Being Constrained and Enabled:

A Study of Pre-registration Nursing Students' Ethical
Practice.

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Table of Contents

Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material of which a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements."

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Abstract

This study uncovers the experience of being ethical from the perspective of pre-registration nursing students. Using the qualitative methodology of phenomenology, specifically that outlined by van Manen, it seeks to show how students act ethically within everyday practice.

Ethics is vital to any health related profession and the growing complexity of New Zealand's health care system requires more responsibility for ethical decision making in nursing care. Providing nursing care is an ethically charged undertaking and despite ethics taking an increasingly important place in nursing education few studies show the contextual nature of ethical practice from the perspective of students. This study aims to partly redress this situation.

In this study I have interpreted the experiences of twelve pre-registration students. Using seventeen stories shared by the student participants, my personal understandings and literature, the meaning of being ethical has been illuminated. Three themes emerged from the interpretation. These include 'keeping things 'nice'', 'being true to yourself' and 'being present'. This thesis asserts that the overarching theme within these themes is that of 'being constrained and enabled'. Being constrained shows the experiences of students as they live through the tensions of being and doing as they strive to be ethical. Being enabled shows the experience of self-determination. Finally the study maintains that the shaping of ethical practice for undergraduate students may be enhanced when their reality is positioned and valued within educational processes.

Key to Transcripts

In presenting the research findings, the following conventions have been adopted within this thesis :

Italics   Identifies the interview data provided by the student participants

Names   with the permission of the student participants, their individual stories are identified through the use of pseudonyms

…   Denotes material deleted from the original text

[ ]   indicates insertion of additional material by the researcher, to assist clarity

The key terms used

Pre-registration nursing student. Use of the term pre-registration nursing student in this study refers to the specific cohort of students from which the participants were selected. Pre-registration students are in the final semester of an undergraduate nursing degree programme.

Clinical lecturer. Clinical lecturers are faculty staff members of the educational institute that delivers the undergraduate nursing programme.

Chapter One: Study Overview

"Nurses at all levels and in all areas of practice are confronted everyday with having to make morally relevant choices and to take action on the basis of these choices during the course of their work" (Johnstone, 2000, p.107)

Background to the study

This phenomenological study concerns the ethical practice of pre-registration nursing students in the clinical setting. Ethics is the science of human conduct and as such is vital to any health related profession. Nursing's ethical practice is central to the professional's commitment to do good and to avoid harm to those receiving nursing care. To practise ethically requires knowledge of what it means to be ethical and the areas of nursing ethics and ethics education are the subjects of a growing body of academic literature. Yet, interestingly, there is little in the literature that invites undergraduate nursing students to share their experiences of being ethical in clinical practice. The clinical experiences of student nurses are of concern for educationalists as this vital environment provides the experience and shaping of ethical practice.

Nursing is a practice-based profession and the stories of nurses are emerging as central to the understanding of nursing's ethical practice. In this study, twelve pre-registration nursing students share their stories of being ethical as they navigate their way through everyday clinical practice. These neglected voices reflect the ontological perspective of the collision between the ideal ethical comportment taught within educational institutions and the clinical reality. It is hoped that the meaning found in their stories will encourage a certain attentive thoughtfulness for those who have an interest in nursing undergraduate education and will assist nursing in the development of ethics education with practice reality as a starting point.

The aim of this study

The aim of this study is to show the world of pre-registration nursing students in terms of 'being ethical'. It seeks to know how these students understand and act ethically by capturing the ethical knowledge embedded in their clinical practice. By showing these students' abilities and capacity to 'be ethical' it is hoped that their actions can be more fully understood and better assessed by educators and clinicians.

The study environment

The student participants in this study are from one school of nursing and have completed the final sixteen-week semester of a three-year undergraduate-nursing programme. In their programme the emphasis of this semester is on the consolidation of clinical practice and students are immersed in one practice setting for eleven weeks of the sixteen-week semester. During this time students have an assigned clinical lecturer who spends one to two hours weekly with them. The lecturer's role involves coaching and guiding the student to help in the development of their own unique nursing practice while demonstrating achievement of the programme's clinical practice competencies. These clinical competencies are critical thinking, the ability to reflect on nursing practice; valuing, being able to act on the value systems of themselves and others in relation to ethical issues; competency, practising nursing by combining theoretical knowledge with practice wisdom; communication, relating professionally and effectively with people; and professionalism by being accountable for their practice. The clinical lecturer role is also one of assessor, who assigns one of three grades to indicate student achievement. These grades are "achieve with merit", "achieve" or "non achieve".

Eleven of the twelve participants undertook their pre-registration clinical practice within an acute care hospital setting. The remaining participant went to a community primary health care setting. The daily supervision of students is undertaken by the registered nursing staff working in the specific health care

setting. The model of supervision is varied. Students can work closely alongside one or two nurse preceptors (buddies) for the entire clinical experience while others may work as part of a team. Some students are allocated a supervising nurse on a daily basis. The supervising role involves the teaching of nursing practice by role modeling, giving guidance, and the sharing of their clinical wisdom. Supervising nurses also assist the clinical lecturer with the evaluation of the students' performance. Within the student supervisor relationship the students, on the other hand, are expected to be accountable for their actions and be pro active in seeking learning experiences to assist them to demonstrate achievement of the clinical practice competencies. The pre-registration clinical experience consistently rates as a positive experience in course evaluations. Students claim their practice finally 'falls into place', alongside feeling part of a team.

Choosing my study

The motivation for this study came firstly from the desire to deepen and extend my understanding of the phenomenon of 'being ethical' from the perspective of pre-registration nursing students. Knowing, according to Palmer (1998) begins in our intrigue about some subject but the intrigue is the result of the subjects' actions upon us. As a teacher who is interested in the ethical dimension of practice I have been part of many undergraduate theoretical teaching sessions and assessment processes involving the ethical dimension of nursing practice. The emphasis of these classroom sessions and written assessments tended to involve discussion and debate concerning what was the right action according to an ethical principle. However what became apparent to me, from my involvement in these sessions, was that students' discussion often avoided or glossed over the actual experience of undertaking care, deemed to be ethical.

As my teaching role spans the worlds of both the classroom and clinical practice I have been privileged to see and share aspects of students' clinical practice whilst striving to be ethical. This experience has left me feeling both moved and troubled and I have come to know something of the tensions of being ethical as a student. I have listened to, seen and read about their struggles and successes as they bring

together naivety and wisdom when fitting their understanding of being ethical into the social, hierarchal and political forces that constitute the reality of practice.

In appreciating that I knew something of the students' practice reality there was always the feeling that there was much I did not know. It is many years since I have worked as a clinical practitioner amongst forces that both support and constrain ethical practice. Within all New Zealand health care settings Woods (1999) claims nurses continue to face difficult and disturbing ethical issues. Nurses are working within environmental conditions that include increasing work loads, a shortage of skilled colleagues, inadequate resources, increasing acuity of patients and increased levels of distress amongst patients due to a lack of continuity of care (Rodney & Varcoe, 2001). Conditions such as these impact on nurses' ability to practise ethically. It is also twenty five years since I have been a student and the clinical environment has under gone enormous change including the advancement of medical technology, the increase in consumerism as well as the tendency towards moral pluralism (Lutzen, 1997, p.218). Unknowing is important in nursing as it can be the impetus to finding out (Munhall, 1993).

This study is also motivated by the desire to better my teaching. The inspirational writing of Parker Palmer (1998) in his book entitled "The Courage to Teach", identified that good teachers are able to join self, subject and students in the fabric of life. Good teaching he claims, cannot be reduced to a technique, but is found through connectedness. It is shown by the teacher's ability to weave a complex web of connections among themselves, their subjects, and their students so that students can weave a world for themselves (p.11). Yet studies suggest that students are governable subjects. Beale (1999) along with Peters and Marshall (1996) claim students can be considered as human sites where the dominant discourses within education and nursing practice attempt to seduce the student. By inviting student participants to share their experiences, I hoped to understand more fully the contextual embeddedness of being ethical and connect this understanding to both my teaching and design of ethical educational processes. I had also wondered how my dual role as a lecturer and assessor of pre-registration nursing students impacts on the connectedness between student and clinical lecturer.

There are inherent conflicts in this dual role. Students can decide what to share and what not to share with someone who decides what clinical grade they will be assigned.

My study is further motivated by the need to help student nurses work ethically in the increasingly complex health care system of New Zealand. This requires educational processes that have the context and experience of nursing practice as a central framework. An exploration of the expected outcomes in relation to ethical practice within this nursing programme showed these to be over a decade old. Students are expected the use ethical frameworks to address ethical problems and to advocate appropriately for patients when their wishes conflict with those of the practice setting. There is also the expectation that students will make informed value judgments and ethical decisions when faced with dilemmas.

There is, however, no evidence to indicate whether these educational outcomes are realistic or support student learning. Personal experience has shown me that most students struggle to achieve such complexity and sophistication of practice. Furthermore collegial discussions raise confusion concerning the depth and breath of students' ethical practice in relation to the grading system previously outlined. This confusion is accompanied by my sense of frustration when trying to find ways of describing and clarifying these. Van Manen (1990) describes this type of frustration as the fuzziness of understanding. Therefore by focusing on how students experience ethical practice there is the potential to share and make public what this practice looks like. This will allow teaching scholarship to better support students mesh together what is right and good within the contextual and relational forces of the clinical setting.

Why pre-registration students as study participants?

As indicated earlier, the participants in this study were pre-registration students. The decision to use this student group was for the following reasons. Pre-registration students are on the cusp between studenthood and beginning nurse status. The accumulation of all previous clinical experience contributes to a

stronger appreciation of the situatedness of practice and the interrelated conditions that impact on nurses' ethical decision-making. The length of time in one clinical setting was also deemed important. In the programme from which they were drawn the pre-registration clinical experience is considerably longer than any previous experience. Extended involvement within one nursing team lessens the transient nature of the clinical experience, often resulting in these students expressing feelings of being trusted and feeling a sense of belonging within the nursing team. Course evaluation evidence suggests these aspects of the clinical environment promote confidence and a level of independence thus enhancing students' learning. This level of clinical experience, I thought, was important for the students' ability to reflect back and share their practice experience of the study phenomena.

Significance of the study

Nursing undergraduate education in New Zealand underwent an extensive review in 2001 (KPMG Report). Acknowledgement of ethical practice as an essential aspect of the role and function of the future nurse is evident throughout this report. Nelson, Gordon & McGillion (2002) consider the skills students need to face challenging institutional arrangements is one of the top ten unfinished issues to inform nursing debate in the new millennium. In New Zealand there is no literature available which investigates the student experience of implementing ethical practice. Consequently there are limitations to developing educational processes that support and promote student learning. The teaching about ethics and ethical decision-making processes are important to the future of nursing and as nurse educators we need to find ways the nursing curricula can dynamically evolve to meet this essential challenge. Furthermore, ethical practice is crucial to effective health care delivery and having a clearer understanding of the experiences of emerging graduates in relation to this aspect of their practice has implications for all stakeholders in nursing practice.

The research methodology

This qualitative study uses the human science of phenomenology. Phenomenology involves wanting to know about peoples' lived experience. The emphasis is on seeking meaning from our everyday activities that we take for granted so they may be better understood and valued. Phenomenological research asks, " what is this experience like?", as opposed to explaining how it occurs. The aim is to offer a deep and powerful description of the phenomena that reawaken the particular human experience in ourselves.

Phenemology uncovers the essential aspects of the experience by the researcher blending the voice of the individual with the voice of a group. In this study twelve student participants were interviewed to share their experiences of ethical practice. This data was then analysed using the phenomenological approach described by Max van Manen (1990). This involved conducting a thematic analysis and determining the essential themes of 'being ethical'. Representation of the participants' experiences is described in three themes: 'keeping things 'nice'', 'being true to yourself', and 'being present'. In their different ways each theme shows a distinct aspect of 'being ethical' however they are all interrelated, as each is not fully understandable without the connections to the other.

Study Approval

The Auckland University of Technology Ethics Committee approved this study.

ORGANISATION OF THE THESIS

This thesis is organised into seven chapters. Following on from this first chapter, which has introduced the thesis topic and provided an overview of this study.

Chapter Two: Exploring the literature

This chapter explores the literature in relation to nursing ethics and ethics education. It argues that traditional western ethical theory underpinned much of nursing's early ethical literature and the teaching of ethics but that this does little in the way of illuminating nurses' ethical practice. The discussion highlights how contemporary ethical literature proposes that the stories of practising nurses, along with a greater emphasis on the ethical dimension of caring, are essential to a clearer understanding of ethical practice. A central component of this chapter is a review of selected studies on students' ethical practice. Throughout much of this chapter it is also argued that there are limitations within the literature in relation to students' perspectives about ethical practice. These limitations are identified to further show the relevance of this study.

Chapter Three: The research process

This chapter explains the philosophical underpinnings of phenomenology and why this research methodology was chosen for the study. It also identifies the way in which the study was undertaken and how it adhered to the ethical guidelines for research. It further shows how rigour was maintained within the research process. There is an emphasis in this chapter on my understandings concerning the study as phenomenologists argue that the researcher cannot stand outside this research process.

The following three chapters, Chapters Four to Six, are devoted to showing the meaning of being ethical through the use of seventeen student participant stories and interpretation of these by using the four phenomenological existentials proposed by van Manen (1990).

Chapter Four: Keeping things 'nice'

This chapter shows how being ethical co-exists as taking care of other but also taking care of self. Keeping things 'nice' captures the way students compromise their ethical ideals in the face of threats to themselves. Compromise is a way of protecting self yet the consequences leave students in conflict with themselves.

Chapter Five: Being true to yourself

This chapter further explores threats to students' ethical practice. However in contrast to the previous chapter it shows how students reunite their ethical identity and ethical practice by striving and struggling to follow through and be the ethical nurse they claim to be. It shows ways of overcoming the barriers students encounter and brings to light the personal investment of self in being ethical. This chapter further shows how students' emotional involvement is crucial to ethical practice by alerting, drawing into and sustaining their ongoing ethical practice.

Chapter Six: Being present

The previous chapters show the constraints and struggles that students experience in being ethical yet clinical practice settings also enable ethical practice. This final data chapter shows experiences of how, when unencumbered by barriers, students shape and determine ethical care within relationships with other. Being present is shown as the quality of being with another in the spirit of concern and openness. It highlights the significance of knowing oneself for the recognition and care of others' concerns.

Chapter Seven: Discussion and Recommendations

This chapter brings the three sub-themes together to show the experience of being ethical as being constrained and enabled. By using the phenomenological existentials proposed by van Manen (1990) the meta-theme of 'being constrained and enabled' is discussed. The implications of the study for nursing undergraduate education and practice are also discussed. This chapter further considers the study's limitations along with the possible implications for further research.

Summary

In this chapter I have endeavoured to lay the foundation for this study that seeks to show the world of pre-registration nursing students in terms of 'being ethical'. It has identified the overall aim of the study and outlined the background, importance and justification for this study. An overview of the structure of this thesis has been presented.

Chapter Two: Exploring the Literature

Introduction

This chapter aims to provide a review of the literature that has relevance to this study question by considering both ethical and educational perspectives. The chapter begins by identifying what nursing ethics is and how this has been theorised about. Included in this chapter is discussion concerning the teaching of ethics that suggests that this seldom reflects the reality of practice. Six specific studies concerning the ethical practice of students have been reviewed. Also included in this chapter is discussion concerning barriers to nurses' ability to practice ethically, along with a review of literature that looks at supervisory student relationships. The limitations of the available literature are also identified. My intention is to argue that although ethics education is an integral part of all nursing undergraduate curricula there is much that is unknown concerning the ethical practice of student nurses within the New Zealand health care setting.

Nursing ethics

Beauchamp and Childress (2001) consider ethics as a generic term meaning various ways of understanding and examining moral life. Nursing ethics was once viewed as at best an off-shoot of medical ethics and at worst a set of rules about manners and morals, which were often largely indistinguishable from professional etiquette (Barker & Davidson, 1998, p.2). However as nursing's professional stance has continued to develop, a contemporary understanding of nursing ethics asserts that nursing has a distinct and rich ethical dimension. Bowden (1997) typifies this view when claiming nursing is a particular way of entering the world of another person and thus has a unique practice of ethics. Johnstone (1999) summarises much of the recent literature concerning nursing ethics in defining it as " the examination of all kinds of ethical, and bioethical issues from the perspective of nursing theory and practice which, in turn, rest on the agreed core concepts of

nursing, namely: person, culture, care health, healing, environment, and nursing itself" (p.46).

Theory and Nursing ethics

As nursing strove to identify a distinct nursing ethic it employed the dominant Western ethical theories of deontology and teleology, often referred as the traditional ethical theories. Deontological theories consider actions are right if they are based on laws or rules regarding duties or obligations, for example telling the truth. It is the enactment of the law or duty which is considered moral, not necessarily the end result. This approach to being ethical assumes one's rational thought in seeking to perform one's moral duty. There is little consideration given to contextual factors. Codes of ethics for nurses are based on a set of deontological principles. They contain the general rights, duties, values and policies that should govern professional practice. In contrast teleological theories justify moral principles or rules in terms of some overall good, or sense of purpose, in society (Thompson, Melia & Boyd, 1994). Based on the quest for happiness or well being, they are concerned with the consequences or the results of actions. Despite the process, an act is right according to teleological theory if it tends to produce the greatest amount of good over evil.

Traditional Western bio-ethical theories contain ethical principles, which act as guides to ethical decision-making (Beauchamp & Childress, 2001). The common principles applied within healthcare, arising from these traditional theories, are those of beneficence (the obligation to do good), non-maleficence (the obligation to avoid doing harm), autonomy (the right of individuals to make choices according to their best interests) veracity (the obligation to tell the truth, not to lie or deceive others) and justice (the distribution of resources across a broad social scale). Advocacy, although not strictly considered as one of the traditional ethical principles, is also central to healthcare ethics. Advocacy refers to helping people become adequately informed to make choices concerning their healthcare.

Early academic writing on nursing ethical theory was framed within this traditional Western ethical theory. This has had, and continues to have, a powerful influence on nurses' understanding of ethics (Fry, 1994; Johnstone, 2000). However as early as 1974, Beatrice Salmon a New Zealand nurse, was questioning the relevance of traditional based ethical theory for nursing. She warned that setting up lists of virtues and vices was like vamping on the keyboard and calling it music (p.97). She considered ethical theories must be built carefully and speak of the true voice and nature of nursing.

More recently, nurse writers (Hislop, Inglis, Cope, Stoddart & McIntosh, 1996; Holt & Long, 1999; Lewin, 1996) have heeded Salmon's (1974) warning. These writers claim the ethical practice of nurses seemed to have disappeared within earlier academic writing. These writers argue that the focus on decontextualised principles through the adherence to one or other of the dominant ethical paradigms is reductionist, deterministic and mechanistic. Other writers add that traditional ethical theory fails to explain and assist the ethical practice of nurses in day-to-day clinical practice, which is contextual and relational (Fry & Johnstone, 2002; Gadow, 1980; Lutzen, 1997). These authors contend that nursing focuses on the nurse patient relationship, which is centred on principled morality, closeness and connectedness. This is in contrast to differentiation, distance and detachment promoted by traditional theories.

Contemporary ethical writing stresses the need to ground ethical theory back in actual practice. Many nurses contend that the articulation of the ethical dimensions of care must be driven by practice (Benner, 1991; Colapietro, 1990; Johnstone, 2000; Woods, 1997). These authors claim that the actual lived experiences of nurses would provide a far more reliable methodological starting point to nursing ethics. Such a position would value the stories of the individual alongside those of the discipline and its traditions. Analysing nurses' stories would, according to Johnstone (1999), reveal ethical issues that are nurses 'own', which a traditional ethical theory would have dismissed as having no philosophical interest or significance. This she also suggests would reveal a whole different configuration of language, concepts and metaphors for expressing ethical issues. Re-personalising

of nurse's ethical practice has significant support within the literature, as removing the ethical debate from the realms of the vast majority of nurses has debased the value of their clinical experience.

Ethics and Nursing Education

The aim of nursing education can be defined as learning how to promote the well-being of patients (Gastmas, 2002). Over the last three decades, this aim has been achieved by basing the teaching of nursing within theoretical frameworks. As the kind of nursing ethics education that is given follows from the theory, the ethical component of nursing education has generally been framed within traditional Western ethical philosophy also. However applying ethical theory to practice is difficult when theory is taught as abstract principles in a decontextualsied format. According to Johnstone (1999) most practising nurses consider traditional ethical theory is irrelevant and oppressive to their ethical practice. This is because nursings' ethical practice occurs within a web of collegial relationships, social policies, economics and politics (Aroskar, 1987; Gastmas, 2002).

Practice settings have an important influence on being ethical (Hartrick Doane, 2002; Penticuff & Walden, 2000). Jaeger (2001), a nurse who teaches ethics writes,

> My nursing students have taught me a few lessons. Perhaps the most important one being that the realities of illness, hospital care and the effects of diminishing social health care funding are far too complex and particular to be covered by the available moral theories and abstract concepts that are still standard fare for courses in health care ethics (p.131).

The organisational structures, within which most senior students undertake clinical practice, are complex, hierarchical and orientated towards a business model of health. There is an emphasis on efficiency, effectiveness and economy. Hewison and Wildman (1996) claim that theories in use by practitioners are likely to be derived from and reflect this current organisation of care. Yet students are expected to work within a one on one relationship espoused within the humanist

discourse, considered the cornerstone of nursing practice (Hewison & Wildman, 1996) and apply decontextualised ethical principles to practice. This situation, often referred to as the theory practice gap, results in confusion, conflict and stress for students. This is because the practices taught within school do not reflect the reality of their clinical practice experience (Hislop, Inglis, Cope, Stoddard & McIntosh, 1996).

Although referring to practice generally, studies concerning students' experiences of the theory practice gap are significant to the understanding of being ethical. Andersson's (1995) study on marginality and its relevance to students and nurse education showed that students were caught between the two conflicting cultures of education and practice. Students talked of the need to fit into the clinical area and prove themselves while at the same time meeting unrealistic education demands. Andersson (1995) found that the contrasting demands of education and practice resulted in feelings of uncertainty and loss of status for students. She concluded this had a detrimental impact on promoting learning.

Similarly Chapman and Orb's (2001) phenomenological study found that students were in a constant process of internal negotiation with themselves when in clinical practice. Their study considered fourteen final year student nurses' lived experiences of coping strategies in clinical practice. Their findings showed that the education and practice tensions resulted in students not wanting to 'rock the boat' and becoming what or whomever the nursing staff and clinical teacher wanted them to be as they wanted to pass the course.

Interestingly Corlett's (2000) qualitative study on the theory practice gap found that there was a marked discrepancy between the perceived size of a theory practice gap between faculty staff and students. The twenty-three students from across the undergraduate three years perceived the theory practice gap to be huge whereas the twenty-three faculty teachers thought it was probably quite narrow. Students viewed the differences as frustrating and gave more credence to what they saw and learned in the clinical setting (p.502).

Woodruff (1985) warns that the ongoing effect of the theory practice gap in relation to ethics education will result in one of two reactions occurring. She claims, "either the values of the school will be rejected in toto, or a deficient self-image may be further damaged as the student looks within herself for an explanation of the visible contradiction" (p.297). Hunt (1992, p.324) suggests that if we are to avoid imposing a jumble of detached abstractions, high sounding slogans and impossible demands on students, then education must get it clear about what is meant by 'nursing ethics'.

The ethical practice of students

Student nurses' ethical practice has been researched from a variety of methodologies. Using 100 Korean senior student nurses Han and Ahn's (2000) study examined the types and frequencies of ethical dilemmas and the rationale for their ethical decision-making. Participants, who were taking a course in nursing ethics, were first asked to describe an ethical dilemma they had encountered in their clinical practice. Secondly they were given a case study to analyse using ethical principles. This study employed both quantitative and qualitative methodologies. Using quantitative methods four types of dilemmas were identified. These were, respect for life, nurses and clients, nurses and professional practice and nurses and co-workers. The most frequent dilemmas involved veracity and families giving up on a patient that could not be cured. Using qualitative analysis students' ethical decision-making processes were analysed. They concluded that the principles of veracity and non-malefience were most frequently used as the rationale for ethical decision-making. However the researchers admitted that they thought it was quite natural for students to base their judgments on what they have learned in class. This leaves one wondering about the relevance of the findings to the practice setting.

