not give normative conclusions: instead, they illuminate human responses to normative questions. According to Rae (2018:14), descriptive studies help establish norms applied in those situations. Therefore, the descriptive facts are building blocks for validation by normative ethics.

2.7.1.2.2 Metaethics or analytic ethics

Metaethics or analytic ethics, as regularly called, is concerned with investigating epistemology of ethics or moral language and justification of judgments and arguments (Rae 2018:20). According to Dhai (2019:4), metaethics examines the meaning of moral terms, the soundness and language of moral reasoning, and the fundamental questions of moral reality, knowledge, and justification. Although analytic ethics is deemed abstract and non-figurative, this inquiry is essential for language, concepts, and reasoning methods inherent in normative ethics (Dhai 2019:4). Metaethics asks questions regarding the meaning of right, wrong, good, and ought and whether morality is objective or

subjective (Dhai 2019:4; Rae 2018:20; Sugarman & Sulmasy 2010:3). Some inquiries include whether morality transcends cultures and how one knows these truths (Dhai 2019:4; Rae 2018:21; Sugarman & Sulmasy 2010:5). Essentially, metaethics is critical for nursing languages and moral concepts because their positions may reasonably form a foundation for normative discussions in nursing ethics. Concepts like advocacy, autonomy, caring, and beneficence aligned to current nursing language and practice need to be clarified for the purses of nurses asserting their ethical stand. For example, nursing advocacy may be elucidated, and questions attributing to the conflicts between autonomy and advocacy may undergo thorough analysis and better understanding.

2.7.1.2.3 Normative ethics

Normative ethics is at the core of ethics. Normative got feeds from the metaethics, which outlines the language and the justification of judgment, and descriptive ethics, which supplies real facts on people's actual acts (Rae 2018:20). The discipline is concerned with constructing ethical standards and rules to answer what ought, or ought not to be done and what kind of person ought to become in a situation? (Sugarman & Sulmasy 2010:4). According to Rae (2018:20), normative ethics prescribes moral behaviour by lying down norms referred to as ethical theories. According to Thiroux and Krasemann (2009:35), *theoria* in Greek means a way of seeing; therefore, ethical theories attempt to understand morality and view moral phenomena comprehensively.

One aspect of normative ethics is the justification of moral standards and values that can only be defensible to the individuals concerned (Von der Pfordten 2012:450). Beauchamp and Childress (2013:352) indicate that normative ethics addresses questions relating to the acceptability of moral norms and why such standards may guide and validate conduct. For the criteria to be considered normative, they should be objective and employ systematic and critical methods relevant to a specific circumstance or situation (Pera & Van Tonder 2018:10; Rae 2018:20; Von der Pfordten 2012:451). Although normative ethics is rational and more compelling as a mandatory approach for individual nurses to be ethical, Tangwa (2011:94) warns that the actions emanating from it alone might lack free will and intentionality, as it is externally compelling. Therefore, morality is needed as the basis for voluntarism and responsibility.

Moral theories have provided a unifying perspective, synthesised ethical rules, and generalised moral experiences (Dhai 2019:4). However, Lawlor (2008:828) warns about the amount of time and disagreement in them and the likelihood of being too abstract for students. Accordingly. There is a possibility of not comprehending or probing the theories in depth if limited time is allocated to teaching nursing ethics.

The moral theories discussed here include consequentialist, non-consequentialist, virtue, Ethics of care, and Ubuntu. There are many moral theories, and this study's choice is based on current practices in South Africa.

2.7.1.2.3.1 Consequentialism account

Consequentialist morality is sometimes called the teleological approach. It is concerned with the consequences, ends, or goals of morality. This account proclaims that human beings should behave in ways that bring about sound effects (Rae 2018:40). The consequentialist ethics trajectory points to the situation and conditions resulting from the individual's actions (Dhai 2019:6). As Pellegrino (2010:98) attests, the consequentialist system provides some health professions with elements for internal morality. For example, Nursing or medicine exists because there is a need to heal, cure, or prevent human frailty (Pellegrino 2010:98). Therefore, the consequences of a right and morally proper healing are plausible in making decisions to protect or preserve the patient's good (Pellegrino 2010:98).

Although the professional codes of ethics are rule-based morality as they command one to conform, they are teleologically validated. The nursing precepts such as beneficence, fidelity to trust, and confidence preservation are mandatory due to their consequences (Pellegrino 2010:98).

The primary form of consequentialist account is Utilitarianism. This theory holds that moral actions must be chosen based on whether such measures will produce the greatest good for the most significant number of people (Rae 2018:45). The theory may allow the state to maximise the subjective preferences regarding a specific matter for the greater societal benefit, irrespective of such preferences' moral acceptability (Beauchamp & Childress 2013:353). An example is a protocol-based approach to making medical decisions in treating illnesses such as hypertension in the primary healthcare clinics.

Utilitarianism suggests that an act's consequences may be judged right or wrong, and what matters is the amount of happiness to be produced by an action (Dhai 2019:15). In that way, the individual's rights are not considered significant if there is the greatest good for a considerable number. The utility formulated by Jeremy Bentham in 1781 also requires an impartial perspective for those affected by the Act (Dhai 2019:15). Focusing on consequences only and ignoring the principle of justice and individual rights makes this theory incomplete as a behaviour guiding theory (Rae 2018:50; Beauchamp & Childress 2013:351). The incompleteness of this theory initiated another approach, such as non-consequentialism.

2.7.1.2.3.2 Non-consequentialism system

The fundamental notion of these theories is that consequences do not and should not enter into the judgment of whether actions or people are moral or immoral (Thiroux & Krasemann 2009:54). Accordingly, Rae (2018:40) points out that the deontological system chooses to abandon the plausibility of consequences. Instead, it is grounded on principles and obligations that appraise an action, character, or intention as inherently right or wrong (Rae 2018:50). Reiterating the notion, Pera and Van Tonder (2018:41) call them formalist theories that hold that certain features of acts and not their consequences make them either right or wrong. For example, actions such as killing, lying, raping, or laziness have incorrect features (Pera & Van Tonder 2018:42). These actions do not bring about the most significant balance of good over evil for an individual or society, and it must be obligatory to avoid them (Pera & Van Tonder 2018:42).

Kantian Deontology is a principles-based system that evaluates the obligations and not the consequences of an act (Rae 2018:50). Furthermore, Kant emphasises that reason motivates and enables individuals to do their duty freely (Rae 2018:50). As reason is responsible for validating duty or obligation for a specific circumstance, all rational beings are likely to react freely towards a particular commitment. It will become impossible for one's moral obligation to change based on desires (Rae 2018:50). Deontologists hold that the exercise of reason enables individuals and societies to have a shared sense of duty or obligation (Dhai 2019:15). The nurse's commitment to caring results from the rationality that motivates one to do that duty freely.

According to Dhai (2019:15), Kant (1724-1804) insinuates respect for persons' self-determination and honouring the rights on this ground of rationality. The nurses' codes of ethics statements are moral rules and, therefore, the pure form of these obligations, as they give what ought to be done, and correctly in a specific situation. Since these rules provide no exceptions, it is hard to break the rules, even when following them would have terrible consequences (Rachels & Rachels 2012:130-131). Doherty and Purtilo (2016 96) attest that deontologists do not display what to do when there is a conflict of obligations. Despite the theory being limited in some situations, it helps one be consistent in executing one's duty. As Black (2020:148) attests, various and complex life situations may make rules unrealistic and risky for one to be guided by absolute command of deontology. Thus, there is a need to engage and scrutinise other moral theories.

2.7.1.2.3.3 Virtue ethics

Unlike other moral theories, whose central question is what the right thing to do in a specific situation (Dhai 2019:15), the focus of virtue ethics is on what character trait makes someone a good person (Rae 2018:61). The concerns are with traits, dispositions, and motives that qualify the virtuousness of a person/nurse. Virtue ethics appraises individuals' character or attributes as virtues or vices and is concerned with neither the consequences nor the rules for determining morality (Rae 2018:61). Virtue ethics assumes that appropriate behaviour flows from good character. According to Volbrecht (2002:95), the character shapes our capacity for making moral judgments and the need for these qualities and judgment in guiding actions (Volbrecht 2002:95). In that regard, virtue ethics attempts to create a virtuous moral agent who does not just act based on obligations, impulses, or whim to achieve good consequences (Black 2020:150; Thiroux & Krasemann 2009:77).

Most importantly, an individual needs practical wisdom, which is the moral skill that enables one to discern everyday activities. Experience is acquired by practical wisdom (Rae 2018:63). Indeed, people are born with temperaments, and as the person interacts with others, a character is developed as an individual responds to various opportunities and challenges (Black 2020:150). It is essential to point out that these traits require practical wisdom, a skill for interpreting, clarifying, and figuring out what is relevant and befitting in a given situation (Stichter 2015:124). Thus, Black (2020:150) substantiates that virtues distinguish a person from being just an ordinary or exemplary nurse. Although

compassion, sympathy, and altruism are traits valued in nursing, they need practical wisdom to be within the realm of virtue ethics.

Nursing institutions' mandate is to help individual students develop the highest virtue (practical wisdom) in producing virtuous nurses. To what extent does the institution contribute to the acquisition of virtue and with strategies? What efforts do the nursing educational institutions and clinical practice make to develop moral virtue? Teaching and learning practical wisdom should expound on what Thompson (2017:218) calls constructs of practical wisdom, such as:

- Rational and analytical capability: the capability to use reason, logic, and intellect to gain a greater knowledge of a situation and apply the knowledge more quickly or efficiently.
- Intuitive insight: gut feel or the non-rational dimension.
- Values/human character: beauty, truth, goodness, humanity.
- Self-awareness: the voice within, higher consciousness, reflection.
- Emotional regulation: humility, generosity, empathy, calm (Thompson 2017:215).

It is evident that virtue ethics is more than knowing and communicating the virtues and conforming to virtuous codes of ethics or credos. What is essential is to form a habit that calls for habit-forming the highest moral virtue called practical wisdom.

2.7.1.2.3.4 Ethics of care

The foundations of care ethics are the conviction that traditional western ethics accept masculine principles as normative and ignore human nature dispositions such as relationships and empathetic involvement (Schuchter & Heller 2018:55). Accordingly, Nortvedt, Hem and Skirbekk (2011:193) attest that other ethics theories are more individualistic and orientated towards rights. As a proponent of care ethics, Carol Gilligan suggests that the conception of morality must be "*in a different voice*" (Brugère 2019:9). Ethics of care also called care ethics, is a feminist philosophical perspective that uses relational and context-bound approaches to morality (Brugère 2019:9). According to Nortvedt et al (2011:196), ethics is perceived as social responsibility in caring for others, while relationships bring out trustworthiness, which serves as a frame for evaluating ethical issues. Empathetic relationships as a point of departure for care ethics are

deemed essential in identifying vulnerability and dependency as features that prevent one from flourishing (Doherty & Purtilo 2016:82). In entering into someone's shoes, the implementation of practices for alleviating suffering may be reflective (Doherty & Purtilo 2016:82).

According to Brugère (2019:12), ethics of care aims at analysing the care practices with a particular focus on the profession. Thus, care ethics would explore the nursing profession's caring techniques to relieve distress. Moral injury is envisaged within the ethics of care when there is a failure to respond responsibly to vulnerable needs, and reasonable care would entail specific dimensions relative to care (Martinsen 2011:26). Therefore, Tronto (1993:130) indicates that maintaining and repairing human well-being involves implementing caring activities. At the same time, Brugère (2019:17) proposes promoting practices that have been collectively acknowledged as caring (Brugère 2019:18).

Tronto (2013:20), Tronto (2010:160) and Tronto (1993:136) extrapolating from excellent and inadequate care, indicates that moral care has different multidimensional foci. According to Tronto (2010:160-161), the moral care dimensions have elements and their respective care phases, and these are summarised in Table 1.1 (overleaf). These elements might provide a meaningful framework through which professions may evaluate their practices (Tronto 2010:171). Thus, nursing ethics education and clinical practice may evaluate their performance based on these elements. Tronto (2010:159) further argues that this framework is useful in revealing public and political dimensions of care within the institutional context. These phases and the corresponding elements may be used in analysing care activities; however, these must be preceded by establishing empathetic relations between a nurse and a patient. This study aims at understanding how the ethics of care have been taught and how nurses in community service practice understand it.

Table 2.1: The phases and corresponding moral elements of care

The moral elements	Phase of care
Attentiveness: noticing unmet needs, suspending one's judgments, and being able to see the world from the perspective of the one in need	Caring about
Responsibility: taking on the responsibility of responding to the need	Caring for
Competence: being competent to care entails the technical, moral, and political aspects**.**	Caregiving
Responsiveness: listening to the response of the person cared for, and gave attention to new and unmet needs	Care receiving
Solidarity: taking collective responsibility, and incorporating the clients and families in thinking of the holistic nature of caring	Caring with

(Source: Tronto 2013, 2010, 1993)

Although the ethics of care has been convincing in dealing with vulnerable individuals accessing healthcare services, the question is how the framework has been implemented. However, these are the following issues: how is the assessment and teaching of nursing ethics conducted by nursing ethics educators? What strategies could be implemented in a reasonable manner? The nursing fraternity has always considered the ethics of care, as the basis for ethical consideration, as caring relationships have been the primary concept in patient-nurse relationships.

2.7.1.2.3.5 Ubuntu

Ubuntu is a being humane as well as attachment of primacy and sacredness to human personality (Ngubane 1979:113). It illustrates the transformative process of a human being into personhood, a state that affirms the common originality of humans and obligates the maintenance of unity for the sake of harmony and equilibrium (Wiredu 2004:17; Moyo 1999:50; Ngubane 1979:113). However, it is essential to note that Ubuntu has another distinguishing feature: interconnectedness with the mythology of the invisible, the spiritual realities of the ancestors, and the supernatural being (Bujo 2003:43). This notion of interconnectedness with the invisible mythology has exposed African ethics to many opposing views (Horsthemke & Enslin 2005:55; Van Hook 1993:29). For this reason, it has become a portion of neglect when discussing Ubuntu as an ethic.

According to Metz (2010:50), the ultimate goal of a human being within the African context is to become a full person to exhibit Ubuntu as a virtue. Menkiti (2004:324) also affirmed

this ultimate goal by indicating that personhood becomes something special to strive for, as it may be susceptible to triumph or failure. At the state of accomplishment, a human being is expected to be a person who can exhibit Ubuntu, meaning to have the full capacity to honour harmonious or communal relationships (Metz 2010:51). Accordingly, a human infant is considered to have the partial capacity, as it cannot yet be identified with and exhibit solidarity towards others. The greatest good of social harmony has a moral element that obligates us to engage with others in relationships of identity and solidarity (Metz 2010:51). An action is right just insofar as it is a way of living harmoniously or prizing communal relationships, one in which People identify with each other and exhibit solidarity with one another; An action is right just insofar as it is a way of living in harmony (Metz 2010:51).

Corollaries are expected to those who are friendly as well as the unfriendly people, for the friendly relationships of identity or solidarity to be honoured. (Metz 2010:51). According to Metz (2010:51), the moral agent should strive to exhibit Ubuntu, a basic principle in which one put a price in the relationship of identity and solidarity with others.

- Identity is how life is shared: To honour one's individuality, a sense of togetherness and corporation is exhibited, or a shared sense of belonging (Metz 2010:51).
- Care for the quality of life is represented by solidarity: One applauds sympathetic altruism and mutual aid for the sake of being in that relationship (Metz 2010:51).

Metz (2010) further attests that the moral obligation is exemplified by precepts such as the fact that one needs to be surrounded with people who are able to assist during bad and good times, also, he/she must practice the same to others; "I am because we are, and since we are, therefore I am". These precepts allow individuals to acquire the shared dignity and do good acts to avoid wrong acts which will cause social discord, and good deeds will sow friendliness and, therefore, contribute to harmony (Metz 2010:52).

2.7.1.2.3.6 Principlism

General norms of analytical framework derived from the common morality forming a suitable starting point for biomedical ethics (Beauchamp & Childress 2013:13). The four universal and fundamental ethical principles are as follows: beneficence (do good), non-maleficence (do no harm), autonomy (respect for the person's ability to act in his/her own

best interest), and justice (Black 2020:150). Each principle has a prima facie obligation that must be fulfilled unless there is a conflict with other principles (Beauchamp & Childress 2013:13; Black 2020:150). In the case of dispute, the rules within the principles are weighed against other duties and balanced to resolve an ethical dilemma or a conflict (Beauchamp & Childress 2013:13; Black 2020:150).

A norm of respect and support is respect autonomous, whereby one will have the capacity to deliberate on the course of action and to put that plan into action (Beauchamp & Childress 2013:102). According to Beauchamp and Childress (2013:101), moral rules of respect for autonomy include: being truthful; respect other peoples' privacy; be confidential: obtain consent to intervene with patients; and, when asked, helping others to make critical decisions.

Norms about relieving, harm prevention, provision of benefits, and balance the benefits against risks and costs. The rules specific to these norms include protecting and defending the rights of others; preventing harm from occurring to others; removing conditions that will cause harm to others; helping persons with disabilities, and rescuing persons in danger (Beauchamp & Childress 2013:152):

Non-maleficence is a norm for avoiding the causation of harm and has these specific moral rules: one is not supposed to kill others; pain, suffering and incapacitating are prohibited; there should be no offence as well as deprivation of others of the goods of life (Beauchamp & Childress 2013:154).

A group of norms for fairly distributing benefits, costs, and risks (Beauchamp & Childress 2013:249). The commended principle of justice suggests that equals all people must be treated equal, there should be no discrimination against each other (Beauchamp & Childress 2013:250). Material Principles in justice theories describe society/community as a cooperative venture. As such, distributive justice is pertaining to distributing goods, advantages and benefits fairly, resulting from collaborative experiences (Beauchamp & Childress 2013:250).

The World Medical Association (2008:30) illustrates that these four principles often clash in particular situations; therefore, a specific criterion or process for resolving such conflicts is followed. Beauchamp (1995:183) clarifies that the principles are always binding unless

they are conflicting with the other obligations. In conflict situations, balancing and harmonising the norms is employed, or else one principle will have to override the other (Beauchamp & Childress 2013:15).

As an ethical framework, the choice of these four principles among the health professional derives from obligation and virtues framed by a commitment of providing medical care, protecting patients from the harmful diseases, and system failure (Beauchamp (1995:185). The ethical principles as guidelines for making justifying decisions have been essential elements of moral judgment in nursing practice (Pera & Van Tonder 2018:50). Besides this framework being popular in nursing ethics, it is deemed easier to teach (Pera & Van Tonder 2018:50).

However, there are cases where these principles do clash or compete. In dealing with competing principles, Beauchamp and Childress (2013:107-204) suggest a need for principles and moral rules to be specified and weighed to focus the rules on them. Beauchamp and Childress (2013:17-21, 404) clarify that the process of specifying and weighing follows a reflective equilibrium model, which is a deliberative process that brings principles, judgments, and background belief systems into a state of harmony. The critical question is whether nursing ethics education and practice teach and practice the process of specification and weighing, in resolving conflicting principles or whether these principles are followed as abstract concepts with limited description.

2.7.2 Morality

Like ethics, the definition of morality is ambiguous and dependent on different perspectives. As Luco (2014:361) attests, the ambiguity in defining morality may be related to differences in viewpoints. According to Bobb (2017:51), apart from ethics and anthropology, the concept of morality is being studied from psychological, psychosocial, cultural, evolutionary, neuropsychological, and economic perspectives because of its importance in justifying our actions, self-image, and excuses. Based on different perspectives, Bobb (2017:51) indicates that Durkheim (1933:122) describes morality as a system of rules that compels egotistic individuals to pay attention to others. At the same time, Bauman (2002:1) views it as a moment of generosity in which individuals stop thinking about their well-being and direct the good to others.

Pera and Van Tonder (2018:5), morality is a set of conduct norms consisting of moral principles, rules, rights, and virtues that society has agreed upon for regulating conduct. Doherty and Purtilo (2016:7) see morality as a set of rules about what persons ought to and ought not to do regarding many aspects of daily life in order to conform to societal norms of behaviour. Elaborating on morality, Doherty and Purtilo (2016:7) designate that morality consists of a collage of values, obligations, traits, and character disposition. Pitak-Arnnop, Dhanuthai, Hemprich and Pausch (2012:92) reiterate this definition by deeming morality a system of unarguable rules given by those with authority for regulating behaviour. Stating that the morality regulations are irrefutable, Ristovski (2017:86) claims that individuals are expected to subordinate society's general and static conduct to conform to group norms. Further, Ristovski (2017:87) posits that the rules in morality do not prompt the discovery of new principles or standards; instead, one must apply the existing laws when confronted with contemporary moral challenges. As such, individuals may become conformists of social behaviours with implications for advancing that society, group, or organisation.

Another aspect of moral rules is that the individuals have to internalise the norms and practice them by persuasion and fear of conviction from the authorities (Bobb 2017:53). However, the repercussions of embarking on something out of fear may define individuals as conformists and confine them to the lowest stage of moral development described by Kohlberg. The concern is whether the current ethical frameworks for nursing ethics education and practice consider morality in absolute rules and norms or take nurses as moral agents. The position of SANC towards morality is likely to affect the micro- and macro-nursing ethics curriculum and how practising nurses view nursing ethics.

Arguing the absolutism of rules in morality, Bobb (2017:52) suggests that morality extends beyond submitting to fundamental norms and regulations but includes a nonconscious aspect of morality. According to Zigon (2009:255), nonconscious morality is an appropriate virtue that individuals acquire through conscious and intentional engagement until it becomes habitual. Zigon (2009:255) extrapolates that though nonconscious morality is obtained consciously through deliberate strategies, and once adopted, it is performed spontaneously without being thought out beforehand. In achieving this habitual morality, individuals develop an ability to sympathetically consider the impact of their actions on others (Ayala 2010:9015). In this regard, nurses would be expected to reflect

on their activities with the patients and clients compassionately. Therefore, nursing ethics education is to assist students in being sympathetically reflective.

Many authors emphasise the importance of good character in morality. For example, Bobb (2017:54) attests that the virtuous self is responsible for linking all moral development levels. The self is the main character in defining good and bad actions, and the character comments on morality beyond rules and submission to authority (Bobb 2017:54). Similarly, Bauman (2002:35) indicates that morality is a moment of generosity in which unconditional responsibility is activated. The responsible other acts out of love in the other persons' mere presence using virtuous dispositions (Bauman 2002:35). In this study, morality is defined as a human endeavour, a product obtained through repeated actions that entail a particular virtue, which involves essential discourses for engaging in logical and moral consistency in a specified ethical situation. This study wants to ask what nursing ethics should be like, given the clarified meaning of ethics, morality, current frameworks of nursing ethics, and the gaps and challenges faced by nursing ethics education and practice?

2.8 CURRENT CHALLENGES FACING NURSING ETHIC

2.8.1 Nursing ethics education challenges

The body of literature about the challenges of nursing ethics is increasing of nursing ethics. For instance, Gallagher and Wainwright (2005:22-23) suggest the presence of an ethical divide, as there is increasing interest in ethics discussions through journals and conferences, yet the practices of nursing ethics continue to face problems. This means that nursing ethics is occupying the academic spaces of discussion; however, the impact of these discourses does not translate into good nursing care as a measure of ethical nursing care. Therefore, these authors allude to a theory-practice gap and that academics fail to promote ethics sufficiently during the training (Gallagher & Wainwright 2005:22).

Focusing on challenges facing basic ethics education for all nurses for providing good care, Gastmans (2002:495) suggests the need to recognise the intersubjective character of nursing. Nonetheless, this aspect of intersubjectivity is limited in many nursing ethics frameworks, with much emphasis on rules and principles. For example, Johnstone (2017:19) posit that nursing ethics has somehow failed advocating for nurses. Although

theoretical deficiencies are cited for the failures (Johnstone 2017:19), others reverence the superficial, transient, and quick-fix approaches such as socialising students into professionalism (Mackenzie 2008:6).

According to Wainwright and Gallagher (2008:46), human dignity is an essential concept in nursing philosophy that needs to be analysed. Should human dignity be studied just as a principle and rule as it appears in many codes of ethics or as a theory to inform nursing ethics? Simultaneously, Woods (2005:5) states that nursing ethics is not preparing nurses fully to contribute to patients' good or contribute appropriately in the current healthcare climate.

Remarking on the current approaches to ethics education, Woods (2005:12) substantiates that nursing ethics education shows nurses as not being fully prepared to deliver the service(s) for their patients or contribute appropriately to the broader health care climate. Cannaerts, Gastmans and Dierckx de Casterlé (2014:871-872) checked the effectiveness of teaching strategies and ethics content. In conclusion, Cannaerts et al (2014:871-872) indicate that both students and educators believe that the teaching strategies are nonmotivating, impractical, and not engaging. At the same time, the ethics content instilled lacked rationalistic approaches pertinent to nursing care, and educators demonstrate ambiguities in teaching specific moral theories (Cannaerts et al 2014:871-872).

Gallagher and Wainwright (2005:22) indicate that nursing ethics is a cornerstone of nursing practices, but nurses' actions towards the patients are not satisfying. The gap in the centre of the theory and practice of nursing ethics is expanding (Gallagher & Wainwright 2005:22). Godbold and Lee (2013:553) attribute the theory-practice gap to the variation in content, approach, and depth of ethics education and ascribe the contentious ethics terminology for the failure of ethics application. Given the discontent regarding ethics education in nursing, might possibly be the fact that ethics education is not reaching the intended goal. Saja (2020:73, 76) sustains that the function of ethics is to allow one to maintain and increase inner personal integrity, harmony, and happiness and coordinate social behaviour and be altruistic toward those who stand before us (Saja 2020:73, 76). Thus, it may be challenging for one to apply what is not cordial. Therefore, there is a need for renewed ethical discussion regarding future nursing ethics' content and direction (Johnstone 2017:19).

2.8.2 Clinical nursing ethics challenges

Nursing practitioners have highlighted the challenges of clinical nursing ethics. There are reports of dropping nursing care standards, unethical conduct, and poor nurse-patient relationships (DoH 2011:46; Gallagher & Wainwright 2005:22). It is understandable for clinical nursing ethics to have challenges if ethics education at the forefront is uncertain and inconsistent in what it does. White et al (2015:8) demonstrate that nurses know little about good ethical practice, and this limitation extends to the obliviousness of the code of ethics. Gallagher and Wainwright (2005:23) report sub-standard and demeaning practices marked by abuse and negligence, despite the continuous reversion of the code of ethics. However, the alleged importance of nursing codes of ethics has always been censured in nursing ethics curriculum and clinical practice because of their lack of support for logical reasoning (Numminen, Leino-Kilpi, Van Der Arend & Katajisto 2009:470-471).

In looking at South African nursing ethics challenges, Jewkes Abrahams and Mvo (1998:1781) illustrate that what is supposed to be good care is characterised mainly by the humiliation of patients and physical abuse, despite nursing discourse accentuating caring in the code of ethics and practice. On the other side, Stellenberg and Dorse (2014:9) highlight ethical challenges relating to human dignity and rights in general, challenges of dealing with diverse cultures and religions, and institutional issues that are likely to violate the ethos of nursing.

Based on these challenges, Johnstone (2017:19) suggests the need for renewed moral discussion regarding nursing ethics' future content and direction to allow nurses in enduring the challenges and opportunities of contemporary nursing ethics. In discussing the current view regarding nursing ethics, it is necessary to revisit the purpose of nursing practice. Pellegrino (2006:65) attests that ethics emanates from the profession's goals, which he calls the profession's internal morality.

2.9 MEANING AND PURPOSE OF NURSING

The definition of nursing is considered to be a core framework for nursing ethics practice (Black 2020:1). Accordingly, Henderson (1978:114) indicates that the main nursing function assist the sick is to help the healthy and the sick to perform duties that contribute

to health or its recovery (or to peaceful death). Also, these individuals are to perform these activities unaided or be helped to gain independence as rapidly as possible based on necessary strength, will, or knowledge (1978:114). In this definition, the patient's position of dependency, the profession's commitment, and how the activities aimed at healing are appraised. ICN (2015:online), mention that nursing is encompassed autonomous and collaborative care of persons of all ages, families, groups, and communities sick or well and in all settings. Nursing includes health promotion, prevention of illness, and care of ill, disabled, and dying people. The ICN definition explicitly indicates that all people are likely to be vulnerable and that nursing activities are ways of dealing with these.

The Nursing Act (No 33 of 2005) describes nursing as a profession that cares, which is supportive and assist a patient in achieving or maintaining health and, where this is not possible, assist the patient with care so that he or she lives in comfort and with dignity until death (South Africa 2005). The description of comfort and dignity illustrates nursing goals as the patient's good ends. The patient's expectancies in nursing are the highest measure of quality, characterised by human dignity, which amounts to respecting human rights, such as the right to life and choice, and respect for cultural rights ICN (2012:online). Condon and Hegge (2011:209) suggest that human dignity is implicitly and explicitly woven in all nursing ethics dialogues and should inform the practice and educational arena.

As Fineman (2008:10) suggests, the structure of institutions such as ethics should be fashioned around the human experience of vulnerability. The notion of vulnerability recognises that human beings need each other due to their fundamental multidimensional realities that are likely to be threatened (Fineman 2008:10). For that reason, nurses are to consider themselves as part of human society, positioned as moral agents in realising and responding to vulnerable others. According to Ward and Syversen (2009:95), a vulnerability agent is expected to have ethical standards and respond respectfully to clients as fellow members of human society. Thus, nursing education institutions are to instil the awareness that moral agents are also likely to be vulnerable. In responding to the human condition of vulnerability, Winter and Winter (2018:213) suggest that human dignity is a common societal good with the potential to justify legislative endeavours and ethical judgments in a pluralistic society.

2.9.1 Vulnerability

Nurses encounter ill patients daily, and according to Råholm (2008:64), illness creates strange terrain marked by suffering, vulnerability, uncertainty, and despair. Vulnerability is the potentiality of being wounded, defenceless against injury, or open to attack or damage (Flanigan 2000:13). Brugère (2019:41) and Sellman (2005:3) describe vulnerability as a profound characteristic of being human, marked by uncertainty and risks, suffering, and despair that threaten human flourishing. Any situation causing stress, including illness and limited access to information, may expose one to harm. According to Macklin (2003:473), the concept of vulnerability in ethics signifies the prospect of being either neglected or exploited and fittingly, these are morally wrong. Dhai (2019:119) revives this postulation by pointing out the risk to personal integrity, whether physical, psychological, moral, or spiritual.

Thus, vulnerability demands response translating from discernment and awareness. Sellman (2005:3) indicates that although humanity shares vulnerability, others are more-than-ordinarily vulnerable. Expounding on the notion, Sellman (2005:3) prompts that every patient is more-than-ordinarily vulnerable due to the restriction of their potential in flourishing. Therefore, Brugère (2019:51) suggests that this accident ontology gives vulnerability an exceptional narrative within moral philosophy. Brugère (2019:51) submits that ethics of care aims at maintaining and repairing the vulnerable world interwoven in a complex life-sustaining web.

Commenting on divergences of vulnerability, Fineman (2017:134) shows that vulnerability has inherent inequality and dependency that call for engagement and discourses to differentiate vulnerability levels for responding. According to Rooney, Schuklenk and Van de Vathorst (2018:332), identifying the causes of vulnerability reflects a person's life realities that produce despair and suffering. Luna (2019:91) specifies that careful consideration of the dispositional structural layers of vulnerability is essential for achieving a thorough ethical evaluation that will depict areas likely to be harmed or exploited. According to Fineman (2008:18), a vulnerability inquiry proposes a more comprehensive and penetrating equality analysis that envisions underlying arrangements in responding to an individual's vulnerabilities. In laying bare the measures for responding, the nursing ethics becomes more transparent to the clients receiving care.

It may be deduced that significant and persuasive nursing ethics should be founded on the insights and personal reflection that all humans are vulnerable, and others are likely to be more-than-ordinarily vulnerable. In this regard, nurses are likely to relate the patients' suffering to their own ledge of shared precariousness of being in the world. Furthermore, acknowledging that these vulnerabilities may be identified for a decisive response through discourses and strategies, not submission to values. In interrogating and rectifying vulnerabilities, there must be recognition of inequalities and afforded opportunities that define nurses as moral agents. As Gastmans (2013:147) attests, caring and vulnerability are interwoven; therefore, the essence of nursing ethics should be founded on reflection of vulnerability as a profound lived experience. Fineman (2017:134) indicates that vulnerability is universal and manifests itself differently in individuals, often resulting in significant differences in position and circumstance. This difference suggests an individualised nursing ethics approach that seeks dialogue and shared decisions regarding care.

Høy, Lillestø, Slettebø, Sæteren, Heggestad, Caspari, Aasgaard, Lohne, Rehnsfeldt, Räholm, Lindwall and Näden (2016:96) attest to the experiences of vulnerability cause threats or losses to the self-esteem. Thus, dignified care that would increase self-worth is the one that focuses on clients' values, strengths, and active involvement, unlike care that is based only on nursing values (Høy et al 2016:96). According to Ward and Syversen (2009:99), the notion of vulnerability and human dignity as a foundation for ethical practice is unique, as it does not demand the selection of a specific normative perspective. Meaning nursing practices may use virtue ethics, principlism or deontology, etc in respecting and maintaining dignity.

2.9.2 Human dignity

The term ‘dignity’ is derived from the Latin Dignitas and relates to an intrinsic value, one’s characteristics and an inter-subjective value associated with being human (Gallagher, Li, Wainwright, Rees Jones & Lee 2008:4-5). The inter-subjectivity stance makes human dignity a complex concept that requires partnership and mutual understanding between the nurse and the patients. As Isidori and Benetton (2015:687) attest, it implies a moral relationship in which there is a mutual recognition between two subjects who perceive themselves as similar and appreciate each other. In such relationships of trust, the conception may be construed and adopted for idealised nursing care. Jacobson

(2007:293) avers that the concept of dignity is complex and multivalent; however, it remains an ideal framework for linking its bearer, grounds for justifications, and the consequences for holding or granting dignity. Therefore, human dignity and vulnerability are related and have a goal-oriented character in nursing care, consisting of an obligation to care and a search for ethically good care (Gastmans 2013:146).

On the other hand, Ward and Syversen (2009:97) suggest that human dignity is an influential moral concept that signifies that all human beings have intrinsic value and universal moral equality. The claim is consistent with the nursing commitment to serving humanity equally irrespective of race, age, culture, or agility. According to Isidori and Benetton (2015:687), the human dignity’s principle is expressed in Kant's categorical imperative, which insinuates that we need to treat a person as an end in her/himself, not as a mere means. The principle of human dignity is further appreciated by Jacobson (2009:294), who extends the discourses to include different ways dignity is conceived or speculated. Jacobson (2009:294) suggests two distinct modes of positing dignity: an inherent and inalienable value belonging to all humans. Secondly, as a universal social value in behaviour, perception, and expectation (Jacobson 2009:294).

Gastmans (2013:144) proposes an interpretative dialogue between the nurse and the patients searching for good care in these intrinsic and social assemblies of dignity. Gastmans (2013:144) calls this process the dialogical aspect of nursing ethical decision-making to address human dignity vulnerabilities. Fittingly, this dialogical process will enable empathetic and analytic deliberations geared towards addressing human dignity with its *multifaceted* viewpoints. Thus, besides making nurses understand human dignity, nursing ethics education should also invest in the students' analytic skills.

2.10 CONTEMPORARY VIEWS REGARDING NURSING ETHICS

Nursing ethics is proposed to reflect an acquiescence regarding the essence of nursing practice (Gastmans 2002:495). Reiterating, the International Council of Nursing (2012) stipulates that the nursing goals engage one to understand the ethical responsibilities in nursing. Endorsing, Pellegrino (2001:560) indicates that the unique goals of each healing profession give a moral force to the duties, virtues, and responsibilities of that profession. Therefore, in enhancing morality in healing professions, the fundamental step is to re-establish the healing relations within the profession's goals (Pellegrino 2006:65).

Pellegrino (2006:65) situates the healing relationships within three phenomena that should establish the nature of ethics. First is the vulnerability of the patient, brought about by illness, dependent position, and unequal relationship (Pellegrino 2006:65). The second is the professional commitment and promise to help. The last phenomenon relates to the professional actions deemed competent and all-encompassing for leading a healing decision (Pellegrino 2006:65). Geddes (2015:400) points out that recognising human vulnerability is the foundation for determining health professions' ethics. Therefore, in developing a framework to enhance nursing ethics, the first step is defining nursing and seeing it within the manifestations of healing relationships.

2.11 ETHICS OF RESPONSIBILITY AS CONCEPTUAL GROUNDING OF THE STUDY

Consonant with the researcher's assertions in section 1.7 of Chapter 1, the ethics of responsibility (as composite to the broad field of nursing ethics education) has been adopted in this study on account of its interrelated constructs that provide a broader explanation of an ideal nursing ethics context. In its conceptual context, the ethics of responsibility broadly describes a set of statements or principles that relate to aspects of nursing ethics as the researcher's phenomenon of interest in this study. Accordingly, Polit and Beck (2017:118) articulate appropriately that theories themselves are developed from propositions or abstract ideas (concepts) that form a logically interrelated framework that provides and drives new statements to understand the investigated phenomenon of interest better. Therefore, in describing aspects of a given phenomenon, the conceptually-driven theory may predict the relationship between propositions and variables regarding nursing ethics education and practice in South Africa.

As Creswell (2014:54) argues, the conceptual parameters of a phenomenon may be used as an analytic tool for specifying *how* and *why* there is a degree of interrelatedness among constructs and their relational statements that explain, describe, predict, or control phenomena. Indeed, Brink, Van der Walt and Van Rensburg (2012:26) corroborate that the conceptual grounding or theoretical frameworks (in cases of a particular or specific theory) enable researchers to utilise relevant concepts in their studies for framing their claims or propositions. In formulating a conceptually-driven perspective for exploring the efficiency of nursing ethics in South Africa, the ethics of responsibility was then considered as an appropriate functional prototype in this study. The set of propositions

within the ethics of responsibility attempts to balance the nursing practice's foundation and the essence of nursing ethics. Within the ethics of responsibility, concepts such as suffering, relationship, reflective dialogues, and human dignity play a profound role (Levinas 1988:69). These concepts are fundamental in recognising, bearing witness, and alleviating suffering in the nursing practice.

2.11.1 Foundational tenets/principles and development of the ethics of responsibility

The purpose of nursing is to provide care to the patient, which is based on the assumption that nurses identify specific responsibilities as essential for the good outcomes of their activities. The ethics of responsibility have constructs similar to nursing care, such as relationships, suffering, multidimensional aspects of being human, dialogue, interpretation, and restoring human dignity. These constructs are aligned with the unique functions of nursing. Therefore, curriculum and perceptions of educators need to reflect these constructs inherent in the ethics of responsibility and translate them into the ethics knowledge and experiences of the Com-serves.

As a framework for theorising ethical intention, the ethics of responsibility is traceable to many philosophers, including Max Weber, Zygmunt Bauman, and Emmanuel Lévinas. However, this study has adopted Emmanuel Lévina's expression of the ethics of responsibility. Levinas was influenced by Husserl's phenomenology and the existentialism of Heidegger (Gracia 2010:60). Thus, a brief discussion of Husserl and Heidegger's influences on ethics of responsibility is imperative. Husserl's phenomenology deals with the significance of consciousness, a manifestation of our state of mind and experiences, evident in our state of conscious or awareness (Husserl 1969:242). In this formation of consciousness and reality, there is the view that humans are reflective beings that identify, transform, and create the essence of their existence (Husserl 1969:242).

Phenomenology seeks interpretation from those with evidence, a skill that requests awareness and attentiveness (Armstrong 2015:144). This conception concurs with Heidegger's (1962:47) emphasis that interpretation is a prerequisite when examining the meaning of “Dasein”, the German concept for human existence. According to Heidegger (1962:47), “Dasein” is a rational being with a conscience and the potential to talk and hold

discourse. At the same time, "Dasien" may refer to facts and intercept these facts with context. Therefore, the ethics of responsibility seek dialogues and interpretation.

Heidegger (1962:20) writes that Dasein is in the world amongst others, and for that, Dasein can save its authentic Self. This human prevents him-/herself from being consumed. Instead, he/she finds ways of preserving the other (Heidegger 1962:20). When an individual imagines the other person to be like himself/herself, he/she distorts any knowledge of his/her uniqueness, and the aspect of sameness (homogeneity) becomes the focal point (Burns 2008:324). In the same vein, Levinas (1981:117) asserts that the misery of the other discloses the capacity to feel the other's pain in one's flesh. Levinas (1978:10) reported that the other, reminds the subject of its responsibility. Thus, nurses feel the misery of their patients as an aspect of their reality. Accordingly, Van der Merwe and De Voss (2008:2), drawing from Levinas's influence, insist that the South African context needs the ethical tenor of being responsible for the other. According to Levinas (1969:200), being responsible for other beings cannot impede our freedom, but allocates meaning to it by arousing the character of our goodness in caring.

The description of relations, according to Levinas (1969:200), is the starting point of morality. Levinas (1969:200) examines the character of human relations and explores the ethical reaction. Given the relation, Levinas (1988:69) indicates that the face is the access to the ultimate human relationship. In recognising the face of another human being, one is reminded that the world is not our own, but a shared reality. Even though these relations may lack formal logic, Levinas (1988:69) further indicates that they are absolute. Reflecting on Levinas, Burns (2008:324) suggests that the face reveals the lived situation that exceeds descriptions and capability to represent itself. Thus, the face of the other is vulnerable and suffering.

According to Levinas (1969:200), there is a relationship between the face of the other and discourse because a suffering face invokes responsibility and follows these descriptions as a permanent fact of oneself to others (Levinas 1969:200). This relationship is what Clemence (1966:500) describes as a philosophical commitment of existence, in which nurses become present for the other. The ethics of responsibility is concerned with the Other's vulnerability as the basis for the ethical response (Gracia 2010:96). Therefore, the nurse's relationships with those vulnerable form the basis of nursing ethics. According

to Burns (2008:315), the abstract face of the other, which is the embodiment and an encounter of suffering, grounds ethics and generates specific responsibilities.

According to Levinas (1987:76), in suffering, there is irresistible disconcertment, which stifles the attempts for survival. The vulnerability of illness is the suffering that leaves one deprived of internal abilities to maintain dignity, and preserve self-determination, given the anxieties brought about by suffering (Levinas 1998:52). Consonant with the goal of nursing, this is the moment nurses are beckoned to take care of ill patients. Based on the multidimensional aspects of the dignity of the human, Levinas (1989:70) suggests that the Other's suffering calls for a sensible narrative that compels one to interpret and act responsibly beyond the command of the universalism of values. Thus, nurses need to invoke a conscious appeal to fulfil the patients' needs at this moment of suffering. Heidegger (1962:64) indicates that "Dasein" uses its original conscience to appeal to others (Heidegger 1962:84). According to Childress (1979:316), conscience appeals mean invoking one's conscience or awareness in interpreting and justifying one's conduct to others. Consequently, the ethics of responsibility calls for dialogue and interpretation as strategies that compel one to respond (Gracia 2010:96).

Within the ethics of responsibility, dialogue and interpretation provide an analysis of rational values and the conflict brought about by contextual issues and experiences of stakeholders in search of good care (Starr 1999:430). Accordingly, Gastmans (2002:495) describes dialogues as the fundamental grounding for nursing ethics education. In the realm of dialogue, awareness of ethical issues, ethical sensitivity to vulnerabilities, and subsequent ethical actions are warranted (Millike & Grace 2017:519). Thus, to be moral, one must be a sympathetic and analytical thinker in understanding all aspects of being vulnerable. Therefore, the ethics of responsibility is defined as an approach that, in the perception of moral ambivalence, demands liability for evaluating our life ethos in an unconditional claim by employing not a single paradigm in ethics instead of acknowledging the benefits and failures of other approaches (Van Niekerk & Nortjé 2013:28).

2.12 SUMMARY

This chapter outlined specific aspects of the reviewed literature regarding the frameworks for nursing ethics and how various aspects were entrenched in the practice of nursing

care for sick or healthy individuals of all ages, families, groups, and communities. Although several studies were conducted concerning the challenges of ethics in the nursing practice, there has been constant enhancement globally. For the South African context, this chapter demonstrates that the gaps within these ethical frameworks and ethical problems are mounting. The literature review identified critical concepts in developing the framework to enhance nursing ethics education and practice amongst professional nurses.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

The preceding chapter (Chapter 2) provided detailed literature-based perspectives regarding nursing ethics and entrenched ethical frameworks in South Africa, the challenges related to nursing ethics, as well as the theoretical grounding of the study. Meanwhile, the current chapter is dedicated to the research design and methodological processes adopted in the resolution of the research problem, accomplishment of the study, aim and objectives; as well as answering the pertinent research questions in this study. The current chapter also encapsulates the processes and procedures for data collection and analysis, study population and participants' sampling, the applied ethical considerations, as well as measures to ensure the study's trustworthiness and scientific rigour through the reliability and validity criteria.

3.2 RESEARCH DESIGN

This study aimed at exploring and describing the state of nursing ethics in South Africa. Given the dynamics of nursing ethics, specific characteristics were envisaged to provide extensive information with the researcher's orientation to the pragmatism research paradigm (perspective or worldview). The qualitative and quantitative aspects or domains were considered critical, given pragmatism's view of reality as fluid and amenable to multiple interpretations (Creswell & Poth 2018:25). It is in this context that the mixed-method approach was adopted to review the nursing ethics course module, as well as the perceptions and knowledge of those who went through the teaching and learning of the self-same module.

