New Zealand nursing students’ experiences of ethical issues in clinical practice:

A descriptive study

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Jill Marlene Sinclair

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ABSTRACT

Background

It has been recognised that nursing students do not experience ethical problems in clinical practice in the same way as graduate or experienced nurses (Cameron, Schaffer & Park, 2001). In order to develop ethical reasoning and competence in nursing students, nurse educators must recognise the unique problems students face (Solum, Maluwa & Severinsson, 2012). There has been no documented research to date that explores New Zealand undergraduate nursing students’ experiences of ethical issues in clinical practice.

Aim of the research

The purpose of this descriptive study was to identify (a) the most frequently occurring ethical issues experienced by Bachelor of Nursing students in New Zealand and (b) the level of distress that the students feel when faced with these issues.

Research design

A web-based questionnaire was developed, incorporating the ethical issues related to patient rights and patient care identified within a literature review along with a qualitative open ended question. The survey was distributed via email to members of the New Zealand Nurses Organisation (NZNO) National Student Unit (NSU). Descriptive and inferential statistical analyses were conducted to ascertain the most frequent and distressing ethical issues evaluated and to determine if any differences existed between certain groups.

Findings

Unsafe working conditions have proven to be the most commonly occurring and one of the most distressing ethical issues facing New Zealand Bachelor of Nursing students. Other issues that occur frequently in clinical practice are breaches of ethical principles relating to patient rights such as confidentiality, privacy, dignity and respect. The most distressing issues were found to be those that involve patient care and the compromising of the safety of patients, including unsafe working environments, unsafe health care practices and suspected abuse or neglect. Themes that emerged from the responses to the qualitative question included lack of support and supervision, bullying, end of life care issues and breaches of the ethical principle of veracity.
Recommendations

Research on this issue may be beneficial in assisting with the organisation and preparation of ethics education and the facilitating of students’ clinical experiences. It is hoped that by developing ethics education around the main concerns that students have in clinical practice, this will enhance students understanding of the issues herein and their ability to respond appropriately.
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Chapter One

Introduction

1.1 Background

The current healthcare environment invariably raises ethical issues and dilemmas for all health professionals (Buelow, Mahan & Garrity, 2010; Garity, 2009; Numminen & Leino-Kilpi, 2009) including nursing students (Erdil & Kormaz, 2009). However, Cameron, Schaffer and Park (2001) recognised that nursing students do not experience ethical problems in the same way as graduate or registered nurses.

Fostering and developing ethically competent nursing practice is an essential aspect of nursing education. In order to encourage nursing students’ moral development, reasoning and behaviour it is important that nurse educators recognise the unique problems and challenges they experience (Erdil & Korkmaz, 2009; Solum, Maluwa & Severinsson, 2012). This has never been more important than it is today, as nursing students are working in an increasingly complex and challenging healthcare environment (Allen, 2003; Hunink, Van Leeuwen, Jansen & Jochemsen, 2009). Doane, Pauly, Brown and McPherson (2004) identify that undergraduate nursing ethics education needs to reflect everyday practices and contextual influences, so that students develop an understanding of the healthcare structures and policies that affect their ethical responsibility as a nurse. Woods (2005) also recognises that in order for nursing education to be authentic, realistic and practical, the everyday and common ethical issues that nursing students experience in clinical practice need to be determined.

The purpose of undergraduate education is ultimately to produce work-ready graduates. It is therefore important that we find a way to integrate ethics teaching into actual practice (Hunink et al., 2009) in much the same way as we develop our clinical curriculum to facilitate theory to practice integration (Arries, 2009). In order to achieve this integration it is imperative that we first understand the ethical issues that students face in clinical practice.

1.2 Researcher’s interest

Working as a nurse educator requires you to be available for students to discuss any issues or problems they experience during clinical placement. At times these issues will be related to breaches in ethical principles or values or involve other ethically challenging situations. These situations can be distressing for students as they struggle to understand and process the healthcare environment while developing their own practice.
During these conversations and reflections with students I began to question why it was that I had not always recognised or viewed the situation in the same way as the respective students, particularly when the issues raised were often the same issues I remember being confronted with as a student. I began to consider whether my moral lens had changed over my years in nursing practice. I also began to question the best or most appropriate way to teach ethics to undergraduates. Perhaps the practice of using case studies or examples involving sensationalised issues such as genetic engineering, abortion or other media grabbing issues were not relevant to students. This lead me to question whether it was more beneficial and appropriate to include real issues in teaching sessions that students needed guidance on how to process and navigate.

I began to observe commonalities in the issues being raised by students and developed an interest in quantifying which issues were most frequently experienced and which caused the most distress for students. This would allow ethics educators to address these issues so as to better prepare students for clinical placement and ultimately the workforce.

1.3 Significance of the study

Students have valuable insights to offer regarding ethical issues in clinical practice. Where other healthcare professionals may take for granted the practices that are considered institutional norms, students view them differently (Newell & Woodroofe, 2000). This may be due to their relative inexperience within the healthcare system or because they are a ‘fresh set of eyes’. Park, Cameron, Han, Ahn, Oh and Kim (2003) suggest that students experience different ethical conflicts from registered nurses due to their relative powerlessness in the healthcare hierarchy.

Determining the ethical issues experienced by nursing students will offer a greater understanding of their unique perspective. This may be of considerable interest to nurse educators, academics, researchers and nursing organisations. By offering a greater understanding of student nurses’ clinical experience, it is hoped that the findings of this study will have the potential to influence undergraduate nursing education in both academic and clinical environments.

1.4 Research aims and question

It was the aim of this research to develop knowledge of ethical issues in clinical practice from the unique perspective of nursing students by determining (a) what ethical issues New Zealand undergraduate nursing students report as occurring most frequently in clinical practice and (b) identifying which ethical issues cause the highest levels of distress.
As this study is descriptive in nature and aims to gain a better understanding of the topic, no predictions or hypothesis were developed. Instead, the following research question was posed:

_What are New Zealand undergraduate nursing students’ experiences of ethical issues in clinical practice?_

### 1.5 Delimitations

This study did not aim to predict the outcome, effect or impact of ethical issues or distress on nursing students. Nor was this study an in-depth exploration of nursing ethics education delivery in New Zealand.

This research was not completed with the aim of drawing conclusions on how students develop ethical competence in practice or ethical decision-making skills, nor does it make definite recommendations on the solutions or curriculum changes required to develop ethical competence. The aim is to simply describe the situation as it is currently experienced by nursing students in New Zealand.

### 1.6 Definition of terms

The term _ethics_ is derived from the Greek word ‘ethikos’, meaning ‘pertaining to custom or habit’ and _morality_ originated from the Latin word ‘moralis’, meaning ‘custom’ or ‘habit’. Thus, the terms ‘ethic(s)’ and ‘moral(ity)’ will be used interchangeably herein, as there is no significant philosophical difference between them (Johnstone, 2004).

According to Johnstone (2004), ethics developed as a branch of philosophy that seeks to clarify and rationalise the assumptions and beliefs that people hold, and to determine what is considered to be acceptable behaviour. Ethics can be defined as “…ways of thinking about, understanding and examining how best to live a moral life” (p.11).

_Nursing ethics_ examines ethical 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 and environment, and nursing itself” (Johnstone, 2004, p.14).

_Ethical principles_ are universally acknowledged and respected principles that are based on a shared understanding of values and acceptable conduct (Thompson, Melia, Boyd & Horsburgh, 2006). An action is considered to be ethically right or wrong based on whether or not it is in accordance with a given ethical or moral principle (Johnstone, 2004).
A dilemma can be defined as any situation where there are reasons for conflicting actions or a situation that involves a choice between two alternatives that are both deemed to be unacceptable (Han & Ahn, 2000). An ethical dilemma can occur in the form of incompatibility between two different moral principles—for example where two different moral principles might apply equally in a given situation, but neither principle can be chosen without violating the other (Johnstone, 2004).

For the purposes of this study an ethical issue or problem is a problem or situation wherein a person is required to identify what would be evaluated as right (ethical) or wrong (unethical). While dilemmas do occur, it is ethical problems or issues that are more commonplace in practice. These may not be as dramatic as deciding between two morally complex or conflicting ethical principles, but they are as important and often go unrecognised by health professionals.

Distress can be described as pain, anxiety, sorrow, mental or physical suffering, affliction or trouble. Moral distress is the “...psychological disequilibrium and negative feeling state experienced when a person making a moral decision does not follow through by performing the moral behaviour indicated by that decision” (Johnstone, 2004, p. 107). Moral distress can also occur as a result of moral perplexity, when confusion exists in regards to a situation where a person is faced with a morally problematic situation—they recognise it is problematic, but genuinely do not know the right thing to do or the right action to take (Johnstone, 2004).

Ethical competence is the development of a sound theoretical knowledge of moral principles and practical skills in ethical decision-making. The kind of competence that is required in nursing practice is the ability to apply ethics to everyday clinical situations (Thompson et al., 2006). Competence in ethics requires that we “gain insight into the relationship between our own moral beliefs and the general ethical policies currently adopted by society and applied in the institutions where we work” (Thompson et al., p. 296).

1.7 Thesis overview

Chapter One: Introduction

The introductory chapter provides the background to the study and identifies the researcher’s area of interest. The significance of the study to both nursing and education is explored and the research aims, research question and delimitations of the study are described. Explanations of key terms used throughout the study are given.
Chapter Two: Review of literature

An overview of the literature pertaining to ethical issues, nursing students and ethics education is given in this section. The literature reviewed was sourced from journal articles and relevant texts on health care and nursing ethics. The themes that emerged from the literature review are discussed and categorised into ethical principles / patient rights, patient care and relationships.

Chapter Three: Research Design

This chapter reviews the paradigm and methodology selected for the study and provides rationale for the adoption of this approach. Other aspects of research design such as population and sample, recruitment, ethical approval, data collection and data analysis are described.

Chapter Four: Results and Discussion

The research findings are presented in this chapter. Demographic information outlines the composition of the participant group and each of the ethical issues outlined in the questionnaire are presented and discussed. Themes are outlined as they emerged from the qualitative question.

Chapter Five: Conclusions and Recommendations

A summary of findings is presented and how these could influence nursing education and clinical practice is discussed. This chapter elaborates further on the study’s limitations, along with the implications for further research.
Chapter Two

Review of Literature

2.1 Introduction

This review explores the ethical issues that nursing students experience in clinical practice. Primary and secondary literature was sourced to provide background to the research problem and identify relevant research studies conducted worldwide.

Other research and literature was sourced to provide further background on nursing education both internationally and domestically, with a particular focus on ethics education.

2.2 Search strategy

An extensive search of electronic databases was conducted. The databases searched include the Cochrane Library, Google Scholar, the Cumulative Index to Nursing Allied Health Literature (CINAHL), Joanna Briggs and ScienceDirect. The parameters of the search covered for research papers in publications printed between 2000 and 2012. A range of search keywords was used, including: ‘student nurse’, ‘nursing student’; ‘moral’ and ‘ethical’ ‘concern’, ‘issue’, ‘problem’ ‘behaviour’, ‘distress’, ‘dilemma’; ‘clinical placement’, ‘practice, experience’ and ‘practicum’.

Search words used to gather background and supporting information included: ‘nursing student’, ‘ethics’, ‘undergraduate education’, ‘nursing curriculum’ and ‘ethical development’.

Titles and abstracts were screened and studies were not included if they were not published in English or involved research that dealt solely with registered nurses or students from disciplines other than nursing. The study by Dierckx de Casterle, Grypdonck, Vuylsteke-Wauters, and Janssen (1997) was also reviewed despite having been conducted outside of the search timeframe, as it was referred to in many of the studies identified within the literature review process.

2.3 Search outcome

No research was found that addressed the research question directly, however nineteen different studies were found to be relevant to the search criteria. The selected articles had quantitative, qualitative or mixed method research designs and were conducted in 11 different countries, with the highest number (six) conducted in the United States of America (USA). Student participants were from both technical and degree programmes, and were enrolled in three and four year programmes in institutes of technology, colleges and universities. The
numbers of participants varied depending on the research design methods and ranged from 10 nursing students in a Malawian qualitative study, to 2,624 students in a Flemish study involving students from 14 different schools of nursing.

2.4 Ethical issues

Although students are typically supernumerary to the workforce, they still engage in many aspects of patient care that involve numerous stressors (Timmins & Kaliszer, 2002). Kim, Park and Ahn (2007) recognise that all students will experience ethical dilemmas when they go on their first clinical placements, as they are only beginning to develop their ability to make moral decisions.

Numerous issues identified by nursing students in clinical practice emerged from the literature review. These issues have been broadly categorised as relating to ethical principles / patient rights, patient care and relationships. The issues within the patient care and relationships categories may involve breaches of multiple ethical principles, such as justice, beneficence and non-maleficence, however they also involve specific aspects of providing patient care or existing relationships.

2.4.1 Ethical principles / patient rights

Many countries have developed codes of ethics to protect the rights of patients and promote ethical conduct in practice and research. These ethical codes reflect and promote human rights and fundamental freedoms, such as respect for autonomy, privacy, confidentiality, justice, beneficence, cultural diversity and personal integrity, and are often enshrined in declarations and legislation (Burns & Grove, 2009; Coup & Schneider, 2007).

Thompson et al. (2006) also acknowledge that for ethics to have credibility within a profession it must be based not only on values but on principles that are universally acknowledged and respected. Although nursing ethics is more than a set of rules and obligations (Lemonidou, Paphthanassoglou, Giannakopoulou, Patiraki & Papadatou, 2004), students are largely guided by professional rules, norms and duties (Dierckx de Casterle et al., 1997). Beckett, Gilberston and Greenwood (2005) argue that while general principles are useful to guide practice, they are not always sufficient in relationships with patients, as there is typically a certain level of uncertainty and ambiguity in real world situations.

 Traditionally, shared sets of values are epitomised in ethical codes. In New Zealand, the New Zealand Nurses Organisation (NZNO) has published the ‘Code of Ethics for Nurses’ (2010). This
code describes the ethical principles that govern nursing and nurses’ ethical responsibilities in their relationships with patients, colleagues and society. Neither this code nor any other holds legislative power; however they do provide a guideline for acceptable behaviour for nurses and students who are expected to demonstrate they can act professionally and ethically according to the Nursing Council of New Zealand Competencies for Registered Nurses.

Many of the ethical issues that were identified by nursing students in the reviewed studies were breaches of fundamental patient rights or ethical principles in healthcare, such as autonomy (self-determination), beneficence (doing good), non-maleficence (doing no harm), veracity (truth-telling) and justice.

Autonomy was found to be the one of the most frequently breached ethical principles. Autonomy is the right of an individual to freedom of choice and self-determination, assuming the individual has the wisdom to make the best choice (New Zealand Nursing Organisation [NZNO], 2010). A Turkish study by Erdil and Korkmaz (2009) involving 153 nursing students found that respect for patient autonomy was violated in most ethical problems. These breaches of patient autonomy were predominantly perpetrated by doctors and nurses in making unilateral decisions on behalf of patients, rather than discussing options and incorporating patient preferences. Violation of patient autonomy was also mentioned in a qualitative descriptive study by Callister, Luthy, Thompson and Memmott (2009). Students’ reflective journals were analysed and these indicated that breaches in patient autonomy caused an ethical dilemma in clinical practice. A Swedish study conducted by Edlund-Sjoberg and Thorell-Eskstrand (2001) identified the most concerning behaviour that nursing students observed as being restrictions of patients’ autonomy. This caused passivity on the part of the student due to a lack of confidence and a fear of not being accepted by staff.

A New Zealand study by Vallance (2003) concerned with the development of ethical practice in undergraduate students reported that nursing students experienced ethical dilemmas when they had to consider a patient’s right to autonomy versus the beneficence of a medical treatment. Participants in this study also reported that time constraints altered the level of patient autonomy they could facilitate and that, although they recognised that promoting autonomous decision making was an important aspect of nursing, it was lacking in practice. This was in part due to the difficulty of applying the principle of patient autonomy in the ‘real world’ of nursing practice. This is supported by Beckett et al. (2007), who found that students struggle with knowing what the right thing is when they are faced with a reality that does not neatly fit text book ethics—in the real world, relationships and decisions are fluid and indeterminate.
A lack of honesty being displayed by other health professionals was one of the themes that emerged from the literature review and one that relates to the principle of veracity. Veracity requires that communications, actions and behaviours between individuals or groups are honest and truthful (NZNO, 2010). Vallance (2003) also reported one participant’s astonishment at witnessing nurses being blatantly dishonest in regards to patient treatment. One participant recalled the distress they experienced when a Registered Nurse (RN) lied during an end of shift clinical handover to a colleague in regards to a patient’s condition.

Other studies highlighted incidents of the principle of veracity being breached when information was withheld from patients regarding aspects of their care. In studies conducted with 100 Korean senior nursing students (Han & Ahn, 2000) and 44 Taiwanese students (Yeh, We & Che, 2010), respectively, a lack of veracity or truthfulness was recognised as among the most concerning dilemmas facing students. One issue that students reported in Yeh et al.’s (2010) study involved students being personally instructed to withhold information or observing information being withheld from patients at the families’ request. Undergraduate nursing students can be dismayed when other health professionals do not tell the truth to patients (Erdil & Korkmaz, 2009). An American nursing student in Callister et al.’s (2009) study reported an incident where information regarding a medication error (a dose administered that was five times the prescribed dose on two separate occasions) was withheld from a patient. The student found this to be unethical and felt it could potentially cause more harm.

Students can also be put in a position where they are unsure whether or not they should tell the truth regarding a patient’s condition for fear of ‘getting it wrong’, or where they remain silent when they observe information being withheld. Lemonidou et al. (2004) discussed one such scenario, in which a student withheld information from a patient as they were unsure what to say regarding a high blood pressure reading. The student ultimately informed the patient, as they felt it important to uphold the principle of veracity, however they were later scolded by the staff nurse. Callister et al. (2009) also highlighted situations where students were party to withholding information, especially from those patients that were critically ill.

Informed consent can be linked to the principle of veracity and relies on full and correct information being given to patients. Not giving patients sufficient information appropriate to their situation was identified as a commonly occurring issue and one that caused concern to student nurses (Callister et al., 2009; Erdil & Korkmaz, 2009; Vallance, 2003). In some cases patients were forced to sign consent forms without having been given comprehensive
information regarding their diagnosis, treatment or prognosis (Erdil & Korkmaz, 2009). Solum et al. (2012) also found that informed consent was considered a patient rights issue and Malawian nursing students in this study experienced difficulty when observing the practice of withholding information from patients.

Lemonidou et al. (2004) found that students observed doctors and nurses providing only enough information to patients to allow them to continue their treatment. Student nurses reported that doctors would smile confidently to reassure the patient, rather than finishing conversations fully and to a patient’s satisfaction. Nurses were observed sternly informing patients of planned care and depriving them of the right to choose.