Using the qualitative methodology of grounded theory, Kelly undertook three studies into the ethical practice of senior nursing students. In 1991 she explored the professional values of twelve British senior student nurses. According to Thompson, Melia and Boyd (1994, p.9), values underpin ethically based care and

are the basis from which we assess the importance of something. Student responses showed that they valued the right of respect and helping people in 'the little things'. Students expected their values would be in conflict with usual hospital practice and to manage this difference they strove to fit in and 'go along with'. Students considered such actions as temporary until their own values could be implemented, as they perceived themselves as powerless to make change. They considered the power to make change resided overwhelmingly with the charge nurse and hospital management. Kelly's (1991) study raises valuable insights into how students work with their ethical values in practice. However what is the experience of holding onto their values as they 'fit in', 'go along with' and hope for a better future? Much about these experiences remains uncertain.

Kelly's second study in 1992 explored professional ethics as perceived by twenty-three American senior nursing students. As in her 1991 study these students identified respect as central to ethical care. Respect was described as, respect for patients and families, respect for self, colleagues and the profession. Alongside respect they also identified caring as central to good nursing. Caring surfaced as 'showing concern', providing psychological support, getting involved and taking the time to do a good job. The data further showed how these participants were clear on their ethical role and espoused values consistent with the American Nurses Professional Code of Ethics. Yet interestingly Kelly raises the ideal versus the real dichotomy as well. Assuming these emerging nurses do value what they profess, she considers they must be acutely aware that they are out of step with the real world of practice. This discrepancy makes her question how they cope in the real world and perhaps influenced her next study.

In 1993 Kelly's third study used interviews and clinical logs to examine how twenty-three senior undergraduate students perceived the 'real world' of hospital nursing as ethical practitioners. Again findings similar to those from her 1991 and 1992 studies emerged, in that students' intrinsic values involved a strong sense of individual professional responsibility and accountability for care. However the complexities of actual practice impacted on their findings. When students considered their relationships with staff could be in jeopardy, their ethical ideals

were often compromised. The consequences of this for students included guilt, disappointment, and feelings of failure when they did not say something and participated in an abuse of rights. In justifying their compromised actions, students sought understanding in light of the tendency of nurses 'not to make waves'.

This study showed how clinical staff may influence being ethical for students. Johnstone (1999, p.60) argues that following the orders of a superior with which you disagree, paves the way for abdication of moral responsibility and accountability and is quite incompatible with autonomous moral action. The experience of putting away one's ethical values, doing as one is told and undertaking care deemed wrong surely involves intrapersonal and interpersonal tensions, alongside possible threats to integrity and identity. Yet little is known of this compromising experience or the experiences of students who decide not to compromise their ethical ideals.

Hartrick Doanne (2002) argues that having a deeper understanding about this aspect of being ethical is important as self-identity is central to one's experience of ethics and the enactment of moral agency. Irurita and Williams (2001) claim that compromising one's integrity is a common source of stress and anxiety in nursing. They argue that our integrity involves relating to situations in ways that bring a sense of completeness rather than feelings of fragmentation within oneself.

The importance of Kelly's (1993) study was that it showed the espoused and actual ethical practice of senior nursing students differed and that a meaningful understanding of being ethical can only emerge from students' actual practice.

Woods (1997) undertook a study of the ethical practice of eight New Zealand registered nurses using a grounded theory methodology. Although the participants were qualified nurses their stories showed that at certain times many students simply do nothing when confronted with an ethical issue in their practice. Woods cites possible reasons for this behaviour. These include perceived powerlessness, lack of awareness and presumed deficiencies in ethical skilfulness. Silence, he

claims, ensures the student is eliminated from the situation or eliminates him or her self (p.116).

Woods' (1997) findings on the silence of students arise from the reflections of qualified nurses whose clinical experience ranged from four to twenty years. Do these findings parallel those of students today? Andersson's (1995) study on student nurses suggests that they are in a marginal position while in the clinical setting. Palmer (1998, p.45) writing from the position of an experienced teacher, also considers students are marginalised. He believes marginalised people have a reason to fear those in power and learn that there is safety in not speaking. Chinn (1991) claims little is known about silence in nursing. As feminist scholars have done for women, Chinn urges nurses to recognise, name and study the silencing and the silences of nurses. She claims, as yet, there are no systematic studies of the silencing and silence of nurses.

Cameron, Schaffer and Park (2001) combined ethical enquiry and phenomenology. They explored seventy senior nursing students' experience of an ethical problem and the experiences of using an ethical decision-making model. Students were asked to write about one situation involving nursing practice that caused the student the most conflict about what to do. The striking finding from this study was that forty percent of student ethical issues involved conflict with nursing colleagues. Conflict occurred when students worked alongside staff who deviated from principles, undertook harmful and poor quality care, gave medication incorrectly, did not report medication errors, force fed elderly people and broke patient confidentiality.

This finding is significant in two ways. Firstly, Greenwood (1993) argues that repeated exposure to less than caring nursing practices results in some students becoming habituated to them. Secondly, students within Cameron et al's. study longed to work well with colleagues and did not want interpersonal conflict to interfere with care. These authors found conflict often left students questioning what to value, who to be and what to do. Benner (1984) concluded from her

research that nursing knowledge emerges from its own practice. This leaves one wondering about knowledge concerning students' experiences between maintaining an outward performance that may seem to be smooth and fluent and their possible inward turmoil.

In seeking answers for the surprise finding concerning conflict, Cameron et al. (2001) propose that it may be representative of the dichotomy between the education ideal and practice reality. Students learn the ideal of ethical based practice only to see that nurses may not practise this way in the real world. However the situation is not unique to student nurses. Studies of qualified nursing staff suggest ethical problems arising from nursing colleagues' actions are also prevalent amongst this group. Gold, Chambers, McQuaid and Dvorak (1995) used a hermeneutic methodology with twelve participants and van der Arend and Remmers-van den Hurk (1999) used quantitative and qualitative data from ninety Dutch nurses, to show that conflict arose for nurses from a variety of colleagues' behaviours. These behaviours included treating patients aggressively, incompetence, keeping silent about errors, sedating patients for staff convenience, being too fearful to act decisively, discriminating against clients, giving treatment against clients' wishes and breaking rules. Notwithstanding the origin, it appears that working with clinical nurses causes ethical conflict for students.

Apart from Han and Ahn's (2000) study referred to earlier, Cameron et al. (2001) consider the experience of conflict with supervising staff has received little attention within the literature on students' ethical practice. The authors cite the example of the conflict caused for a student who is working with a nurse who takes shortcuts in patient care. They argue that an imaginary subtle line exists between care involving shortcuts and care that is unethical (p.441). Understanding and working with subtle lines in being ethical is not considered in the nursing literature.

Another finding emerging from Cameron's et al. (2001) study concerned conflict resolution. Data showed students enjoyed the feeling of relief when they acted with integrity and pursued actions they considered right and caring. Students also felt a sense of satisfaction that their care made a positive difference. Although not

explored within this study, these experiences involve the acquisition of knowledge and understanding in relation to being an ethical agent. This may have involved their need to go out on a limb, or break their established trust with a staff member. Pask (2003) argues that the literature fails to consider adequately the influence of the student in pursuing care for patients, believed to be ethical. She wonders why these aspects of practice have been ignored in light of educationalists' aim to nurture students towards care that is good and proper.

An ethic of care

For Heidegger (1927/1962) caring is a universal phenomenon, which reflects the way we relate to the world. Although not unique to nursing the concept of caring has long been synonymous with nursing, and according to Radsma (1994) a component of nursing that few would dispute. Caring has been considered at great lengths by numerous authors, yet despite ongoing deconstruction and reconstruction, it remains firmly embedded in nursing. Caring was seen as an important aspect of students' ethical practice within several of the previously cited studies on students' ethical practice. This depicts the more recent trend within nursing literature to ascribe caring an ethical dimension within nursing (Benner & Wrubel, 1989; Bishop & Schudder, 1990; Fry, 1989; Johnstone, 2000; Leininger, 1988; Watson, 1990; Tschudin, 1995).

The use of the term, 'a nursing ethic of care', suggests that there is an ethic within nursing practice that is based predominantly on caring as a complete moral response to the health needs of others (Woods, 1997, p.32). The nursing literature concludes that there are two aspects to the successful enactment of an ethic of care. These are first that the nurse will connect and interact with patients on an emotional level; and secondly that nurses have an ethical obligation to act on behalf of the patient. Within relationships considered as caring comes the motivation by the nurse to address ethical issues with the emphasis on respect and concern for the good of the patient. An ethic of care has gained credibility within nursing ethical discourse by supporting the belief, long held by nurses, that it is the

patient that is of concern, not the task or the doctor or the institution (Dyson, 1997). It has also provided a challenge to the objective application of ethical principles.

Yet a caring ethic is not without its critics. Many nursing authors are concerned that a nursing caring ethic is a description of words and definitions that does little to show the influence of the practical enactment of such care (Bowden, 1997; Crigger, 1997; DeMarco, 1998; Dyson, 1997; Hoagland, 1991). Interestingly, Young-Mason (2001) who writes about an ethic of care and students' practice relies on descriptions. She considers a student caring ethic to involve, "strong communication skills, integrity, thoughtfulness, respectfulness, patience, kindness, advocacy, gentleness, sincerity, empathy, and compassion and that it requires selflessness and a genuine desire to help others reach their optimum level of health" (p.103).

Dyson (1997) and Young-Mason (2001) are amongst many authors who consider ongoing research is crucial in relation to a nursing ethic of care. This is because a caring ethic attempts to articulate and acknowledge the everyday caring and ethical practice of nurses. However Young-Mason proposes another reason as well. She warns there is danger for nurses both professionally and privately if this does not happen and believes that a caring ethic has the potential to mask the power inequity by convincing nurses that because they are there to help others no one is oppressed, no one victimised and power just isn't relevant (p.103).

Barriers to ethical practice

Considered as bold and pioneering in 1978, Curtin was one of the first nurses in the literature to identify the constraints on nurses' choices to be ethical. She argued that nurses have little authority and power to make ethical choices for patients. Curtin considered these barriers to include institutional policies, obeying physician orders and a general disregard for the legitimate authority of nurses in regard to nursing care. Many authors have supported her arguments (Davis & Aroskar, 1983; Jameton, 1984). However it is Yarling and McElmurray (1986) who

are perhaps best known for their contribution to the literature. Based on case studies they argued that nurses "are deprived of the free exercise of moral agency" (p.63). Their findings mirrored much of the previous work. However they brought a further perspective to the literature, by considering the historical legacy of the general apolitical nature of nursing as relevant to this debate. Yarling and McElmurray (1986) claimed this ensured nursing was more concerned with changing individuals rather than with reforming institutions.

A qualitative study by Erlen and Frost (1991) examined twenty-five nurses' perceptions of their role in influencing the resolution of a practice ethical dilemma. This study also added further perspectives to the literature in respect of barriers to ethical practice. The authors showed that the repeated effect of nurses' inability to exert any influence on resolving ethical dilemmas was significant to this phenomenon. They also identified that nurses lacked knowledge of alternatives to implement ethical care. However a decade later Johnstone (2000) challenges Erlen and Frost's claim that nurses are not aware of alternatives. Instead she argues that barriers to ethical practice remain structural rather than knowledge based. Along with Adamson and Kenny (1993) she contends that the continuance of the dominance of the power and control of doctors to determine care remains a significant barrier. Johnstone (2000) and Corley (1995) further consider that negative attitudes and lack of support from co-workers and management, combined with the impact of inadequate staffing, create further barriers to the ability to work ethically. The result is decreased interpersonal communication, inability to get to know and appreciate individual patients, high turnovers of staff with inexperienced staff unable to appreciate the systems to resolve issues.

Closely interwoven with the literature on barriers to ethical practice is the concept of moral distress. Originating in the nursing ethics literature, this concept has strong foundations in the historical and structural organisation of nursing. These foundations perpetuated a nurse's role as one of not questioning authority or openly participating in ethical debate. Wilkinson's (1987/88) work and later literature (Hamric, 2000; Hartrick Doane, 2002; Johnstone, 1998; Quint Benoliel, 1993; Rodney & Starzomski, 1993; Rushton, 1995) define moral distress as a

phenomenon that produces painful feelings ranging from a nagging sense something is wrong, to anger, frustration, anguish and outrage. These feelings are often accompanied with a loss of integrity. Wilkinson (1987/88) draws the conclusion from her study that the depth of moral distress is influenced by the degree to which the nurse identifies with the patient and also by her/ his terms of passive rule following versus active decision-making (p.26-27).

Moral distress is considered a powerful impediment to ethical practice (Hamric, 2000). Bringing together the findings of Wilkinson's (1987/88) study concerning the relationship between moral distress and rule following, with Dierckx de Casertle, Grypdonck, Vuylsteke-Wauters and Janssen's (1997) study, it would seem that moral distress is a significant aspect of students' ethical practice. Dierckx de Casertle's et al. empirical study considered ethical reasoning and the probability of the implementation of ethical decisions amongst 2624 Belgian nursing students. Findings showed that students are mainly guided by professional rules, norms and duties. Making personal ethical decisions on the basis of their own principles and acting on such decisions had yet to occur in their practice.

However the literature, along with that in relation to barriers to ethical practice, generally excludes the student perspective. The exception is that of Kelly (1991,1992,1993). Data in all Kelly's studies reflects this phenomenon but it is only in her 1991 English study that she refers specifically to ethical distress, by considering student responses such as, 'soul destroying', 'frustrating', 'demoralising' and 'intolerable', as being attributable to ethical distress amongst this student group. The assumption in the literature is that the student nurses' experience of structural barriers and ethical distress is similar to those of the qualified nurses they are working alongside in clinical practice. Yet Cameron, Schaffer and Park (2001) concluded from their research that senior nursing students do not experience ethical problems in the same way as qualified nurses. Their status is lower and as such they feel more powerless to resolve conflicts.

Erlen and Frost (1991) urge nurses to investigate how nurses grapple with issues of powerlessness and Johnstone (2000) considers that an examination of nurses'

lived experiences would reveal important insights about the need for cathartic moral talking to help relieve moral distress.

Supervisor student relationships

Clinical lecturers and clinical staff undertake supervision of students' clinical practice as stated earlier. Several studies have considered the relationship between clinical lecturers and students (Booth, 1997; Forrest, Brown, & Pollack, 1996). These studies generally found that lecturer support is influential in student learning. Students valued lecturer input, to help them explore and clarify practice issues relevant to the clinical area but lack of access to the clinical lecturer limited the effectiveness of this role. Students who did not have a supportive clinical lecturer relationship considered their learning was compromised (Forrest et. al., 1996; May & Veitch, 1998).

However it seems students want the clinical lecturer to retain a practice focus. Lecturers who advocated and demonstrated unrealistic nursing practices within the clinical setting caused confusion and conflict within students. Their unrealistic practices interfered with the routine in the area causing a split between the lecturer and the clinical staff (Forrest et al., 1996). Yet these studies consider clinical practice as a whole. They do not address the specific experience of clinical lecturers' impact on students' experiences of being ethical. They do however prompt further questions such as; what is the students understanding of unrealistic ethical practice; what is the experience like while working with a clinical lecturer who insists on unrealistic ethical care and how does a student work amongst supervisors who are split over how ethical practice should be implemented?

As most of the supervision of students is by clinical staff, this relationship with students is significant to the ethical practice of students. Despite the problems identified in earlier studies, clinical staff are considered by students to be the most effective teachers, through studies undertaken by Dunn and Hansford, (1997); French, (1992); Forrest, Brown and Pollack, (1996). Students generally yearn to learn and work well and tell us that relationships with staff are crucial to their

success while in the clinical area (Hart & Rotem, 1994; Power, 1996; Timmins & Kaliser, 2002). Successful relationships with colleagues means they feel valued and accepted as members of the team, which enhances students' learning (Cooke, 1996; Philips, Davies & Neary, 1996). However these authors' studies again refer to practice generally. The literature has little to share on how clinical staff support students being ethical.

What literature is available tells us that learning environments that foster ethical skills involve the students. Clinical staff support understanding of different ways of ethical thinking and its integration into practice (Turner & Bechtel, 1998). Nyland and Lindholm's (1999) study concerning the importance of ethics in clinical supervision involved fifty-seven students writing about the characteristics of the ideal clinical supervisor. They identified warmth, support in gaining access to learning environments and willingness to engage in teaching relationships. Foley, Minick and Kee's (2002) study involved sixty two registered nurse participants and their data showed that watching other nurses interact with patients and talking with them was an important factor in how nurses learn advocacy. These three sources all highlight the positive relationship of talking and exploring issues to being ethical.

Talking about practice allows the student to explore the staff members' intentions and purposes rather than just observing unexplained behaviour. Cameron (1997) and Engebreston and Wardell (1997) consider these are ethical relationships. They claim ethical relationships lead to personal development by encouraging receptivity and flexibility which fosters individual competence along with opening up to new ideas. The end result is increased productivity and the provision of better care. In contrast unethical relationships cause exploitation and dissatisfaction, with patients receiving lesser care. Further, Langston (2001) believes unethical relationships discourage students from fulfilling their potential in the nursing profession. They shatter or hinder the eagerness of a nursing student to extract knowledge and skills from these experienced nurses.

Knowing more about ethical relationships is important to Cameron and Diemert Moch (2000), as experiencing ethical problems with colleagues is something most of us face at some time. They argue the nursing literature lacks evidence of research about the nature of an ethical relationship amongst nursing colleagues, including students. They consider research is needed about the nature of ethical relationships and how nurses can maintain and develop these.

Conclusion

This chapter has situated the study question amongst the pertinent ethical and educational literature. It has been shown that traditional ways of viewing and teaching ethics are being challenged within contemporary literature. This contemporary literature calls for a better understanding of and teaching about nurses' ethical practice through studying the lived experiences of nurses. This chapter has also shown how there is the presumption within some literature that students' experiences of ethical practice are the same as those of qualified nurses. These assumptions have been identified as limitations within the literature thereby identifying the need for further qualitative investigation of student nurses' ethical practice within the clinical setting.

Having provided further background to the study through the consideration of relevant literature the following chapter, Chapter Three, concerns the research methodology of this study, which is phenomenology. Phenomenology is a methodology that is able to explore the lived experiences of participants and supports the push in contemporary nursing literature for the actual experiences of nurses to be the starting point for a better understanding of nursing ethics. This chapter further explains how the study was undertaken with a central theme of this discussion being the adherence to ethical guidelines of research.

Chapter Three: The Research Process

Introduction

This chapter explains the methodology and design of this study. It provides an overview of phenomenology as the philosophical foundation of this study. There is an emphasis on the phenomenological interpretation of van Manen (1990) as it is his phenomenological interpretation that is used extensively within this study. This chapter provides a rationale for the choice of phenomenology. It argues that this methodology is well suited for exploring the meaning and significance within the everydayness of students' clinical ethical practice, which was shown in the previous two chapters to be an aspect of nursing education that requires further consideration. This chapter also describes the methods and techniques used to collect and analyse the data including how the principles of research ethics were upheld. In addition this chapter endeavours to show the reader how the notions of validity and trustworthiness were upheld. A further aim of this chapter is to show and weave my personal understandings concerning this study amongst the discussion, as phenomenological researchers claim the researcher can never stand outside this process.

Phenomenological underpinnings of this study

Phenomenological philosophy focuses the researcher on the world as it is experienced. It involves wanting to know the world in which we live as human beings, often referred to as the life world. We live our lives day to day in a world that is filled with meaning. That meaning directs our everyday actions, yet we usually fail to take notice of most of these actions. We tend to take them for granted. These ordinary day-to-day experiences are the focus of phenomenological research. That research aims to 'lay open and let be seen' that 'which is taken for granted' in our everyday world (Heidegger, 1927/1962) and as such phenomenologists speak of going back "to the things themselves" (Cohen, 1987, p.32).

As a research methodology, phenomenology allows understanding to emerge from studying human experiences as they are lived, rather than attempting to explain how they occur. As a way of understanding, phenomenology challenges the positivist scientific notions of an objective reality separate from the subjective (Thompson, 1990). Objectivity encourages truth to be sought in the detachment of ourselves from the very thing we want to know about. In contrast phenomenology begins in our human experiences and our involvement in the world through our consciousness. Therefore meaning within phenomenology is always contextually constructed. The task of phenomenological research is to make the phenomenon in question appear in a clear and understandable way, as meaning is related to understanding phenomena. Phenomena refer to situations and events, as they are understood to a person prereflectively, in their most original meaning. This is before any theorising or classifying through interpretation or as Heidegger (1927/1962) says "that which shows itself in itself"(p.54).

The concept of intersubjectivity, that is the belief in the existence of others who share a common world, is important to phenomenology (Cohen, 1987, p.3). Despite participants' differences related to age, ethnicity, life experiences and the varying clinical practice settings, there is the assumption that there is an essence of 'being ethical'. This essence is beyond any individual's experience regardless of the fact that each participant's life world is different. Phenomenology searches for this essence through sameness and difference, finding "that what makes a thing what it is (and without which it would not be what it is)" (van Manen, 1990, p. 177).

While phenomenological studies concern the knowing and understanding of lived experiences, phenomenologists, principally Heidegger (1927/1962) consider this is part of the larger question of "what is being?" In researching from a phenomenological perspective, the "being" means the being of entities. Entities exist within time and a specific situation, thought of as the lived experience. It is these entities that are researched as a way of understanding the meaning of being (Munhall, 1994). Yet in searching for the 'being' of a phenomenon it is possible that the phenomenon may be hidden, covered up or in disguise (Smythe, 1998). The

illusiveness of phenomena means the researcher must remain open to possibilities of meaning.

The concept of openness is fundamental yet challenging in phenomenological research, as the researcher's life world will always have an impact on the interpretation of the phenomenon. Although openness can never be absolute, as prejudice is our window on the world (Arnold & Fischer, 1994), researchers strive to make their personal understandings explicit and leave aside expectations and assumptions. The literature warns that the process of remaining open and faithful to the phenomenon can be confusing and disorientating as one begins to make sense of the unfamiliar amongst the familiar. As the research process unfolded this warning became my reality. However remaining open to the possibility that my understandings may change was fundamental to my being a researcher in this study. Openness allowed me to look and see in a different way that extended and shaped my understanding, eventually allowing the phenomenon to show itself.

Central to phenomenology is also the concept of intentionality. Intentionality is the belief that we are born into and inseparable from an already existing historical and cultural world. The students in this study are part of the socially constructed world of nursing in New Zealand with its history, culture and traditions. They have inherited the ethical standards of the profession that outline expected ethical practice. Yet while we are constituted by our world, we also constitute our world. Interacting with other human beings also creates meaning for all individuals. The New Zealand author Janet Frame in her book entitled " To the Is-Land" (1983) brought this concept to life for me.

> *I was born Janet Paterson Frame, with ready made parents and a sister and a brother who had already begun their store of experience, inaccessible to me except through their language and the record, always slightly different, of our mother and father, and as each member of the family was born, each, in a sense with memories on loan, began to supply the individual furnishings of each Was-Land, each Is-Land, and the hopes and dreams of the Future. (p.17).*

All participants brought to this study a unique system of personal constructs. These constructs depend on perception. Perception is integral to phenomenology as it centres meaning (Munhall, 1994, p.47). Perception and meaning both emerge from the inextricable interrelationships of our 'being-in-the-world'. It is through our being in the world that things, which have importance to us, become significant. I bring to this study an assumption that caring is important to students. Caring can however, only be known through the participant's experience and interpretation, as caring is a structure of our being that gets expressed in all the different ways we relate to the entities in our world (Crotty, 1996, p.84).

By seeking understanding through individuals' life world, phenomenologists search for a deeper knowing about the nature of everyday experiences. The aim is to awaken us. Phenomenological studies can show us what we may have forgotten, been unclear about or have no understanding about. Thompson (1990, p.229) claims that it is crucial to illuminate through phenomenology the persistent enduring values and goals of nursing that empower, emancipate and impassion caring and awaken sensitivity to our shared human situation.

Van Manen's life existentials

As mentioned earlier, meaning within a phenomenological study is contextually situated. For van Manen (1990) there are four essential contexts of the life world to consider when studying the lived experience. Known as "existentials", he claims they pervade all human beings regardless of their historical, cultural or social situatedness. Van Manen stresses they cannot be separated but can be differentiated (p.105). The first of these is corporeality or being a body in the world. We are always in the world through our bodies and they both reveal and conceal our experience of Being. In certain contexts being ethical was experienced as being distressed and the students' bodies both revealed and concealed this distress. Secondly there is spatiality or being a body in a space. The clinical environment was not perceived as the number of rooms or walls but how this space felt for the student participants. Thirdly there is temporality or being a body in time. Van Manen claims we are always on our way and lived time as opposed to

clock time shows us the past present and future understanding of our world. Fourthly there is relationality, or being a body living with others. Participants bring to this study an understanding that certain relationships impact on their success in the nursing programme. Together, van Manen (1990) suggests, these four existentials can be used as guides to help see a phenomenon. In my experience they became part of my fresh eyes and an aspect of the openness I strove for in this study.