Thus, the study's approach to the state of nursing ethics was explored using various (qualitative and quantitative) research designs in compliance with the pragmatic perspective of drawing from different taxonomical environments in fulfilling the needs and purposes of the research (Creswell & Creswell 2018:10). It is in this regard that Creswell and Creswell (2018:11) further reflects that research designs are like roadmaps for the

research process. Accordingly, the study employed both the convergent and mixed-method research design approaches as the study's 'roadmap' towards a comprehensive analysis of the research problem and its resolution (Creswell & Creswell 2018:15).

3.2.1 Convergent designs

For the purpose of providing a complete understanding of the state of nursing ethics, every supposition from diverse stakeholders was envisioned as critical in order to draw conclusions derived from logical interpretations. In that regard, a parallel convergent research design was conducted in this study with various categories of stakeholders in order to answer appropriate research questions on nursing ethics in South Africa. Convergent design is a mixed-method design that integrates qualitative and quantitative methods concurrently because they (methods) have equal priority and complementarity with each other (Polit & Beck 2017:724). There was a distinction in the collection and analysis of quantitative and qualitative data, followed by the merging or blending of the results of the two data sets (Creswell 2015:36). Furthermore, the blending or integration of both the numeric and prosaic or narrated information were in tandem with the pragmatic research paradigm, according to which the quantitative and qualitative data were collected, analysed, and compared for similarity, dissimilarity, and complementarity (Grove & Gray 2019:432). Therefore, a convergent concurrent strategy was selected because quantitative and qualitative findings were envisioned for confirming, cross-validating, or corroborating both qualitative and quantitative data sets (Grove & Gray 2019:432).

In this study, the qualitative inquiry was used for better insightful understanding of the experiences of the educators and community service practitioners (Com-serves) regarding the South African state of nursing ethics practice and education. While the educators provided their perspectives regarding the content of nursing ethics and the strategies for teaching, the community service practitioners provided their insights regarding the application of their nursing ethics knowledge. Grove and Gray (2019:89) indicate that qualitative researchers may generate valuable descriptions of the experiences necessary to understand how best to intervene in each situation.

The perspectives of the educators and community service practitioners were explored in their own familiar settings, which enabled them to provide perspectives on situations or

phenomena as it naturally unfolds (Polit & Beck 2017:726). As Grove and Gray (2019:54) affirm, the participants describe *what* exists and establish the frequency of such existence in natural settings. The philosophical base of qualitative research is interpretive, humanistic, and naturalistic concerns for understanding the meaning of social interactions and shared interpretations by those involved (Grove & Gray 2019:35). Thus, the description provided tangible and non-speculative information concerning the current practices of nursing ethics in South Africa.

Quantitative descriptive designs were adopted because there was limited information regarding the status and impact of ethics knowledge in the ethos and professional practice training such that the descriptions of the findings are useful for guiding future studies (Grove & Gray 2019:204). In determining the current nursing ethics practice, the module guide for the ethos and professional practice (EPT215/225 and EPP100) in the programme (Regulation R.425) was reviewed for the supported or limited ethics competence variables (SANC 1985).

Thus, the exit outcome and content, unit outcomes, and strategies for teaching and assessment were evaluated. As Grove and Gray (2019:202) highlight, the description of these variables was for either justifying the existence and continuation of the current practice, or identifying problems in nursing ethics education without introducing any intervention. Therefore, this study adopted descriptive designs, which focus on describing and examining the relationship of variables as they naturally occur (Grove & Gray 2019:202).

The quantitative and qualitative data collection processes were conducted simultaneously, and the results of the two methods were integrated during the interpretation phase (Grove & Gray 2019:432). This merging provided the magnitude and frequency of evidence, while the research problem's perspectives, depths, and context were also revealed.

In this study, the documents, self-administered questionnaires, and individual interviews with the ethics educators and community service practitioners served as separate, but complementary and concurrent data sets. Accordingly, the quantitative and qualitative tenets were weighed equally. As Grove and Gray (2019:432) comment, the phases of the research process (data collection and the analysis of the two components) were

performed independently and concurrently, and the researcher interprets the results together as part of the same study. Creswell and Creswell (2018:15) suggest that convergent design comprehensively analyses the research problem as it merges qualitative and quantitative data. However, Creswell and Creswell (2018:15) caution that there are also instances of the sets of data yielding contradictory findings.

Conversely, if the findings from the two data sets are different, the results may be used to describe the problem in broader terms (Grove & Gray 2019:530). This design is considered to enable further explanation and additional probing if the databases end in contradictory or incongruent findings (Creswell & Creswell 2018:15). Therefore, this design was deemed exceptional for nursing ethics because of its complexity.

Grove and Gray (2019:432) suggest that if the findings from the study are different, the researcher may seek additional results to provide a broader description of the problem. For example, the qualitative approach may seek further probing of the research participants for clarity or theoretical sampling (Creswell & Creswell 2018:15). In theoretical sampling, eligible participants are recruited to enable clarity on some dimension/s of an emerging theory. In this regard, multiple qualitative data sets may be used if there are contradictions between quantitative and qualitative inferences.

Figure 3.1 (overleaf) is a schematic representation of the mixed-methods approach's implementation in researching complex issues associated with nursing practices. The qualitative data sources were the educators who were teaching nursing ethos and professional practice, as well as the community service practitioners. Meanwhile, the quantitative data was derived from the document review and administration of surveys among the community service practitioners through self-administered questionnaires.

Thus, it is evident that there were four data sets: document review, individual interviews, self-administered questionnaires, and the survey. The review of documents and individual interviews concerning ethics was conducted with educators and alongside each other. On the other hand, the self-administered questionnaires with the community service practitioners and individual interviews were conducted on the same date. Thus, there were two phases of data collection, in which the qualitative and quantitative components occurred concurrently.

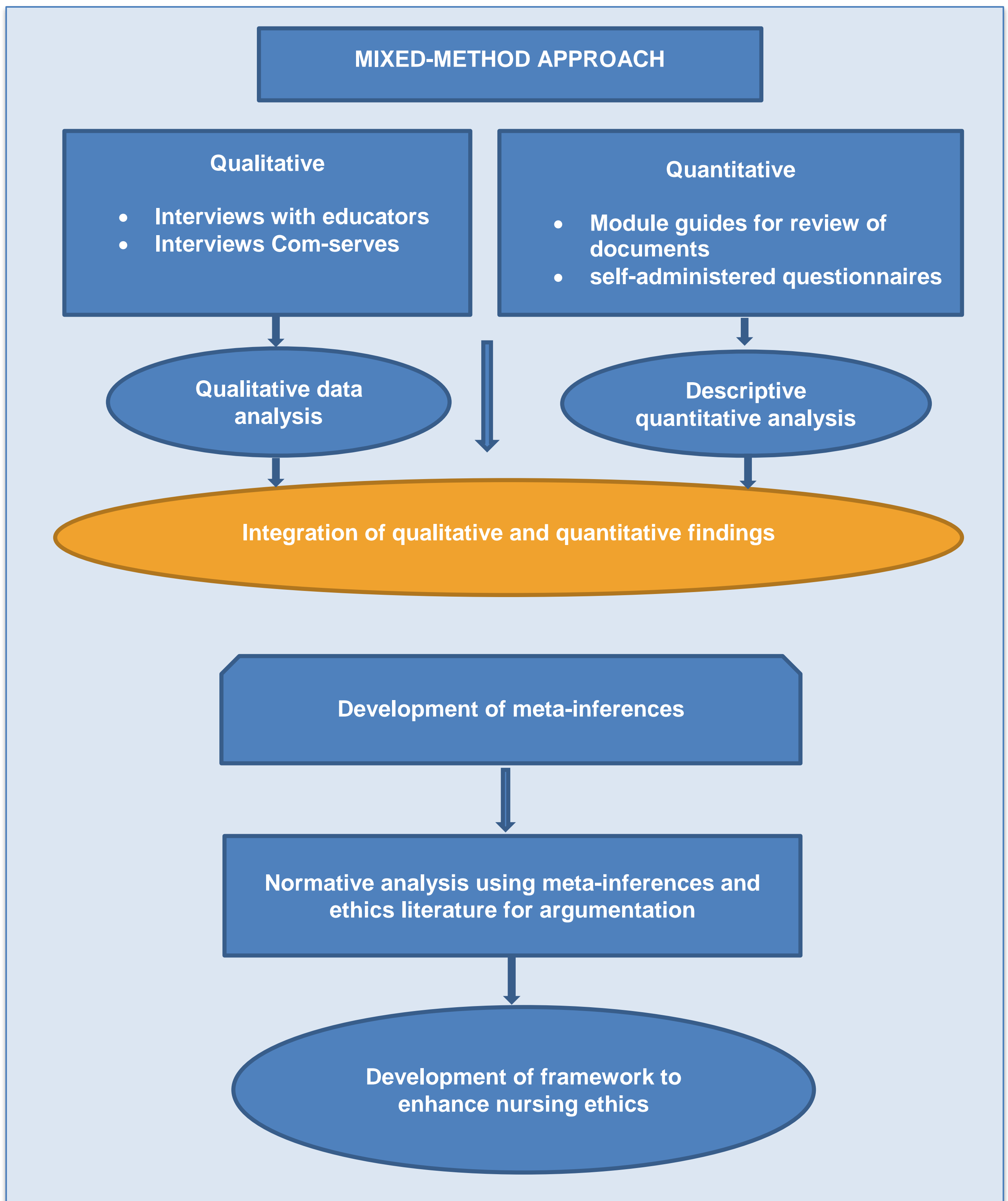

Figure 3.1: Schematic representation of research design

Figure 3.1 above shows that once the two (qualitative and quantitative) research strategies effectively contributed to answering the research questions, the findings and results were then utilised to develop the schematic framework in conjunction with the

literature review. Thus, there were two phases with both qualitative and quantitative approaches and diverse samples, resulting in four data sets.

3.2.2 Rationale for the mixed-methods approach

Nursing ethics is complex, and a single methodological approach would not be enough to portray a larger picture of its actual or current state and the improvement strategies required to enhance this dynamic field. Therefore, the researcher adopted Greene's (2007:xii) mixed-methods proposition for integrating multiple coherent models into respectful conversations and dialogues to better comprehend the phenomenon being studied. It is in this regard that Cohen et al (2018:33) affirm the inclusivity and completeness of mixed-method designs in the conceptualisation of the researcher’s phenomenon or phenomena of interest. Accordingly, the mixed-method offered a logical and practical process for assembling, analysing, and interpreting quantitative and qualitative data in a single study (Creswell 2015:2). The researcher obtained multifaceted answers from the review of documents and the perspective of educators regarding nursing ethics education, as well as the views of Com-serves regarding the application of nursing ethics and knowledge through self-administered questionnaires.

In this study, the documents relating to the nursing ethics study materials influenced by SANC guidelines and the ethics educators’ perspectives were relied on as sources for better understanding and acquisition of different dimensions on the phenomenon of nursing ethics education itself. Bowen (2009:29) avers that documents are often used in combination with other methods of data collection to seek convergence with different data sources in assessing the effectiveness of a programme or initiative. Furthermore, the ethics knowledge of the Com-serves and their views concerning the application of that knowledge were also engaged as standpoints of the moral agents. As Creswell and Creswell (2018:10-11) affirm, every specific idea of knowledge implies action and intended consequences.

According to Mertens (2010:294), the mixed-method approach entails the incorporation of multiple methods, beginning with the problem identification, data collection and analysis, and culminating in the stage of inferences. In justifying mixed-method use, Greene (2007:137) and Greene, Caracelli and Graham (1989:259) proffer that mixed-methods are valuable for:

- Triangulation purposes, which seek convergence, corroboration, and correspondence of results from different methods.
- Complementarity reasons, which pursue elaboration, enhancement, illustration, and clarification of the results from one method with the results from the other method.
- Developmental intents seek to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions.
- Initiation purpose for engaging in the discovery of paradox and contradiction, new perspectives of frameworks, the recasting of questions or results from one method with questions or results from the other method.
- Expansion reasons in which extend, breadth, and range of inquiry are pursued using different methods for different inquiry components.

In this study, the researcher was greatly enriched by the advantages presented by the mixed-methods approach, in which quantitative and qualitative approaches were used for their practicality, complementary and collaborative purposes in enhancing the validity of the results (Polit & Beck 2017:578).

3.3 RESEARCH METHODS

This study adopted the quadrupled research methods because the research design adopted was concurrent, in terms of which quantitative and qualitative forms of data were collected and analysed concurrently. The research methods and processes involved various tools of data collection, analysis, and interpretation which the researcher used for answering the research questions (Creswell & Creswell 2018:16). The choice of method is dependent on the type of information the researcher wants to generate. According to Creswell and Creswell (2018:16), information may emerge from the participants in the qualitative method or be predetermined through instruments that yield numeric information. Although the data sets are different, they are equally important and used in two data-collection phases (Creswell 2015:4). In each stage, methods representing qualitative and quantitative approaches were employed for this study.

3.3.1 Quantitative data collection processes

Grove and Gray (2019:30) state that quantitative research is a rigorous and systemic process for generating numerical information about the researched phenomenon. Quantitative methods make it possible to determine the cause-effect relationships amongst the variables. When executing quantitative studies, Polit and Beck (2017:266) suggest that researchers need to identify the purpose of data as there are diverse purposes, which may sometimes overlap. In this study, data for the descriptive purpose was considered relevant to address the occurrences of behaviour and its frequency (Polit & Beck 2017:206). Quantitative data collection is inclined towards measuring variables that answer specific research questions. This study used questionnaires related to nursing ethics to determine the ethics knowledge amongst the Com-serves. At the same time, study guides as learning documents were reviewed.

A cross-sectional self-administrative questionnaire was developed for the new graduates on community service (Annexure L) and a checklist for reviewing study materials (Annexure H)). The questionnaire portrayed the participants' actual characteristics and circumstances regarding clinical nursing ethics. At the same time, the checklist for the module guides was used to record items for module guide development and overall evaluation of the content for developing and encouraging students' skills and attitudes in comparison with nursing ethics.

3.3.1.1 Development of the questionnaire

It has been identified that developing a new instrument may be challenging; thus, Polit and Beck's (2017:268) opinion of benefiting from the existing tool was followed. The researcher identified that few studies had assessed healthcare ethics knowledge, attitudes, and practices among doctors and nurses. For example, Hariharan, Jonnalagadda, Walrond and Moseley (2006:2) used the 30-item questionnaire to evaluate the healthcare ethics knowledge, attitude, and practice among doctors and nurses in Barbados. In India, Chopra, Bhardwaj, Mithra Singh, Siddiqui and Rajesh (2013:104-105) undertook a 34-item descriptive cross-sectional study among physicians and nurses. The instrument identified knowledge gaps and practical ethical issues among these physicians and nurses (Chopra et al 2013:106). With the same intent, Adhikari, Paudel, Aro, Adhikari, Adhikari and Mishra (2016:1-8) undertook a study in Nepal and

revised the items used by Chopra et al (2013:106) and Hariharan et al (2006:2). These instruments are in the public domain. Accordingly, the researcher did not seek permission from the authors, instead gave them credit through citing their work. Given reliable, validated information from other studies, the researcher devised a questionnaire by including Acts and policies and re-worded some concepts to reflect South African's context.

3.3.1.1.1 Characteristics of the questionnaire

The instrument development process consisted of selecting the original items from these studies, assessing them against the literature reviewed, and wording them to be consistent with the context of nursing ethics in South Africa. Acts and policies pertinent to the legal framework for the South African nursing context were also incorporated. The researcher then categorised the items because the originals were not classified.

The revised instrument generated 44 items. These items were categories that provide information about the following:

- Demographic information: age and level of education, and checking whether the respondents were still doing community service practice or had completed.
- Confidence in Ethics, to determine whether nursing ethics was taken as a course and, how comfortable they are about engaging with other professions regarding ethics.
- Awareness of ethical and legal frameworks governing the nursing profession and healthcare services.
- Knowledge of Moral theories and statutes.
- Open-ended questions regarding the nursing ethical-legal system. This was to allow the identification of applicable statutes that govern health care in South Africa.
- Ethical decision-making, for determining moral reasoning and the knowledge of ethics in nursing care.
- Self-perception and conduct. This determined how nurses classify themselves as moral agents and view their behaviour in diverse situations.

The questionnaire was piloted using three registered nurses who completed community service and did not fulfil the inclusion criteria to participate before the initiation of the study. This pilot produced the desired results.

3.3.1.2 Development of a checklist

The researcher developed a checklist for reviewing the module guide in this study. The researcher expected all material for nursing ethics, but the institution provided the module guide only. The module guides contain aspects of the nursing ethics curriculum. According to Li, Klein, Balmer and Gusic (2020:1084), a curriculum is a planned educational experience that consists of an integrated series of purposefully designed, sequenced, and evaluated learning activities centred around a subject in order to fulfil defined goals and objectives of a specified learner. Module documents are a range of written materials that may be available for private or public scrutiny (Kayesa & Shung-King 2021:67). Documents for analysis were based on a study guide, including practicals in ethos and professional practice. Thus, the review identified the goal of the ethos and professional practice module, the number of objectives, and the final assessment criteria for ethical competence. Thus, the checklist demonstrated the presence or absence of the goal of ethos and professional practice modules, the number of units, objectives for each learning unit, substantive content and time spent, expected specific ethical skills, and the assessment strategies.

The content and teaching techniques were evaluated for the nurses' ability to encourage and develop moral reasoning, reciprocal negotiation, reflection skills, and tools for supporting evaluation. Also checked were the teaching and assessment strategies for instilling awareness of personal values and self-evaluation of ethical acquisition at the end of the course. Creswell and Creswell (2018:188) mention that documents as data may be a hidden source of information, in which much attention has been allocated to its development. Also, documents have advantages, such as obtaining the language and the words used (Creswell & Creswell 2018:188). While documents may seem to have benefits, there are times when they may be difficult to access (Creswell & Creswell 2018:188).

3.3.2 Qualitative data collection processes

Qualitative research is known for its exploration of people's understanding of the social problem, putting together a complex array of data from various sources, and using different methods of collecting data (Creswell & Creswell 2018:4; Polit & Beck 2017:463). Unstructured interviews were opted for, as the preferred qualitative data collection instruments. The unstructured interviews with the new graduate nurses provided the perceptions of the newly qualified nurses on community service regarding ethics and its application in clinical practice.

3.3.2.1 Unstructured interviews

Unstructured interviews were conducted with educators and the Com-serves. The interview as a data collection method is a circumscribed communication between the research participants and the researcher, and is intended to provide information on pertinent aspects of the study (Grove & Gray 2019:280). In qualitative studies, semi-structured questions with a fixed set of questions or unstructured interviews with open-ended questions followed by probing questions may be employed (Grove & Gray 2019:77). One-to-one unstructured interviews were conducted with the participants. Furthermore, unstructured interviews are conversations for understanding the world from the perspective of participants, involving specific approaches and techniques for questioning (Brinkmann & Kvale 2015:27). According to Polit and Beck (2017:509), unstructured interviews are uninterrupted discussions in which the participants tell a story after being informally asked a broad question. As Polit and Beck (2017:509) attest, the next question may be asked to provide direction after the initial general question.

Annexure I and Annexure M show the interview questions that engaged the educators and Com-serves to reveal their perspectives. The advantages of interviewing are that the researcher can observe and record the participant's understanding of the questions imposed on them (LoBiondo-Wood & Haber 2018:255). However, there may be biases if the researcher unwittingly leads the respondents to answer differently (LoBiondo-Wood & Haber 2018:255). In this study, the researcher bracketed her knowledge regarding nursing ethics and created a welcoming environment using non-communication cues to enable the participants to respond to questions spontaneously. However, probing was also used for clarification purposes.

3.4 DATA COLLECTION

The data collection process was categorised into two phases that followed a convergence mixed-method design approach. Data collection took place at the public and private nursing campuses and the public hospital and primary health clinic. While quantitative information was used to describe the variables of nursing ethics, qualitative research was executed to explore and understand the meaning individuals ascribe to multiple-pronged aspects of nursing ethics. Although the quantitative and qualitative data collection and analysis approaches were concurrent, there was a time gap between the data sources. The ethics knowledge questionnaires and interviews with Com-serves were conducted together, while the study material review was performed concurrently with ethics lecturer' interviews.

Grove and Gray (2019:35) suggest that descriptive and correlational studies are undertaken primarily in natural settings, a real-life physical situation for the participants. The researcher interacted with the participants in a natural environment to prevent any environmental manipulation that could have affected the flow of insights and information. Permission from Free State Department of Health, the Free State Department of Health, School of Nursing and the private institutions and was first granted to access the participants in these institutions (Annexure C, Annexure D and Annexure E for the permission letters).

3.4.1 Phase 1 of data collection

3.4.1.1 The study population

A population is a well-defined set of people, animals, objects, or events with specific properties to be studied (LoBiondo-Wood & Haber 2018:213). The ethos and professional practice educators in accredited higher education institutions were the target population, while the study material analysis relied on accessible populations. An accessible population is defined as that portion of the target population to which a researcher had access (Grove & Gray 2019:229). Only study materials from public institutions were made available to the researcher in this study.

3.4.1.1.1 Sampling method

The possible sample was recruited from public and private higher learning institutions in Free State Province. Recruitment was conducted through the help of the Provincial Department of Health and the heads of schools of public and private higher education institutions. The non-probability convenient sampling method was deemed appropriate in this regatrd.

The material study documents for review were also accessed based on the convenience of accessing them. According to Dalglish, Khalid and McMahon (2020:1425), document analysis can generate quantitative and qualitative data components. However, only the quantitative data aspect was used in this study.

3.4.1.1.2 Sample

A sample is a subset of the population from which data was collected (Polit & Beck 2017:250). All eleven lectures teaching ethos and professional practice were recruited in Free State Province's public and private institutions to provide their views and perceptions concerning ethos and professional practice. At the same time, the study material documents from the public institutions were made available for review.

3.4.1.2 Data collection process

Data collection in phase one included interviews with the educators and accessing the documents for review. Principled ethical considerations were upheld to protect participants from any harm before data collection. Once permission was granted, educators were invited to participate by e-mail correspondence to which the information leaflet (Annexure F) and consent form (Annexure G) were attached, clarifying, amongst others, the purpose of the study, the type of data to be collected, that participation is voluntary, and the likelihood of disseminating the findings through publications and conferences. The information leaflet indicated further that the participants provided the micro- and macro-curriculum documents for analysis. A week after the e-mails, telephonic follow-up was made. All eleven educators responsible for the ethos and professional practice showed interest, and eventually participated in the study.

The researcher secured appointments with the participants a week before the date scheduled for the interviews. Accessibility and comfort may determine the location of the interviews (Polit & Beck 2017:514). In that regard, the participants were allowed to select their preferred setting at their campuses. The day before the interview, the researcher called to confirm their availability and travel arrangements as some campuses were about137 km and 415 km away. All COVID-19 preventative protocols were followed on the interview day, and the researcher came with disposable masks and hand sanitisers. The educators' offices were used as venues as these were quiet and spacious to accommodate the required social distancing.

The researcher established rapport by assuming a colleague's role during the uncertain times of COVID-19 and the difficulties of facilitating the students' clinical learning. After the ice-breaking exchanges, the researcher explained the information leaflet's contents, asked for their impression of the research, and asked questions to clarify these activities (Annexure F). Informed consent was sought from the educators (Annexure G). Although the audio-recording and voluntary participation were mentioned with information sent by e-mail, this was emphasised again, and participants gave their verbal consent. The educators provided the researcher with the module guides as the source of the quantitative data discussed below. Once the documents were available, the researcher made copies for viewing later. The researcher then proceeded with collecting the quantitative data as discussed below.

3.4.1.2.1 Quantitative component

The quantitative data was collected from the study material of public institutions of higher education. As the participants were informed by voluntary participation, they only provided copies of module guides. Other materials such as old tests or examination papers, assignments, and the curriculum were not provided. The researcher used the checklist to review the study guides from the public institutions of higher education. The three campuses supplied the study guides for the ethos and professional practice (EPT215/225 and EPP100). The modules were for both theory and practice. The ethos and professional practice (EPT215/225 and EPP100) are studied in the third and fourth-year under the Regulation R.425 programme (SANC 1985). In the third-year module, EPT215 was used, while EPT225 and practical component EPP100 were studied during

the fourth year of study. The module guides were checked for their structure and specific components, which is in concurrence with Dejene's (2018:1) view that self-contained course work constitutes an area of specialisation to build skills and knowledge in discrete units that have the following aspects:

- The exit level outcome demonstrates how the professional with experience in the module should have gained specific knowledge, skills, and attitude.
- The critical cross-field outcomes were also checked as these inform teaching and learning for effective working in a clinical area, e.g. whether teaching and learning strategies may produce learners who can identify and solve problems critically.
- The review checked for comprehensiveness in assisting students in judging the progress of their learning
- The documents were reviewed for the content for nursing ethics to include the moral theories and health law as the ethical and legal framework applicable for nursing practice in South Africa.
- The teaching strategies were reviewed for the acquisition of ethical competence in nursing.

These descriptive accounts of the documents illustrated the *what, how*, and *why* of the ethos and professional practice (EPT215/225 and EPP100). The extent to which nursing ethics was dealt with during these study periods was explicit.

3.4.1.2.2 Qualitative component

The unstructured interviews with eleven participants from public and private higher education institutions were undertaken on a one-to-one basis. The interview's purpose was to explore and describe educators' perspectives regarding nursing ethics content and teaching strategies. And based on the results, suggestions for enhancing nursing ethics were made. Once the rapport was built with the participants, the researcher asked them to relate their perspectives regarding nursing ethics, the choice of nursing ethics content they teach, and the strategies they use for teaching. The following questions were asked to structure and guide the interview:

- Would you please tell me about the views you associate with nursing ethics and interpreting the SANC guidelines for ethics education?

- Would you please tell me how you translated these guidelines into ethics content and strategies for learning and teaching?
- How did you choose these ethics content and strategies for learning and teaching?
- What support do you think is needed in doing this in the future?

Once these questions were memorised (Polit & Beck 2017:515), the researcher utilised one initial question and some of the questions to probe and direct discussions where necessary. The initial question was:

"Would you please tell me about your general views regarding nursing ethics and how you came to choose the content and teaching strategies you employed?"

The closing questions were about their views regarding the need for a future nursing ethics outlook. Although data saturation was reached after interviewing only eight educators, the researcher interviewed eleven of them, as they all wanted to contribute to the study. As a closing instruction, the researcher thanked the participants and asked if it would be possible to contact them should the need arise for further clarification of their responses during the transcription from voice to text. This data collection phase was of two months' duration, and once completed, the second phase commenced.

3.4.2 Phase 2 of data collection

3.4.2.1 Study population

The population in this study were nurses in community service practice and those who have completed, as well as the ethos and professional practice educators. Studying all of them may not be easy, but a target population had to be determined. According to Grove and Gray (2019:229), the target population is all the individuals or elements that fulfil the sampling criteria. The target population for this study was the nurses who were community service practitioners for at least six months or just completed within six months and were placed in Free State Province.

3.4.2.2 Sampling method

Social research mostly occurs where a probability sample with a large scale is impossible (Babbie 2020:192). Accordingly, this study occurred in almost the same circumstances. The possible sample was recruited from the Com-serves placed in the public healthcare service institution in Free State Province. Thus, Free State Department of Health was the employer of most participants. The new graduates and those who have completed Com-serves at twenty-four public hospitals and their Primary Healthcare Clinics in five districts, were recruited for participation in the study. E-mail messages were followed by telephone discussions with the directors of these institutions for the participants to be selected according to their convenience and accessibility. Participants judged to be informative during the survey were purposively included for participation in the unstructured interviews. According to Polit and Beck (2017:254), purposive sampling is sometimes called judgmental sampling, as it uses exceptionally knowledgeable experts as judged by the researcher.

The sampling inclusion criteria are defined in terms of their portrayal of the characteristics of the expected target population's characteristics (Grove & Gray 2019:231). In contrast, exclusion criteria are those characteristics that may cause a prospective participant to be excluded from the study (Grove & Gray 2019:231). The exclusion criteria applied to those participants who did not consent to their involvement in the study. For one to be included, the following were considered:

- Enrolled and passed the four-year Diploma/Degree in nursing and midwifery qualification programme.
- Registered as a community service practitioner for six months or more, or just completed the service for at least one to six months.

3.4.2.2.1 Sample

A sample is a subset of the population from which data was collected (Polit & Beck 2017:250). The new graduate nurses who already completed six months of community service and those who had just completed the community service and are placed in healthcare institutions in Free State Province during 2020-2021 were recruited for both the ethics knowledge survey and individual interviews. Of the 180 Com-serves placed in

public healthcare institutions, 48 were sampled according to the non-probability consecutive sampling for involvement in the study. The low turnout of respondents was attributed to the challenges induced by the COVID-19 pandemic, as the potential respondents were a workforce allocated to the areas designated for patients infected with the COVID-19 virus. From this sample, seventeen were interviewed, and this was the sample for the qualitative component of the study.

3.4.2.3 Data collection process

The study's second data collection phase premised on questionnaires for ethics knowledge and interviews with the Com-serves. After the designated authorities granted the requested permission, participants' recruitment and data collection were initiated to enable data collection to run smoothly within the stipulated time frames. All the municipalities' district health managers were duly informed about the reasons for requesting for such permission, as well as the overall ethical considerations pertaining to the participants (e.g., non-discrimination, privacy, and confidentiality). The chief executive officers of the hospitals and clinics in Free State Province were also asked to grant approval of the study on their respective premises and provide a suitable venue for conducting the interviews. The researcher had to send e-mails to the directors to corroborate the approval. The e-mails were followed by calls to confirm the presence of the Com-serves in the facility. The director was also asked telephonically to distribute the information leaflet, informed consent, and the questionnaires to the Com-serves (Annexure J, Annexure K and Annexure L).

Once the researcher was duly authorised for conducting the study, information was provided to all research participants, including the information leaflet (Annexure J). Amongst others, the leaflet clarified the purpose of the study, the nature/type of data required and *how* it would be collected, voluntariness to participate in the research and the likelihood of disseminating the findings through publications and conferences. The participants had enough time to read the information leaflet and ask questions as the contact details were provided. This gave them time to consult with the researcher and clarify issues before signing the informed consent. The respondents were expected to fill-in the required information and send the completed form back to the researcher. However, only two returned the completed informed consent and questionnaires. After telephonic follow-up with the directors of the sampled institutions, the researcher was requested to

send the hard copies of the informed consent and questionnaires. As such, some were hand-delivered, while some were posted. The researcher and the participants agreed on a timeframe of two weeks to complete the questionnaires.

3.4.2.3.1 Quantitative component

The self-administered questionnaires were distributed, which explored the knowledge of nursing ethics among the Com-serves. Enough time and contact details of the researcher were provided to the respondents to inspire their voluntarily participation and for contacting the researcher in the event that some clarifications were needed. The researcher personally collected the questionnaires, and the interviews with the Com-serves were scheduled on those collection dates.

3.4.2.3.2 Qualitative component

The qualitative aspect of data collection is intended to explore, describe and interpret the perceptions of the newly qualified nurses on community service regarding ethics knowledge and its application in clinical practice. The Com-serves who volunteered to be part of the study were invited for the interviews. The researcher adhered to ethical considerations and requested the participants choose a comfortable and non-intimidating venues conducive to audio-recording while also ending itself to privacy and free expression of feelings. (Grove & Gray 2019:78). Only seven interviews were conducted at the hospital’s unused tea-rooms, and the other ten were conducted at the participants' respective homes.

The researcher asked the participants to discuss their expectations regarding their involvement in the study. These preliminary ‘talks’ (‘ice-breakers’) were used to clarify any misconceptions which the participants could have (Creswell & Creswell 2019:191). Informed consent was obtained before the commencement of the interviews. The researcher first explained the purpose and duration of the interviews (Dhai 2019:65), which ranged from forty-five minutes to an hour. Also discussed was the use of an audio-recorder and confidentiality issues relating to information and institutions where participants were employed, after which the researcher proceeded with the interviews.

Creswell and Creswell (2019:191) recommend that the probing questions and sub-questions should be both friendly and sensitive to the participants. In that regard, the researcher articulated the following questions for the interview, and some were used for probing purposes:

- Would you please tell me about a situation you were confronted with within your practice where you had to use your ethics understanding?
- Tell me what happened and how you responded to that situation.
- Did your ethics training help you to make decisions?
- What support do you think you need now?

As Grove and Gray (2019:78) propose, the researcher did not follow a fixed sequence of questions. Instead, the researcher initially posed the following 'grand tour' question and allowed the participants to respond spontaneously:

"Would you please tell me about any event in which you believed you employed ethics according to your understanding?"

Once the question was asked, participants were provided with adequate time to reflect on their views and actions when applying nursing ethics in their practice. Their answers displayed the features of a story or narrative, whose main plots and subplots (Brinkmann & Kvale 2015:180-181) were significant to the participants. On the whole, the participants addressed their collective experiences in working with other healthcare workers.

The researcher encouraged the participants to share their views using non-communication cues and communication strategies such as nodding, listening, and probing. Grove and Gray (2019:78) indicate that the interviewing process becomes more freely when there are trusting relationships between the researcher and participants with value-laden aspects. This was the case in this study as participants gave immense information. Although some information was repeated, the participants narrated their views for more than an hour; however, they all said the interviews allowed them to debrief. The interviews were conducted until data saturation was reached with the twelfth interview. However, the researcher conducted three more interviews to ensure no new responses were forthcoming. The researcher thanked the participants, downloaded and labelled the recording numerically, and kept them safe.

3.4.2.4 Ethical considerations related to data collection in phase 1 and phase 2

Conducting research calls for ethical considerations to be upheld in order to protect participants from harm, which is an obligation for research integrity. Thus, the quality of the research was ensured through personal and professional integrity. The researcher consistently strived to be aware of personal values and biases that may influence data collection. Besides, the ethical issues were initiated first with the Scientific Review Committee of the University of South Africa (UNISA), which checked the social relevance and methodological appropriateness of the study. This process ensured that the research was addressing an urgent and relevant issue for the local setting, and that the proposed methodology would achieve the intended objectives of the study.

Before data collection, the researcher obtained permission from formal gatekeepers who made it possible for the recruitment of the participants. The following ethical protocols applied in this study:

- Ethical clearance from the University of South Africa (Annexure A).
- Permission letters from the Head of Department, Free State Department of Health, Free State Department of Health, School of Nursing and private institutions (Annexure C, Annexure D and Annexure E).
- The district health managers of all the municipalities were informed. The chief executive officer of the hospitals and clinics in the Free State province also gave verbal permission for the study and the times when the participants were made available for data collection. This enabled data collection to run smoothly within the stipulated time frames.
- The nursing ethics educators received an invitation to participate by e-mail after receiving a signed letter for permission from the Heads of the nursing education institutions.

On the field, the researcher considered the ethical issues concerning sampling and collection of data. The sampling process is prone to errors, especially when trying to gain an accurate picture of a larger population (Babbie 2020:225, 227). Therefore, sampling-related ethical issues were considered. The risk-benefit analysis was very low. Instead, there were observable benefits for participating in the study. Providing limited or average

information and knowledge concerning ethics may come with minor concerns. However, the potential participants could reflect and focus on their nursing ethics learning and developmental endeavours. Engaging and benchmarking one's knowledge is essential for continuous development. Thus, the study has more benefits than harm. Although harm was not anticipated, the researcher adhered to the following ethical considerations:

- Fair selection of participants. According to Dhai (2019:65), an appropriate selection of participants is concerned with acceptable practices informed by the principle of justice in the recruitment, selection, exclusion, and inclusion of participants. By sending the e-mails and following-up telephonically, all the potential participants were afforded equal and fair chances to participate.
- Informed consent is one aspect upheld. Dhai (2019:65) proposes that consent should be a process of information sharing and voluntarism that may be expected to change at any time of the study process. Other aspects, such as comprehension of information and clarification before signing for voluntary participation, were upheld (Dhai 2019:65). Proper disclosure and understanding of the study were followed by the voluntary participation of mentally-competed participants, who were not from vulnerable groups. They were between 18 and 65 years of age. Moreover, their right to self-determination, privacy, and confidentiality were maintained because no names were used; but each participant was allocated a numeric identifier. Participants were informed that withdrawal from the study without fear or prejudice is allowed, and that they may not provide reasons for withdrawal.
- All the participants signed informed consent after they were allocated two to three weeks of reading through the information leaflet and to phone the researcher, her supervisor, or the research ethics committee for any further clarification, or if there were any doubts and inquiries. A signed informed consent signifies that the right to self-determination has been maintained. Thus, the researcher respected the participants as people with rationality to make autonomous decisions (LoBiondo-Wood & Haber 2018:236).
- Right to anonymity and confidentiality. These ethical viewpoints emanate from protecting human rights (LoBiondo-Wood & Haber 2018:236). The right to anonymity relates to an inability of individuals, including the researcher, to link the subjects' identity to the responses (LoBiondo-Wood & Haber 2018:236). The questionnaires could not be anonymous. Instead, they were allocated a code number for identification to maintain confidentiality.

- Protection from harm or discomfort is based on the principle of beneficence. People are expected to take a significant role in promoting research that is anticipated to promote good effects for participants (LoBiondo-Wood & Haber 2018:237). This principle was coupled with justice, as fair treatment of *what* was due was distributed to the participants equally.

Commenting on the ethical challenges of interviews, Patton (2015:495) mentions that interviews evoke the participants' feelings, knowledge, and experience, which affects interviewees as they start to be aware of what they know about themselves. Thus, the process may be transformative. Therefore, interviewers are advised not to judge, but to stay focused on the purpose of the interview (Patton 2015:495). According to Brinkmann and Kvale (2015:37), while conducting interviews, one should reflect on, and acknowledge power relation asymmetry that exists. The researchers are advised to provide a therapeutic dialogue (Brinkmann & Kvale 2015:29). In this study, the interviewees were asked to suggest ways that may seem ideal regarding their situation, and various strategies were identified and discussed.

While personal information is a data source (LoBiondo-Wood & Haber 2018:253), it is also cautioned that interviews may inadvertently become platforms for confessions or revelation of secrets unintentionally (Patton 2015:495). Therefore, acknowledgement of the promise of confidentiality is essential. The participants and their institutions were not identified during the data collection as interviewees were allocated numbers instead of personal information.

3.5 DATA ANALYSIS

Data analysis is a systematic process that entails preparing or organising data for analysis to make inferences (Creswell & Creswell 2018:219). Qualitative and quantitative approaches to data analysis are known to be different. In the quantitative approach, analysis occurs after collecting all the data. Qualitative analysis may begin during or immediately after data collection (Polit & Beck 2017:84). Since convergent design was employed in this study, integration of findings was undertaken for the overall conclusion, explanation, or understanding of the inferences obtained from the qualitative and quantitative inferences (Creswell & Creswell 2018:219). As Creswell and Creswell (2018:219) suggest, a three-phase approach was followed. In phase one, qualitative

analysis was undertaken by coding transcripts from the interviews and collapsing the code into broad themes. Phase two focused on quantitative analysis of statistical results (Creswell & Creswell 2018:219). The third phase is the convergence of the mixed method, during which the various sets of results were integrated and interpreted (Creswell & Creswell 2018:220).

3.5.1 Qualitative data analysis

Data collection and analysis occurred concurrently (Polit & Beck 2017:84). The audio-recorded interviews from the educators and Com-serves were transcribed verbatim by an independent transcriber. However, the researcher read through the transcripts and checked whether every recorded detail had been typed. During the process, the researcher also incorporated the accompanying field notes. Although this was time-consuming for the researcher, it is indicated that this process helps researchers dwell on data as they read and reflect on it. The analysis of interviews for Com-serves and educators was performed separately. While the educators' transcripts followed a thematic analysis process, the Com-serves' transcripts were analysed using interpretative content analysis.

3.5.1.1 Analysis of educators' transcripts

The educators' transcripts were analysed in answering the research questions, and themes were identified. Analysing data aims to gain meaning from the enormous interview transcripts by structuring and organising them for interpretation (Polit & Beck 2017:549). The researcher then organised the data into segments or categories, and these were preceded by questions such as: what this is, what does it stand for, what else is like this, as advised by Polit and Beck (2017:531).

Thematic data analysis was employed, which is the process of identifying categories emerging from data (Creswell 2014:186). According to Polit and Beck (2017:535), a theme encapsulates the experience into a meaning, and thematic analysis involves looking for units of information with similar content and finding out how content differs from other content, thus identifying the distinctiveness of the emerging themes. The researcher followed Tesch's eight coding steps as described by Creswell (2014:198).

The transcriptions were read, and open coding was used, in which conclusive phrases were used as codes Creswell (2014:197). In this study, the researcher used the actual words and phrases of the participants to code data, as described by Streubert and Carpenter (2011:158). The coding process includes aggregating text into small categories called codes, seeking evidence from different databases, and assigning a label (Creswell 2014:180). According to Charmaz (2006:61), this type of coding identifies a category's properties and features and builds uniformity and consistency of relationships based on the connection of a category. The researcher reviewed all the transcripts, and the codes that have been developed were compared constantly. As Creswell (2014:193) commends, short phrases of the participants' statements were grouped into larger units of information called themes or categories. There was also a constant comparison with other transcripts to ensure consistency, which assisted in identifying negative cases, as advised by Charmaz (2008:164). This process was central to the decision regarding codes allocated to theoretical categories (Charmaz 2008:164).

All coded phrases and words were read through to identify and cross out duplicates, which were grouped into themes. To generate assumptions about how concepts are related, the researcher continually asked questions about the data and captured the thoughts about the emerging ideas. Streubert and Carpenter (2011:134) refer to this capturing of thoughts as 'memo-ing', which helps researchers to discover the main themes.

An independent co-coder and the researchers independently performed the analysis to ensure consistency in coding. The co-coder held a meeting and discussed the coding process until an agreement was reached regarding the identified categories. Finally, the code, themes, and links were made relevant to the research question, and these were also abstracted to a more significant meaning in interpreting data. This process organised categories into larger units of abstraction called themes.

3.5.1.2 Analysis of Com-serve transcripts

In responding to the research question above, the com-serves gave narratives of their experiences, and these were audio-recorded and transcribed into text interviews. Interpretive content analysis was applied to analyse the transcripts from the interviews conducted with the Com-serves. The analysis of data involves clarifying the essence of

the phenomenon and then capturing and synthesising the meaning of experiences without distorting or losing the quality of the data (Streubert & Carpenter 2011:89). The reading of the transcripts was repeated several times in order to obtain and identify the essential features of the content. According to Lindh, Severinsson and Berg (2008:139), the interpretive content analysis focuses on the deep and hidden message the text is conveying, and is characterised by moving back and forth between the whole and the parts of the text. One of the interpretative elements is to transform people's experiences into intelligible language (Streubert & Carpenter 2011:89). However, there must be fit to the truth claims embedded in the text or discursive strategies employed (Bergman 2010:386). The researcher used the independent co-coder and had discussions regarding the reasonable abstractions that seem congruent for summarising the perspectives.

3.5.2 Quantitative data analysis

Quantitative analysis is expressed by manipulating data using the statistical procedure to describe a phenomenon or assess the magnitude numerically (Polit & Beck 2017:741). In this study, two sets of quantitative data were analysed. The descriptive statistics facilitated the researcher to summarise and describe data obtained from the documents review and questionnaires for ethics knowledge. Descriptive statistics analysis is defined as a means of organising and representing data by numbers using means, frequencies, and percentages in tabular or graphic forms to allow observation (LoBiondo-Wood & Haber 2018:285; Polit & Beck 2017:741).

Thus, nominal, ordinal, and interval levels of measurement were used in which frequencies and percentages were used to organise numeric data (Polit & Beck 2017:358). Through the assistance of a statistician, questionnaires were captured using the Microsoft Excel spreadsheet to generate statistical strategies that were applied to describe and make the findings more meaningful. The guidelines with specifications were also entered into an excel spreadsheet to calculate descriptive statistics. There were also open-ended questions within the questionnaires. Therefore, the common themes and their frequencies were identified and compared with some of the findings using comparative analysis of open-ended and closed-ended results. According to Friborg and Rosenvinge (2013:1398), embedding open-ended within closed-ended results is beneficial as this brings the descriptive analysis to a natural conversation full of detail and

clarification. In this study, embedded analysis was performed when the participants claimed knowledge of the ethical and legal system governing nursing and health care. The results of the embedded analysis were meant to remove the expectation bias that may influence the results (Creswell 2015:83).

3.5.2.1 Convergence phase

Convergence aims to integrate the qualitative findings and quantitative results for corroboration and complementarity purposes. Nursing ethics is a complex phenomenon in this study, and multiple data sources were used. The purpose of integration was to gain a good account of what was being researched (Creswell & Creswell 2018: 219). it is stated that qualitative and quantitative data may be integrated differently. Creswell (2015:83) alludes that merging may be undertaken during the data collection, analysis, or results section. As the study design is convergent, the integration occurred at different levels during the research process and when the qualitative and quantitative data results were merged and compared.

The aspect of integration in this study is discussed in more detail in Chapter 6 of this study. Creswell and Creswell (2018:219-220) mention that the results in convergent designs may be discussed in a side-by-side approach, starting first with the qualitative and then quantitative to develop the meta-inferences. These results are compared to yield convergence, divergence, or interpretation, which may necessitate follow-up actions (Creswell & Creswell 2018:221). The meta-inferences, as evident by the results, are linked with literature for normative analysis intended to develop the framework to enhance ethics.

3.5.2.2 Framework development through normative analysis

The normative analysis in this study is intended to determine and persuade the development of a framework for enhancing ethics based on set norms and values of nursing practices, as well as the empirical evidence from the results of this study. Various ethical frameworks pertinent to nursing, general discourses in ethics, and philosophical commitments of nursing practice are to be used in this study for their explanatory power. According to Von der Pfordten (2012:450), the normative analysis aims to criticise and justify primary normative orders such as morals, law, politics, and resolutions, as well as

produce some normativity while situating these norms within the descriptive evidence about the world. In planning to improve nursing ethics, the first step is to provide normatively assessed and reasoned arguments and the conclusions thereof were used as prescriptive statements for enhancing nursing ethics.