Justice in nursing ethics is underpinned by the belief that society has a responsibility to treat all people fairly (NZNO, 2010). In the nurse-client relationship this means acknowledging and respecting a client’s perception of what they consider to be fair and appropriate. Justice was found to be a frequently violated ethical principle by Erdil and Kormaz (2009) in their study of 100 Turkish students in their 3rd and 4th years of study. Fifteen percent of students surveyed reported experiencing the principle of justice being breached.

Applying the principle of justice in the ‘real world’ of nursing can involve considering more than just the interactions between patient and nurse, but also the allocation of resources and provision of care. This is a complex issue and can be morally perplexing for experienced health professionals, let alone those individuals that have had limited experience in the healthcare system. The allocation of resources to those who may not be perceived to have good quality of life at the expense of others who would benefit was a dilemma for students identified by Callister et al. (2009).

Equality and justice was a sub-theme that emerged in Solum et al.’s (2012) qualitative interpretative content analysis. One student nurse explained:

Sometimes in the mission hospital here, we have noticed that people related to staff receive attention first, for example the wife of the priest, even if she comes later than the other patients.

(Solum et al., 2012, p. 132)

In Buelow et al.’s (2010) study, the most common issue for American undergraduate students was the lack of care provided to those who were uninsured; this unequal access to healthcare caused the greatest level of concern to students.
Breaches of confidentiality were common among the studies included in the literature review and these were linked to issues of professionalism. Confidentiality is the privacy of the written or spoken word acquired through privileged access (NZNO, 2010). Twenty-four percent of students surveyed by Erdil and Kormaz (2009) indicated that they had witnessed or experienced breaches of patients’ privacy or confidentiality. Examples given included patient records in clinics being available for anyone to see and private medical information about certain patients being shared among staff not directly involved in their care. This is similar to findings in Callister et al.’s (2009) study, where one American student described a scenario in which a lack of confidentiality was observed in a clinical placement:

The nurses began to chat about their shift and their patients. One patient had the concentrated focus of all the nurses in an open ended conversation that could be heard down each of the hallways.

(Callister et al., 2009, p.503)

Solum et al. (2012) found that almost all of the participants in their qualitative study indicated that they been pressured to reveal private and confidential information relating to patients by family. All of the students in this study expressed that they had had difficulty maintaining the privacy and confidentiality of their patients due to the constant presence of family and the structure of the hospital.

Issues of dignity, privacy and respect were highlighted in several studies and relate to human rights. The actions or comments students felt were disrespectful and a violation of a patient’s right to dignity were generally those of other nurses, doctors or health care assistants. Lemonidou et al. (2004) and Erdil and Kormaz (2009) both highlighted breaches of privacy, with patients being exposed and uncovered during care and nurses performing care procedures without attempting to maintain the patient’s privacy by closing curtains or moving the patient into a private area. Erdil and Kormaz (2009) identified this lack of privacy afforded to patients as the second most common issue student nurses observed in clinical practice.

Other issues relating to patient dignity included health care staff making rude and disrespectful comments that were viewed as unethical and that caused moral distress for students (Callister et al., 2009). Themes relating to patient rights identified in other studies included ‘ignoring patients’ privacy’ (Erdil & Korkmaz, 2009), ‘breaches of privacy and confidentiality’ (Callister et al., 2009; Hunink et al., 2009; Solum et al., 2012), ‘violation of patient rights’ (Callister et al, 2009), ‘lack of respect for life’ (Han & Ahn, 2000), ‘disrespect shown to patients’ and ‘disregard of patients’ rights’ (Edlund-Sjoberg & Thorell-Eskstrand, 2001), and ‘dereliction of duties and
responsibilities of health care providers in relation to patient rights’ (Sato, 2005). Solum et al. (2012) discovered that students found unprofessional behaviour to be unethical and worrying. Incidents categorised by participants as violating patients’ right to respect and dignity involved nurses ignoring patients’ needs or shouting at them.

Studies have also found that many students have experienced or witnessed patient discrimination in clinical practice. Examples given were discriminatory treatment related to socio-economic or educational status (Erdil & Korkmaz, 2009) and/or levels of insurance cover, and drug abuse and non-compliance by the patient (Callister et al, 2009). Callister et al. reported that students had observed patients considered to be ‘frequent flyers’ (patients who make frequent and regular visits to a clinical area) or patients with drug problems being discriminated against. This discrimination came in the form of withholding or refusing care or providing care that lacked respect and kindness. Solum et al. (2012) reported that students recognised that unequal care was sometimes given based on patients’ level of education.

The principles of beneficence and non-maleficence were also identified as being among those breached in the clinical environment. Beneficence, or ‘doing good’, and non-maleficence, or ‘doing no harm’, are two of the ethical principles applied in healthcare that arise from traditional theories (Johns, 2004). In order to ensure beneficence, actions must now or in the future lead to an outcome that is considered worthwhile and to ensure non-maleficence these actions must avoid harm or prevent future harm (NZNO, 2010).

Behaviours identified by students as being in direct violation of these principles were ‘physical and psychological maltreatment of patients’ (Erdil & Korkmaz, 2009) and ‘potentially harmful and unsafe practices’ (Callister et al., 2009). These issues are discussed further in the next section, which focuses on patient care.

### 2.4.2 Patient care

End of life care and issues such as withdrawal of treatment, euthanasia and resuscitation orders were found to cause ethical dilemmas for students (Callister et al., 2009; Nolan & Markert, 2002). Timmins and Kaliszer (2002) found that one of the most concerning factors for students and one that caused considerable stress to patients was witnessing death and dying. A study by Range and Rotherman (2010) also identified issues relating to end of life care as being of concern to American undergraduate students. These students were morally concerned about the provision of inequitable or substandard care in the terminal stages of illness. This
inequitable or substandard care caused more concern to students than treatment decisions that hastened an individual’s death.

Decision-making in end of life care can be challenging for the most experienced of health professionals. Students’ reflective essays, as discussed by Callister et al. (2009), showed that there was a focus on patient care issues such as end of life decision-making. Park et al. (2003) replicated the Callister et al. (2009) study with 97 Korean nursing students, all of whom wrote reflective essays on an ethical issue they had experienced in practice. Sixteen percent of these students wrote about issues involving quality of life / death and dying. Students highlighted concerns about the treatment of patients with incurable diseases, families being forced to accept certain treatments and a lack of support being offered during this stage of life. Han and Ahn (2002) also stated that one of the most common student concerns in regards to end of life care was the family giving up on patients because they could not be cured. Students were ethically challenged by the fact that the decision to withdraw treatment may have been made by families for financial reasons or the time burden imposed by a sick and dying relative.

End of life care issues are complex and multifaceted. Other issues identified by nursing students included issues such as a patient’s right to die, when to initiate non-resuscitation orders and when to withdraw life support from patients (Buelow et al., 2010), dying patients and euthanasia, and leaving an incurable patient alone without treatment (Han & Ahn, 2002). Students also identified many of these issues as being the result of innovations and technologies being used in futile situations to prolong a patient’s life (Buelow et al., 2010).

Another dilemma that students face and tend to find considerably distressing is observing or being involved in incompetent or inadequate care. Witnessing or being party to potentially harmful and unsafe practices are two of the most common situations that prompt students to consider using an ethical decision-making tool in clinical practice (Callister et al. 2009). Lemonidou et al. (2004) found that nursing students frequently reported nurses having a general lack of interest in patients and being hasty and reckless in nursing procedures, with little regard for correct procedure.

One of the unsafe care issues highlighted by Cameron et al. (2001) was the inappropriate administration of medications and treatments. Another issue was staff providing care they were not properly trained for and not always following standard procedures and protocols. One student described feeling conflicted when choosing whether to follow staff instructions to force feed a client or to refuse and feel as if they had neglected their responsibilities to the patient.
Students felt that nurses at times took short cuts that could be potentially harmful to a client and that they acted unprofessionally (Cameron et al., 2001). This is supported by the findings of a Korean study conducted by Park et al. (2003), in which 69% of students indicated they had experienced ethical problems with the behaviour and conduct of other health professionals. This included nursing staff not providing treatments and medications properly, not giving quality care and acting unprofessionally. In another Korean study, medication errors were also raised, along with failing to report errors and using incorrect aseptic techniques (Han & Ahn, 2000).

Students can experience moral distress when they witness unsafe and unprofessional practice. This is compounded when errors are made and students feel a staff member does not follow protocol, such as not completing incident reports when a patient falls or when medication errors are made (Callister et al., 2009). Roberts (2006) found that being asked to care for patients they did not feel competent to care for caused students the highest mean distress score on the Moral Distress Scale (MDS). Overall students were most concerned with incompetent care—whether administered by themselves or by practising nurses, physicians or other health professionals.

The physical or psychological maltreatment of patients is unacceptable by any standard and something that students in Erdil and Korkmaz (2009) reported as occurring at concerning rates. Sixteen percent of participants indicated they had observed physical maltreatment of patients and 52% reported observing psychological maltreatment of patients during their clinical placements. Some of the students’ observations included the following:

*Some patients were lying on wet sheets and nurses did not care.*

*A doctor performed frequent and unnecessary vaginal examinations to improve his practice skill.*  
(Erdil & Korkmaz, 2009, p. 593)

Other comments by students relating to psychological maltreatment included observations that other staff scolded, humiliated, verbally abused and mocked patients (Erdil & Korkmaz, 2009).

### 2.4.3 Relationships

Students can experience stress when interacting with a new environment and with clinical staff. When students experience non-conducive relationships with staff, this stress can be compounded. In a South African study of 56 nursing students it was reported that staff did not respect their feelings or points of view, did not communicate in a respectful manner at all times and that in some of their encounters staff nurses were unjust (Arries, 2009). Timmins and Kaliszer (2002) found that clinical placements often caused stress and this was often due to the
behaviour of staff. Nearly one third of participants reported that interpersonal relationships with staff on the ward caused some form of stress.

Several studies found that a substantial portion of students’ ethical problems were related to the behaviour of other nursing staff (Cameron et al., 2001; Park et al., 2003; Yeh et al., 2010). Unethical behaviour, such as a disregard for patient rights or disrespect shown to patients by nursing or medical staff, was also found to be common (Edlund-Sjoberg & Thorell-Eskstrand 2001). The study conducted by Yeh et al. found that 40% of nursing students’ ethical dilemmas were related to the behaviour of other nursing staff and Erdil and Korkmaz (2009) found the common contributing factor to be the unethical and unprofessional behaviour of doctors and nurses.

Similar themes emerged from a study of Japanese nursing students, where students were concerned with the duties and responsibilities of health care providers and the fidelity of health care workers (Sato, 2005). Sato speculated that this may be due to students’ perceptions of these ethical issues and their expectations being more closely aligned to those of patients rather than healthcare workers.

Savage and Favret (2006) conducted a mixed method study to determine the views of nursing students in regards to the ethical behaviour of their nursing instructors. The questionnaires and narratives of 101 students were examined and issues from both the academic and clinical environments analysed. Within the clinical environment students reported instructors insulting students in public and discriminating against some students while giving preferential treatment to others. Students also reported that instructors indiscriminately breached the confidentiality of patients and students (Savage & Favret, 2006).

2.5 New Zealand undergraduate nursing programmes

In New Zealand 17 different institutions provide a Bachelor of Nursing programme. These programmes are available at a range of universities, institutes of technology, polytechnics and wananga across 22 different sites. Nursing education is funded in accordance with strategic plans by both the Ministry of Health (MOH) and the Ministry of Education (MOE). The majority of these funds come from the Tertiary Education Commission (TEC), which sits within the MOE (Walker & Clendon, 2012).

New Zealand undergraduate nurses are not registered with the NCNZ, nor are they held accountable or regulated through the Health Practitioners Competence Assurance Act (HPCA) 2003, which was put in place to ensure all health services and providers are consistent in their
education and competence requirements. Education programme standards are set, approved and monitored by the NCNZ through an audit process to ensure the required standards are met (Walker & Clendon, 2012). The NCNZ set the standards for nursing education that are outlined in the ‘Handbook for nursing departments offering programmes leading to registration as an enrolled or registered nurse’. These standards state that a nursing programme must have an organised and systematic structure that enables students to achieve the NCNZ Competencies for the registered nurse scope of practice. It is stated that professional responsibilities and conduct and ethical and legal responsibilities should be addressed within the curriculum (Nursing Council New Zealand [NCNZ], 2012). These standards do not directly address or dictate the content or time allowed for ethics education or any other specific subject within the theory component of the curriculum.

Currently the NCNZ requirement for registration is completion of an approved undergraduate programme, a minimum of 1,100 clinical hours and a declaration from their tertiary provider’s Head of School. This declaration must state that the student fulfils the ‘fit, proper and good character’ requirements for registration within the NCNZ prior to sitting the State Final Examination (NCNZ, 2012).

2.6 Ethics education

Doane et al. (2004) highlight that undergraduate nursing ethics education must be reflective of everyday practices and contextual influences, and that students require an understanding of the healthcare structures and policies that affect their ethical responsibilities as a nurse. In New Zealand, however, it has been acknowledged that students are generally not fully prepared to meet the demands of the ethically challenging workforce they will enter and that newly qualified nurses’ struggle with ethical confidence (Woods, 2005).

Individuals develop their own values over a life time and are influenced by various sources—personal, professional and societal. Although it is natural for a person’s initial feelings to be influenced by their subjective feelings, perceptions and attitudes (Erdil & Korkmaz, 2009), it is important for nursing students to reflect on and clarify their personal and professional values in relation to ethical dilemmas before they can consider the best way to manage them (Garity, 2009). It has been stated that the most influential factors in the development of moral and value judgements are parents and teachers and that this does not change during a person’s training (Nolan & Markert, 2002). Therefore, nursing educators have the opportunity to guide and develop nursing students in how they manage and deal with ethical issues and dilemmas in clinical practice.
New Zealand nursing students have found that while on clinical placement they have difficulty balancing the ‘ideal vs. real’ realms of nursing practice (Vallance, 2003). Nursing students in Kim et al.’s (2007) study had learned idealistic nursing ethics and became distressed when they had to contend with real ethical dilemmas that did not reflect the learned theory. In reality, placements tend to deny students any realistic opportunity to truly reflect on the ethics of a particular situation and process it accordingly (Newell & Woodroffe, 2000).

2.7 New Zealand research

There has been some New Zealand research that has examined the experiences of healthcare professionals in relation to the ethical aspects of their working environment. Most recently, research by staff from Massey University involving 412 New Zealand nurses found that registered nurses were morally distressed in situations where less than optimal care was given due to management or resourcing pressures to reduce costs and when watching patients suffer due to a lack of provider continuity. Working with nurses or other health professionals who are less competent than the patient’s care required, carrying out physician orders for unnecessary tests and treatments and initiating extensive lifesaving treatments when the nurse felt it would unnecessarily prolong life were also situations that caused distress (Massey University, 2012).

Vallance (2003) explored how nine newly graduated registered nurses’ undergraduate ethics education had prepared them for practice. Although this study provides some insight into the ethical issues and dilemmas the participants faced as undergraduates, it was conducted after the participants had graduated and thus allowances must be made for potential changes having occurred in their perception, awareness or understanding of ethical issues since entering the workforce. This in-depth exploration of a small number of students does not provide findings that can be generalised to the wider population of undergraduate nurses.

There has been no published research looking at the ethically challenging workplace from the viewpoint of the nursing student and how they were impacted, or that quantified the research objectives of this study.

2.8 Relevance of international literature to New Zealand

There are cultural and contextual factors that limit the ability to draw parallels from either research involving registered nurses or overseas research involving nursing students with New Zealand undergraduate nursing students. Cultural and educational differences need to be taken into consideration when examining overseas studies, as these can influence an individual’s perception of what constitutes ethical behaviour and their ethical decision-making ability
(Garity, 2009). In some of the studies it was evident that families play a much larger role in medical decision-making (Han & Ahn, 2000, Yeh et al. 2010, Solum et al., 2012) than is common in New Zealand society.

Other contextual factors to be considered include healthcare structure—for example, public policy and insurance are highlighted as one of the most frequently occurring ethical problems facing healthcare students in the United States (Buelow et al., 2010). These factors would not be relevant in New Zealand, as we have a significantly different healthcare sector organisational structure.

2.9 Conclusion

There is no study within this review that addresses the research aims outlined for this study or that analyses all the aspects of the New Zealand undergraduate environment—clinical experience, course length, curriculum delivery, cultural considerations and demographics.

What is clear is that the experience of ethical issues and distress is high amongst those in caring professions and students are no less likely to experience ethical issues or feelings of distress relating to compromised moral integrity. It is, however, not necessarily the controversial or media attention grabbing ethical issues such as euthanasia, abortion or genetic engineering that cause nursing students the most distress. Instead, it is breaches of commonly accepted ethical principles such as patient autonomy, respect and dignity, the unethical behaviour of others and issues that compromise patient care.
Chapter Three

Research Design and Method

3.1 Introduction

The literature review has shown that although international literature that explores the ethical issues that nursing students experience exists, there has been no such research that has provided knowledge relating to New Zealand nursing students.

The purpose of this chapter is to describe the research design, along with the rationale for specific design features. The implementation of the chosen design will be discussed and a description of the population, sample process, ethical and cultural considerations, data collection and analysis required in order to conduct this research will be offered.

3.2 Paradigm

A paradigm is a philosophical approach or belief system. This research resides within a positivist paradigm, which is commonly used in the natural sciences by psychology, medical and health care researchers. It is sometimes referred to as the scientific approach (Walsh & Wigan, 2003) and is representative of a quantitative research approach (Whitehead, 2007).

3.3 Research design

A research design is the overall plan or blueprint for obtaining answers to the questions being examined so as to meet the objectives of the study (Polit & Beck, 2004). To achieve the research objectives previously outlined, quantitative research was conducted in order to generate quantifiable data. A quantitative research methodology was considered the most appropriate for this study, as it aligns with the positivist paradigm and adopts a logical approach that emphasises deductive reasoning (Whitehead, 2007).

Quantitative research lends itself to investigating phenomena that require precise measurement and quantification, often involving a controlled design (Polit & Beck, 2004). A quantitative design tends to be structured in order to enhance objectivity. Objectivity is an important element of all aspects of quantitative research, including the conceptualising and defining of the problem to be studied, controlling the environment, replication and validity (Elliott & Thompson, 2007).
The most suitable research design was determined to be a non-experimental, univariate, descriptive survey design. This design was selected due to its high degree of representativeness and the relative ease with which a high number of participants’ opinions could be obtained.

Descriptive study designs are used to gain information about characteristics within a particular field in order to provide a clearer picture of a situation as it naturally occurs. Descriptive studies can be used to develop theory, identify problems, make judgments or justify practice (Burns & Grove, 2009). In descriptive research, the variable is examined as it exists, without the researcher manipulating or interfering with the environment. The researcher also has little or no interaction with participants. Common variables of interest in descriptive studies include participants’ beliefs, attitudes and knowledge levels. The effects of variables cannot be tested in this design and descriptive studies cannot make a determination of causality or determine if any relationships exist between variables (Elliott & Thompson, 2007).