Interpretation

The process of investigating the experience as it was lived amasses a considerable amount of data. As I looked at the piles of paper that held my study I understood what Sandelowski (1995) meant when she wrote "one of the most paralysing moments in qualitative research is the beginning analysis" (p.371). Once my initial 'now what' and 'can I do it' anxiety settled through supervisor support, re- reading articles and books concerning data analysis, I began my journey of interpretation. I came to eventually understand that interpretation in phenomenology is not a process of describing the thoughts and actions of others. Phenomenology utilises these as clues to go beyond what is given in order to understand meaning (Crotty, 1996). My role was to uncover rather than assign meaning to the study phenomenon.

This was an evolving and reflective process that brought together the participants' understandings, my life world and literature. By returning to the object of inquiry again and again I moved between the parts of the phenomenon and the whole. As this dialogical process continued my understandings began to deepen (Allen & Jensen, 1990). At times I wondered when this process would come to an end. Colleagues who had undertaken phenomenological studies suggested that a sense of completeness would tell me this. This proved to be so and it felt somewhat like the scene from the popular movie Forrest Gump where one day after running continuously for several years he just felt the need to stop.

Van Manen (1990, p.62) believes that in undertaking a phenomenological study we borrow other people's experiences to better understand an aspect of human experience. However the meanings that emerge from a study using this methodology belong to the researcher. Smythe (1998) reminds me that this does not mean that I consider my interpretations as the researcher to be better than the participants' own, simply that I am the person making this journey of interpretation. Van Manen (1990) also reminds me that in phenomenological description no one single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even richer or deeper description. This is because meaning is found moving between the parts and the whole to which there is no end. This infinite availability of understanding at times felt daunting. When I thought I was coming to the completion of my interpretation I happened to stumble across a new book in the library. This book opened further understanding returning me to my writing. It was difficult to realise after my engrossment in this study that there is another book, article or conversation that can do the same. The boundness yet openness of phenemology initially bought feelings of anxiety, however I have come to understand this as the tensions of living with this methodology (Spence, 1999).

Selection of this method

Nursing ethical theory developed significantly in the 1970s by borrowing from the principle-based Western ethical movement and consequently the packaging of nursing ethical theory was within positivist ideology. This legacy remains embedded in the teaching and learning of ethical practice within the curriculum undertaken by these participants. Yet contemporary nursing ethical literature argues that this decontextualised approach to theory generation does little to convey the everyday ethical practice of nurses, as it forgets the fact that it is human beings who bring theories into being and not the reverse (van Manen, 1990, p.45). Phenomenology offered a unique way to understand students' ethical practice as a human experience, as phenomenology is guided by the belief that understanding is woven into our very being and is therefore within every experience (Smythe, 1997). Furthermore phenomenology is able to explore the everydayness of human experience. Playle (1995) considers the everydayness of

student nurses' experiences is minimised as they have had little impact on the nature, the design or delivery of nursing curricula. This he argues has resulted in nursing education having been constructed from the 'knowing that' of educators rather than the 'knowing how' of students.

In bringing together a methodology with my interest in student ethical practice I initially toyed with the idea of using a critical methodology. I brought to this study some understanding of the tensions experienced by students related to their subordinate and transient role within the nursing hierarchy. Critical theory, like phenomenology, challenges the limitations of positivist science. In contrast to the individual meanings emerging from phenomenology, critical theory emphasises understanding of the patterns of human behaviour and their relationship with societal structures. The aim is the illumination and relief of oppression by communication and action through education (Campbell & Bunting, 1991). After considerable thought I decided that although oppressive structures seemed a significant aspect of a student's world, I believed these tensions would emerge from the data, as phenomenological studies concern the indissolveable unity between the person and the world (Koch, 1995, p.831).

Van Manen's structure of phenomenology

The diversity amongst phenomenologists has ensured that there is no one method by which to undertake phenomenological research. Van Manen (1990) has however given guidelines about how this type research can be put into practice. It is these guidelines I have utilised within my study. The following is an overview of these and how they were used in this study.

Turning to a phenomenon that seriously interests us and commits us to the world

My task was to find something that truly interested me, as this is the starting point for phenomenological research. Ethical practice is critical to the quality of students' lives and as a nursing teacher I have become interested in the teaching, learning

and understanding of student nurses' ethical practice. For several years I have facilitated a workshop on ethical practice for pre-registration students before their immersion in clinical practice. During this workshop I use case studies as a teaching method and ask students to debate the nursing issues involved in each example. Although lively group discussion usually occurs, it became noticeable to me that student discussion seldom focused on the actual experience of being ethical. There seemed to be the assumption that their decided action could just happen. Yet it is very apparent to me that this classroom certainty seldom matches the complexity of actual practice, as ethical based practice is always contextual and situated. Nursing literature has shown that nurses' ethical practice is both constrained and enabled within practice settings, so I wanted to understand more about how students work ethically in this environment. Palmer (1998) believes that when you are committed to your work as a teacher, the only way to get out of such a situation is to go deeper in. He writes, "we must enter not evade the tangles of teaching so we can understand them better and negotiate them with more grace, not only to guard our spirits but also to serve our students well" (p.2).

Investigating experience as we live it rather than as we conceptualise it

The aim of phenomenological research is to capture and record simple pre reflective descriptions of how the study phenomenon is experienced and accept this as truth. I began each interview with the broad inquiry statement "can you tell me what 'being ethical' means to you"? Following this initial question I invited participants to share stories from their practice, for example, "can you tell me about a situation where you believe you acted ethically?", "can you recall a situation that was ethically difficult for you?" At times participants would start to generalise about the experience and this meant I needed to ask further questions to return them to the actual experience. Questions that helped me do this were ones such as, "what was important to you in this situation?" "what was it like working with that person following this situation?" Remaining close to the actual experience is fundamental in phenomenological research. The concern is not primarily with the subjective experiences of the participants as a way of reporting how something is seen from their particular perspective (van Manen, 1990, p.62). Instead the deeper goal is

asking the question what is the nature of this phenomenon as an essentially human experience?

Reflecting on essential themes

The researcher's role is to recover the essential themes from within this data. Themes are the parts of the whole and I found it helpful to consider these as the knots around which being ethical was spun. Finding themes involves "seeing meaning" according to van Manen (1990, p.79) and I began the search for the themes by firstly weaving together the anecdotes from within each participant's data. Ethical situations are always contextually embedded and it is difficult to understand the complexities and subtleties of the particular situation without sharing the situation. The writing of these anecdotes allowed the students experiences to emerge as their stories were often scattered throughout the transcript. As I re read each story I kept asking myself what seemed to really matter and what is this story telling me about 'being ethical'? Stories which felt similar were then grouped together and the regrouping continued as I read and reflected on the meaning in each story.

Phenomenological writers say themes tend to emerge and evolve slowly and this was my experience. Moving from my initial six groupings of similar stories to settling on the final three themes needed a lot of time to think deeply about what I was seeing. Walking helped this process. Walking allowed me time to think and reflect and I was often surprised what 'popped' into my thoughts and came home with me. Alongside my walking, I also found colleagues helped with my theme analysis. As possible themes emerged I would share these with clinical teaching colleagues. I learned to judge their initial reaction and found that a delay in their response was important and indicative that I had not yet found the essential aspects of the phenomenon. Through the continued writing, reflection and critique by others I eventually grasped the three themes that rendered 'being ethical' its special significance. As I shared each of the final themes with colleagues, I found it was interesting that they were able to immediately relate these themes to student experiences.

The art of writing and rewriting

Van Manen (1990) describes interpretation within phenemology as the art of writing and rewriting. This is necessary to bring to speech that which we wish to communicate. Writing began in this study as the means of bringing together the students' anecdotes as the way to relate their experiences. Van Manen considers anecdotes are devices in human science to make comprehensible some notion that easily eludes us. As I began the process of grasping the meanings within these anecdotes by further writing and rewriting I found myself going back and forth between anecdotes and my emerging interpretation. While my writing continued, my focus moved from the stories to surfacing the themes. Van Manen warned that this writing and rewriting would distance the researcher from the lived experience. I found this 'letting go' extremely difficult. However with supportive guidance I came to see that distance was required in my writing to 'let us see that which shines through and that which tends to hide itself' (van Manen, 1990, p.130). As I continued to write I was surprised how some stories I thought I would never use came forward as being important to the study and how those I considered crucial were left behind. Through much pondering, reflecting and dialoguing with the text, this process returned me to the deeper understanding that the phenomenological research process promised.

Maintaining a strong and orientated relation to the phenomenon

Throughout the research process I have strived to uphold a firm orientation to the research question. In the very beginning stages of this process I found myself wanting to explain the 'how' rather than let the data speak to the experience. However this tendency settled and through returning again and again to the tapes and the written data I was able to retrieve, regain and recapture the phenomenon (van Manen, 1990, p.149) by trying to answer the ongoing question, what is the meaning in what I am hearing or reading? As I was coming to grips with the meanings that were hidden, my experience was one of working with anxiety. My anxiety related to the possibility of making an inaccurate or contaminated

interpretation and needing to always be open to this possibility. I kept in mind that you do not go in search for agreement for your own opinions and understanding but you must remain open and alert to values that differ from your own, as it is in this space between own and other that new insights will emerge.

Balancing the research context by considering the parts and the whole.

By weaving between the data and the emerging meanings I found that each new meaning was layered with previous understandings with forward movement to new understandings. No one meaning stayed static or fixed during this process and as I attempted to uncover the experience I found that creative visualization was helpful. I tried to 'see' how the whole was constituted by the parts and vice versa.

The participants

There is no formula for the right number of participants for a qualitative study. Following discussion with colleagues who had undertaken qualitative research studies I decided on the selection of twelve participants. Following approval from the Auckland University of Technology Ethics Committee, seventy final semester students from one undergraduate nursing programme were asked to be participants and given an information sheet (Appendix A). Twenty potential participants volunteered. In phenomenology the criteria of a good participant according to Morse (1989) is one who is articulate, reflective and willing to share. Using a purposive sampling method I selected participants based on my personal judgments about which participants would be the most representative or productive. From the twenty potential participants, I sought diversity in relation to age, gender and ethnicity thus ensuring that the data as a whole could be construed as a 'many voiced' account (Koch & Harrington, 1998 p. 888). The selected participant group comprised two men and ten women. The fewer men was not surprising as there were only eight men in the potential participant group. Participants' ages ranged from twenty to fifty one and six identified as having ethnic backgrounds different from my own. Two participants were second level nurses prior to their entry to the course.

Participant consent

Prior to each interview written consent was obtained to audiotape the interview. Consent was also sought for the interview data to be used for publication and for possible future verbal presentations. Participants were informed of their right to withdraw at any time and to request removal of or amendments to their transcript (Appendix B). Each participant was given a pseudonym to protect their identity and by which they would be identified.

Data Collection

Data collection was undertaken using individual taped interviews. The use of an audiotape was selected, as Moustakas, (1990) and Spence (1999) suggested that this method would allow me to listen supportively while being able to interact with the participant as partners. This they considered would enhance participants' capacity to talk freely about their experiences. Tapes were transcribed using a professional transcriber. The decision to use a professional transcriber was based on my limited keyboard skills. A typist accustomed to confidential typing undertook the transcribing. All written material used participants' pseudonyms.

On return of the typed transcripts I again listened to each tape checking the transcriber's interpretation. Bourdieu (in Wellard & McKenna, 1996) claims that even the most literal form of documenting spoken data represents a translation or even an interpretation. I found this process was helpful not only in checking the interpolation of the transcribed tapes but it was the beginning of my immersion into the data. I also recorded any pauses, silence and any expression on the transcripts as suggested by Sandelowski (1994) to help my understanding. Copies of the interview transcripts were returned to each participant for checking. Along with the transcript I sent a stamped addressed envelope and a letter of thanks, which also outlined options if they wished to communicate with me further. One participant returned her transcript with minor changes.

My study proposal and consent form stated that a focus group interview would be part of my study. After completion of the individual interviews I realised this was not going to be possible. Their new role as registered nurses had scattered the participants geographically throughout New Zealand and Australia. Participants were notified of this change.

The interview process

Interviews took place in a setting convenient to the participant with the exclusion of my work office. I considered that my office could emphasize the power issues within the teacher student relationship and risk the identification of the partiticipant to others. I brought refreshments to each interview to assist in the 'warm up' period. Moustakas (1990, p.46) suggests that such measures create an atmosphere of comfort encouraging trust, openness and self-disclosure. The 'warm up' period varied in length and frequently involved talking about future career plans. Interviews varied in length from approximately forty to seventy minutes. Following each interview I made notes about the mood of the interview, any problems and the progression of interviewing skills. One issue became apparent from my early interviews. This was my discomfort with silence during the interview. As I reflected on 'hurrying the silence' in my journal, I became aware that my discomfort came from not wanting to waste participants' time. However I soon realised that this was a positive experience for the participants and subsequently created a space for the silence.

Listening is often described as an art and I found the degree of concentration and attentive listening needed to direct the interview draining, especially in the earlier interviews. This meant not only concentrating on the immediate moment but holding onto and returning to some issues raised by participants. The ability of the researcher to 'track' issues is considered important by Sandelowski, Davis and Harris (1989) as it minimises the interviewer's interference with the natural flow of the subject's conversation. As I became more confident in the process and less anxious of equipment failure, I began to relax more and found the interviewing process less tiring.

Sorrell and Redmond (1995) describe the unique intimacy that is shared between the interviewer and the participant. I was frequently humbled by participants' experiences and at times the tape was turned off to allow for participants' tears or support from me. From within this atmosphere came stories that challenged my personal understandings of what I thought I knew. My teaching role with this group of participants meant my involvement with the participants varied. I bought a sense of 'knowing' some better than others related to our time together in the clinical setting. Not all of these participants' experiences were new to me, however I was astounded at the stories some participants had not shared with me as their clinical lecturer, but offered at interview.

All participants thanked me for the opportunity to be listened to and considered the experience therapeutic. This supports Hutchinson, Wilson and Skodol-Wilson (1994) and Johnstone's (2000) claim, that an examination of nurses' lived experiences would yield important insights into such areas as the need for cathartic moral talking.

Relevance to the Treaty of Waitangi

As part of honouring research ethical principles, the Auckland University of Technology, where this study was undertaken, strives to honour The Treaty of Waitangi. Durie (1998) described the principles underpinning the Treaty as participation, partnership and protection. These principles were integrated into my study in the following way.

Participation

All pre-registration students who had completed the undergraduate nursing programme were potential candidates. In seeking a broader understanding of the topic I acknowledge that I sought diversity of age, gender and ethnicity. The interview process also provided a voice for students who often view themselves as powerless to create change (Beale, 1999).

Partnership

During the interview process I strove to promote an atmosphere that minimised the potential teacher researcher and student participant power differentials. I listened respectfully and made no judgments about what participants shared. All transcripts were returned to the participants for checking and approval. This ensured the participants' partnership in the data collection process.

Protection

I protected the participants by ensuring I adhered to the ethical guidelines outlined by the Auckland University of Technology. I also consider studies that surface a nursing voice, help protect the moral voice of nursing in what is rapidly becoming a most perplexing health care system (Woods, 1999).

Ethical Considerations

This study upheld the ethical principles for research as described by Burns and Grove (1993) and Polit and Hungler (1997). The following is a summary of the ethical dimensions supporting this study.

- **Principle of beneficence**

All participants were informed in the participant information sheet (Appendix A) that this research may cause some personal distress. It was clear on the information

sheet that should this occur I would assess the participants' need and provide assistance as required. Participants were also advised that they were able to withdraw at any time.

• **Freedom from exploitation**

The consent form (Appendix B) outlines the uses to which the participant's data will be put. Participants had the right to comment and amend the data transcribed.

In undertaking this study I was acutely aware of the ethical and power issues related to my position as a teacher of this group of students. The following steps were taken, acknowledging this relationship. 1) The study was introduced to the potential participants when all assessed course work had been completed in respect to their programme. 2) A colleague was present when I introduced the study topic to the potential participants. This colleague distributed the information sheet and collected names of volunteers. 3) As students may have perceived that the role of a teacher researcher was to judge them, my information sheet stressed that my role was only to listen. 4) Data collection interviews occurred after my responsibilities as a teacher to this group had terminated. This cohort of students had a ten-week delay between course completion and receiving confirmation of their status as registered nurses from the Nursing Council of New Zealand. I collected the data during this time.

• **Risk/ Benefit Ratio**

As identified earlier the risk of this study for participants was that it could cause some personal distress, however the benefits for participants included catharsis. I considered the interview process was a safe place to speak about and ventilate their feelings, concerning their ethical based practice. Hutchinson, Wilson, and Skodol-Wilson (1994) consider telling one's story and feeling really heard can be empowering for participants. A further benefit was the satisfaction that the information they shared may assist others. Hutchinson et al. also believe participants feel good about sharing information with researchers when they appreciate that they may increase awareness about a particular experience.

Principle of Respect for Human Dignity

• **Right to self determination**

I emphasized to participants they were volunteers and the amount of information they shared was their choice. I stressed they could at any time seek clarification as to the procedures and purpose of the study.

• **Right to full disclosure**

I disclosed the full nature of the study addressing the students' roles and my role. I also described their and my roles verbally and in writing.

• **Informed consent**

The participants gave voluntary consent to take part in the research. The participants received information about the study and had the opportunity to clarify any concerns. Their written consent was then obtained. Participants were informed the study would be available to them through the Auckland University of Technology library.

• **Issues relating to the principle of respect**

I did not deceive the participants in relation to the nature of the study. Nor did I practice concealment or covert data collection.

Principle of Justice

• **Right to fair treatment**

The participants were treated fairly throughout and after the study. I treated them respectfully, remaining courteous and tactful at all times. I honoured my agreements with the participants. I was available to clarify the study details with the participants and I supported them when needed throughout the interviews.

- **Right to privacy**

The participants were promised confidentiality of information and identity. The tapes and transcripts were stored in a secure place during the study. My supervisor will retain them for six years after the completion of this study as required by the Auckland University of Technology. All published material arising from this study will use pseudonyms to protect participants' identities.

Trustworthiness and Rigour

The debate concerning appropriate methods of assessing validity and trustworthiness in qualitative research continues with validity being presented in ways which are best suited to the epistemological assumptions and goals of the lifeworld ontology in which interpretative research is situated (Angen, 2000). Validity is no longer concerned with normative methodological criteria adapted from the positivist paradigm but with broad principles. Angen proposes there are two broad principles, which are ethical validation and substantive validation and these are utilised to guide the discussion on trustworthiness and rigour.

Angen (2000) along with Smythe (1998) and Spence (1999) argue that rigour and validity overlap with morality therefore all research agendas must be questioned as to the research 'product' being able to uphold the ethical principle of beneficence. Angen (2000) claims valid interpretations are inextricable from issues of usefulness. In Chapter One it is noted that there is little available research on this study topic and it is hoped that this research will bring a better understanding of the actual experience of student nurses as they strive to be ethical. Through this understanding it is argued that better teaching and assessment processes may be implemented for students. Furthermore, as this research study was undertaken on a part time basis whilst I continued in my teaching role I have been able to share my emerging understandings with both clinical colleagues and other students. I can feel and see a positive change in my teaching and clinical supervision because of my clearer picture of students' ethical practice. This understanding has helped create more supportive relationships with students, which has had a flow on effect to their practice. In particular, fellow colleagues and I have found that the theme

'keeping things 'nice" has struck a special chord with students. It has opened up an entry into their practice where they appear more willing to share the difficult aspects of their practice so it may be discussed further. This process has been helped by students using the stories shared in this thesis and by calling on the meanings my interpretation has offered.

Angen (2000) claims that all interpretative nursing research should provide a thoughtful, caring and responsible answer to van Manen's (1990) question " how do we become more fully who we are"? (p.12). From the wider perspective of nursing this has been demonstrated by the selection of a question that had little available research. It has also been upheld by the choice of methodology. As stated previously one of the driving reasons behind this choice of topic was that I considered my understanding of the everydayness of students' ethical practice was fuzzy. It is argued in this study that as a research methodology phenomenology allows the everydayness of things to be examined, so meanings involved in our everyday existence can be more fully understood and appreciated.

Van Manen's (1990) question can further be considered from a purely personal perspective, as phenomenological research is not possible without a personal investment of self (Mitchell, 2002). The process has encouraged a certain degree of introspection and as I reflect on my entries in my study journal I am aware of the personal growth that this undertaking has brought. One poignant entry in my journal followed an out of the blue conversation with a former nursing colleague. She talked of the horror of battling breast cancer and I found my conversation revolved around pulling out the meanings of this experience for her. We talked for a long time and that night she rang me to thank me for our time together. I would also argue that the interview process was a positive experience for all participants and that in the safety of an interview, where their practice was not judged, they were able, if only for a limited time, to be more fully the person and student they were. This was shown, as noted earlier, in my surprise in what was shared by students I believed I had 'known'.

A further aspect of ethical validity outlined by Angen (2000) relates to whether the research promotes an equitable context within which all voices may be heard (p.384). In selecting the participants for this research I have stated that I actively sought diversity in participants in relation to age, gender and differing cultural backgrounds than my European New Zealand background. This was considered essential to ensure the data reflected the cultural diversity of students entering into the nursing programme where this study was undertaken. In addition I have included at least one story in the data from each participant and have attempted to show the differing ways that the theme held meaning for participants. This issue of voices being heard also influenced my presentation of the data. I chose to include complete anecdotes from students as I found their voice was weakened when I initially attempted to present pieces of their story to illustrate a certain meaning.

Angen (2000) draws on the work of Gadamer (1994) to further expand her notions of ethical validation. Gadamer considers that interpretative research has an ethical role in moving us beyond our present understanding of a situation to some new and more generative understanding. This research topic has been carefully and creatively considered and in settling on the final themes there has been intense thinking and deliberation that moved me beyond my initial understandings. I ensured I remained open to hear those 'niggles' in my thoughts that I came to learn were telling me there was more to see within the data. I tracked my deepening understandings not only through a study journal but also through two taped interviews. A colleague interviewed me at the beginning and again further on during the study. In addition, my interpretation of the 'us' Gadamer speaks of, is not only I, the researcher, but also others. Therefore, an aspect of the trustworthiness included exposing my work to others. In particular four people reviewed my work as it neared completion, one of whom was not involved in tertiary teaching or nursing. All found the work of immense value. For the three nurses in this group the dialogue concerning the findings was lively and called into thinking their own present day practice and that of being a student. The fourth person found the sub themes had many parallels with her work within her role as a manager.

Parallel to ethical validation Angen (2000) argues that substantive validation of qualitative research is essential. Therefore the study must be able to show how the various present, historical, intersubjective understandings of the topic come into play. This process includes firstly one's own understandings. I have attempted to make my understandings clear including my prejudices. I found it helpful in chapter five to include my initial prejudicial response to the actions of one participant. Through surfacing and writing about this I was able to move my understanding forward. Secondly, the study must show understanding derived from other sources. The main source of understanding that shaped the interpretation was literature. The work of others was integral to the understanding as it provided a window to look and see differently. At times when I felt stuck I found that returning to the literature frequently provided the key to unlock what I was trying to see.

The conversation with other was also essential. Gasquoine (1996) recommends regular conversations with fellow interpretative researchers to help clarify issues of methodology and interpretations. It is also through dialogue that Sandelowski's (1993) notion of credibility as a validity check is achievable. This peer debriefing (Long & Johnston, 2000) became an important aspect of the development of this study. As mentioned previously the felt sense of colleagues about whether the work was a worthwhile interpretation and able to evoke an immediate sense of authenticity or an 'aha' experience was also important in its development. Besides the responses from colleagues I also was able to try out my understandings on other pre-registration students and both audiences became integral to settling on the final themes. As Long and Johnstone (2000) suggest this undertaking stimulated consideration and exploration of additional perspectives (p.34).

As well, written accounts must resonate with the intended audience in that they must be compelling, powerful and convincing Angen (2000, p.393). This aspect of validity further helped me decide to present the data in anecdotal form and I have attempted to write in a way shows the world of students as it has not been commonly revealed before. Its believability, plausibility and whether it is worthy of attention can only be judged by the reader.

Angen (2000) considers the researcher's position requires vigilant self-critical reflection. This involves reflecting on their own beliefs in the same manner as they examine those of the participants. The reflective process has been a crucial part of the research process and throughout the study I maintained a research journal to write, mind map and reflect on the process. As the study progressed my journal entries have sign posted just how far my understanding progressed. It has also helped me understand why those who have read my work tell me 'they can hear my voice'. Beside this my journal also became a private place to consider what Spence (1999) describes as 'cool spots' in the data. At times the data was overwhelming in what I initially thought of as its negativity. My journal was a way to capture and express these feelings and in doing so became a way to practise my writing skills, as the skills of being a persuasive writer are essential to this process. Angen (2000) concludes her discussion on validity by adding that validation further depends on the characteristics of the researcher. The skills she lists as requirements include resilience, patience and persistence in the face of ambiguity and slow progress. My journal also acted as a way to explore my progress and to help me stay involved in the topic when the challenges appeared overwhelming.