3.6 TRUSTWORTHINESS AND RIGOUR OF THE STUDY

The scientific rigour in this study is indicative of for the pursuit of excellence, accuracy, and precision in research. Rigour is about measuring tools and the merits of evidence (Grove & Gray 2019:34). In quantitative studies, the scientific value is assessed by reliability and validity criteria, in which the selection of concepts within the instruments is measured for soundness (LoBiondo-Wood & Haber 2018:263). At the same time, trustworthiness is an approach to ensure rigour in qualitative research.

3.6.1 Validity and reliability

Reliability is reflective of the ability of a research tool to measure the variables consistently, while validity is the extent to which the instrument accurately measures the concept's attributes (LoBiondo-Wood & Haber 2018:263). The questionnaire was piloted using three registered nurses who completed community service and did not fulfil the inclusion criteria for participation in the study. The self-administration questionnaire gave desired results. Thus, this confirmed that the questionnaire successfully measured what it intended. Although some items within the questionnaire may be guessed or discussed with others as it was a self-administered questionnaire, the researcher used a multiple-item scale that collates with other items to ensure internal consistency and reliability (Polit & Beck 2017:267). In this study, the questionnaire was modified from previous questionnaires to fit the context of South Africa. Given that the instrument is not new but adapted, the consistency or repeatability was deemed reliable.

Furthermore, some items within the questionnaire were asked more than once using open and closed-ended questions with indirect wordings to validate each other. Using open-ended questions within questionnaires, the researcher wanted to ensure inter-rater reliability, which Barnett, Minto, Lander and Hardy (2014:667) define as the consistency or agreement in scores obtained from two or more raters. Accordingly, Kottner, Audigé, Brorson, Donner, Gajewski, Hróbjartsson, Roberts, Shoukri, and Streiner (2011:668)

indicate that the vital aspect of inter-rater reliability is to estimate the error in the scoring of items and classification of procedure

In ensuring construct validity, Grove and Gray (2019:266) indicate that the instrument measured what it intends to measure, and therefore the results are sound and unbiased. Through a broad literature review, the researcher used questionnaires from other authors in the public domain to develop the instrument for this study, which increased the validity. The questionnaire was piloted on nurses who completed Com-serve to check correct context modification. Lastly, the researcher teaches nursing ethics and has bioethics qualifications for checking that constructed items relate to ethics and morality content.

3.6.2 Trustworthiness

Although qualitative approaches ensure trustworthiness through credibility, transferability, dependability, and conformability, it is argued that these are parallel to interval validity external validity (Patton 2015:685). Patton (2015:685) alludes that credibility is similar to internal validity, while transferability is equivalent to external validity. Similarly, dependability is related to reliability and conformability to the objectivity of data and interpretations (Patton 2015:685).

3.6.2.1 Credibility

Credibility establishes the truth of the findings as viewed through the eyes of those observed/interviewed in the research context. This criterion also questions the researcher's confidence in the truth about the state of nursing ethics in South Africa based on the research design, informants, and context (Lincoln & Guba 1985:290). In this study, there was prolonged engagement with the participants to establish rapport and build the trust necessary to uncover what was going on; therefore, overcoming misinformation, distortion, or presented fronts (Patton 2015:495; LoBiondo-Wood & Haber 2018:253). According to Patton (2015:495), building trust pledges that confidentiality is respected and there are no hidden agendas. Therefore, the interests of the participants and their institutions and input will be honoured during the inquiry and dissemination of results.

3.6.2.2 Transferability

Transferability implies the degree to which findings of this study may apply to other subjects in another context. Although qualitative research aims to understand the experiences of those involved and not generalise to the larger population, the researcher believes the findings may be generalised. Especially for this study, the extracts of participants provided context and circumstances in which one may learn about the phenomenon, which may be familiar to a larger population.

3.6.2.3 Dependability

Dependability is concerned the consistency of the findings in the event of the inquiry being replicated in a similar context, but with different participants. To ensure dependability, the researcher explained the data collection methods, analysis, and interpretation of findings and results thoroughly in order to enable the study to be repeated in a coherent and logical manner.

3.6.2.4 Conformability

Conformability refers to the assurances that data support findings, conclusions, and recommendations. First, the researcher bracketed ideas about ethics during data collection and analysis to prevent imposing on the client and his/her autonomously stated views or perceptions. Creswell and Creswell (2018:221) attest that validity in mixed methods should be based on establishing both construct validity and triangulation. Triangulation is premised on conclusions regarding the nature of truth as drawn from multiple referents (Polit & Beck 2017:563).

Validity was ensured by using various data sources such as questionnaires and individual interviews with different levels (Com-serves and educators), and documents to converge and corroborate the results. An independent transcriber was engaged, and the researcher checked the transcripts against the audio recordings. During data analysis, a co-coder, an external auditor experienced in qualitative research, was also engaged (Creswell & Creswell 2018:201). Accordingly, the data supported the findings, conclusions, and recommendations as there was an agreement between the researcher's interpretations and the actual evidence. Creswell and Creswell (2018:200) and Patton (1999:1206)

suggest that researchers are concerned with accuracy, fairness, and validity by requesting the participants to respond to their data. In this study, the audio recordings were played back for the respondents to verify and clarify their responses and confirm whether it was a true reflection of their views. Bracketing was essential in this study for the purpose of allowing the participants to express their reality in its entirety as the researcher is familiar with the phenomenon.

Reflexivity was also used, emphasising the importance of deep introspection regarding the influence of the researcher's background, perception, and interest in the research process, as Patton (2015:70) propounds. In this study, the researcher used personal notes to reflect on their own feelings, which had little or no influence on the results.

3.7 SUMMARY

This chapter presented the research design and methodology in terms of which the convergent parallel mixed methods were employed in this study. These methods were congruent with the philosophical foundation of the study. The discussion regarding the sample includes the context of this research.

The data collection and analysis phases were presented and discussed in conjunction with the applicable ethical issues in the context of the various categories of participants involved in the empirical data collection phases of the study. The measures to ensure trustworthiness (validity and reliability) were examined in order to allocate the expected modicum of scientific integrity and methodological rigour. The following chapter then presents the qualitative findings and discussion thereof.

CHAPTER 4

ANALYSIS AND PRESENTATION OF QUALITATIVE FINDINGS

4.1 INTRODUCTION

The previous chapter presented the methodology which is employed in this study. In this current Chapter 4, the researcher shares the findings from the qualitative phase of the study. Presentation of the findings is on themes and extracts. The findings emanate from the researcher's perceptions regarding ethics content and strategies for ethics education. Perception of Com-serves regarding ethics knowledge and its application in the clinical area are discussed, and findings from both sources are substantiated with literature.

4.2 DATA MANAGEMENT AND ANALYSIS

Interviews from the educators and the Com-serves were converted from audio recordings to transcripts. The transcripts were re-identified into numbers, in compliance with confidentiality. The place, date and time were also written to track the documents. The data was fractured into codes or concepts and grouped into categories. As Cohen et al (2018:643) attest, analysis entails organising and managing data and noting themes, sub-themes, categories, and sub-categories as deductions regarding the research question. The researcher's discussions commenced with the educators' responses, followed by the Com-serves' findings.

4.3 PRESENTATION OF FINDINGS

In presenting the findings, the demographic data is given quantitatively to summarise the sample's characteristics and facilitate an understanding of the participants' profiles. Themes and sub-themes are presented and supported by narratives from the participants.

4.3.1 Demographic characteristics

The sample for the study consisted of eleven educators teaching nursing ethics in institutions of higher education in Free State. From the (N=11, 100%) educators, (n=9, 82%) participants were from public education institutions, while (n=2, 18%) were from private nursing education institutions accredited with the SANC. Following is the demographic information as reflected in Table 4.1.

Table 4.1: Demographic information of participants (N=11)

Demographic Information		Respondents (N=11)
Age	34-45 years	3
	46-55 years	3
	56-65	5
Total		**11**
Gender	Male	0
	Female	11
Total		**11**
Qualification	Post-basic diploma	0
	BCur (Nursing Science)	3
	Master's degree	8
	Doctoral Degree	0
Total		**11**
Experience in teaching ethics	Less than one year	1
	1-2 years	1
	3-4 years	3
	Five years and more	6
Total		**11**

As illustrated in Table 4.1, the participants' educational qualifications ranged between BCur (Nursing Science) degree and a Master's degree in nursing. The above table depicts that the majority of (n=6, 55%) participants had more than five (5) years of experience teaching nursing ethics, followed by (n=3, 27%) who were between 3-4 years as well as (n=1, 9%) less than a year as well as another (n=1, 9%) between 1-2 years of experience.

4.3.2 Thematic responses from educators

Based on the research objectives, six themes emerged from the coding process: meaning of nursing ethics, viewpoints on SANC guidelines, ethics content in the curriculum, strategies for teaching nursing ethics, the effectiveness of ethics education, and

recommendations for enhancing nursing ethics. The theme and their evolving sub-themes are reflected in Table 4.2 overleaf. The researcher employed P1, P2, P3, etc., to present the various participants' responses.

Table 4.2: Themes and sub-themes

Themes	Sub-themes
1 Meaning of nursing ethics	1.1 Belief system 1.2 Humanistic way of caring 1.3 Application of ethics principles 1.4 Professionalism
2 Viewpoints on SANC guidelines	2.1 Clear guidelines 2.2 Misinterpretation of guidelines
3 Ethics content in the curriculum	3.1 Third-year content 3.2 Fourth-year content 3.3 Viewpoints regarding content
4 Strategies for teaching nursing ethics	4.1 Teaching methods used 4.2 Experiences of ethics teaching methods
5 Effectiveness of ethics education	5.1 Opinions regarding the character of students 5.2 The behaviour of students
6 Recommendations for enhancing nursing ethics	6.1 Recommendations to SANC 6.2 Recommendations for nursing ethics education 6.3 Recommendations for ethical practice

4.3.2.1 Theme 1: Meaning of nursing ethics

The meaning of nursing ethics is one of the emerging themes. Participants expressed the meaning of ethics by referring to a belief system, humanistic way of caring, application of principles, and professionalism.

4.3.2.1.1 Sub-theme 1.1: Belief systems

Embedded within the meaning of nursing ethics, the participants described the belief systems or worldviews as one way of understanding nursing ethics. This occurrence demonstrates the importance of these concepts in defining and conceptualising nursing ethics. Nursing ethics within the realm of belief system was stated by participants as reflected below:

> "In my view, ethics is what one believes in, and often what one believes comes from how you were brought up and how people view the world around you. We often measure ethics against the correct way of doing things, such as not harming people or stuff like that." [P1]

> "Ethics are the basis together with the science of nursing that allows a person to have art in nursing, and the important thing is to do no harm just because you are a scientist. And harm is not what I think is harm, and harm is what the patient thinks is harm." [P5]

> "Ethics in nursing is about my belief and philosophy, where I am coming from, and my worldview. What it is that I want regarding caring for a sick person? I want to promote health and give care to other people. I like this ill person to enjoy life and all those things." [P6]

> The right way, you were brought up to take care of other people every day. Also, to respect them in their views." [P7]

The participants asserted that one's belief system might comprise science, culture and religious values. The participants integrated some belief systems with the notion of caring. Based on the literature by Dhai and McQuoid-Mason (2011:5), a belief system is complex because it represents different worldviews that embodies values for an individual or a group. Understanding worldviews is necessary for value clarification and negotiation with others' views (Dhai & McQuoid-Mason 2011:6).

4.3.2.1.2 Sub-theme 1.2: Humanistic way of caring

Some participants referred to a humanistic way of caring regarding the meaning of nursing ethics. The humanistic methods of caring were uncounted five times, whereas some participants reflected on concepts such as being there or being available for the client. Nursing ethics as a humanistic way of caring was perceived as follows:

> "Dealing with patients and their relatives in a humanistic manner. Treating people with respect is all about humanity (Ubuntu). Ethics is about taking people as people)." [P8].

> "Is about being there, be available for the client, be honest and be there for the patient." [P4]

The above responses reflect that patients and clients deserve respect for human dignity. According to (Pellegrino 2008:358), nursing presence in the moments of illness is equivalent to acknowledgement of the dignity of the other. Such presence may not be seen as a puzzle to solve or fix a problem but is always considered critical in enhancing dignity (Pellegrino 2008:358). Hodges (1955:312) corroborates that the phrase such as being there for the other person or taking people as people are the same as acknowledging that they have dignity. According to Milton (2008:208), dignity is an unconditional acknowledgement of distinctiveness, regard, and affirmation of the inherent worth of humankind that coexists with potential disregard for humankind

According to Pellegrino (2008:356), human dignity is an indefinable phenomenon of human life that is taken for granted but becomes noteworthy only when threatened, demeaned, or wrenched forcibly from us. Only when dignity is threatened do humans apprehend its inseparability from our humanity.

4.3.2.1.3 Sub-theme 1.3: Application of ethics principles

The majority of (n=5, 45%) participants mentioned the principle of not harming people (beneficence and non-maleficence), while (n=3, 27%) participants alleged respecting humans.

> "Nursing ethics is a collection of principles that assist nurses in dealing with patients' work, even in public." [P9]

> "The foundation of behaviour is the correct application of principles applicable in a particular field, whether in nursing or any other profession. Nursing ethics is about developing our neophytes and ensuring that those who are professionals behave in a normative manner to nursing." [P3]

The excerpts illustrate that participants view ethics as guidelines that specify what should happen in the nursing's and midwifery's practice as contained in the Nursing Act (Act No. 33 of 2005) (South Africa 2005). However, Shatz (1996:75) suggests that compliance to

a set of rules as specified in codes of ethics is an insufficient condition of ethical uprightness. Such an approach guides one to behave according to moral ideals (Shatz 1996:75). Although these ideals are reasonable, conflict arises when the codes are not explicit and precise to what should be done (Shatz 1996:75).

4.3.2.1.4 Sub-theme 1.4: Professionalism

Other participants equate nursing ethics with professionalism, emphasising acquiring qualities and realising the norms and expectations of the nursing profession.

> "Ethics in nursing I'd match it with professionalism because when children enter this profession, they move from being a layperson to becoming a professional. And as a professional, there are some behaviours attached to a person we call a professional. So, we want to see professionalism in a person, so ethics is the way a person should conduct themselves in a profession." [P11].

The extract above concurs with Muller's (2009:7) understanding of professionalism. According to Muller (2009:7), professionalism is about the novices being socialised professionally to become experts who will assimilate and later grasp the values and norms of their own's profession. Accountability, leadership, competencies, self-regulation, commitment to excellence, social values, self-directedness, duty, honour, integrity, respect for others, and compassion and empathy are attributes (Muller 2009:7). These qualities are to be taught and learned as the basis for those entering the profession, as one participant highlighted as follows:

> "Nursing ethics is a science that deals with the morals, conduct and attitudes of personnel within the institution according to the constitution. With ethics, we are dealing with human beings, like patients, so we need to respect the patients. In a nutshell, ethics is how personnel conduct themselves in their function." [P10]

Seeing ethics in terms of professionalising the individuals and conforming to guidelines and codes of ethics according to SANC regulations stems from the Nursing Act (Act No. 33 of 2005). As (n=1, 9%) of the participants mention the constitution from which the Acts translate. Although the participants seem to rely on the concept of professionalism, Black (2020:59) indicates that this approach is not without challenges. On the other hand, Shatz

(1996:75) alludes to the need for another source of moral propriety, Black (2020:69) suggests that the continuing interrogations for proving that nursing is a profession distracts and obscures advances in nursing ethics. Concurring, Woolf, Grol, Hutchinson, Eccles and Grimshawl (1999:529) indicate that some guidelines may be misinterpreted, compromising the quality of care.

4.3.2.2 Theme 2: Viewpoints on South African Nursing Council [SANC] guidelines

Almost all the educators had views regarding translating the SANC guidelines into nursing ethics content and the strategies for teaching. The participants shared some viewpoints that were grouped into two sub-themes.

4.3.2.2.1 Sub-theme 2.1: Clear guidelines

The majority of participants indicated that SANC directives are essential and correlate with nursing education and practice, and some considered them congruent with the module guide. Clear guidelines offer concise instructions on handling situations and have an explicit endorsement in guiding practitioners to areas of uncertainty (Woolf et al 1999:525). As such, (n=1, 9%) participant considered the guidelines as offering guidance that is required, as reflected below:

> "SANC guidelines are about what I think ethics is all about … So far, I don't feel there is a contrast between those approaches." [P8]

Similarly, the majority of participants indicated that the module guide, as the learning tool, relates well with what the directive from SANC suggests. Participants demonstrate this by giving an example of how this relationship plays out in education and practice:

> "What we are teaching correlates with the guidelines. For example, when doing the procedure, you should introduce yourself & ask the patient for their consent. So that will be in theory and practice." [P10]

> "The module goes hand-in-hand with the SANC guidelines because we have regulations of the council that guide this profession." [P2]

> "I think I see guidelines to be good, to be precise because the very ethics of SANC are the ones that groomed us as nurses, so I see them as good ethics to groom this generation of nurses even though there are some challenges." [P9]

> "They are the starting point, the basis from which all nurses start, and then from which you decide how you are going to apply profession or how you are going to do your job and how you are going to make peace with the things you are not going to agree with." [P5]

The excerpts show that the majority of participants judged the guidelines to be good, as they groomed the educators during their nursing training. According to Graham and Harrison (2005:68), guidelines need to be rigorously developed and adopted for local use because they may lead to ineffective interventions if validity is questionable.

4.3.2.2.2 Sub-theme 2.2: Misinterpretation of guidelines

The participants use the guidelines for the educational activities of their students. However, the majority view policies as too broad and likely to be misinterpreted or limited in scope for practical issues pertinent to nursing ethics.

> "We usually get the regulations, but they aren't always explained, and people may interpret them differently. I think we need more clarification and more training on rules." [P4]

Thus, getting the wrong impression about these guidelines may negatively impact the acquisition of ethics' competence.

> "The guidelines are very broad. And they may often be misinterpreted because it depends on how you were brought up & how you will interpret the guidelines. So, how one perceives ethics may conflict with guidelines." [P1]

Most participants indicated that although the call to develop ethical nurses is audible, the guidelines for executing this are challenging. The participants illustrated in diverse ways how they were being challenged.

> "Challenges in the sense that nurses today believe that those guidelines are a little bit rigid, they are not flexible. They do not match their lives today." [P11]

> "They are not necessarily suitable as they have limited ethics and they may have disagreements with how you do things." [P7]

> "But some things are not included in these guidelines and regulations, which I think are essential and best for our patients." [P6]

The participants' responses explicitly demonstrate how educators are committed to developing the ethical competencies of their students, but they are challenged by broad, rigid, and unexplained guidelines. Furthermore, some participants were concerned that guidelines have limited ethics and do not include essential issues about patients' care. This view is congruent with Song's (2018:14) findings that guidelines were not a sufficient framework for teaching nursing ethics. The study participants viewed the guidelines as ambiguous to the current lifestyle. This view was also related to Song's (2018:14) findings, in which the universality of ethical principles was problematic because cultural factors affect how one understands the principles. The participants pointed to the responsibility of SANC in clarifying these misinterpretations thus:

> "I think SANC could come to us because we treat different people from different backgrounds in various institutions. In that case, SANC must get our views regarding the community we are treating." [P6]

Concurring with the participants' responses, Song (2018:14) indicates that inclusion of culture based safe nursing practices in ethics education should be encouraged. Therefore, the participants suggest a need for engagement with the SANC regarding nursing ethics directives.

4.3.2.3 Theme 3: Ethics content in the curriculum

In this study, participants shared what they were teaching in their programmes' third and fourth years and their views on nursing ethics. The participants indicated that content is spread from the third to the programme's fourth year.

4.3.2.3.1 Sub-theme 3.1: Third-year content

The participants make evident that in the third year, the course runs for six months, and in the fourth year, ethos and professional practice is offered in two semesters, and it is at this point that the course is coupled with a practical component. This is what they said about the content:

> "I taught them things like the history of nursing, Florence Nightingale's pledge, how a nurse should be like, characteristics of a nurse, responsibility of a nurse towards self, employer, patient and community." [P9]
>
> "We are teaching students advocacy responsibility and accountability, the scope of practice they have to follow when executing their duties in the wards. They also have critical decision making." The third-year content includes the history of nursing, the importance of professional organisations, the principles of professional practice-duty to take care." [P2]
>
> "We teach about the evolution of nursing; where does nursing come from & where is nursing now. Then they must understand nursing from that perspective. After understanding the evolution, the changes that happen in nursing are coming from, and then we teach the professional practice. We teach them that these are the expectations as a nurse, your obligation, and responsibilities in nursing. These are the duties as a nurse." [P6]

The participants' statements illustrate that the evolution of nursing is one aspect of socialising the neophytes into the profession, as some participants averred their views based on the meaning of ethics.

4.3.2.3.2 Sub-theme 3.2: Fourth-year content

The content designated for the fourth year of study entails professional practice as indicated by the participants. Following are the views of the participants in this study, about the four-year content:

> “In the fourth year, they do a lot of labour-related issues and there are some things on policy development and philosophy of the unit, and all these apply to management and leadership.” [P3]

> “The content is quite broad, the amount of stuff that we are looking at such as the mission, vision, and values of our company. All these management and leadership are part of the practice or the practical work.” [P1]

> “Content includes fundamentals of nursing management, formulation of policies, activities of the manager, planning by use of policies and procedures, organisation of staff, the supply and equipment, the nursing care using different methods, applying control as a manager, staff development, directing care through allocating subordinates and control as a manager.” [P2]

The findings indicate that participants were aware of a wide range of content that may pose a problem, and (n=1, 9%) participant mentioned the following:

> However, the relationship is not very obvious from the onset, but as you get used to them and internalise them, you see the connection. Once you have internalised the content, you will realise that the regulations and scope of practice go hand in hand with the patients' rights or Batho Pele.” [P8]

Given the vast range of professional practice content, Poitras et al (2016:12) suggest that this poses a significant barrier to developing an all-embracing description of what constitutes professional practice in nursing. The participants in this study also raised their views regarding this content.

4.3.2.3.3 Sub-theme 3.3: Viewpoints regarding content

The participants raised different views regarding nursing ethics content. Only (n=1, 9%) participant indicated that the content was alright and adequate, and the majority (n=10, 81%) of participants were concerned about the outcome, given that there was no progression in modern times. The participants raised their concerns as follows:

> “The content is quite broad, the amount of stuff that we are looking at, it's still according to what the law says. I think it's still much of what we believe, and we are afraid to get out of our comfort zone.” [P1]

> “But labour and labour-related issues are not that important for me, but so many hours are put into this.” [P3]

> “They are introduced to professional associations and trade unions. As the years go forward, more politics collide with our ethics. There is a tug of war between politics & us as nurses.” What was taught 20 years ago is still being taught now, irrespective of what was happening in the country. For instance, the history of nursing in the module is not our history or what is happening now, yes, it is relatable, but it has nothing to do with nursing ethics today.” [P11]

Although the majority of the participants were having some disquiets regarding the content, only (n=1, 9%) of them mentioned a different point of concern, saying:

> “There is nothing wrong with the content, but the students' interpretation is wrong. I feel more emphasis is needed for them. I don't know how this can be instilled in them, but there is nothing wrong with the content the way I see it because it teaches them exactly what is happening in the wards.” [P2]

While this participant was disputing the ethics content challenges, others identified ethics-specific content limitations in the programme’s fourth year.

> “There is no specific module on ethics in the fourth-year curriculum. There is nothing about ethical principles. It lacks on ethics.” A lot has changed in nursing because of technology, and our communities are also more enlightened and know many things. However, the SANC guidelines still direct us to teach the old curriculum that does not refer to new things in the clinical area. [P6].

This participant further illustrated that ethics is absent in the fourth year even though the module is concerned with the ethos and professional practice.

> “In the second semester, they do research, disaster management, grievances, staff development, directing the nursing care, and applying control as a manager. Clinical education and staff development, teaching, and orientating new staff.

> Performance appraisals, induction, and in-service training and keep. the second semester includes research, disaster grievances, discipline, conflict management, and trade unions." [P6]

> "Maybe we should include more about ethics in the teaching aspect of the programme because I don't see it a lot in the fourth-year curriculum." [P4]

> "There is limited nursing ethics in South Africa as there are no books about developing nurses as ethical agents. Books like the one written by Mellish are old and have no information. There is nothing about how to develop them to be ethical. So how do you go about it? How do we go about it because there are no books about ABC? Then how do we develop ethical competence using principles of nurses only?" "We don't know where some information in ethos books is coming from, as we don't have a reference where they come from and why. Sometimes, if students ask us as educators, we will find that we don't know where we got it, even if this information may be helpful for the patient." [P7]

> "You have to try and develop in them a feeling of responsibility towards ethics, even though they might not do it as you would like them to." [P5]

Only (n=1, 9%) participant considered the content appropriate for ethics, while the majority of (n=10, 81%) participants were concerned about content limitations. Therefore, participants call for re-evaluating directives from SANC, which should be clear and clarified to avoid misconceptions.

4.3.2.4 Theme 4: Strategies for teaching nursing ethics

The participants reported various teaching strategies; however, there were also some concerns regarding their effectiveness. The sub-themes from this theme include the teaching methods employed and the lecturer's experiences regarding ethical teaching methods.

4.3.2.4.1 Sub-theme 4.1: Teaching methods used

The participants in this study employed various ways of teaching ethics. While all the participants used formal lectures, presentations, and discussions, some used other

strategies to encourage students to assimilate into the nursing profession. The educators mentioned teaching methods like these:

> "I do a lecture, problem-solving, discussion groups, and case studies because there is content where we need to solve problems. Assessments are through classwork, oral and formal assessment through predicate tests and exams". [P6]

Some participants recounted the other method they used as follows:

> "Some students also have prior learning experiences, and they use these experiences and are pretty open to discussions." [P1]

> "I would use the pictures of Florence Nightingale, in which I point out how a nurse should look. Other strategies would be role-playing on how nurses should behave." [P9]

> "One of the components is to provide them with a topic which they should present to the type of visual learners or audio learners we are dealing with." [P1]

> "I like reflection because if you teach something practical, you need to be realistic. I teach them using case studies, an incident for abortion and informed consent to allow students to learn how to apply rules, ethics, and policies of the institution in a case." [P5]

4.3.2.4.2 Sub-theme 4.2: Experiences of ethics teaching methods

The participants were aware of the association between nursing ethics and strategies for teaching. Although they appreciated the efforts they were making, they were mindful of the shortcoming, which included:

> "You can teach someone the theory, but it isn't everyone that can handle a situation correctly. Again, we also don't have strong role models; the students are being taught the right things in the college." [P4]

> "We don't have preceptors, so there's no progression because there is a problem with accompaniment." [P11]

> “Having to teach teens who are individualistic and materialistic is uncomfortable; they're more materialistic; what can I get from this world, and how can I benefit from it as a person. Students cannot leap to integrate theory and practice.” [P5]

> “Professionalism is not about what one can be taught, as you cannot force on anyone. Professionalism must also come from within, so the person must be compatible with professionalism.” [P6]

The participants conveyed that the challenges in nursing ethics education emanated from other areas, such as the clinical facilities and the inability of the individual students to develop. However, (n=2, 33%) of the participants shared a reflective thought regarding problems relating to educators themselves:

> “When things become uncomfortable, often the discussion becomes dead because you are now not comfortable with what is being discussed. I think it's still a lot of what we believe, and we are afraid to get out of our comfort zone.” [P1]

> I believe that people should specialise in what they do and are interested in, like nursing ethics, but people are being shifted around because it is a belief that we are so comfortable if we are placed in one area for a long time. The management should look into this because it disadvantages our students if people cannot specialise and do what they like most. This shifting is disadvantaging the development of our students, and people should be allowed to develop their subjects instead; there is too much moving of people from one area to another, and people end up not specialising in what they like.” [P3]

These statements by the participants emphasise that there must be criteria for assigning people to teach nursing ethics. While showing interest is a motive, specialising in ethics will likely help students.

4.3.2.5 Theme 5: Effectiveness of ethics education

The participants were also concerned about the effectiveness of their courses, given the current frameworks of ethics education. In this study, educators raised a list of issues regarding the impact of education in ethics. Grady et al (2008:4) support this notion by indicating that many factors need to be explored pertinent to the impact of ethics

education. According to Grady et al (2008:4), the trainees' confidence, relationship between education's ethics and ethics' resources training, as well as their moral actions are some factors that may judge the impact. Gordijn and Have (2013:1-2) believe that trainees may exhibit ethical behaviour if ethics knowledge is adequate. Koo, Ryu and Kim (2018:2903) affirm that good ethics education helps students develop an ability to perceive ethical situations and a sense of call for moral conduct and ethical decision-making.

4.3.2.5.1 Sub-theme 5.1: Opinions regarding the character of students

Almost all the participants realised a gap between theory and practice. The participants ascribe the widening gap to the persona of students coming to nursing. The participants in this study conveyed views regarding their students:

> "I think educators have done a lot to influence them to behave ethically in the classroom, but now when they go to the clinical area, they don't behave as they have been taught. During class, it will be like they hear you what you are teaching, but in the clinical area, it's something different". [P9]

> "They're more materialistic; what can I get from this world, and how can I benefit from it as a person, not as a nurse? This means Money plays a more significant role in caring for human beings." [P5]

The quotes above illustrate that the educators believed their responsibility was accomplished as expected; however, it was up to the students to do something about their ethical appropriateness. Some of the participants blamed the changing time and said:

> "What I have realised is that they don't change. Today's nurses don't take nursing seriously. … the olden days … nursing was a calling. So, I think this should be within them before they come to nursing so that you can take it seriously." [P2]

> "They don't have a responsibility towards the profession. I think what they learn from books is limited and what they see and meet within the practice is challenging them." [P6]

> "When they are being taught, these children will be telling you that this is the old-fashioned things and so on." [P10]

The extracts expound on educators' concerns regarding their effort to help students become ethical. The majority of educators view their students as self-centred generation with limited responsibility. According to Gülcan (2015:2623), ethics education aims at improving humankind by stimulating the students' intellectual abilities, given a wide range of moral prerogatives, including personal ethics, life experiences, and institutional norms. So, the question is whether the educators' efforts align with the expectations of the students. However, do the participants' views in this study concur with Smith and Knudson (2016: 911), that there is a gap in practice among the students, as there is the emergence of unethical conduct once students begin clinical practice.

4.3.2.5 2 Sub-theme 5.2: The behaviour of students

The participants emphasised that they teach students so that ethics may affect their behaviour; however, they observe differently. This was voiced as follows:

> "Their behaviour and interaction with patients & the community. It's chaos." [P9]

> "They don't have that thing that we had previously that you don't leave the ward without permission. It's like nobody is taking responsibility and control." [P4]

> "There are some litigations, and sometimes confidentiality is not kept and so many problems." [P10]

> "When you accompany them to the wards, you find them standing there and saying they are finished with their routine, but you became surprised to see that they don't care about patient hygiene." [P2]

The participants' desire to see their efforts of refining students into responsible social beings prosper, is observed through their responses. The educators' perception of the impact of ethics education calls for evaluation of nursing ethics education in general to embrace professional socialisation and ethical practice. Ethics education stimulates changes in learners' ethical knowledge, perception, and cognitive development (Avci 2017:138). However, Avci (2017:138) warns against the traditional moral education, in

which morality is ready-made, and what is required is for students to submit to pre-existing norms of good character, with no enhancement of ethical awareness and moral reasoning. Participants who were educators in this study, presented the researcher with some recommendations pertaining to nursing ethics. However, Holt and Long (1999:247) argue that unless nursing ethics is considered a subject with formal grounds from philosophy, the student won't be equipped to tackle thorny ethical issues in clinical practice.

4.3.2.6 Theme 6: Recommendations for enhancing nursing ethics

Participants shared a lot of recommendations, which were grouped under diverse sub-themes. The sub-themes and the descriptions relating to the suggestions raised are therefore discussed.

4.3.2.6.1 Sub-theme 6.1: Recommendations to SANC

The rigidity of SANC in relation to their directives for nursing ethics and the regulations regarding the practice of nursing practitioners was a critical aspect of concern. One (n=1, 9%) participant felt that their call to SANC has been falling on deaf ears and commented that the regulatory body must come to the grass hoods of nursing. She highlighted:

> "I think SANC could come to us because we treat different people from different backgrounds in various institutions. SANC must get our views regarding the community we are treating and the new technology that is being used in healthcare services." [P6]

This participant is mindful of the changes happening with SANC; however, the narrative shows that the progress made regarding nursing ethics was still not good enough. This is what was shared:

> "The SANC guidelines are changing, but slowly, they have not reached where nursing is today. A lot has changed in nursing because of technology, and our communities also are more enlightened and know a lot of things. However, the SANC guidelines still direct us to teach the old curriculum that does not refer to new things in the clinical area." [P6]

The statement by this participant had support as some of the participants had this to say:

> "If SANC guidelines would be a little bit flexible to match the lifestyle of today." [P9]

> "I think the guidelines must be more specific because there are so many different views of nursing ethics." [P1]

> "I think we need more clarification and more training regarding SANC guidelines and regulations." [P4]

4.3.2.6.2 Sub-theme 6.2: Recommendations for nursing ethics education

The recommendations that the participants made were aimed at improving nursing ethics education, as reflected below:

> "If we can go back to the clinical setting and check what is lacking and what is happening there. We also need to look at the causes of SANC disciplinary hearings to see where people went wrong regarding ethics. Then these are the things that should be the focus of teaching our learners ethics. In that way, I think we would get somewhere in teaching our students to be ethical may have an impact on that way our nursing ethics would have an effect." [P3]

While the above participant emphasised what the content should entail, the other one was concerned about how selection into the profession should be made, and this was recounted as follows:

> "If we could call people who want to be nurses to come for a week before selection to know who we are selecting." [P6]

The course's layout was also checked by the participants, who suggested for nursing ethics within a programme the following adjustments:

> "I wish the third year could have a practical part because the content of the third year contains the basis of ethics." [P3]

> "If the fourth-year curriculum could have ethics, as it lacks ethics content." [P4]

> "So, if our scope of getting information is extended to international authors." [P4]

One (n=1, 9%) of the participants was more concerned about the teaching strategies and recommended that support be available to discuss complex issues such as abortion. And she reiterated:

> "If there can be some help or tools to assist us in how we go about it when we are becoming uncomfortable with a situation during the discussions." [P1]

The majority of participants raised the importance of clinical education, and these are some of the recommendations made regarding this:

> "If we can also get support from the same clinical people, it can help because the complaints we get from students are left on their own. the students need guidance and supervision." [P2]

> "If I were to suggest, I would say that they must come to class after seeing and experiencing responsibility in practice. Things like accountability advocacy must be from the view of a professional, in the clinical area, not as a student." [P6].

4.3.2.6.3 Sub-theme 6.3: Recommendations for ethical practice

Other recommendations were directed at nursing ethics as a core aspect of the nursing profession. While some participants felt that the practising nurses need content regarding ethics, others felt that other disciplines like moral philosophy should be incorporated to strengthen nursing ethics. And this is how some of them narrated their view:

> "I think each and every professional nurse in the clinical area is supposed to be acquainted with the content of ethics." [P10].

> "We need to work closely with the specialists to develop a sound ethical structure that will work onwards. There can be seminars and workshops arranged to ensure that those providing academic support and the facilitators of the modules are developed in ethics to help the students." [P3].

4.3.3 Responses from community service practitioners

The Com-serves gave narratives of their experiences, and these were audio-recorded and transcribed into text interviews. Interpretive content analysis has been utilised in analysing the transcripts from the interviews conducted with the Com-serves.

4.3.3.1 Demographic characteristics

The participants' demographic information relates to their gender, age, current position in community service practice, and level of education.

Table 4.3: Demographic information (N=19)

Demographic Information		**Frequency**	**Total (N=19)**
Gender	Female	17	19
	Male	2	
Age	20-25	5	19
	26-30	11	
	>30	4	
Current position	Community services	10	19
	Completed community service	9	
Level of education	Bachelor's degree	4	19
	Diploma	15	

As illustrated in Table 4.3, the researcher had (N=19, 100%) Com-serves who participated in this study. Ten majority of (n=10, 5%) participants were still engaged in community practice service, while (n=9, 47%) had completed the programme. The majority of (n=17, 89%) participants were females, and (n=2, 11%) were males. Their ages ranged from 20-35 years of age. Pertaining to level of education, the majority of (n=15, 79%) had a Diploma in nursing, while (n=4, 21%) had a Bachelor's degree in nursing under the four-year programme in nursing (general, psychiatry, community) and midwifery (Regulation R.425) (SANC 1985). It must be emphasised that the foundation course for these students was ethos and professional practice, and the participants were from different institutions of higher learning within Free State Province.

4.3.3.2 Presentation of categories and sub-categories

From the transcripts of (N=19, 100%) Com-serves who participated in this study, meaningful concepts were extracted and assembled. Based on structural meaning, these ideas were arranged into three categories. The main categories that were identified are reflected in Table 4.4 overleaf. These categories are explained within the ambience of their corresponding subcategories.

Table 4.4: Categories and sub-categories

Categories	Sub-categories
1 Comprehension of nursing ethics	1.1 Care prompted by responsibility 1.2 Establishing relationships 1.3 Enhancing communication skills 1.4 Ascertaining the ethical environment 1.5 Upholding quality care 1.6 Respecting human rights and upholding ethical principles
2 Viewpoints regarding senior professionals' ethical conducts	2.1 Moral attitudes of nursing professionals 2.2 Moral attitudes of medical practitioners
3 Recommendations to enhance ethical practice	3.1 Ethics education 3.2 Continuous development

4.3.3.2.1 Category 1: Comprehension of nursing ethics

The category comprehension of nursing ethics emerged from views of Com-serves that were grouped into sub-categories. These sub-categories are care prompted by responsibility, establishing relationships to facilitate decision-making, enhancing communication skills to promote care, ascertaining an ethical environment, upholding quality, respecting human rights, and upholding ethical principles.

4.3.3.2.1.1 Sub-category 1.1: Care prompted by responsibility

Participants explained how they executed their caring activities from the basis of responsibility. The participant did what they considered a responsible action at that moment. This accountable care was narrated thus by the participants:

> "So, in my Com-serve, I was confronted with a situation whereby I had to make use of nursing. I mean, with my nursing ethics that I was taught about nursing: to go

> and save. […] The main thing is to save the baby and the patient, whereby even if you want to put on gloves, you can't anyway because you just want to catch the baby and save the mother. So that was what I was confronted with." [P7]

The participants emphasised on being a Com-serve, which signifies limited knowledge. However, the participant executed responsibility despite being a Com-serve and just performed the correct actions without thinking. On the other hand, the other participant also reiterated by responding towards the responsibility without searching for the rule as follows:

> "We didn't know if the lady was from here, so I think we were just acting human. We were feeling for her. We listened to her when she said her passport expired and that she could not go back…even though I somehow felt it was a lie. But because we wanted to help her, we went ahead and wrote the proof of birth." [P4]

The accounts above happen in different environments; however, the actions were translated from the same milieu of responsibility. While the other participant mentioned responsibility as centrality to the care actions taken, the other participant mentioned responsibility as being decisive in the uniqueness of being human. Following is the statement by another participant:

> "Though we know she did not attend the clinic and maybe it could have avoided or prevented her from giving birth to a stillborn, we did not make her feel less of a human, but at the end of the day, we took her to another room, where she had her privacy. She was there, and we did everything on that side. [Implying away from prying eyes of other mothers] We did everything we did for the other women; the only difference was that there was no baby. The baby had passed." [P19]

The description of this participant illustrates that if the patient were treated differently from other patients, such a treatment would equate to treating a person as something less than a human being. Thus, the motivation for their nursing care was influenced by being responsible towards another human person. Even though she did not attend the clinic (which might have prevented losing a child), the nurses embodied her human existence as another human. Another participant gave a viewpoint that clarified this embodiment like this:

> "By putting myself in the patient's position. It was as if I was the one who is now in need of the ultimate care … at least if there is a chance to survive. Even if I know I don't have a chance, at least there must be this person who will care enough for me till the very end and not say: [This is it, this is the line, I can't go further than that]. So, I felt like I had to put myself in that patient's position and say, [Okay, I would want someone to try and help even though, yes, everyone says otherwise]. But at least I know this person cared for me, and they did as much as they could because a hospital is a place where you feel like, okay, this where I can get better … As soon as you feel sick, you come here." [P11]

The participant's response above suggests that he/she reflected like a responsible human who relates his/her situations with other persons, saying today is you, and tomorrow is me. This notion of seeing oneself in another vulnerable person, is an aspect of Levinas' ethics of responsibility. According to Levinas (1981:82), ethics is the relationship of responsibility whereby an individual finds herself as being available at all times for her neighbour/s. Thus, this participant describes nursing ethics as a unique involvement of total commitment, in which an individual nurse views self as being situated for the patients. And being situated, one realises her responsibility in providing holistic caring practices that have moral accountability and are paramount to being human (Cusveller 2013:766).

4.3.3.2.1.2 Sub-category 1.2: Establishing relationships

Building relationships was another attribute that the participants described how they harnessed decision-making and nursing care. The participants itemised the uniqueness of trusting relationships in explaining how they used their ethics knowledge. While some participants brought themselves to the level of the patients by sitting them down, others used the tone of their voices to build trusting relationships with the patients. Following are the responses from participants:

> "The patient was admitted during the night. So, it was our shift during the day. We came on duty and reported that this patient was refusing examination, so they did not know how dilated her cervix was. I feel like the person who admitted her did not sit her down and explain the importance of doing this because I know the patient has the right to refuse treatment, but … it's her right, but it also goes with the responsibility. So, as I sat her down and explained to her the procedures and

why we are doing it, that's when she understood, and she allowed us to examine her." [P13]

The anecdote above evolves around the idea of sitting someone down, which may equal to humbling oneself to the level of the client. The participants explained that they were aware of the patient's autonomy and felt the immediate step in confronting conflicting principles was establishing a trusting relationship. The midwife's practice of doing vaginal examination was an act of goodwill, and the patient's refusal to be examined was an autonomous decision. The participant negotiated a relationship and referred to sitting the patient down, which other nurses failed to do. Another participant explained this sitting in this manner:

> "I sat her down and then explained the reason for her to stay longer at the hospital because she was not expecting to stay a longer time. I had to explain … about covid-19 that it's not a death sentence … … Finally, I saw that she understood then finally she said, "Okay, I will stay." Then finally, she seemed relaxed …" [P8]

4.3.3.2.1.3 Sub-category 1.3: Enhancing communication skills

The sub-category of enhancing communication was brought up as a tool for facilitating care. The participants appreciated that they engaged in communication, resulting in holistic care. One (n=1, 5%) participant mentioned the following when relating to the process of communication:

> "So, I started asking her, "is there anything bothering you?" And she kept saying "no." Then I stood next to her and softly asked, "are you sure that you are fine" and then she just started saying, "no, I am not," … she had recently broken up with the father of her baby, and that's where I picked up … that this person is stressing, she is thinking about a lot of things, what is going to happen after the baby is born? ... So, in a way, I just thought, okay, let me put the nursing things aside now and let me talk now; that's when she got comfortable, she started telling me her story, she broke up with her boyfriend now she's left alone." [P2]

Some participants illustrated how they delved into communication strategies to enhance holistic nursing care. In this study participants also referred to the notion of sitting down, which they detailed below:

> "I think there was more to it if we could have sat her down and tried to find out more psychologically how the pregnancy occurred? Where is the father? I think it has more to do with those kinds of things. It was only when the counselling started, and we asked her how she was feeling that she told us her boyfriend had been locking her inside the room." [P19]

The other participant, as shown below, described communication as a human attribute intended to help others, and this is how it was said:

> "I think she just needed someone to talk to her, sit her down, in a human manner, if I may put it like that. Not just because she doesn't want to do something, and we say … then that is her problem. She just needed someone to guide her, sit her down, and explain to her why certain things are being done, not just give up on the patients. So I think ubuntu helped me; if I may put it like that, I just left my professionalism and all and sitting her down." [P13]

> "When I talk to a person, I don't just talk like to you now, but then I want to go deeper into who you are? How are you feeling? Because sometimes, we have illnesses that are associated with our thinking. And then … sometimes you just say, aah! she says she has a headache give her paracetamol, give whatever, and she can go. Then the patient comes back again, sometimes you will meet somebody who met another nurse, but then she comes back again you wonder why this medication is not working with this person, could there be an underlying problem." [P1]

The descriptions from the participants demonstrate how engaging in good communication makes an impression on other people and allows things to happen. The other participants indicated how genuine dialogue helped with the continuation of care. The majority of participants emphasised the critical role of dialogues, and as the latter participant said, these types of talks go deeper into areas beyond physical suffering.