This study sought to obtain and describe the views of the participants with regard to the frequency of ethical issues in clinical practice and the associated distress levels. The focus of the study was on a single variable—namely, certain views. As the views of nursing students relating to the research questions and objectives of this study had not been examined before, a quantitative non-experimental descriptive study design was considered appropriate, as this type of research can help to describe what exists, determine frequencies and categorise information. It is also typically conducted when little is known about a topic or to explore a research question (Burns & Grove, 2009).

The focus of the study is concise and narrow, which is reflective of a quantitative approach. Those employing this approach within a positivist paradigm often make use of a questionnaire to survey a representative sample of the population (Walsh & Wigens, 2003). The term survey can be used to designate any research activity in which the investigator gathers data from a portion of the population for the purposes of examining the characteristics, opinions or intentions of that population (Polit & Beck, 2004). The advantages of a survey were considered when developing the research design so as to best to answer the research question. Surveys can save time otherwise spent interviewing, reach a large number of people easily and allow participants time to consider their responses (Walsh & Wigens, 2003). This is an advantage when the data being collected relies on the participants’ recall of events in the past. Ultimately a structured questionnaire was developed for this study that enabled responses to be quantified and a statistical analysis was conducted in order to ensure external validity.
The research designs that had been utilised by researchers in similar studies were reviewed to determine the appropriateness of the selected research design. Both quantitative and qualitative methodologies were used within a number of different research designs in these studies. Two published studies involving registered nurses were found to have had similar objectives to the research questions posed for this study. An abstract reviewed by the Boston College William Connell School of Nursing Ethics outlined a study conducted by Fry and Currier (n.d.) in 1997-1999. The objective of this study was to identify the ethical issues experienced by registered nurses in practice and to quantify how frequently they occurred and how disturbed the registered nurses were by the issues. This research adopted a quantitative, descriptive survey design using the 35 item Ethical Issues Scale (EIS) and descriptive statistics were used to answer the research questions. A similar study in Australia by Johnstone, Da Costa and Turale (2004) was found to adopt the same research design to look at registered and enrolled nurses’ experiences of ethics and human rights issues in nursing practice. A descriptive survey design with a questionnaire using an adapted version of the EIS was used to identify the frequency of and disturbance levels associated with issues.

Both of these studies had similar objectives and aims to this study, with the most frequent and most disturbing issues identified using quantifiable data. Johnstone et al. (2004) also performed a thematic analysis of the additional comments written on the questionnaire by participants. The use of a similar research design in these earlier studies supports the appropriateness of the selected research design.

3.4 Population and sample

A population is “a well-defined set that has specific characteristics” and a sample is “a sub-set of sampling units from the population” (Schneider & Elliott, 2007, p.176). The target population is the aggregate of cases about which a researcher wishes to make generalisations (Polit & Beck, 2004). The target population for this study was under-graduate nursing students.

A non-probability convenience sample of nursing students was used due to the difficulties in obtaining a conclusive list of undergraduate nursing students. This sampling approach is considered to acceptable for small exploratory quantitative studies and useful when the total population is unavailable (Schneider & Elliot, 2007).

Information received from the MOE Tertiary Sector Performance Analysis Unit stated that 9,392 students were enrolled in Bachelor of Nursing degrees in 2012. This number includes part-time
students in formal qualifications greater than 0.3 Equivalent Full-time Student (EFT) (Ministry of Education [MOE], personal communication, March 14, 2013).

The nursing student population in New Zealand is not registered with a national body or council. Individual educational institutes hold enrolment and demographic information relating to students, including contact information. Accessing the entire population via their educational institutes would have raised privacy issues and was considered time consuming and cost prohibitive. Therefore, the sample for this study was drawn from nursing students who were current members of the New Zealand Nurses Organisation (NZNO) National Student Unit (NSU). The NSU is a voluntary student union and had 4,422 members in 2012 from various TEIs. This sample was chosen partly for its accessibility and its reflectiveness of the national student body as a whole. The 2012 student numbers available from the MOE indicate that approximately half of all nursing students elect to be members of the NSU.

The limitations of a convenience sample and self-selection include a low response rate, bias and a limited ability to generalise to the wider population (Schneider & Elliott, 2007). The advantages are the relative ease with which the participants could be obtained and that members of the NSU were students from various schools of nursing across New Zealand. With members of the NSU being representative of different nursing schools the risk of bias is reduced, as it is likely that students will have experienced clinical placement in various hospitals and primary health placements across New Zealand.

3.4.1 Participant recruitment

A formal application for assistance to access the NSU database and recruit members for the study was sought from the NZNO Professional Services Manager (PSM) after ethics approval was received. The NSU database was accessed for the purposes of recruitment independently of the researcher and at no time were members’ details accessible to the researcher. An email invitation was sent from the Professional Services Team Leader inviting students to participate in the study.

3.4.2 Eligibility criteria

Burns and Grove (2009) define eligibility criteria or sampling criteria as the characteristics that are necessary to be considered for inclusion in a study. Participants in this study were not recruited or selected for their representativeness of any particular cultural background, age, ethnic group or gender within the target population.
Participants met the inclusion or eligibility criteria for this study if they were aged over 18 years, were enrolled as a full or part-time Bachelor of Nursing student and had been on a clinical placement lasting for a minimum of two weeks in the previous six months.

Exclusion criteria are those characteristics that would cause a person to be excluded from the target population and the study (Burns & Grove, 2009). Participants were excluded from this study if they were under 18 years of age at time of completing the survey, if they held qualifications or were employed as another registered health professional (i.e. Enrolled Nurse) or if they were enrolled in the Diploma of Enrolled Nursing programme. This final criterion was included so that the recollection of facts would be solely from students’ experiences, rather than from experiences working as a registered health professional. Students who had not attended a clinical placement in the previous six months were also excluded so as to ensure participants’ recall of situations was relevant and current.

3.5 Ethical considerations

A researcher’s responsibilities during the research process involve professional, ethical, legal and sociological obligations to the participants of a study (Polit & Beck, 2004). This study complies with the ethical guidelines described by the Health and Disability Ethics Committees. The Health and Disability Ethics Committees (HDEC) are Ministerial committees (established under section 11 of the New Zealand Public Health and Disability Act), whose function it is to secure the benefits of health and disability research by checking that it meets or exceeds established ethical standards (Ministry of Health [MOH], 2012, October 26).

3.5.1 Ethical approval

HDEC approval was not formally sought after reviewing the requirements for ethics approval outlined in the Standard Operating Procedures for HDEC (Health and Disability Ethics Committee [HDEC], 2012). See Appendix I for the flowchart provided by HDEC for clarification of studies that require HDEC review.

The research proposal was submitted for the approval of the Eastern Institute of Technology (EIT) Health Sciences Faculty Academic Committee (see Appendix II). This committee approved the proposal and gave permission for the study to be conducted. Ethical approval was subsequently sought from the EIT Research Ethics and Approval Committee and the research project was approved for 2 years from July 2012 (see Appendix III). Approval was subject to clarification of the use of the term ‘moral distress’. Written clarification was provided for the committee and this fulfilled their requirements (see Appendix IV).
3.5.2 Protection of participants

Researchers have an ethical responsibility to recognise and protect the human rights of those individuals who participate in research. The human rights that require protection in research are not dissimilar to the rights and core ethical principles discussed in Chapter Two, such as the rights to autonomy and self-determination, informed consent, privacy, confidentiality, fair treatment and to be protected from discomfort and harm (Burns & Grove, 2009).

In order to ensure participants’ right to autonomy or self-determination, they must be provided with sufficient information about the study to meet the requirements of informed consent (Coup & Schneider, 2007). It is important that researchers are able to demonstrate that their research participants have freely consented to being involved in the research and that they have a full understanding of what the research involves. Participants in this study were sent an email invitation (see Appendix V) by the NZNO NSU. This email included a general statement regarding the purpose of the study, a description of the study procedures and a list of potential risks and benefits. Also included was the contact information of the researcher and Principal Supervisor. This gave potential participants the opportunity to gain further information about the study or method to inform their decision-making. Further information about the study and the content of the questionnaire was provided when participants entered the survey from the direct link provided in the email. For more information on this, refer to the questionnaire section titled ‘General Information, Consent and Confidentiality’ (see Appendix VI).

Participants were advised that participation was voluntary and a statement was included in the questionnaire that stated that the completion of the survey indicated voluntary agreement to participate and certification that participants were 18 years of age or older at the time of the study. Borbasi, Jackson and Langford (2008) recognise that where it is not practical to gain written consent, the completion of a questionnaire can provide implied consent. No reward was offered for completion of the questionnaire, nor was there any threat made that a participant’s identity would be made available to the researcher or their educational institute if they did not participate. This avoided the implication that a participant’s right to autonomy would be breached by the offer of a reward or threat if a person did not participate (Coup & Schneider, 2007).

All research participants have a right to privacy (Walsh & Wigens, 2003). The United Nations Declaration on Bioethics and Human Rights includes a principle protecting the privacy of any research participant (Coup & Schneider, 2007). A violation of this right resulting from information about an individual being made public constitutes a civil wrong (Burgess, 2008).
Maintaining confidentiality requires that the identities of the participants cannot be linked to the information they provide (Coup & Schneider, 2007); therefore no personal information that could identify participants was collected during this study. There were no questions in the survey that required the identification of an educational institute, clinical placement or geographical location.

During this research there was an obligation on the part of the researcher to protect individuals or organisations from being identified. Any comments made when answering the open-ended question that could potentially identify a hospital, clinical placement or health professional were removed from the data. Maintaining confidentiality also pertains to the storage of data (Coup & Schneider, 2007). All information and data collected in the development phase was stored in a locked filing cabinet. Electronic data collected was downloaded from SurveyMonkey® and entered into Microsoft (MS) Excel® spread-sheets using code numbers for identification of participants and was stored in password protected files.

Participant anonymity was also protected in this study, as participants could not be linked to their responses even by the researcher (Burns & Grove, 2009). Participants remained anonymous to the researcher throughout the research process, as the researcher was not involved in their recruitment and the survey was configured to ensure that students’ return email address or Internet Provider (IP) address were not available to the researcher. SurveyMonkey® Secure Sockets Layer (SSL) encryption was activated to secure transmitted information.

No physical risks were foreseen for participants. However, there were potential psychological implications that required consideration, such as a participant’s mental or spiritual well-being being impacted in the process of them recalling ethically challenging or unethical practice. The participant information sheet and the final closing statement gave advice on avenues that could be accessed for assistance if guidance or debriefing was required.

3.5.1 Treaty of Waitangi considerations

The proposed research is not Kaupapa Māori research in essence, nor does it fit within a Māori-centred research paradigm, however Māori student nurses were involved in the research as part of the student body being sampled. Although different cultures were studied as they appeared in the nursing student population, it was predicted that the culture of nursing students would be central.
With respect to Treaty of Waitangi obligations, researchers must consider how their research will include benefits for Māori and non-Māori equally. Article Two of the Treaty of Waitangi also stipulates that Māori must retain control over all of their resources, including their people, and that it must be acknowledged that Iwi have authority over their people’s involvement in research (Tolich, 2002). Māori have an expectation and a right to expect equivalent states of health and an equitable share of all benefits of health funding (including research funding).

As this research is reflective of New Zealand nursing students’ views, it may help to improve retention and completion rates for nursing students, including Māori students, which may have a positive influence on Māori health workforce development.

Further research stemming from this descriptive study may include a closer examination of the differences in moral distress, moral reasoning or ethical decision-making of Māori nursing students compared to other ethnic groups. This may relate to or extend current work by Māori researchers and academics who are developing a Māori research ethical framework that reflects the beliefs of the indigenous Māori people, rather than the dominant Judeo/Christian value system (Caldwell, Lu & Harding, 2010).

3.6 Data collection method

The data collection method for this study was an original questionnaire developed for this study. Other tools identified in the literature review, such as the EIS and MDS, were not accessible and are designed specifically for practicing nurses rather than nursing students.

The web-based questionnaire was developed using SurveyMonkey® (see Appendix VI). SurveyMonkey® allows a web-link to be attached to an email that gives participants access to the questionnaire. The collector web link settings allowed multiple responses per computer or IP address. This is recommended when it is likely that participants are responding from computer labs / institutes with the same IP address, however it does introduce the potential for individuals to respond to the survey more than once.

3.6.1 Questionnaire development

The findings of the literature review and the experiences of the researcher served as a basis for the development of the questionnaire. Initially 20 ethical issues were developed into questions based on ethical principles / patient rights and patient care. A preliminary paper-based questionnaire was developed and distributed to a purposive sample of 47 nursing students in the second year of their nursing degree for feedback. Participants were asked to voluntarily
review the questionnaire to determine if any questions posed difficulty in regards to wording or understanding. They were also asked for feedback on the relevance of each item included in the questionnaire. An open ended question was also included in the preliminary questionnaire to enable the identification of any issues not evident in the literature review process.

In response to verbal and written feedback the wording of some questions was modified and questions deemed to be duplicates or irrelevant were removed, leaving a total of 15. No strong themes or new issues were found in the open-ended responses. The format of the questionnaire was also modified, as students felt that addressing their frequency and distress concurrently would decrease confusion.

Māori students were actively sought during the development phase to ensure that Māori views and perspectives were included within the questionnaire design. Māori students were asked to provide feedback on wording, interpretation and understanding. Advice was also sought regarding cultural perspectives that may impact on Māori students recalling distressing ethical issues. Māori students approached for this purpose did not highlight any differing opinions to students of other ethnicities, enforcing the belief that the nursing culture is the focus of the research.

3.6.2 Questionnaire format

The questionnaire included a general information page including a statement regarding consent and confidentiality and three preliminary questions to identify participants who met the inclusion criteria. These questions needed to be answered in the affirmative for the participant to meet the eligibility criteria and included confirmation (1) they were currently studying towards becoming a New Zealand Registered Nurse, (2) they were not registered with the NCNZ as an Enrolled Nurse (EN) or a Nurse Assistant (NA), and (3) they had attended a clinical placement for a minimum of two weeks in the past six months.

Participants who meet the inclusion criteria then progressed to Section A, which collected descriptive variables of gender, age, ethnicity and year of study and included further information about the study. Participants were also instructed at this time that they would be asked to recall experiences from their time as nursing students and not from their workplace if they were employed as health care assistants, caregivers or nurse aides.

The next two sections, B and C, were designed to gather data relating to the participants’ views on pre-determined issues relating to ethical principles / patient rights and patient care. Likert
scales were utilised, as they enable participants to report their opinions on a continuum (Burns & Grove, 2009). High scores correlated with high frequency and high distress levels.

Firstly, participants were asked to identify the frequency of the issue outlined in the question on a Likert scale: ‘Never’ (1); ‘Rarely’ (2); ‘Sometimes’ (3); ‘Frequently’ (4); ‘Very Frequently’ (5). Skip logic was applied to the frequency question to ensure that if participants indicated they had ‘never’ experienced the issue, the corresponding distress question was bypassed. If the participant indicated they had experienced the issue they would proceed to the distress question related to the issue and indicate their distress level on a second Likert scale with the following rankings: ‘No Distress’ (1); ‘Some Distress’ (2); ‘Moderate Distress’ (3); ‘High Distress’ (4); ‘Very High Distress’ (5).

3.6.3 Pilot Testing

The purpose of piloting the data collection tool is to identify any faults or weaknesses in the methods chosen before they are used on a larger scale to help the researcher avoid problems and improve their intended data collection methods (Walsh & Wigen, 2003).

The email containing information regarding the research and the link to the web-based survey was distributed via email to six registered nurses and nurse educators. The feedback received allowed grammatical errors to be corrected and ensured the web link was operational. Data collected during the pilot testing phase was not saved electronically and was deleted from the collector file in SurveyMonkey® prior to distribution of the survey questionnaire to the sample.

3.6.4 Questionnaire distribution

The distribution of the email invitation and information with the web link was done independently of the researcher and participants’ information was not forwarded or available to the researcher at any time. The email invitation with the embedded web link to the questionnaire was sent by NZNO to the 3,383 student members who had an email address recorded with their membership details. There was no information available on how many of these email addresses were current or valid.

The return email address on the email invitation was the NZNO so that any questions relating to the questionnaire would be directed to the NZNO then forwarded to the researcher by the NZNO Professional Services Team.
3.7 Reliability and Validity

Instrument quality plays an important role in the selection of an appropriate instrument. A tool that is valid and reliable ensures that the data it collects measure the appropriate content of the concept under investigation (Borbasi et al., 2008).

The questionnaire was submitted to experts in the field of nursing ethics and education to determine content validity. Content validity is the logical evaluation and judgement of whether the instrument adequately reflects the content of the concept under investigation (Borbasi et al., 2008). Criteria for evaluating the questionnaire were provided and focused on assessing the technical soundness, clarity and relevance of the items included in the questionnaire.

Burns and Grove (2009) state that readability is an essential element of validity and that reliability should be formally identified as a component of content validity. The reading comprehension of the population was not tested, however the wording was reviewed during the development phase and deemed suitable for participants within a degree programme. Excessive jargon and technical terms were avoided to ensure ease of reading and understanding.

The questionnaire was refined and adapted, incorporating the suggestions provided by the field experts. This involved including an open ended question at the end of the survey allowing participants to identify any other ethical issue not included in the questionnaire. The questionnaire was also reviewed by a statistician to determine whether any irregularities existed that may have hindered the data analysis.

The questionnaire was submitted for reliability testing after the completion of the data collection. Cronbach’s co-efficient alpha scores were calculated to test the reliability of the questionnaire with reference to its internal consistency. This score communicates reliability statistics (Burns & Grove, 2009) and is the most commonly used test of internal consistency for an instrument that utilises a Likert-scale response format (Elliott, 2007).

3.8 Data analysis

As this research project has a quantitative descriptive design, the majority of the data was examined using statistical analyses (Polit & Beck, 2004). The qualitative open-ended question included at the end of the survey provided participants with the opportunity to identify any additional ethical issues they faced in clinical placements. These responses were subject to
qualitative thematic analysis. Data analysis was conducted using SurveyMonkey® and MS Excel® software.

All the completed questionnaires were numerically coded and reports were generated using the SurveyMonkey® analyse tab. A filter was applied to exclude incomplete surveys (n=339). Cross tabulation reports were also constructed using SurveyMonkey® for year of study and ethnicity for the purposes of inferential statistical analysis. These reports were downloaded in numerical and text form into MS Excel® spread sheets.

3.8.1 Quantitative data analysis

Section A of the questionnaire contained nominal data, including gender, age, ethnicity and year of study. Data from this section was calculated to determine the total number of participants in each category and provide percentages.

The data collected in sections B and C included responses relating to frequency and distress levels regarding the pre-determined ethical issues outlined in each question. Responses to these questions were analysed to provide counts and percentages allocated to each frequency and distress level and highlighted the most common answer. Mean rating scores were calculated for each of the 15 ethical issues to determine the average levels of either frequency or distress and to enable the issues to be ranked.