Conclusion

This chapter has introduced the philosophical underpinnings of this study. It has given the guiding perspectives of phenomenology and has outlined the way this philosophical stance has directed the study. This chapter also described the reasons for choosing phenomenology as the research methodology. Furthermore, the details of how the study was undertaken have been discussed including the ethical principles that guided this study. It has attempted to illustrate how I have demonstrated adherence to these ethical requirements and to show my subjective involvement in aspects of the study. As all studies must be open to critique and discussion about how validity and rigour have been implemented this has also been included.

Having explained how the study was undertaken I now in the following three chapters, chapters four to six, illustrate the three essential themes that share the qualities of the phenomenon of being ethical without which it would not be what it is

(van Manen, 1990, p.107). The first of these themes is 'keeping things 'nice''. Using van Manen's existentials, six stories show how this theme focuses on the actions and meaning of compromising espoused ethical ideals.

Chapter Four: Keeping Things 'Nice'

Introduction

This chapter is the first of three chapters that uncover the themes that constitute 'being ethical' from the perspective of pre-registration-nursing students. In gathering the data, all student participants were asked at the beginning of their interview, what being ethical meant to them. Their replies uniformly spoke about doing what was right and good for patients. Yet much of the data spoke a different answer to this question. In the complexity of a clinical setting, the data showed how students experience threats to their ethical integrity and in some circumstances these threats separated their ethical identity from their ethical practice. To cope with the separation of their ethical identity from their ethical practice, students attempt to protect themselves and in describing how one particular student orchestrated this she spoke about how "you just keep things nice". This became the theme to capture this essence of being ethical as a student. Through six stories the theme of 'keeping things 'nice'' is shown and interpreted using van Manen's four existentials.

Kelly (1998) considers being respected and being part of the team is an important milestone in nursing undergraduates and new graduates. The student in the opening story considered her position within the team would be under threat if she did what she considered was the right thing. Here is her story.

Louise's story: silently following along

A senior nurse asked me along with the bureau nurse to help roll a patient so she could have her redivac removed. I knew from rolling this patient before that it was unbelievable agony. She was already in a lot of pain because of her massive injuries anyway. I suggested that she have IV morphine and the bureau nurse was with me but the nurse said, "no it was a waste of time, its going to hurt anyway, we're just going to do it" This senior nurse was a scary and powerful person and I didn't say anything because I am a student. We rolled her and she screamed and screamed in agony, she was just screaming and the walls started closing in around me in the single room. It was awful, I had her head by my hip

and most of her body against me and she just screamed. All I could do was keep saying, take some deep breaths, take some deep breaths and you could see her going oh my god shut up deep breaths aren't going to help. I felt sick to my stomach, I felt like fainting and I had to go to the bathroom afterwards and just sit with my head between my legs. I think she felt let down and she didn't want us near her after that. I just knew I could have done something, I knew I could have probably prevented that lady being in so much pain but being a student I didn't say anything. It drained me for a while and obviously it still does. It was this overwhelming experience of guilt that still sticks in my head and a kind of disappointment in myself that I didn't have the guts to say anything but students quite often don't say anything because of the power thing. You don't want to challenge someone because you are scared of what may happen, you get into a coping situation on the ward and you are getting on well with everyone and you don't want to rock the boat. Isn't it awful, but as a student you are always being watched and if you do something that they don't like, they tell another who tells another and its like a domino effect and you are treated differently…its scary, especially if you are thinking of getting a job there.

Ethical care emerges out of concern for others but when different things matter concern goes in different directions. Both the staff nurse and Louise would speak of taking care of this patient but Louise feels she is being asked to do something wrong. She knows that for this patient turns without pain relief cause not only agony but unbelievable agony. Doing what Louise believes is right means making this patient's pain visible by suggesting pain relief but her idea is not received graciously and the experience becomes one of being dismissed when her suggestion is tossed away. The 'being-with' is now one of feeling powerless and vulnerable and Louise is incapable of making further suggestions, as to advocate for the patient here and now would be to risk self and future opportunities.

Being overwhelmed into silence by the power of this staff member, Louise tucks away what she knows is right and goes along with the dismissal of this woman's pain. Being powerless and being vulnerable means walking her student silence into the patient's room, but what thoughts travelled with her as she followed this powerful and scary staff member? Being powerless and vulnerable also means touching a body that knows about the agony of pain. What was Louise feeling as she placed her hands on an anxious body and waited through the count of one,

two, three in preparation to turn? Perhaps she was hoping that this turn would just be different.

Being vulnerable and powerless means Louise helped bypass the bodily event of pain but as screams begin to pour out of this head near her hip it is no longer possible to ignore. Louise is forced listen to a patient's body announcing its pain and as she keeps things 'nice' for herself, by doing what the staff nurse wanted, she must live through the experience of inflicting pain. Her arms and hands must keep holding a hurting and screaming body while it sucks in enough air so it can continue screaming. Being-in-the-world with hurt and pain means the room is shrinking and Louise is forced to listen to screaming that is becoming more intense as it fills a smaller space.

While pleading with a hurting body to change its screams for deep breaths Louise again experiences being dismissed. This body wants the 'being-with' to be 'being-without', for Louise to shut up and go away. Being-in-the-world and being engulfed by pain also means Louise's body is unable to hide its distress. As she continues to hold the screaming body she must also cope with her own body, which is feeling sick and feeling faint. As the turning and holding comes to an end, keeping things 'nice' for Louise now becomes getting away. Maintaining this level of self-control is emotionally draining and perhaps she is grateful to be dismissed by the patient, as now she can choose her own walls to enclose herself in.

Louise's experience of keeping things 'nice' was one of being dismissed and bypassed and then becoming part of a team who dismissed and bypassed a woman's pain. The vulnerability experienced in being ethical is experienced as a loss of what should and could be. The effects are far reaching, as having no choice and not being in control of your actions is difficult and painful. The tension between the student nurse Louise thought she would be and what she did cannot be held back and there is a sense of emotional pain as Louise sits in toilet. What was uppermost in her thoughts as she sat with her sick stomach? Maybe this space just became a place of comfort and safety where for a short time she could let her body display its disappointment and drained feeling. How long did she stay cocooned in

the toilet? Was it long enough to settle her stomach and fainting feelings? Maybe she felt the pressure to get back to the ward and left before these feelings could leave her. Perhaps keeping things 'nice' meant she felt there was a time limit on how long she could hide away. And when will the drained feeling go away? It is many weeks since this happened. Harm to patients through pain and suffering matters to many nurses and is a major source of moral distress. Perhaps still feeling drained is Louise's way of describing her moral distress.

Trust is considered an important aspect of nursing practice. The act of trust entails relying on others to be respectful, caring and good. Trust is something that has the ability to alter ways of being together and Louise's experience of keeping things 'nice' is now one of experiencing distrust. Distrust creates a barrier between herself and this patient. How do you nurse someone who cannot be left alone, someone who has lost all trust in you and wants no one near her? Maybe the 'being-with' was just too hard and Louise avoided her and what of the experience of avoidance? When I have found myself in situations where I want to avoid someone it often creates extra work and added anxiety and my avoidance only aggravates an already unsatisfactory situation. Or perhaps Louise tried to act as if this situation had not happened, only to find this is not possible. What could Louise say or do to return to 'being-with-in-trust'? Perhaps Louise wanted to tell the patient about how she tried to help in the hope of resurrecting their relationship. And what of Louise's relationship with the scary staff nurse. Maybe now this was also one of mistrust.

Keeping things 'nice' is a reminder of power and going along with the orders of others shows us how vulnerable students are to compromise. Holding a screaming body means knowing what it is like to feel something is wrong yet be part of it. Compromising has left guilt sticking in Louise's head therefore keeping things 'nice' can also be considered in the temporal notion of dealing with guilt. She blames herself and coming to terms with her guilt involves creating a fittingness (Hartrick Doane, 2002) between what she believed was right and what she did. Louise begins this by reassuring herself that she knows what is right. This experience is evident in the language she uses. She tells us she, "could have prevented the pain" and she "could have done something". Louise shows us that she recognises

the treatment of pain encompasses an ethical dimension and that tucking away what is right doesn't mean she has changed her mind about what is right. Rather, being-in-the-world where you feel powerless to challenge decisions means having to keep hidden what you believe is right.

Louise also shows how creating fittingness means returning to the safety of a student's role. The pre-registration clinical experience is a time students begin to shed their student role and there is a blurring of boundaries between student and new graduate. These students strive to 'go it alone' and minimise their level of supervision. My many years of being with this cohort of students has shown me that the ultimate sense of satisfaction for a pre-registration student is to be told by clinical staff that they are functioning at the level of a new graduate. However as the demands of ethical practice overwhelm Louise, she keeps things 'nice' by reattaching the left behind aspects of her student status and by retreating to the cover of her student role. Being a student provides a feeling of safety and relief from the guilt of following along and wounding this patient. Possibly 'because I'm a student' also helps in forgiving herself.

Perhaps the tension is that ethics seems to imply looking after other but this student has come to see that first she needs to look after herself. Following along and doing as you are told is something that must happen to keep things 'nice' with staff. For some there may be little in this student's actions that may seem about being ethical but Smythe (1997) writes, " what we see may not represent what we think it represents or only partly. What is wrong may also be right" (p.81). This story seems to suggest being ethical is an intermittent experience as there are times of being unethical. Yet Louise is living a situation where tradition provides a judgment of this situation along with the situation itself. Her response to being with other is largely dependent on her status in relation to this senior staff nurse. The submissiveness and relative powerless position of students has for the greater part come to us from the past, to the present and will follow students into the future.

The following story also speaks of relationships with staff. Unfolding these lived relationships shows further understanding of being ethical. Although Lexie tells us

it is difficult to describe the relationship she has with supervising nurses, she shows us something about keeping things 'nice' as she works with supervising nurses. Consider Lexie's story,

Lexie's story: doing what is wanted

It's really hard to describe the kind of relationship you have with the nurses out there but if you want to get to do things you have to stay in their good books. It puts huge barriers on your practice I think ethically. I feel that most times it's more important to become part of the ward culture and sometimes to cope with the place, you have to work with the staff rather than what you believe. What you want to do for a patient might not be what one of the staff member thinks, so I won't do what I believe because that's going to make me look as if I'm challenging them, and sometimes the nurses like to be challenged but most don't, you can tell by their cold looks. They like you to do what they do, they don't like you doing anything differently and this really restricts you because you want to give patients your best possible care and you want to say, well why are we doing that but you can't because that makes you practise differently. As a student, you feel like you are at the bottom of the heap. That's how you feel and I guess you try to fit into that environment and I guess when you are under someone else's guidance you have to kind of go with what they want you to do. They sometimes ask you but there is a hidden undertone of do it my way and you want to please them because if they show a warm and friendly attitude to you I think you are accepted into the ward, then it kind of makes your placement. If they don't, they are really cold and it breaks it.

Lexie's practical knowledge, which is born out of her day-to-day experiences, tells her that the concern of staff toward her learning varies. Differing concerns means that some staff are able to close down her learning through their power to silence her. She describes how the experience of keeping things 'nice' is one of deciding how to 'be' along with ways of 'fitting in'. Assessing whether a supervising nurses body language is one of concern or one of disinterest is crucial and Lexie focuses on their eyes. This means deciding whether these are warm eyes or cold eyes, followed by allocating them one of these two categories. However deciding how to 'be' by gauging receptiveness is not always straightforward. There are times when the 'being- with' is tricky to categorise. Being asked for your opinion is one such situation as this brings fuzziness to the warm and cold categories. Deciding how to 'be' in a fuzzy situation involves sorting out the doubt and this means relying on listening skills. Listening attentively is crucial, as the answer is always in the tone.

Lexie has come to understand that 'being-with' a cold staff nurse occurs more frequently than 'being-with' a warm one, therefore getting a 'cold one' means tolerating and negotiating the paradox of being uncared for in a caring profession. Fitting in with a cold one means being silent and going through the motions of others, as the extent to which she holds any power in a cold relationship is by making herself available in the manner of cooperation and obedience. This story also challenges the taken for granted assumption that being supervised means a student is learning about being ethical. Merton (1955) considers that "our being is not to be enriched merely by activity or experiences as such. Everything depends on the quality of our acts and experiences" (p.107-8). Lexie tells us that 'being-with' a cold staff nurse is never 'being-with' in a caring educative way as learning is minimal when the relationship is one of disengagement and where the ideas of others dominate. Learning is further minimised when assumptions are made about you before you can demonstrate your abilities. By its absence we are able to see how important knowing and connecting with students is to being ethical.

Paterson and Zderad (1976) speak of the awesome and lonely human capacity for choice that presents both hope and fear. Lexie shows us the tensions of 'fitting in' through hope and fear. She knows that overcoming the relational chasm and 'fitting in' is dependent on her becoming what individual staff and the group norms want her to be. Being accepted means hoping that she is successful in becoming what is wanted as this opens up the possibility of being able to do things, possibly things that Lexie thinks are right and good. Perhaps her hope involves hoping that she will not have to compromise her ethical care too significantly as she sees the rewards of 'fitting in' are alluring. Yet 'fitting in' is not a constant state of being. There is always the fear that being someone who is accepted can become someone who is not. Lexie knows this and her response to this fear is keeping vigilant in her 'fitting in' work, by doing what everyone else does. Having confirmation of your worth as a student by receiving staff support appears significant to being ethical and perhaps this constant vigilance also shows us the vulnerability and fragility of being ethical.

Lexie's story suggests that her experience of being ethical is frequently one of being-in-the-world as not herself. This self-estrangement means being less real and comes about through undertaking nursing practice in a robotic way and feeling fragmented, controlled and silenced. The paradox here seems to be that ethics is about enacting our moral self, often in a creative and imaginative manner. However being our moral self is often only possible by a period of hiding one's Being and becoming like everyone else.

In contrast, the following story shows a different experience of keeping things 'nice'. This student strives to retain her Being when caught in a web of concern. Nursing literature resonates with the ethical dimension of the nurse patient relationship where this relationship is grounded in the spirit of concern. There is the assumption throughout this literature that concern is understood as considerateness and forbearance to the other, as described by Heidegger (1927/1962, p.83), but concern for Heidegger is also constituted by inconsiderateness and perfunctoriness. In interpreting Heidegger, Smythe (1997, p.164) suggests that relationships can therefore build and strengthen or neglect and harm. Being caught in a web of concern we see something further about the experience of keeping things 'nice'. Isabella tells her story.

Isabella's story: doing only so much

The nurses and doctors joined forces and avoided this patient. He was this really intelligent and assertive 50 old man who had this problem but was also HIV positive. The staff in this area had never worked with an HIV patient, their knowledge was prehistoric, there were so many stereotypical comments and judgments made. He used to make jokes about the only time he saw a nurse was when they bought him food and stuff when it wasn't me…he was a lovely guy, we got on really well. He picked up on the way every staff member, bar me, responded to him and that hurt him. One time a registrar palpated his pedal pulses and then ran out of the room in front of him. It was so ridiculous and terrible and I felt guilty and so embarrassed. I would have loved to just yell blue murder and say look what are you all doing? But you can only do so much as a student because you have to maintain a certain level of support. There's a felt position that will cut you off and you need to stop. It's a line of support and you always have to maintain a certain level of support. I talked with him and it made it a little better. Communication and valuing has always been my strength, I find it really easy. I've always had quite an insight into psych and social stuff as my

Mum's a psychologist and he really valued it, he openly said so. The staff saw me talking to him a lot and I know that made them uncomfortable around me. I think for a while they did not know what to say to me. You see everyone else labelled him as difficult. He'd tried and successfully advocated to have surgery after initially being told he couldn't because he was going to die from HIV, but he'd never even had an HIV related illness. They happily offered the 86 year old lady next to him surgery. The staff would bitch and moan about him and I would be there. I would never join in and they were aware of that and I think they bitched and moaned more to try to recruit me, you know come on our side, we are actually right. It was really difficult, I felt a huge obligation to try and make up for the staff. It was something I put on myself; no one else put it on me so I did other jobs as quickly as I could so I could spend time with him, as I felt so sorry for him.

Isabella is working with staff that all see this patient as difficult, deadly and someone to be avoided. She, on the other hand, sees someone very different. Isabella speaks of his loveliness, his intelligence and his assertiveness however encountering and accepting difference means she also experiences the hurt created by stigma and judgments. Her response to this is to feel so sorry. Yet her sorriness only adds to her being different and being different, Isabella tells us, is really difficult. Perhaps this is because she is alone, with no one understanding the huge obligation she is feeling.

Yet feeling obliged to someone doesn't always mean we act on this, it just means Isabella is experiencing feeling obligated. Knowing she can't take away the staffs' hurtful attitude and behaviour she can continue feeling obligated, or act on this feeling. Either way she is making a decision. In making this decision her personal responsiveness means she is unable to ignore the sorriness and the hurt of this patient. Isabella, like Lexie, also shows us about her hope. By using her knowledge concerning HIV and her desire to care, Isabella is hoping to make things better for this patient. Hope is the catalyst and it pulls her into this situation. Knowing she is alone means the experience of keeping things 'nice' begins by Isabella placing the responsibility of undoing the isolation and separateness and reinstating this man's humanness on her.

Keeping things 'nice' is visible firstly by 'undoing' work. This begins by reorganising time. Isabella sees time as something that can be given or taken away and in this

story it needs to be taken. Isabella shows us how she chooses to do this. She starts by increasing the pace of her work. Isabella 'speeds up' and rushes through her jobs with the other patients. However changing the pace of her work means changing her relationships with the other patients. This undoing work makes visible the difficulties in maintaining the ethical notion of treating everyone the same. Other patients are now seen and treated differently. They are seen as a way to 'make up time' and Isabella submits them to her rushing. However rushing patients brings its own difficulties for the carer and the cared for. Isabella must work amongst the tension between her obligation towards this one patient and meeting the needs of others. Perhaps she experiences this as feelings of anxiety and frustration, especially if patients don't respond to her rushing. Maybe the other patients felt a little isolated and separated from Isabella as she rushed their care. However what seems to matter most is that time has been made up to spend with an isolated patient and this seems to justify the rushing aspect of 'undoing' work. Being ethical it seems can be shaped and changed by the quality of time.

This 'made up time' appears precious, not only as Isabella has worked hard to get it, but also it allows the 'undoing work' to continue by 'making up' for staff. Suffering or hurting strikes at the very root of nurses' ethical practice therefore 'making up' is important. The experience of 'making up' is one of reaching out to this patient and drawing on her strengths, which are communication and valuing people. 'Making up' means Isabella talks to this patient and through talking she shows us about the giving and receiving that constitute this relationship. Isabella's giving is her comforting caring talk that creates an atmosphere of support and makes room for individuality, dignity and autonomy. In return she receives and experiences the appreciation from this patient.

Yet continuing to keep things 'nice' for this patient also means she must talk a lot. Is keeping 'making up' talk flowing easy to do? When he made jokes, how did she respond? I wonder if she laughed at the one about the only time he saw staff apart from her was when a meal was delivered. What effect did the uncomfortable gaze of staff have on Isabella's 'opening up and making up' talk? Perhaps the difficulty

she speaks about is also the experience of being watched over by disagreeing staff whilst keeping things 'nice'.

There is the sense from Isabella's story that as she sits or stands talking, keeping things 'nice' also involves guarding this man against the isolating and separating effects of the joint force of others. However even standing guard fails at times and both Isabella and this patient must experience the effects of this failure. As her guarding fails, Isabella is left watching a doctor bolt out of this patient's bed space, as his fear of touching an HIV patient overtakes him. Experiencing the visible fear of others means the 'being-with' and making up is difficult. What could she say? Perhaps the easiness she speaks about concerning her communication skills suddenly isn't that easy. Gadow (1999, p.64) believes that in joining another in vulnerability that I myself may become vulnerable and the other's pain may silence me. Maybe she needed to reach inside herself to seek new ways of relating. Or perhaps this is the time where keeping things 'nice' means all she is able to talk about is her guilt and embarrassment.

As Isabella continues to keep things 'nice' for this patient over subsequent shifts, she shares something of this experience. Being-in-the-world is like being a tap, open at one time and closed or shut at another. When the bitching and moaning recruitment campaign starts she knows that in keeping things 'nice' she must 'close down'. However there is a sifting process to be undertaken when listening to staff, as it is necessary to separate the 'shutting down' times from the 'opening up' times in order to be alert to the talk that concerns care of other patients.

Keeping things 'nice' is part of her being-in-the-world and to sustain this Isabella positions herself in a space between the patient and the staff. This is visible as her switching space. She shows us she must switch between 'being closed' with staff to 'being open' with this patient, but how easy is this? James (1992, p.500) considers the emotional component of care, like the physical component, is labour in the sense of hard work. How many switches does Isabella make in a day? Is the walk from the nurses' station to this patient's room enough time to make her switch? Maybe this has elements of trial and error as much of student learning has.

Isabella's switching to 'being closed' often involves making her body hold in its anger and desire to yell blue murder, while at the same time pretending nothing is wrong. Maybe though, there are times when stifling anger is hard and feelings of wanting to yell, "what are you all doing" fights 'being closed off' and tries to escape, rather like a jack in the box.

Isabella feels she cannot change the wider context of the situation as being ethical is also experienced as being confined by a line erected especially for students. Kelly (1993) claims that students are clear about the price to be paid for living up to their ethical ideals and keeping things 'nice' means working within this student space and being hostage to its power. The effect of being in this space is one of being unfulfilled as you can only do so much. Past experiences rather than speculation seem to be ensuring Isabella's does not step over this line but how has she arrived at this place of knowing? However there is the sense from her story that she has come to terms with working within a 'student space' by accepting this is just the way things are for a student. Yet accepting these constraints illuminates the fear in the experience of being ethical. Ethical care involves making choices and the fear of choice that Paterson and Zderard (1976) speak of becomes evident in this story. Being fearful-in-the-world is experienced as continually deliberating about choices of care, along with deciding whether what she wants to do will mean being abandoned from essential student support.

There is a sense of certainty in Isabella's actions that shows the significance of knowing oneself and having the inner strength to use one's knowledge of self in being ethical. She also shows us that being a student means being unable to control the actions of others. Responding to this understanding involves balancing out what is and isn't achievable and doing the best one can. Alongside this, we also see the difficulties of being ethical when neither Isabella nor the staff show an understanding about the situation beyond their own.

However being certain of her actions is something the student in the following story has difficulty with. This story captures the experience of keeping things 'nice' when

being uncertain about whether to tell a patient the truth. Consider Lexie's second story.

Lexie's second story: being uncertain

A regular renal patient came in; she was young, the same age as me. She was really cool and inspirational and I had a really good relationship with her. She's got no kidneys at all, and she knows when she's got high potassium and when she's going flat. She told me that she's going to need a heart transplant soon. She'd been in this situation for years. She knew her body and knew about ECG's. While we were talking she said to me, "I just don't want this ECG to be bad because I know that it's getting closer and closer for another operation and another bit of me that is going to go". I did her ECG and after taking it I knew enough about them to know it didn't look good, but I had it in my hand and she asked me if it was bad. I could see the T waves were quite peaked and she kind of looked at me, then I looked at it, and then I was looking at her and then I was looking at the paper and I was thinking do I tell her. I was sort of thinking, and she kept just looking at me, pleading for me to say something and I'm thinking, oh my gosh. My face I know shows it all, it's hard when I know I'm not meant to say something and I have to be blank. I'm not very good at doing that sort of thing, its quite hard. I felt like I wanted to tell her. She knew, I know she could tell from my eyes but I looked up and said I'll get one of the doctors to look at it and I almost ran out of the room with the ECG machine. It was in such an awkward position, but I was scared, I know this sounds silly but I didn't want to hurt her. I was sure of the peaked T's but I didn't want to get it wrong…. I was right the doctor told me.

Feelings of attunement and connectedness result in Lexie getting to know someone who is cool, inspirational and who knows her body as being either in or out of balance. Through this reciprocity Lexie considers she has created a good relationship with this patient but as the ECG results glide out from the machine Lexie knows enough to see this paper as trouble. Tearing the paper from the machine Lexie holds trouble and it feels as if she has this young girl's body in her hand. Seeing the peaked lines on the paper, their relationship is the same but also immediately different. The technology has drawn what was in the dark. It is now visible and in the visibility lie the tensions in answering "is it bad"? As issues of truth telling are interwoven with the concept of respect for persons, keeping things 'nice', while being the same and being different, become visible in Lexie's uncertainty about how to answer.