4.3.3.2.1.4 Sub-category 1.4: Ascertaining the ethical environment

The participants expressed how they establish whether a specific situation carries a moral encounter when describing the circumstances in which they felt they correctly applied

ethics knowledge. Participants mentioned that some state of affairs where they could see that an ethical issue is likely to occur. Some of them gave this illustration:

> “There was a patient who was diagnosed with TB. They didn't isolate the patients from anyone and let the patient sleep in the same room with other patients. We complained, but we were never attended to; that was a hurtful part. We were thinking about other patients.” [P9]

The above-mentioned response was from one participant who felt hurt after perceiving a problem and raising complaints ignored to the detriment of other patients and staff in the ward. Another participant gave this explanation:

> “The patient came with difficulty breathing, and she complained of feeling very fatigued, like very tired, but I noticed that she needed oxygen to make her better. So, on that day the doctor didn't come. All we had to do was give oxygen and monitor the vital signs … And then I have to report to the sister in charge because we work with hierarchy. The sister in charge tried to call the doctor; still, he refused to come; then sister in charge called the CEO, the matrons…those people that are there in management but still with that as well …” [P7]

The factors that prevented teamwork for the patients' well-being made the participant sense that there was an ethical situation where one is expected to realise the patients' needs. The participant understood that the patient would be harmed in the process. One participant indicated that the particular behaviour was allowed to prevail in a healthcare institution where she worked regardless of its consequences. In a public space, there is no expectation of harassment, but this happened without limit, and the participant narrated such harassment as follows:

> “And from what I heard around the hospital, he is used to such comments, like having comments like compliments … It’s not complimenting but talking about someone's body, telling them that “you are so beautiful today, can we go out?” things like that. He is used to such comments, so I feel like if people are aware of certain things that are not done in professional settings, people are aware that this is what sexual harassment is. Because now it seems like even after the whole suspension thing happened, some people were questioning her, saying the “she is

> exaggerating, she just wanted to get rid of him" things like that. So, I feel like people need to be made aware of such things." [P12].

4.3.3.2.1.5 Sub-category 1.5: Upholding quality care

The participants reflected on accountability as paramount to maintaining quality care to realise nursing ethics. Following are their responses on accountability:

> "I was supposed to be working like under supervision as a Com-serve, but I worked the whole hospital alone at night. I was all alone and providing patient care, making sure they got quality patient care that I was supposed to be giving … It's according to my discretion how you prioritise patients." [P10]

> "There was a 15-year-old patient that was HIV reactive, and she had a child. And nobody referred her to the social worker or psychologist or anything … So, I went to another doctor to ask his opinion about the patient situation … I strongly felt that this patient needed to be referred. And then I ask him to fill in a referral form for me and phone the social worker for her to see the patient before we discharge her." [P6]

Each of the participants in this study linked ensuring good quality of care either to their character, being able to identify ethical situations promptly as well as offering equitable care that has quality; as one of them said:

> "My action was a response to the fact that I was acting so that we don't lose a patient. We don't want to lose a patient; we just try by all means to save the patient's life. At least to the best of my ability, that is what I can do to save the life of a patient …" [P7]

4.3.3.2.1.6 Sub-category 1.6: Respecting human rights and upholding ethical principles

This study's participants recognised their duty to respect and maintain the patients' fundamental rights. Besides respecting the patients' rights, the participants felt a need to empower the participants regarding their rights. In asserting the human rights of the patients, the following descriptions were used:

> "I had to put the patient first, I had to respect her rights, and I also had to explain what was going on so that we were on the same page. We should educate our patients with whatever concerns them, like their rights, the procedure we are about to do to them…we should also educate them primarily when they come to the hospital, at least what to expect." [P10]

By placing the patient first and explaining everything, this participant enabled access to health care and capacitated the patient's autonomy. Other participants respected the confidentiality of the patients, as enshrined in the Bill of rights.

> "We did not talk about her in front of the other patients because others that were admitted with her were asking, "where is so and so?" obviously, some were saying, "where is that lady that we were with?" So, we said "no, she has gone home, or she is at the back" just like that … we are protecting the patient's privacy." [P19]

The other participant recalled that trade unions and their functions were dealt with in their ethos class. That aspect of self-protection as a fundamental right was explained by the participant as follows:

> "I then told them that we were not going to write the incident report; we would consult our union representatives because of their approach to the incident. I then proceeded to call my union representative, and luckily, some of the representatives were outside. They came in and told us in front of the superiors that we should not write anything and that we still have time to write the report and not immediately." [P17]

The participants had an indication of awareness of ethical principles in this study were as well as fundamental human rights prevailing in their nursing practice. In defining the responsibility of their practice, the participant exhibited a caring aspect intertwined with professionalism which is inherent and inseparable from ethical principles and human rights. The caring actions and attitude of the participants reflected ethical principles such as autonomy, beneficence, non-maleficence, advocacy, and veracity.

> "My ethics training helped me … I saw that the patient would struggle to breathe in the bathroom; she might lose her life, so I had to bring the bedpan to her bed so

> while she helped herself, she was still on oxygen. So, it was helping me to make that informed decision, and I also avoid negligence or something like that." [P7]

The participants highlighted that their intention for the ethical decision was to avoid negligence which carries a legal and moral liability. Failure to care and measure up to standards accompany harm, and participants aligned themselves to the scope of practice. On the other hand, (n=1, 5%) participant indicated that by reflecting on ethical principles and personal values of Batho Pele, team managed to get consent to disclose the HIV status of the client to the grandmother. The latter was looking after the client's baby.

> "My values as a person helped to make the decision. I said now … I can't just be negligent and say, "no, it is not my problem to tell the grandmother if she doesn't want to tell the grandmother. And I wouldn't just leave her like that." So, I brought it to myself and said, "what if it was me? What if the situation was around my family? I would have liked it to be handled with care and Batho Pele. I didn't just make that decision on my own. It was teamwork, and we had the mother's consent to disclose her personal information to the grandmother." [P5]

Motivated by the principle of non-maleficence, some participants did good acts like referring the patients for further care and providing bedpans for COVID-19 patients to prevent harm that they felt was imminent.

4.3.3.2.2 Category 2: Viewpoints regarding senior professionals' ethical conducts

The participants viewed senior professionals, including doctors and senior nurses, as their supervisors because they were newly qualified nurses. Their views regarding the moral attitude of senior nurses and doctors include issues relating to communication and interaction between the nurses, doctors with nurses, and their relationships with patients.

4.3.3.2.2.1 Sub-category 2.1: Moral attitudes of nursing professionals

All the participants (N=19, 100%) mentioned that the senior nurses were acting unethical, and some even thought it was how the institutions were supposed to operate. Community service is a crossing point between studying and independent practice; thus, participants reported that their ethics were still fresh compared to their seniors. The participants

mentioned different ways of how senior nurses treat the patients, and narratives such as these were shared:

> “The attitude and the tone of voice of the seniors were not good. Sometimes, someone may shout it out and say, “she hasn't been going to the clinic, now the child is dead, stuff like that.” [P19]

Although the participant viewed themselves as bystanders, they had no courage to stop the behaviour. At the same time, the participant agreed that it was wrong not to attend the antenatal clinic, but none checked the conditions that prevented her from attending the clinic. In another setting, the participant felt that the human dignity of the mother was not respected.

> “She did not get proper treatment as a patient like she should. Her dignity wasn't being respected. I understand that it might be very annoying to listen to the ten women screaming but let's just try to help patients.” [P18]

Another participant indicated that she was supposed to work under the supervision of a senior personnel as a Com-serve. However, she worked alone on night duty and was told to call the senior home if there were some problems. And this is how she recounted the story:

> “Then I called my senior to come and help me, but it was like she was fighting. She didn't want to come and help … She didn't like that I sent people to fetch her, but I told myself she would somehow see what I was trying to avoid somewhere. Like you wouldn't want to lose a pregnant woman and a child at the same time.” [P10]
>
> We need support from the sisters, especially in practice …, but nowadays, nobody wants to get too involved. But he didn't take me that seriously because I am Com-serve or was a Com-serve there. So, if the sister supported in that way, then.” [P6]

Although the participants were disappointed with how those considered ethically knowledgeable conducted themselves, they deemed themselves ethical and honest, as they were still new in the system.

> "I feel like I am coping ethically. The sisters that do such things are the ones that need moral support; they need to be sat down and get taught how to treat patients. And be reminded of their duties as professional nurses and why they're here." [P3]

> With us recently trained, we still have that ethical duty towards the patient, but with other nurses that have been in the profession for a long time, some of them are just pushing let's get done." [P2]

> "I think somewhere along the line, the nurses have forgotten what ethics is… they don't remember what they should do in certain instances, the ethical principles they should follow, I think that is totally lost. So, if someone can come in and remind them as to what should be done, that would be helpful to prevent further cases." [P18]

The participants raised concerns regarding the moral conduct of those supposed to be role models. As one of the participants pointed out along the line of being an experienced nurse, there is a state of forgetfulness regarding ethical responsibility. Thus, further moral learning is critical for the seniors as role models. Role modelling is one trait in nursing that is considered vital, especially in ethics, as one may portray the model's character (Van der Wal & Pera 2018:359). As a spectator, one may decide to imitate some elements of morality (Van der Wal & Pera 2018:359) in situations that are likely to be similar.

4.3.3.2.2.2 Sub-category 2.2: Moral attitudes of medical practitioners

The participants expressed concerns that some medical practitioners' attitudes compromised their means in providing high-quality and safe care. The distinctive medical perspectives have a shared goal with nursing practices; hence the participants expected a collaborative ethics attitude. Some participants conveyed their views regarding the bearings of medical practitioners thus:

> "Like in the COVID ward, here we normally experience difficulties with doctors whereby … as a nurse I have to advocate for the patient, by keep reminding the doctor that this patient needs to be seen now so that you can give the orders that we must take out to the patient." [P7]

Given the pandemic, moral distress, and ethical uncertainty that many healthcare professionals were confronted with, it may be argued that the pandemic challenged the ethical responsibilities of these professionals. The challenges of working under stressful conditions are accounted for below:

> “When the patient got here, the other doctor who was on call didn't want to come and see the patient because there was no communication from the referring doctor, and he didn't know about the patient. He refused to come to say he never knew about it. So, we had to act … we had to write it down as a nurse that doctor didn't want to come.” [P7]

Whilst the senior doctor refused to come and attend to the patient, the participant needed to balance fears and frustrations with the responsibilities and commitments of caring activities. Complaints like these are likely to affect trust relationships and teamwork. Regarding teamwork, a participant recounted how one doctor obligated them to infringe on the confidentiality of the patient.

> “We did not tell her that we are going to phone the family to get the history because the doctor made that suggestion. And on the admission slip was the patient's name and all that. There was also next of kin as a legal person, I think. So, we called that person just because the doctor wanted to treat her.” [P15]

Participants detailed various ways in which senior professionals challenged their standards of care. They assume these seniors have a moral responsibility to help with character development and acquire ethical competence. Accordingly, Chowdhury (2016:1) asserts that organisations whose residents uphold moral values and manifest specific virtues are likely to flourish. Therefore, the senior professionals are expected to uphold virtues and good morals to demonstrate to the Com-serves that they are competent professionals.

4.3.3.2.3 Category 3: Recommendations to enhance ethical practice

All the participants in this study came up with propositions regarding how ethics may be improved. These are classified under nursing ethics education and continuous development of professionals.

4.3.3.2.3.1 Sub-category 3.1: Ethics education

Participants gave a lot of suggestions regarding how nursing ethics education may be augmented. In responding to questions regarding their support needs, most of the participants reflected on their nursing ethics training and gave the narratives below:

> "You know, in nursing, you must be empathetic right and not sympathetic. So, you get to be close to the patient. You see, if you can hear that the patient passed away, you feel sad and sometimes need some kind of counselling and support … I think maybe psychologically because we are not the same. Some will be affected deeply, but others can take it lightly." [P7]

The participant above indicates that although confident in dealing with ethical problems, there is a limitation in dealing with conflicting emotions and values and requests more training for emotional residue. While the participant struggled with competing empathy and sympathy, the other raised the challenge of dealing with rules versus humane practices. In this regard, following is the response of the participant, whose humane aspects reign but left a sense of discomfort is indicated below:

> "I was taught ethics at school, our lecturer usually told us that sometimes you will find a situation where you have to be firm, where you have to do the right thing even if you feel, okay, this person is human, but I have to do this. So, we could not chase her away at that time because that's what we were told to do. We wrote the proof of birth anyway, but we had to report it as we report each and everything that happens." [P4]

This participant was uncomfortable about their decision even though she felt it was humane. According to hospital policy, they are not allowed to give proof of birth to foreign nationals, but as personhood prevailed, there was some discomfort. The other participant indicated that his/her ethics knowledge is insufficient and felt the need for further training.

> "Sometimes here and there, there are situations whereby I find that no, here I think I need some support. Like maybe my ethics knowledge. I think it is insufficient. If maybe I can find in-service training about ethics so that I can maybe upgrade my knowledge." [P8]

This narrative of insufficient knowledge was raised in another narrative thus:

> "Real-life situations should be brought to class. That's how we are supposed to learn them because, truly speaking, when we are studying nursing, there are practicals. There are also practical components in general and midwifery. So, things like ethics we study them to write the exams, and we don't really…practice them much in the hospital." [P16]

Relating to the challenge of studying ethics for exams and lack of practical aspect of teaching them how to solve problems, this participant continues this conversation by sharing the following:

> "And even if we are in the hospital setting, we deal with things like the Acts and policies. You go through auditing, and you do things like that … Auditing, you go through acts, you go through policies, but the actual situation that happens in the hospital that forces you to be solving ethically, you rarely meet." [Participant 16]

This participant further demonstrated that what is considered to be ethics practice consists mainly of acts and policies. This participant indicated that the clinical staff does not assist with the ethics education of students. This lack of assistance was narrated as follows:

> "Because … when we were students, the nursing managers will always try to hide us away from things like this. Even when there are situations that need to be solved by the team, they will be like, "students, can you please excuse us." Maybe because they don't want us to see them reprimanding someone who is our in-charge, that we are supposed to respect. They will always be saying "students can you please excuse us" then they would leave us and solve things on their own. So, we don't see much of ethics … So it becomes difficult to solve things when we are involved in the future." [P16]

4.3.3.2.3.2 Sub-category 3.2: Continuous development of the professional ethics

All (N=19, 100%) participants suggested continuous development of the professionals. The participant below felt the health professionals should go through ethics consultation to reach a consensus for the welfare of the patients.

> "I think every now, and then we need to go through ethics as a team because everyone comes with their own opinion on the matter, and everyone wants what they want despite what the patient is saying, despite what ethics is saying. Everyone just gives their opinions, and there become conflicts between the doctors and the nurses over such matters. And then, at the end of the day, we don't reach a consensus because the doctor wants this, and he is fuming. He wants this, he is adamant that he wants this, and the nurses are also on their side; they are also fighting with the doctor. So, if we could have ethical training every now and then even if it's not …" [Participant 15]

The need for moral support was suggested by all participants, some mentioning debriefing sessions or in-service training:

> "I think if we could have like surveys … not me to directly answering a survey but someone doing in on my behalf … Sort of like PDMS, where you would evaluate me on-I'm using my ethics correctly, am I lenient to the patient, am I fair, my behaviour around my patients and the staff, I think if it was done yearly. You know, if you are into something for too long, you sort of like get used to it, but then if there's somebody reminding you to remember why you are here, then you come back, you know what I mean? It is sort of like a wake-up call. Remember why you are here. What is needed is something like refresher courses." [P13]

4.4 DISCUSSION OF FINDINGS

4.4.1 Educators

The educators' perception of ethics content and the teaching strategies used to develop the students' ethical competence are discussed here. The conclusions clarify the state of the ethics and recommendations for enhancing it. These findings reveal the problems and impact of ethics education in Free State Province.

4.4.1.1 Meaning of ethics

The educators had various ways of recounting nursing ethics. According to their descriptions, nursing ethics cut through the individual's worldview to a humanistic way of

caring for others and applying principles. All these areas were evident in most of the participants' descriptions. Given that the worldviews are pluralistic, Dhai and McQuoid-Mason (2011:5) suggest that everyone's preconceptions must be interrogated because humans exercise their free will in every ethical encounter. The findings denote that participants believe that the meaning of ethics should consider people's reflection on their belief systems which entail values about right and wrong. Thus, nursing ethics education should entail clarification and deliberations of matters around values and worldview. According to Dhai and McQuoid-Mason (2011:5), a belief system is complex due to the fact that it represents different worldviews that embody values for an individual or a group. Understanding worldviews is necessary for value clarification and negotiation with others' views (Dhai & McQuoid-Mason 2011:6).

The participants considered care in terms of humanness; therefore, doing good for the benefit of humanity was described as an aspect of nursing ethics. Caring is the notion of permitting the flourishing of human beings, in which carefulness and devotedness towards others and self are signified (Heidegger 1962:242-243).

The findings demonstrate that the participants considered patients and their relatives as having an intrinsic value conferred upon others by virtue of being human. Furthermore, the participants referred to being present, which Pellegrino (2008:358) defines as a way of enhancing human dignity. Hence Simões and Sapeta (2019:250) suggest promoting human dignity with its different dimensions and factors that intertwine and influence each other should be encouraged in nursing care. Condon and Hegge (2011:211) indicate that acknowledging human dignity manifests in being truly present with a patient and being a compassionate person. Thus, enhancing the patients' dignity is the same as improving nursing ethics.

Furthermore, another viewpoint brought to light by the findings is the application of ethical principles. The majority of participants mentioned that applying the principles is considered a limiting aspect of nursing ethics, as it is associated with conforming without proper deliberation. Though ethical principles are appropriate and legally binding, Woolf et al (1999:529) indicate that by conforming only, nursing care may be compromised as there are diverse interpretations between an activity and a principle. Thus, ethical principles should be regarded as means through which others may evaluate nurses' actions, not as absolute rules for guiding activities.

As reflected in the findings, the participants also define nursing ethics in terms of professionalism. Such understanding concurs with Muller's (2009:7). According to Muller (2009:7), nursing ethics is professionalism in which the novices are socialised professionally to become experts who will assimilate and later grasp the values and norms of the profession as their own. The attributes that the learners are to incorporate are competencies, accountability, self-regulation, leadership, commitment to excellence, honour, social values, duty, integrity, duty, integrity (Muller 2009:7). Some participants mentioned that Acts translate from the constitution, so the concept of professionalism was viewed in the realm of rules and regulations as mandated by law.

The guidelines development emerged from the professionalisation of nursing, as Vasuthevan (2015:42) attests that a group of people who underwent through a specialised occupation and agreed to abide by rules of conduct are referred to as profession. From this background, participants in this study refer to nursing ethics as professionalism. The notion that Ricks and Van Rooyen (2015:12) describe as the extent to which individuals identify with the profession and adhere to set standards. Black (2020:69), however, suggests that efforts should be made to illuminate nursing ethics. Black (2020:69) suggests that efforts to improve ethics should not be mingled with justifying nursing as a profession, as these distract and obscure advances for nursing ethics. Given the various ways of looking at the meaning of nursing ethics, Shatz (1996:75) alludes to the need for another source of moral propriety in nursing care. It is necessary to analyse what is essential for a particular context based on its needs and experiences.

4.4.1.2 Viewpoints on South African Nursing Council [SANC] guidelines

The directives from the SANC influenced the viewpoint of educators regarding the choice of nursing ethics content. The findings reveal that the guidelines made a choice too complex, as the guidelines are too broad, unexplained, and too limiting for ethical competence development. Concurring, Woolf et al (1999:529) indicate that some guidelines may be misinterpreted, compromising the quality of care. Although few participants were comfortable with the way the directives from SANC are, there was a general agreement that the ethos and professional practice content is too broad and limited ethics content. Thus, some confusion with interpretation is inevitable.

The findings explicitly demonstrate how educators are committed to developing ethical competencies for their students but are challenged by broad, rigid, and unexplained guidelines from SANC. Some participants were concerned that guidelines have limited ethics and do not include essential ethical elements about patients' care. This view is congruent with Song's (2018:14) findings that guidelines are not a complete framework for teaching nursing ethics. At the same time, others view them to be ambiguous. This view was also related to Song's (2018:14) findings, in which the universality of ethical principles was problematic because cultural factors affect how one understands the principles.

4.4.1.3 Ethics content in the curriculum

The findings reveal no ethics content in the fourth year of study, and the scope for nursing ethics in the third year lacks a practical component. This scope and how nursing ethics should be spread across the nursing curriculum have always been a concern in many nursing education institutions. Hoskins et al (2018:1) argue that regardless of nursing scholarship and clinical ethical concerns, imperfect consensus reigns regarding the role of education in ethics within the nursing curricula and expected goals and importance of ethics education in nursing. Thus, Hoskins et al (2018:1-2) believe that there are still some difficulties regarding appropriate nursing ethics. This complexity is reflected in the findings, as nursing ethics education guided by SANC still dwells on professional practice issues that emphasise the history of nursing, managing the ward, and leadership. Poitras et al (2016:12) state that professional practice incorporates many roles, domains, and activities to comprehend meaningfully. Thus, this may result in limited ethics content in such a module.

According to Tsuruwaka (2018:157), the challenges relating to superficial ethical thought amongst nurses are associated with content, teaching strategies, and time schedules for ethics education in a programme. Gordijn and Have (2013:1-2) believe that trainees may exhibit ethical behaviour if ethics knowledge is enough. Koo et al (2018:2903) affirm that adequate ethics education helps students develop an ability to perceive ethical situations and a sense of call for moral conduct and ethical decision-making.

4.4.1.4 Strategies for teaching nursing ethics

The findings revealed that formal lectures, presentations, role-playing, and discussions were used as the teaching strategies. Although other educators tapped on the prior experiences of their students in initiating the discussions, and some made use of the reflections, few made use of these methods. Issues around effective teaching strategies for ethics continue to enjoy a lot of discussions and debates. As Pandya, Shukla, Gor and Ganguly (2016:144) attest, formal lectures, class discussions, case studies, and classroom exercises have always been considered effective delivery methods if used to supplement each other.

The findings in this study illustrate that participants were using some of these methods in their classrooms. Still, they reported that these were limited in instilling professionalism or integrating theory and practice. As echoed by some participants, the interest and skills of the lecturer are of paramount importance. Therefore, most participants wanted to be supported in this regard. According to Pandya et al (2016:144), teaching methods should be integrated with theory and practice, should not only be theoretical teaching of constructs to students without assisting them with translating them into practice. The role of ethics educators, expertise, and skills emerged as aspects that need to be considered regarding teaching ethics. The findings relate to those of Borhani, Alhani, Mohammadi and Abbaszadeh (2010:6) that nursing instructors' role, such as instructor's technical knowledge and strength, when facing ethical issues, has a significant function in increasing students' capabilities in ethics.

4.4.1.5 Effectiveness of ethics education

The findings reveal that educators are concerned about the effectiveness of their courses, given the current frameworks of ethics education. Grady et al (2008:4) suggest many factors that need to be explored pertinent to the impact of ethics education. According to Grady et al (2008:4), the bond between ethics training resources and ethics education, the confidence of the trainees, and their moral actions are some factors that may judge the impact. Gordijn and Have (2013:1-2) believe that trainees may exhibit ethical behaviour if ethics knowledge is enough. Koo et al (2018:2903) affirm that adequate ethics education helps students develop an ability to perceive ethical situations and a sense of call for moral conduct and ethical decision-making.

The main concern was the character of students coming to the nursing profession. The educators consider their students to be materialistic and not being changed by the ethics education. According to Gülcan (2015:2623), ethics education aims at improving humankind by stimulating the students' intellectual abilities, given a wide range of moral prerogatives, including personal ethics, life experiences, and institutional norms. So, the question is whether the educators' efforts measure the expectation of the students. However, Font-Jimenez, Ortega-Sanz, Acebedo-Uridales, Aguaron-Garcia, De Molina-Fernández and Jiménez-Herrera (2020:2240) suggest that nursing is the most trusted profession, the participants' views in this study concur with Smith and Knudson (2016:911) that there is a gap in practice among the students as there is the emergence of unethical conduct once students begin clinical practice.

The educators' perception regarding the impact of ethics education calls for evaluation of nursing ethics education in general, to include the idea of professionalisation and nursing ethics. The effectiveness of nursing ethics education is one component of apprehension in nursing as Hoskins et al (2018:3) demonstrate that when a newly qualified nurse is deployed to the clinical environment, the expectations increase and begin to have more responsibilities in delivering care in a complicated environment, engulfed by relationships with patients, families, physicians, nurses, and other members of the healthcare team. Nursing practice is inextricably entwined with moral complexity (Hoskins et al 2018:2).

Ethics education stimulates changes in learners' ethical knowledge, perception, and cognitive development (Avci 2017:138). However, Avci (2017:138) warns against the traditional moral education, in which morality is ready-made, and what is required is for students to submit to pre-existing norms of good character, with no enhancement of ethical awareness and moral reasoning. The educators in this study gave some suggestions for nursing ethics. However, Holt and Long (1999:247) argue that unless nursing ethics is considered a subject with formal grounds from philosophy, the student won't be equipped to tackle thorny ethical issues in clinical practice.

4.4.1.6 Recommendations by the educators

There was a common understanding that the content and teaching strategies are in vain as they consider students to have limited ethics knowledge, skills, and attitude. The

findings demonstrate that the educators want SANC to relook at the directives, be specific, and look at the changing dynamic of society and nursing practice. According to the educators, nursing ethics education should be given more attention, and periods for ethics education need to be extended. Of interest was the recommendation that specialists and moral philosophers work with nurses to develop a sound ethical structure for nursing. The idea concurs with Hoskins et al's (2018:2) recommendations that ethics content experts should be identified and partnered with professional organisations in increasing access to standardised ethics education content. Again, there was a request that all professionals in practice be acquainted with ethics content and training.

4.4.2 Discussion of findings: Com-serves

The discussion of findings relates to generated themes from the perception of the Community service practitioners regarding how they comprehend and apply nursing ethics in their practices. Their opinions reveal the standpoint of nursing ethics in South Africa, as they are at the interface between education and clinical practice. The perception of community practitioners regarding the application of ethics in their nursing practice uncovered three categories. These were: comprehension of nursing ethics; views regarding senior professionals' ethical stance; and suggestions for improving ethical practice.

4.4.2.1 Comprehension of nursing ethics

Setti and Ruffa (2012:online) define the comprehension of ethics as the ability of an individual to evaluate and distinguish the different values as rules necessary for the full exercise of responsibility in each situation. Thus, the participants' comprehension of nursing ethics helped them to understand diverse aspects of a problem to inform rational assertions of their acts. The findings display sub-themes such as care prompted by responsibility, establishing relationships to facilitate decision-making, using communication skills to promote care, ascertaining the ethical atmosphere, upholding quality care, respecting human rights, and maintaining ethical principles.

The participants declared activities explicitly show how their care was prompted by responsibility. In defining responsibility, Argandoña (2016:63) indicates that it arises from the relationship with another person and entails virtues. Argandoña (2016:63)

demonstrates that virtues entailed are awareness and pursuit of excellence in one's activity and sustaining and supporting that excellence. According to Argandoña (2016:65), responsibility as a basis of moral appraisal of a person's activity must have some components that include:

- Acknowledgement of the past actions of the agents, as responsibility attributed to the agents' actions, their objectives, motives, and consequences.
- A duty in which the agents decide to act or have an obligation to perform and being prepared in accepting the recent and future responsibilities.
- An attitude in which the agents act by being willing to attest to the needs or demands of others, which is what constitutes the agents' responsiveness, is also called virtue responsibility.
- Accountability: The agents must account for their wrongdoing and being a motivator, the strategy in which they are embedded, the means used, and their results.

Findings illustrate that they were aware of the possible outcomes of their caring activities, meaning they reflected on their past actions. The responsible activities at that moment are what Argandoña (2016:63) calls duty, an attitude that entails virtue and accountability. According to Lindh et al (2008:137), responsibility in ethics is a relational way of being a human that signifies the complexity of everyday interaction. Setti and Ruffa (2012:online) illustrate that ethical comprehension is the main requirement to provide responsibility that promotes or enhances any possible actions fully. All the occurrences narrated by the participants demonstrate that everyday nursing practice equipped them with the awareness that calls for personal endeavour and reflection upon their previous activities and to act appropriately. Every facet of their caring activity reflected responsibility. According to Tollefsen, Olsen and Clancy (2021:34), ethical responsibility is fundamental in all settings where patients are exposed and vulnerable and is an inherent part of being human.

The participants' responsibility in this study emanated from being human and not merely conforming to the prescribed rules, which were stated in various ways. According to Lindh et al (2008:137), activities stemming from response because of a shared context of humanity are described as moral responsibility. Their responsibility approach differed from Geyer's (2015:135) reference, which comes purely from accepting liability for the acts and omissions set out in the country's scope of practice and legislation. In this

manner, responsibility is only limited to one component. According to Gardiner (2018:32), viewing ethics through the lens of what is appropriate, conforming to norms, and not listening to our conscience may fail to reflect genuinely on the day's problems. In this regard, Lindh et al (2008:137) advise that to develop moral responsibility in nurses, students must be given space to build their ideals and values of what is good so that they may feel encouraged in striving to translate their models into practical reality. Consequently, this may help students to develop ethical reflection.

What is unknown about these Com-serves is whether they were exposed to building their ideal and values during their ethics training. According to Lindh et al (2008:137), ethical reflection progresses from realising values and dreams and translating these into practical reality. The questions to nursing ethics education are: (1) how would nursing training institutions encourage the students in striving to translate their ideas and values into practical reality; (2) what approaches and ethics content are appropriate in enabling all components of responsibility to be developed in caring activities; and (3) how these ethical responsibility components would be assessed.

Establishing relationships in facilitating decision-making was another aspect of comprehension of nursing ethics. Establishing the rapport to help one make a rational choice is similar to the sub-theme narrating ethical responsibility in caring for another human. Burkhardt and Nathaniel (2014:231) state that nurses have relationships with patients, colleagues, physicians, subordinates, and the institution, with explicit and implicit mandates. While the divisions' relationships may sometimes be confusing and contradictory, Burkhardt and Nathaniel (2014:231) indicate that these relationships need a critical examination to smooth the services promised (Burkhardt & Nathaniel 2014:231). Råholm (2008:67) suggests that a trusting relationship is founded on appreciation and responsibility and facilitates the discovery of those experiencing suffering.

For the patients to make decisions, findings demonstrate that the participants engaged in some activities to convince the clients to make decisions. These activities were identified as allowing the patient to feel comfortable and sitting next to the patient. The findings reveal that participants were aware of patients' self-determination, which was facilitated more by the fostered relationships. According to Bondolfi (2002:45), respecting autonomous decisions within the premise of protecting human existence is a totality of mutual relationships. Thus, the patient's refusal did not become a decisive factor in

decision-making, but some strategies were incorporated to establish a relationship that benefited the patient.

One more feature used to comprehend nursing ethics was dialogues as a form of communication to promote care. According to Starr (1999:425), dialogues are a moral duty that helps with a holistic look at the client, as it is interwoven with genuine analysis of the other's experiences. On this understanding, Gastmans (2002:495) claims that dialogues should be one of the bases of nursing ethics. This concurs with Walker and Lovat's (2019:81) statement that dialogue processes allow partakers to understand each other's values and concerns better because these are made bare during the discussions. Findings show that their discourse became meaningful as the participants sat the patient down. Kramer, Strahan, Preslar, Zaharatos, St Pierre, Grant, Davis, Goodman and Callaghan (2019:7) suggests that dialogue entails speaking meaningfully and reacting responsibly. This dimension of the patient-nurse relationship is what Råholm (2008:67) describes as being beyond the knowledge of nursing science, the one that bears witness to the truth of the other person's experience. These findings regarding establishing relations and engaging in dialogues request a core move for nursing ethics education and practice.

Attributes relating to the ability to ascertain ethical environments emerged during the study. According to Teresi, Pietroni, Barattucci, Giannella and Pagliaro (2019:1), the ability to perceive ethical situations consists of perceptions that assist in shaping expectations through policies for ethical behaviour. In this study, participants could see that patients were likely to be harmed. This ability is illustrated by assessing how certain cases were handled in their work environment. Bartholdson, Sandeberg, Lützén, Blomgren and Pergert (2015:2) describe moral climate as workplace factors that enable individuals to ascertain ethical problems while providing patients with ethically good care. The narratives clarify how the contexts for nursing care were infested with the elements that impacted the nurses' ability to act as moral agents. Moral perception is considered the first phase of the caring process (Gastmans 2002:497). According to Gastmans (2002:497), caring persons with the capacity to ascertain moral issues become sensitive to the surroundings and attentive to situations that may weaken life-sustaining activities.

The findings display those feelings amongst the participants accompanied moral perceptions. According to Jormsri, Kunaviktikul, Ketefian and Chaowalit (2005:586),

moral perception involves an experience of emotions as an aspect of one's ethical sensitivity, imbued by compassion. The findings concur with Joolaee, Jalili, Rafii, Hajibabaee and Haghani's (2013:238) conclusion that moral distress is likely if perceptions conflict with institutional constraints regarding the right course of action. According to Numminen et al (2009:485), a work unit climate is essential to nurses' behaviour and practice. Therefore, ascertaining an ethical environment is related to good quality care.

Findings revealed that the way participants comprehended their activities within the notion of nursing ethics was the Upholding of good quality care. According to Gastmans (2002:496), nursing care aims at providing care considered good. This striving entails being sensitive to a human being in a situation of stress or distress and is, therefore, an aspect of morality in nursing (Gastmans 2002:496). The participants' stories exposed views of being concerned with the client's overall well-being, which prompted the participants to search for suitable activities. The narratives are compatible with what Nylenna, Bjertnaes, Øyvind, Saunes and Lindahl (2015:12) describe as the health care, categorised by its degree of increasing the likelihood of desired outcomes of health by services for individuals and populations. According to Lavoie et al (2006:227), caring is a moral imperative that involves a human trait and interpersonal interaction and a series of therapeutic interventions that should be desirable.

Respecting human rights and upholding ethical principles emerged as sub-theme for understanding nursing ethics. The ability to respect human rights and maintain ethical principles starts with knowing these rights and principles. Burkhardt and Nathaniel (2014:59) suggest that understanding moral principles is vital for nurses, as it precedes meaningful and consistent application. Findings reveal that ethical principles and human rights upheld in this study were confidentiality and privacy, Batho-Pele respect for autonomy, principles and non-maleficence. The ethical principles are understood as comprising rules of obligations, as each principle has rules such as do not harm or kill (McQuoid-Mason 2018:90). Thus, their understanding helped nurses to deliver care with moral truths. According to Dhai (2019:5), these principles are to be used as a comprehensive framework for deliberation and application in any situation, and not in isolation, unless they conflict. The findings show that emphasis was placed on some and not all the principles. Although Van der Wal and Pera (2018:66) emphasised that ethical principles are maintained within the fiduciary nurse-patient relationships, participants

were very selective in incorporating them into their care. This particular use of principles and human rights demonstrates the need to make students adept in these fundamental aspects of nursing ethics.

4.4.2.2 Viewpoints regarding senior professionals' ethical conduct

This study's findings illustrate concerns regarding the moral conduct of senior professionals in health care services. Com-serve is considered a period of supervision and monitoring for the professional growth of the newly graduated nurses as they become acquainted with the policies and procedural aspects of the institutions (Thopola, Kgole & Mamogobo 2013:174). Nonetheless, the findings reveal that the reality was some forms of negligence, misconduct, breach of confidentiality regarding patient information, and poor trust between doctors and nurses. Similarly, findings were revealed by the undergraduate nursing students' experiences in the study conducted by Fadana and Vember (2021:e2) in the Western Cape health facilities (Fadana & Vember 2021:e2). In contrast, Mabusela and Ramukumba (2021:e4) displayed a poor work ethic and lack of commitment amongst the Com-serves. Thus, there are general doubts about senior and junior nurses regarding ethics competence.

Although on a small scale, the moral conduct of senior professionals in this study portrays the ethical and legal challenges these professions face. The perspectives of Com-serves display a need for ethical competence in nursing as most participants moaned for further ethical development. Chowdhury (2016:1) asserts that organisations whose residents uphold moral values and manifest specific virtues are likely to flourish. Given that the participants are in the interface of being appointed as professional nurses, they presented some recommendations for the way forward for nursing ethics.

4.4.2.3 Recommendations to enhance ethical practice

The findings voiced recommendations to enhance ethical practice. The suggestions from the community service practitioners show the need to address nursing ethics education and practice gaps. The results reveal that nursing ethics education needs to be relooked and extended to include practical components. The requisite to involve the clinical professional in teaching students was proven to be critical. Another issue revealed by the findings was the in-service training that should be guided towards the nursing personnel

and the medical practitioners, as their moral attitudes were deemed to be deteriorating with time.

4.5 SUMMARY

The qualitative findings emerging from interviews with educators and Com-serves have been presented. The findings revealed that the educators and Com-serves have diverse views in conceptualising nursing ethics. They reflected on challenges facing nursing ethics education and suggested ethics education and continuous development of all health practitioners. The following Chapter 5 is focussed on the analysis and presentation of quantitative findings.

CHAPTER 5

ANALYSIS AND PRESENTATION OF QUANTITATIVE RESULTS

5.1 INTRODUCTION

In this chapter the researcher presents and discuss the results obtained from quantitative data. The results emanate from the quantitative review of the module guides and the self-administered questionnaires. The researcher assessed the ethics knowledge of the newly qualified nurses using questionnaires with 44 variables. These variables measured the respondents' confidence regarding nursing ethics, awareness of moral theories and the legal system informing health services in South Africa, and the determination of their moral reasoning and self-conduct when faced with ethical issues. The researcher reviewed the module guides to establish whether the theory and practice illustrated in the module guides are likely to assist in acquiring ethical skills. Tables and graphs are used in presenting the results.

5.2 PRESENTATION OF DOCUMENTS REVIEW

In undertaking the document review, the researcher requested various records from the designated nursing education institutions in Free State Province. The researcher was expecting to get all the curriculum records from the institutions. However, the curriculum of the Regulation R.425 programme, previous tests, and exam papers for review were not made available by the relevant institutions (SANC 1985). Private institutions declined the request for the documents, and three public institutions provided the module guides. The module guide was for the subject ethos and professional practice (EPT215/225 and EPP100) under the programme four-year Diploma in nursing (general, psychiatry, community) and midwifery (Regulation R.425), which is offered in the 3rd and 4th years of the study (SANC 1985). The three institutions have one central curriculum development office, and their module guides are similar.

Based on the module guides, the researcher developed a checklist to fit the module guide. In addition to the general components of the module guide, the checklist was made to include items specific to nursing ethics.

5.2.1 Ethos and professional practice (EPT215/225 and EPP100)

The three institutions offer courses in the 3rd and 4th years of study. In these levels of study, students are assumed to have gone through other nursing courses and understand the theoretical aspects of disease and its effect on humankind. This background, as a requirement, make the ethos and professional practice course appropriate for the students in the group, as this links to their previous learning experiences.

5.2.1.1 Module guide structure

The checklist was used to establish the presence or absence of specific components that are considered to inform the development of the module guide, as illustrated in Table 5.1. The checklist demonstrates that all the modules had a validating goal and learning units' outcomes for this course; ethos and professional practice; refer to Table 5.1.

Table 5.1: Broad perspective of module guide

Module guides contents	**Review**	
Presence/absence	**Yes**	**No**
1 Exit level outcome	X	
1A Critical cross-field outcomes	X	
1B Module board objectives	X	
2 Learning hours	X	
3A Contact 40 hours per semester	X	
3B Practical experience	X	
3C Student-lecturer interaction; schedules	X	
4 Theoretical learning units	X	
4A Learning units' outcomes	X	
4B Unit-specific study material	X	
4C Preparation material	X	
4D Content material	X	
4E Learning activities	X	
4F Number of activities	X	
5 Clinical learning units	X	
5A Learning units' outcomes	X	
5B Unit-specific study material	X	
5C Preparation material	X	
5D Content material	X	
5E Learning activities	X	
5F Number of activities	X	
6 Prerequisite and student responsibilities	X	

Module guides contents	**Review**	
Presence/absence	**Yes**	**No**
7 Module calendar		X
8 Associated assessment criteria	X	
8A Calculation of the final mark		X
8B Assignments	X	
8C Test	X	
8D Clinical assessments	X	
8E Exams	X	
8F Criteria for passing the module		X
9 Course evaluation		X
Total=31	**27=87.10%**	**4=12.90%**

Most variables were identified to be present within the module. 87.10% of all the module requirements were determined to be present. Thus, it may be said that the completeness of the module was evident. However, there is room for improvement as 12.90% of the required components of the module were not there. However, 12.90% is likely to have a restrictive factor, given that the module guide aims at assisting students. As shown in Table 5.1 above, the module calendar, criteria for passing the module, and the course evaluation are not included. The course evaluation may confer the students' subjective experiences regarding the effectiveness of the course, and these are some of the items that point to areas that need attention upon revising the module.

Furthermore, Table 5.1 above indicates that the module guide for ethos and professional practice (EPT215/225 and EPP100) has exit-level outcomes in the module guide. According to the South African Qualifications Authority (SAQA) (2014:24), outcomes include the knowledge, skills, and attitudes a learner must have mastered upon completing the course. According to Butcher, Davies and Highton (2006:21), these outcomes should show coherence between the curriculum, course, and teaching processes. The exit outcome for the ethos and professional practice (EPT215/225 and EPP100), as demonstrated by the three nursing education institutions, was:

> "The goal was to ensure that each student who has undergone the training will be able to function throughout the period of professional practice as a knowledgeable, competent, confident, concerned, compassionate, and caring practitioner".

The critical cross-field outcomes were also incorporated in the module, as illustrated in Table 5.1. Critical cross-field outcomes are crucial competencies that inform teaching and

learning and are essential for effective participation in work organisation SAQA (2014:24). And these critical cross-field outcomes are stated as follows:

- Collect, organise, analyse, and evaluate information in a critical manner.
- Communicating in an effective manner, whereby language skills is used for oral and/or written presentations.
- Become aware of the responsibilities and the effective learning strategies' importance.
- Show and understand that the world is a systemic set which is interrelated and to recognise and understand that problem-solving contexts do not exist in isolation.
- Identification and problem-solving.
- Organise and manage the own activities in a responsible and effective manner.
- Utilisation of science and technology in an effective and critical way, showing responsibility towards the environment and health of others.
- Work efficiently with others as a team, group, organisation, or community member.

The module guides have objectives, as shown in Table 5.1 above. According to (Harden, Laidlaw & Hesketh 1999:249), every module guide defines learning objectives related to knowledge skills and attitudes. These objectives are interpreted in terms of the intention of the content, teaching strategies, and assessment for the specific course (Butcher et al 2006:44). These six broad objectives were outlined thus:

- Acquire and utilise knowledge and skills about complex medical, surgical, and psychiatric conditions within the framework of ethos and professional practice in caring for individuals and groups.
- Solving of complex health care problems holistically, within the legal and ethical framework of the profession.
- Utilise the scientific and social skills during interaction with individuals, groups, and communities with consideration of cultural diversities.
- Combining basic natural science and knowledge in providing scientific care.
- Management of comprehensive health services professionally and independently by being a leader of the nursing team.
- Conducting research and the utilisation of results for the promotion of high standards of health.

The ethos and professional practice courses in these three institutions are offered in the 3rd and 4th years of the study. The researcher checked how the objectives were spread across these two levels of learning and teaching. Although the third and fourth-year objectives overlap, some of the objectives are specific to the year of study. The researcher checked the course content, teaching strategies, allocation of hours, and the assessment against these objectives. The learning units and outcomes thereof are given in Tables 5.2 and 5.3 respectively below.

5.2.1.2 Ethos and professional practice in the third year of study

As stated above, the first three objectives are relevant to the ethos and professional practice in the 3rd year of study. A total of eight learning units were completed during this period, as displayed in Table 5.2 below. Interestingly, the teaching strategies such as formal lectures, group discussion, role-play, buzz session, individual assignments, self-study, and the assessment method such as class tests, predicate tests, and exams are written as general statements at the beginning of the module guide. Although Lee (2005:103) recommends that teaching strategies support the development of lifelong learning skills, this was not made explicit in the module guide. The way the teaching and assessment strategies are presented makes it difficult for one to determine which method was used for which unit content and for which outcome.

Table 5.2: Third-year content components

Learning units	Unit outcome	Specific outcomes	Time allocation
History of nursing	Demonstrate understanding of the effects of various factors on the evolution of nursing	Demographic factors and availability of personnel. Socio-cultural and socio-political factors and health policy	2 hours
Professional organisation/associations	Demonstrate understanding of differences between the professional organisation, association, and trade union: characteristics, functions, and activities	Approaches to negotiations terms and conditions, membership, protection of professional advancement, education, and research. Mutual insurance, collective bargaining. concerns	5 hours
Principles of professional practice	Demonstrate understanding of relevant concept litigation, duties, accountability, the role of nurse-patient advocacy, and the situation in which a nurse may refuse to cooperate with a multidisciplinary team.	Principles of professional practice. Instrumental and expressive role of a nurse. Duties and functions of nurse: Accountability and advocacy roles of nurse and function of a nurse. Duty to take care and understand categories of litigations from lack.	5 hours
Standards of practice	Demonstrate understanding of standards of care and knowledge	Understanding of the concept standard. Principles used for developing standards. Characteristics of standards and purpose of standards of care. The use and benefits of nursing practice standards	5 hours
Managerial and Leadership	Demonstrate knowledge and understanding of relevant concepts relating to leading the way, directing, effective leader and approaches	Understand: concepts of leadership, director, authority and power; connotation leading the way, General principles of directing-worldview, self-knowledge, knowledge of followers' communication skills, role modelling problem-solving group dynamics and accountability; characteristics of an effective leader and leadership approach characteristics, principles and processes	10 hours

Learning units	Unit outcome	Specific outcomes	Time allocation
Ethical decision making	Demonstrate knowledge and understanding of relevant concepts, differentiate between these concepts, approaches, and process	Understand non-maleficence, ethics-autonomy, beneficence, justice, veracity, fidelity, altruism and caring; differentiate between non-maleficence and beneficence, veracity and fidelity; ethical decision making and deontological, utilitarian and naturalism approaches; dilemma; ethical dilemma and Decision making-ethical analysis and assessment, ethical resolution strategy development, execution and review of strategy	9 hours
Problem-solving	Demonstrate understanding of concepts, principles, and processes of problem-solving	Demonstrate understanding of problem-solving, principles of decision making, and problem-solving. Identification of challenge; analysis, diagnosis and assessment. Formulation of decision-making criteria, alternatives, and evaluation of options, selection of and implementation, and evaluation of goal achievement.	4 hours
Change process	Demonstrate knowledge of understanding of concepts relevant to the change process. Types, characteristics, differentiation, levels, models, phases, factors leading to resistance, strategies, emotional reaction, and management.	Understanding of concepts relevant to the change process. Characteristics and levels of Planned and unplanned types of change. Describe the seven phases of planned change in Lewin's model phases of change.	4 hours

As highlighted in Table 5.2 above, some learning units include the history of nursing, professional organisations, assassination, professional practice principles, and standards of practice. The practice standards are those specialised nursing practices that assist in nurses' professional role development and growth from novice to expert (Harper, Maloney, Shinners 2017:330). Emanating from Table 5.2 above, the principles of professional practice entail accountability and advocacy roles and functions of a nurse, which must be understood that lack of these may result in litigations. Therefore, the student must conceptualise these principles and the history of nursing, which will provide knowledge of how the profession evolves. This is what Jooste (2010:9) defines as nursing professionalism.