Cross tabulation tables were created for each of the years of study and ethnicity to determine the frequency and distress levels attributed to each group. Mean rating scores were calculated and issues ranked accordingly. Independent t-tests were calculated for the issues with the most noticeable differences in mean rating scores or rank between groups.

An overall distress score was allocated to each group, calculated as an average from the mean rating scores of the 15 individual issues. Independent t-tests were calculated to assess the statistical differences in the overall distress scores between New Zealand European and New Zealand Māori participants and between years one & two and two & three of study. Frequency scores were not assessed for statistical difference, as it was determined that these would be expected to rise across the three years of study due to increased exposure to clinical placement.

The flowchart outlined in Figure 1 was reviewed to determine the most appropriate statistical test to apply to analyse the statistical differences between groups.
Figure 1. Determining that a \( t \)-test is the correct statistical test (Salkind, 2011, p.191)

The \( t \)-test for independent samples was calculated using MS Excel, with the differences between the two groups considered statistically significant when \( p = < 0.05 \), which is appropriate for most studies (Fisher & Schneider, 2007).

### 3.8.2 Qualitative data analysis

The qualitative data provided by responses to Question 38 ‘What other ethical issue have you experienced in clinical practice?’ (see Appendix VI) was analysed using a thematic analysis in order to evaluate the unstructured descriptive data gained and to seek patterns and themes (Wood & Ross-Kerr, 2011). This involved the responses being divided into codes and then grouped into categories and subcategories so that a number of abstracted elements of data became a like-set or group (Annells & Whitehead, 2007).

The researcher reviewed the responses multiple times in order to become familiar with the data. SurveyMonkey analysis software was used to generate a report of the most commonly used words and to label responses into broad, colour coded categories. The data was again reviewed in text format and the broad categories and themes were further defined and named. The data was reviewed for explicit rather than implied meaning because, as the research was anonymous, the data and its meaning could not be verified by participants.

The findings from the qualitative responses are presented in a descriptive narrative format in chapter four. Excerpts provided from the participants provide a description of the themes presented (Polit & Beck, 2004). The corresponding frequency and distress scores allocated by
the participants to these themes were also calculated to provide a mean frequency and distress rating score for the theme.

Participants also used the opportunity provided by the open ended question to elaborate on situations that corresponded with the pre-determined ethical issues outlined in other questions in the questionnaire. Excerpts from the comments provided by the participants that provide further information relating to the pre-determined issues have been included in the presentation of findings.

3.9 Limitations of research design

The limitations of this research study relate to the nature of its design. In particular, researchers who conduct descriptive survey design research take a broad, systematic view of a topic at a specific moment in time and collect empirical data on it. Ultimately, the results obtained using purely quantitative methods do not allow the researcher to establish a relationship between cause and effect or to predict outcomes (Borbasi et al., 2008).

As the questionnaire was distributed via electronic mail, there is also no way to confirm the rate at which the questionnaire was received by the sample or who actually completed the questionnaire. The numbers of invalid email addresses or returned emails were not collected by the NZNO Professional Services Team to determine an accurate response rate. A low response rate is a disadvantage to survey based research, as it can in turn limit the researcher’s ability to generalise the findings of this study to the entire population (Burns & Grove, 2009). The data collected during the research was not subject to verification; instead it was based on individual participants’ recollections and interpretation of events.

3.10 Conclusion

A quantitative, non-experimental descriptive research study designed to answer the research question has been described in this chapter. Elements of the research design including sampling, recruitment, data collection, ethical, legal and cultural considerations, data analysis and the limitations of the research have been discussed, along with corresponding rationale.
Chapter Four

Results and Discussion

4.1 Introduction

This chapter will describe and discuss the results of the survey, providing both quantitative and qualitative data. The numerical data will be presented in absolute numbers and percentages. The differences in responses that can be attributed to ethnicity or year of study are presented with an overview of the most frequently occurring and most distressing issues for these groups and overall.

The email invitation was sent to 3,383 students registered with the NZNO NSU. NZNO was unable to identify students from their database by qualification prior to the distribution of the questionnaire; therefore students outside of the target population would have received the email invitation. This may have included students completing a Diploma of Enrolled Nursing, a Bachelor of Health Science or a Return to Nursing programme.

A total of 509 responses to the email questionnaire were received. Participants were asked three preliminary questions to ascertain if they met the inclusion criteria. Sixty respondents were not studying towards becoming a New Zealand RN, indicating they were mostly likely enrolled in a Diploma of Enrolled Nursing programme. Thirty respondents had not attended a clinical placement for a minimum of two weeks in the six months prior to the survey being sent. Eighty three respondents (16.3%) were currently registered with the New Zealand Nursing Council as an EN or NA and therefore did not meet the eligibility criteria. This number was higher than expected, which may indicate that respondents believed this question included those working as nursing or healthcare assistants, rather than those registered as an EN or previously registered as a NA with the NCNZ.

A total of 373 respondents met the eligibility criteria and commenced the survey. Three hundred and thirty nine (91%) of those eligible fully completed the survey and were included in the data analysis. It is unknown how many of those sent the survey link were representative of the target population, thus it is not possible to calculate an accurate response rate. The nominal overall completion rate of 10% was given based on the number of NZNO NSU members sent the survey email invitation, rather than the eligible population.

The distress questions were assessed and the Cronbach’s alpha for the 15 item distress scale was calculated at 0.88. Internal consistency is supported by a Cronbach’s alpha above 0.8, as
this provides evidence that the items measure the same underlying construct (Burns & Grove, 2009).

4.2 Demographic data

Participants answered questions relating to demographic variables such as age, gender, ethnicity and year of study in order to provide a description of the sample and to determine the appropriateness of generalising findings to the wider population (Burns & Grove, 2009).

4.2.1 Gender

The majority of participants (91%) in this study were female, which is reflective of the overall nursing population. Ninety three percent of the nursing workforce in New Zealand is female (Walker & Clendon, 2012).

The percentage of female and male participants in this study is largely reflective of the 2012 NZNO National Nursing Student survey conducted by Walker and Clendon, wherein 91.5% of participants were female and 8.5% male. MOE data also reported similar figures, with 90.5% of the students in a Bachelor level nursing programme in 2012 registering as female (MOE, personal communication, March 14, 2013)

4.2.2 Age

The majority of participants (61%) were aged between 18 and 29 years of age and 79% of all participants were aged under 40 years (Figure 3). This sample is generally representative of the undergraduate nursing population, with 84% of degree level nursing students in 2012 being under 40 years of age (MOE, personal communication, March 14, 2013).

Figure 2. Age of Participants
4.2.3 Ethnicity

The majority of the participants (53%) identified as New Zealand European (Figure 4). The MOE 2012 information on degree level nursing students reports that 63% of students indicated they were of European descent (MOE, personal communication, March 14, 2013).

The third largest number of participants (9%) identified as Māori, which is not reflective of the general population, wherein 15% identify as Māori (Census, 2006), or of the MOE 2012 data, which showed that 13% of degree level nursing students identify as being Māori (MOE, personal communication, March 14, 2013). It is, however, more representative of the Registered Nursing population, wherein 7% of nurses identify as Māori (Walker & Clendon, 2012).

Participants of Asian and Pacific descent also appear to be under-represented within the study, as according to 2012 MOE data 18.8% of degree nursing students are Asian and 7.4% are Pacific people. The group that participated in this study consisted of 7% of Asian ethnicity and 2% of Pacific descent.

This study included a ‘New Zealander’ option, which was chosen by 15.9% of the participants. The MOE data collection did not allow this option and this may account for some discrepancies as these participants may have indicated New Zealander rather than the ethnicity recorded with the MOE.

![Figure 3. Ethnicity of participants](chart)

There was also no option to select multiple ethnicities and if participants did not identify with one of the ethnicities available they could record their ethnicity under ‘Other’ (Table 1).
Table 1. Other Ethnicities

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number (n) of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>4</td>
</tr>
<tr>
<td>Finnish</td>
<td>1</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
</tr>
<tr>
<td>Turkish</td>
<td>1</td>
</tr>
<tr>
<td>Canadian</td>
<td>3</td>
</tr>
<tr>
<td>Bhutanese</td>
<td>1</td>
</tr>
<tr>
<td>Pakeha</td>
<td>1</td>
</tr>
<tr>
<td>English</td>
<td>1</td>
</tr>
</tbody>
</table>

4.2.4 Year of study

Participants were asked to indicate in which year of study they were currently enrolled. The Bachelor of Nursing degree in New Zealand is a three year full-time undergraduate Level 7 degree. If students had been studying part-time over more than 3 years, they were directed to indicate in what year of the degree the clinical paper in which they were enrolled would typically be taken by students.

The majority of participants (81%) were in their second or third year of the degree programme (Figure 5). The spread of participants across each of the years of study is likely to be reflective of the eligibility criteria, as it was expected that fewer year one students would meet the criteria for inclusion given their more limited clinical exposure.

*Figure 4. Year of study for participants*
4.3 Patient Rights

Section B of the questionnaire covered eight issues pertaining to patient rights, including confidentiality, autonomy, respect and dignity.

The following section provides a summary of each issue, outlining participant responses and the mean rating score for the frequency and distress levels related to each of the ethical issues. Higher mean rating scores equate to higher frequency and distress levels.

The mean rating scores correspond with the following frequency and distress levels:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = never</td>
<td>1 = none</td>
</tr>
<tr>
<td>2 = rarely</td>
<td>2 = some</td>
</tr>
<tr>
<td>3 = sometimes</td>
<td>3 = moderate</td>
</tr>
<tr>
<td>4 = often</td>
<td>4 = high</td>
</tr>
<tr>
<td>5 = very often</td>
<td>5 = very high</td>
</tr>
</tbody>
</table>

Comments made by participants in response to the open-ended question—Question 38—that relate to the issues outlined in the questionnaire have been provided in each section to enhance the scope of the student experience.

4.3.1 Breach of confidentiality and/or privacy

The majority of participants (73.2%) indicated they had experienced breaches of a patient’s confidentiality and/or privacy. The most common response was ‘sometimes’, with 35.9% indicating this level of frequency. Only four participants (1.1%) indicated that breaches of confidentiality and/or privacy occurred ‘very often’. The mean rating score was 2.23.

Of the 248 participants who stated that they had indeed experienced breaches of a patient’s right to confidentiality and/or privacy, 95.6% experienced some level of distress. The mean rating for the distress level experienced by participants was 2.92, which approximately equates to a ‘moderate’ distress level. This was also the most frequent response, chosen by 38.7% of the participants. More than a quarter of the participants (26.6%) indicated they experienced ‘high’ or ‘very high’ levels of distress.

Participants reported that nurses breached patients’ confidentiality by indiscriminately discussing patient details outside of acceptable areas.

*Nurses breaching patients confidentiality by discussing their patients with other nurses in times like their lunch breaks ... things like if they are a high demand patient complaining about them and telling the other nurses about the patients they have they consider funny or are in hospital for something unusual (Participant #243)*

... nurse’s talking about clients in a manner which was not professional and in public too ... (Participant #315)
There were a number of studies in the literature review that highlighted confidentiality as a frequently occurring ethical issue for nursing students (Callister et al., 2009; Erdil & Kormaz, 2009; Solum et al., 2012). Participants in this study ranked this issue as the fourth most frequently occurring issue, which closely corresponds to Erdil and Kormaz’s findings—they ranked this issue as the second most frequent ethical issue. However, participants in this study report this issue in far higher numbers, with over two thirds having experienced it to some degree, compared to one quarter in Erdil and Korkmaz’s study. Solum et al. (2012) reported that nearly all of the students in their qualitative study had experienced breaches of confidentiality however this study had a relatively small number of participants in comparison to Erdil and Korkmaz.

Participant #243’s comment above mentions nurses discussing patients outside of the appropriate forums, therefore not maintaining confidentiality. This is supported by Callister et al.’s (2009) study, wherein a participant mentioned nurses discussing patients with people not directly involved in a patient’s care and where these conversations could be overheard by others.

Comments were also made by participants that reflect breaches of patient dignity, such as exposing patients during care. Erdil and Korkmaz (2009) and Park et al. (2003) had similar findings, with students finding that patients were treated like numbers and that their privacy was not protected. One participant also made a comment about breaching patient dignity by allowing students to observe a procedure.

Too many students observing a procedure on an extremely distressed patient without prior consent (Participant #74)

Grob, Leng and Gallagher (2012) highlight that large breaches of patients’ confidentiality have been reported in parliamentary and Ombudsman reports on patient care in the United Kingdom. This is also a topical issue in the New Zealand media, with health professionals being reprimanded for gross breaches of patients’ privacy in New Zealand hospitals (Auckland District Health Board, 2013; Carville, 2013; Johnston, 2013)

4.3.2 Information withheld from a patient

The principle of informed consent, autonomy and veracity is breached when information is withheld from a patient. The majority of participants (54.6%) indicated they had never experienced information being withheld from a patient regarding their diagnosis, treatment or
prognosis. Other participants reported they had experienced this issue ‘rarely’ (21.2%) or ‘sometimes’ (20.6%) in clinical practice. This issue had a mean frequency rating of 1.74.

The 154 participants (45.4%) who reported they had experienced information being withheld had a mean distress rating of 3.03, which is equivalent to a ‘moderate’ distress level. A further third of participants (32.5%) experienced a ‘high’ or ‘very high’ level of distress.

Participants made comments relating to information being withheld regarding treatment plans and claimed that families were involved in the decision to withhold information from patients.

I was caring for a woman in residential care who was admitted on the understanding that it was to help her rehabilitate (post CVA) ... a caregiver informed me that the woman had no home to go back to because her daughter has sold her house without telling her. I felt quite distressed that no one had informed the woman that she would be staying in the nursing home permanently (Participant #140)

Patient being treated in a hospice who did not know they were dying as family did not want her to be told (Participant #201)

Staff having a family meeting behind a patient’s back about their treatment (Participant #241)

Erdil and Korkmaz (2009) found that health professionals would make unilateral decisions about patient care rather than engaging in discussion, a reality that is reflected in all the comments made above by participants. Yeh et al. (2010) found that participants had difficulty with the fact that these decisions were often made at the request of families and that families withheld information from patients.

Han and Ahn (2000) reported that not telling the truth to patients was a common issue, with 15% of their participants reporting this occurring in practice. Yet et al. (2010) observed similar distress levels both when participants witnessed information being withheld and when they were instructed to withhold information from patients.

Withholding information relates to the ethical principles of informed consent and veracity. Participants in Solum et al.’s (2012) study felt that this was a fundamental patient right—the right to give consent based on full information. They experienced distress observing information being withheld from patients, as this prevented the patient’s rights from being fulfilled.

4.3.3 Medical or nursing care provided without informed consent

Over half of the participants (60.7%) had experienced care being given without informed consent being obtained from the patient. The most common response was a frequency level of
‘rarely’ (31.6%), which corresponds with the mean rating score of 1.96. One quarter of the participants (24.8%) indicated they experienced this issue ‘sometimes’ and less than five percent indicated it occurred ‘often’ or ‘very often’ in clinical practice.

A mean distress rating score of 3.03 was calculated across the 205 participants who had experienced this issue. This rating corresponds with ‘moderate’ distress levels, which was the most frequent response (38.3%). The second most common response was ‘some’, with 26.2% of participants experiencing this level of distress and just under one third (31.5%) experiencing ‘high’ or ‘very high’ distress levels. Less than 4% of participants reported that they experienced no distress when care was given without informed consent, which may indicate they were recalling situations where informed consent was not possible (for example with an unconscious patient), rather than as a result of the unethical behaviour of others.

Comments made by participants demonstrated the prevalence of a lack of communication and negotiation in planning care with patients.

- *Care that has been planned without consultation with the patient or family about what the client wants; the lack of having the patient and their family at the centre of care (Participant #280).*

- *Patients being handled/moved without their consent (Participant #7)*

- *Too many students observing a procedure, on an extremely distressed patient, without any prior consent (Participant #74)*

- *Medical staff deciding on a plan for a patient without consultation with patient or their family (Participant #200)*

- *Not involving them [patient] in decision about their own care even when the patient is able to make decisions (Participant #244)*

The comments above reflect the practice of providing no information or insufficient information to allow the patient to provide informed consent. Several other participants made comments around other aspects of patient care, such as hygiene care and the manual handling/lifting of patients where no consent process was evident prior to the provision of this care. This issue was also present in Han and Ahn’s (2000) study, wherein nursing students described finding patients were not provided with all the information regarding their treatment to allow them to make autonomous decisions. The issue of not involving patients in the decision-making process was evident in other studies within the literature review, including those of Callister et al. (2009), Erdil and Korkmaz (2009) and Vallance (2003).

Participants involved in the Erdil and Korkmaz (2009) study found that patients were at times forced to sign consent for treatments about which they were not fully informed and Solum et al.
(2012) found that the lack of informed consent in clinical practice was concerning to nursing student participants. Although forced consent was not indicated in the comments made by participants of this study, one participant indicated patients were influenced by doctors.

*Medical officers influencing the patient’s decision about care options
(Participant #14)*

4.3.4 Discriminatory treatment of patients

Two thirds of participants (67%) stated they had witnessed the discriminatory treatment of patients. The most frequent response of those that did experience this issue was ‘sometimes’ (28.6%). Eleven and a half percent of participants indicated that discriminatory treatment of patients occurred ‘often’ or ‘very often’. This issue had a mean rating score of 2.22.

Of the 228 participants who reported witnessing discriminatory treatment of patients, half indicated ‘high’ or ‘very high’ associated distress levels, with ‘high’ levels of distress being the most common response (37.3%). The overall mean distress rating was 3.43, indicating a distress level of between ‘moderate’ and ‘high’.

Comments made by participants indicated that ethnicity, health status and socioeconomic status were factors in the discriminatory or prejudicial treatment of patients. This is supported by Erdil and Korkmaz (2009), who also found that socioeconomic and education levels appeared to relate to discriminatory treatment of patients.

*Discrimination against skin colour..... at times racist statements and action is obviously seen made in front of patients ... (Participant #14)*

*Racial and cultural discrimination by the nursing staff of the ward ... (Participant #19)*

*Treatment being declined based on apparent stigma, e.g. homelessness, alcohol misuse (Participant #92)*

The comments made above mirror those made by a participant in Callister et al.’s (2009) study, who observed basic treatments such as water and a blanket being withheld from a patient with a substance abuse problem.

*Negative beliefs and generalisations of populations expressed by peers, based on a lack of understanding and/or not wanting to bother or care to understand (Participant #191)*

*A client kept waiting longer than needed because he was Hep C positive. Prejudice was very apparent (Participant #215)*
Negative attitudes towards repeat presenters to Emergency Department (Participant #304)

The comment above made by Participant #304 closely resembles a comment made by another participant in Callister et al.’s (2009) study, who observed patients who were known as ‘frequent flyers’ being discriminated against and staff showing a lack of kindness and respect to these patients.