Knowing how best to respond within the moment in situations of uncertainty is not easy and the feelings of uncertainty spread through Lexie's body so it resembles that of a tennis umpire. Her head moves back and forth, from the paper to the young girl, from the young girl to the paper. However unlike the quick change of direction as the ball is followed by an umpire, she lingers longer at each end, firstly to check to see if the peaked T's are still there and then moving to the other end to see a 'kind of look'. What kind of look was this? She doesn't tell us but whatever the look revealed it sends her back to the other end to check the paper again. Seeing no change, she moves back to the young girl. The to and fro movements of uncertainty are helpful by creating time to consider this situation, however wrestling with uncertainty is also conspicuous as a hide and seek experience.

Being uncertain suggests she is hiding her understanding concerning nurses and their 'licence to tell', only to seek this out later. Perhaps in hiding away this understanding she is showing us her way of being-in-the moment is one of experiencing the tensions of respecting rules and respecting the person. These tensions become evident in the struggle to accommodate concerns for this patient along with her own, as Lexie knows that nurses in this department can share certain test results with patients and this is not one of those.

Lexie also shows us that the experience of being uncertain is also one of doubting self. Side tracking into self-doubt means questioning your knowledge base even when you know you are right. Perhaps Lexie's self-doubt makes visible the conflict in keeping things 'nice' when professional and personal understandings differ. She tells us she wants to tell the truth and acknowledge this young patient's understanding of her own out of balance body however concern not only constitutes itself but is also constituted by the world of practice. Perhaps her self-doubt makes evading the truth easier. Maybe it's easier to lie about or evade the issue by convincing yourself you may be wrong and that you could hurt someone. Or possibly self-doubt is part of Lexie's ethical reasoning as it gives another perspective on this situation. Possibly her self-doubt is just a way of providing momentary relief from the hardness of keeping things 'nice'.

However, being uncertain means Lexie must endure the impact of her uncertainty on this young girl. Being uncertain means she must look at eyes that are pleading for an answer. These pleading eyes are powerful and they make her come to the realisation that she must bring her uncertainty to an end and answer the question. Yet there is the sense from her story that the experience of answering the question is one of being deprived of choice. Being encumbered by rules means being unable to think and act independently and this becomes a barrier to choosing freely how to respond. It is possible that Lexie may have made the same choice but when rules invade the being-with a patient how possible are the possibilities in keeping things 'nice'?

While Lexie's experience of keeping things 'nice' is one of wanting to tell the truth, the behaviour expected of her is to be blank. Suppressing what you know is easier said than done when it is prescribed, but previous experience helps. Lexie knows the talking part is achievable but she is anxious about her face. It shows it 'all', especially her eyes. Knowing this, maybe she tried something new. Whatever she tried her eyes disobeyed and delivered the truth. Her uncooperative body has been unable to sustain her evasion possibly showing us that detachment and objectivity are not congruent with being ethical. Running from the room captures her next experience of keeping things 'nice', as how else could she close herself off and be blank in front of this patient? Perhaps her running out also highlights that being respectful is grounded in actual persons, which means the experience is one of being particular, personal and emotional.

Ethics concerns a commitment to the principle of truth but this story illuminates and holds open how principles do not accommodate timing or context easily. It also shows us that the tensions of the social and contextual side of ethics only become visible when they contradict intrapersonal expectations of doing good. And perhaps this story also exposes the situation that there is an expectation that students will know how to act and 'be' when asked to be deceptive which calls out to teachers to consider the preparation of students. Possibly it further calls out for nurses to address the oppressive conditions that constitute their working environments.

The next story also involves intrapersonal understandings of doing good. Yet the experience of keeping things 'nice' for this student is made visible through her past present and future. Here is Mia's story.

Mia's story: walking away

It's a very busy ward, it's stressful, short staffed and everyone is rushing around and they are trying to find the quickest way to do things but it isn't always ethical…I find patients get coerced into things. There was this patient and I was going to help the staff with him but I just had to walk away, I couldn't stand the way he was saying, "I don't want this done to me right now". I was thinking am I only one who is hearing what this man is saying, but he was just ignored, rolled over, told it wouldn't take a second and had suppositories 'popped' in. I was so angry; as to me this is abuse. I had to walk away but they were already doing it and walking away actually doesn't help that much because although you are not involved I actually felt involved anyway. You still have that guilt, and I felt like I had done something terrible.

Busy and stressed staff ask Mia to help them with a patient but as the staff are getting organised this patient delivers a message to those around him that this is not something he wants done to him right now. The message seems to slide off all other staff only to land on Mia. She is quite surprised at this as she can hear it, why can't the others? Mia is left holding this patient's message but rather than responding to the patient's need, her concern is the meaning the 'being-with' has for her. Being with staff as they ignore this man and roll him over exposing his buttocks to have suppositories 'popped 'in is something Mia knows as abuse. Abuse seems to have a special meaning and walking away appears her only choice, as saying something now seems just too emotional.

In searching for meaning in Mia's actions Heidegger tells us that time must be brought to light and genuinely conceived as the horizon for all understanding of Being. Our past is not something that follows along behind but something that travels ahead of us. Smythe (1997, p.120) writes that Heidegger suggests the 'is' of Being is not a mere chance set of behaviours. We act out our Being in the light of all of our being that has gone before. What might Mia's walking away in keeping things 'nice' show us of her past? Mia continues her story,

I suppose because of the things I have gone through in my life I feel nearly 100 years old. I have been through such hardship, if you had boxes to put it in and say this sort of hardship and that sort of hardship, I could fill all the boxes. So I keep to myself, I'm quite alone in myself, my personality, I'm quite used to standing alone. Being alone I find it easier to challenge because I don't really mind if they don't like me. I'd care if they thought I was terrible but if you want to get along with people it would be quite hard to say no when they tell me to do it this way and I want to do it another way.

Mia tells us that the experiences of a 'century' of hardship travel ahead of her. Through her '100' years could she too have been ignored and abused, perhaps as a child, or as a daughter, as a wife, as a patient? Possibly she has said no to abuse and walked away before. She knows walking away is not fearful. Walking away and not going along with can be liberating, as in 'being alone' is the 'being able to disagree'. The hardship of her past creates a separateness from other, which brings a sense of safety in being-in-the-world with other. However being alone and being able to disagree doesn't mean being able to change things for this man. Crotty (1996) reminds us, " one may be without others…one is never without others" (p.85). She has heard this man and seen what happened. She is a part of what happened and although she didn't actually 'go along with' she is left feeling as if she did and like Louise she also has guilt sticking to her. She again experiences surprise in feeling guilty by association.

Emotions can be considered as modes of attention enabling nurses to notice what is morally salient or important in themselves and their surroundings (Gastmas, 2002). Mia tells us she is so angry about the abuse of this patient but maybe her anger is also telling us about being-in-the-world of practice. Mia is experiencing the world of practice as busy and stressed where patient care is compromised. Stressful, busy and short-staffed wards are a reality now and in the probable future. Perhaps her anger is fuelled not only by the past and the present but also the future. Possibly Mia's 'not going along with' as a way of keeping things 'nice' is something she is fearful about in her future. Maybe she is already thinking that one day when stressed and busy as a new graduate she may have to let patients' voices slide off her and that she will need to stay and help in giving compromised care.

This story challenges the taken-for-granted assumption concerning the relevance of clinical practice experience in being ethical. The assumption is that students are novices in practice and this perception often pervades the being-with staff. Yet students' lifeworlds can mean they have a wealth of understanding and expertise about the underlying human responses that accompany ethical situations. Furthermore the notion that being ethical can be removed from our Being, is also called into thinking about. Perhaps students' lifeworlds and the experience of staff are both necessary in being ethical with neither sufficient as students are relatively new to the world of nursing practice

Similar to the previous story, the concluding story concerns keeping things 'nice' from a temporal perspective. However this story shows us keeping things 'nice' is never free from one's culture. This student has had a career as a health professional in a different culture and he makes visible the cultural connectedness in being ethical. Hamish shares his story.

Hamish's story: containing anger

In China because it's a different culture, we sometimes treat a patient and call that patient just by a number, like number one, number two, bed five or bed three. We do not call a patient by their name. But here you show so much more respect for the patient than in China. Here you should appear professional and meet the patient's needs. I think nurses should understand patients and to deeply understand patients you must put yourself into the patient's position. But in New Zealand this is hard for me if for instance I feel angry inside. In China you just straight away express that you are angry to the patient but here I need to hide my anger, hide that I am unhappy. One night a patient refused to take a panadol but in her situation she needed to take the panadol. So I spent ten minutes with her just persuading her to take a panadol and she still refused. I got so furious because I had another job to do so I couldn't spend a long time with her. I just compared this with China. They never ask the patient's permission but here I always ask a patient's permission. In China you come to hospital and it is my job to treat you so you must accept it although you may dislike this treatment you should still accept it. But here, using respect sometimes makes me so tired because you always have to ask the patient's permission and you always keep your face professional and it's so tiring and hard.

Benner and Wrubel (1989, p.409) write that a habituated body is one that includes all culturally and socially learned postures, gestures and customs. However being a recent immigrant to New Zealand from a vastly different culture means Hamish's habituated body has lost its taken-for-grantedness in the world as a health professional. Knowing that an angry body is not respectful in a New Zealand healthcare setting means keeping things 'nice' is evident in Hamish's containing body. This containing body must fight back a decade old response and capture initial rushes of anger before they escape. Once caught, holding this anger captive means Hamish's containing body must continue containing by stifling, hiding and holding in furious feelings. Stifling, hiding and holding in is hard work especially in relation to his face, as maintaining a professional face means using facial muscles to keep a smile planted on his face. However at times this face work fights his habituated body to remain, rather like being at the dentist when you just want to close your mouth, as your jaw aches to return to its natural position.

Hamish's containing body must also restrain its voice. Again this constitutes hard work. He must hide his irritation and maintain a friendly tone in his voice whilst getting patients' consent for care and dealing with individual requests. Being-in-the-world that encourages individuality and choice is new and strange and the constant effort to be ready to do what is appropriate is tiring. Hamish's containing body shows us that feeling tired and feeling exhausted constitutes being ethical. His weariness also seems to be pointing to his wish that, despite thinking a New Zealand perspective on being ethical has merit, there are times when he just wants to feel comfortable and at home in a familiar world. Perhaps his being tired and exhausted not only pertains to maintaining a containing body but also to working through his sadness and senses of loss of no longer being in a taken-for-granted world.

Keeping things 'nice': bringing the meanings together

Keeping things 'nice' is concern for and protection of self when caught between differing voices. Being an ethical agent implies taking care of others but finding themselves caught in relationally complex situations, students realise that ethical

possibilities for action outstrip the simplications of rule bound moral frameworks (Bowden, 1997, p.109). Therefore being ethical as a student coexists as taking care of others and taking care of self. Concern for self means seeking out ways to protect themselves when actual or potential threats challenge their espoused ethical practice. Chapman and Orb (2001) claim that students are in a constant process of internal negotiation while in the clinical arena. Keeping things 'nice' shows ways and meaning of protecting self by compromising with self and with others within the context of a social organization. The specific ways emerge from the combination of the lifeworld of a student and their understanding concerning the degree of the threat. However it also means their ethical practice falls short of their expectations leaving students in conflict and in a place of limbo between being themselves and not being themselves.

The meaning of keeping things nice, as being fearful, is also relevant. Fear is the state of alarm or dread (The Shorter Oxford English Dictionary, 1973). Fear devolves or limits their identity as ethical agents. The fear of being rejected as 'one of the team' or fear of our past, meant that students were not the ethical agents they espoused to be. Fear also ensures differing degrees of silence within students yet paradoxically, responding to fear through being silent also means being hopeful that their silence will also keep things nice. Silence is accompanied by emotions such as disappointment in self, guilt, anger, helplessness and vulnerability and their student bodies are called forth to hide and stifle such feelings. Using their bodies in this manner ensures that moral distress, as a student, is overwhelmingly a corporeal experience. Both Woods (1997) and Mitchell (2002) consider the passive or 'doing nothing' involvement of students in ethical situations. In considering the meaning of keeping things 'nice' it shows that 'going along with', or containing anger involves hard emotional and physical work, thus offering another way of considering students' involvement in such situations.

Keeping things 'nice' also has meaning for the contrasting demands of education and practice. It is a reminder that students have a clearly delineated value and status within the clinical practice arena, which affords them little control of the

clinical environment, yet at the same time they are being held both academically and emotionally accountable for their expressions of being ethical.

Conclusion

In the reality of the clinical setting students experience the interconnectedness of ethical practice. The theme of keeping things 'nice' has been shown as the ways of and meaning of compromise, as students come to realise contextual and relational forces constrain both their identity and ethical action (Hartrick Doane, 2002). Holding the good of the patient as their ethical aim is never free from threats to both their professional and personal self and keeping things 'nice' is the way students make decisions about how to respond to protect self. This chapter has also shown that keeping things 'nice' concerns the ways in which students work through the separation of their identity and their ethical action. This separation is often justified in terms of the powerlessness associated with being a student or for one student the overwhelming influence of his embodied knowing.

The theme of keeping things 'nice' has shown how students compromise and adapt what they believe is right in the midst of threats to themselves. The following chapter shows how these threats to self can also be considered as opportunities to be the ethical agent students espouse to be. The following chapter, "Being true to yourself", shares the experience of students as they strive and struggle to unite their identity and morality (Hartrick Doane, 2002).

Chapter Five: Being True to Yourself

Introduction

In the previous chapter I showed how being ethical encompasses 'being oneself yet not oneself '. Not being oneself means compromising one's ethical integrity in a way that leaves the student feeling incomplete. Through five stories, the aim of this chapter, "Being true to yourself", is to show that in certain circumstances the students felt a strong need to be the kind of student nurse they believed themselves to be. These five stories show ways in which students unite their identity and morality by overcoming personal, social and institutional barriers to ensure care to patients is grounded in their ethical ideals.

Students' ethical ideals emerge from their lifeworlds, which includes their immersion in a nursing programme. Threats to these ideals can become the impetus to preserve their ethical integrity by taking action to achieve these ideals. Taking action means keeping silent is no longer possible and students must find the courage to speak up and meet self-expectations of doing the right thing. This chapter begins with a story where a student's understanding of respectful care for the elderly is threatened by the institutional culture. Consider Mia's story.

Mia's Story: speaking up

> *I find it really quite hard at times to see how other people are deciding elderly people's lives for them. They are not all old and confused and it doesn't mean that they are confused just because they are elderly. I found it really awful at the three health services meetings for the elderly I had been to, how they were putting all the confused elderly in one little box saying they are confused therefore they need a rest home or private hospital care. A lot of patients that come to the private hospital where I work as an aide, really don't need to be there and by being there they become institutionalised and therefore do need to be there and it is so disheartening. At the last meeting I attended they were discussing placement decisions about a 92 year old lady I had been caring for. Because she was 92 it was thought she was too old to live at home. It was terrible because they were going to re SNAP.[1] her and put her in a*

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[1] SNAP is a term that abbreviates Self Needs Assessment Protocol

rest home just because she was confused at the time. It was just assumed she must always be confused. It was just the fact that she was dehydrated and they hadn't gone into why she had suddenly become confused. It just seemed to be ignored that she was fully mobile and independent before coming into hospital. The family had said to me that there must be more to her confusion but no one seemed to listen or seem to worry about the reason for the confusion, it was all, "we need the bed, we need the bed, we need the bed, we need to get her out of here so its either a rest home or private hospital". Towards the end of the meeting I had to say something. I had to remind them that she wasn't like this a few days ago. It felt really good afterwards because she was dehydrated and she did have a urinary tract infection and once we got her drinking again and we treated her infection she wasn't confused and we sent her home. I thought it was terrible because here was a wonderful lady who has got to the age of 92 and been fully independent and to just take all that away from her would have been such a shame.

The rights and care of elderly patients have a special meaning for Mia. Her health care assistant job in a geriatric hospital has contributed to her belief that decisions made at these Health Care Services for the Elderly meetings are significant to maintaining the individuality and dignity of elderly patients. However prior experience of two of these meetings has left her feeling unsettled as her taken for granted understanding of being ethical is often ignored. She feels some of the decisions being made leave patients stripped of their autonomy and their potential to be all that they can be. She expected talk that wonders and worries, questions and considers the vulnerability inherent in being an elderly patient, especially elderly and confused. Instead she witnessed 'taking up a bed' rhetoric that left her feeling elderly patients were considered as things or objects and that staff were concerned more with the institution than the individual. All together this leaves her feeling really disheartened, as she has seen that negative things happen to elderly patients when domination occurs.

This wonderful and confused woman matters to Mia and she does not believe she is a candidate for the 'confused box'. She has come to know not only a confused person but an independent woman who just a few days ago was caring for herself in her own home. Mia can see that fixed attitudes preclude other possibilities and she seems to know that this is the time to be true to her self by confronting these

differing values. Our actions it seems surface what matters. Why else would she find time to go to something that was optional but which she considered terrible? For the third time Mia feels awful while listening to talk that excludes what she believes matters. Sitting through talk that makes you feel awkward is seldom easy, so how did she do this? Maybe she squirmed in her chair or hung her head and looked at the table or floor as I do in such situations. However her feelings of awfulness also alert her to what matters and in being be true to herself she speaks up. Yet why did she wait until almost the end of the meeting before speaking up? Perhaps she was being courteous and giving others every chance to realise that hastily dispatching this lady to a private hospital on the basis of her recent confusion was based on a superficial assessment. Or maybe she saw herself as the newcomer and just waited as a form of respect. Possibly it just took this long for her discomfort to reach its threshold of tolerance. Perhaps there was one piece of talk that finally makes her realise she just had to speak up. Perhaps it was the '*we need, we need, we need*' bed space chorus that reminded her that she had to remind them about their assessment of this lady.

Berman (1994, p.12) believes that being called to care means having a voice and entering into relationships with the other. Is it easy finding one's student voice to speak up and respect your views when others about you do not? Speaking up means inviting others into thinking about things in a different way. This involves dropping in fresh questions that call forth more thinking about the elderly, with the hope of turning the conversation around from what McCormack (2001) describes in relation to the elderly as "speaking for you" to "speaking for me" (p.161). How did Mia begin? Did she quietly wait for an opening in the discussion or did she butt in? Was it necessary to raise her voice to get others attention? And how did the group react to Mia's speaking up? Being reminded about this patient, she was also reminding them about the limitations and shame of care that is not individualized and which ignores the resources and abilities of elderly people. I have found that being reminded by students is at times refreshing and from time to time a relief, however at other times it can be irritating.

By speaking up Mia shows us that 'being true to yourself' is the experience of being an individual who is prepared to take risks and have the courage to defend one's beliefs. In making room for her beliefs Mia was also making room for the consideration of care options that had been covered over and hidden as health professionals are pressured for 'throughput'. Furthermore as the struggle for the bed space unfolded in this story perhaps we are being reminded that being ethical is never free of the social and political forces of a health care system. Maybe we are further being reminded that nursings' contemporary philosophy, which is enmeshed in humanism and articulated through patient centeredness, is struggling to be heard in today's health care organisational management culture.

The next story further explores a student's experience of trying to fit her beliefs in to practice. She considers the pain management of a patient does not reflect her understandings of ethical care. Anna shares her story.

Anna's story: sticking to it

I was looking after a young Japanese exchange student with abdominal pain, she had been in and out of hospital about four times with the same complaint but nothing could be found. The situation was really difficult. She was in a foetal position rolling on the floor in pain one minute and the next going down stairs for a cigarette. Nobody believed she had pain, they thought it was all in her mind. A lot of it could be, she was in a country culturally different from her own but I tried to explain that she was in pain, that I had seen her on the floor, that's not made up. And she was showing signs of depression which is a big sign of pain. To me it was pain, no one except me believed she had any pain but you can't say she didn't have pain, psychological pain can become physical pain, I believe so anyway. So she wasn't really being treated and she refused to have medication apart from panadol if the pain became excruciating but I don't think she'd actually had any explanation about the analgesics and how they weren't going to harm her. So I tried to organise some strong analgesics and explain their actions to her and I was trying desperately to advocate and be non-judgmental. But you are stuck in the middle, its difficult and you are trying to get yourself out of being in the middle of that situation where I felt powerless. The doctors not believing she had this pain and my patient saying that she has 9 out of 10 pain, you are sort of stuck in the middle, it's the real nurses they go by as you are not quite there yet. People look down on you because you are a student but I've done this almost three year training, I do know what I am doing and they are sort of saying it is worth nothing at the moment until you have

actually got that registered nurse badge. You're just stuck, you do feel really powerless, because there is nothing that you can do and you are trying so desperately, but nobody wants to know and no nurses support you because they didn't believe she had pain either. It was just me stuck in the middle feeling inadequate but eventually I finally managed to talk them through it and got something through and her pain was relieved. It felt good to finally help her after all that work but it was a pretty poor situation to be in.

Anna is drawn to the space left by others. Watching a patient climb off her bed and seek the hospital floor as a place to express her pain is something Anna seems unable to disregard. Seeing this patient on the floor of a busy adult acute hospital appears to ignite her distress and her strength to resist distancing herself from this patient's pain. Being-there with pain at her feet as this patient writhes around resorting to the foetal position is not something she can ignore. Yet in responding she is alone as the '*real nurses'* no longer react, having slotted her into the 'not real pain' category.

In responding, Anna's values of compassion, empathy and a desire to help become visible. As Anna watches pain overwhelm this woman's body maybe she tried to comfort her. Possibly she crouched down on the floor to be closer, as how do you comfort someone standing over them? What would be the challenges in attempting to use comforting touch on a writhing body expressing its pain in a language that Anna probably doesn't understand? Perhaps while being physically close Anna was able to see the impact of pain on this patient's face and what she saw was the face-to-face result of ethical detachment. Perhaps this face made a claim on Anna as van Manen (1999) suggests that in being face to face with other, one is taken hostage in a manner that is initially beyond our control. Maybe she kept returning to these images for help to keep her call to care ongoing when she felt stuck.

Peter and Watt-Watson (2002) claim that although pain is a private experience it is possible for one person to experience vicariously, through close intersubjectivity, the pain of another. So how did Anna feel while pain visited this patient? Did she experience the pain also? Perhaps this dragged Anna further into responding and

doing something to help not only this patient but also the others in the room. In this story the other patients who occupy the room are silenced, but what effect did the writhing around have on them? How effective can hospital curtains be in this situation? Possibly this patient's pain had a voice as she sought the floor, if so, was this agonising for those that listened? Maybe this made the other patients feel caught in the middle also.

The relief of pain is central to nursing care hence pain assessment is crucial to managing the complex issue of pain (Allcock & Standen, 2001). Anna knows this 'is pain' because to her pain is private, personal and culturally embedded. She also believes that pain can be fickle. It can visit, leave and still return all in the short space of time. However having a frame of reference and putting it into practice amongst evidence tensions is another thing. The experience of being true to oneself surfaces the complexities concerning the truth when nurses judge someone's pain.

Van Manen (1990, p.102-3) writes that we know the space in which we find ourselves affects the way we feel and that there are cultural and social conventions associated with space that give the experience of space a certain qualitative dimension. Anna is a pre-registration student and although as noted previously, this brings a certain blurring of student and registered nurse boundaries there is still a separate hierarchal space that the culture of nursing channels her into. Anna describes this as the '*not quite there yet'* space and occupying this space has implications in 'being ethical'. She shines some light on this space as she tries to organise 'proper' pain relief.

'Being true to yourself' in this space is experienced as struggling to be heard along with feelings of discouragement. Anna tries to connect with staff and assert her point of view but the attention she received was minimal, as their replies were empty of the support, assistance and encouragement she was seeking. There is the feeling from her story that the experience of struggling to be heard is also one of pleading to be considered as someone with credible knowledge concerning pain assessment. The experience is layered with the temporal aspect of hope when

Anna describes how she wishes she could break through the notions of 'real nurse' and 'unreal student nurse' and be heard. Feeling simultaneously able and disabled leaves her feeling bad. Perhaps her feeling bad also speaks about the threat this brings to her professional self. We can hear a tone of resentment in this story that concerns the threats to her knowledge and confidence acquired during other placements.

In trying to relieve this patient's suffering Anna comes up against the strength and prevalence of nursing and medical staff that leaves her feeling she is going nowhere. When no help is offered the experience becomes one of feeling squashed and caught in the middle between staff and this patient. Together these feelings result in Anna believing she is powerless and inadequate. Being squashed cannot be pleasant and in working with these feelings as she fended for herself, perhaps there were pockets of time when her struggle just felt too hard and complicated as the situation seemed unalterable. Maybe in being squashed she was tempted to rescue herself with a quick fix solution and leave this patient alone with her pain as others had done. However Anna keeps these accompanied thoughts quiet and instead shows us how being true to herself embraces rescuing herself.