Table 5.2 above demonstrates that the content relevant to nursing ethics entails the standard of practice, principles of professional practice and ethical decision-making principles. The principles of professional practice and standard of practice are allocated five hours each, while nine hours are designated for ethical decision-making. This gives 19 hours of nursing ethics. As shown in Table 5.1 above, the unit dealing with ethical decision-making discusses moral theories. Moral decision-making ideals are limited to ethical principles, deontological, utilitarianism, and naturalism approaches. Theories such as virtues ethics, care ethics, and Ubuntu are excluded.

As exemplified in Table 5.2 above, the total time allocated for these learning units is 44 hours. The principles of professional practice and standard of practice are allocated five hours each, while nine hours are designated for ethical decision-making. This gives 19 hours to the content that may be aligned with nursing ethics.

The learning unit on Managerial and Leadership, as shown in Table 5.2 above, indicates that some specific outcomes include general principles of directing worldview and self-knowledge. Although these outcomes talk about awareness of one's worldview and personal values, these are required to lead and handle others and not as the first step in moral judgment. Koscielniak and Bojanowska (2019:2) indicate that values are guiding principles and enormously impact judgment and decision-making. Therefore, reflection on diverse theories and personal values calls for teaching strategies to develop these skills and attitudes.

5.2.1.3 Ethos and professional practice in the fourth year of study

As presented in Table 5.3 below, the content offered in the fourth year of study is relevant to the last three objectives previously mentioned, and Table 5.3 clarifies how these objectives were translated into the content.

Table 5.3: Module guide components at the fourth-year level

Learning units	Unit outcome	Specific outcomes	Time allocation
National core standards for health	Understand and utilise the domains of national core standards	Understands and utilises in the nursing practice: Rights of the patient. Patient care, clinical governance, and safety and security. Clinical support services. Public health. Leadership and corporate governance. Operational management. Facilities and infrastructure.	Not reflected
Nursing unit management	Identify fundamentals of nursing unit: planning, organisation, directing, control, financial management, and nursing and the law	Identify policies relevant to a specific unit. Compile duty roster, handle scheduled 5,6,7 substances under supervision, delegate personnel according to their capability and scope of practice and compile an organogram for the unit. Take charge of the unit, do doctor's rounds, record and handle instructions, write progress reports, and compile a care plan. Audit healthcare user records. Do ward inspection. Write an incident report.	Not reflected
Clinical education	Be able to explain and demonstrate ability in clinical and personnel development	Explain personnel development, Performance appraisal, in-service training, induction, orientation, and continuous education. Compile orientation programme.	Not reflected
Research	Evaluate a research article	Identify whether the title is descriptive or simple, statement of the problem, designs used, sampling, instrument, and dissemination of data methods, data collection methods, ethical considerations.	10 hours
Disaster nursing	Relate disaster nursing content to the national core standards for health	Describe types and causes of the disaster, preparedness of the nursing unit, and working according to the code of Conduct. Describe principles in dealing with a bomb threat and train personnel regarding disaster management. Taking care of the next of kin and deceased persons. Describe the post-disaster time	10 hours

Learning units	Unit outcome	Specific outcomes	Time allocation
Labour relations	Explain the concepts	Management of complaints and grievances in a nursing unit. Describe the purpose of a grievance procedure, disciplinary action, and different types of discipline. Describe the purpose of the Labour Relation Act and the rights of employer and employee. Describe the purpose of the Industrial Relations Policy. Analyse scenarios in relation to grievance and disciplinary action taken by the professional nurse in a unit. Describe the process of conflict management and strategies to prevent or limit conflict. Describe trade unions: freedom of association, motivation to join a trade union, functions of trade union representative/shop steward.	20 hours

Table 5.3 elucidates that the content such as National Core standards for health**,** nursing unit management, and clinical education has not been allocated time. Although the National Core standards for health may be relevant to nursing ethics, especially regarding the nursing practice and patients' rights, these are within the crest of corporate governance and leadership, infrastructure, operational management and facilities.

Teaching strategies such as formal lectures, group discussion, role-play, buzz session, individual assignments, self-study, and the assessment method such as class tests, predicate tests, and exams are also written as general statements at the beginning of the module guide**.**

5.3 PRESENTATION OF DATA FROM RESPONDENTS REGARDING ETHICS KNOWLEDGE

A total of a 180 Com-serves placed in public healthcare institutions received the questionnaires. However, there was a low turnout of respondents, which was attributed to the challenges brought about by COVID-19, as the potential respondents were from a workforce allocated to the area designated for patients with COVID. This is, therefore, a limitation of the study as only forty-nine questionnaires were returned. A total of 49 questionnaires were cleaned for the descriptive statistical analysis. However, one case

of unreliable data during the cleaning did not reflect the population under study. Therefore, only 48 questionnaires were managed and prepared for statistical analysis. The biostatistician assisted with descriptive statistical analysis of the questionnaires, and the researcher interpreted the results.

5.3.1 Respondents' demographic data

The respondents' demographic variables, which is gender, age, educational profile, and current position, are illustrated in Tables 5.4 and 5.5; and Figures 5.1 and 5.2.

5.3.1.1 Respondents' gender distribution

Table 5.4 illustrates that the majority of respondents were females, 85.42% (n-41), while males were only 14.58% (n=7) from a total number of (N=48, 100%) respondents.

Table 5.4: Respondents' gender distribution (N=48)

Variables	Category	Frequency	Percentage (%)
Gender	Female	41	85.42
	Male	7	14.58

According to statistics in South Africa [Stats SA] (2021:27), the mid-year population estimates show that Free State Province has a population of 2 932 441, of which 48.33 are males while females make up 51.67%.

5.3.1.2 Respondents' age distribution

The respondents' ages varied from 20 and above, and the majority were between the ages of 29 and 25, as per Table 5.5 overleaf.

Table 5.5: Respondents' age distribution (N=48)

Variables	Category	Frequency	Percentage (%)
Age	20-25	18	37.51
	26-30	16	33.33
	>30	14	29.16

Although the average age of graduates is acceptable at 20-25 years, this age in this study reflected 37.51% (n=18) of the respondents. However, the nursing profession is seeing a

significant number of mature and older students, which might be the reason why 33.33% (n=16) and 29.16% (n=14) were above 26 years and 30 years, respectively. Maturity may benefit others with focused perceptions and diverse strategies for dealing with an ethical problem.

5.3.1.3 Respondents' positions in community service practice

As per the graph below, most respondents were still engaged in Community service. The majority of n=34 (70.83%) participants were still doing community service, while 29.17% (n=14) completed the community service practice. Figure 5.1 below illustrates the period of the current position, which ranges between 0-6 months and 7-12 months. A small percentage, 34.4% (n=16), had an experience of more than seven months, while the majority of 31 had 0-6 months of experience. In that regard, of the 31 with service of 0-6 months are 14 of those who have completed Com-serve. The variation of community service status is expected to bring various understanding and different depths of ethics knowledge and application.

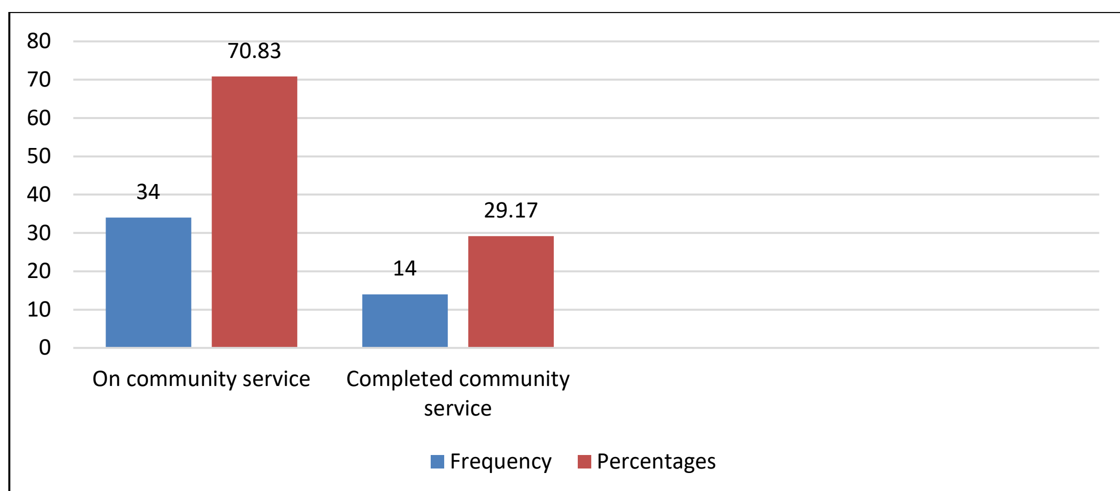

Figure 5.1: Current position in community service practice (N=48)

5.3.1.4 Respondents' academic levels

Reflecting on the respondents' level of education, Figure 5.2 overleaf, indicates that the majority of participants, 79.17% (n=38) had a Diploma while 20.83% (n=10) had a Bachelor's degree in nursing. These differences in education may be ascribed to different factors.

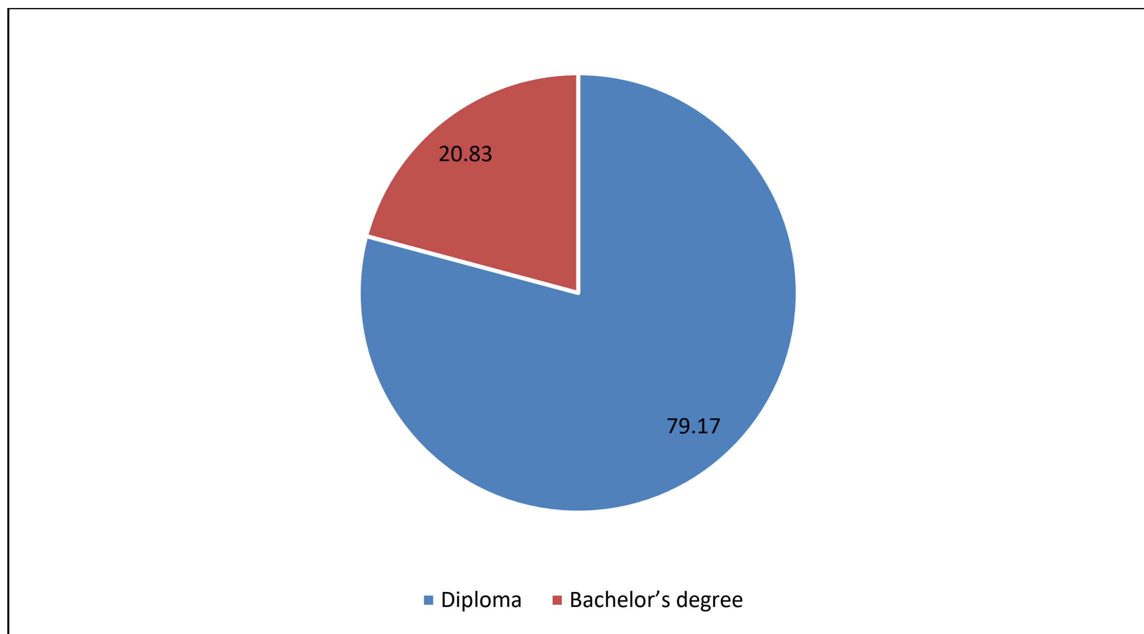

Figure 5.2: Educational level distribution (N=48)

Mulder and Uys (2012:60) indicate that students at public institutions are under the Department of Health governance, which caters for their education's financial expenses. As such, many may opt to have a Diploma rather than a degree. Another reason may be matriculation marks that qualify a limited number to study at the university.

5.3.2 Information relating to ethics knowledge

Nursing practice necessitates a high ethical awareness as nurses' activities hold a moral significance (Liaschenko & Peter 2016:S19). According to Gastmans (1999:215), nursing ethics does not derive its activities from mere tasks. Instead, these tasks demand good nursing standards that request a 'more than a competent practitioner who is aware and confident in caring activities (Gastmans 1999:215).

5.3.2.1 Confidence in ethics training

Table 5.6: Confidence in ethics

Variables	Category	Frequency	Percentage (%)
Q6. Did you have ethics education during your basic nursing training?	Yes	48	100.00
Q7. Do you think you have enough ethical knowledge to apply in your daily nursing practice?	No	4	8.33
	Yes	44	91.67
Q8. Do you think you need further assistance regarding nursing ethics?	No	13	27.08
	Yes	35	72.92
Q9. Are you confident in exchanging ethical views with other medical professionals?	No	3	6.25
	Yes	45	93.75

Table 5.6 above, explicates the frequency of self-measures questions regarding confidence in acquiring ethical knowledge. All the respondents (N=48, 100%) reported to have undergone ethics training, and only 8.33% (n=4) considered themselves not to have enough understanding of ethics to carry out their daily nursing care. The majority of (n=45), 93.75% participants, felt confident discussing and exchanging views on ethics with other professions. That was followed by (n=35, 72.92%) confirms a need for further ethics training. On the other hand, (n=13, 27.08%) participants responded that they don't need additional ethics knowledge.

5.3.2.2 Importance of ethics and awareness in nursing

Table 5.7 below depicts nursing ethics' awareness and the importance of different parts of nursing ethics among the respondents. The majority of (n=47, 97.92%) respondents, agree that ethos is an essential aspect of nursing education, and all (n=48, 100%) Com-serves, agree that ethics is crucial for patient care. While (n=40, 88.33%) agree that nursing ethics content was relevant, furthermore, (n=8, 16.67 %) respondents, consider it irrelevant. As such all (n=48, 100%), believe it is essential, whilst (n=32, 66.67%), were unsure whether other nursing courses are more important than ethics. More surprising was when (n=6, 12.50%) agreed that ethics is not that important compared to other nursing courses (B4).

Table 5.7: Importance and awareness of nursing ethics

Questions	Agree		Agree sometimes		Do not agree at all	
	N/n	Percentage (%)	n	Percentage (%)	n	Percentage (%)
B1. Ethos is an essential aspect of nursing education	47	97.92	1	2.08	0	0.00
B2. Ethos is crucial for good patient care	48	100.00	0	0.00	0	0.00
B3. The ethics topics taught were relevant to nursing	40	83.33	8	16.67	0	0.00
B4. Other nursing courses are more crucial than ethics	6	12.50	32	66.67	10	20.83
B5. I am aware of values that are necessary for ethics practice	42	87.50	6	12.50	0	0.00
B6. I am aware of the nursing code of ethics	44	91.67	4	8.33	0	0.00
B7. Teaching of rules and regulations is adequate for patient care	45	93.75	1	2.08	2	4.17

Table 5.7 further depicts the degree to which the respondents consider the significance of ethics in their nursing activities. As question B1 points out, the majority of (n=47, 97.92%) participants agree that ethics education is crucial. Question B2 shows that (N=48, 100.00%) of the respondents agree that ethics is an integral part of patient's care. In comparing the importance of nursing ethics education with other nursing subjects in Question B4, (n=6, 12.50%) agree that other nursing subjects are more critical than ethics, while (n=32, 66.67%) accord that sometimes-other fields of nursing are deemed vital, and only (n=10, 20.83%) indicate that ethics training is of the essence. On the other hand, the majority (n=44, 91.67%) of the Com-serves were aware of the nursing codes of ethics.

Nonetheless, only (n=42, 87.50%) were aware that nursing values are enshrined within the codes of ethics. Given that the Com-serves are novices within the nursing profession, it is not surprising that a large proportion of the respondents, (n=45, 93.75%), believed that they count only on rules and regulations in their nursing practice. These respondents believed the teaching of regulation and rules is adequate on its own to guide their nursing activities.

5.3.2.3 Knowledge of moral theories and statutes relevant to nursing care

Emerging from Table 5.8 below, is the extent to which the respondents self-measure their knowledge regarding theories and laws that form the framework for nursing ethics practice in South Africa. The majority of (n=30, 62.50%) knew about the principles, while (n=10, 20.83%) respondents were unsure, and (n=8, 16.67%) knew nothing about them. When asked about consequentialist and utilitarianism being one example, only (n=27, 56.25%) respondents demonstrated awareness of such a moral theory. In contrast, (n=13, 27.08%) of the Com-serves were unsure, and (n=8, 16.67%) reported a lack of knowledge. Familiarity with Kantian Deontology scored (n=30, 62.50%). And (n=11, 22.92%) were oblivious of Kantian Deontology, and (n=7,14.58%) doubted their knowledge. Awareness of virtue ethics saw a slight increase of (n=39,81.25%), while (n=2, 4.17%) were not acquainted with it, and about (n=7, 14.58%) respondents were unsure of themselves.

In collaboration with previous questions regarding the use of rules and regulation, the acknowledgement of respect for human dignity, respect for life, advocacy, and altruism was as high as 97.92% up to 100.00%. Nonetheless, the recollection statutes of (n=37, 77.09%), indicated that they know the laws in health care, while (n=10, 20.83%) of the respondents were unsure and only (n=1, 2.08%) had no insight.

Table 5.8: Knowledge of moral theories and statutes

Questions	Agree		Agree sometimes		Do not agree at all	
	N/n	Percentage (%)	n	Percentage (%)	n	Percentage (%)
QB8A Four principles	30	62.50	10	20.83	8	16.67
QB8B Consequentialist/ Utilitarianism	27	56.25	13	27.08	8	16.67
QB8C Kantian Deontology	30	62.50	7	14.58	11	22.92
QB8D Virtue ethics	39	81.25	7	14.58	2	4.17
QB8E Care ethics	43	89.59	4	8.33	1	2.08
QB8F Ubuntu/African ethic	45	93.75	2	4.17	1	2.08
QB8G Human dignity	47	97.92	1	2.08	0	0.00
QB8H Respect for human life	47	97.92	1	2.08	0	0.00
QB8I Honesty	47	97.92	1	2.08	0	0.00

Questions	Agree		Agree sometimes		Do not agree at all	
	N/n	**Percentage (%)**	**n**	**Percentage (%)**	**n**	**Percentage (%)**
QB8J Altruism	46	95.83	1	2.08	1	2.08
QB8K Advocacy	48	100.00	0	0.00	0	0.00
QB9 Statutes or law that guides my practice	37	77.09	10	20.83	1	2.08

As portrayed in Table 5.8, most respondents have substantial knowledge of various moral theories and South African statutes applicable in healthcare services. Table 5.8 depicts knowledge of moral theories and statutes, whereby (n=10, 20.83%) respondents indicated that they are not sure about their knowledge regarding laws in health care, and only (n=1, 2.08%) had no insight.

5.3.2.4 Responses to open question regarding ethical principles

In verifying if there will be a significant difference between the opinions and actual knowledge of the ethical-legal framework, the findings in Figure 5.3 were tested using open-ended questions. The open-ended questions asked the respondents to write down ethical principles that form a framework for decision-making during nursing care practices and the legal environment of health care they practice. The responses in Table 5.9 emanate from the responses of the open-ended question pertaining to the principles (autonomy, beneficence, non-maleficence and justice). Even though none of the respondents could recall and write down all four principles, the majority (n=26, 54.16%) could mention only three principles.

Table 5.9: Response to the open question regarding principles (N=48)

QB10	Frequency	Percentage (%)
Autonomy, beneficence, non- maleficence	26	54.16
Do not remember	18	37.51
Confidentiality, autonomy, justice	1	2.08
Patients' advocacy, integrity, protection	1	2.08
Respect for autonomy, beneficence,	1	2.08
Veracity, autonomy, non-maleficence	1	2.08
Total	**48**	**100.00**

Although some respondents did not write all four principles as common morality descriptors, they recollected veracity and confidentiality. While 8.32% could remember at

least two principles, a large percentage of the Com-serves, 37.51%, indicated that they could not remember the principles underlying ethical practice.

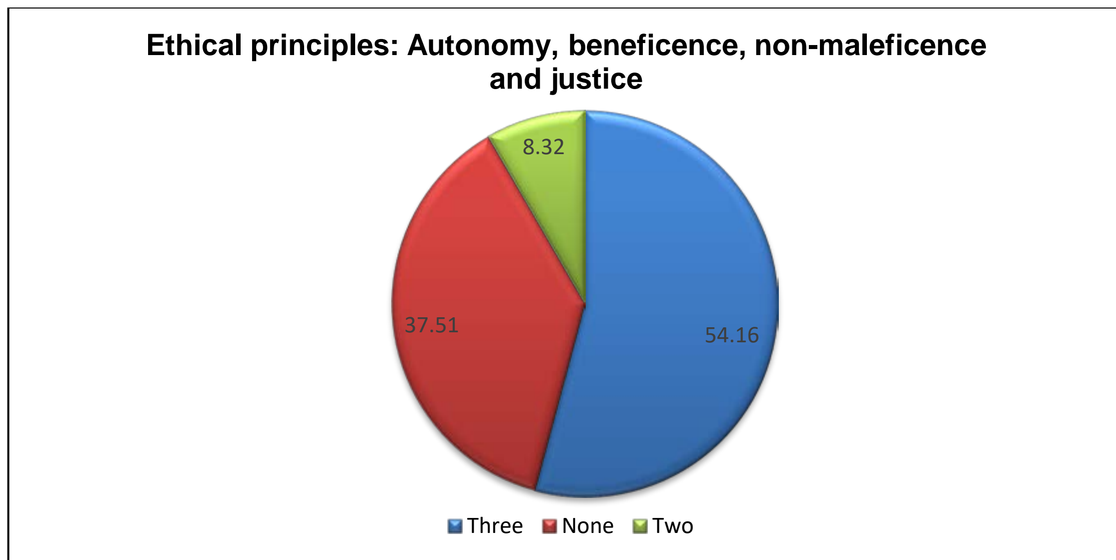

Figure 5.3: Response to open question regarding principles (N=48)

Figure 5.3 represents the state of moral knowledge as authored by the respondents. Based on Figure 5.3, the majority of (n=26, 54.16%) respondents could recall the principles, while (n=18, 37.51%) had no idea of the ethical principles. Therefore, a picture of limited knowledge of these guidelines is portrayed.

5.3.2.5 Responses to open questions regarding laws and regulations in nursing practices

An open-ended question was asked to determine the reality behind the (n=39, 77.09%) respondents who agreed to know laws relevant to healthcare services (see Table 5.8, QB9). Given the alarming increase in medical malpractice litigation in South Africa, the understanding and knowledge of nurses is imperative in understanding laws pertaining to health care and the regulation of the nursing practice. Table 5.10 below, summarises the written responses of statutes that guide nursing activities in the health care system. The table provides the frequency with which the participants mentioned a particular Act.

Table 5.10: Response to the open question regarding laws in nursing practice

QB11	Frequency	Percentage (%)
Don't know	18	46.08
Nursing Act (Act No. 33 of 2005)	12	30.72
Scope of Practice of Registered Nurses and SANC Regulations	6	15.36
The National Health Act	4	10.24
South African Constitution	3	7.68
Patient's Rights Charter	2	5.12
Mental Health Act	2	5.12
Batho Pele Principle	2	5.12
Labour Law	1	2.56
Children's Act	1	2.56

In Table 5.10 above, (n=18, 46.08%) of the respondents indicated that they don't know the laws that guide health care services. The knowledge of the Nursing Act (Act No. 33 of 2005) stood at 30.72% (n=12), while the scope of practice and SANC regulations bore 15.36% (n=6). Of particular interest was the limited reference to the South African Constitution, which stood at (n=4, 10.24%), the National Health Act scored (n=2, 5.12%), and the Children's Act, which had only (n=1, 2.56%). The level of knowledge regarding these Acts are consistent with the review of the micro-curriculum in Figure 5. 4 overleaf.

5.3.3 Responses regarding moral reasoning knowledge

The dimension of nursing care is characterised by a stressful and challenging work environment, in which nurses are regularly faced with ethical decision-making (Goethals, Gastmans & Dierckx de Casterlé 2010:635). Cognitive process is when a decision is made which is influenced by contextual and personal factors (Goethals et al 2010:635). Thus, decision-making calls for conscious reflection on moral theories and statutes. However, Haidt (2001:815) indicates that in most cases, ethical decisions are initially paved by instinct. Haidt (2001:814) mentions that the primary source of moral judgment is instinct, influenced by feelings that lack evidence; however, for morally correct assertions, intuition is to be followed by reflection processes. In establishing the moral reasoning knowledge of the Com-serve, various versions of issues were grouped for testing.

Figure 5.4 depicts Com-serves' responses on various issues relating to ethical decision-making of practicing ethics. Figure 5.4 highlights that (n=47, 97.92%) of the respondents

are motivated to provide good patient care. While more than half, 64.58% of the Com-serves, consider that good care entails making decisions for their patients, 54.17% believed such decisions translate mainly from knowledge of nursing courses and not ethics. Another significant finding of the study was that the majority of (n=44, 91.67%) respondents agree that patients' involvement in their care is essential, and the least number of (n=4, 8.33%) Com-serves indicated that clients' participation might sometimes be considered. This variation is interesting because it can be assumed that the patients state that these Com-serves were caring for needed decisions for the patient's interests. Most of the completed Com-serves were working in COVID-19 wards, and the condition of the patients might have informed their choice of response.

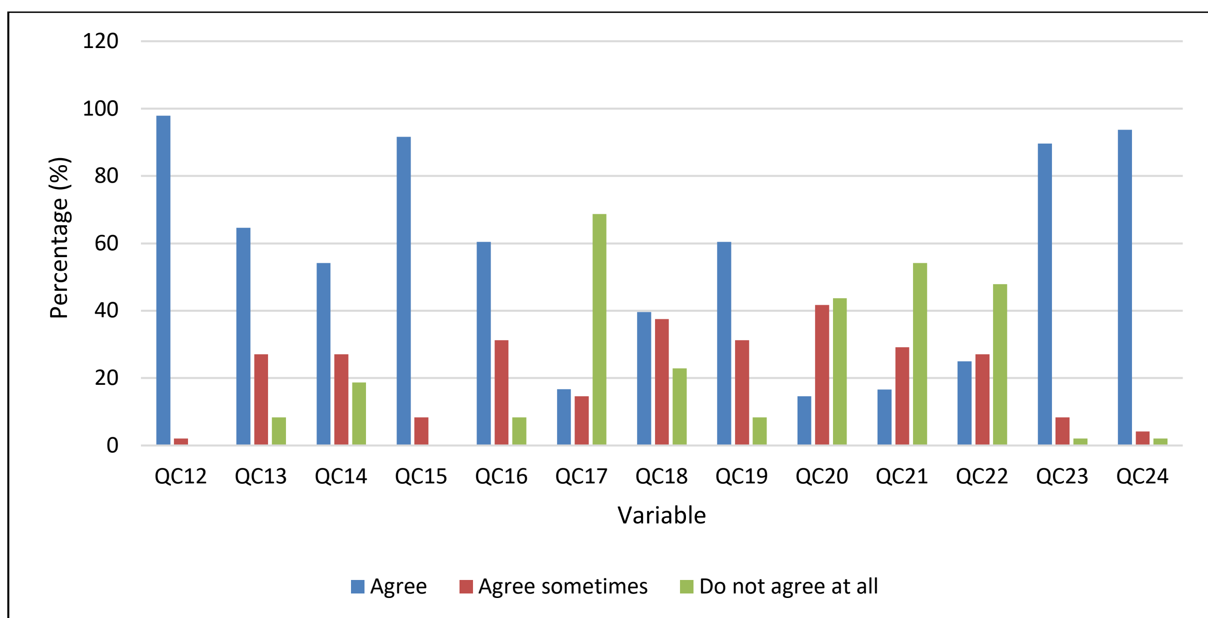

Figure 5.4: Knowledge regarding ethical decision-making (N=48)

Although a significant portion agrees on patients' involvement in their care, only (n=8, 16.67%) concur that patient consent is needed to check vital signs and administer the medications to patients. The majority of (n=33, 68.75%) respondents, disagree that permission is required for implementing such activities. Such an approach might emanate from a lack of knowledge regarding consent's legal and ethical aspects. Furthermore, the obligation to perform one's duty may have enjoyed preference without one being aware that such duty may compete with the patient's self-determination.

The finding in QC19 depicts that (n=29, 60.42%) which is half of the respondents, indicated that they would inform patients regarding errors that are likely to happen during the care of patients. Another favourable aspect of the data was the responses to adhering

to the patients' requests. The findings illustrate that (n=29, 60.42%) of the respondents indicate that they would abide by such a request, while (n=15, 31.25%) would sometimes do that, and (n=4, 8.33%) would disagree with a request. In QC20, a small percentage of 14.58% indicates that patients' information may be shared with relatives, while 41.67% said sometimes and 43.75% would never disclose patients' data to relatives.

It was intriguing when the majority of (n=23, 47.92%) respondents, indicated that they would not disclose the information, even for care facilitation. In this regard, only 25.00% of respondents agreed, and 27.08% said sometimes they would disclose information to facilitate the patient's care. The disclosure of information also reveals that 54.17% of the Com-serves would not disclose, even when requested by law. Only a minority of (n=8, 16.66%) agreed to disclose if the courts ordered. Thus, the limitation of the legal aspects of health care is a weighty issue.

5.3.4 Responses regarding self-conduct and ethical behaviour

Stemming from Figure 5.5 is the self-conduct and assessment of own behaviour during nursing care practices. According to Rua, Lawter, and Andreassi (2016:289), self-control or self-regulation is the capacity to override, delay, interrupt, and alter one's behaviour. As exhibited in Figure 5.5 overleaf, the respondents were asked whether they would never hurt anyone (QC25); a significant number of (n=42, 87.50%) Com-serves agreed to not harming anyone.

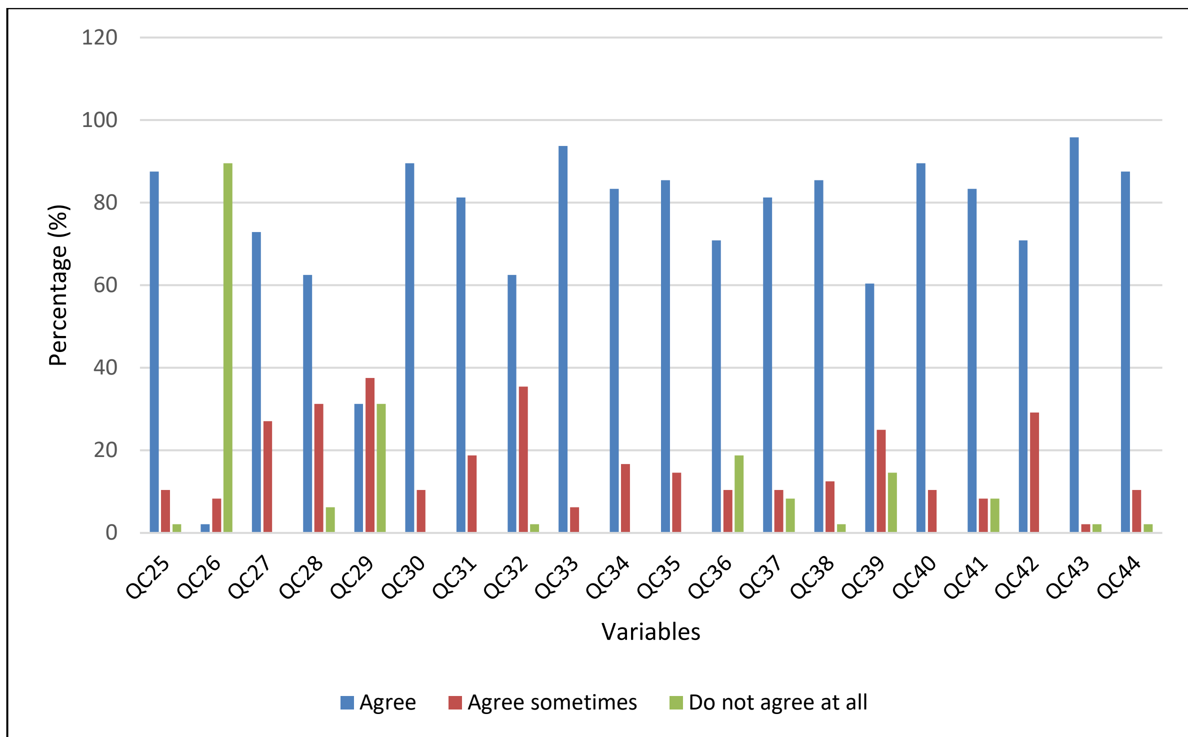

Figure 5.5: Self-regulation and conduct (N=48)

Similarly, (n=43, 89.58%) of the respondents attest that they may not cover up physical or psychological harms to avoid complaints from patients and relatives. While the majority of (n=35, 72.92%) respondents take the stand in caring for clients who were rude to them without bad feelings, only (n=13, 27.08 %) indicated that sometimes they would care for such patients. Even though the majority of (n=45, 93.75%) respondents, indicated that they know personal values may conflict with professional values, they still insist on taking care of rude patients. The findings in this study are congruent with the nurse's pledge that nurses joining the serve commit to. Another aspect of the code of ethics is the appreciation of teamwork in decision-making. Regarding collaboration (n=41, 85.42%) of the respondents agree to a partnership, and (n=40, 83.33%) indicate that they would strive hard to achieve the expected goals employer.

Although there are no established ethical principles and laws about nurses receiving gifts from patients and their relatives, it has been a thorny issue addressed by institutions' policies. However, self-regulation or control plays a significant role in such cases. In terms of QC37 in Figure 5.5 above, (n=39, 81.25%) respondents indicated that they agree with disclosure of gifts, while (n=5, 10.42%) Com-serves said that sometimes they would agree and (n=4, 8.33%) said never. According to Davies (2015:online), unsolicited gifts from patients or their relatives are acceptable, provided such gesture does not affect how

one cares for the patients, and there were no influences to pressure patients to offer gifts. Thus, evaluating each case and exploring the intention of gifting is ethical willpower that needs discretion.

The idea of respecting human beings has a distinctive sign that entails certain stringent ethical norms with a set of capacities that ground one's dignity (Riley 2015:95). Consequently, QC39 to QC44 relate to how the Com-serves regulate their ethical behaviour in respecting dignity through simple measures. The majority of (n=46, 95.83%) com-serves agreed to measures for enhancing patient dignity, except for QC39, where just above half, 60.42%, agreed that not exposing a patient's illness enhances the sense of dignity.

5.4 DISCUSSION OF RESULTS

5.4.1 Review of documents

The review of the module guides revealed that the ethos and professional practice course has three modules EPT215, a theory module presented in the third year and EPT225, a fourth-year module offered together with EPP100, which is a practical component. The extent of time spent and practical components are remarkable trends in these modules. Spending more time teaching ethos and professional practice, concur with Ten Have (2014:7) that ethics education may never be a once-off approach or a few courses. Still, it needs sufficient time for reflection and acquisition of analysing skills and resolving the ethical dilemmas that will confront health professionals in their future practice.

According to Butcher et al (2006:21), the modules' guides have exit-level outcomes and should show coherence with the curriculum, course, and teaching processes. The modules demonstrate that the exit goal for the Regulation R.425 programme is ensuring that each student who has undergone the training would function throughout the period of professional practice as a knowledgeable, competent, confident, concerned, compassionate, and caring practitioner (SANC 1985). Relative to ethics the students are expected to be a knowledgeable, competent, confident, concerned, compassionate and caring practitioners. Although the intention is good, it is accompanied by some constrained upon reviewing.

The programme's exit outcomes concur with components of being a professional practitioner as described by Girard, Linton and Besner (2005:e5). Within this framework, Girard et al (2005:e5) also emphasise competence concerning knowledge and technical skills and commitment, which focuses on confidence in one's abilities, accountability, and advancement of the profession.

- These exit outcomes are thus benchmarking with the international results because Girard et al (2005:e5) explain the framework for professional practice in Canada.
- The critical cross-field outcomes also concur with Butcher et al’s (2006:30) understanding that the critical cross-field outcomes give an idea of what a typical programme graduate should do able to do. Although the critical cross-field outcomes are considered hidden expectations, the teaching and assessment processes are to achieve these outcomes (Hashmi & Tabassum 2019:3).
    - The review, however, illustrates that the test and exams, lecture methods and discussions were employed in these modules. And these do not support the critical cross-field outcomes.
    - Although these skills are to develop during the module learning and teaching, it must be understood that these skills are subject-independent (Butcher et al 2006:30). As such, it was challenging to say whether these are expected from ethos or professional practice. Though these skills are considered hidden expectations, educators must be aware of and encourage them even during social processes in the educational setting (Alsubaie 2015:125).

Dejene (2018:1) stated that a module is a self-contained coursework that constitutes a particular area of specialisation to build skills and knowledge in discrete units. The module guide is a comprehensive, research-based tool designed to assist the students by illustrating what, how, and self-reflection of what has been learned (Harden et al 1999:249). The module guide gives guidance about the relevant resources and outlines the teaching and assessment processes to achieve the outcomes (Hashmi & Tabassum 2019:3). According to Hollingsead, Ostrander and Schilling (2004:57), module guides are essential in facilitating students' metacognitive skills.

- The module guides did not explain how the teaching process is linked to all other student learning aspects.

- Teaching is expected to fit with the module and the programme, and all these components ensure coherence and alignment to the curriculum (Butcher et al 2006:21).
- The variables that determine the completeness of the module guide were identified as present. However, certain variables that aim at assisting the students were excluded.
  - The module calendar aims at enhancing self-efficacy as students learning styles are different. With a calendar, an individual student may plan the study activities and content based on what is scheduled on a day. The criteria for passing the module and the course evaluation are not included.
  - The course evaluation may confer the students' subjective experiences regarding the effectiveness of the course, and these are some of the items that point to areas that need attention upon revising the module.

Based on the review of the module guide, it is concluded that the following are constraining factors:

- As given in the module guides, the ethos and professional practice make it hard to teach the aspects of nursing ethics extensively. The course has a wide range of professional associations, trade unions, labour law, management, leadership, and research, which are given noticeable attention. As such, this critical component (nursing ethics) may be overlooked. Therefore, the content is broad and covers many professional practice aspects with and without a significant direct role in nursing ethics. While the module should reflect the components of professional practice, the nursing ethics course, according to Robinson, Lee, Zollfrank, Jurchak, Frost and Grace (2014:15), must have moral theories. These moral theories are for acquiring associated language and application in analysing ethical problems. Therefore, the ethical and legal framework should reflect moral theories and laws applicable to nursing practice in South Africa.
- Nursing ethics content comprises small parts, such as principles of professional practice, the standard of practice, and ethical decision-making. In decision-making, students are introduced to the deontological, utilitarianism, and naturalism approach. These approaches are rule-based and, therefore, demand one to conform. What was intriguing was the exclusion of what to do in the case of competing principles, in which weighing and balancing rules enshrined within the principles is considered. Other

moral theories that are not rule-based and specific to developing the learner as a moral agent are excluded. The analysis demonstrates that although the moral theories and statutes relevant to healthcare services are part of the content specific to nursing ethics, some ethical theories such as virtue ethics and care ethics were omitted despite being the backbone of nursing ethics. There are no reasons provided in the module guides for why these are excluded. Therefore, the researcher believes these approaches to ethics are too limited, especially when the exit outcome is to have a *competent, confident,* and compassionate practitioner. The belief is that focusing on virtues and care ethics and Ubuntu would enable the learners to reflect on their caring practices within these approaches.

- The expected time frame for nursing ethics education is limited. The principles of professional practice and standard of practice are allocated five hours each, and nine hours are designated for ethical decision-making. Furthermore, 19 nursing ethics are allocated 22.62% of the time. The other aspects of the module have 65 hours, which is equivalent to 77.38%.
- The teaching strategies cannot be expected to aid reflection or critical thinking, given that they may be formal lectures as there is no indication within the module guides. Tests and exams may never show whether one has developed moral skills or not, as these are testing knowledge. No evaluation measures for the students to assess the course outcome.
- One of the limitations identified was the aspect of student evaluation of the module on completion of the course.
- Specific to ethics, it could be argued that the outcome that the learner would have knowledge of ethical and legal terms and acquire virtues such as compassion and caring after training may not be achieved. It may be an assumption, as the goal was not specific to nursing ethics, and virtue ethics and care ethics as theories pertinent to nursing practices are excluded.

5.4.2 Responses from Com-serves regarding ethics knowledge

The findings regarding variables, which are gender, age, level of education, and current position, reveal that most of the respondents were females and those between the ages of 26 and above were the mainstream. Massingham (2019:2) indicates that age and experience as developmental factors contributing to maturity are associated with tacit knowledge of morality and phronesis, as practical wisdom to enable one to exercise

virtues rationally. The respondents were all above 20 years of age and had an experience of more than six months in community service practice. These factors and their academic level are expected to contribute to understanding and consistent application thereof.

All the respondents had ethics education within the realm of ethos and professional practice under the programme (Regulation R.425) (SANC 1985). Most respondents considered themselves to have a good understanding of ethics to the point of having confidence in exchanging views regarding ethics with other professions. What was intriguing was the fact that the majority of 72.92% confirmed a need for further ethics training. This contradicted the response in Q7, where the respondents believed they had enough ethical knowledge to apply in their daily nursing practice. However, such answers are inevitable when there is uncertainty about what one knows.

In elaborating on this ambiguity, just above half of the respondents claimed knowledge of ethical principles; however, when asked to write them down, only 54.16% of the participant could recall some of the ethical principles and not all. Thus, it seems reasonable to view their knowledge to be limited. This conclusion is also based on the fact that only half of the respondents could identify utilitarianism, and only 62.50% of respondents knew Deontology. Although all the Com-serves considered ethics important for nursing care practices, the findings also reveal that (n=45, 93.75%) believed they could depend on rules and regulations only in their nursing practice.

The knowledge of laws guiding nursing practice and health care was at 77.07% amongst the Com-serves in this study, and this was considered limited given that many of them were saying they could count on rules only. This little knowledge of South African statutes applicable in healthcare services was also demonstrated when respondents in this study were asked to recount these laws on paper. The results reveal that nearly half, 47.08%, of the participants, did not know statutes, while 30.72% could relate only to the Nursing Act (Act No. 33 of 2005). The claim that teaching rules only is adequate for patient care in question B7, revealing a score of 93.75%, is conflicting because the respondents had no such knowledge. This limited legal expertise was also identified by Singh and Mathuray (2018:136). With this level of legal expertise, it is not surprising that (Emmett 2017:1) reported that the number of claims against healthcare professionals increased by 35%, while the litigation claims during this period increased by 121%. In situations like this, Singh and Mathuray (2018:136), suggest that there is a need to teach legal

knowledge amongst nurses in South Africa, as such education will help practitioners foresee risks and avoid lawsuits.

The results reveal that a high number of respondents, 97.92%, are committed to providing good care; however, a large percentage, 64.58%, consider such entails deciding for their patients. The responses concur with Haidt (2001:815) that some decisions are initially paved by intuition in most cases. Haidt (2001:814) posit that intuition is the moral judgement’s primary source. Thus, considering good as being based on making decisions for the patients may infringe the autonomous choices of the patients. The inability to acknowledge the patients' self-determination became evident again, whereby 68.75% of respondents indicated that checking vital signs and administering the medications to the patients may be done without consent. Furthermore, only (n=29, 60.42%) indicated that they would inform patients regarding errors that are likely to happen during the care of patients. These responses demonstrated the need for reflection by the respondents.

Another aspect of morality in nursing is self-regulation and conduct. The results reveal that the respondents are committed to teamwork and partnership in caring for the patients. In caring for rude patients, the majority of (n=35, 72.92%) participants indicated that they would still care. Although there are no established ethical principles and laws about nurses receiving gifts from patients and their relatives, the results show that most respondents would disclose such gifts. Although this is a thorny issue that the respondents attest not to engage with, Davies (2015:2) advises that if these are unsolicited gifts, they are acceptable, provided such gesture does not affect the way one cares for the patients. There are no influences to pressure patients to offer gifts.

5.5 SUMMARY

The quantitative databases were presented and discussed in this chapter. The module guide relating to the ethos and professional practice served as the documents for review. The domain of professional practice seemed to be given much time, and though convincing, this approach may limit the time for developing students to be ethically competent. The moral theories and laws that apply to every health worker are given a restrictive frame.

The results concerning the ethics knowledge of the Com-serves demonstrated that the ethical and legal framework need to be given attention as results illustrate limited expertise and quest for more ethics training. The following chapter outlines the integration of findings from the qualitative and quantitative components of the study.

CHAPTER 6

INTEGRATION, DISCUSSION AND INTERPRETATION OF QUALITATIVE AND QUANTITATIVE RESULTS

6.1 INTRODUCTION

The quantitative and qualitative findings were separately presented and discussed in Chapters 4 and 5. As the study followed a mixed-method approach, the focus of this chapter is the integration of the qualitative and quantitative. Merging results in convergent designs entails using various strategies to determine whether there is congruency or divergence (Creswell & Plano Clark 2011:223). Furthermore, the joint display was used to compare the results as an iterative process of developing a visual representation of qualitative and quantitative findings for conveying the integrated results.