Staff spending more time with more famous patients even though they are not as acute as other patients (Participant #314)

The comment made by Participant #314 is similar to a finding in Solum et al.’s (2012) study, where a participant reported that they were distressed that nurses and doctors would provide better care for patients relative to their status in the community (such as prioritising important religious figures), rather than based on their presenting problem.

4.3.5 Restriction of patient freedom

Thompson et al. (2006) recognise that patient management is a complex art form and that acting in the best interest of the patient means that nurses have to make clinical and moral judgements. The restriction of a patient’s right to freedom can cause ethical concerns in regards to the conflicting principles of patient autonomy, beneficence and justice.

Question 16 asked participants if they had experienced the use of chemical or physical restraints to control a patient’s behaviour in cases where they felt it was not in the best interests of the patient. There are institutional policies and procedures that outline the level of restraint that may be ordered, typically by a restraint team, for protection against personal harm and with the patient’s best interests in mind.

The majority of participants (70.8%) indicated that they had never experienced restraint used in this manner, giving this issue a relatively low mean rating score of 1.43. The 99 participants (29.2%) that indicated that they had experienced the use of inappropriate restraints reported that this occurred ‘rarely’ (17.1%) and ‘sometimes’ (10.9%). Less than 2% of participants reported that this restriction of patient freedom occurred ‘often’ or ‘very often’.

The mean rating score for distress was 3.24, indicating a level higher than ‘some’ distress. A ‘moderate’ distress level was the most common response and was reported by 35.4% of participants and ‘high distress’ and ‘very high’ distress were reported by 25.3% and 14.1% of participants, respectively.
One participant made a comment regarding the use of restraints that describes the distress felt when faced with this issue and their lack of knowledge about the situation:

... at times restraints did not allow time for the patient to feed themselves. This caused embarrassment and distress for the patient. I felt distressed because I did not know enough about the situation, the patient, the nurse or the organisation or understand the policies and procedures and time constraints involved to feel I could intervene (Participant #84)

An RN who made me restrain (not fully restrain, only held his hands because I felt uncomfortable) a patient who was trying to pull out his nasogastric tube. I let go and the RN growled at me ... I told her I was uncomfortable and she got a watch to takeover ... I was not sure of all the circumstances of his case but it made me feel uncomfortable and highly distressed (Participant #98)

These comments reflect that although students recognised they had limited experience making clinical judgements regarding restraining patients, they still experienced a level of discomfort regarding these decisions. This is supported by another New Zealand study, wherein participants reported having difficulty balancing a patient’s right to autonomy and freedom with the beneficence of a treatment (Vallance 2003).

4.3.6 Derogatory or disrespectful statements

Overall 87% of participants indicated they had experienced healthcare personnel making derogatory or disrespectful comments about patients. Over one quarter (27.1%) of participants reported this occurred ‘often’ or ‘very often’. The most common response was ‘sometimes’ (38.1%), which closely corresponds with the mean frequency rating of 2.88. The remaining participants reported that this issue occurred ‘rarely’ (28.1%) or ‘never’ (13%).

High distress levels were reported relating to this issue, with a mean rating score of 3.39. Nearly half of the participants (47.5%) who experienced this issue indicated ‘high’ (33.9%) or ‘very high’ (13.6%) distress levels. A further 97 participants (33.9%) reported ‘moderate’ distress levels and 17.6% and 2% experienced ‘some’ or ‘no distress’, respectively.

The following comments made by participants indicated that derogatory or disrespectful statements are made frequently in practice and that this is viewed as unprofessional by students. This corresponds with findings in Solum et al.’s (2012) study, which found that unprofessional behaviour was considered unethical by and worrisome to students.

I have listened to registered nurses laughing about patients and their family’s personality and that they need a bullet to their head! I have seen an enrolled nurse speak to a Māori patient so poorly she ended
up crying ... I am appalled at a lot of nurse’s level of professionalism ...
(Participant #32)

There are a LOT of discriminatory names, descriptions and pre-conceived ideas around these [mental health patients] ... (Participant #37)

... mainly the derogatory remarks made between nursing staff and other patients. Totally disrespectful (Participant #66)

These comments could also be related to the ethical principles of dignity and respect that were found to be an issue in the literature review. Callister et al.’s (2009) study found that rude and disrespectful comments were viewed as unethical and distressing to students.

... remarks about a patient i.e. calling them fat when they can hear...
(Participant #77)

Staff having name labels for patients. Patients being called ‘annoying’ or ‘difficult’ (Participant #147)

Park et al. (2003) also found that participants reported staff using demeaning names for patients and referring to them by these names to other staff.

4.3.7 Breach of patient dignity

A high number of participants (77.6%) indicated that they had witnessed a health care professional not respecting a patient’s dignity. The mean frequency rating score for this issue was 2.43, indicating a level between ‘rarely’ (28.9%) and ‘sometimes’ (36.9%). This issue did not appear to occur ‘often’ or ‘very often’, with only 12.1% indicating either of these levels of frequency.

Of the 264 participants who indicated that this issue had occurred in their placement, the majority (35%) reported a ‘moderate’ level of distress. Forty six percent had ‘high’ (31.9%) or ‘very high’ (14.1%) levels of distress, giving a mean distress rating score of 3.4.

Comments made by participants that relate to breaches of patient dignity indicate that participants believe nurses become desensitised to the effects of the tasks they must do during the course of their duties caring for their patients. Examples of the comments made are shown below:

*The Health care assistants .... have a habit of treating them [patients] as a body or sack of meat (Participant #29)*
I sometimes get the feeling that some [nurses] are so used to their job that they focus solely on the job and getting it done ... not things such as covering up a patient or pulling a curtain. Some nurses may not notice this but the patients’ sure do (Participant #84)

These comments reflect findings made by Park et al. (2003), whose participants reported patients being treated like machines and privacy and dignity not being respected. Lemonidou et al. (2004) also found that students were shocked by nurses not attempting to cover patients and continuing to provide care in view of other patients.

... patients not treated with enough respect and dignity ... too many health professionals don’t have the level of compassion that nursing requires (Participant #164)

Nurses ignoring the wishes of the patient (Participant #241).

Nurses ignoring patient buzzers or refusing to take them to the toilet (Participant 253)

Participant comments made in this study are supported by the findings of Solum et al. (2012), who reported one of the most common ethical concerns for student nurses as being nurses disregarding a patient’s right to dignity in the course of their work or ignoring patient needs.

4.3.8 Medical or nursing care given against patient wishes

The most common response to the question relating to whether participants had experienced care being given against a patient’s wishes was ‘never’ (64%). One hundred and eighteen participants (34.9%) experienced this issue ‘rarely’ or ‘sometimes’ and only 1.1% indicated this occurred ‘often’ or ‘very often’. The mean frequency rating score for this issue was 1.5, indicating the level of frequency below ‘rarely’.

The majority of participants (32.8%) experienced ‘some’ distress when faced with this issue in practice, with 28% and 26% experiencing ‘moderate’ and ‘high’ distress levels, respectively. Less than 10% of participants experienced ‘very high’ distress levels. A mean rating of 3.07 was given to this issue and this closely corresponds with a ‘moderate’ distress level.

Patients have a right to autonomous decision-making relating to their care and the right to provide informed consent, as discussed earlier. Comments made by participants indicated that they witnessed these rights being violated and care being given against patient wishes when a health professional had deemed that it was necessary or when a patient was unable to make a decision for themselves. Erdil and Korkmaz (2009) found that these patient rights were breached predominantly by doctors and nurses.
To force a patient [to take] medication (good for the patient) when the patient declined the medication (Participant #125)

Forcing a needle procedure on a child with a needle phobia (Participant #65)

Nurses not respecting the patient’s wishes to refuse treatment due to being ‘old’ or ‘confused’ (Participant #189)

Doctors overriding family and clients wishes (Participant #228)

Patient not wanting a procedure and the family does. Family had power of attorney and did not listen to the patient even though she was very comprehensible (Participant #230)

Participant #230’s comment above reflects the findings of Solum et al. (2012), who reported that nursing students experienced distress when a patient’s right to refuse treatment was denied due to family members acting as guardians. Beckett et al. (2007) also found that students outlined situations where their ability to decide what was in the best interest of the patients was overridden and the patient’s right to choose for themselves was ignored so as to adhere to normal ward procedure. It was suggested this was due to the importance nurses placed on institutional norms, which in turn limit the choices of patients.

4.4 Patient Care

Section C of the questionnaire covered seven issues relating to the delivery or provision of patient care.

The following section provides a summary of each of these seven issues, outlining participant responses and the mean rating score for the frequency and distress levels related to each of the ethical issues. Higher mean rating scores equate to higher frequency and distress levels.

The mean rating scores correspond with the following frequency and distress levels:
Frequency: 1 = never 2 = rarely 3 = sometimes 4 = often 5 = very often
Distress: 1 = none 2 = some 3 = moderate 4 = high 5 = very high

Comments made by participants in response to the open ended question that relate to the issues outlined in the questionnaire have been provided in each section to enhance the scope of the student experience.

4.4.1 Unsafe healthcare practices

The majority of participants (63.1%) had experienced or observed unsafe healthcare practices in the clinical environment that they felt placed a patient at risk. Nearly one third of participants
(32%) reported this occurred ‘rarely’ and 26% reported it occurring ‘sometimes’. Seventeen participants (5%) reported ‘often’ and ‘very often’ frequency levels. The mean frequency rating score was 2.0, which corresponded with a frequency level of ‘rarely’.

All but one of the 214 participants who had experienced this issue also experienced some level of distress, with the most common response being ‘high’ distress (37.8%). Other participants indicated ‘some’ (17.8%), ‘moderate’ (25.2%) and ‘very high’ (18.7%) distress levels. The mean distress rating score for this issue was 3.57.

Frequency levels and participants’ comments relating to unsafe healthcare practices support the findings of Park et al. (2003), who reported that 69% of students had experienced ethical problems with the conduct of other health professionals, such as not providing proper treatment. Cameron et al. (2001) also found that students became distressed when staff did not follow standard protocols when delivering care.

**Nurses not complying with the contact isolation protocols for patients in isolation rooms (Participant #56)**

Park et al. (2003) also reported a nursing student’s concern over infectious patients who were not isolated and thus placed other patients at risk.

*I witnessed a Registered Nurse move a patient by her neck to sit her up straight in bed. The fact that she was not physically able to move or vocalise any discomfort, and was delirious was even more reason for her to be treated with care. I was shocked … (Participant #134)*

*EN wanting me to administer drugs without her supervision. EN not wanting me to wear gloves … making derogatory comments about patients in her care … I identified her practice as very unsafe … (Participant #212)*

*Not using the hoist to lift people in and out of chairs and the way they are moved around like rag dolls! (Participant #275)*

*I experienced a patient being transferred in a dangerous manner which was disturbing but this was due to lack of staff (Participant #289)*

*Observing some nursing staff not following best practice guidelines but feeling that I would be looked upon negatively if I spoke up about it, or questioned the practice (Participant #294)*

*… seeing not so good practice and not sure whether to say anything about it. As a student we want to get along with people because they’re giving us our marks etc. But unsafe practice ought to be reported or challenged … (Participant #307)*
Lui, Lam, Lee, Chien, Chan and Ip (2007) found that providing safe and competent care rates as the most important aspect of professional conduct for nursing students. This is reflected in the comments above, as the students’ lack of confidence to speak up, possibly for fear of being isolated and left unsupported in the clinical environment. Park et al. (2003) reported many situations where students felt they had wanted to intervene or correct a nurse during an unsafe procedure but they feared the consequences, one of which might be receiving a negative evaluation.

4.4.2 Unsafe working conditions

The vast majority of participants (85.5%) reported that they had experienced unsafe working conditions, such as low staffing levels, lack of resources or equipment, or lack of staff training. The most common response by participants indicated this issue occurred ‘often’ (29.2%), followed by ‘sometimes’ (28.9%). A frequency level of ‘very high’ was reported by 13.7% of participants. The mean frequency rating score for this issue was the highest of all the issues, at 3.14.

A mean distress rating score of 3.66 was also among the highest of all the issues. Over one third of participants (36.9%) reported a ‘high’ level of distress and a further 21.4% experienced ‘very high’ distress levels related to this issue. Forty one percent of participants had ‘some’ or ‘moderate’ distress.

Numerous comments were made by participants relating to unsafe working conditions and these focussed predominantly on staffing issues. Lui et al. (2007) found that nursing students in Hong Kong reported that providing care to the best possible standards within the reality of the working conditions was the most difficult aspect of nursing to achieve. Erdil and Kormaz (2009) also recognised that understaffing was one of the main factors that contributed to ethical problems in the clinical environment.

The unit was understaffed on occasions when there were very unwell patients on the ward. Nurses often spent a lot of time in nurses’ station doing work therefore there was a lack of monitoring of patients, as a student I on occasions felt very unsafe …(Participant #8)

Instances of ‘missed care’ due to high acuity in ward situations (Participant #50)

Lack of appropriate knowledge by RNs (Participant #62)

My main issue was lack of staffing (Participant #75)
Due to staffing issues often basic daily needs are neglected. Patients often have to wait long times to be assisted to go to the toilet and the time taken to mobilise them by busy staff means reduced dignity. ... I found this highly distressing but now that I have seen it several times I am probably moderately distressed about this situation as I feel powerless to change the situation (Participant #182)

Limited staff numbers leading to limited nurse-patient time, lack of safety on ward with fewer HCA’s and nurses (Participant #227)

Low staffing level in many of the healthcare organisations with leads to increase in stress level and affect nursing care (Participant #290)

Low staffing is the biggest issue I have experienced in clinical practice (Participant #139)

Low staffing (Participant #301)

Not enough time in a shift to care for patient properly. Basics not being done properly this could be due to staffing levels or lack of training (Participant #306)

Understaffing, resulting in sub-optimal care for clients who deserve the best care from us ... (Participant #315)

These comments are reflective of Holmström and Karsson (2005), who found that a lack of resources and the emphasis placed on cost effectiveness limited nurses’ ability to act in the best interest of the patient and prohibited nursing students from delivering care that they felt reflected their desire to provide genuine care. Acceptable working conditions were the highest priority for these Swedish nurses, ranking above higher salaries.

4.4.3 Requested to provide care outside level of competence

Approximately two thirds of participants (62.3%) indicated they had been asked to provide care (without supervision) that they did not feel competent to provide. The mean frequency rating of this issue was 2.04, which corresponded with the most frequent response being ‘rarely’; this was reported by 31% of participants. The remainder of the participants who experienced this issue reported frequency levels of ‘sometimes’ (22.1%), ‘often’ (8.3%) and ‘very often’ (<1%).

The majority of participants who had experienced this issue indicated ‘high’ distress levels (32.4%), followed by ‘moderate’ (25.8%) and ‘very high’ (21.1%). A mean distress rating score of 3.51 indicated a ‘moderate’ to ‘high’ level of distress over this issue.

Comments made by participants indicated that the tasks they were requested to do were outside their scope of practice or competency level, as they were working without supervision.
Roberts (2006) found that this was a highly distressing issue and that it was linked to the delivery of incompetent care; this was also reported to be a common situation by Callister et al. (2009).

Six participants (2.8%) experienced no distress when asked to provide care outside their level of competence, which may be due to the feelings of confidence instilled by mentoring nurses, as described by the following participant:

... I was asked to mix an IV antibiotic. This was out of my scope of practice but I did it anyway because the nurse made me feel confident ...

(Participant #12)

4.4.4 Providing care at risk to own personal safety

Less than half of the participants (40.5%) had been requested to provide care to a patient that posed a risk to their own personal safety, with participants reporting experiencing this issue ‘rarely’ (24.8%), or ‘sometimes’ (12.7%). This issue was not reported as occurring at high frequency levels, with less than 3% of participants indicating frequency levels of ‘often’ or ‘very often’. The mean frequency rating score was 1.59, indicating a level below that of ‘rarely’.

The most common distress level associated with this issue by the 137 participants who had experienced it was ‘moderate’ (32.1%), followed by ‘some’ (24.9%). Fifty four participants reported ‘high’ (20.4%) or ‘very high’ (19%) distress levels. The mean distress rating score was 3.26.

Dementia patients in rest home hospital wing who get very aggressive and abusive (verbally and physically) towards staff who are washing and dressing them, but staff do this anyway (Participant #224)

The comment above showed a participant who was distressed at the need to provide treatment to those patients who were aggressive. No other comments made by participants directly related to this issue. Providing care at risk to one’s safety has been shown to be an issue for qualified nurses (Massey University, 2012) and medical students (Wiggleton et al., 2010) and was an item on both the MDS and the EIS questionnaires. This issue being highlighted as an issue for nurses but not nursing students may indicate that nursing staff protect nursing students from this issue in clinical practice.
4.4.5 Medication or treatment error not reported

The vast majority of participants (80.5%) indicated they had ‘never’ experienced a medication or treatment error that had not been reported by staff. Forty six participants (13.6%) indicated a frequency level of ‘rarely’ and less than 6% indicated a frequency level higher than this. The mean frequency rating score was 1.27, signifying that this issue does not often occur in practice.

A mean distress rating score of 3.44 was calculated based on the responses of the 66 participants who had experienced this issue. The majority (31.8%) rated their distress as ‘moderate’, with a further 25.8% having ‘high’ distress levels and 21.2% having ‘very high’ distress levels.

No comments were made by participants that directly related to this issue. The data suggests that although this issue does not occur with any great frequency, when it does it causes moderate to high distress. This is supported by Callister et al. (2009) who found that students become morally distressed when staff do not follow the appropriate procedures or report incidents. Han and Ahn (2000) also reported that students experienced distress when nursing staff failed to report patients’ falls or medication errors.

4.4.6 ‘Do Not Resuscitate’ order implemented without consultation

End of life care can be complex and distressing for healthcare professionals and resuscitation orders have both legal and ethical implications. The majority of participants (93.3%) had never experienced a ‘Do Not Resuscitate’ order being implemented for a patient without consultation with the patient or their family/whānau. Ten participants (2.9%) indicated that this occurred ‘rarely’ and another eight (2.4%) found this occurred ‘sometimes’. Five participants found this issue occurred ‘often’ in their clinical placements. The mean frequency rating score for this issue was 1.12, which corresponds closely with a frequency level of ‘never’.

Based on the responses of the 23 participants (6.8%) who had experienced this issue, a mean distress rating score of 3.3 was calculated. Eight participants felt ‘moderate’ distress and three and six participants reported ‘high’ and ‘very high’ distress levels, respectively. The remaining six participants indicated ‘some’ or ‘no’ distress. It may be that those participants who had low levels of distress were recalling situations where consultation with the patient or family/whānau was not appropriate or was impossible in the situation and thus medical officers made the decision not to resuscitate on medical grounds.
4.4.7 Suspected abuse or neglect

One hundred and thirty five participants (39.8%) had experienced caring for a patient they suspected may have been abused or neglected. Twenty three percent reported that this occurred ‘rarely’ and 13.3% reported a frequency level of ‘sometimes’. Less than 4% indicated a frequency level of ‘often’ or ‘very often’. This issue had a mean frequency rating score of 1.61, indicating a level below that of ‘rarely’.