Berman (1994, p.13) speaks of mobilising ethical and intellectual energies to provide actions in times of patient suffering but rescue plans that overcome the attitudinal and relational barriers are limited when you are unsupported and caught in the middle. Yet Anna is able to come up with one, and that is explaining. Were there other options that she just couldn't see and if so what might these be? Explaining encompasses explaining to the patient, to the nurses, to the doctors. How do you start explaining when staff do not want to know? Did she pick random staff or did she sense that some might be more open to her explaining than others? She doesn't tell much about the explaining but we know it must be non judgmental, involves advocacy and takes time. Explaining is also experienced as persevering and remaining strong, which is hard work. What did she say as she talked the staff *'through it'*? Perhaps she talked of things that drew them closer to the patient as Madjar (1999) believes that patients in pain are ultimately distanced as a coping

mechanism for staff. Did Anna choose something different for the 'nurse talk' compared to her 'doctor talk' as it is the attending to human need through the subjectivity of patient's experiences that nursing argues its difference to other health professionals (Peter & Watt-Watson, 2002).

While 'being true to yourself' means feeling despair and frustration that may not succeed, the experience is one of joy when you do. Overcoming barriers to relieve this patient's pain feels good, perhaps as her own vision of herself as nurse has come to fruition. There is a sense of worth that accompanies the hard work of students if their values are given expression through their practice. Yet feeling good is tinged with feelings of disappointment in that being a student meant having to struggle to get what was right.

This story supports Johnstone's (2000) understanding that nursing ethics is often grounded in the how to help a patient in distress in the here and now. Johnstone also claims that nursing ethics involves knowing how to stop things going bad for a patient (p.113). In the following story the student finds herself in such as situation. Consider Alice's story.

Alice's story: being unwilling

An elderly man went into hypovolaemic shock, he was my patient for the morning and when I got there after report he actually was icy cold. So first I grabbed a blanket, took his observations and that's when I recognised that this man was heading for problems. Throughout the whole time I was talking to him and he told me that he had kept telling the night staff he was in pain and I recognised all those signs and symptoms straight away. He was in a state of shock, so I rang the bell immediately and a staff nurse came over, I said "get the doctor" and she says "no doctor". She said, "no, get the blanket first", so again I said, "I think he needs a doctor" and she says, "forget the doctor". The other thing too, we discovered that his colostomy was full of blood which is not a good sign but she says, "get the blanket, the special blanket", I said, "no, no". I was so anxious and I said, "get the doctor please" and she says, "well if you get the blanket", I said, "what's the blanket got to do with it ", and she says, "it will help". This is where I get so annoyed and I get so frustrated. I was angry, I was arguing I realise that. I got so angry and frustrated about the things I wanted to do by myself but being in the student category I also felt that okay, being a student, well you do as you

are told. I knew that to save all the hassle, the thing to do was to get the doctors there quickly because this man was quite sick. So I got the blanket but by the time we put the blanket on he actually started coughing up blood so this time I couldn't wait. I felt this is where you advocate and I always believe if you are caring you respect yourself and that person, and I so desperately wanted to help that man. I didn't bother to ask her anymore, I just put him on his side and rang three bells. I had to do so and I didn't care whether she said, you know you shouldn't press the buzzer because when they arrived they discovered that he was heading for a serious crisis as by then he was starting to drift off.

It is not the fact that the patient was icy cold and in pain that bewilders Alice, this is something she recognises as hypovolaemic shock. She knows what is needed, a doctor to review the colostomy bag full of blood attached to a freezing patient. She also knows what to do: that is to get help, but when the help arrives it is not what Alice knows is needed in this situation. Hearing the response *'no doctor get the blanket'* leaves her bewildered even if it is a special blanket and her bewilderment means she needs to check her understanding of this situation again. She repeats her request, perhaps wondering if the staff nurse had heard her correctly but the staff nurse had heard and she had also seen the blood in the colostomy bag. Again Alice is left bewildered. In this situation she can see that a blanket is going to make not a scrap of difference in this developing crisis. However now she is at least clear that it is the blanket before a doctor.

Alice shows us that despite disagreeing with the care in a serious situation, she continues to believe she must do as she is told. Yet leaving a patient in this state without the assistance they need and following orders that get in the way of immediate help, show us just how strong her belief is that must do as she is told. However doing as she is told in this situation is not something she does willingly and the tensions of being true to herself become visible in her unwillingness. Being unwilling sees her trying one more time to get help. She asks the staff nurse again for a doctor, only this time she adds a 'please'. Perhaps her 'please' is not only a please to get help here and now for this man but also a please do not send her down the 'do as you are told road' as this is wasting crucial time.

The experience of being unwilling is closely interwoven with that of working with the difference between what she believes is acceptable practice for a student and that of a supervising nurse. One cannot get out a ruler and measure the difference between Alice and this staff nurse but for Alice there is a difference, one she calls a '*student category'*. Alice shows us something of this difference when she considers she is unable to announce this emergency without permission. Knowing what one should do in an emergency situation but thinking this is not an immediate possibility shows the distance which separates the 'not quite there yet' student from the 'there' supervising nurse.

As this patient's body continues to tell Alice it is in trouble, being unwilling means living through the anxiety of this unfolding crisis. Being anxious causes her to try harder by arguing about the orders she is being given. However in being true to her belief of respectful student behaviour, contradicting can only go as far as arguing. Overriding these orders by picking up the bell and calling for further help seems something she is unable to do. Perhaps what further complicates this situation is Heidegger's thought that being anxious is always accompanied by experiencing darkness (Heidegger, 1927/63). He considers anxiety is like darkness, since in the dark one is surrounded by equipment and yet one is unable to use it. The solution for Alice seems straightforward. Pick up the patient's call bell again, buzz three times and get help from at least the twenty other people in the ward. But in her 'anxiety darkness', the call bell seems to have disappeared out of her view and maybe the staff nurse was also lost in her anxiety. We know she looked at the blood in the colostomy bag but perhaps this was also in darkness.

Alice's anger and frustration seem to announce her unwillingness as well. Yet just as being frustrated was part of this experience for Alice, it was also something I initially needed to work through. I ached for this student to just ring the bell and get help. However I came to realise this perspective did not take into view the historical and cultural aspects that come together to shape the truths of one's life. Being lost, even momentarily in the darkness of anxiety, Alice gives us the opportunity to see something further of being true to ourselves. In darkness we seek out something familiar as it helps us feel more comfortable. As we are all shaped culturally and

historically, possibly she regressed to the comfort of her familiar twenty-year-old role of an enrolled nurse, which also limits what she can do in practice. Or perhaps when she tells us, "*I think, as a Samoan you more or less care for others before you care for yourself and this was instilled in me I cannot deny that",* she found familiarity in caring more how the supervising nurse felt rather than herself.

This story shows us how being true to ourselves we are simultaneously engaged with the familiar and the new. Returning from her do as you told order, the noise of coughing and the sight of blood dribbling down this patient's chin causes Alice to quickly interpret the past from this new vantage point, as different aspects of this situation now stand out as important (Benner & Wrubel, 1989). This sees Alice becoming aware of a new level of being herself and being true to herself now means harnessing her anxiety and respecting her knowledge about what needs to happen. She stops asking and suggesting. She stops being worried about her relationship with the nurse and on her own takes control of this situation by making things happen to help this man.

The student in the next story also makes things happen. She is working in a primary health care setting that has a philosophy of taking health care to the people, her people. The organisation has decided to double the price of a certain contraception medication following a governmental surcharge increase. Here is her story.

Bev's story: not giving up

I was so passionate about going to a Maori health provider but I feel that the patients are still at the bottom of the heap and for me this is ethically difficult. They are supposed to take health care back to the people but when the surcharge on depo-provera[2]* is put up a little they immediately take it up to double what it was. Ethically I could not see why this was necessary and I had to open my mouth. It was terrifying but I am here for the patients and to advocate for the patients, our patients can hardly afford to come to the doctor. But it was, who do you think you are, you have been here five minutes, but I kept my ground and I kept arguing the

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[2] surcharge refers to the part funding from the New Zealand Government for the contraception medication depo-provera

point with the health professionals and administration staff executives. I was shaking like a leaf at times, and felt really alone, there was no support. I was told by one person that I should be careful of when I start saying things because I could jeopardise my position, and I told them, well I have only been here five minutes I am not worried. I won't be bullied, I have worked too hard and I believe in what I am doing, and I was going to stick to my guns and hang on in there. I got a few cold shoulders for about a week but I kept my body posture up and I didn't hide from anyone. I didn't have my lecturers and I missed my little haven of my nursing school. I didn't have my other peers to fall on. I felt really alone even though I'm a Maori and I was in a Maori establishment, there was no support, not one nurse came up to me to support me. But I kept being myself, I didn't sulk or be shy, I just had faith in myself and I put that faith and support back on myself, I just kept being me. I cried when I got home though, that's the only time I could release my sadness was when I got home to be with my family. But I hung in there and I kept arguing to the point where they have taken it further to discuss and in the end they agreed that I did have a point. Yet not one said well done or do you want to talk about it. I thought well I am the new one on the block, am I being cocky[3] and trying to put all this knowledge in and want to save the world in five minutes but I thought no, I have to because I was bought up by my grandparents and I learn't their values and the language of Maoridom first hand, not through a book but through the heart, they spoke it and they lived it. I am being made aware of what is ethically right and why shouldn't I practise it. I didn't have some of this knowledge before I went to school and that's given to us for a purpose, we must give it to our patients because that is what we are trained for, to help them, and it's been a good experience for me as I know if anything else happens I know I can speak up.

Bev's past present and future self flows from the heart of her grandparents, through her use of Te Reo[4] and her embodiment of Maori values. In her passion for the health of her people Bev was not expecting a management decision such as this. This decision not only brings a threat to her professional self but also her personal self and in her heart was the call to care as the call of conscience. For Heidegger conscience is in the nature of a call to our inner most potentiality for being our selves (Nelms, 1996) and for Bev the journey to her inner most self starts when she ' *had to open her mouth'*.

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[3] Slang term for over confident
[4] Language of New Zealand Maori

The injustice of this decision is something that Bev is unable to let go by as just one of those management decisions that nothing can be done about. This is something that needs confronting. In being true to herself she takes the plunge into the role of being a patient advocate by speaking out about what she believes. Speaking out involves finding the courage to support your conscience and going 'out on a limb' alone. Yet going out on a limb is far from easy and Bev makes us aware of how this can be. It is so terrifying that her body responds by shaking like a leaf. It means you are different and this exposes you to the taunts of staff while they try to knock you off the branch. Sadly this also means experiencing the bullying of one staff member. Going out on a limb appears to involve gambling with one's fragility, as you cannot predict what will happen. Yet the paradox seems to be that the threats and bullying only strengthen the commitment to her conscience. 'Being true to yourself' is sticking to one's beliefs and battling to assert one's point of view.

Berman (1994) believes that in being called to care there is a rethinking of what it means to be in places where dilemmas and hurt abound. This clinical area feels like a battleground yet Bev is determined to remain and fight this battle to the end by '*sticking to her guns'*. Battling for the patients sees Bev keeping herself visible to staff. Yet how difficult is it to remain visible and work amongst staff that are ignoring you and causing you such sadness? Perhaps staying close to staff was a battle strategy, as being close allows for persistence in arguing her point. Bev's body also helps show us something further of the experience of sticking to one's beliefs by battling on. Keeping up an erect posture is important, as it seems to help her endure the sadness and pain of this battle. Maybe she feels that if she continues standing tall her body will hide her vulnerability that is perceptible within her story. But again, how difficult is it to keep your body erect in battle? Perhaps she sought out a space in this clinical area where she could rest 'her keeping up' posture for just a short while. Maybe the only place available was the toilet. And when did she feel she could let her erect posture down? Perhaps as she walked to her car at the end of a day or maybe she could only do this in the safety of her home.

Despite the presence of others Bev feels alone. Being alone is the result of her people isolating her because of her 'speaking out'. She feels the isolation through the coldness of certain staff shoulders for about a week. Maybe Bev experienced the cold shoulders for all of the seven days or perhaps there was a gradual warming up process and if so did all the shoulders warm at the same time? Bev is also the only student in this placement and the refuge of her nursing school along with the importance of her peers for support becomes evident to her through being alone. Being alone makes her appreciate their role in her student life and she misses them both. Yet Bev has managed to get the executives talking about the impact of this decision on their people, people who can barely afford to come and use their services. However even the feeling of success is one of being alone. Not one nurse congratulated her and nor did any think to ask her if she would like to talk about this experience of achieving something that might help their peoples' health.

For Bev the experience of sticking to her guns was one of feeling alone, upset and sad. These feelings capture the negativity of 'being true to yourself' and Bev tells us of the need to find a safe place and safe people to be able release these feelings. Being ethical it seems is difficult without people and places that sustain one. Perhaps being with her family has always been experienced as being supported. However, 'being true to yourself' means the support becomes evident in new ways.

The ethical knowledge that Bev has acquired through her nursing education is important to her actions but battling on in this situation seems impossible without something more to help. For Bev this something extra is the faith she has in herself. 'Being true to yourself' is not possible without believing in yourself. Her faith allows her to soldier on and to keep the momentum of this battle going. Yet at times this was not so easy. In telling us she puts her faith back on herself there is the feeling that it seems to have slipped off momentarily, perhaps as she was shaking like a leaf. And where on her body did she reattach her faith? Was it over her heart?

In finding the courage to be true to oneself in the midst of threats to oneself and one's passion, Bev insists she is just being herself. Yet this experience has changed her. Through her reflection she has come to see this terrifying experience as a positive one. The emotional toll of fighting this battle makes Bev go back and think through if it was worth it. This process is helpful, as on reflection she confirms to herself that this was the right thing to do, leaving her with a new awareness of her direction in the world. As she looks to her future role as an ethical agent it is now with hope. Surviving this experience has left her with increased confidence in herself and a greater awareness of her capabilities. Being ethical now encompasses being prepared for the professional, personal and social implications that battling for your beliefs, amongst those who do not want to hear, brings. Bev is pleased about this because in the face of further threats to her understanding of communal caring and her passion for social good she knows she will be able to speak up.

Being true to ourselves means doing what we believe is best but it does not necessarily mean that our actions achieve the right outcome for others. The student in the concluding story in this chapter must decide if being true to herself in a crisis was the right thing to do. Laura tells her story.

Laura's story: questioning self

I'm not sure why I went down to that part of the dormitory area that day but I did and I heard the shower running and something made me think that the shower noise wasn't right. It was muffled and God only knows why but I pushed the shower door open and found this young girl hanging from the shower rail. I was at the end of a corridor and there were no staff around. There were no bells or anything for me to call so I was just holding her, I had her, just holding her, then I finally saw a patient so I called out to him that I needed help and he helped hold her while I ran for help and oxygen. We put her down and got her going but later that day during the debrief the Charge nurse told me that the young guy I had called to help had tried to hang himself also and I'm like, oh my God, have I ruined this young boy's life by calling him in? It just was so devastating for me to hear. Finding someone and then hearing that within hours the person I had got to help had also tried to hang himself, it was like a double whammy. I came home that day and brushed it right out of my mind. I was just blank but that night I couldn't sleep, I kept thinking why can't I sleep, but I must have eventually and then the next day we

were at school and sitting outside and someone said to me, " oh how was your shift" as students do. You want to know how people are getting on and what its like, I said, "ok but I found someone hanging", and this girl said, "you what?", and I go, "yeah". She said, "have you spoken to anyone" and I said, "no". I really didn't know why I had to speak to someone, I thought I could cope with this and it was like a mechanism in me blocked it out until the next day. It was such a traumatic thing that I couldn't for the first 24 hours see how traumatic it really was and when I saw how concerned people were for me I thought oh that must have been something really major.

The next time I was back on the ward I had this funny feeling that I didn't really want to talk with this girl. It was strange but I needed time to think as it had had a major impact on me and I went out of my way to keep away from her. It didn't help that I read in her notes that she was terribly angry and upset with the person who had found her as she really was serious and did want to go. I suppose that influenced me but also I felt really annoyed with her for doing something like this, annoyed as she had caused so much distress for the staff and other people, annoyed and bothered that the protocols, you know all those protocols are there in writing for the care of this girl, weren't being put into action. It took me two days before I could interact with her and she never bought the subject up but when I left she gave me the most moving note, so I do wonder if she did know it was me. The note made me feel more comfortable and feel better inside. That made me feel that what I did was right for me and because I am doing that for that person it must be right for them, it may not be right for them but it's not being wrong if you know what I mean. I just feel that if it makes a difference to someone and it has a positive outcome even though it may be negative in some way, that if it has a positive outcome it's got to be right and it's got to be ethical and good. I have thought about this so much but looking back on it now I still would have done the same thing because I did need help to hold this person up while I got help but I can't pretend it wasn't a really frightening experience for me.

Finding a young girl hanging means Laura is immediately jettisoned into holding up the dead weight of her body for what seems like ages. As she keeps on with the holding up to save this life, there is no time to work through an ethical decision-making matrix to decide if the one person finally available to help is appropriate. She just sees this person as the help she needs and grasps at this. However this decision has challenging consequences and Laura finds herself in the frightening position of deciding while being true to herself in a crisis, did she do the right thing?

Being frightened and devastated means this decision cannot be considered at this particular time, so Laura puts on hold any examination of her actions. She does this by brushing it out of her mind, yet how is this achieved? The details are sketchy but she does share with us that she switches on a mechanism. It is a mechanism that tells her she can cope but what is this mechanism? Does it have a manual or automatic start switch and where does it get its energy? It must be reasonably powerful as it is also able to block out feelings of devastation and confusion. This mechanism seems to function well as the desired blankness is achieved although Laura must have some unease about its efficiency, as throughout the night she checks its effectiveness with a '*why can't I sleep?'* self test.

The experience of deciding whether you did the right thing is one of hearing the concern of friends. Catching up with her friends, Laura tells us again that her blanking out mechanism is working. When asked about her previous day's shift she tells them it was O.K. and as the O.K. is absorbed by her friends Laura tells them about finding someone hanging. One friend requested confirmation, and when the 'yeah' came back her friends show their concern by trying to help Laura come to terms with what had happened to her. They begin by talking but much of what was said remains concealed. However we are shown that their talking was laden with concern as Laura's friends recognise that in deciding if one's actions are right in such an emotional situation, friends have their limitations.

As her blankness subsides Laura is reunited with her feelings. Responding to how she feels, Laura creates a personal space by distancing herself from the patient she saved. Her space is a place to think about her anger concerning this patient and a hospital system that she felt failed her. Acknowledging and settling her anger seems essential before examining her actions further.

Examining her actions is visible through her thinking deeply about rightness and wrongness and the quantification of these nebulous concepts. It is also a thoroughly personal experience as her feelings are knitted into this situation and pervade her thinking. Thinking deeply about such a situation is perplexing, all

consuming and undertaken alone, as only she can make the final decision. This participant has a busy life as a student, a mother, homemaker and part time paid employment. How did she create time for this deep thinking? There is also a hint of confusion that escapes from her words as she recounts this experience of trying to balance out the right and wrong in what she did.

Yet unlike other students who have travelled this pathway of deciding about the rightness of their actions Laura receives some comfort. Examining her actions seems to be easier after she received a letter that made her feel good inside. Perhaps when her self questioning came to an end, Laura wondered about students who have never been able to settle this question. And how will this experience now travel with Laura? Possibly some part of her will always be listening to the noise a shower is making.

Being ethical concerns deliberation and scrutinizing one's actions but the story tells us being ethical moves beyond rational and logical deliberation to justify one's actions. Rather than striving to overcome the particularities of human feelings, being ethical is enmeshed in our personal emotions and feelings, which we are unable to separate from our body. The body becomes the judge, as it is through the feelings of warmth and comfort or coldness and hollowness that we are alerted to the rightness of our actions toward another.

Being true to yourself: bringing the meanings together

'Being true to yourself' describes the meaning and ways of meeting students' personal expectations of ethical care. It emerges from threats to one's ethical ideals and concern for other. Concern for other drives students to seek out ways to uphold their ideals and overcome threats, thus preserving and developing their ethical integrity. Mitchell (2002) writes about the notion of a personal investment of self when students strive to be there for patients. This notion has meaning in 'being true to yourself'. Students strive and struggle alone to achieve their espoused ethical ideals. Struggling and striving includes finding the courage and energy to confront disillusionment, fear, sadness, uncertainty and fragility, along with being

tenacious, persistent, courageous and stubborn. It also can mean searching for innovative ways to be ethical that call on one's experiences from the lifeworld. Furthermore a personal investment of self means students must find their voice and speak up and speak out. This means putting their values out for public critique and being able to defend these.

'Being true to yourself' has further meaning in relation to emotion and perception. Emotions are woven into students' ethical perception and ethical agency (Scott, 2000). Emotional sensitivity, such as feelings, attachments, and desires pull students into situations of concern and sustains them once involved. Emotions are also important to students' ongoing development as ethical agents. Feeling good about one's ethical actions brings a sense of wholeness, purpose and hope for their future practice. Furthermore emotions guide the students as to whether one's decisions were for the good of the patient or not.

Conclusion

This chapter has shown the struggles students go through to be the ethical nurse they want and need to be. Concern for other is integral to 'being true to yourself' and students' own personal characteristics influence reasoning and motivation for ethical action. This chapter has also shown how being ethical means acknowledging and responding to one's emotions when encountering a situation that alerts one's concerns, along with following through the concern in its entirety. Rather than stifling or hiding one's emotions when students 'keep things 'nice'', emotions are in certain circumstances, integral in tugging students into action and in sustaining this. 'Being true to yourself' has further shown how self responsibility is an important aspect of being ethical by the ways that students overcome barriers to fulfill their ethical ideals. It also means a sense of wholeness, yet this is only visible following the struggles to be themselves.

The previous two chapters have shown the constraints and challenges on students' ethical practice and the ways of dealing with or overcoming these. The final data chapter provides a contrasting yet essential part of the phenomenon of being ethical. Constraints and challenges are experienced side by side the experiences

of being enabled while being an ethical agent. The following chapter, "Being present", will focus on the ways ethical practice is undertaken and understood without the hindrances shared in the previous chapters.

Chapter Six: Being present

Introduction

The previous chapters have shown how students' ethical practice has been constrained or a struggle to enact. Yet students work not only in constraining circumstances but also in those that enable ethical care. Within this chapter, six stories are used to show the enabling experiences of being ethical. 'Presencing oneself' is a term that is prevalent within the interpretive nursing literature. It has made its way into our literature through the work of Heidegger. Benner and Wrubel (1989) interpret this as meaning, "being available to understand and be with someone" (p.13). Being present is deeply embedded in the caring ethic of nursing. Cooper (1991) describes an ethic of care as being grounded in the nurse patient relationship, which is the journey and quality of that relationship. These stories are about students' ways and meaning of being present. Through relating to other, whether it be 'just talking' or sitting in silence, being present surfaces what matters to other and shows the 'hows' of responding that bring understanding and individuality.

This chapter begins with the story from a student who is concerned how a particular patient understands his illness and upcoming surgery. Benner (1984) believes illness can cut the person off from self-understanding and Andrew shares his story of 'just talking' to this man. Here is his story.

Andrew's story: just talking

In the first few days I meet one old man and I just started talking to him. He was isolated in a single room so I was just talking to him and found out he was really worried about his procedure. Just talking he seemed very uneasy about it and he didn't seem to have a lot of knowledge. I remember just talking to him, showing him a video and we talked. So it was just a situation of keeping people informed about their situation and just talking about the procedure and making sure they are comfortable with the procedure. It's just a way of interacting with people, which I have learnt throughout the years. You know, recognizing the scary situation that lots of people are in. That just comes from using my own

experiences from what I have encountered. I have had bad times throughout my life and just using that and recognising those situations. He seemed a lot more comfortable about it and it was just by recognising it rather than just letting it go. I think as a student maybe we have a bit more of the luxury of time to stand back and look at a situation. Really what we do all the time involves ethical decisions, even the little things such as this.

Andrew further shows us that being ethical is intertwined with our lifeworld and background. His story encapsulates how being present is enriched by years of interacting with others and by drawing on his own experiences of adversity. This embodied knowing recognises there are shared aspects of humanness that tie all human beings together and the significance for the patient is that Andrew is able to recognize that something is not right. The fear he sees in the patient brings to light the knowledge that Andrew has also shared times such as these. Taylor (1994) calls this self- likeness and describes it as seeing a part of oneself in a patient. Rather than letting these concerns go by, Andrew's past provides him with sensitivity to this man's current feelings, along with the confidence to gather in the patient's concerns.