6.2 DATA MANAGEMENT AND ANALYSIS

The findings were independently drawn in Chapter 4 and Chapter 5 of this study. Qualitative results were discussed first, and quantitative results last because the qualitative aspect seems dominant. Venkatesh, Brown and Bala (2013:38) indicate that choosing qualitative first may be due to the fact that it has rigorous collection of data, analysis and the qualities of the researcher that may influence the dominating approach (Polit & Beck 2017:582). The quantitative and qualitative analysis occurred in no chronological order.

The mixing of the quantitative and qualitative data is described as an analytic technique because such a framework is designed to answer the mixed-method research question and to meet the purpose of the design (Onwuegbuzie & Combs 2011:3). The convergence design followed in this study in merging quantitative and qualitative to provide evidence with added depth for more understanding of nursing ethics. The purpose was gaining complementary views through the same occurrence or relationships, where qualitative study was utilised in gaining additional insights into the findings from a quantitative study. According to Ramlo (2021:200), complementarity in mixed methods is based on the idea that findings are addressing different aspects or dimensions of an

investigation; thus, they could neither confirm nor refute each other instead, they complement each other. Strategies used to merge quantitative and qualitative generated meta-inferences as the synthesis product.

Integration aims at generating meta-inferences described as theoretical statements, narratives, or stories inferred from integrating findings (Venkatesh et al 2013:39). According to Doyle, Brady and Byrne (2016:631), meta-inferences go beyond aspects of quantitative and qualitative approaches and provide a sense of the overall findings. In essence, the meta-inferences answered the mixed methods questions. The integration of multiple inferences helped gain a complementarity view and a complete picture of the stance of nursing ethics education and practice in South Africa. The researcher went beyond the quantitative and qualitative findings in creating an all-inclusive understanding of the phenomenon (Venkatesh et al 2013:38). Figure 6.1 below demonstrates how results from the qualitative and quantitative were integrated for complementarity and generation of the meta-inferences.

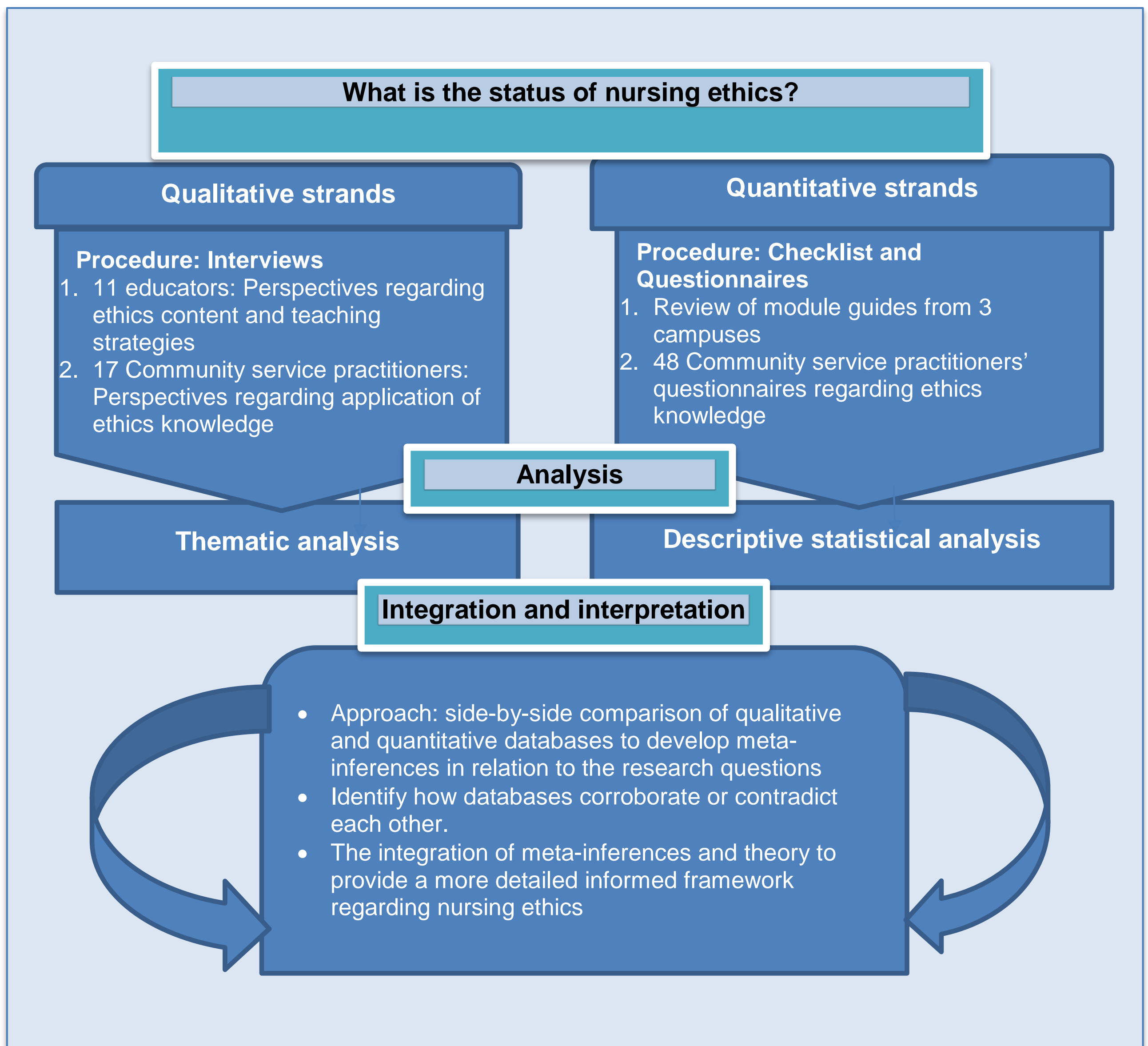

Figure 6.1: Process of qualitative and quantitative integration

6.3 FINDINGS FROM INTEGRATION OF QUANTITATIVE AND QUALITATIVE

The purpose of the study was to describe the state of nursing ethics education and practice in South Africa and develop a framework to enhance ethical practice in the nursing profession. The quantitative and qualitative databases were used to develop the meta-inferences to achieve this aim. Onwuegbuzie and Combs (2011:3) indicate that analysis strands may not interrelate at a time and suggest a variable-oriented analysis level of integration may be used. Thus, this study utilised detailed descriptions of a few instances of a specific phenomenon as variable-orientated for complementarity and completion purposes.

A side-by-side joint display table was followed in which qualitative themes and quantitative results were arranged and compared (Creswell 2015:85). According to Haynes-Brown and Fetters (2021:1), the joint display is an iterative process of developing a visual representation of qualitative and quantitative findings for conveying the integrated results. Thus, a joint display analysis brings the data together through an optical means of either graphs, tables or figures (Guetterman, Fetters & Creswell 2015:555).

6.4.1 State of nursing ethics education

Various stakeholders described the position of nursing ethics education and practice in South Africa. The educators gave their perspectives regarding the ethics content and the teaching strategies for developing ethical competence. The module guide was also reviewed using a checklist that looked for the presence or absence of certain aspects and an appraisal analysis of ethics content. Furthermore, the community service practitioners shared their perspectives regarding nursing ethics knowledge and application during their practice. The state of nursing ethics education was illustrated by various themes such as conceptualisation of nursing ethics, content used in teaching nursing ethics, strategies used for teaching ethics and the perspectives regarding the content and teaching strategies. The joint-display graphs and tables are used to compare the strands for interpretation.

6.4.1.1 Conceptualisation of nursing ethics

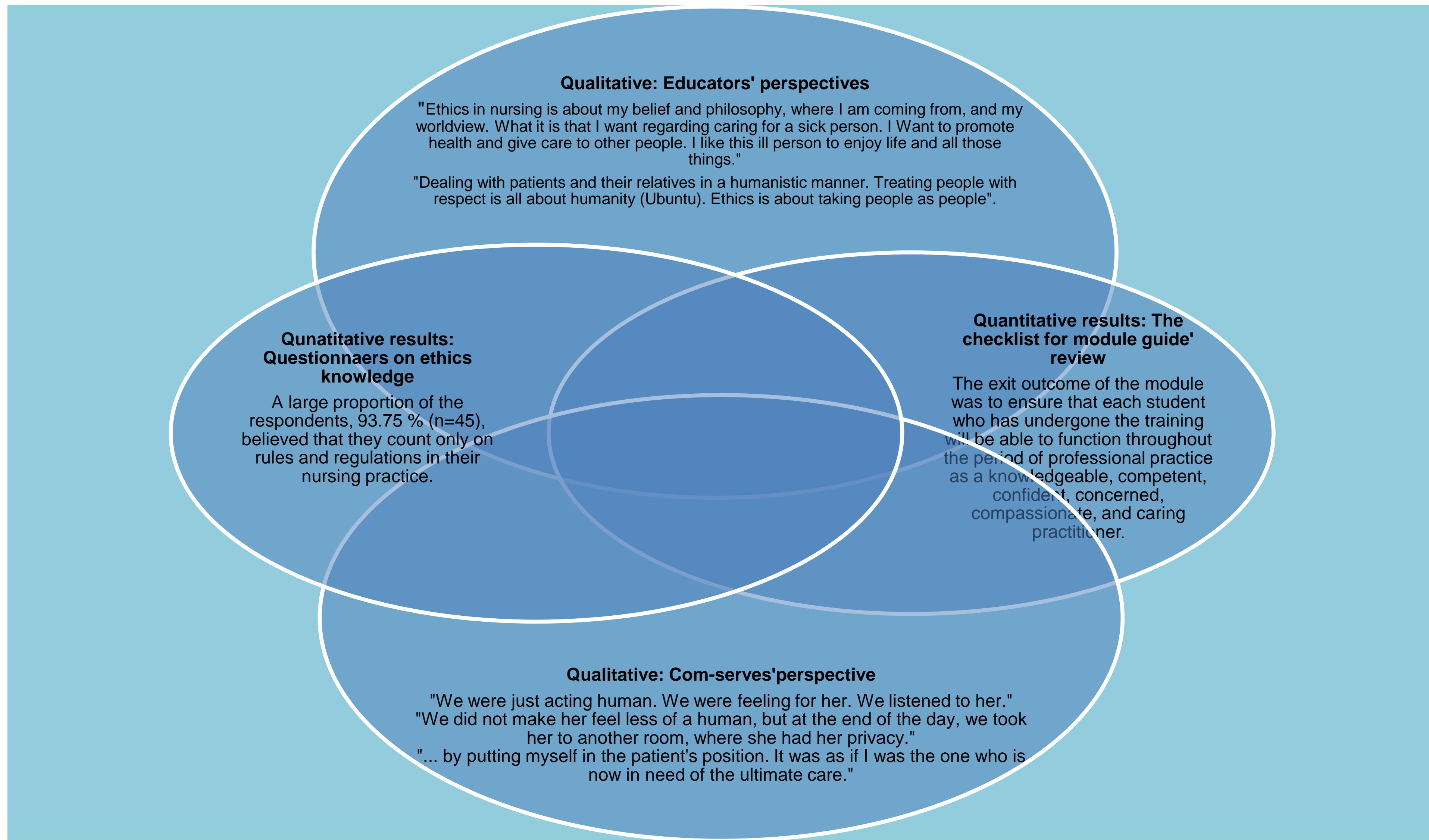

Figure 6.2: Conceptualisation of nursing ethics

The results from the qualitative database uncovered that the educators and Com-serves had a desire to talk about their understanding of nursing ethics. The educators indicated that the conceptualisation of nursing ethics might influence the teaching of nursing ethics. The findings further illustrate that the educators believe that their understanding of nursing ethics may contribute to the misinterpretation of SANC directives for guiding content for nursing ethics. The definitions from the Com-serves demonstrate that individual discernment of nursing ethics was used in executing ethical activities. While the results from the review documents show the expected outcomes of the module guide, the self-administered questionnaires from the Com-serves gave the preferences in considering ethics. Thus, individuals' insight into what nursing ethics involve is essential in teaching and practising ethical endeavours. Accordingly, Setti and Ruffa (2012:online) allude to the understanding that ethics enable one to evaluate and distinguish the different values in each situation necessary for the exercise of responsibility.

The results from the review of module guides elucidated that each student who has undergone the training would function throughout the course as a knowledgeable, competent, confident, concerned, compassionate, and caring practitioner. Therefore, the exit outcome is the basis of what ethics may mean from the standpoint of the module guides. As the module guides include components of professional practice, it is understood that the understanding of ethics may evolve from the idea of professionalism. According to Liaschenko and Peter (2004:489), professionalism is foundational in acquiring ethical values, as it inherently requests individuals to constitute a body of knowledge, competency of nursing skills, and proper attributes of altruism and caring. Professionalism is aimed at collective identity, which mandates competency, legal right to practice, public acceptance, ethical practices and discipline of incompetent and unethical practitioners (Black 2020:59).

The results from the self-administered questionnaires from the Com-serves demonstrate that the majority of (n=45, 93.75 %) respondents, believed that they could count only on rules and regulations in their nursing practice. The respondents believed the teaching of rules and regulations is adequate on its own to guide their nursing activities. These findings concur with the definition of Bah and Sey-Sawo (2018:68) that ethics in nursing means the set of rules or principles that guide nurses' decision-making and behaviour. Rules and regulations are self-authored provisions of tenets that an autonomous profession declares to the society it serves. As such, the respondents, in thinking this

way, were still within the notion of professionalism. Although Song (2018:14) highlights that nursing students' and teachers' understandings of ethics may differ due to rapid social changes in nursing, the results from the Com-serves and educators underlined professionalism.

The comprehension of nursing ethics was extended to the idea of dealing with humans. While educators raised constructs such as the human manner of caring, the Com-serves emphasised the themes of responsibility in dealing with humans. The findings regarding ethics in terms of the human way of caring suggest that the educators viewed nursing ethics from the perspective of human dignity. This view concurs with Rónay (2019:184) that human life is closely related to the dignified union of body and soul, which is to be respected because a violation of the body also damages the soul (Rónay 2019:184). The Com-serve also raised this notion, their application of ethics knowledge introduced views such as treating the patient not less than human or using humane attitudes and considerations in dealing with clients.

At the same time, the Com-serves mentioned responsibility, establishing relationships, and enhancing communication skills as aspects of human endeavours in caring. According to Lindh et al (2008:129), responsibility in ethics is a relational way of being human, in which a person acts and reflects how the responsibilities are realised. Lindh et al (2008:129) highlight the importance of the individual in the ethics of responsibility, unlike responsibility in obligations of the individual in a given Nursing Act (Act No. 33 of 2005). Moral responsibility is defined as an activity performed for others because we share the same context of humanity. Therefore, educators' idea of the human person and the viewpoint from the Com-serves concur with the ethics of responsibility as defined by Levinas. According to Levinas (1981:82), responsibility is a condition of being a human person, not a system of rules imposed on individuals.

The belief system was another theme raised by educators, which is paramount in nursing ethics and would encourage clarification of a sense of reality. As the findings reveal, the educators thought that the belief system could conflict with SANC guidelines and influence the nursing ethics content. The belief systems are defined as narratives through which individuals convey their sense of reality and often include representations of complex worldviews characterised by personal commitment, values and ideologies

focusing on the vital interests of an individual (Usó-Doménech & Nescolarde-Selva (2015:148).

6.4.1.2 Nursing ethics content selected

The review of the module guides highlights that the subject ethos and professional practice (EPT215/225 and EPP100) were offered in the third and fourth years of the study. Although they are being provided in two years, the ethos is only presented in the third year of the study. Students were expected to understand litigation, duties, accountability and advocacy. Comprehension of the code of ethics with explanatory ethical principles was also expected. Figure 6.3 below gives a reflection on the ethics content offered.

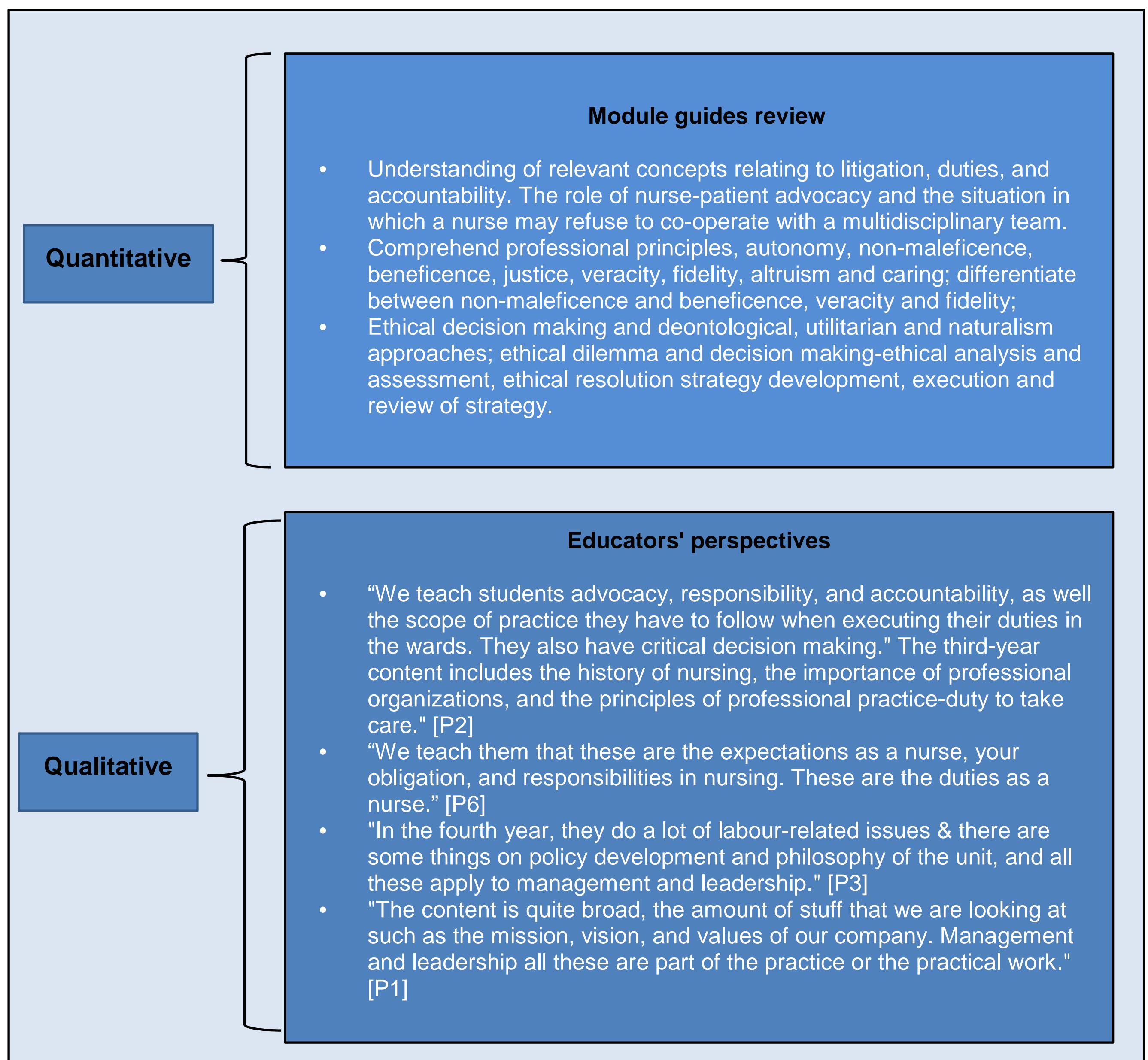

Figure 6.3: Reflection on nursing ethics content

The findings from the review of the module guide show that decision-making, ethical analysis, and moral resolution strategies were to be executed within the provision of deontological, utilitarian and naturalism approaches. The responses regarding knowledge of moral theories and laws view that (n=30, 62.50%) respondents knew about ethical principles, hence (n=27, 56.25%) were aware of consequentialism and utilitarianism, on the other hand (n=39, 81.25%) were aware of virtue ethics. Furthermore, (n=37, 77.09%) respondents indicated that they know laws in health care, while (n=10, 20.83%) respondents averred that they were unsure, followed by (n=1, 2.08 %) who had no insight.

The qualitative findings from the educators' perspective corroborated with module guides' conclusions. However, they highlighted that the content is quite broad and that a larger amount they engage with is unrelated to ethics. Therefore, they emphasised that the SANC's directives are responsible for the far-reaching content, as they are not interpreted. Thus, this has resulted in limited ethics. Sometimes these guidelines seem to oppose how one does things.

6.4.1.3 Opinions regarding nursing content

Various views were made known by findings from qualitative, while quantitative results gave some complementary viewpoints. The perspectives of the educators and Com-serves gave significant insights regarding the content of nursing ethics expected to aid the acquisition of ethical competence by the nursing students. The qualitative and quantitative findings are illustrated in Table 6.1 overleaf.

Table 6.1: Reactions regarding nursing ethics content

Qualitative	**Educators' perspectives** "The guidelines from SANC are very broad and often misinterpreted because it depends on how you were brought up & how you will interpret them. But some things are not included in these guidelines and regulations, which I think are essential and best for our patients." [P1] "A lot has changed in nursing because of technology, and our communities are also more enlightened and know many things. However, the SANC guidelines still direct us to teach the old curriculum that does not refer to new things in the clinical area." [P6]. "But labour and labour-related issues for me are not that important, but so many hours are put into this." [P3] "They are introduced to professional associations and trade unions. As the years go forward, more politics collide with our ethics. There is a tug of war between politics and us as nurses." [P11] "There is limited nursing ethics in South Africa as there are no books about developing nurses as ethical agents. Books like the one written by Mellish are old and have no information. There is nothing about how to develop them to be ethical. So how do you go about it?" [P7] **Com-serves' perspectives** "Sometimes here and there, there are situations whereby I find that no, here I think I need some support. Like possibly my ethics knowledge. I believe it is insufficient. Perhaps I can find in-service training about ethics to upgrade my knowledge." [P8] Real-life situations should be brought to class. That's how we are supposed to learn them because, truly speaking, when we are studying nursing, there are practicals. There are also practical components in general and midwifery. So, things like ethics, we study them to write the exams, and we don't really … practice them much in the hospital." [P16]
Quantitative	**Self-administered questionnaires from Com-serves** 54.16% of the respondents could recall three principles, 8.32% remembered two principles, and 37.51% couldn't remember the principles underlying ethical practice. 46.08% of the respondents indicated that they don't know statutes guiding nursing activities in the health care system. The South African Constitution stood at 10.24%, the National Health Act scored 5.12%, and the Children's Act had only 2.56%. **Module guides review** The broad scope covers various professional practice aspects with indirect significance for nursing ethics. Nursing ethics is allotted nineteen hours which is 22.62% of the allotted time, while other elements of the module have sixty-five hours, 77.38%. Most of the content in the third year relates to Managerial and Leadership skills. The content in the fourth year is within the crest of leadership and corporate governance, operational management, facilities and infrastructure.

The educators highlight that SANC directives made the choice of nursing ethics content complex and too limiting for developing the students' ethical competence, as it does not

include essential moral elements about patients' care. The present ethics framework published for a bachelor's degree in nursing and midwifery emphasises advocacy, understanding and interpretation of the SA Nursing and Health Care legislation, ethical codes, accountability and responsibility, and standards for nursing and midwifery practice (SANC 2013a). Although ethical principles and SA Nursing and Health Care legislation are emphasised in the current ethical framework, results demonstrated limited knowledge.

The results of self-administered questionnaires reveal a misunderstanding of ethical principles. About 37.51% had no idea of the ethical principles, whilst 54.16% of the respondents recalled only three and 8.32% of the Com-serves remembered two principles. Unsurprisingly, these students could not recount all the principles because many nursing ethics educators across the globe consider principles and codes of ethics inappropriate for nursing ethics education. As such, Benner, Tanner and Chesla (2009:15-17) claim that principle-based nursing ethics comes with narrow boundaries of rationality, and as a result, nurses encounter problems with them. Johnstone (2017:18) calls their use in nursing a justification of ill-considered actions, as they are inflexible. In the same way, Cannaerts et al (2014:870) claim nursing ethics should focus on ethical frameworks that encourage the process instead of the once-off approach brought about by principles. Rodger and Blackshaw (2017:560) indicate that although the four (4) principles can be easily memorised, they are not intended as a moral formula to calculate what should, or should not be done.

Given the alarming increase in medical malpractice litigation in South Africa, it is imperative for nurses to know and understand laws on health care and the regulation of the nursing practice. Emanating from the results was a lack of knowledge regarding the law guiding health care. The results show that 46.08% of the respondents don't know statutes directing nursing activities and health care systems. Referring to the South African Constitution of 1996, the knowledge regarding the Bill of Rights stood at 10.24%, while the National Health Act scored 5.12%. Insight regarding the Children's Act stood at only 2.56%.

This limited knowledge of principles and statutes guiding nursing and health care practices concerns other authors. For example, Singh and Mathuray (2018:136) obtained the same findings about limited legal expertise amongst nurses in South Africa. With this

bit of knowledge of health law, foreseeing risks and avoiding lawsuits is likely to be a challenging endeavour. These challenges are laid bare by the increasing medico-legal hazards litigations in South Africa. Singh and Mathuray (2018:136) argue that the solid silos within which the profession operates and the hierarchies in nursing may contribute to limited knowledge of laws on health care services. In this regard, Singh and Mathuray (2018:136) suggest that nurses be taught health law, as they are the backbone of the health system and must therefore be familiar with it. They deal with vulnerable patients; consequently, they must acquire knowledge and practical application of the legal aspects enshrined in national and international law (Fitchett, Ferran, Footer & Ahmed 2011:259).

These findings illustrated the bleak knowledge of fundamental ethical principles and law among the Com-serves. By recollecting these principles and rules, one would quickly identify ethical and legal nuances in complex nursing practices. The module guides reveal that principles form part of the ethics content in the third year of study, but the findings show limited awareness. The module guides further highlight that professional practice is done in the fourth year of study as well as the practical aspect of the course. Although Poitras et al (2016:1) indicate ethics is the basis of professional practice, which combines practice standards, nursing skills, and expected professional activities that guide a nurse to ensure quality, the results give a different outlook. The findings demonstrate that lectures saw the gap between ethical theory and practice, while the Com-serves lamented the clinical aspect of nursing ethics in their training. Further, Com-serves were also worried about the moral attitudes of senior professionals. Thus, there were incongruences in the ethics teaching and practice, which needed attention.

For the content to be pertinent to nursing practices, it must relate to the purpose of nursing. As Black (2020:90) attests, the definition of nursing is considered a core base of a framework for nursing ethics. Johnstone (2017:19) assumes the purpose of nursing ethics is to promote patients' well-being through appropriate nursing care activities requesting the cultivation of humane disposition and a sense of civic duty.

6.4.1.4 Teaching strategies used for nursing ethics

The findings regarding teaching strategies emanated from the review of the module guide as the quantitative strand, while the qualitative part is represented by the educators' perspectives, as shown in Figure 6.4.

The qualitative findings show that various teaching and assessment methods were used even though they were considered inadequate. The educators were concerned that they could not help students develop an ability to perceive ethical situations and have a sense of call for moral conduct and ethical decision-making. This deficit in moral reasoning may have also resulted from formal lectures and group discussions as teaching strategies because these strategies were alluded to in the modules' review. Pandya et al (2016:144) concur that formal lectures have always been the standard method of communicating ethics information; however, students lose interest quickly if abstract subjects like ethics are about informing. Thus, more effective strategies that supplement the lectures and discussions should be implemented to allow students to develop critical thinking and problem-solving skills (Pandya et al 2016:144). Again, the review of the modules shows that tests and exams were the only modes used for assessing ethical competence, and these may never show whether one has developed moral skills or not, as these are testing knowledge only.

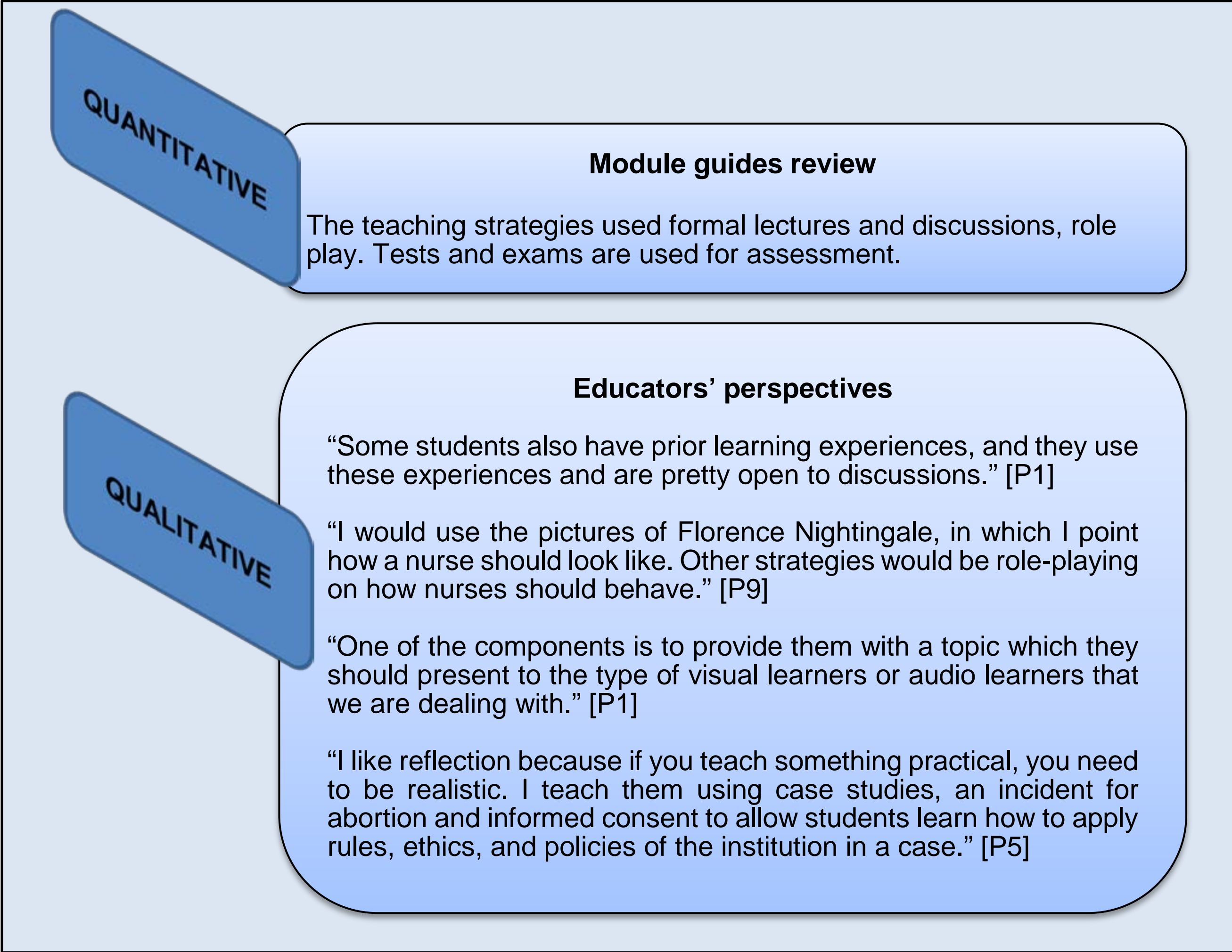

Figure 6.4: Teaching strategies used for nursing ethics

Hoskins et al (2018:2) perceived a gap in nursing ethics curricula despite the importance of nursing ethics. This notion was revealed by the educators who called it a theory-practice gap. Reiterating, Vynckier et al (2015:287) indicate that their study conveys that the students perceive ethics courses as failing to meet the primary objectives of ethics education, as it only helped them to be aware of their values only.

The results of Com-serves also demonstrate the challenge of studying ethics for tests and exams and passing without being exposed to practical aspects of solving ethical problems. The educators suggested a gap in theory and practice amongst the students, as unethical conduct emerges once students begin clinical practice. The educators' perception regarding the impact of ethics education calls for a general evaluation of nursing ethics education. The educators' results pointed to detachment of the clinical personnel regarding the ethics education of students in clinical areas. Therefore, it is critical to consider nursing ethics in clinical teaching.

Another aspect encompassed in the results from the educators was the idea that nursing ethics educators must have a specialisation and demonstrate interest, as these serve as motivation and ethical obligations toward ethics education. These suppositions relate to the claim made by Behrns and Fellingham (2014:143) that to be able to teach moral values to the students, one ought to accept responsibility for being professionally ethical. Taking such responsibility means one is a role model of virtues and helps students to be active constructors of their own transformation into moral agents (Behrns & Fellingham 2014:143; Song 2018:15).

6.4.1.5 Views regarding nursing ethics teaching strategies

Views regarding the teaching strategies employed in teaching ethics come from qualitative strands, as depicted by the educators and Com-serves. According to Avci (2016:7), teaching methods are essential strategies for actualising the ethics curriculum. Qualitative data from the educators show that formal lectures and discussions were used. However, the educators indicated that problems always arise if the debates challenge their belief system. In the same way, Vynckier et al (2015:303) suggest that the students in their study viewed group discussions as having little or no impact on their ethical development. Thus, the discussions, and lecture-style teaching, which are widespread worldwide (Avci 2016:7), need to be used wisely.

Table 6.2: Perspective regarding nursing ethics strategies

Qualitative	
Educators' perspective	**Com-serves perspective**
"I do a lecture, problem-solving, discussion groups, and case studies because there is content where we need to solve problems. Assessments are through classwork, oral and we have formal assessment through predicate tests and exams". [P6] "When things become uncomfortable, the discussion becomes dead because we are now not comfortable with what is being discussed. I think it's still a lot of what we believe, and we are afraid to get out of our comfort zone." [P1] "I recommend that specialists and moral philosophers work with nurses to develop a sound ethical structure for nursing." [P7]	"You know, in nursing, you must be empathetic, correct and not sympathetic. But we are not being taught how to deal with emotions. So, you get to be close to the patient. You see, if you can hear that the patient passed away, you feel sad and sometimes need some counselling and support. I think maybe psychologically because we are not the same. Some will be affected deeply, but others can take it lightly." [P7] "I was taught ethics at school. Our lecturer usually told us that sometimes we would find a situation where we have to be firm and do the right thing even if we feel, okay, this person is human, but how do you do this?" [P4] So, things like ethics, we study them to write the exams, and we don't really … practice them much in the hospital." [P16]

Qualitative data from the Com-serves revealed that they were taught not to be easy-going when dealing with rules and regulations. However, the Com-serves felt that there were no strategies to allow them to mitigate between laws and being humane, and these minor issues cause stress. Unresolved stressors in nursing may have far-reaching effects, including nurse turnover or influence the ethical aspect of patient care. The results reflect that the nursing ethics educators demonstrate that help from moral philosophers and other disciplines dealing with teaching strategies would be of value. Educators recommended that specialists and moral philosophers work with nurses to develop a sound ethical structure for nursing.

6.4.2 State of nursing ethics practice

The qualitative and quantitative strands reveal imperfect ethics reflection, as highlighted in Table 6.3 below. The perspectives of the educators and the Com-serves as qualitative findings to make evident the state of nursing ethics in the clinical areas. In the same way, the practical component of the module guide review and the self-administrative

questionnaires, as the quantitative part, corroborate with other findings to give a clear understanding of the nursing ethics practice.

Table 6.3: Quantitative and qualitative findings regarding clinical ethics

	Educators' perspectives	**Com-serves' perspectives**
Qualitative	"I think educators have done a lot to influence them to behave ethically in the classroom, but now when they go to the clinical area, they don't behave as they have been taught. During class, it will be like they hear you what you are teaching, but in the clinical area, it's something different". [P9] "I think what they learn from books is limited and what they see and meet within the practice is challenging them." [P6] "The clinical facilities personnel are not taking part in teaching ethical behaviour, despite raised importance of clinical ethics education." [P11]. "There are some litigations, and sometimes confidentiality is not kept and so many problems." [P10]	"The attitude and the tone of voice of the seniors were not good. Sometimes someone may shout it out and say, "she hasn't been going to the clinic, now the child is dead," stuff like that." [P19] "She did not get proper treatment as a patient like she should. Her dignity wasn't being respected. I understand that it might be very annoying to be listening to the ten women screaming but let's just try to help patients." [P18] "When the patient got here, the other doctor who was on call didn't want to come and see the patient because there was no communication from the referring doctor, and he didn't know about the patient. He refused to come to say he never knew about it. So, we had to act … we had to write it down as a nurse that doctor didn't want to come." [P7] "We did not tell her we would phone the family to get the history because the doctor suggested. And on the admission slip was the patient's name and all that. There was also next of kin as a legal person, I think. So, we called that person just because the doctor wanted to treat her." [P15]
Quantitative	**Document review**	**Self-administered**
	The practical aspect of EPP100 has nothing to do with ethics	64.58% of the com-serves consider good care entails making decisions for their patients, 54.17% believed such decisions translate mainly from knowledge nursing courses and not ethics

The qualitative findings from the educators highlight the gap between theory and practice because of the emergence of unethical conduct once students begin clinical practice. The educators see their students as a self-centred generation with limited responsibility. One participant described the behaviour as chaotic regarding patient-nurses' relations and the

families. In the same way, the Com-serves raised concerns regarding the moral conduct of the senior nurses, as they were acting unethical, while the medical practitioners' unethical practices and attitudes compromised their ability to provide high-quality and safe care. The results portray a bleak view regarding ethics among health professionals considering that they are ideally thought to be knowledgeable of ethical approaches. These results were drawn from the professionals groomed under multifaceted approaches of ethical principles, regulations and professional practice standards that underlie good ethical practices. In the background of such results, Holt and Long (1999:246) suggest a need to distinguish whether the ethics education was an ethics education or moral guidance. In moral guidance, ethics is not a subject like other nursing courses, but its foundation is types of principles and conduct to give guidance to what is acceptable and right.

Although the Com-serves viewed themselves as bystanders when unethical behaviour and attitudes were happening, they had no courage to stop the unethical behaviour toward the patients. According to Lachman (2010:3), Moral courage is a disposition that enables one to speak out in the face of unethical acts. The findings in this study were similar to those of Høy et al (2016:97), which demonstrated nurses being not aware of the ethical dimension of their work, and often overlooking ethical issues or even adjusting work routines to avoid them. Lachman (2010:4) attest to the need to teach nurses moral courage as a virtue. In this regard, Lachman (2010:5) uses Einstein's ([s.a.]) quotation that the "*world is a dangerous place, not because of those who do evil, but because of those who look on and do nothing".* Thus, there is a need to devise strategies to develop the moral courage to diminish limited ethical reflection in nursing practices.

In demonstrating the minor reflection, the results from the Com-serves indicate that that 64.58% of the Com-serves consider good care to entail making decisions for their patients, and 54.17% believed such resolutions translate mainly from knowledge of nursing courses and not ethics. This view is also made explicit by the review of the module guide, in which the results reveal that a more significant aspect of Ethos and Professional Practice, including the practical module [EPP100], has nothing to do with ethics; instead, the objective is to develop policies and managerial skills. Given these varieties of findings in this study, it is advisable to reflect on Johnstone's (2017:19) argument. Johnstone (2017:19) argues that there is a need to question whether nursing ethics is achieving its goal of promoting patients' well-being through delivering good nursing care.

6.5 INTERPRETATION AND DISCUSSION

The integrated findings of the module guide review, questionnaires regarding ethics knowledge, community service practitioners' perspectives and the lectures are now discussed as meta-inferences drawn beyond quantitative and qualitative findings. These meta-inferences are discussed below in answering the research question concerning the state of nursing ethics.

6.5.1 Conceptualisation of nursing ethics

The key findings from integrating qualitative and quantitative strands reveal various themes in conceptualising nursing ethics. These provide insights into how ethics in nursing is expressed and experienced. This analysis is also shared by Rich (2008:4) that nursing ethics *mean different things to people because it is continuously evolving due to different values and ways of justifying moral action*. However, Yildiz (2019:1145) suggests that defining nursing ethics may be inadequate or challenging because of the changing internal and external factors.

Liaschenko and Peter (2004:489) attest that the conceptualisation of nursing as a practice, profession and work should provide a more extensive vocabulary for defining nursing ethics. This concurs with Pellegrino (2001:563) that the nursing activity as nurses *qua* nurses is to guide definition. Fawcett (2007:98) describes nurses *qua* nurses as unique nursing knowledge that encompasses all patterns of knowing rather than understanding developed by members of other disciplines. Thus, according to Pellegrino (2001:563), this knowledge is used in clinical encounters with individual patients. As the findings infer, professionalism, worldviews, the human way of caring, and responsibility were the themes that emerged.

The results from integration demonstrate that nursing ethics was conceptualised from the perspective of professionalism, in which rules and regulations inform nursing practice. Rules and regulations are self-authored provisions of tenets that an autonomous profession declares to the society it serves.

Another theme includes one's belief system, which according to Dhai and McQuoid-Mason (2011:5), is complex as it represents different worldviews embodying sets of

values for an individual. Belief systems are defined as narratives individuals convey their sense of reality and often include representations of complex worldviews characterised by personal commitment, values and ideologies focusing on the vital interests of an individual (Usó-Doménech and Nescolarde-Selva (2015:148). Thus, the meaning of nursing ethics might be used for each student as a starting point for the internal development of morality. This type of value clarification might emanate from one's choice of nursing as a career, individual traits and depositions, and aspirations and responsibilities as a human person.

The human manner of caring came from various datasets and responsibility in caring endeavours. According to Levinas (1981:82), responsibility is a condition of being a human person, not a system of rules imposed on individuals. Thus, understanding ethics from caring for human activity reflects responsibility. The participants' responsibility in this study emanated from being human and not conforming to prescribed rules. This responsibility differed from Geyer's (2015:13) reference of responsibility, which accepts liability for the acts and omissions set out in the country's scope of practice and legislation. In this regard, Gastmans, Dierckx de Casterle, and Schotsmans (1998:44) characterised nursing as ethical practice, which is orientated towards commitment to methods initiated for the wellbeing of the patients.

This study concluded that diverse ways of understanding ethics are apparent and necessary. However, these need to be interrogated by stakeholders in nursing ethics.

6.5.2 Nursing ethics education

The results in this study reflect the challenging directives from SANC for lacking context and novelty of nursing practices and likely to be misunderstood. One of the concerns regarding these guidelines was that they do not provide a sufficient framework for teaching nursing ethics. Misinterpreting directives and one's conceptualisation of nursing ethics may also distort how content and strategies for teaching ethics are considered. In situations of uncertainty, any creed or dogma considered to be ethics may be thrown into the teaching of nursing ethics. Johnstone (2017:19) asserts that an ideology driven by public policy is threatening the foundation of nursing ethics. Thus, in developing guidelines for ethics education, the idea of nurses *qua* nurses is to inform the SANC

directives, not what other practitioners believe about nursing ethics. In this regard, findings call for a re-evaluation of directives from SANC.

There is a view that nursing ethics content for teaching has limited ethics content as much of the content is geared toward professional practice and not ethics per se. This inadequate ethics content is also proved by the number of hours reserved for ethics education. The involvement of clinical nursing ethics education, as they lacked that aspect. Thus, these results concur with Song (2018:12) that classroom nursing ethics must be synchronised with clinical practice.

The critique of nursing ethics education has been ongoing, and the submission of the results in this study is not new. For example, Woods (2005:15-16) indicates that nursing ethics educators should be concerned because there is a struggle among newly qualified nursing students and senior nurses with essential ethical sensitivity. Likewise, Lynch, Salamonson, Glew and Ramjan (2021:12) report escalating misconduct cases among nursing students and commend the moral commitment of educators to meet student ethical learning. Ethics education in nursing is seen as the first step in nurturing student nurses in the profession's values and, therefore, a tool toward professional identity (Hoskins et al 2018:3). Based on the literature by Rokhafrooz, Hatami, Hemmatipour, Abdolahi-Shahvali and Salehi Kamboo (2017:152), there is a significant correlation between nurses' ethical difficulties and patient care. Thus, patients' satisfaction is an index of the quality and effectiveness of nursing ethics (Izadi, Bijani, Fereidouni, Karimi, Tehranineshat & Dehghan 2020:1).

As the results demonstrate, there is limited interest or emphasis on the importance of ethics during the training. On the other hand, much interest and effort must be geared toward increasing the effectiveness of ethics education (Song 2018:12). It can be concluded that ethics education in the current form is ineffective, as there are various ways in which the results in this study reflected the ineffectiveness of nursing ethics education. To be considered efficient, nursing ethics education should be given proper directives from SANC that lead to nursing ethics content and teaching strategies that consider the purpose of nursing in both theoretical and practical areas of student learning. Thus, in this regard, nursing ethics content should be pertinent to nurses (Song 2018:12).

6.5.3 Nursing ethics content

The findings demonstrate the present ethics framework published for a bachelor's degree in nursing and midwifery emphasises advocacy, interpretation and understanding of the SA Nursing and Health Care legislation, accountability, ethical codes, responsibility, as well as the standards of nursing and midwifery practice (SANC 2013a). Although ethical principles and SA Nursing and Health Care legislation are emphasised in the current ethical framework, results demonstrated limited knowledge of principles and Health care legislation amongst the Com-serves.

Benner et al (2009:15-17) claim that principle-based nursing ethics comes with narrow boundaries of rationality, and as a result, nurses encounter problems with them. Reiterating, Johnstone (2017:18) calls their use in nursing a justification of ill-considered actions, as they are inflexible. Thus, principle-based nursing ethics may be considered to lack the idea of nurses *qua* nurses.

Given the alarming increase in medical malpractice litigation in South Africa, the knowledge and understanding of laws on health care and the regulation of the nursing practice, is imperative for nurses. Singh and Mathuray (2018:136) suggest that nurses be taught health law, as nurses are the backbone of the health system and must therefore be familiar with the law. In dealing with vulnerable patients, nurses should acquire knowledge and practical application of the legal aspects enshrined in national and international law (Fitchett et al 2011:259).