The majority (62.2%) reported ‘high’ or ‘very high’ distress levels, with the most common response being ‘high’ distress (38.5%). Thirty one participants (22.9%) indicted ‘moderate’ distress and another 17 (12.6%) ‘some’ distress. There were three participants (2.2%) who experienced ‘no distress’ when caring for a patient they suspected had been abused or neglected. The mean distress rating score was 3.69, and ranked as the most highly distressing of the issues outlined in the questionnaire.

The question did not specify where the suspected abuse may have occurred or by whom (i.e. prior to admission or during admission). However, 10% of participants in an overseas study (Erdil & Korkmaz, 2009) indicated physical abuse of patients had occurred while patients were in care. No other studies were found to have reported students’ concerns regarding the abuse or neglect of admitted patients.

The comments made by participants indicated they had not witnessed the suspected abuse or neglect first-hand, although they had experienced caring for patients they felt had been abused or neglected prior to admission. Students showed high distress levels in relation to the abuse they believed had occurred prior to admission or had the potential to occur after admission.

Withholding information from CYF’s regarding a child’s welfare. The grandmother had the potential to harm the grandchild had she gained custody (Participant #291)

I have found that patients coming into hospitals from rest homes often show signs of neglect or maltreatment (Participant #78)

Suspected child abuse, parents did not want tests done on baby ... (Participant #201)

Family member being physical with an elderly patient with mild dementia (Participant #274)

An elderly patient ... wounds all over their body from family abuse (Participant #335)
One participant made a comment that they had witnessed physical mistreatment of patients and sexual harassment.

_Inappropriate sexual comments by nursing and care giver staff and rough treatment of patients (Participant #115)_

The question did not define the term abuse, thus it could have been understood to be referring to psychological or verbal abuse, which nursing students report at a rate three times that of physical abuse, according to Erdil & Kormaz (2009). Several comments made by participants indicated verbal abuse.

_A CMN speaking to a client with mental health issues in a very intimidating and aggressive way (Participant #63)_

_Verbal bullying of a psychiatric patient while on placement (Participant #286)_

4.6 Overview of responses

An overview of the 15 issues covered in this study and the spread of responses regarding frequency and distress are provided in Figures 6 and 7. Figure 6 shows the total percentage of participants that had experienced each issue, as well as the spread of responses for these participants. Figure 7 gives the spread of the distress levels experienced by participants.
**Figure 5. Overview of responses per issue: Frequency**

**Figure 6. Overview of responses per issue: Distress**
4.5 Rank order of issues

Issues have been ranked in order to show how issues ranked in relation to each other and to identify the highest ranking issues. Issues were ranked using the mean rating scores for both frequency (Table 2) and distress (Table 3) for each of the 15 issues outlined in the questionnaire.

Table 2. Rank order of issues by Mean Frequency Rating

<table>
<thead>
<tr>
<th>Ethical Issue – FREQUENCY</th>
<th>Rank</th>
<th>Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe working conditions</td>
<td>1</td>
<td>3.14</td>
</tr>
<tr>
<td>Derogatory or disrespectful statements</td>
<td>2</td>
<td>2.88</td>
</tr>
<tr>
<td>Breach of patient dignity</td>
<td>3</td>
<td>2.43</td>
</tr>
<tr>
<td>Breach of confidentiality and/or privacy</td>
<td>4</td>
<td>2.23</td>
</tr>
<tr>
<td>Discriminatory treatment of patients</td>
<td>5</td>
<td>2.22</td>
</tr>
<tr>
<td>Requested to provide care outside level of competence</td>
<td>6</td>
<td>2.04</td>
</tr>
<tr>
<td>Unsafe healthcare practices</td>
<td>7</td>
<td>2.00</td>
</tr>
<tr>
<td>Medical or nursing care provided without informed consent</td>
<td>8</td>
<td>1.96</td>
</tr>
<tr>
<td>Information withheld from a patient</td>
<td>9</td>
<td>1.73</td>
</tr>
<tr>
<td>Suspected abuse or neglect</td>
<td>10</td>
<td>1.61</td>
</tr>
<tr>
<td>Providing care at risk to own personal safety</td>
<td>11</td>
<td>1.59</td>
</tr>
<tr>
<td>Medical or nursing care given against patient wishes</td>
<td>12</td>
<td>1.50</td>
</tr>
<tr>
<td>Restriction of patient freedom</td>
<td>13</td>
<td>1.43</td>
</tr>
<tr>
<td>Medication or treatment error not reported</td>
<td>14</td>
<td>1.27</td>
</tr>
<tr>
<td>A 'Do Not Resuscitate' order implemented without consultation</td>
<td>15</td>
<td>1.12</td>
</tr>
</tbody>
</table>
Table 3. Rank order of issues by Mean Distress Rating

<table>
<thead>
<tr>
<th>Ethical Issue – DISTRESS</th>
<th>Rank</th>
<th>Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected abuse or neglect</td>
<td>1</td>
<td>3.69</td>
</tr>
<tr>
<td>Unsafe working conditions</td>
<td>2</td>
<td>3.66</td>
</tr>
<tr>
<td>Unsafe healthcare practices</td>
<td>3</td>
<td>3.57</td>
</tr>
<tr>
<td>Requested to provide care outside level of competence</td>
<td>4</td>
<td>3.51</td>
</tr>
<tr>
<td>Medication or treatment error not reported</td>
<td>5</td>
<td>3.44</td>
</tr>
<tr>
<td>Discriminatory treatment of patients</td>
<td>6</td>
<td>3.43</td>
</tr>
<tr>
<td>Breach of patient dignity</td>
<td>7</td>
<td>3.40</td>
</tr>
<tr>
<td>Derogatory or disrespectful statements</td>
<td>8</td>
<td>3.39</td>
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<td>A 'Do Not Resuscitate' order implemented without consultation</td>
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<tr>
<td>Providing care at risk to own personal safety</td>
<td>10</td>
<td>3.26</td>
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<td>Restriction of patient freedom</td>
<td>11</td>
<td>3.24</td>
</tr>
<tr>
<td>Medical or nursing care given against patient wishes</td>
<td>12</td>
<td>3.07</td>
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<td>Information withheld from a patient</td>
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<td>3.03</td>
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<tr>
<td>Medical or nursing care provided without informed consent</td>
<td>13=</td>
<td>3.03</td>
</tr>
<tr>
<td>Breach of confidentiality and/or privacy</td>
<td>15</td>
<td>2.92</td>
</tr>
</tbody>
</table>

4.7 Differences between groups

Cross tabulation tables were created for Māori and New Zealand European ethnic groups and for each year of study in order to determine if any differences occurred in the mean frequency and distress rating scores for each of the issues or in how the issues ranked. These ethnic groups were chosen because they represent the two most prominent cultural groups in New Zealand and the goal was to determine if further research was indicated to establish if the ethical issues studied affect Māori students more profoundly.

Descriptive statistics were used to define the results for each group and highlight the differences between them in regards to frequency and distress. Where extensive differences occurred in the frequency or distress rating scores, independent t-tests were conducted to determine statistical significance. Overall distress scores were calculated for each group as an average of the mean rating scores found for all of the 15 issues and compared. As these groups were of unequal sizes an unpaired, two tail t-test was used assuming unequal variance.
4.7.1 Ethnicity

The frequency rating scores varied marginally between New Zealand European and Māori participant groups across the majority of the 15 issues (Table 4). The top five ranking issues were the same in both groups and corresponded with the overall rankings. Unsafe working conditions ranked as the most frequently occurring issue for both groups.

Table 4. Mean Frequency Rating and Rank Order of Issues for Māori and NZ European

<table>
<thead>
<tr>
<th>Overall Rank</th>
<th>Ethical Issue - FREQUENCY</th>
<th>Māori</th>
<th>NZ European</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unsafe working conditions</td>
<td>3.13</td>
<td>3.17</td>
</tr>
<tr>
<td>2</td>
<td>Derogatory or disrespectful statements</td>
<td>2.81</td>
<td>2.89</td>
</tr>
<tr>
<td>3</td>
<td>Breach of patients dignity</td>
<td>2.71</td>
<td>2.40</td>
</tr>
<tr>
<td>4</td>
<td>Breach of confidentiality and/or privacy</td>
<td>2.03</td>
<td>2.20</td>
</tr>
<tr>
<td>5</td>
<td>Discriminatory treatment of patients</td>
<td>2.16</td>
<td>2.15</td>
</tr>
<tr>
<td>6</td>
<td>Requested to provide care beyond own competency level</td>
<td>1.87</td>
<td>2.07</td>
</tr>
<tr>
<td>7</td>
<td>Unsafe healthcare practices</td>
<td>1.90</td>
<td>1.99</td>
</tr>
<tr>
<td>8</td>
<td>Medical or nursing care provided without informed consent</td>
<td>1.81</td>
<td>1.94</td>
</tr>
<tr>
<td>9</td>
<td>Information withheld from a patient</td>
<td>1.55</td>
<td>1.76</td>
</tr>
<tr>
<td>10</td>
<td>Suspected abuse or neglect</td>
<td>1.74</td>
<td>1.58</td>
</tr>
<tr>
<td>11</td>
<td>Providing care at risk to personal safety</td>
<td>1.68</td>
<td>1.55</td>
</tr>
<tr>
<td>12</td>
<td>Medical or nursing care given against patient wishes</td>
<td>1.68</td>
<td>1.42</td>
</tr>
<tr>
<td>13</td>
<td>The use of chemical or physical restraints</td>
<td>1.48</td>
<td>1.45</td>
</tr>
<tr>
<td>14</td>
<td>Medication or treatment error not reported</td>
<td>1.35</td>
<td>1.23</td>
</tr>
<tr>
<td>15</td>
<td>A 'Do Not Resuscitate' order implemented without consultation</td>
<td>1.13</td>
<td>1.12</td>
</tr>
</tbody>
</table>

1.94 Overall Frequency Score

One notable exception in the frequency ranking was the issue of ‘information being withheld regarding diagnosis, treatment or prognosis’. Overall, and in the case of New Zealand European participants specifically, this issue ranked ninth. However, Māori participants reported experiencing this issue at a lower frequency and it was ranked 12th. Although the mean rating score between these groups differed slightly (1.55 for Māori and 1.76 for New Zealand
European), the difference was not statistically significant (p=0.24), indicating that this issue is experienced to a similar degree by both New Zealand European and Māori participants.

Greater variances in the distress levels were noted between Māori and New Zealand European participants for some issues. It is worth noting that Māori participants reported equal or higher levels of distress in 11 out of the 15 issues (Table 5.)

Table 5. Mean Distress Rating and rank order of issues for Māori and New Zealand European

<table>
<thead>
<tr>
<th>Overall Rank</th>
<th>Ethical Issue - DISTRESS</th>
<th>Māori</th>
<th>Rank</th>
<th>NZ European</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Suspected abuse or neglect</td>
<td>3.62</td>
<td>4</td>
<td>3.65</td>
<td>1=</td>
</tr>
<tr>
<td>2</td>
<td>Unsafe working conditions</td>
<td>3.54</td>
<td>8</td>
<td>3.65</td>
<td>1=</td>
</tr>
<tr>
<td>3</td>
<td>Unsafe healthcare practices</td>
<td>4.18</td>
<td>1</td>
<td>3.46</td>
<td>3</td>
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<tr>
<td>4</td>
<td>Requested to provide care beyond own competency level</td>
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<td>6</td>
<td>3.36</td>
<td>5</td>
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<tr>
<td>5</td>
<td>Medication or treatment error not reported</td>
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<td>2</td>
<td>3.23</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>Discriminatory treatment of patients</td>
<td>3.61</td>
<td>5</td>
<td>3.41</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Breach of patients dignity</td>
<td>3.70</td>
<td>3</td>
<td>3.35</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>Derogatory or disrespectful statements</td>
<td>3.50</td>
<td>9</td>
<td>3.29</td>
<td>7</td>
</tr>
<tr>
<td>9</td>
<td>A 'Do Not Resuscitate' order implemented without consultation</td>
<td>3.00</td>
<td>13=</td>
<td>3.07</td>
<td>10</td>
</tr>
<tr>
<td>10</td>
<td>Providing care at risk to personal safety</td>
<td>3.00</td>
<td>13=</td>
<td>3.00</td>
<td>12</td>
</tr>
<tr>
<td>11</td>
<td>The use of chemical or physical restraints</td>
<td>2.90</td>
<td>15</td>
<td>3.27</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>Medical or nursing care given against patient wishes</td>
<td>3.55</td>
<td>7</td>
<td>2.84</td>
<td>14</td>
</tr>
<tr>
<td>13</td>
<td>Information withheld from a patient</td>
<td>3.20</td>
<td>11</td>
<td>3.01</td>
<td>11</td>
</tr>
<tr>
<td>13=</td>
<td>Medical or nursing care provided without informed consent</td>
<td>3.19</td>
<td>12</td>
<td>3.00</td>
<td>12</td>
</tr>
<tr>
<td>15</td>
<td>Breach of confidentiality and/or privacy</td>
<td>3.22</td>
<td>10</td>
<td>2.81</td>
<td>15</td>
</tr>
<tr>
<td><strong>3.33</strong></td>
<td>Overall Distress Score</td>
<td><strong>3.44</strong></td>
<td></td>
<td><strong>3.23</strong></td>
<td></td>
</tr>
</tbody>
</table>

The issue that presented the largest difference between Māori and New Zealand European participants was the distress associated with observing unsafe healthcare practices that placed a patient at risk. Māori participants reported high to very high distress levels, with a mean distress rating of 4.18, while New Zealand European participants reported distress levels equating to 3.46. This was a significant difference in distress levels (p = 0.003). Medical or
nursing care given against a patient’s wishes also elicited significantly different distress levels (p = 0.03).

Independent t-tests were also conducted on distress levels relating to breaches of confidentiality and/or privacy between Māori and New Zealand European groups. Frequency levels were experienced similarly in both groups (p = 0.44), however, Māori participants experienced non-significant higher levels of distress, with mean ratings of 3.22 compared to 2.81 (p = 0.09). The definition of privacy as a legal requirement and an ethical concept has been developed through Western philosophical paradigms and may not encompass traditional collectivist cultures (Cullen, 2009). It is widely recognised that Māori view their personal information as a taonga, a treasured object, and do not feel comfortable giving it to other people. It could be that Māori nurses or nursing students also view patient information as a taonga and consider that breaches of privacy have occurred where other nursing students may not, or may be more distressed by breaches of privacy. This would explain the higher mean distress ranking and rank of this issue.

Findings suggest that being of Māori or New Zealand European ethnicity was not a significant factor when considering the frequency with which ethical issues were experienced in clinical practice. Maori participants did have a significantly higher distress in some issues and a higher, non-significant, Overall Distress Score (p = 0.07). There is evidence to suggest that Maori nursing students experience higher than average distress levels and that further research on this phenomenon is indicated.

4.7.2 Year of study

Participants in their second and third years of study reported higher mean frequency rating scores, with the largest increase in frequency level observed between year one and two participants (Table 6). Overall the most frequently occurring issues were the same for participants in each of the three years of study and these corresponded with the overall rankings for frequency.
Table 6. Mean Frequency Rating and Rank Order by Year of Study

| Overall Rank | Ethical Issue – FREQUENCY | Year One | | Year Two | | Year Three | |
|--------------|---------------------------|----------|----------|----------|----------|----------|
| 1            | Unsafe working conditions | 2.55     | 1        | 3.24     | 1        | 3.3      | 1        |
| 2            | Derogatory or disrespectful statements | 2.34 | 3       | 2.92     | 2        | 3.09     | 2        |
| 3            | Breach of patient dignity | 2.37     | 2        | 2.46     | 3        | 2.44     | 3        |
| 4            | Breach of confidentiality and/or privacy | 2.08 | 4        | 2.18     | 5        | 2.33     | 5        |
| 5            | Discriminatory treatment of patients | 1.77 | 7        | 2.3      | 4        | 2.34     | 4        |
| 6            | Requested to provide care outside level of competence | 1.94 | 6        | 2.1      | 4        | 2.02     | 6        |
| 7            | Unsafe healthcare practices | 2.0      | 5        | 2.05     | 8        | 1.96     | 8        |
| 8            | Medical or nursing care provided without informed consent | 1.69 | 8        | 2.08     | 7        | 1.97     | 7        |
| 9            | Information withheld from a patient | 1.32 | 13       | 1.72     | 9        | 1.93     | 9        |
| 10           | Suspected abuse or neglect | 1.42     | 12       | 1.57     | 11       | 1.73     | 10       |
| 11           | Providing care at risk to own personal safety | 1.54 | 9        | 1.66     | 10       | 1.56     | 11       |
| 12           | Medical or nursing care given against patient wishes | 1.46 | 10       | 1.51     | 12       | 1.51     | 12       |
| 13           | Restriction of patient freedom | 1.45 | 11       | 1.34     | 13       | 1.5      | 13       |
| 14           | Medication or treatment error not reported | 1.12 | 14       | 1.23     | 14       | 1.37     | 14       |
| 15           | A 'Do Not Resuscitate' order implemented without consultation | 1.03 | 15       | 1.2      | 15       | 1.09     | 15       |

The mean distress rating scores and rank for each issue are included in Table 7. Those issues that showed an increase in mean distress levels between the participants in each year are highlighted in red. The mean distress ratings for most issues were higher in year two than year one participants and year two participants had a significantly higher overall distress score (p = 0.04).

The mean distress rating scores decreased for the majority of issues between year two and three participants. The overall distress score was lower in year three (3.27) than year two participants (3.42). Although this overall score is representative of the decrease in distress levels across all of the issues, it is not a statistically significant decrease (p=0.18). The issues that did show higher distress levels were ‘unsafe working conditions’, ‘unsafe healthcare practices’ and ‘information withheld from a patient regarding diagnosis, treatment or prognosis’.
The only issues to show an increase in mean distress rating scores across participants in each subsequent year of study were ‘unsafe working conditions’ and ‘unsafe healthcare practices’; these issues were ranked first and second, respectively, by year three participants. The other issues that ranked consistently in the top five in each year included ‘suspected abuse or neglect’ and ‘being requested to provide care outside competence level’.