Being present is also furthered by acceptance of self. This story shows how being present calls out the humility to accept ourselves as we are. Merton (1955, p.109) writes how we must first recover the possession of own being before we can act wisely or taste any experience of human reality. The bad times that identify Andrews's past are not hidden but accepted as something he is willing to use in a positive way. He acts on what he sees and feels and this opens up further opportunities to experience and learn about being human. This story also calls us to consider the circular nature of being ethical in that the personal infuses the professional self and this has a way of changing the professional, which in turn changes the personal self.

Being present involves creating an atmosphere of support to sensitively surface the reason behind this patient's unease. In being supportive Andrew attends to the concerns by 'just talking' but bringing another into the understanding about this procedure means Andrew dominates the communication. Slunt (1994) believes

authenticity thrives in a 'we' relationship but the experience of guiding this man through the details of his procedure was one of dealing with someone who had little understanding of what it entailed. In being new to this area some of this man's concerns could have also been foreign to Andrew, however there is a sense that there is technical knowledge 'in use' as he just talks. In attending to this patient's worries Andrew later complements his talking with a video about the procedure and afterwards he tells of talking again, only this time it is 'we talk'. Possibly the 'we talk' included this elderly man telling stories as McCormack (2001) found that elderly patients frequently use story telling as means of expressing themselves.

Described as bringing comfort, being present emerges out of being personally involved as a caring human being. Furthermore, what seems essential in being present is what Andrew thinks of as 'student time'. This sort of time means you are able to consider patients' perspectives without the stresses that greater responsibilities bring. The effect of student time in being present is that it allows thoughts to wander beyond the patients' immediate physical needs. The effect seems to be that there is more space for talking, listening and responding to patients.

However Andrew considers making this patient feel more comfortable as 'a little thing'. In categorising being present as little it appears that being ethical is already deeply embedded within his practice and it almost goes unnoticed. In a sense it has become hidden in his everyday activities. Along with this it has also been hidden from all but the patient. His practice remains invisible to other staff when undertaken in a private place. Perhaps this story further tells of the spatial vulnerability of being ethical as a student. There is the possibility of their ethical practice disappearing into the doneness (Star, 1995) as having a grade awarded to one's ethical practice depends on what can be seen by other staff.

Through being present the following story continues to surface that which is hidden. This story emerges out of anticipation and shows the limitations anticipation can bring as the situation itself has its own power to influence being present. Consider Isabella's story.

Isabella's story: being trusted

I had one older woman who was ready for discharge. Her cardiac problems turned out to be quite mild and she was stabilized with no trouble and she was ready to go home. I was showering her with the idea of putting her in her clothes and then she could be picked up and go home. I just started talking to her in the shower and she just didn't want to go home. She'd had a hip replacement and her husband had died, she was by herself and she didn't cook properly. She was eating a piece of toast for dinner and stuff like that. It was more advocacy that she needed. She ended staying two more days because she needed to get meals on wheel and she needed all the social services basically that were out there. It wasn't just one thing like nutrition but it was nutrition. She needed modifications done to her house as she couldn't get out of some doors and couldn't physically wash herself because she would get short of breath to do with her cardiac condition. She also had mobility issues. She ended up getting meals on wheels, occupational health and safety rails fitted and all that kind of stuff. I think it is the ethical responsibility of the nurse but that ended up happening because I found out that information in the shower. I was surprised because I had thought discharge planning was very good in that ward and I think that unfortunately one person slipped through.

Being present is revealed in Isabella's being there to help this patient prior to her discharge home. Isabella starts talking to her in the shower and this seems to have included thoughtfulness about and a willingness to understand this patient's situation. Benner (1984) also writes of capturing a patient's readiness to learn and how this is an important aspect of the teaching and coaching function of the nurse. Yet, what about a patient's agenda and their need to sort out whether the nurse is ready to learn about their concerns. Perhaps Isabella's concernful communication indicated to the patient that she was available and ready to listen as she asked about things that mattered for this patient. I wonder what questions were asked that allowed her availability to shine through, as there was something in Isabella's talking that alerted this woman that she could trust her with her concerns that had been concealed up to now?

Being present is also evident as attentiveness and openness to what matters for this patient. As Isabella asked a question maybe she stopped helping her go about her shower and listened because listening requires the listener to relax and to be

able to embrace the listening rather than the doing. The 'talking' and 'listening' have significance in 'being present' as Sartre (1996) argues 'being for others' precedes 'being with others' because an understanding of the other is essential to 'being-with' (p.414). As the talking continued during the soap, water and possibly shampoo, being present is further visible as being trusted with this patient's understanding of her situation. Being trusted allows barriers to come down and the fear of returning to an empty home is able to show itself. Through surfacing the fear of going home, being trusted also allows the breakdown in this woman's discharge plan to be recognised. This means Isabella sees her responsibility as sorting out the breakdown and by her organisation of the multiple resources we see she has the skills to translate fear into management.

Yet Isabella's experience of being present has lifted up and shown us what has been hidden through separation. Isabella begins her story by presenting her understanding of the object body (Gadow, 1999). Through public inspection plus the perspective of science such as a rhythm strip, a black and white photograph of her heart and lungs and the numbers on a laboratory card, she has come to know this body as a mild cardiac one. A body such as this is able to go home. But this body was stripped and separated not only of its clothes to shower but also of its particularity and as this older and mildly troubled cardiac body opens up through the talking Isabella must make room for the lived body (Gadow, 1999).

Similar to Sartre mentioned earlier, Munhall (1993) suggests "the art of unknowing is an essential pattern of knowing in nursing" and that "it is essential that we understand our self and our patient as two distinctive beings, one of whom we do not know. Each patient has a unique perspective of their situated context and a unique perspective of who they are as a person in the world" (p.125). As Isabella listens she learns what was hidden concerning this lived body. She describes how this lived body doesn't have a companion to snuggle up to anymore and how this lived body struggles to feed itself and is fuelled mostly by toast. She also learns it cannot walk far and when it walks not only does it have a fear of falling, it puffs. Being present creates openness. This openness allows Isabella to hear about the alienation experienced as a result of deteriorating physical circumstances and how

this lady's body is a daily reminder of this. Openness also allows Isabella to learn how the experience of incapability brings an awareness of the body as a being in its own right with an irreducible reality of its own (Gadow, 1980, p.97). Openness further allows the meaning of advocacy to move beyond attaining services and support, to encompass advocating for patients' wholeness.

Being present in this story surfaces the hidden fear of a patient. However fear is not always limited to the patient. The next story tells of a student's fear and how she must overcome this. Bev tells her story.

Bev's story: showing she matters

> *Because I was brought up to respect my elders, what they say is right and what they do is right. I was afraid of having to nurse someone older than me especially Maori but I just take a deep breath and I think yes I can do this. I use different things, things that I have not necessarily learnt during the course. If I am going to treat an elderly person who is Maori I keep in mind they might know the language so I use my language to bring trust between us. There is always something else other than what you have learned during the course that can help you to just take those fears away. I came up against this situation where an elderly Maori lady was due for a pap smear and she didn't really want to have it. I just spoke to her and made her a cup of tea and then spoke to her some more, giving her simple terms, speaking in plain language on what was involved in a pap smear and blah blah. It just takes that time, it is something and sometimes you look at something and think god this is going to be a long time, but hey a person's health. You can take all night to talk to her if you want to as long as they come around and they say yes I am ready to have it. My job is to give that information because it doesn't belong to me so I give it to them so that they can make the choice. I am not there to make their choices for them but eventually she came round and she had it.*

Being present with an elderly woman, who is one of her own people, Bev reveals further understandings concerning being ethical. Working amongst the multiple meanings of health promotion, Bev feels pulled between respecting her culture and respecting her knowledge about health. Being pulled in two different directions means feeling afraid. Heidegger suggests that fearing about is "being-afraid-of-oneself" (1927/1962, p.181). Bev is scared to challenge this woman's understanding of her health and at the same time she is scared of what may

happen if she doesn't. Yet fear for Heidegger "can reach and yet it may not" (1927/1962, p.180). Bev's knowledge and her concern for this woman underpin her decision that fear will not reach her on this particular day. She must contain her fear and the paradox here is that this woman's fear is visible only after Bev contains hers. Her containing body is similar to that of to Hamish, who told his story in Chapter Four and we see how Bev's body also gives meaning to being ethical by providing its breath to calm and help prepare for the experience of being present.

Being present is a way of being-with that conveys to this woman a sense that she matters. Bev knows that there is no 'one size fits all' way of being present and that she must reach beyond what her nursing education has taught her and look for different ways to connect the differing aspects of this situation. Being present it seems is constituted largely by feeling and intuition, which means drawing on her personal knowing. For Bev this type of knowing will always be intertwined in her Maori language as her Te Reo comes from her heart and as she sits with 'one of her own' it is her language that she reaches for so fear may not reach her. In her language is that something different, which becomes an essential aspect of being present. Perhaps as she reaches for her language she is showing us that teaching ethical practice will always remain limited if our Being and creativity are overlooked in the process.

Being present means being-with-in-uncertainty and Bev considers it ethical to share her understanding of the rationale for this procedure. Yet such rationale is grounded in the object body and perhaps as the undecided time ticks by this woman ensures a space is created which allows other ways of understanding to be considered. Gadow (1990) believes that, "during a gynecological examination the patient experiences an abrupt contradiction between her body as her own individual reality, rich with private emotional associations and her body as a sheer object which others examine impersonally as a technician inspects a machine"(p.93). The 'in doubt time' seems to tell us this woman is hesitant to separate her body in this manner and the experience of being present becomes one of Bev using her empathy and understanding of this situation. However

alongside this, there is the desire to continue supporting this woman while gently encouraging further consideration.

Gentle encouragement is a way of being present that moves the talking-with to 'coming around talk'. In such talk Bev balances the object body talk so does not overwhelm in its science terminology. Yet she hides some of the 'coming around' talk in the 'blah blah' but perhaps this is Bev's way of keeping private what she shared of her lived body experience of having a cervical smear. Bev's 'coming around talk' takes time and there is the suggestion of periods where there is no talking. Letting silence 'be' creates a space for the thinking and silence can be a deep well out of which important messages can emerge. Their silence seems to be telling us about the harmonisation between Bev and this woman that being present has fostered and nurtured by ensuring this woman feels cared for, encouraged, important and reassured. Perhaps the silence is also telling us that the lived body crafts its own time.

Gadow (1999) considers in composing a narrative between a nurse [albeit a student nurse] and a patient, it does not matter who is the author, because each is a poet; it only matters that there are enough words between them to make a story (p.65). We did not hear any actual words from the woman involved in Bev's story nor do we from the woman in the next story, as the words she spoke, the student was unable to comprehend. Yet there is a story and Milly shares this with us.

Milly's story: being alongside in death

An elderly Chinese lady was dying. She had started cheyne stoking and she was getting really bad and the staff couldn't contact her family. As she just kept getting worse I decided to sit with her as I had more time because I was a student. I held her hand and she was grasping my hand. We rang the family and couldn't get them and so at that moment I became that family role even though she couldn't understand me. I couldn't let her die on her own, that's important to me. It's just being there so I held her hand and just spoke quietly. She couldn't understand my English and I couldn't understand her Chinese but I kept smiling at her and although I had no idea of what she said to me, she could have said tell my daughter good bye or tell her where the keys are, it was a wonderful moment as sometimes there was a connection. I just kept

looking and smiling and not trying to have an anxious face on me and just talking to her in a very low voice. I tried to keep control and keep calm but that's hard yaker. When I stepped out of the room I thought Oh god, I was shaking and you just fall to pieces because it is hard work to do that but I couldn't leave her alone, it's not my culture. My culture means if someone is dying they are never left alone, they are with someone all the time, so ultimately that is what I thought when I went into the room. I didn't want her to die on her own. I wanted to make sure she was comfortable as best that she could but when I left the room I was a mess.

Death, Heidegger (1927/62) points out, cannot be experienced by Milly, as it can only be experienced indirectly by the meaning that death has for oneself. By making room in her day to be present in death Milly unveils some of her meaning concerning death. She sees this as a passage in one's life that cannot be experienced alone. Yet what if the pressure of Milly's day meant that she had to prioritise other care over this? How might she deal with such tensions when she no longer has 'student time'? Such tensions are not present in this story though others are.

The experience of being present alongside death is one of striving for connectedness. Being without the patient's family Milly feels she must step into this role and try, without a common language, to bring a sense of connection to this relationship. Roy (2001, p.78) claims, " in our society the hands play a significant role in who we are and how we behave as human beings" and Milly turns to her hands in seeking a way to connect with this dying stranger. Milly's offer is clutched upon and as this patient grasps an unknown hand perhaps she finds the connection that Mok (2000) considers is needed for harmony with the universe when dying. Mok claims that for many Chinese people, power comes from harmony with the universe and interconnectedness. She writes, "just as all matters and energy are connected through rhythmic interactions, so all individuals in a family are connected" (p.70). Perhaps the seeking out of this patient's hand and the welcome found, was the beginning of the 'being alongside' and getting it right for Milly.

Connecting with a stranger without a common language presents challenges. Milly responds by controlling the volume of her incomprehensible words in the hope of bringing a calmness between them. Her face is also employed to keep visual contact and to maintain a smile. This is significant to connecting with another, as Berman (1994) claims the face is the threshold to another's being. Maybe as she kept looking at this dying face she was not only trying to 'connect with' but also she was searching for evidence of success, as Milly knows that without being connected, the patient is alone no matter who is present. Perhaps being present alongside death means heightening one's sensitivity concerning the effects of one's actions.

However being present alongside death is a very emotional and personal experience and this seems to catch her by surprise. As Milly sits watching death claim this woman, Walters (1995) suggests such situations can spark off intense feelings within us, as we never sit alone alongside death. It is twenty years since I climbed into bed with my five stone yellow mother to hold her as she died. And it is twenty-five years since I stood alone in a hospital room as a new staff nurse being told that my father was going to die and not really taking in what was being said. I can summon back the vividness of these times whenever I need but it is the death of others when this aspect of my past seeks me out. So what of Milly's past? Could this situation have triggered intense feelings within her, feelings that could contribute to her shaking and falling to pieces? Perhaps the answer to these questions is in what she further shares with us. Milly continues her story.

> *My Dad was a boozer; booze, booze, booze and it finally killed him in my second year of this course. You just flick back to how it was when my dad passed away that does tug at you and you are in your own sort of world thinking about what has happened to you and how I came from a background of very abusive parents, drinking and alcohol. You never learnt what was right and or what was wrong, whatever you did was wrong anyway so you just got a smack or a hiding. So I have had to just learn it as I have gone along.*

Being present in death seems to surface aspects of one's self awareness and a willingness to engage in self-disclosure. Yet surprisingly, self-disclosure also brings

to light the wonderful sense of paradox in that such an 'uncaring' childhood has led to such a commitment to care.

Death also pervades the next story. Being present means the student in the next story receives and accepts an invitation into a child's place of need. Here is Ginny's story.

Ginny's story: being there

I was working with a 35 year old lady who was diagnosed with cancer, she had four children between 2 and 7 and I felt as if I had to speak a lot of different languages, not just English, but in different levels from the health professionals and to the 7 year old who was so intelligent. This 7 year old girl took me outside her mum's room after the doctors told her mum that there was not a lot else they could do and she told me it wasn't fair that the doctors just gave her mum a death sentence and she's not going to be there for my eighth birthday. My heart just sunk. I think the best thing I did for her was to actually get down to her level and I knelt on the ground and just talked to her and looked eye to eye with her so that she knew I was there for her and that I wasn't some big person looking down on her. They need to know that you are there for them and not taking sides. So I guess I made a difference to her. I got a picture the next day it was really sweet, it had her and me just holding hands and when she gave it to me she told me she used to hate hospitals because nurses were mean and the doctors horrible but the nurses are all right and that made me feel good.

Being present for the seven year old daughter of a patient whose prognosis is poor is experienced as an invitation into her place of need. Yet in accepting this invitation Ginny must stay and encounter what happens. Being alongside the vulnerability of a seven-year is so sad and she cannot stop her heart responding to the sadness. Perhaps it was her strangely acting heart that prompted the call to speak face-to-face with the child. Yet what can one say to a young girl who realises her mother will not be celebrating her next birthday with her?

Van Manen (1990, p.23) says that there is much talk in life and that talk is the concrete stuff of human discourse, yet he differentiates 'real' or 'true' talk from 'everyday' talk. Ginny does not share what she talks about in letting this girl know she is there for her but how could her talk be any other kind but the 'real' or 'true' talk van Manen speaks of. Yet in our death denying society (Benner & Wrubel,

1989) where does Ginny find the courage and imagination to sustain her 'real' talk? Perhaps the picture Ginny receives indicates that her 'real' talk was full of what Taylor (1994) terms 'allowingness'. Allowingness is giving unspoken permission to express feelings and be ready and willing to share the experience with one another. It involves heartfelt listening and ensures a quality in being present that enables making things easier for this girl through shared feelings of hope, despair, sorrow and anticipation.

Being present also becomes evident in the physical closeness and Ginny gets down at her level so they may see each other's faces. Berman (1994) believes that access to the face is straight away ethical and Ginny makes herself available so this young girl can see and sense her embodied caring and concern. Furthermore perhaps the drawing that emphasises a physical closeness speaks of the power and potential of being present in an embodied way and to make positive differences to the lives of other. Maybe through being present the gifts of engagement have surfaced that 'privileged place' of nursing that Benner and Wrubel (1989) speak of.

The students' stories thus far are about being present with patients or a family member but the last story shared in this thesis concerns a student on the receiving side of being present. Milly shares a further story.

Milly's second story: feeling wonderful

I am still a student but some staff would just talk to you as if you were a registered nurse and that was wonderful. I would always try to work with those people because they were influential as they were always priming me. Because of their influence I am more prepared to speak up but you have to be with a nurse who is willing to step back a bit and let you say this person is what I think. I am still wheeling through them and finding the ones I like. I might say," we shouldn't use such and such" and a nurse will say, "well why do you say that?" I feel confident to say, "because it promotes whatever" and they will say, "I think such and such is better" and I will say "why do you say that?" They will say whatever and I think oh yeah and then you end up in a compromise and you think this is actually going to be a better.

Curtin and Flaherty (1982) argue that nurses have a moral commitment to care not only for their patients but also for each other and in caring for each other the focus of being present shifts from the patients to students. Experiencing the presencing skills of a supervising nurse makes Milly feel wonderful, so much so that she scans and processes all staff by 'wheeling through them' to find those nurses who make her feel this way. Such staff have a way of talking to Milly that make her feel valued and as if she belongs to the nursing team. In describing how they 'prime her' she sees that staff are concerned and interested in her practice development knowledge.

Milly feels she matters through the respect she is shown by these nurses who make time in their day to listen, review and extend her developing clinical practice knowledge by sharing their practice wisdom. She feels reassured and encouraged and being-with such a staff member leaves Milly knowing they want to help her. She therefore receives their suggestions in an open and eager manner. There is also a sense of togetherness and safety when working with these staff and Milly has the perception she has something valuable to contribute. Being with wonderful staff inspires confidence and Milly describes how influential they are because of their encouragement. Being present for Milly leaves her feeling connected to her nursing role and she searches out those who will continue to keep her so.

Being present: bringing the meanings together

The meaning of being present is the quality of being with another. It is the way in which relationships are established and maintained in the spirit of concern and openness. It involves sensitivity to sameness and uniqueness in the other. One's language and body gestures have meaning in being present. They convey to another they matter and this sets up a sense of trust and openness, which allows peoples' individuality to be understood and upheld. It also concerns being sensitive to the feelings and gestures of another and attributing meaning to these, as each can convey a unique meaning (Paterson & Zderad, 1976). Through being present the students and the staff embrace themselves as caring human beings (Nelms, 1996) and the personal and often private interpersonal moments have a

motivational quality for those involved. Furthermore there is a closeness that emerges from being present. Rather than one's energy being channeled into overcoming barriers, this can be directed towards creating a connectedness with other.

Self-awareness also has meaning in being present. Being with another and being present means one is able to discern what is integral to one's selfhood, what fits and what does not. It means becoming more real by acknowledging the whole of who I am (Palmer, 1998). Knowing and being oneself in a supportive environment means different meanings are attributed to silence and fear from those shown in the two previous themes. Bev in her story shows us how silence means comfort and allowingness and how fear was her call to care in innovative ways rather than shutting down her possibilities of being ethical.

Conclusion

This chapter has shown the meaning of being present within the context of this study. Being present concerns practice that is grounded in caring relationships, which foster wholeness and integrity for both the student and patient. Being present means confirmation and challenges of who they are as individuals and future nurses. When the experience of caring was unhindered students were able to determine and shape care, thus showing how self-determination, confidence, knowledge and 'student time' constitute being ethical.

The meaning of being ethical has until this point been achieved through the three sub-themes presented in Chapters Four to Six. Yet the parts are not the whole just as the whole is not the parts. The next and final chapter will discuss the common meanings that have emerged, with the aim of creating a sense of the whole experience of being ethical. Common to and pervasive throughout the three sub-themes are the notions of being constrained and enabled. Constrained means to force or compel, to restrict the motion of a body to a certain course whereas the meaning of enable is to invest with power, to strengthen, to make to be or do something (The Shorter Oxford Dictionary, 1973). Thus the meta-theme of 'being

constrained and enabled' draws together the three sub-themes and will be used to show meaning of being ethical.

Chapter Seven: Discussion and recommendations

Introduction

The aim of this thesis has been to show the world of pre-registration nursing students in terms of 'being ethical'. Through three sub-themes I have shown how students are constantly in the throes of keeping things 'nice', being true to themselves and being present. As this thesis argues the lifeworld of students can be more fully understood through the four existentials proposed by van Manen (1990), these are used in this chapter to show the meaning of being ethical through the meta-theme of 'being constrained and enabled'. This chapter will also discuss the implications of this study for undergraduate nursing education and clinical practice. Further research is recommended and the limitations of this study are identified.

Being constrained and being enabled

This study has shown how being ethical for a pre-registration student is the pursuit of care which is right for the patient and self in the everydayness of practice. Students within this study showed how they lived the tensions of being enabled and constrained when striving to meet their understanding of doing 'the right thing' for patients. This thesis supports previous studies in that ethical practice is shaped in practice, not the classroom, as the broader social, cultural and historical contexts are part of our very being and influence every aspect of being ethical.

Lived other

Relationality is the lived relation we maintain with others in the interpersonal space we share with them (van Manen, 1990). This study has found that relationships are the interpersonal site of constraining or enabling ethical practice.

Student nurse and nurse relationships

Over the last decade there has been an interest in the relational aspects of ethics. This interest has focused predominately on the nurse patient relationship, yet Jaegar (2001) claims that nurses have the power to enrich or limit ethical engagement and Kelly (1998) considers individual ethical standards of students are influenced by group norms. This study has shown how in their role as the day-to-day supervisors of students, supervising nurses have a direct and considerable impact on the experience of being ethical. Students tolerated the varying ways of being with staff but their lived experience of being ethical was a response to their relationships with different supervising nurses. Lexie for example claims "staff make or break your clinical placement" (Chapter Four, p.55).

Van Manen (1990, p.104) writes of gaining an impression of the other in the way that he or she is physically present with us. The accommodation of students' pursuit to do 'the right thing' by supervising staff varies and a student's lived relationship is one of deciding whether a particular staff member will trust and allow a student to be his or her ethical self. Gastmas (2002) claims atmosphere determines who expresses which moral convictions and the influence they have on care. Supervising staff determine the atmosphere, from which students make a judgment about the individual or the collective capacity to constrain or enable being ethical. In Chapter Four Lexie speaks of the coldness of staff and how such an atmosphere dictates and constrains being ethical (p.55). In contrast Milly (Chapter Six, p.102) spoke of an atmosphere of concern towards her and how this enabled her ethical practice. This finding also makes explicit the invisible work involved in being ethical as it involves sifting through and monitoring the atmosphere portrayed by staff.

Pre-registration students are experienced students seeking an appropriate level of independence. Van Manen (1990) claims lived relationships can bring a sense of support and security that allows one to become a mature and independent person. This study has shown how supportive and respectful relationships established between supervising staff and students are enabling of being ethical. Cameron and

Diemert Moch (2000) consider respect means to recognise a person's inherent worth, abilities and dignity. Nurses, these authors claim, show respect by understanding and accepting each others' competencies such as varying expertise and educational preparation. The experience of working within an enabled relationship has shown that time, patience, and above all respect is afforded to the student. The chapter on being present, for example, revealed numerous ways of students being enabled to pursue their self-determined ethical care through the trust of staff. Thus the staff's presence in these stories has faded into the background. The experience of an enabling relationship is one of being able to think and act independently within a supportive nursing community when implementing care considered ethical.