It is therefore concluded that there is an appeal for nursing ethics content to be central to nursing practice. For the content to be pertinent to nursing practices, it must relate to the purpose of nursing.

6.5.4 Strategies for nursing ethics education

The formal lectures, discussions, tests and examinations were viewed as strategies for nursing ethics education, and results reveal that educators were stranded as to what to do to instil professionalism. The results uncover that once the students are in the clinical area, there is a gap between theory and practice because the knowledge demonstrated in passing tests and exams is not there. Again, tests and exams were the only modes

used for assessing ethical competence, and these may never show whether one has developed moral skills or not, as these are testing knowledge.

The results highlight a lack of expertise and interest in teaching ethics, complicating the quality of nursing ethics education. The arguments regarding expertise in nursing ethics education have heightened awareness in the face of increasing ethical challenges in nursing. For example, Hansson (2008:225) asks who should teach ethics as the philosophers are not familiar with the technical details of discipline, while Fletcher (1973:4) claims that it must be a two-person approach of a clinician and ethicist. The conclusion is to align expertise and the strategies for nursing ethics education

6.5.5 State of nursing ethics practice

The findings illustrate that educators see their students as lacking ethical appropriateness. In the same way, the Com-serves consider the senior nurses and physicians as having little concern for their patients. This behaviour at the moment of reflection can be understood as a limited reflection in the face of clinical facts. Verkerk, Lindamann, Maeckelberghe, Feenstra, Hartoungh and De Bree (2004:32) indicate that ethical reflection is the proficiency of individuals to identify the moral dimensions of the situation and the responsibilities attached to them. According to Johnstone (2017:19), tremendous work has been offered to improve nursing ethics since the subject's publication in 1889; however, nurses continue to be superficial in ethical reflection. To be reflective, Schotsmans (1999:10) suggests that the starting point for reflection is the knowledge of different moral theories and their essence in the context. However, the results from the review of the module guides depict limited teaching of ethical theories.

The notion of ethical reflection is synonymous with clinical judgment, which is the cornerstone of the nursing profession. Tanner (2006:204) defines clinical judgment as a skill for interpreting and making conclusions about the needs of the patient or health problems and the decision necessary to enable one to modify or act standard approaches deemed appropriate by the patient's response. This capability goes beyond understanding a patient's ailment to include the illness experience of the patients and their families and their coping strengths (Tanner 2006:205). Therefore, this demands nurses to go beyond the patients' illness to include the sufferings that come with it.

According to Shutte (2018:181), ethical reflection entails a built-in dialogical engagement between two partners. It includes cognition of one another's identities, values and relationships that define the responsibilities that compel one to look into a person's life as a whole (Shutte 2018:181). Shutte (2018:181) further indicate that it is a mental activity in which individuals consider reasons for and against, pros and cons regarding practices involved, and the stance one takes (Shutte 2018:181). Thus, it is concerned with how individuals arrive at judgements regarding professional activities. One draws on personal experiences and examines that judgment through the broader moral context of the institution. There were various ways the results echo limited ethical reflection amongst the nurses and other health professionals in the clinical area.

6.6 SUMMARY

The chapter dealt with integrating findings from qualitative and quantitative methods. The purpose was for the qualitative and quantitative strands to complement each other in determining the state of nursing ethics at the educational and practical levels. In revealing this nursing ethics position, the qualitative and quantitative findings were illustrated by a joint display presented in graphs and tables, and meta-inferences were generated. The discussion and interpretation of the key findings were made with the literature support. Following Chapter 7, discusses establishing a framework for enhancing ethics education and practices.

CHAPTER 7

DEVELOPMENT OF A FRAMEWORK TO ENHANCE ETHICS EDUCATION AND PRACTICE IN THE NURSING PROFESSION

7.1 INTRODUCTION

The previous chapter integrated qualitative and quantitative results, in which meta-inferences were generated. The meta-inferences revealed the nature of ethics education and the challenges experienced pertaining to the teaching and practice of nursing ethics. In that regard, the researcher describes the development of a framework to enhance nursing ethics education in South Africa. The normative analysis is being followed to develop this framework. Accordingly, meta-inferences discussions are aligned to the normative analysis to form an argument pertinent to nursing ethics.

7.2 JUSTIFICATION OF NORMATIVE ANALYSIS

A normative analysis involves coherent thinking, in which deontic and evaluative dimensions are assessed for endorsing or rejecting a specific viewpoint. Viens (2019:1) and Vogelstein and Colbert (2020:8) indicate that normativity featuring a deontic domain is grounded within ethics, law, values, and rationality from relevant literature and practice, as well as values, determining the right, wrong, just, unjust, required, prohibited dimensions of actions (Viens 2019:1). Thus, normative analysis assists in advancing the evaluative dimension concerned with judging the viewpoints as to whether they are reasonable, harmful, or better than others (Vogelstein & Colbert 2020:8).

The normative analysis aims at establishing, dispute, or examine the plausibility of the proposition and its potential justification (Vogelstein & Colbert 2020:8). Thus, logic, critical reasoning, conceptual analysis, moral theories and various argumentative strategies are used to weigh the facts established through empirical premises (Vogelstein & Colbert 2020:8). Neves, Morgado and Zagalo (2010:60) attest that normative expressed models depend on communication-oriented patterns, in which the norms serve as baseline prototypes, while evidence from scientific research serves as an interpretation. Thus, in resolving the conflict, nomothetic and normative knowledge is utilised to understand the

whole and yield a practice-relevant model (Neves et al 2010:60). For that reason, the results from this study are used to enhance the arguments for approving or eliminating a specific viewpoint for improving nursing ethics. Various ethical frameworks pertinent to nursing, general discourses in ethics, and philosophical commitments of nursing practice are applied in this study for their explanatory power.

7.3 BACKGROUND AND ENGAGING QUESTIONS

In this study, the development of a framework is purported to improve ethics education and practice in the nursing profession, based on conclusions from the findings that revealed a poor outlook on the state of nursing ethics education and practice in South Africa due to ineffective nursing education. It is necessary to highlight that nursing ethics education is inextricably entwined with nursing practice, and to this, Hoskins et al (2018:online) indicate that by entering the clinical environment, students and qualified nurses are expected to deliver quality decisions and navigate dynamic interaction with families, patients and other members of the healthcare team. In this background, Vogelstein and Colbert (2020:10) suggest that the field of nursing ethics has relied so much on descriptive ethics at the expense of normative scholarship, which aims at establishing what ought to be the case of nursing ethics. Therefore, Vogelstein and Colbert (2020:12) emphasise that the lack of normative engagement has implications for nursing ethics practice and research because that lead to weak engagement in nursing discourses needed to promote a more profound and fuller understanding of ethical nursing.

Avci (2017:132) indicates that the need to improve ethics education is a long-standing commitment. Yet, such recognition has never yielded results or solved the challenges of insufficient ethics knowledge or unethical conduct amongst those that have undergone the training (Avci 2017:132). Therefore, other avenues like the normative analysis suggested in this study will likely enhance discussions around nursing ethics education and practice. The literature demonstrates that there has never been improvement in good ethical behaviour despite advances in the implementation of moral principles, codes of ethics, policies and rules and numerous types of research undertaken in nursing ethics (Cannaerts et al 2014:874; Wright 1995:17). Therefore, the benefits of normative analysis were appraised in developing the framework to enhance ethics in this study.

Volbrecht (2002:3) argues that the long history of nursing ethics and the varied applications to changing contexts have resulted in language shifts for nursing ethics with implications for ethics training. Reiterating Bah and Sey-Sawo (2018:68) suggest that nursing ethics has reached a point where it is mandatory to challenge the status quo. In challenging the existing state of affairs, old boundaries are likely to be deconstructed, setting new landmarks for developing effectual ethics (Bah & Sey-Sawo 2018:68).

According to Neves et al (2010:60), normative expressed models depend on communication-oriented patterns, in which the norms serve as baseline prototypes, and evidence from scientific research serves as an interpretation. Thus, meta-inferences emanating from the results were used as nomothetic knowledge, and the norms from the literature served as baseline standards in negotiating the gap toward resolving the conflict. Accordingly, Neves et al (2010:63) suggest that utilising nomothetic and normative knowledge is necessary to understand the whole and to yield a practice-relevant model. In this study, nomothetic information came from the interviews with the educators and Com-serves, as well as responses from the module guides review and survey on ethics knowledge.

Therefore, in doing this normative analysis for improving nursing ethics, the first step is to give normatively assessed and reasoned arguments based on the meta-inferences discussed in Chapter 6 and a set of norms from various ethical frameworks and general discourses in ethics from the literature. These arguments resulted in these questions that are to engage the analysis:

- How should the conceptualisation of nursing ethics be articulated for a coherent structure for ethics education?
- What flaws in the current goal and teaching scope of nursing ethics influence the effectiveness of nursing ethics education?
- How should the goal and objectives of nursing ethics be designed to establish an efficient teaching scope? and
- What should be emphasised in nursing ethics education for morally acceptable ethical nursing practices?

7.4 ARGUMENTATION

Based on the evidence presented by results, the researcher argues that the current nursing ethics framework has flaws that reflect the historical artefacts of nursing ethics practice despite the changing South African nursing curriculum and practice. The lecturer raised the issue of the SANC insisting on old concepts that do not reflect the changes in society and technology. Furthermore, the results raised the issue of using old sources and that certain concepts are used in nursing ethics with no reference to their origin. As such, the meaning and the goal of nursing ethics education remain unclarified and blurred, even though these are crucial to the effectiveness of the teaching scope of nursing ethics. According to Avci (2016:5), the teaching scope concerns the ethics content, teaching methodologies, processes for instructions, and optimal assessment strategies, including the teaching hours and where ethics courses are taking place. As the results reflect, the exit outcome for ethics education reveals that based on critical reflection on the suitability of ethical value (and legal) systems to the nursing and midwifery practice within the legal framework, the identification and addressing of ethical and legal issues is imperative for students (SANC 2014a). Even though this outcome may seem reasonable, the study participants consider it to be limiting the ethics content.

The researcher concurs with the participants' views that the exit outcome is restrictive because conceptualising appropriate ethical values and legal systems within a legal framework may be complex for many educators, given the diverse frameworks for teaching nursing ethics. Thus, nursing ethics may be limited to the teaching of ethical values and rules and regulations, as the requirement is for all to be within the legal framework. Therefore, a clarified goal and objectives of nursing ethics education may ensure measurable exit outcomes for ethics education. The researcher's argument reflects various discussions on the meaning of nursing ethics, as these influence the goal, objectives and teaching scope.

The Com-serves and educators raised the issue that nursing ethics education is confined to classroom activities. All the participants attest that this classroom teaching is informed by passing tests and exams. While at the same time, nurses' ability to apply the knowledge remains questionable. As this aspect of training remains unexplored in many South African nursing education’s institutions, the consequences for practice are unfortunate for the face of nursing. Thus, this study argues that effective nursing ethics

education is likely to achieve its purpose if there is a collaborative approach between the nurses in academia and clinical practice. Therefore, the goal and objectives of nursing ethics education must be clarified so that the teaching scope is well aligned with virtue and care ethics in this collaborative approach.

The researcher claims that the changing scope of nursing resulted in distorted goals of ethics education, in which the desired virtues were amended into rules. It is argued that most of these modifications are ascribed to the history of the nursing profession, in which military roots are evident (Duma, De Swardt, Khanyile, Kyriacos, Mtshali, Maree, Puoane, Van der Heever & Hewett 2008:7). Because of the ability to bring order and structure, this military outlook was therefore found plausible in informing the conduct of nursing practices and ethics. As such, the code of ethics for nurses in South Africa has virtues as ethical values that are legally binding.

Dispositions such as fidelity though they are virtues, do appear regularly in the code of ethics for nurses. Snelling (2016:229), however, argues that the integration of virtues involving emotional responses with codes of ethics, whose functions are managerial and disciplinary, may lead to ambiguous practices and ineffective outcomes. Therefore, the researcher argues that although virtue and care ethics are ideal approaches, as the results demonstrate, there are limitations in teaching and assessing these in ethics education. The results show that the current framework is limited in instilling ethical responsibilities. At the same time, there are some constraints in teaching virtue and care ethics; therefore, reconstruction of nursing ethics education is crucial. The researcher further argues that besides codes of ethics, the rules and regulations currently informing practice, virtue and care ethics should be the focus of this collaborative approach, as these are pertinent to nursing practices.

Pellegrino (2006:65) suggests that the reconstruction of ethics should first refer to a philosophical foundation of the practice, which in this case is the phenomena of nursing. The distinctive foundation of nursing ethics lies in the nature of the encounter between nurse and patients; thus, the researcher argues that the current encounter, which emphasises advocacy has competing interpretations; therefore, human caring as a philosophical foundation of nursing reflects the ethics of care and its virtue, the researcher argues that they are the bases for good nursing practice. Watson's philosophy of human caring offers a well-founded link between nursing science practices and nursing ethics.

7.5 DISCUSSION

The discussion reflects on the following questions:

- How should the conceptualisation of nursing ethics be articulated for a coherent structure for ethics education?
- What flaws in the current goal and teaching scope of nursing ethics influence the effectiveness of nursing ethics education?
- How should the purpose and objectives establish an efficient teaching scope of nursing ethics? and
- What should be emphasised in nursing ethics education for good and ethical nursing practices?

These questions are integrated with existing literature to find judgement deemed satisfactory to endorse or reject a specific viewpoint in enhancing ethics in nursing.

7.5.1 How should the conceptualisation of nursing ethics be articulated for a coherent structure of ethics education?

The study's results reveal that the meaning of ethics was conceptualised as a belief system, a humanistic way of caring, application of principles, and professionalism by the educators. The Com-serves describe nursing ethics based on care prompted by responsibility, establishing relationships to facilitate decision-making, enhancing communication skills to promote care, ascertaining an ethical environment, upholding quality, respecting human rights, and upholding ethical principles. Thus, the results revealed multifaceted ways of understanding nursing ethics. Resonating, De Villiers (2015:169) demonstrates that there are different answers regarding the meaning of nursing ethics in South Africa because SANC does not sufficiently emphasise what nursing ethics is. Therefore, the researcher's concerns are whether these variations will likely challenge the nursing education institutions in determining the purpose of nursing ethics and the ethics content, strategies, and expertise for teaching ethics. This variation in defining nursing ethics is also evident in the literature and many nursing discourses.

The difficulty of defining nursing ethics has always been ascribed to the changes in the nursing activities, goals, and boundaries (Baker 2020:98). Volbrecht (2002:2) indicates

that sometimes nursing ethics is seen in terms of clarifying values and analysing ethical issues emerging in practice. Bah and Sey-Sawo (2018:68) describe ethics in nursing as the principles guiding the decision-making and behaviour of nurses. Setti and Ruffa (2012:online) describe conceptualising ethics as an ability to evaluate and distinguish between different values that arise in each situation necessary to exercise responsibility. In clarifying what may be right or wrong, there must be quantities to measure against and enforce compliance. Accordingly, De Villiers and Jooste (2010:26) state that nursing ethics is bound to a code of conduct for safe nursing practice and ethical standards as norms against which nursing practice may be measured. The researcher concurs with the definition that clarifies professional values, as this is mandated for every profession. However, the researcher believes this is not enough for the internal ethical (intrapersonal) development of nurses; thus, nursing ethics must encamp other strategies for personal growth.

Robb (1913:60) indicates that nursing ethics relate to moral virtues and duties in service to others. Although the healing relations in ethics are ascribed to the benefit of others, Saja (2020:73, 76) views the importance of ethics toward individual nurses as inner personal integrity and harmony, which are expected to increase while coordinating altruism and social behaviour. Accordingly, Saja (2020:73, 76) describes ethics as allowing one to maintain and increase inner personal integrity, harmony, and happiness and helps coordinate social behaviour and altruism toward those who stand before us. Van der Wal and Pera (2018:8) depict nursing ethics as a field that is exploring the meaning of being a good nurse and good nursing practices in increasingly complex settings. Virtue ethics is implied as critical in defining nursing ethics, but the results of this study revealed that this theory was not part of the ethical theories taught. Therefore, the researcher insists that moral theory should be taught in totality when virtues are identified to signify the meaning of nursing ethics. This view is supported by Pellegrino (1989:55) that the affliction of moral malaise amongst professions may be corrected by virtue ethics, in which character and self-interest are accentuated.

The definitions above espouse the character of nurses, pertinent rules of conduct, and processes involved in attaining good practices that are judged as reasonable. According to Stockel (2022:26), the fundamental philosophy of the ethics of care resembles Aristotelian virtue ethics. Care ethics revolve around interdependencies of relationships and responsibilities appropriate to the needs of others (Stockel 2022:26), and virtue ethics

provides the state of character for bringing about the goals of the profession (Pellegrino 1989:56).

In early nursing ethics practices, emphasis was on a virtuous woman with a character that manifested healing powers (Fowler 2016:S8). However, with the notion of professionalism and intensive academic preparation, the narratives of virtue ethics became adjusted into professional identity, which is considered to be acquired through the influences of role models and experiences. The researcher claims that although the proper place of virtues is satisfactorily acknowledged in nursing practices, there has been a lack of coherent engagement in nursing ethics education towards establishing it as a conventional morality for nursing. These difficulties, notwithstanding other challenges in nursing practices, have resulted in nursing ethics being rested on contradictory philosophical foundations. The contradiction lies with virtue ethics within the notion of deontology, which has led to changing the teaching scope for nursing ethics.

The researcher argues that the virtuous component of nursing ethics and care ethics should translate from SANC directives as underpinnings of professional ethics in nursing education and practice. According to Pellegrino (1989:56), professional ethics involves the analytical and systematic ordering of principles, rules, virtues inherent to achieving the profession's goals and responsibilities. Thus, nursing ethics may be defined as a synergy of moral character and values in a specific situation in which responsibilities are charged into righteous action. As the conceptualisation of nursing ethics has been revealed to be complex, it has to be approached pragmatically to include virtues, principles, values, and responsibilities that define our humane position in society. Furthermore, Rossillo, Norman, Wickman and Winokur (2020:117) indicate that caring is the hallmark of professional nursing practice evolving in different contexts; therefore, the researcher believes that it should be in line with this philosophical understanding of human caring in which virtues, principles and rules interplay. This interplay emanates from the results of this study.

There are numerous reasons the researcher finds the plausibility of using narratives in exploring one's understanding of nursing ethics. For example, Walker (1998:9) affirms that people recruit their moral capacity to the responsibility from their understanding of things that unwrapped human care. Thus, the nursing students' stories about understanding ethical care and not the justification of moral prescriptions may enhance

nursing ethics. Enrichment of nursing ethics is foreseeable because narratives commingle facts, values, and context, and through deliberations with peers, innovative adjustments and modifications through teaching strategies are possible (Verducci 2014:610). Taylor (2008:6) affirms that narratives may afford students a rich opportunity to transform, in which they invest in their growth and values capital and therefore become producers of personally situated curricula. As such, transformation is likely to happen, in which the encounter or experience with new information and values will make one acknowledge self-step back and let go; and eventually move forward with the new self. The researcher sees the practicability and rationality of presenting narratives on caring activity experiences as a starting point of ethics education. In these presentations, students will be motivated to identify their developmental plan for being ideal ethical nurses.

Daltone and Crosby (2006:1) attest that students must be helped to explore their inner lives and stimulate ethical reflection and decision-making, in which a sense of wholeness and integrated life guides them. Thus, a pragmatic way of conceptualising nursing ethics may enable informed discussions and induce interest, curiosity, and significance of the subject in nursing ethics education.

7.5.2 What flaws in the current goal and teaching scope of nursing ethics influence the effectiveness of nursing ethics education?

Avci (2016:13) indicates that the goals are decisive factors in measuring the quality of ethics programmes and are thus crucial topics in ethics education that need to be decided upon before applying for ethics programmes. The results of this study reveal that SANC is not stipulating clear goals, which blurs the objectives for ethics education; therefore, drawing the teaching scope becomes ineffective. Thus, the overall findings validate an inconsistency between the practice and theory during nurses' training, as students could not practice what was taught once they were in the clinical learning areas. The educators see the students as a self-centred generation with limited responsibility despite the educators' efforts to help students become ethical. In the same way, the Com-serves considered the senior nurses at health care services unethical. What was intriguing was the lack of courage as a virtue amongst the Com-serves to stop or interrogate the unethical behaviour of senior nurses. Thus, it may be argued that there are limitations in the current ethics education framework. According to Avci (2017:126), efficient goals and

objectives of the ethics programme are critical for the teaching scope. Avci (2016:5) describes teaching scope as concerned with the ethics content, teaching processes, assessment strategies, and the timeframes and context for ethics courses. Thus, explicit goals, objectives, ethical content, and teaching strategies are essential in demonstrating the continuum in nursing ethics. Camenisch (1986:494) postulates that the purposes of the ethics course answer why it is necessary to invest in the course and what the expected outcomes will be like.

Accordingly, Camenisch (1986:498) indicates that the goal should reveal whether the ethics course would be descriptive or normative. In the normative goal, the approach would stimulate imagination of moral in recognition of ethical issues, develop analytical skills and evoke moral obligation, responsibility, and tolerance in ambiguous situations that pose disagreement and resistance (Camenisch 1986:495). On the other hand, the descriptive goal influences the student's moral choice in which values, rules, and solutions are presented as correct (Camenisch 1986:498). The results from the document review uncover that the goal is behaviour-based with standards to assist in acquiring the desired competencies. As such, the goal was descriptive, in which learners must accept ethical guidelines. Camenisch (1986:499) considers descriptive goals as having distinct dynamics of indoctrination whose outcome is conformist professionals with limited moral development.

The educators in this study complained about the exit outcome being too broad for comprehension. Therefore, the ethics content became limited because the professional practice aspects were extended to compensate for ethics. The results also illustrated that some participants resorted to old ways of teaching ethics, which were marked by rules and regulations only. However, participants also complained that they struggled to instil ethical conduct amongst the students. The difficulty in understanding the goal also led to the teaching strategies identified as formal lectures, group discussions, tests, and exams. Camenisch (1986:499) attests that this ethics education approach doesn't contribute to moral development because accepted ethical guidelines, rules, and solutions to problems are presented and assessed to ensure conformation to these standards models. As such, the rules may not be disputed or interrogated. Moreover, Camenisch (1986:499) states that these models rely on predictive judgements, which, if not used analytically, may lead to negligence or abuse of rules and standards.

The researcher claims that the increasing ethical problems and litigations observed amongst healthcare professionals may be brought about by nursing ethics education' reliance on descriptive goals of ethics. This claim is signified by this study's results, in which healthcare professionals were considered to have a lack of ethical reflection by the Com-serves. There is also a relentless picture of nursing in social media and newspapers. In this regard, SANC should revise the goal of nursing ethics education to meet the desired outcomes for the benefit of the patients, family, and the profession, as the participants suggested.

In commenting on the purpose of ethics education, Avci (2017:140) indicates the ethical knowledge should be increased, ethical skills improved, sensitivity of moral should be strengthened, as well as the development of ethical behaviour and promotion of cultural competence. The educators indicated that the SANC guidelines contributed to limited ethics education and did not include essential things about patients' care. Furthermore, the results revealed that ethical principles are problematic because belief systems factors may affect how one understands the principles. Therefore, the results show that the goal of ethics couldn't instruct which course content to pursue and how the ethics course would demonstrate a measurable change amongst the students. The researcher, therefore, reasons that the ideal goal of nursing ethics education should encompass descriptive and normative approaches as these are critical in enhancing nursing ethics education.

The statement of establishing goals and objectives to have efficient teaching scope is defended by the participants' outcry that current exit outcomes and objectives are limited and misunderstood. Furthermore, the results of this study reveal limited teaching scope as ethics content are restricted, while teaching strategies are bound to be formal lectures and discussions. Although group discussions are valued in ethics education, the participants clarified that belief systems might limit the discussions around sensitive issues. Thus, the character and expertise of lectures play an essential role in facilitating discussions. In this regard, most participants indicated they need support in facilitating sensitive issues discussions in ethics.

Although the ethos and professional practice had practical components, the participants complained that there is no clinical practice for ethics which aligns with the theoretical aspect of nursing ethics. The Com-servers believed that ethics must be like other nursing subjects with a practical component. Again, the Com-serves raised the issue of

assessments being based on tests and exams, which they pass without understanding the practicability of ethics. This issue concurs with Bertolami (2004:414), who claim that dishonesty and misbehaviour happen after the ethics courses have been offered and test and exams have been passed. Therefore, it is critical to reconstruct the teaching scope of nursing ethics.

7.5.3 How should the goal and objectives establish an efficient teaching scope of nursing ethics?

Carrese, Malek, Watson, Lehmann, Green, McCullough, Geller, Braddock and Doukas (2015:744), aver that ethics goals are expounded differently in different institutions. As the results demonstrate, this is primarily due to misinterpretation of SANC guidelines. The question is why there is such a variety when there are overarching expectations. Thus, Carrese et al (2015:744) suggest that institutions must have a consensus regarding the goal of ethics education. Within the realm of nursing, the main expectation is good nursing care. According to Pellegrino (2001:569), there are four dimensions of such good that several levels of ethics objectives should meet. These dimensions of good include good that relates to the profession's aims, good that serves the complex facets of the patient's perception, good that is peculiar to humans, and good that acknowledges life beyond material well-being (Pellegrino 2001:569-571). Thus, good nursing care should reflect these dimensions of good in the goal of ethics education.

In addition, Pellegrino (2006:65) suggests that the philosophical foundation of a professional should be established first if ethics is to be constructed. Thus, the researcher intends to verify this before revising the goal of nursing ethics, as there must be a relationship. Accordingly, Tesh (2020:200) considers Watson's philosophy to be evolving in addressing questions about nursing, nurses' activities, and the nature of caring in humans. Watson’s philosophy of human caring offers a well-founded link between nursing science practices and nursing ethics. Accordingly, the theory of human caring intends to promote healing, preserve dignity and respect the wholeness and interconnectedness of human persons while enabling a measure of subjective evaluation by those at the receiving end (Watson 2009:471). Thus, this philosophy delineates caring as a virtue for transforming nursing practices, in which the intent is to preserve dignity and respect the wholeness of the human person in a healing process. Therefore, nursing ethics education' goal should help students care for the patients humanly so that families, society, and the

profession could also give a subjective judgement by linking the caring activities' outcomes with the rules and virtues.

Since the current goal and teaching of the scope of ethics have flaws, there is a need to suggest another goal and objective of the nursing ethics programme. Avci (2017:138) indicates that ethical reasoning develops while acquiring moral knowledge and skills, and this needs to be acknowledged in the goals and objectives. Therefore, the researcher finds it suitable to establish how ethics education goals have been presented in the literature and revise some recommendations. Post (2004:1900) shows the goal that states that teaching nursing ethics should produce ethically accountable nurses with ethical decision-making skills. This goal, according to Post (2004:1900), has the following objectives, which guide educators to help students to be ethically competent:

- Examination of personal commitments and values concerning patients' care.
- Engaging in reflection of ethics.
- Skills development in moral reasoning and moral judgment.
- Development of the ability utilising ethics in broadly reflecting on issues with the implications of policy and research with regards to the moral foundations of practice (Post 2004:1900).

Avci (2017:140) suggests that the ethics education's aims should be on increasing ethical knowledge, improvement of ethical skills, strengthening of moral sensitivity, awareness and judgement, development of ethical behaviour, and the cultural competence promotion. The researcher, therefore, comments that for nursing ethics to be enhanced, the goal of ethics education should acknowledge and take account of skills, attitudes and behaviours while considering the beneficiaries of the efforts.

7.5.4 What should be emphasised in nursing ethics education for good and ethical nursing practices?

Proponents of virtue ethics argue that dispositions and traits are the natural substance of daily moral life, in which day-to-day decisions and moral activities are made (Rae 2018:63). Thus, the researcher claim that daily nursing care activities should be charged from well-formed moral character. Accordingly, Beauchamp and Childress (2013:366) affirm that motivation founded on appropriate attitudes and concerns has more merit than

doing care from a sense of duty. This is because attitudes, feelings, and motives involved in moral actions are attributes of being human, as most participants raised the notion of humanness. According to Doukas, Ozar, Darragh, De Groot, Carter and Stout (2022:1), virtue and care ethics are associated with humanistic behaviour. Suitably, Virtue ethics emphasises how optimum moral character predisposes one to behave ethically (Doukas et al 2022:1). Subsequent to that view of a character, care ethics acknowledge care in unequal relationships, in which one is more vulnerable because of the temporary or permanent absence of capacities that prioritise on to receive care (Doukas et al 2022:1-2). Thus, these normative approaches are related to and supplement each other and the researcher's reasons for their use in enhancing ethics.

It can be claimed that nurses have a moral obligation to the patients, relatives, the team of healthcare professionals as well as nurses, the general publication, the employer and the profession, as mentioned in the Code of Ethics (Nursing Act (Act No. 33 of 2005)) (South Africa 3005). These obligations are coupled with professional competencies that are per the standard. Thus, it would be considered adequate and reasonable for an individual nurse to act ethically according to these standards. However, there are arguments that these standards lack a moral foundation, as they do not point to any ethical theory from which these obligations have been generated (Edwards 1996:91). For example, Post (2004:1901) indicates that advocacy, accountability, collaboration, and caring define the nurse-patient relationship dimensions. The question is, which moral foundation are these concepts based on? This question emanates from the results, as the educators in this study were concerned about not knowing where some information in ethos books is coming from, and there is no reference of where and why. Thus, teaching virtue and care ethics may give reference points and enhance nursing ethics.

In care ethics, the caregiver acts for the benefit of the dependent other, in which caring attitudes manifest appropriate awareness and sensitivity to the needs while avoiding paternalism. Similarly, a morally ideal man in virtue ethics will display self-consciousness, excessive focus on ethical reflection in a situation where there is acknowledged dependency and the accompanying facts of vulnerability to a range of harms (Thomas 2011:138). Thus, it is argued that virtue and care ethics are aligned with nursing practices and, therefore, nursing ethics.

The findings demonstrate that participants considered patients and their relatives as having an intrinsic value, and their care was understood in terms of humanness. Furthermore, some participants referred to being present, while others talked about responsibility, establishing relationships and using communication skills to facilitate care and decision-making. The results show that the participants' notion of nursing ethics was based on their dispositions in fostering care. When the participants were uncomfortable about something or focused on improving the quality of care, their dispositions were used as the first reference. Such a stance coincides with Rae's (2018:63) opinion that virtue ethics is a fundamental substance of daily moral life compared to act-orientated ethics that intends to solve ethical dilemmas. Although other moral theories are essential for resolving moral dilemmas, Beauchamp and Childress (2013:32) argue that virtues enable and qualify a person to comply with the standards of practice deriving from roles and responsibilities. As such, virtue ethics precedes obligations.

Regarding responsibilities, the participants point to the fact that they were moved by responsibility to care. Argandoña (2016:64) indicates that responsibility arises from the relationship with another person and entails virtues; therefore, the participants executed their nursing activities under the command of virtue. Argandoña (2016:64) demonstrates that virtues within responsibility include awareness and pursuit of excellence in one's activity as well as sustaining and supporting that excellence.

Rae (2018:63) argues that virtues remain the basis of motivation to do the right things and are expressed before executing principles associated with responsibilities. Thus, virtues are essential for developing relationships which are daily occurrences. Unlike being concerned with moral dilemmas that do not happen daily (Rae 2018:63), virtue ethics must have a larger share in ethics education. By being essential for establishing relations, virtue ethics become compatible with ethics of care; thus, they reconcile the nature of nursing care activities. On the other hand, Thomas (2011:144) claims that the care of ethics is a form of virtue ethics as they are inherently contextual, and they request the deliberating agent to be open to the evaluative demands of the world. Thus, virtue ethics is to be taught not only in terms of possessing abstract traits, but there should be proper identification of virtues and the ability to develop practical wisdom for these virtues to produce flourishing. In this regard, the goal of ethics education should illustrate the importance of clinical practice and the challenges emanating there for developing practical wisdom as an aspect of human flourishing. Therefore, it is recommended that

the ideal approach to enhancing nursing ethics should be the narratives of one's understanding of nursing ethics within the context of caring experiences.

As a criticism, it may be argued that virtue ethics may lead to some form of relativism, as students in training are likely to uphold some culturally appraised virtues that may not constitute the ideal virtues for others. The researcher argues that ethics training is about classification, assimilation and transformation; therefore, the mandate in teaching virtue ethics has to entail identifying and interrogating all virtues for clarity and universal application. Regarding practical wisdom, Blomberg and Bisholt (2016:762) affirm that it involves acting appropriately to meet concrete situations with deep perception and imagination.

Accordingly, the participants in this study recommended that clinical education be part of nursing ethics education and concur with Blomberg and Bisholt (2016:762) that clinical supervision uses complex situations to develop critical thinking in which nuanced assessments are required for good judgement before applying virtues. Thus, clinical learning experiences for ethics education should be incorporated to strengthen the practical wisdom of the students. At the same time, these may encompass aspects of in-service learning for the Com-serves. This will contribute to acquiring ethical competency in which virtue and care ethics would be aligned to a set of rules.

7.6 FRAMEWORK TO ENHANCE NURSING ETHICS EDUCATION AND PRACTICE IN THE NURSING PROFESSION

In developing the framework to enhance ethics, the researcher considers the following to be of uppermost importance:

- SANC to formulate clear goals for nursing ethics education.
- Conceptualisation of nursing ethics using personal narratives regarding care experiences.
- Consideration of virtue and care ethics as fundamental to human caring.
- A refocus on the clinical component of nursing ethics.

These points are given below in a schematic presentation of a framework to enhance ethics education and practice of professional nurses in South Africa, which are discussed next.

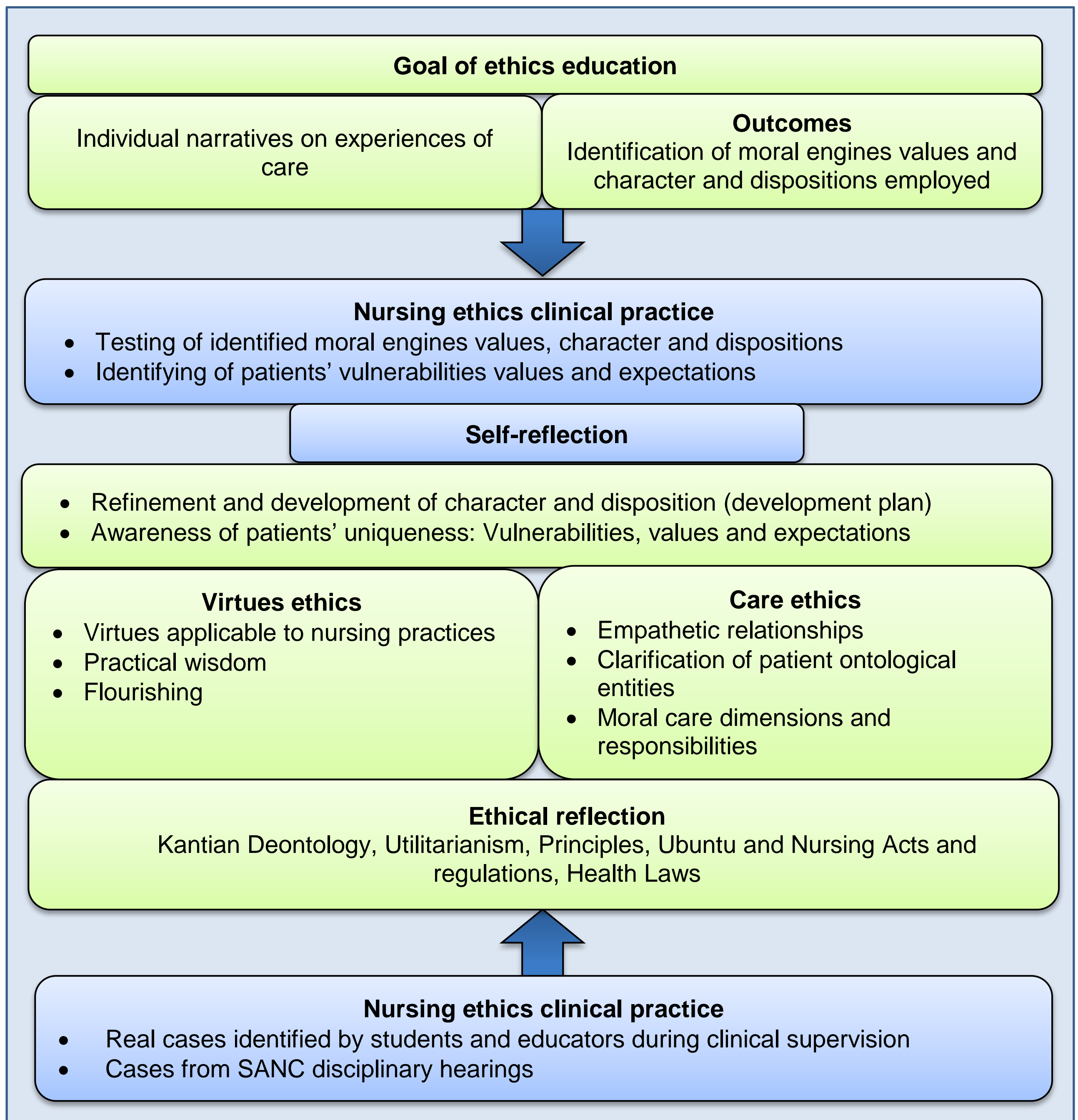

Figure 7.1: Framework to enhance ethics education and practice

7.6.1 South African Nursing Council (SANC) to formulate clear goals for nursing ethics education

The researcher, according to the findings, suggests that the exit outcome for ethics education in nursing should be to enable humanly caring rooted in ethics and engagement of laws for the benefit of diverse patients, families, society, and the profession in which there is:

- Increased ethical knowledge, in which the values concerning the care of patients are examined and interrogated and aligned with virtue and care ethics and personal commitments.
- Improve ethical reflection, communication, and negotiation skills, by engaging with laws in nursing and health care and reflecting on moral theories in the daily activities of nursing.
- Clinical practice placements are effectively used to strengthen moral sensitivity, awareness, judgement, and moral reasoning.

The researcher believes these goals may enhance nursing ethics, as the objectives would enable one to choose applicable content and teaching strategies to encompass the process of ethics education in the classroom and clinical settings. As Avci (2017:126) affirms, comparable teaching scope for the ethics programme may be delineated easily from this goal. According to Avci (2017:138), ethics education should stimulate changes in learners' ethical knowledge, perception, and cognitive development and not be a traditional moral instruction focusing on ready-made pre-existing norms of good character, with no enhancement of ethical awareness and moral reasoning. Further recommendations to enhance ethics education are to:

- Increase the credits for ethics education to incorporate the content and strategies likely to yield positive results for ethical nursing practices.
- Use of expertise in ethics education and teaching strategies. The interest and expertise of nursing ethics educators are critical; otherwise, constant support to these individuals is needed, as the results demonstrate.

7.6.2 Comprehension of nursing ethics using personal narratives regarding care experiences as a basis for a coherent structure of nursing ethics

The results demonstrated that there were diverse ways of comprehending nursing ethics. And these were personally constructed by lectures and Com-serves and may be articulated to nursing ethics for personal development. Similarly, students may never be empty vessels to be filled with ethics knowledge; instead, they must be helped to acknowledge and tap on their knowledge, skills, attitudes and emotions in their developmental journey. Every student brings to nursing various traits and dispositions which, at a certain point in life, have been used in dealing with vulnerabilities that humans experience from birth, old age, and illness to death. Accordingly, students come with experiences of what could be understood as their conceptualisation of nursing ethics. Additionally, as human beings, students have moral drives that include virtue, opportunities, and freedom (Dyring, Mattingly & Louw 2018:9). Thus, the conceptualisation of nursing ethics should be drawn from the personal caring experiences of students. As Van Manen (1977:216) attest, experiences are constructed by knowledge and consist of collections of distinct perceptions, notions and skills that may perfectly judge actions and influence motives, emotions dispositions.

The researcher reason that personal narratives are likely to connect the character to interaction, relationships, consequences, and actions to the judgements. As such, these become a tapestry of virtues and values, which, according to Hoffmaster (2014:6), require transparency, respect, humility, and sincerity. Narratives may take many forms, including poetry, art, diaries of personal experiences and storytelling from families and friends. It is essential to allow innovation that, through the participation of peers, is likely to contribute to the collection of the contextual and complex dynamic of experiences from which students may learn from each other.

It must be understood that these narratives of experiences are derived from distinct personal experiences with various contingencies that may be difficult for the educators to untangle or for other students to learn and copy or otherwise probe. Therefore, it is necessary to locate them in the social dynamics of being and transcend them into moral reality, such as relationships. As Dyring et al (2018:9) attest, the ontological relationship between self and world is theoretically construed, and therefore, it is advisable to incorporate strategies that may allow the transition of experiences into practice (Van

Manen 1977:206). Thus, Critical-dialectical discourse should be extrapolated into narratives experiences in which peer education is used through the help of a facilitator. Critical-dialectical discourse is a valuable method for exploring, analysing, synthesising and judging values, beliefs and experiences (Mezirow 2003:59). And through testing conclusions and scrutinising the coherence and credence of the stories, the formal and informal reasoning methods are examined for efficiency (Hoffmaster 2014:5).

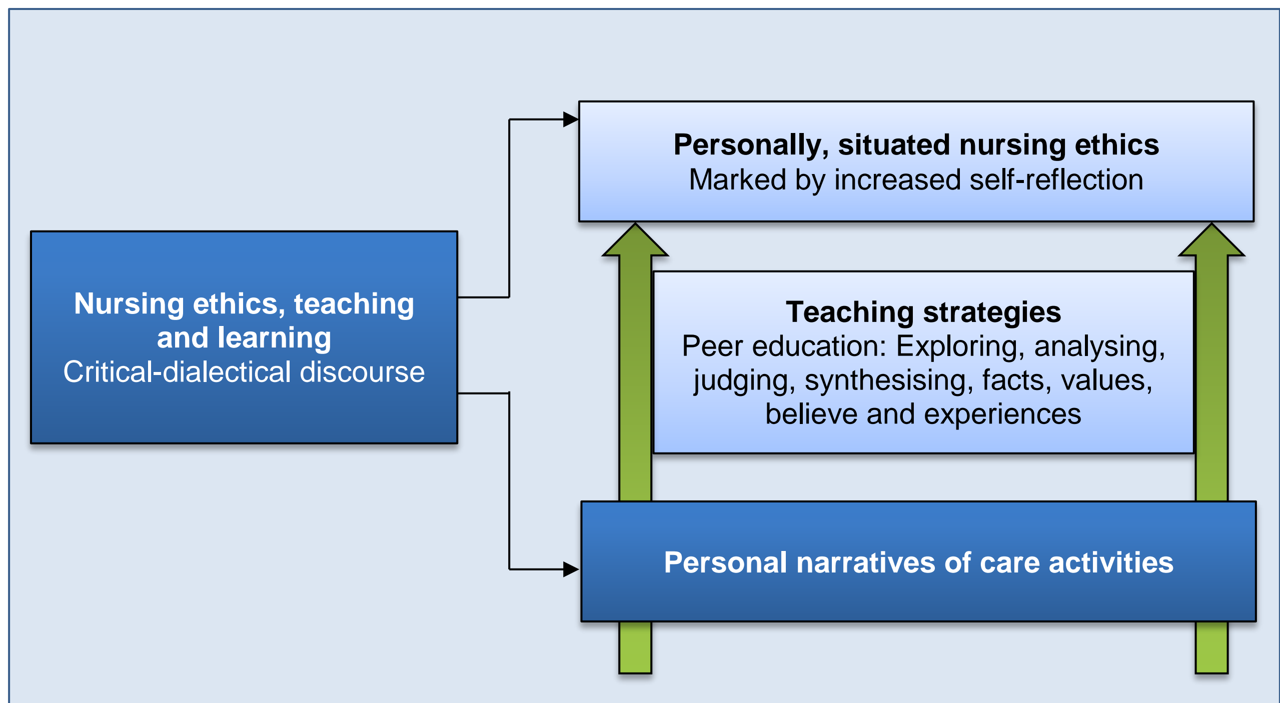

Figure 7.2: Elements of critical-dialectical discourses

Critical dialectical discourse is a pedagogy that appraises practical applications and does not blindingly accept one's story without checking the facts and values concerning the context, as this would result in mere conformity (Elbih 2018:189). This approach upholds civic engagement and empowers students with critical thinking and self-reflection (Elbih 2018:190). As peer education is a proposed mechanism for engagement, educators should be prepared to adjust the timeframes for ethics education and have a classroom culture that embraces civil discourse.

7.6.2.1 Guidelines for using narrative in nursing ethics education

Although narratives have the potential to articulate the essence of each story to values and virtues into a coherent structure for ethics education, narrating one’s account may also be threatening. Thus, proper planning by the lecturer is essential. The lesson will

come with mandates for the lecturer, the students, and the specific student who will be telling the story.

It is indispensable to emphasise that the role of educators has to change into a facilitator, as it is in this role that the lecturer becomes part of the group and shares stories. In this manner, the lecturer becomes an exemplar. Individual students are expected to share their narratives in an original form. Through the help of peers, they should identify their virtues, values and weaknesses and start to plan their development vision of virtuous nurses. The narrative should clearly state what inspired them to describe the incident, and they should be asked why they performed the activity the way they did. What drove them to do that? What values or traits urged one to get involved? If they were to redo, what areas would need more attention and why?