Table 7. Mean Distress Rating and Rank Order of issues by Year of Study

<table>
<thead>
<tr>
<th>Year One</th>
<th>Year Two</th>
<th>Year Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical Issue - DISTRESS</td>
<td>Mean Rating</td>
<td>Rank</td>
</tr>
<tr>
<td>Suspected abuse or neglect</td>
<td>3.65</td>
<td>1</td>
</tr>
<tr>
<td>Unsafe working conditions</td>
<td>3.51</td>
<td>2</td>
</tr>
<tr>
<td>Unsafe healthcare practices</td>
<td>3.37</td>
<td>5</td>
</tr>
<tr>
<td>Requested to provide care outside competence level</td>
<td>3.42</td>
<td>3</td>
</tr>
<tr>
<td>Medication or treatment error not reported</td>
<td>3.33</td>
<td>6</td>
</tr>
<tr>
<td>Discriminatory treatment of patients</td>
<td>3.39</td>
<td>4</td>
</tr>
<tr>
<td>Breach of patient dignity</td>
<td>3.29</td>
<td>7</td>
</tr>
<tr>
<td>Derogatory or disrespectful statements</td>
<td>3.20</td>
<td>9</td>
</tr>
<tr>
<td>A 'Do Not Resuscitate' order implemented without consultation</td>
<td>3.00</td>
<td>13</td>
</tr>
<tr>
<td>Providing care at risk to own personal safety</td>
<td>3.22</td>
<td>8</td>
</tr>
<tr>
<td>Restriction of patient freedom</td>
<td>3.06</td>
<td>11=</td>
</tr>
<tr>
<td>Medical or nursing care given against patient wishes</td>
<td>3.10</td>
<td>10</td>
</tr>
<tr>
<td>Information withheld from a patient</td>
<td>2.79</td>
<td>15</td>
</tr>
<tr>
<td>Medical or nursing care provided without informed consent</td>
<td>3.06</td>
<td>11=</td>
</tr>
<tr>
<td>Breach of confidentiality and/or privacy</td>
<td>2.91</td>
<td>14</td>
</tr>
</tbody>
</table>

Overall the frequency rating scores and distress scores for the majority of issues increased for participants across the three years of study with the highest frequency scores seen in year three participants and the highest distress scores observed in year two participants.
The increase in frequency scores was expected due to there being greater exposure to the clinical environment in each subsequent year of undergraduate nursing education. It could also be suggested that the increase between these groups may be related to their increased level of education regarding healthcare ethical principles and their heightened awareness of what constitutes an ethical breach in the clinical environment.

The significantly higher overall distress scores observed between year one and two participants (p=0.04) could be due to the second year of study bring forth a lot of firsts. Although nursing students have some clinical experience in their first year, this is generally limited to one placement and does not expose students to multiple, complex clinical environments. This reasoning is supported by an Australian study (Lo, 2002), which found that stress levels were greater for nursing students in their second year of study and that this was possibly due to the second year of training being when students engage in more clinical practice—and that it is the clinical component of nursing training that is the most stressful. Beckett et al. (2007) also recognise that year two nursing students may not have learnt to protect or defend themselves against the stressors inherent in nursing.

All but three issues saw a decrease in mean distress rating scores reported in year three compared to those participants in the second year of their degree. Five issues also had a lower mean distress rating than that reported by participants in their first year. Overall there was a non-significant (p=0.18) decrease in the overall distress scores reported by year three participants compared to those in year two.

There are many possible factors that may have influenced the decrease in distress levels observed in year three participants. One possible scenario is that students with high distress levels may leave the nursing programme prior to year three for reasons related or unrelated to the clinical environment or ethical practice. Decreasing distress levels may also be related to the socialisation of nursing students in the clinical environment, moral blunting or a level desensitisation to the issues with which they are confronted. One participant’s comment may provide some insight into the decrease in distress levels at year three:

I found this [breach of dignity] highly distressing but now that I have seen it several times I am probably moderately distressed about this situation as I feel powerless to change the situation (Participant #182 - Year Three student)
This sentiment was echoed in other studies, where students or newly graduated nurses chose not to assert themselves in situations of moral distress but instead to accept, compromise and find ways to cope (Edlund-Sjoberg & Thorell-Ekstrand, 2001; Kelly, 1998; Vallance, 2003). Lo (2002) found that students developed better ways of dealing with academic stressors during their nursing training in part by developing a greater knowledge of what is expected. Perhaps the same phenomenon occurs in the clinical environment.

Randle (2003) recognises that nursing students initially experience conflict and confusion in situations where ethical principles are breached, but that later in their course of study they have developed ways of conforming to the situations that caused them initial shock and confusion. The same students also failed to recognise that their behaviour during the latter part of their training mirrored that of the nurses by whom they were initially shocked. It may also be that a nursing student’s perception of what is ethical and unethical in the workplace becomes more aligned with the views of the healthcare professionals they work with towards the end of their training rather than with those of the patient, as speculated by Sato (2005).

It could also be suggested that distress levels are lower in year three participants because they are not as powerless as they have been in the previous years of their training and they now have the ability to process and rationalise situations so as to avoid possible distress. Kim et al. (2007) identified that nursing students in their final year had a higher level of moral development than those in their first year of a nursing programme. Year three students may also have developed ways of avoiding or managing ethical problems in the clinical environment as they have learned to work more independently and autonomously towards the end of their training.

Unsafe working conditions and unsafe healthcare practices are the only two issues that showed an increased frequency and distress level in each of the years of study. It could be that this is due to the structure and function of the work environment becoming increasingly important to students and future nurses towards the end of their training, as this is the workplace in which they will ultimately work. Perhaps the increasing distress level associated with this issue is as much about their concern for their own working conditions, stress levels and coping ability as it is for the patient care deficits that are pronounced in this environment.

In order to prove or disprove the theory of moral blunting or desensitisation a longitudinal study would need to be conducted to ascertain if decreasing distress levels are evident during training, registration, new graduate training and beyond.
4.8 Qualitative analysis

One hundred and fifty participants answered the open-ended (Question 38), which offered them the opportunity to identify any other ethical issues they had experienced while on clinical placement. These comments were analysed using SurveyMonkey analysis software, which found that the words ‘care’, ‘staff’, ‘student’, and ‘client’ were used most frequently by participants in answering this question. Many of the comments made in response to Question 38 related directly to the questions included in the survey. Other themes emerged from the data using thematic analysis, included issues such as the lack of support and supervision available to nursing students in the clinical environment, bullying, issues surrounding end of life care and the lack of veracity or truthfulness displayed by healthcare staff.

4.8.1 Lack of support and supervision

In total, 10% of those participants who answered Question 38 made comments relating to a feeling of lack of support of supervision. These students recorded that this occurred anywhere from ‘sometimes’ to ‘very frequently’, with a mean frequency score of 3.2. Fourteen of the 15 participants who highlighted this as an issue indicated a lack of support or supervision caused ‘high’ or ‘very high distress’ levels. This issue had a mean distress score of 4.3.

Support and supervision are vital to developing clinical skills and ethical competence in nursing students. Whether or not the lack of support and supervision is in and of itself an ethical issue, it could certainly impact how nursing students view the ethical behaviour of their RN supervisors and the ethical climate of the workplace. A lack of support and supervision can also potentially put nursing students in situations where they feel ethically compromised.

Epstein and Carlin (2012) felt that difficulties within the student and preceptor relationship were ethically concerning, although they realised that students did not always frame their negative experiences in terms of ethical issues or concerns. This may explain why less than five percent of participants made comments relating to a lack of support and supervision by nurses in the clinical environment. Participants in the study who identified this as an ethical issue made comments to the effect that they felt unwelcome and unsupported by staff.

*Students being placed with nurses that clearly do not want students or do not have the experience to have students with them (Participant #16)*

*Nursing staff not wanting to have a student nurse working with them (Participant #117)*
Not feeling welcome as a trainee nurse in the hospital environment. Surely trained health professionals remember what it was like to be learning and value future staff members (Participant #177)

Other students mentioned that they felt there was a lack of support from RNs when they were being asked to provide care, and that without their support and supervision they felt they missed learning opportunities available to them during clinical placement.

Lack of support from RN when it came to clinical skill (Participant #35)

… nurses not interested in teaching student nurses … this makes it really difficult for those students who are keen to learn (Participant #61)

… students being 5 hrs. by ourselves without any support or RN to be found (Participant #75)

Several participants made additional comments stating that they felt this lack of support and supervision was at times due to a high workload, acuity of patients or a lack of understanding regarding the nursing students’ scope or boundaries.

Curtis, Bowen and Reid (2007) completed a study of year two and three nursing students in Australia and found that a common theme was ‘powerlessness and becoming invisible’. Student participants reported being ignored, treated as if they were invisible, being left unsupported and unaided and that some staff refused to work with students. Students felt that this lack of support and supervision impacted on the level of care that was given to patients.

4.8.2 Bullying

Bullying was an issue identified by nursing students in the NZNO 2012 National Nursing Student Survey. Bullying was defined for the purposes of the NZNO study as “intentional threatening, demeaning or intimidating behaviour causing harm, manipulation or coercion” (Walker & Clendon, 2012, p.14). The incidence of bullying reported by the participants in the NZNO study was 15.7%, which represents a decrease from 18.6% for a similar NZNO nursing student study in 2011. The experiences of bullying reported occurred both on campus and during clinical placements, however it was noted that the observation or experience of bullying was more apparent on clinical placement than on campus and was perpetrated mostly by clinical and teaching staff rather than by other students (Walker & Clendon, 2012).

Bullying was not included in the questionnaire’s closed ended questions, as it was determined to be more appropriate to examine unsolicited reports of bullying. Some participants may not see this as an ethical issue, however 10% of the students who answered Question 38 indicated
that they had observed or experienced the bullying of nursing students. This issue had a mean frequency rating of 4.2 and a mean distress rating of 4.5. Comments made by participants include:

*Student bullying by staff nurses (Participant #88)*

*Bullying of nursing students, very common, almost my entire class of 200 reported instances of this (Participant #209)*

*Bullying by tutors and nursing staff to students (Participant #226)*

Participants also commented on bullying between members of the nursing staff.

*Bullying among nurses which results in lowered care towards patients because the nurse is distressed ... (Participant #232)*

*Aggressive and/or bullying treatment of both nurses and student nurses (Participant #234)*

One participant indicated the impact that the experience of bullying was having on their perception of nursing.

... there is definitely a lot of bullying that takes place and it’s really sad, has definitely made me think seriously about where I want to work and at this stage it’s not in a hospital or rest home ... (Participant #121)

Randle (2003) recognised that students were often bullied in the clinical environment and this was distressing and psychologically damaging. The result was that students felt powerless and they worked harder at fitting in so that nurses would accept and respond to them more positively. Randle also found that students who identified that they had experienced bullying found it extremely distressing, which corresponds with the high distress level reported by participants in this study.

### 4.8.3 End of life care

End of life care issues are a part of the nursing role and can cause distress for staff as well as students. This issue was not included in the questionnaire, as it is a specialist area of nursing that involves complex decision-making. Personal and professional experience and views can impact on a nursing student’s perception of these issues. Students will also have varied levels of academic preparedness and experience in this area of nursing as undergraduates. Range and Rotherham (2010) recognise that end of life care education is not always in-depth in the earlier stages of training and that preparation can make a difference to the distress levels experienced by students.
Of the participants who responded to the Question 38, 5% indicated they had experienced end of life care issues that caused distress. The situations outlined involved single patients rather than regular or systemic issues and as such the most commonly indicated frequency levels were ‘rarely’ to ‘sometimes’. This issue had a mean frequency rating of 2.8. The distress associated with end of life care issues overall gave a mean distress rating of 3.1, indicating a ‘moderate’ level of distress.

Some of the comments made by students highlight the complexity of end of life care and the moral struggle associated with the personal values attached to the treatment of terminally ill patients and death. Students in Callister et al.’s (2009) study also recognised that end of life care decisions were not ethically clear or easy to understand. Comments made by participants in this study involved ethical issues where care was given to either avoid life saving measures or prolong life when the participants felt it may have contradicted the patient’s wishes.

A patient who was ‘not for resuscitation’ … was denied antibiotic treatment because her family was against it … (Participant #49)

I helped look after a patient in a rest home who asked constantly if someone will help him die … he asked many times a day … there were many elderly patients in the facility who request euthanasia (Participant #57)

Elderly patient’s right to be resuscitated not being respected – nurses saying that they would ‘walk slowly’ to the patient because of their age (Participant #126)

Patient who wished to be put in palliative care … being given a nasogastric feeding tube (Participant #193)

These comments reflect findings in Cameron et al.’s (2003) study, wherein nursing students identified quality of life issues and questioned the right of patients to decide for themselves and the ethical dilemma of prolonging life for the benefit of others.

Very sick 18 – 20 week neonates being kept on ventilators (Participant #139)

This comment made by Participant 139 is similar to an extract from a reflective journal written by an American student who struggled with the ethical principles of justice and beneficence when they experienced intensive care being given to low birth weight premature babies (Callister et al., 2009).

Overall these comments support the studies outlined in the literature review that highlighted withdrawal of treatment and euthanasia (Callister et al., 2009; Nolan & Markert, 2002) and
inadequate and substandard care in end of life situations (Park et al., 2003; Range & Rotherman, 2010) as issues.

4.8.4 Veracity

The NZNO Code of Ethics defines veracity (truthfulness) as ‘actions, speech and behaviour that ensure communications between individuals and/or groups are honest and truthful” (NZNO, 2010, p. 13). Five percent of participants who responded to Question 38 identified overt acts of dishonesty they had observed in clinical practice. While the issue of withholding information from patients was covered in the questionnaire, these participants highlighted dishonest behaviour in relation to recording care given.

I experienced someone’s attempts to add notes re: a meeting that happened weeks before, as the client had died (Participant #69)

Handover notes from the night shift were as stated: PATIENT SLEEPING SOUNDLY ALL NIGHT. When I went to see the patient he was uncomfortable and he confirmed he was having chest pain ... he said that he did not get any sleep as pain occurred at 1am. Someone was not telling the truth ... further investigation showed that it was not the patient! (Participant 135)

Falsification of patient’s pain assessment on patient’s chart
(Participant # 203)

These incidents highlight specific cases of breaches of truthfulness in relation to patient care. Participants indicated they had experienced breaches of veracity with a mean frequency rating of 2.0, which corresponded with a frequency level of ‘rarely’. The mean distress rating for this issue was 3.9 or ‘high’ distress levels.

A lack of honesty displayed by health professionals was found in other international studies and evidenced in the literature review. For example, Han and Ahn (2000) and Yeh et al. (2010) found that a lack of truthfulness was among the most concerning issues students faced in the clinical environment. Vallance (2003) also reported a New Zealand nursing student feeling particularly distressed at a RN being dishonest during clinical handover.

4.9 Summary of findings and discussion

The demographic characteristics of the participants in this study are generally representative of the nursing population and the Bachelor of Nursing national student body. The majority of participants were of New Zealand European descent, under 40 years of age and in year two (38%) or three (43%) of their degree.
In general, the questionnaire results showed the most frequently occurring issues were unsafe working conditions and breaches of ethical principles relating to patient rights, such as the use of derogatory or disrespectful statements, breaches of patient dignity, breaches of confidentiality and/or privacy and discriminatory treatment of patients. These issues consistently ranked as the five most frequently experienced issues for participants in the Māori and New Zealand European ethnic groups and in each year of study.

The overall frequency rating scores across the 15 issues varied marginally between Māori and New Zealand European participants, indicating that the culture of nursing was more dominant than cultural or ethnic values and beliefs of the individual participants, relative to the recognition of these ethical issues in clinical practice. Typically, higher frequency rating scores were seen in participants in their third year of study, which was expected due to their increased exposure to the clinical environment.

The results illustrate that breaches of ethical principles that directly affect the delivery of patient care or have the potential to cause physical harm to patients appear to cause the most distress to nursing students. Patient care issues were prominent among the most distressing issues reported and included suspected abuse and neglect, unsafe working conditions and unsafe healthcare practices, with the latter two being the only issues that showed increasing distress levels for participants in the later years of study. It has been suggested that these issues caused by an increase in distress levels while others decreased due to a greater awareness of and importance being placed on the working environment during training. Lui et al. (2008) recognise that nursing students tend to focus on the nursing techniques they need to develop and on client safety, which supports the findings of this study, wherein participants found patient safety issues to be of greatest concern.

Overall distress scores showed a significant increase between year one and two participants, but a decrease in year three participants. The increase in overall distress levels between year one and two participants may be in part due to students having greater exposure to more ethically complex environments in their second year of training and/or due to the compounding effects of experiencing ethical issues more frequently.

Moral blunting, desensitisation or socialisation may be to some level responsible for the reduction in distress levels seen in year three participants, however this reduction was not statistically significant and may be due to other factors or drivers. The nature of this research limits the researcher’s ability to draw definite conclusions regarding what factors may have
influenced the increased distress levels observed in year two participants and subsequent decrease reported by year three participants.

Higher distress scores were recorded relating to the majority of issues for Māori compared to New Zealand European participants, with some showing significant differences. Issues that showed significant differences included the experience of unsafe healthcare practices, care being provided against a patient’s wishes and breaches of confidentiality and privacy. These differences could indicate that cultural influences affect the level of distress felt by Māori nursing students when faced with ethical issues. Further research would need to be conducted by a suitably qualified Kaupapa Māori researcher to ascertain causation of these differences.

Other issues that emerged from the qualitative data analysis included issues involving other staff in the clinical environment and focused on the lack of supervision and support afforded to students and on bullying behaviour. These issues were not reported in high numbers, which may be in part due to the fact that not all students would have identified these relationship issues as having an ethical component; they would simply have viewed them as negative experiences. End of life issues and a lack of veracity displayed by staff were also reported by a lower number of participants. It was found that some of issues outlined in the qualitative question had relatively high frequency or distress scores compared to those issues outlined in the questionnaire; however, the ability to compare these scores is limited as not all participants had the opportunity to consider these issues. Further research would be required to clearly determine how frequently they occur and how distressing these issues are for nursing students.

4.10 Conclusion

This chapter has outlined the demographic profile of the participants involved in this study. The most frequently occurring and most distressing issues from the 15-item questionnaire have been presented and discussed, along with the differences that were evident between groups. The themes that emerged from the qualitative question included in the questionnaire have been presented and comments made by participants have been included to provide greater understanding of the experience of participants.
Chapter Five

Conclusions and Recommendations

5.1 Introduction

This final chapter presents a summary of the background, objectives, design and findings of this study. Recommendations regarding ways in which nursing education could better prepare and support undergraduate nurses in developing and maintaining their ethical integrity are offered. Finally the strengths and limitations of the study are discussed and the implications of these for future research in this area are highlighted.

5.2 Summary

The healthcare environment causes distress for nurses and nursing students due its ethically complex and challenging nature. The impact of this distress on nursing students is a relatively unexplored field in the current literature, both within New Zealand and internationally. There is an increasing need to maintain compassion and ethical integrity within the healthcare environment. In order to do this, the ethics education provided to undergraduates needs to be reflective of everyday issues (Doane et al. 2004) and to prepare them for the ethically challenging workforce they will enter. In order to facilitate the integration of realistic and pertinent ethics education into our undergraduate curriculum, it was important to establish what issues our nursing students faced in clinical practice and what level of distress they experienced as a result.