Yet the influence of power can never be avoided and being enabled does not mean that students do not experience the effects of status and power. Rather, being enabled to pursue ethical care with support and guidance from staff, showed how false differences in power disappear but real differences remain (Palmer, 1998). Palmer claims real power is the power to use one's knowledge and wisdom to develop, nurture and guide learning. False power, on the other hand, is used to dominate and control learning. Milly (Chapter Six, p.102) speaks of being enabled through dialogue. This allows her voice to be heard but also demonstrates how she is influenced and guided by the practice wisdom of staff, which in turn impacts on her learning and care in a positive way.

In contrast van Manen (1990) also claims that a lived relationship with limited trust and confidence in the others' abilities is one of difficulties and challenges. The constraints on being ethical, due to challenging or difficult staff relationships, was a significant finding from this study. Difficult relationships emerged as those that disempowered and controlled students' ethical practice with little consideration for the individuality or particularity of the students' knowledge or understanding concerning the ethical situation. Being constrained within such relationships meant experiencing degrees of powerlessness that compromised students' ethical practice. The chapter on keeping things 'nice' exposed the varied ways students compromised ethical care, such as tucking away what they believe, being silent,

and following orders. Students were aware that they themselves were part of dubious practices which placed patients in vulnerable positions, yet they felt powerless to question staff over what was right or wrong, or to act in alternate ways.

The study further showed how being in a difficult relationship could at times appear as being enabled. Isabella (Chapter Four, p.57) overcame difficult interpersonal relationships with staff to provide her understanding of ethical care to a patient with HIV. Yet this story brought to light the relational constraints when she spoke of only being able to do so much. Being a student ensured she placed limitations on how she interacted with staff due to fear of being rejected from the nursing team.

Van Manen (1990) considers the teacher [supervising nurse] student relationship is experienced as a special lived relationship to the other and charged with interpersonal significance. Kelly (1998) identifies the importance of being accepted into the nursing team as a student 'milestone' and passing and failing is naturally highly significant to students. Through constrained yet highly significant relationships the students showed how the element of fear became visible and pervaded the experience of being ethical. Louise (Chapter Five, p.50) showed how being fearful of a scary and powerful staff nurse and fearing for her position within the nursing team meant she undertook care that left her feeling shattered and guilty. It also showed the burden carried by students who undertake such care. Palmer (1998) considers fear is everywhere, in our culture, in our institutions, in our surroundings and in ourselves. He claims fear cuts us off from everything. Fear of failing or fear of rejection by the team was shown to separate the unity between students' ethical being and doing. This separated self meant being ethical was experienced as a loss of what could or should be and therefore its lessons were somewhat more acute (Bowden, 1997).

The fragmentation of students' ethical integrity necessitated ways of coming to terms with their lost ethical ideals and the findings brought forth how students achieve this. Students reassured themselves they were still ethical agents but at times they were powerless against relational forces, which mitigated their ethical

actions. The study further showed how being ethical within a constrained relationship shaped aspects of students' experience of moral distress. Moral distress, emerged from feeling vulnerable and fearful within constrained relationships with nursing staff. This contrasts with much of the literature concerning qualified nurses that places the spark of moral distress in relationships with medical staff. This finding does however support the fledgling literature concerning unethical relationships amongst nurses (Cameron & Diemert Moch, 2000).

The study also shows how relationships with staff which are constrained and challenged by fear, as opposed to constrained and dominated, means being constrained coexists with being enabled. The chapter on being true to yourself has brought to light the ways and experiences of students moving beyond relational fear. In this chapter, personal feelings of vulnerability with staff were reconciled in the interests of patients and themselves. Remember Bev for example, who felt she just had to say something and open her mouth (Chapter Five, p.82). Being ethical was shown to be relationally effected and affecting and the stories showed the back and forth movement between being constrained and being enabled which involved not only speaking up or going out on a limb but also feeling unprotected, exposed and alone.

Lecturer student relationships

The experience of being with a clinical lecturer has also been shown to be constraining and enabling of ethical practice. My role as the clinical lecturer for some of the student participants has shown this to be restrictive on students' ability to be open and honest about their ethical practice. Boud and Walker (1998) claim students express themselves in the conditions of trust and security, yet many of the stories shared by the students, who were known to me, surprised me. When confronted with the prospect of a rating performance to pass the clinical practicum, students were selective in what they shared with a lecturer. In this way students were keeping things 'nice' for themselves as the consequences of being judged as not coping or not passing, limited the choice of situations to share and reflect on

with their lecturer. Boud and Walker also claim students expect to write for assessment what they know, not reveal what they do not know and these findings highlight the assumed notion that students will view the lecturers' role differently because the lecturer is also in a coaching role. Furthermore despite the enabling role of the clinical lecturer being reiterated through the literature, the findings from this study revealed that this was not borne out in the data.

Peer relationships

Johnstone (2000) writes that the examination of nurse lived experiences would yield important insights into such areas as cathartic moral talking. This study has shown how cathartic moral talking is enabling of being ethical, yet the opportunity to discuss feelings and to make sense of their experiences within a safe environment is limited, as the role was allocated to fellow students. Fellow students help to reflect and debrief on ethical issues in the safety of friendship and the trust that being students together brings. In Laura's story (Chapter Five, p.87) we see how peers enable her by offering support as she reflects on and tries to understand her ethical actions. Furthermore friends are the catalyst for Laura to seek further help. The support of peers also has meaning in its absence. Coping with the emotions of being constrained and enabled is part of the being and doing of being ethical and finding herself with no peer support, Bev comes to see their importance (Chapter Five p.83).

Patient Relationships

Fredriksson and Ericksson (2003) claim the relevance of ethics has become more and more significant in the process of understanding the caring conversation, which they describe as one that occurs between a nurse and a patient where the patient can carve out his or her suffering. The chapter on being present showed how the interpersonal skills of students intertwined their availability, initiative, authenticity and responsiveness. Isabella's story (Chapter Six, p.94) encapsulated the caring conversation by listening to a patient's experience, deciding what mattered and responding. Caring conversations often brought to light the

significance of students' lifeworld experiences to being ethical. Bev (Chapter Six) recognizes the 'more than' aspect of being ethical. She knows she must look beyond the ethics preparation from her nursing school for something else when entering caring conversations with paitents. And Isabella feels her mum's background as a psychologist assists her caring conversations as she is comfortable with 'real talk' (van Manen, 1990). Isabella credits this to her mother's influence on her ability to consider patients' psychosocial needs.

Van Manen (1990, p.105) claims that through the meeting of others we are given the possibility to develop a conversation that allows us to transcend ourselves thus bringing a sense of purpose in life and meaningfulness. The study also brought to light how enabling conversations brought a sense of meaningfulness and personal identification with the ethical ideals and values of the nursing profession. This was empowering and a source of self-validation (Bowden, 1994). Ginny for example, shared how being there for the seven year old girl who was confronting the death of her mother left her feeling good. Yet enabling conversations were spoken of as 'just talking' (Ginny, Chapter Six, p.101). Thus students were already silencing their intuitive, emotional and embodied knowing and perpetuating the invisibility of caring within ethical practice.

The nursing literature attests to the significance of the nurse patient relationship in the ethical role of nurses. However in the reality of practice, students are working in organisations that are maintained by rules and etiquette where certain voices or views are privileged over others. The oppressive nature of healthcare environments to nurses' ethical role has also been well documented within the nursing literature. Farrell (2001) asserts that such an environment still exits. Students showed how the power of certain voices imposed constraints within their relationships with patients. Rules about what a nurse, albeit a student nurse, was able to talk about with a patient saw Lexie being unable to continue her relationship with a patient (Chapter Four, p.62). Constraints were also made visible when the actions of students contradicted what would be considered as appropriate care. Student silence in such situations threatened the student patient relationship and further communication became fragile.

Relationality and Emotions

Being ethical as a student means experiencing and being guided by emotions. Benner and Wrubel (1989) maintain that emotional connections are central to our involvement in situations as feelings enable a person to live out meanings and concerns that emerged from the students' emotions that were triggered by others played a role in the detection of ethical problems. The findings showed how emotions are embedded in the call to care by tugging students into and sustaining ethical care. The despair and anger felt by Anna (Chapter Five, p.75) when seeing a patient in pain triggered her expression of ethical care and action. Experiencing certain emotions was also a vital part of broadening one's perspectives and developing one's understanding of certain aspects of the human condition. Laura (Chapter Five, p.86) shows how feelings of devastation prompted her intense introspection to come to understand the ethical meaning within her actions. Yet despite students aiming to do the right thing for patients certain emotions limited their expression of being ethical. Fear, as discussed earlier in this chapter, along with anger and dread impeded their ethical practice. Fear of making themselves unpopular or fear and anger concerning past personal trauma limited their possibilities of ethical care.

The lived body

Van Manen (1990) writes "we are always bodily in the world" (p.103). Yet Jaegar (2001) argues that in Western accounts of rationality, the body has all but disappeared. This thesis has shown how living the tensions between being constrained and enabled was constituted in embodied ways. Although the stories presented in this thesis tend to highlight the lived body through being constrained, the data showed how a heart acting strangely, a brain that switched off temporarily and an upright strong body posture were bodily ways of being in the world that enhanced ethical practice.

Benner and Wrubel (1989) consider the habitual and skilled body allows the person to share the world with others and students showed how surviving in a constrained world of ethical practice was only possible by controlling their bodies. Feelings and emotions associated with their sense of powerlessness, frustration and disillusionment called forth their constraining bodywork. Isabella (Chapter Four, p.57) shows how her body is called to stifle her feelings of wanting to yell 'blue murder' and Hamish's story in the same chapter vividly shows how his body is required to contain his furious feelings (p.68). Being ethical requires students to control their eyes, voice and muscles especially those of the face so they could keep things 'nice'. Yet the experience of being ethical was also one of fearing that their bodies may betray them. A disobedient body, when the context demanded obedience, was not helpful to sharing the world with others. Hochschild (in Smith and Gray, 2001, p.230) claims the induction or suppression of feelings in order to sustain an outward appearance is emotional labour. The notion of emotional labour shows the invisible hard work that constitutes being ethical as a student. However at times it was evident that the work involved in containing their bodies became overwhelming, and their bodies responded by shaking, crying and feeling sick.

Lived space

The experience of being ethical was influenced by the lived or felt space of being a student in the nursing and wider health care hierarchy. Hamric (2001) builds on the work of Bishop and Schudder (1990) by claiming nurses are in an in-between space, which Hamric argues is a privileged place for nurses. In this space she claims nurses can move between the patient and the institution to organize what is appropriate for the patient. Such a space was also evident for students and like that of qualified nurses it has emerged from nursing's history, culture and traditions and informs students about how to act, who to relate to and how to relate. Remember Anna's description of this space as 'not quite there' (Chapter Five) and how Isabella (Chapter Four) described it as a felt space which contains and controls through fear of rejection by the nursing team.

A student nurse space positions students between the patient and the staff and the study showed how at times this space was one of privilege. Both Milly and Andrew (Chapter Six) speak of the reduced workload this space affords students. This was seen as an important aspect in enabling being present. This space was also seen to be a place of safety and retreat. Louise (Chapter Four, p.51) talks about 'just being a student' and she uses this space to justify her part in the unethical care of a patient.

Yet at other times the student space is one of limitations and difficulties. The chapter on being true to yourself shared how this space affords students little credibility and valuing of their ethical knowledge. Students showed how maintaining a commitment to their own ethical beliefs often resulted in disagreement or conflict with staff. In such situations students showed how they lived and participated in their space in times of conflict by railing against their difficulties. They struggled, were persistent, maintained hope, rescued themselves and broke outside their space by going out on a limb. Being constrained in their space meant they worked harder to be ethical and to lessen what they considered was compromised ethical care for patients. It also meant students were expected to manage constraints by themselves, rather than through the social relationships a student is enmeshed in. Furthermore to survive in this student space in times of tensions we saw how other spaces become visible in their role in being ethical. Bev (Chapter Five) makes visible how the warmth and love of her home is needed to continue working through the tensions of this student space.

Besides the student space being enabling and a place of tension to being ethical, it was also a place of fragility and compromise. Although all students are positioned in this space by virtue of their student role it is not a secure position by any means and this study has highlighted a further space for students in the nursing hierarchy. This space amongst the student space is one that students are allocated to if they are not accepted by the team. It is a feared and scary place where there is no support from staff and the threat of being relegated to this place is instrumental in the student experience of being ethical. The chapter on keeping things 'nice' showed how students compromised and balanced their ethical care, thus ensuring

staff would not reposition them in this unsupported space. At times the fear of this space was so great that it paralysed their ethical role and became a potent source of moral distress. Fear of this unsupported space also necessitated developing intricate ways to avoid relegation and Isabella (Chapter Four, p.56) for example showed how she balanced and switched her persona from 'being open' with a patient, to 'being closed' with staff to achieve this.

Lived time

The past, present, and future constitute the horizons of a person's temporal landscape (van Manen p.104). This thesis has shown how being ethical is grounded in the expression of self which can enhance or diminish being ethical. A past steeped in adversity and hardship unfolded in the present to provide the personal capacity to resist compromising one's ethical values and to provide the strength to exert one's ethical beliefs. Mia's past is the catalyst to walk away from an unethical situation yet at the same time her emotional past is a powerful influence in her not speaking out in the present (Chapter Four). Andrew's difficult past brings a sense of humility and sensitivity to his practice (Chapter Six) while Bev's culture is her strength and she draws on this to provide innovative care in the present (Chapter Six) and hope for the future care of her people (Chapter Five).

Today's notions of nursing ethics have emerged from past understanding of ethical practice as doing one's duty, which implies implicit, unquestioning obedience (Barker & Davidson, 1998). There is evidence within this study that the long standing legacy of obedience continues to show the experience of being ethical. Remember the story of the student who felt she could not initially disobey the staff nurse when a patient was haemorrhaging along with the stories in Chapter Four concerning silently following along and doing as one is told. These are all grounded in students' obedience and show how being obedient provides hope for the future by gaining acceptance within the nursing team and possible future employment.

Munhall (1994) claims the present becomes the past that we can reflect on. Reflecting back on their ethical actions was enabling to the experience of being ethical. It bought to light a greater understanding about self and new ways of being.

Implications for undergraduate nursing education and practice

Contemporary nursing literature is re-personalising the ethical role of the nurse and by returning to the actual practice of nurses to inform an ethic of nursing, the importance of emotions and their significance to ethical care is gaining attention. Benner and Wrubel (1989) claim feelings and emotions have got bad press by being understood as a threat to rationality, control and self-possession, perhaps explaining why Boud and Walker (1998) consider emotions and feelings are often played down in educational settings. This study's findings verified that emotions are central to the enactment of ethical practice and its omission, and as such require better recognition in education and practice. Boud and Walker further claim that denying the power and influence of emotions leaves staff and students with no strategies for dealing with them. Scott (2000) and Jaegar (2001) argue that emotions should be a feature of the ethical education of the nurse with Jaegar speaking of 'educated emotion' and how appropriate emotion and accurate perception from the student can increase personal control and competence in their ethical role.

Within both classroom and clinical settings nursing education must continue to work on creating a climate for students in which the expression of feelings is accepted and legitimate. Students need to be able to express themselves in conditions of trust and security knowing it is not going to lead to negative consequences (Jaegar, 2001). Pursuing such a climate for students is necessary in light of the constraining effects of fear on practice that have surfaced in this study. Some authors suggest caution in respect of this recommendation. Boud and Walker (1998) caution that emotional disclosure from students is not without its challenges and Jaegar considers that constant vigilance is required to ensure that ethical considerations are not drowned out by the forces of self interest (p.133).

A further recommendation of this study is to broaden the way in which ethics is taught. The teaching of ethics must include ways to bring together the ideological influences of both education and practice and prepare students in a more informed way for the contextual influences that will shape their ethical role. Cave (1994) interestingly challenges the educators of nurses to ensure they too will be able to demonstrate how knowledge imparted in the classroom can be integrated and applied in practice. Johnstone (2000) and Gastmas (2002) recommend that ethics teaching include the vocabulary of emotions such as suffering, sympathy and compassion. Jaegar (2001) also suggests that teachers need to focus attention on the bodily dimensions of being ethical. Bodywork does not fit into the standard ideas of teaching ethics yet how are students taught, for example, to hide the truth from patients?

Being ethical is an investment of self and there is a need for nursing education to consider the ways in which self-confidence is developed and nourished within students. Berman (1994) speaks of attention to self and as I read the stories of students not being themselves I was left wondering about the long-term effects of not being oneself. Randle (2002) claims nurses who do not have a healthy sense of 'self' affect the quality of care in a negative way. As being ethical is overwhelmingly embedded within relationships, a further recommendation of this study is the formal and systematic acquisition of complex interpersonal skills including assertiveness skills. McCabe and Timmins (2003, p.31) consider assertiveness skills will equip students to deal with oppressive atmospheres that may exist and help students confront oppressive issues. Further support for this recommendation is given by Allcock & Standen (2001) who argue that failure to acquire more in-depth communication skills will see students developing strategies with the potential for avoidance of ethical situations.

It is an important professional responsibility to help students acquire competency in clinical settings without causing distress to themselves and patients during the learning process (Taylor, 2002). The influence of the preceptor and clinical staff on student learning has been well documented and the literature shows how creating a positive climate is crucial for learning. There are many challenges for staff, within

clinical settings, to create a positive learning climate yet both education and practice must continue to strive to seek ways of ensuring supervising staff value, work with and support student learning.

The role of the clinical lecturer also warrants further review. The place of thoughtful reflection to unfold the meaning of practice in developing a student's ethical agency presently relies predominantly on that student's self-disclosure. If such teaching practices are to remain, the findings from this study are problematic and the issues of power and fear must be addressed within this relationship. Boud and Walker (1998) write, "teachers must build appropriate ways of relating, which respect the different approaches of individuals and foster an atmosphere of trust and respect" (p. 204). As the role presently encompasses supervision, mentorship and assessment, further development is required to consider how such aims may be achieved.

My final recommendation is that the teaching and learning of undergraduate nursing practice be grounded within a student centered approach by inviting and supporting students to become more active participants in the ongoing review and development of the curriculum. The aim of this recommendation is to provide learning concerning the ethical dimensions of practice that is more meaningful to students.

Limitations of this study

The findings of this study relate specifically to the experiences of twelve students within one school of nursing where I teach. These experiences may differ from experiences of other students throughout New Zealand. I am also aware that only one participant was from a culture significantly different from what could be thought of as New Zealand's culture. Since commencing this study, I have seen the student population entering the school, where the study was undertaken, increasingly become multicultural, with larger numbers of students entering with vastly different lifeworlds. As students with an Asian or African background for example, who are 'new' New Zealanders grow in

number, it is these voices that need to have a greater say in ongoing studies. A further limitation of this study is that only two of the participants identified as Maori and in honouring the commitment to further bicultural understanding within nursing, these voices also require a stronger platform.

Further research

This study has raised more questions than answers and several questions have emerged as significant to consider in further research. I believe there is a need to hear more about undergraduate nursing ethics in relation to;

- The role of emotion in ethical care
- Fear and ethical practice
- How differing world views of ethics are experienced within a New Zealand healthcare setting
- Assertiveness and ethical practice
- Educational preparation for ethical practice
- The invisibility of ethical practice
- Self determination

In selecting a method to explore the experience of being ethical I discussed in Chapter Two how I originally toyed with the idea of a critical methodology. This study has highlighted how power and position are central to students' experience of ethical practice. Therefore it is recommended that future research considers a critical approach to assist in the ongoing development of an understanding concerning the ethical practice of undergraduate students. The nursing community could also consider the possibility of ongoing research that includes other disciplines for example psychology when considering research into areas such as emotions.

Concluding statements

This thesis is about the world of student nurses and their meanings of being ethical. My involvement with this study has sought a methodology to show the students' world of being ethical in a vivid way. I have attempted to reveal the complexities and intensity of the emotional and physical work inherent in this aspect of being a student nurse. I am very aware the experienced nurses reading this study, will also have their stories and their world, which may or may not parallel a student's world

Van Manen (1990) claims that in undertaking phenomenological research the researcher "must meet with it, go through it, encounter it, suffer it, consume it and as well be consumed by it" (p.153). My involvement in this study is also the experience of being enabled and constrained. As a part time student it has constrained and dictated my time yet enabled my life other ways. It has enabled me to see a world I thought I knew with fresh insights and understandings. It has shown me the complexities and enormous challenges that students endure. I have a more respectful appreciation of their courageous attempts to be ethical and greater understanding when they are not. It has offered me the ability to become the better teacher that I hoped for when starting this study. It has shown me how my role as a teacher must be one striving to provide a safe space in which students may bring and share their experiences and where listening and seeking meaning prevail. Such a space must also embrace Palmer's (1998) notion of allowing false differences in power to disappear so that the real may remain. Undertaking this study has further enabled me to bring a stronger and more informed voice to support the ongoing development of a student focused curriculum.

Appendix A

Participant Information Sheet

Researcher: Susan Johns

I am a registered nurse with fifteen years experience as a nurse educator and I am currently enrolled in a Masters thesis programme. I am interested in the ethical practice of undergraduate nursing students and I would like to listen to you and discuss issues that you believe influenced the provision of ethically based nursing care during your final semester (pre-registration) of the Bachelor of Health Science (Nursing)

The aim of the Project

The aim of the study is to explore and analyse the ethical practice of pre-registration nursing students. The purpose of this study is to find meaning, not to judge individual practice or situations, and my aim is to hear you describe your ethical practice and perhaps reach a new understanding of meaning. A further aim is to use the understandings gained to make recommendations for undergraduate education changes and improved teaching practice.

Uses to which the Information will be put

The findings from this research will form the basis of a thesis towards a Master of Health Science.

I hope to able to make recommendations that will enable teachers and students to better understand some of the ethical practice issues that arise for pre-registration students in clinical practice.

The data may also he used as a basis for future publications and conference presentations.

Your Participation

You are invited to volunteer participation in this study but are under no obligation. If you do decide to participate, you are free to withdraw from the project at any time without giving any reasons. You may also withdraw information you have provided at any time prior to the completion of data collection.

If you agree to participate you will be asked to take part in two phases.

Phase One

You will be asked to take part in an interview, and with your consent the interview will be audio taped. This interview will last approximately one hour and will be held at a time and in a place of your choosing over the month of July 2001. This time frame has been selected as you will have completed the course and my role as a lecturer in the Bachelor of Health Science (Nursing) will no longer impact on you. The interview will be informal and conversational in nature and will focus on your experiences working in clinical practice to provide ethically based nursing care.

Phase Two

You will be invited to participate with approximately fourteen other participants in a one hour focus group discussion (structured) in September 2001. I will present some of the preliminary findings from the first phase of the research and will then ask for your input into the validity and relevance of my interpretations. Agreeing to participate in this focus group will mean that the other participants will know your identity.

Perceived Risks

A perceived risk of this study could relate to personal distress when talking about an ethical incident. If this should happen, I will provide you with assistance at that time and help you think where you might find other sources of support. I plan to incorporate a debriefing period in the interview time, or at a later date, should there be any issues that you may wish to discuss. The only inconvenience of note is the time required to participate.

Confidentiality

Every effort is made to protect your identity and minimise the risk of your being recognised. A pseudonym will be used in all written material and only you and I will know your true identity. Any names, places and locations will be disguised in the thesis and any other publications that arise from it. You will receive a typed copy of your transcripts and will be free to add or delete any information, as you desire. You will be asked not to disclose the names of the other participants that you will meet in the focus group interview.

All information you may choose to share with me will he strictly confidential. Three other people will have access to the anonymous raw data: my supervisors Dr Jo Walton and Dr Deb Spence and a typist who will be required to sign a confidentiality agreement. All information will be kept securely for six years as per Auckland University of Technology guidelines.

There will be no financial payment available to participants. Your decision to participate is voluntary, and should you decide to participate you may withdraw at any time.

You will be able to access the thesis through the Auckland University of Technology library.

Thank you for reading this information sheet and should you wish to discuss any aspects of the research please feel free to contact me, Susan Johns, ph 522 4083 or my supervisor Dr Jo Walton (ph 9179999 ext 7160).

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. Concerns regarding the conduct of the research should he notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.co.nz   ph 9179999 ext 8044.

Appendix B

Consent Form

"Being Ethical" in Clinical Practice: The Experience of Pre-registration Nursing Students.

Researcher: Susan Johns

I have been given and have understood an explanation of this research project to be conducted by Susan Johns. I have been given the opportunity to ask whatever questions I wish and all such questions have been answered to my satisfaction. I understand that I am free to refuse to answer any specific questions, withdraw any information, and withdraw from the research project without having to give any reasons.

I agree to participate in an interview that will be audio taped.

I agree to participate in a focus group and not disclose the identity of any other participant in the research project.

I agree that the information collected for the study may be published provided that my name is not used and privacy is maintained.

I agree to participate as a volunteer in the study described.

Signed:

Name:
(please print clearly)

Date

Reference no 01144
Approval Date. 4/7/01

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