7.6.2.2 Requirements for a context to facilitate a narrative process

- The conducive classroom that allows free discussion and confidentiality of information nonthreatening setting.
- Significant time to be allowed for the discussion to yield good results.
- Ground rules that relative to civic discourses: propensities such as hospitality, mindfulness, participation, mutuality, humility, hope and self-determination should guide the discussions.
- The description of emotions that were felt during and after the caring incident. Feelings experienced now when the story is being narrated.
- Students' sentiments and beliefs may make one vulnerable; therefore, educators must have strategies in place for protecting and debriefing the students.
- Plan strategy on how these should be tested in clinical learning, and there should be a peer evaluation with checklists.

7.6.3 Virtue and care ethics are fundamental to human caring and need to be given prioritised in ethics education as normative approaches for good nursing practices

Drawing from the results regarding virtues and care ethics, participants talked about using traits and dispositions of being human as well as enhancing communication techniques

and motivation to quality standards in executing their ethical care. Thus, virtue and care ethics were considered sound approaches for their nursing practices, even though the module review demonstrates that these approaches were not part of the teaching scope. Therefore, this is a missed opportunity as Porz, Landeweer and Widdershoven (2011:354) believe that interpretation of clinical practice should be used to establish new theoretical concepts. The Com-serves in this study had no such opportunity of engaging in what they called "*sitting the person down and having a woman-to-woman talk*", which involved character, values, and caring activities that were used to improve their theoretical understanding of nursing ethics. Instead, their conceptualisation of nursing ethics which emphasised virtue and care ethics was counteracted with teaching that emphasised deontology, utilitarianism and principles that have rule-based aspects.

Woods (2011:266) points to the fundamental importance of caring in nursing and indicates that it becomes evident in interpersonal relationships and appropriate ethical responses. Thus, care and virtue ethics become more critical in nursing. Caring is a fundamental virtue of being human in the world outlined by the phenomenology of suffering; as such, the practice of caring is a moral ideal rooted in the notions of respect for dignity (Fry 1989:91). Therefore, notions of human dignity raised by educators in their understanding of ethics in which concepts such as being present for the patient, helping an ill person to enjoy life, and treating people with respect, being human and Ubuntu emphasis the need to teach virtue and care ethics effectively.

The restoration of human dignity equals flourishing in virtue ethics. Thus, these normative approaches should be thoroughly taught and made explicit to students, as demonstrated in Chapter 2 of this study. In their everyday activities, nurses meet patients with physical anguish and mental or spiritual suffering, which a professional obligation may not merely address on its own. Indeed, most suffering may be subjective because engaging in all-embracing responsibility to the patients requires moral intentions that will motivate the moral duties (Pongiglione & Sala 2019:59). Thus, the idea of subjectivity is virtue and care-based, as Levinas (2009:229) esteems subjectivity for exploring human beings and getting spiritual, moral and psychological insights regarding the effects of physical anguish.

The researcher believes that virtue ethics should inform the encounter between a nurse and patients. This, therefore, requires that nurse-patient relationships be clarified and

taught to the students. Encountering patients translate into responsibility and, therefore, should be a philosophical foundation for nursing ethics as described by Levinas (1978:10). It is in such underpinnings that ethical reflection would become a continuous developmental endeavour for nurses, based on increased moral knowledge, skills, and attitudes for the patient's benefit, society, and the profession increases. He and Van Heugten (2021:1222) indicate that in developing a virtue ethics framework, the interior and exterior aspect of the self, the universal and situational features of virtue ethics, and the need for a reflective approach to balance both; as well as ethical development of the reflective approach need to be addressed. Thus, it is by acknowledging one's strengths and limitations through testing in clinical practice that the cultivation of new virtues and ethical reflection is set in motion for continuous development.

It would be a falls assumption that by teaching virtue and care ethics, students would be well equipped to tackle ethical challenges. Furthermore, it is well known that students do not develop moral competence simultaneously; thus, guiding them with rules and principles enshrined in the codes of ethics is essential. Therefore, it is critical to mention that though virtue and care ethics are imperative for nursing care, the development of moral reasoning and judgements requires other moral theories and nursing and health care laws. Therefore, nursing ethics content should also encompass traditional moral theories and rules to guide this development. This development needs testing and affirmation; thus, clinical practice should be used effectively.

7.6.4 Emphasis on the clinical component of nursing ethics

The results exemplify that the educators and the Com-serves express the need for clinical components for nursing ethics education. Clinical learning areas for nursing students are resource rich with ethical issues that can be used to enhance practical wisdom and responsibility as aspects of virtue and care ethics. Besides, this platform is critical for identifying and representing cases for teaching moral theories and health laws to facilitate moral reasoning and judgement and develop ethical reflection. Thus, the problematic situation of the student's experiences in clinical practice entangled in their stories might be in teaching and learning. As such, this teaching and learning in class would be student-driven under the facilitation of the educators. Indeed, Porz et al (2011:354) attest that the narrative approach provides the basis for clinical ethics.

The researcher reason that clinical nursing ethics education is at the footing of the nurse-patient relationships and is, therefore, a significant component of ethics education. As argued above, it is the place where students can test their traits and disposition and then learn new ones through interaction with other stakeholders in health care services. In this manner, the interior dimension of their virtues will start to mature and, through habitual practice, become ingrained. Nursing requires a nurse to be a character of character with espoused virtues such as benevolence, courage, compassion, integrity, etc. As such, these need a good clinical area foundation and sound theoretical underpinnings.

Clinical nursing ethics, an essential aspect whose potential benefit is to improve patient care quality, should be demonstrated during ethics education strategies of accompaniment. The fall assumption of relying on theory in hoping for an excellent practical outcome should be interrogated for the purpose of using clinical as a place where the students see suffering, patients ask for help and raise concerns regarding aspects of care. Thus, ethical competence has a high possibility of being acquired through clinical ethics education. According to Gallagher (2006:228), moral competence entails ownership of ethical knowledge next to the ability to identify a situation presenting an ethical issue, the ability of critical reflection and initiate an ethical behaviour. As Porz et al (2011:354) attest, clinical ethics should be used to establish new theoretical concepts. Therefore, moral theories should be linked to these new theoretical concepts and brought to the classroom in an attempt to integrate theory and practice.

7.7 SUMMARY

The chapter argues for a framework to enhance ethics education and practice in nursing, in which the researcher concludes that a revised goal for nursing ethics is necessary. In summary, the goal and objectives must suggest an outcome that will enable humanly caring rooted in ethics and the engagement of laws for the benefit of diverse patients, families, and society.

Classroom ethics education should enhance ethical knowledge and personal commitments to improve ethical reflection, while clinical practice will effectively strengthen moral awareness, sensitivity, judgement, and reasoning. Personal responsibility will also emanate from students' narratives, which allude to nursing ethics education structures. These personally structured nursing ethics are the initial step in ethical

reflections. A coherent ethical development is envisaged by engaging other moral theories and laws. The next chapter discusses the conclusion, recommendations, suggestions for further research and the study's limitations.

CHAPTER 8

CONCLUSION, RECOMMENDATIONS LIMITATION OF THE STUDY

8.1 INTRODUCTION

The latter chapters conversed the qualitative and quantitative results of the study, as well as the integration process that developed the meta-inferences. As illustrated in Chapter 7, meta-inferences were used in normative analysis to establish the framework for enhancing nursing ethics practice and education. This chapter presents the conclusion, recommendations and suggestions for further research, the limitation and the remarks of conclusion.

8.2 RESEARCH DESIGN AND METHOD

The state of nursing ethics education and practice has been revealed through a convergence mixed-method designs, in which quantitative descriptive methods were adopted to review the module guides for ethics education and explore the ethics knowledge amongst the Com-serves. The unstructured interviews conducted with ethics educators and Com-serves gave qualitative descriptions. The complementarity value of mixed methods was achieved by incorporating multiple techniques. There was elaborating, enhancement and clarification of the results from one method to another (Greene et al 1989:259). Inferences from these diverse data sources portrayed the state of nursing ethics and gave insight into the trajectories that may be taken to enhance ethics and, therefore, ethical patient care.

8.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The study's overall intention was to explore and describe the South African state of nursing ethics education and practice. The framework to enhance ethical practice in nursing was developed based on the results. To achieve the purpose, a convergence mixed-method approach was used. The documents for ethics education were reviewed, a survey exploring the ethics knowledge of the Com-serves was carried out. Lastly, unstructured interviews were conducted with ethics educators and Com-serves. Inferences from these diverse data sources portrayed the state of nursing ethics and gave

insight into the routes that may be taken to enhance ethics and, therefore, ethical patient care.

The study's findings demonstrate that the study's objectives were achieved as the goal of ethics education, teaching scope for nursing ethics, the experiences of the educators and the Com-serves revealed the state of nursing ethics. The findings affirm an ineffective nursing ethics education endorsed by ethical challenges in practice, as the results illustrate. The findings acknowledged the ethics of responsibility as the framework of the study when participants described their understanding of nursing ethics. Thus, salvaging and enhancing ethics education is critical. In demonstrating how the purpose was achieved, the objectives of the study are therefore summarised:

8.3.1 To review nursing education institutions' nursing ethics documents

The review of the module guides demonstrates that the ethos and professional practice make it hard to extinguish the educational aspects relevant to nursing ethics. The goal of ethics education in this module was to develop students' ability to identify and address ethical and legal issues based on critical reflection on the suitable ethical value (and legal) systems to the nursing and midwifery practice within the legal framework. The ethos and professional practice (EPT215/225 and EPP100) emphasised compassionate and caring practitioners as the traits and character that should be achieved. The results made it explicit that it was difficult for educators to comprehend the exit outcome of ethics education, which impacted the teaching scope that was considered ineffective. Avci (2016:11) emphasises that the first step is to clarify the goal of ethics education. By giving a clear purpose, it is considered that specific ethics content, strategies for teaching and assessment, and where training should take place will be unambiguous (Avci 2016:11).

The results from the review of module EPT215/225 and the provision of literature demonstrate that the tangible consequences of nursing ethics would be the traits and character of a nurse, which the ethics education should help the students to expand their vision of virtuous life (Giacalone & Promislo 2013:96). Although, the virtue-based and care-based approaches are to be regarded as significant for the content, these were omitted in the module guides. In decision-making, students are only introduced to the deontological, utilitarianism, and naturalism approaches. The results reveal that the course ethos and professional practice (EPT215/225 and EPP100) has a wide range of

professional associations, trade unions, labour law, management, leadership, and research, which are given noticeable attention. As such, the critical component (nursing ethics) was overlooked. Nursing ethics content comprises small parts, such as principles of professional practice, the standard of practice, and ethical decision-making. The followed approaches are rule-based, and demand one to conform and not critically analyse a moral situation and its applicable ethical approaches.

Although the ethical principles were part of the content, what was intriguing was the exclusion of what to do in the case of competing principles. The analysis demonstrates that although the moral theories and statutes relevant to health care services are part of the content specific to nursing ethics, some ethical theories such as virtue ethics and care ethics were omitted despite being the backbone of nursing ethics. The researcher, therefore, believes that these approaches toward developing students as moral agents are too limiting, and this translates from the exit outcome. The belief is that focusing on virtues and care ethics would enable the learners to develop their internal morality, which is paramount for their reflection and caring practices.

The results illustrated that scheduled time frames for nursing ethics education are minimal. Besides time constraints, other shortcomings were the teaching strategies, as formal lectures and group discussion were the main teaching strategies indicated in the module guides. It is therefore argued that other extensive methods would have made an impact. The tests and exams as strategies to evaluate competency may never show whether one has developed moral skills or not, as these are intended to test knowledge. Furthermore, there was no evaluation of the course measures for the students to assess the course outcome. Thus, in curbing the impediments to competence in ethical practices amongst students, SANC should, as a regulatory body, necessitate structural changes in ethics education for nurses.

8.3.2 To explore and describe the perceptions of educators concerning ethics content taught to students

The educators are of the opinion that the directives from the SANC were unclear, which made the choice of ethics content very complex, as the guidelines are too broad, unexplained, and too limiting for ethical competence development. Though educators care about imparting ethics knowledge in their teaching, they noted that the gap between

the theory and practice in ethics continues to expand, despite their efforts. The educators had various ways of recounting nursing ethics. They believed nursing ethics is about clarifying and deliberating matters around values and worldview and being there for the patients. The findings demonstrate that the participants considered patients and their relatives as having an intrinsic value of being cared for. Benito and García 2016:445) state that these ethical encounters are inherent to professions grounded in human beings, such as nursing; therefore is uplifting that the perceptions of educators exhibit this aspect of humanity in describing nursing ethics.

In articulating personhood, the results concur with Levinas' (1978:10) ethics of responsibility because human dignity is an inter-subjectivity stance that requires partnership and mutual understanding between the nurse and the patients. This understanding concurs with ethics of responsibility because the concepts such as being present for the patients were also used to describe nursing ethics. Another viewpoint brought to light by the results is the application of ethical principles and professionalism, which entails rules and regulations. The findings reveal that educators are concerned about the effectiveness of their courses, given the current frameworks of ethics education and recommended that professionals in clinical practices should be retrained.

8.3.3 To explore the teaching strategies used by education institutions to develop students' ethics competence

This study's findings illustrate that participants used formal lectures, presentations, role-playing, and discussions as the teaching strategies. Few of the educators tapped on the prior experiences of their students in initiating discussions, and only one participant used reflections in their classrooms. However, as educators, the issue was that they tended to stop discussion once sensitive issues questioned their belief systems. Still, they reported that these were limited in instilling professionalism or integrating theory and practice. As echoed by some participants, the interest and skills of the lecturer are of paramount importance. Therefore, most participants wanted to be supported in this regard. The role of ethics educators, expertise, and skills emerged as aspects that need to be considered regarding teaching ethics.

8.3.4 To explore and describe the ethics knowledge of the newly qualified nurses on community service

Most respondents considered themselves to have a good understanding of ethics to the point of having confidence in exchanging views regarding ethics with other professions. What was intriguing was the fact that a large percentage of 72.92% confirmed a need for further ethics training. This need contradicted the response in Q7, where the respondents believed they had enough ethical knowledge to apply in their daily nursing practice. However, such answers are inevitable when uncertain about what one knows. In elaborating on this ambiguity, just above half of the respondents claimed knowledge of ethical principles; however, when asked to write them down, only 54.16% of the participant could recall some of the ethical principles and not all. Thus, it seems reasonable to view their knowledge as limited. The findings also reveal that 93.75% (n=45) believed they could depend only on rules and regulations in their nursing practice. The insight of law or statutes that guide the nursing practice and health care amongst the Com-serves in this study was low. This limited knowledge of South African regulations applicable in healthcare services was also demonstrated when respondents in this study were asked to recount these laws. The results reveal that nearly half, 47.08%, of the participants, did not know statutes, while 30.72% could relate only to the Nursing Act (Act No. 33 of 2005). This limited legal expertise amongst nurses was also identified by Singh and Mathuray (2018:136). Therefore, laws that nurses subscribe to, also as healthcare workers, should form part of the nursing ethics picture.

The results reveal that a high number of respondents, 97.92%, are committed to providing good care. The results indicate that the respondents are committed to teamwork and partnership in caring for the patients. However, their response to questions requiring moral reflection demonstrates that the respondents have limited reflection.

8.3.5 To describe the perception of the newly qualified nurses on community service regarding ethics knowledge and application in clinical practice

The perception of community practitioners regarding the application of ethics in their nursing practice uncovered three categories. The Com-serves also had their way of describing nursing ethics. Nursing ethics, in their view, is about care prompted by responsibility, establishing relationships to facilitate decision-making, using

communication skills to promote care, ascertaining the ethical atmosphere, upholding quality care, respecting human rights, and maintaining ethical principles. The Com-serves tell of daily encounters with ill patients, and just like Råholm (2008:64) describes, they witnessed a terrain of suffering, vulnerability, uncertainty, and despair which was awaiting their responsibilities, relationships, and communications. All these were awaiting care, which Brugère (2019:51) submits that ethics of care aims at maintaining and repairing the vulnerable world interwoven in a complex life-sustaining web. This claim is consistent with Levinas' (1998:103) ethics of responsibility, which says the suffering-other is an equal or is the other-self. And it is this resemblance with the other that initiates the principle of accountability (Levinas 1998:103). A person suffering inducts a call for responsibility and commitment, even to the end of life (Levinas 1978:10). The misery of the patients becomes a standpoint of Com-serves' reality to remember their moral responsibility.

Findings illustrate concerns regarding the moral conduct of senior professionals in health care services. The findings reveal that the actual reality was some forms of negligence, misconduct, breach of confidentiality regarding patient information, and poor trust relationship between doctors and nurses. Similar findings were revealed by the undergraduate nursing students' experiences in the study conducted by Fadana and Vember (2021:e2) in the Western Cape health facilities (Fadana & Vember 2021:e2). Com-serve is considered a period of supervision and monitoring for the professional growth of newly graduated nurses. The moral conduct of senior professionals in this study portrays the profession's ethical and legal challenges.

8.4 CONCLUSIONS

The review of the module guide verifies the constraints of nursing ethics, and these are further illustrated by the survey of ethics knowledge by the Com-serves. The perspectives of the educators and Com-serves also affirmed that nursing ethics education is ineffective. The reasons cited range from limited ethics content as per SANC unclear guidelines, no clinical practice for ethics, and teaching and assessment strategies being limited to those that do not instil professionalism nor promote ethical reflections. Thus, objectives were able to reveal that the state of nursing ethics is disturbingly poor. It is in the background of the study's findings that the following recommendations were made.

8.5 RECOMMENDATIONS

In this study, the recommendations are presented in the context of ethics education, which directly impacts ethical practice. The recommendations, therefore, consist of concepts for the framework to enhance ethics education and ethical practice within the nursing profession in South Africa.

8.5.1 A framework to enhance ethics education

As illustrated in Chapter 7, a framework to enhance ethics education should start with establishing the goal for ethics, developing self-reflection from personal narrative, in which individual experiences are used to conceptualise nursing ethics. The virtues and care ethics should be thoroughly taught in theory and clinical practice, and other moral theories, SANC rules and regulations and health law should proceed once students have planned their visions of a virtuous nurse.

- It is recommended that SANC should develop clear goals for nursing ethics education. As Camenisch (1986:498) attests, the ideal is a normative goal, as it stimulates moral imagination, which is essential for the recognition of ethical issues, aims at developing analytical skills and elicits moral obligation, responsibility, and tolerance in ambiguous situations that pose disagreement and resistance (Camenisch 1986:495). A clear understanding of the goal of ethics education will make it easier for the nursing ethics educator to develop the teaching scope that will direct them to the content of ethics, teaching and learning strategies and how ethics can spread to clinical practice. Thus, the time frames would have to be increased to accommodate the increased ethics content.
- It is recommended that the conceptualisation of nursing ethics using personal narratives regarding care experiences be used to let students develop self-reflection and plan for their virtuous development. According to Zigon (2012:204), narratives involve people in a specific situation and are about the particular dynamics of the complex and yet vulnerable, in which people make, remake, articulate, interpret, and come to understand the meaning in their lives. As Zigon and Throop (2014:3) attest, it is through narratives that moral experiences, which include forms of being human such as the power of freedom, honouring, passion, and evaluation, are exhibited in

recognising virtuous forms of being in the world with others. Thus, Zigon and Throop (2014:3) would consider narratives about the conceptualisation of the fact of being in the world as the starting point for analysing ethics, as these impact how one notices, react, and motivates one to act in a given situation. Thus, they are like the initial stage of self-reflection.

- Effective teaching of virtue and care ethics are fundamental to human caring and the internal development of nurses; thus, it is recommended that this be given priority and must precede other moral theories. The ultimate goal of nursing ethics is the promotion of patients' well-being through good nursing care (Johnstone 2017:19). Johnstone (2017:19) comments that the cultivation of moral character and humane disposition in advancing humanity's good, coupled with a sense of civic duty, are activities that have been improved toward acquiring the goal of nursing ethics (Johnstone 2017:19). Thus, virtue ethics should be taught to include moral wisdom and flourishing, not the just the naming of virtues that nurses should possess. Because by naming virtues, the students are just being introduced to the ideal and are never given a chance to envisage their vision in moral development.
- Incorporation of the clinical component of nursing ethics as part of ethics education content. In this way, ethics content would be integrated in theory and practice. It is suggested that clinical practice has the potential to help students test their virtues and enact the newly learned virtues. Through repeated informed exercises by students themselves, coherent habitual morality will develop. Given the challenges in clinical facilities, the researcher believes these will likely enhance practical wisdom and responsibility as aspects of virtue and care ethics. It is in clinical accompaniment where case studies may be identified, and strategies for teaching and assessment may be diversified.
- Other moral theories and health laws, including SANC rules and regulations, may be taught for a more substantial basis for their decision-making.

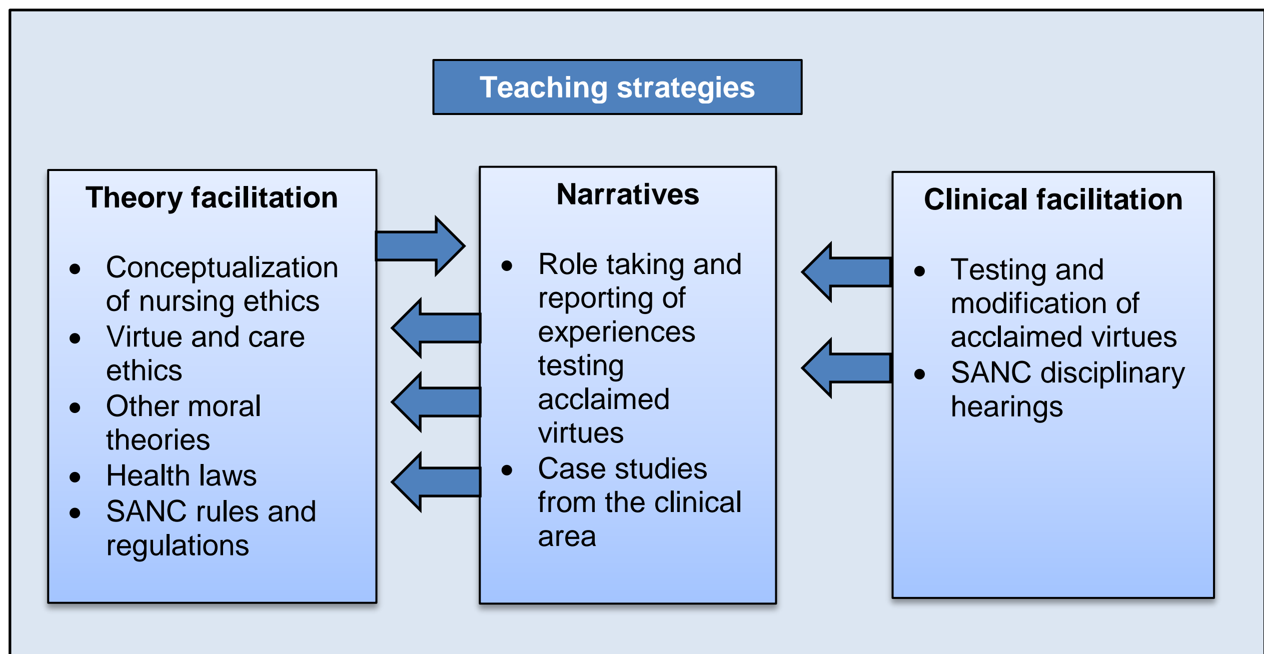

Figure 8.1: Elements of teaching scope for nursing ethics

Figure 8.1 illustrates that the only component of nursing ethics that will be initiated in the classroom should be the conceptualisation of nursing ethics, in which the first-year students will have to narrate their caring stories and identify the virtues and values that facilitated their caring options. As the participants in this study proposed, nursing ethics initiatives must be from the clinical facilities and SANC disciplinary hearings.

8.6 CONTRIBUTIONS OF THE STUDY

The study covers the challenges faced in teaching and practising nursing ethics. And the articulation of issues in the literature demonstrates that an effective nursing ethics education is the cornerstone of good nursing practice. The study's findings deepen this awareness and further proposes changes that would benefit students in their journey of ethical development, in which they will invest in their virtues and values that are currently undermined under the notion of professionalism. The framework proposes improving the use of virtue and care ethics, which are pertinent to nursing ethics.

8.7 LIMITATIONS

The following are limitations of this study:

- Documents analysis. The researcher expected the curriculum, module guides, tests, and examination to be evaluated, but only the module guides from the three campuses were made available, and these study materials were similar. The private institutions could not allow any material to be released or communicated to the researcher.
- Self-administration of questionnaires regarding ethics knowledge were sent to the participants during the COVID-19 wave in 2020, which yielded a slow return of complete questionnaires. In early 2021, the return remained low even though the researcher made an effort to visit the facilities.

8.7.1 Future research

In getting the state of nursing ethics education, the researcher would like to recommend that a survey on ethics knowledge be implemented via SANC registration of students as Com-serve. This can give a collective view, and data can be under SANC archives, which can be accessible to interested researchers.

8.8 CONCLUDING REMARKS

The researcher views nursing ethics education as a social responsibility and an obligation to build a sustainable intrapersonal moral development that aims at benefitting patients, their families, society, and the profession. The current ethical crisis that the nursing profession is undergoing is to be met with moral responsibility from all who commit to changing the state of nursing ethics in South Africa. There has been a broad spectrum of complaints by all the participants in this study and various media quarters about the poor quality of nursing care standards, exacerbated by nurses' attitudes, which the virtues of ethics could have corrected. Therefore, the scapegoats of our current ethical challenges are the SANC, which insists that nurses should demonstrate conformity to the relevant codes of ethics and the lectures that perpetuate these attitudes that prevent reflection.

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ANNEXURES

ANNEXURE A: Ethical Clearance Certificate from the University of South Africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

04 March 2020

Dear Moliehi Rosemary Mpeli

Decision: Approval

HSHDC/962/2020

Student: Moliehi Rosemary Mpeli

Student No: 63306484

Supervisor: Prof JM Mathibe- Neke

Qualification: PhD

Joint Supervisor:

Name: Moliehi Rosemary Mpeli

Proposal: A framework to enhance ethical practice within the nursing profession in South Africa

Qualification: PhD

Risk Level: Low

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 04 March 2020 to completion.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 03/03/2020.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology,*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *You are required to submit an annual report by 30 January of each year that indicates that the study is active. Reports should be submitted to the administrator HSREC@unisa.ac.za. Should the reports not be forthcoming the ethical permission might be revoked until such time as the reports are presented.*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JM Mathibe-Neke
CHAIRPERSON
mathijm@unisa.ac.za

Prof KM Masemola
DEAN OF COLLEGE OF HUMAN SCIENCES

ANNEXURE B: Cover letter to Unisa Health Sciences Research Ethics Committee

Paul Roux Street, No 61 A
Dan Pienaar
Bloemfontein
South Africa
18 May 2020

HSREC UNISA
Department of Health Studies
PO Box 392
UNISA
0003

Dear HSREC Chair: Prof JM Mathibe-Neke

REQUEST FOR AMENDMENTS

May I kindly request that I be allowed to amend some parts of my proposed study? This request agrees with the University of South Africa's COVID-19 position statement on research ethics regarding face-to-face contact with the participants.

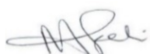
My initially proposed data collection method entails face-to-face contact and group discussion. In light of the COVID-19 pandemic, the proposed methods carry high risks for the potential participants. Besides, recording and facilitating a conversation in social distancing might have problems. Nonetheless, I would like to reduce the risks associated with group discussion and do individual interviews with all the participants.

Although face-to-face will still be applicable, the researcher would like to highlight the following measures that will be taken to keep the risk at a low level.

- The researcher will only conduct the interviews during levels 2-1 of the lockdown period.
- The venue for conducting the interview will accommodate the social distancing of 2 meters, as prescribed.
- The participants suffering from medical conditions will be excluded
- The researcher will be responsible for the supply of sanitisers and wipes for the researcher and participants. Although the use of masks is a general requirement, the researcher will make provisions for those without masks.
- The participant's rights to self-determination will be strongly emphasised as well as the right to decline participation or to withdraw from participation

I hope to hear from you soon.

Kind regards



Moliehi R Mpeli
Signature **Date: 18 May 2020**

ANNEXURE C: Free State Department of Health permission letter to conduct research

health
Department of Health
FREE STATE PROVINCE

05 May 2020

Mrs MR Mpeli
Dept. of Nursing Science
UNISA

Dear Mrs. MR Mpeli

Subject: A framework to enhance ethical practice within the nursing profession in South Africa.

- Please ensure that you read the whole document. Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation in the study must be voluntary.
- A written consent by each participant must be obtained.
- Serious Adverse events to be reported to the Free State department of health and/ or termination of the study
- Ascertain that your data collection exercise neither interferes with the day to day running of **Free State School of Nursing (Main, Northern and Southern Campus) and facilities where the nursing COMSERVEs are placed** nor the performance of duties by the respondents or health care workers.
- Confidentiality of information will be ensured and please do not obtain information regarding the identity of the participants.
- **Research results and a complete report should be made available to the Free State Department of Health on completion of the study (a hard copy plus a soft copy).**
- Progress report must be presented not later than one year after approval of the project to the Ethics Committee of the University of South Africa and to Free State Department of Health.
- Any amendments, extension or other modifications to the protocol or investigators must be submitted to the Ethics Committee of the University of the South Africa and to Free State Department of Health.
- **Conditions stated in your Ethical Approval letter should be adhered to and a final copy of the Ethics Clearance Certificate should be submitted to** sebeclats@fshealth.gov.za / makenamr@fshealth.gov.za **before you commence with the study**
- No financial liability will be placed on the Free State Department of Health
- **Please discuss your study with Institution Manager on commencement for logistical arrangements see 2nd page for contact details.**
- Department of Health to be fully indemnified from any harm that participants and staff experiences in the study
- Researchers will be required to enter in to a formal agreement with the Free State department of health regulating and formalizing the research relationship (document will follow)
- **As part of feedback you will be required to present your study findings/results at the Free State Provincial health research day**

Trust you find the above in order.

Kind Regards

Dr D Motau
HEAD: HEALTH
Date: 7/05/2020

Head : Health
PO Box 227, Bloemfontein, 9300
4th Floor, Executive Suite, Bophelo House, cnr Maitland and, Harvey Road, Bloemfontein
Tel: (051) 408 1646 Fax: (051) 408 1556 e-mail khusemj@fshealth.gov.za@fshealth.gov.za/chikobvup@fshealth.gov.za

www.fs.gov.za

ANNEXURE D: Free State Department of Health, School of Nursing research approval letter

health

Department of Health
FREE STATE PROVINCE

28 May 2020

Moliehi Mpeli
Lecturer: School of Nursing
Faculty: Health Sciences
PO Box 339,
Bloemfontein
9300,

SUBJECT: A FRAMEWORK TO ENHANCE ETHICS EDUCATION AND ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

Dear Mrs. Mpeli

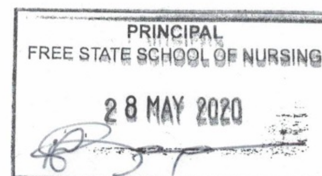
Permission is hereby granted for you to conduct research on a framework to enhance ethics education and ethical practice within the nursing profession in South Africa at the three campuses of Free State School of Nursing (FSSON).

This permission is subject to adherence to the conditions stated in your approval from Head of Free State Department of Health and point 3 of the Health Sciences Research Ethics Committee.

Wishing you all the best with your studies.

Kind regards

Mrs. NMM Ralikonyana
Acting Principal
Free State School of Nursing



Me N.M.M. Ralikonyana: Acting Principal, Free State School of Nursing, Private Bag X20520, Bloemfontein, 9300. Tel 051 403 9831 Fax 051 430 6469, e-mail ralikonynmm@fshealth.gov.za

ANNEXURE E: Permission letter from private institution to conduct research

Dear Rosemary,

Thank you for your Email. I hereby give you permission to use our sit and the applicable Educator /s that facilitate Ethos in the learning centre.

Kind regards

Doreen Bredenkamp
Learning Centre Manager
MEDICLINIC SOUTHERN AFRICA
Mediclinic Ltd. Learning Center Central Region
Quantum Building 2nd Floor
3rd Avenue, Westdene,
Bloemfontein, 9301
Suite 152, Private Bag x01,
Brandhof, 9324
T +27 51 411 4101/03
M +27 82 821 9016
F +27 866811227
www.mediclinic.co.za

ANNEXURE F: Educators' information leaflet

Appendix
Information leaflet

A FRAMEWORK TO ENHANCE ETHICS EDUCATION AND ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

I, Moliehi Rosemary Mpeli, invite you to be part of the research project that may benefit nursing ethics education and practice. This leaflet explains what will happen if you decide to take part. The choice to participate and later terminate your participation in the research relies entirely on you. You are advised to ask questions about the study, and I will provide answers to your satisfaction.

I am a PhD student at the University of South Africa, and I am interested in knowing about your thoughts and experiences in interpreting and translating the South African Nursing Council guidelines into nursing ethics content and learning and teaching strategies in your institution. I would also like to see your ethics module guide and the content of your ethics curriculum.

If you decide to partake in the study, I would like to interview you using an audiotape, which will take place at an agreed time and place. It will take about an hour to complete the exercise with you. The audiotaped interviews will be transcribed, and you will be sent a copy of the transcription to verify its accuracy. Your confidentiality will be protected. The transcriptions will be coded; thus, there will be no identifying reference to you in the publication of this study's results. Only I and the research supervisor will have access to encoded records to ensure confidentiality.

If you decide to partake in this study, it is expected that you might have a reflective experience, which will be rewarding for increased ethics awareness and knowledge. Your concerns regarding your participation will be forwarded to the researcher, the supervisor and the ethics committee, whose contact details are provided below.

The researcher' contact details are: 0720224815

ANNEXURE G: Educators' informed consent

Appendix
Informed Consent

A FRAMEWORK TO ENHANCE ETHICS EDUCATION AND ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

As I have been requested to participate in a research project, whose title is mentioned above, I hereby confirm that:

I have read the information leaflet provided. I also had a discussion with the researcher regarding the purpose of the study, and all the details of the research have been explained. The questions I have regarding the study have been answered to my satisfaction, and I have been told that I may ask questions during this research if such a need arises.

I have agreed to provide information on learning and teaching documents and ethics curricula.

I have also agreed that the interview may be audiotaped.

I understand that my participation is voluntary, and I can withdraw from the study when I feel uncomfortable in the process of my participation.

I understand that my privacy and confidentiality will be protected. I am aware that the study results will be made public through conferences and journal publications; however, my personal information or that of my institution may not be linked to the results.

I understand that I may request a summary of the findings after completing the study.

I fully understand what my involvement in the study means. Therefore, I agree to participate.

Signature of participant: ……………………..……

Full name printed: ……………….………

Date signed: ……………..…………

ANNEXURE H: Document analysis checklist

Module guides contents		Review	
Presence/absence		**Yes**	**No**
1	Exit level outcome		
	1A Critical cross-field outcomes		
	1B Module board objectives		
2	Learning hours		
	3A Contact 40 hours per semester		
	3B Practical experience		
	3C Student-lecturer interaction; schedules		
4	Theoretical learning units		
	4A Learning units' outcomes		
	4B Unit-specific study material		
	4C Preparation material		
	4D Content material		
	4E Learning activities		
	4F Number of activities		
5	Clinical learning units		
	5A Learning units' outcomes		
	5B Unit-specific study material		
	5C Preparation material		
	5D Content material		
	5E Learning activities		
	5F Number of activities		
6	Prerequisite and student responsibilities		
7	Module calendar		
8	Associated assessment criteria		
	8A Calculation of the final mark		
	8B Assignments		
	8C Test		
	8D Clinical assessments		
	8E Exams		
	8F Criteria for passing the module		
9	Course evaluation		

ANNEXURE I: Educators' interview guide

Interview Guide
Unstructured Interview

A FRAMEWORK TO ENHANCE ETHICS EDUCATION AND ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

The initial question was:

"Would you please tell me about your general views regarding nursing ethics and how you came to choose the content and teaching strategies you employed?"

The following questions were used to structure and guide the interview:

1. Would you please tell me about the views you associate with nursing ethics and interpreting the SANC guidelines for ethics education?
2. Would you please tell me how you translated these guidelines into ethics content and strategies for learning and teaching?
3. How did you choose these ethics content and strategies for learning and teaching?
4. What support do you think is needed in doing this in the future?

ANNEXURE J: Com-serves information leaflet

A FRAMEWORK TO ENHANCE ETHICS EDUCATION AND ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

I, Moliehi Rosemary Mpeli, invite you to be part of the research project that may benefit nursing ethics education and practice. This leaflet explains what will happen if you decide to take part. The choice to participate and later terminate your participation in the research relies entirely on you. You are advised to ask questions about the study, and I will provide answers to your satisfaction.

I am a PhD student at the University of South Africa, and I am interested in your understanding and knowledge of nursing ethics in South Africa. I would also like to know if you have an account of ethical issues to which you applied this knowledge.

If you decide to partake in the study, you will be asked to fill in a questionnaire and participate in an interview. I would like to interview you using an audiotape, which will take place at an agreed time and place. It will take about an hour to complete the exercise with you. The audiotaped interviews will be transcribed, and you will be sent a copy of the results of all the transcriptions per request. Your confidentiality will be protected. The transcriptions will be coded. Thus, there will be no identifying reference to you in the publication of the study's results. Only I and the research supervisor will have access to encoded records to ensure confidentiality.

If you decide to partake in this study, it is expected that you might have a reflective experience, which will be rewarding for increased ethics awareness and knowledge. Your concerns regarding your participation will be forwarded to the researcher, the supervisor and the ethics committee, whose contact details are provided below.

The researcher's contact details are 0720224815

ANNEXURE K: Com-serves informed consent

Com-serves
Informed Consent

A FRAMEWORK TO ENHANCE ETHICS EDUCATION AND ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

As I have been requested to participate in a research project, whose title is mentioned above, I hereby confirm that:

I have read the information leaflet provided. I may also discuss with the researcher the purpose of the study and have all the details of the research explained. I have been informed that I may ask questions during this research process if such a need arises.

I understand that my participation is voluntary, and I can withdraw from the study when I feel uncomfortable in the process of my participation.

I understand that my privacy and confidentiality will be protected. I am aware that the study results will be made public through conferences and journal publications; however, my personal information or that of my institution may not be linked to the results.

I understand that I may request a summary of the findings after completing the study.

I fully understand what my involvement in the study means; therefore, I agree to participate.

Signature of participant: ………………………………

Full name printed: ………………………………

Date signed: ………………………………

ANNEXURE L: Com-serves questionnaire

QUESTIONNAIRE ON ETHICS KNOWLEDGE

Participant code: ……………..

SECTION A: DEMOGRAPHIC DATA

In this section, you have to tick the appropriate box or fill in the required information.

<table>
<tr><td rowspan="2">1. State your gender</td><td>MALE</td><td colspan="2">TRANS-GENDER</td><td>FEMALE</td></tr>
<tr><td></td><td colspan="2"></td><td></td></tr>
<tr><td>2. How old are you</td><td colspan="2">YEARS</td><td colspan="2"></td></tr>
<tr><td>3. Are you currently employed as a</td><td colspan="2">Community service</td><td colspan="2">Completed Community service</td></tr>
<tr><td>4. How many months have you been on this service?</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>5. What is your highest level of education?</td><td colspan="2">DIPLOMA</td><td colspan="2">BACHELOR'S DEGREE</td></tr>
<tr><td>6. Did you have ethics education during your basic nursing training?</td><td colspan="2">YES</td><td colspan="2">NO</td></tr>
<tr><td>7. Do you think you have enough ethical knowledge to apply in your daily nursing practice?</td><td colspan="2">YES</td><td colspan="2">NO</td></tr>
<tr><td>8. Do you think you need further assistance regarding nursing ethics?</td><td colspan="2">YES</td><td colspan="2">NO</td></tr>
<tr><td>9. Do you have the confidence to exchange ethical views with other medical professionals?</td><td colspan="2">YES</td><td colspan="2">NO</td></tr>
</table>

SECTION B

For each of the statements below, please tick the most appropriate response.

QUESTIONS	Agree	Agree sometimes	Do not agree at all
1. Ethos is an important aspect of nursing education			
2. Ethos is crucial for good patient care			
3. The ethics topics taught were relevant to nursing			
4. Other nursing courses are more crucial than ethics			
5. I am aware of values that are necessary for ethics practice			
6. I am aware of the nursing code of ethics			
7. The teaching of Rules and regulations is adequate for patient care			
8. I have considerable knowledge of the following concepts:			
• Four principles			
• Consequentialist/Utilitarianism			
• Kantian deontology			
• Virtue ethics			
• Care ethics			
• Ubuntu/African ethic			
• Human dignity			
• Respect for human life			
• Honesty			
• Altruism			
• Advocacy			
9. I am aware of statutes or law that guides my practice.			

10. If your answer agrees to the knowledge of four principles, please mention them

…………………………………………………………………………………………

…………………………………………………………………………………………

11. If you answered agree to question 9, please mention them

…………………………………………………………………………………………

…………………………………………………………………………………………

…………………………………………………………………………………………

SECTION C

For each of the statements below, tick the most appropriate response.

QUESTIONS	Agree	Agree someti	Do not agree at all
12. My first concern is to take good care of the patients.			
13. I believe that good care entails making decisions for my patients.			
14. I rely on my nursing knowledge only to make good decisions for the best care of my patients			
15. I believe that patient participation is essential at all times			
16. Patients' requests must always be adhered to.			
17. Consent is not required for medication and checking vital signs.			
18. I believe it is necessary to think about my values and norms that may influence how I react to certain situations.			
19. Patients should be informed of the errors I made while providing nursing care.			
20. Close relatives should always be told about the patient's diagnosis			
21. Personal information of patients may be disclosed without the patient's consent if required by law			
22. Patients' personal information may be disclosed against their wishes to facilitate care.			
23. Patient's religious and cultural practices form part of holistic care			
24. Physical and psychological harm may occur during my nursing care, and I have to minimise these as much as possible			
25. I may never physically or psychologically harm anyone			
26. If physical or psychological harm does occur during my care, I must just cover it up for the patient, not complain.			
27. I often have concerned feelings for all the patients, even those that are rude to me.			
28. What is ethical varies from one situation and society to another.			
29. My duty is to allocate my time more strictly to those sick than others.			
30. I know that time is one of the limited resources of my practice, and I have to share it equally with all patients allocated to me.			
31. I am aware that ethical values may be competing/conflicting during the provision of my care.			
32. I know what to do in the case of competing/onflicting ethical values.			
33. I am aware that my personal values may compete or conflict with my professional values.			
34. I often push myself very hard to achieve the goals of my employer.			
35. I try to consider everybody's views in a team of health professionals before I make a decision.			
36. Abortion is legal, and as a nurse, I cannot refuse to do it			

QUESTIONS	Agree	Agree someti	Do not agree at all
37. I should disclose the gifts given to me by patients and relatives in my care			
38. Healthcare professional's behaviours, such as being present/keeping others company, enhance the patient's sense of dignity			
39. Healthcare professional's behaviours, such as covering up embarrassing markers of illness, enhance the patient's sense of dignity			
40. Healthcare professional's behaviours, such as facilitating patient's self-sufficiency and moral agency, enhance the patient's sense of dignity			
41. Healthcare professional's behaviours, such as ignoring or insufficiently acknowledging the patient, may be considered a violation of the patient's sense of dignity			
42. Being interrogated about their health issues, financial or poor social or economic status may make patients feel humiliated, and it is a violation of dignity			
43. Exposing the patient's body for physical examinations without the definite patient's permission may violate the patient's sense of dignity			
44. Being seen only as a member of a group, such as women or “handicapped or any other general category, though it may have relevance for appropriate diagnosis and treatment, if not correctly handled, risks violation of dignity.			

END OF QUESTIONNAIRE

THANK YOU FOR ANSWERING THE QUESTIONS

ANNEXURE M: Com-serves interview guide

Comserve Interview Guide
Individual Unstructured Interviews.

A FRAMEWORK TO ENHANCE ETHICS EDUCATION AND ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

The question was:

"Would you please tell me about any event in which you believed you employed ethics according to your understanding?"

Questions used for probing purposes:

1. Would you please tell me about a situation you were confronted with within your practice where you had to use your ethics understanding?
2. Tell me what happened and how you responded to that situation.
3. Did your ethics training help you to make decisions?
4. What support do you think you need now?

ANNEXURE N: Language editor's letter

I, the undersigned, hereby confirm my involvement in respect of language and academic editing, technical compliance, text redaction, and research methodology compatibility for the manuscript of **Mrs Moliehi Rosemary Mpeli (Student Number: 50752693)** in fulfilment of the requirements for her Doctor of Philosophy (PhD) in Nursing Science degree registered with the University of South Africa (UNISA), and entitled:

A framework to enhance ethical practice within the nursing profession in South Africa

As an independent academic editor, I attest that all possible means have been expended to ensure the final draft of **Mrs M.R. Mpeli's** thesis manuscript reflects the acceptable research methodology practices and language control standards expected of postgraduate research studies at her academic level.

In compliance with expected ethical requirements in research, I have further undertaken to keep all aspects of **Mrs M.R. Mpeli's** study confidential, and as her own individual initiative.

Sincerely.

T.J. Mkhonto
BA Ed: North-West University, Mafikeng (1985)
MEd: School Administration; University of Massachusetts-at-Boston, USA, Harbor Campus (1987)
DTech: Higher Education Curriculum Policy Reform, Design and Management; University of Johannesburg (2008)

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Signed: **Date:** 30 November 2022

Dr T.J. Mkhonto dd/mm/yyyy

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ANNEXURE O: Turnitin originality report

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A FRAMEWORK TO ENHANCE ETHICAL PRACTICE WITHIN THE NURSING PROFESSION IN SOUTH AFRICA

by

Moliehi Rosemary Mpeli

Student Number: [illegible]

Submitted in accordance with the full requirements for the degree of

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Supervisor: Prof J.M. Mathibe-Neke

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