The quantitative research methodology used was identified and outlined in Chapter Three, along with the elements of the descriptive survey research design implemented to achieve the research aims and objectives. The research findings showed that overall, the frequency of the ethical issues described increased for participants in the later stages of their degree and similar frequency levels were seen in Māori and New Zealand European participants. Although significant differences were observed in the responses of Māori participants to some of the issues, the higher overall distress score for Māori participants was not significant. The results showed that there was a significant increase in overall distress levels in year two participants compared to those in year one and a small but non-significant decrease in overall distress levels in participants in their final year of their degree compared to year two.
Overall, unsafe working conditions proved to be the most commonly occurring and one of the most distressing ethical issues facing New Zealand nursing students. Other issues that occurred frequently were breaches of ethical principles relating to patient rights such as confidentiality, privacy, dignity and respect. The most distressing issues were those relating to patient care, such as unsafe working conditions, unsafe health care practices and suspected abuse or neglect.

Overall, similarities were observed between the findings of this study and those of studies within the international body of literature, with ethical principles such as confidentiality, dignity and respect being breached most commonly. The most distressing issues reported were also found to be of a similar nature to those reported in the overseas literature, with suspected abuse and neglect, unsafe working conditions and unsafe health care practices being highlighted as distressing issues for nursing students. Similar situations and ethical issues to those seen in international literature were recalled by those that answered the qualitative question, suggesting cultures of nursing are not dissimilar. Comments made by participants were at times uncannily similar and showed the relative powerlessness students felt. The themes that emerged from the qualitative open-ended question did not provide any unique or undetermined issues that had not been found overseas. It must be recognised that there are, however, limitations to drawing comparisons with those research articles reviewed herein, as not one study had the same research aims as this study and frequency and distress levels were not quantified in the same manner.

The following sections in this chapter will make suggestions on how the findings of this study could be used to guide and enhance ethics education. Recommendations are also provided for those in clinical practice and in particular those involved with mentoring or coaching undergraduate nursing students.

5.3 Recommendations for clinical practice

Students recognise that nurses have a great deal of ethical responsibility in their workplace and they are acutely aware of the mandatory requirements for ethical practice in relation to competency-based standards (Kalaitzidis & Schmitz, 2012). Nursing students have identified that principles relating to patient rights are breached indiscriminately and considerable numbers of students observed derogatory or disrespectful statements being made about patients, breaches of patient dignity, breaches of patient confidentiality and/or privacy and discriminatory treatment of patients. Student nurses also easily recognise unethical and
unacceptable practices that place patients at risk and find these highly distressing, although they have difficulty intervening. Practising nurses need to be aware that students do recognise ethically compromising practices being role modelled in the clinical environment and that they are distressed by this. There is also evidence to suggest that practising nurses need to be more acutely aware of the capabilities and competency levels of nursing students, as two thirds of the students surveyed indicated they had been asked to provide care they did not feel competent performing without supervision and that most were highly distressed by this.

As mentioned earlier, nursing students are more than capable of identifying unethical practices and the comments made in this study reflect that students believe nurses, at times, value the practical aspects of their work over ethical conduct. However, situations in clinical practice which maybe more complex than students realise and nurses make ethical judgements or decisions based on experience and often feel comfortable that they are adhering to ethical principles such as non-maleficence, beneficence and justice within the resources that are available to them. Nursing students need to be aware of the ethical decision-making process that may be taking place, perhaps unbeknownst to the nurses themselves. The role of mentor and preceptor is extremely important and effective ethical role modelling in practice is crucial for the ethics education of nursing students (Epstein & Carlin, 2012).

In order to develop an ethical environment, those working in it need to acknowledge and address the ethical issues that arise within the practice setting. The safety of patients depends on the development of a moral climate that supports ethical practice (Epstein & Carlin, 2012). Exposing students to a clinical setting that has not developed a moral climate means we are setting them up to fail by not providing them with the tools to address ethical issues and enhance their ethical integrity.

It is not practical or even possible to rid the clinical environment of ethically complex and difficult situations. However, the behaviour of other health professionals should not encourage or endorse unethical behaviour, nor should we give the impression that the basic human rights that nurses are legally and morally obliged to uphold are in some way optional or unattainable in the current clinical environment. Due to the worldwide nursing shortage, the aging nursing workforce and the considerable investment required to produce a qualified nurse, workforce retention is imperative. It is therefore important that we support, role model and encourage the development of an ethical climate for our students and newly
qualified nurses. Registered nurses and other healthcare professionals also need to recognise that student nurses’ heightened ability to empathise with patients is not a weakness, nor should it be regarded as being a product of a naïve perspective.

5.4 Recommendations for nursing education

Grob et al. (2012) recognise that recently there has been increased media attention in the United Kingdom relating to the unethical behaviour of healthcare professionals and that it has been suggested this is due, in part, to failings in nursing education. Woods (2005) also recognises that, although we now have more ethics education in our New Zealand undergraduate programmes than previously, we are consistently failing to produce ethically competent graduates.

Nursing schools are responsible for preparing practitioners to bring the necessary knowledge, clinical reasoning, skills and ethical comportment to patient care settings (Comrie, 2012). When we teach ethics in the classroom, the general focus is on theory and ethical principles, which are often linked to case studies. This may create a disconnection between the classroom and clinical practice, or the ‘ideal vs. real’ environments. As educators in the clinical environment, we may have difficulty seeing the magnitude of nursing students’ experiences when it comes to ethical issues, as it is difficult for ethical issues to be recognised by an outsider (Epstein & Carlin, 2012). We therefore need to foster a relationship with students that allows appropriate time to generate discussion and stimulate critical thinking around strategies they can adopt to cope with ethical issues as they begin their practice (Callister et al., 2009).

The results of this study indicate that the two most distressing issues for New Zealand undergraduate nurses are working conditions and healthcare practices that they determine are unsafe or place a patient at risk. As nurse educators, it is important we understand that these issues are often sensitive in nature, as they may identify the unethical behaviour of others. For this reason students may be reluctant to speak up, choosing instead to remain silent out of a fear of ‘rocking the boat’ or jeopardising their relationships during their clinical placement (Epstein & Carlin, 2012). Students may also have difficulty speaking up for fear of reproach in the form of exclusion or negative feedback. Educators may develop ways of teaching students to question or comment in a manner that will not cause others to feel judged and does not jeopardise relationships with clinical staff. This may stifle open communication and dialogue, however it could be argued that developing these skills is a
necessary and important part of a nursing student’s education. Each situation they find themselves in will be different and only the nurse educator at the time can make the call about whether the ethical issue or the unethical behaviour of staff needs to be addressed openly or used to teach nursing students the delicate manoeuvres that may right an ethical wrong now or in the future without causing a negative impact on relationships. This in no way suggests that nurse educators should ignore unethical behaviour or lower their idealist standards for nursing students. Rather, it recommends that, whatever the outcome, students are given the opportunity to recognise, discuss and apply ethical decision-making processes to the issues they may encounter.

Developing both classroom and clinical ethics education around the main concerns that students have may enhance students’ levels of understanding and ability to respond appropriately. Lin, Lu Chung and Yang (2010) suggest that nursing ethics education is more effective when founded on problem-based learning with ethical decision-making tools, rather than within a conventional lecture-based teaching model. Learning from experience and engaging in realistic role playing can also be effective ways of enabling students to understand ethics (Grob et al., 2012). This integration of ethics education into the clinical environment and everyday situations needs to be considered when developing education curriculums for undergraduates, as knowing the right thing to do theoretically does not necessarily translate into taking the right action.

Encouraging discussion and learning around the common issues that nursing students will face in clinical practice may also be helpful in building resilience. This is necessary for all students, especially in clinical practice, as they have restrictions on their ability to alter care decisions. Resilience is a trait that can be developed over time and a supportive environment that focuses on student-centred learning may help to improve or develop resilience (Grob et al., 2012). A comment made by a nursing student participant in Callister et al.’s (2009) study demonstrates that students are able to learn and develop from ethically challenging situations:

Every mistake we make, or every ethical situation we are placed in, there is much that can be learned from our course of action and the consequences that follow. Each experience we encounter can lead to the redefining of personal values and morals. (p.505)

Fostering this resilience and embedding appropriate and relevant ethics education into undergraduate nurse training may enhance the confidence and capacity of our graduates. As nurse educators, we have a responsibility to produce graduates who are ethically
competent. After all, we are not only providing nursing education, we are training future nurses.

This research also has implications for continuing competency education and training for qualified staff. The Nursing Council of New Zealand’s competency-based standards clearly outline that ethical and professional behaviour are essential in the RN scope of practice (NCNZ, 2009). As leaders and educators within the practice setting establish training and educational priorities, they need to ensure that competency-based ethics training is incorporated into the on-going education plans of registered staff.

5.5 Recommendations for further research

As is often the case with descriptive research, it is hoped that this study will provide a basis for further research that investigates the relationship between nursing ethics education and behaviours that have been identified or observed in clinical practice.

Quasi-experimental research could further identify causal relationships involved in students’ ethical practice or the development of ethical decision making skills. A qualitative research approach could be taken to further explore the lived experience of nursing students in relation to ethical issues, dilemmas and decision-making in clinical practice. These approaches may reveal the deeper meaning behind some of the issues identified and further our understanding of the unique ethical experiences of nursing students. There is also scope to explore what factors influence moral development and ethical values so as to further tailor ethics education of nursing students.

The impact or consequences of moral distress have been previously studied and discussed as they pertain to qualified and practising nurses, however there could be issues of moral distress that are unique to nursing students and their development. A study that reviewed the effects of moral distress and their impact on nursing students and newly graduated nurses would further enhance our understanding of this subject. A study of this type could also lead to further research around how ethical perceptions change or differ between undergraduate and graduate nurses.

Further research relating to the different areas of clinical practice would be useful in identifying the areas where unique ethical problems occur so as better to prepare and orientate students to these areas. It has been recognised that physical practice
environments, such as hospitals or community settings, can contribute to the creation of different ethical issues (Epstein & Carlin, 2012).

As unsafe working conditions and unsafe healthcare practices have been found to be distressing to undergraduate nurses, it would also be of interest to investigate whether there are similarities or differences in how this distress affects their perceptions of the work environment, as well as how these perceptions or conditions could be changed.

5.6 Limitations

Although this research has provided some useful and meaningful data regarding the frequency of and distress levels caused by ethical issues for nursing students in clinical practice, several limitations should be noted.

The relatively small sample size precludes any generalisation of the findings beyond the study population. As well, this study looked only at selected characteristics of the individuals and the clinical environment as a whole, rather than identifying in what different clinical environments these issues are being experienced or causing the most distress. The descriptive nature of the research design also prohibits drawing causal relationships. Follow up data or further research may allow conclusions regarding the cause and nature of the distress felt by students to be made and causal inferences to be drawn more confidently.

A further limitation relating to the design of the study was that responses were limited to the questions included in the survey and relied on the participants’ perceptions of situations, which were not subject to verification. Some qualitative responses identified other issues that occurred for small numbers of participants however had these issues been included in the questionnaire the number may have been substantially higher.

There could be potential gaps between responses and reality and one limitation of adopting a Likert scale could have been that participants were encouraged to select the central point of the scale and avoid the extremes of frequency or distress. Also, although participants were instructed not to include experiences from their work as healthcare assistants, caregivers or nurse aides, it is recognised that participants may have had difficulty separating these experiences from their experiences as nursing students, and therefore the results may not be fully reflective of nursing students’ perceptions.
5.7 Conclusion

This study has examined the ethical issues experienced by Bachelor of Nursing students and has enabled the identification of the most frequently occurring and distressing issues facing nursing students. The findings highlight the issues registered nurses and nurse educators need to be aware of in terms of the experiences of students and around which they need to offer understanding, support and education. Although the limitations of the study preclude the ability to generalise this to the wider student body, it has given 339 students the opportunity to have their experiences recorded and examined.

It is clear that undergraduate Bachelor of Nursing students experience distress during their education, the majority of which is related to their work environment and the delivery of patient care. We have an obligation as nurse educators to enable students to become ethical practitioners and to be able to advocate for themselves, their patients and the nursing profession. We must educate and empower our nurses of tomorrow to enable them to actively and intelligently argue in the necessary forums to ensure that their voices are heard. To do this, we must recognise their struggles and mitigate the impacts of distress and help them to avoid the erosion of their moral integrity by never exposing them to deal with the distressing aspects of their job when they are still ill-equipped to do so.
References


APPENDIX I

Health and Disability Ethics Committees Flowchart
Does your study require HDEC review?

1. Main criteria

Will your research use or create a human gamete, a human embryo or a hybrid embryo?
- Yes
- No

Does your study involve human participants recruited in their capacity as:
- Consumers of health and disability support services, or
- Relatives/caregivers of such consumers, or
- Volunteers in clinical trials?
- Yes
- No

Does your study involve the use, collection of storage of human tissue (as defined by the Human Tissue Act 2008)?
- Yes
- No

Does one or both of the exceptions to paras 27.2.1 and 27.2.2 of the SOPs apply to this use, collection or storage?
- Yes
- No

Does your study involve the use or disclosure of health information (as defined by the Health Information Privacy Code 1994)?
- Yes
- No

Does one or both of the exceptions to paras 27.3.1 and 27.3.2 of the SOPs apply to this use or disclosure?
- Yes
- No

Your study must be approved by the Ethics Committee on Assisted Reproductive Technology (www.echart.health.gov.nz).

2. Exemptions

Does your study involve a medical device that is (or would be) classified as a low risk (class I) medical devices by Australia’s Therapeutic Goods Administration?
- Yes
- No

Is your study a minimal risk observational study?
- Yes
- No

Is your study an audit or related activity?
- Yes
- No

Does your audit or related study involve the use, collection or storage of human tissue without consent?
- Yes
- No

Does a statutory exception to the need to gain informed consent apply to this use, collection or storage?
- Yes
- No

Is your study an observational study that is to be conducted for the purposes of an educational qualification at Masters level or below?
- Yes
- No

3. Inclusions

Does your study involve the use of Guthrie cards?
- Yes
- No

Is your study:
- Funded by the Health Research Council, and
- Not able to be reviewed by an HRCEC-approved university ethics committee?
- Yes
- No

Does your application involve the establishment or maintenance of a tissue bank?
- Yes
- No

YES. HDEC review is required for your study.

NO. HDEC review is NOT required for your study.
APPENDIX II

EIT Research Proposal Approval
21 June 2012

Jill Sinclair
114 Milton Park Road
RD 1
INVERCARGILL 9871

Dear Jill,

The Faculty Academic Committee met on 19 June, and approved your research proposal topic “New Zealand undergraduate nursing students' experience of ethical issues: a descriptive study”, to progress.

If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Ruth Crawford
MN9.490 Course Coordinator
For the Faculty Academic Committee
Faculty of Health Sciences

Cc: Dr Bob Marshall; Chris Ball
APPENDIX III

Eastern Institute of Technology Ethics Approval
Reference Number 25/12

30 July 2012

Jill Sinclair
Master of Nursing Student
C/- Faculty of Health Science
EIT Hawke’s Bay

Dear Jill,

I am pleased to inform you that your research project “New Zealand undergraduate nursing students experience of ethical issues” was reviewed by the Research Ethics & Approvals Committee at their meeting held on 27 July 2012, and formally approved for two years.

The Reviewer(s) have noted the use of the word ‘moral’ distress in the Research Outline and have raised the question why not use just ‘distress’ as articulated in other sections? Please clarify and respond back to the Committee.

You are reminded that should the proposal change in any significant way, then you must inform the Committee.

Please quote the above reference number on all correspondence to the Committee.

Please provide the Committee with a progress report after one year of the project and a brief summary at the conclusion.

The Committee wish you well for the project.

Yours sincerely,

Jeanette Fifield
Secretary – Research Ethics & Approvals Committee

cc: Bob Marshall, Chris Ball (Supervisors)
APPENDIX IV

Letter of Clarification to EIT Research Ethics & Approvals Committee
114 Milton Park Road
RD1
Invercargill

10th August 2012

To: Eastern Institute of Technology Research Ethics & Approvals Committee

Re: Ethics Approval Reference Number 25/12

I am writing to clarify the wording of the Research Outline submitted for my research project “New Zealand undergraduate nursing students experience of ethical issues”, which received approval in July 2012.

The term ‘moral distress’ was used within the Research Outline which raised a question from the reviewer(s) on the committee. I agree that this term should read ‘distress’ rather than ‘moral distress’ to reflect the terminology and scope of the research as outlined in other sections of the Ethics Application and the Research Proposal. I would like to assure the committee members that the word ‘distress’ is articulated in the proposal and within the questionnaire administered to the sample population.

I apologise for any inconvenience this matter may have caused. I would also like to take this opportunity to thank the committee for their consideration and subsequent formal ethics approval of my research project.

Yours sincerely,

Jill Sinclair

Jill Sinclair
Master of Nursing Student
Eastern Institute of Technology
APPENDIX V

Email Survey Invitation
New Zealand Nursing Students Experience of Ethical Issues in Clinical Practice

You are invited to participate in a survey, endorsed by NZNO that aims to identify what ethical issues NZ nursing students experience in clinical practice and how distressing these issues are.

Please take some time to complete this survey and tell us about YOUR experience.

You can access the survey at the link below:

http://www.surveymonkey.com/s/NursingStudentsEthicalIssues

(if this link does not take you directly to the site, please copy and paste it into a web browser)

Your rights:

- You do not have to participate in this research if you do not wish to.
- You can withdraw from the research at any time and this will not affect treatment or assessment in any courses or programme of study.
- You may request a summary of the completed research.
- You may contact the researcher for clarification about the research Jill Sinclair (EIT Master of Nursing Student) at jill.sinclair@vodafone.co.nz

While no physical risks are anticipated by the completion of this study, you may experience some psychological or emotional distress recounting ethical issues or dilemmas you have faced in clinical practice. You are encouraged to seek assistance through the appropriate channels available at your educational institute or contact the researcher for further information regarding services. The benefit of this research is the development of knowledge regarding ethical problems experienced by student nurses in clinical practice. Findings of the proposed research may provide nurses, educators and health care agencies with a measure of ethical issue frequencies and distress levels related to ethical issues in clinical practice which can guide undergraduate education and discussion. Recruitment of participants and the distribution of the questionnaire will be completed independently of the researcher and participants’ information, including email addresses, will not be forwarded or available to the researcher. This survey is anonymous. No one, including the researcher, will be able to associate your responses with your identity. Responses will be stored within a secure server and the data is only available to the researcher. Data will be kept for a minimum period of 10 years.

Emma Hay | PA to PSM / Team Leader emmah@nzno.org.nz | 04 494 8235 | www.nzno.org.nz
New Zealand Nurses Organisation | PO Box 2128 | Wellington 6140

Note:
This message is for the named person's use only. It may contain confidential, proprietary or legally privileged information. No confidentiality or privilege is waived or lost by any mistransmission. If you receive this message in error, please immediately delete it and all copies of it from your system, destroy any hard copies of it and notify the sender. You must not, directly or indirectly, use, disclose, distribute, print, or copy any part of this message if you are not the intended recipient. The New Zealand Nurses Organisation (NZNO) and any of its subsidiaries each reserve the right to monitor all e-mail communications through its networks. Any views expressed in this message are those of the individual sender, except where the message states otherwise and the sender is authorised to state them to be the views of any such entity. Thank you.
APPENDIX VI

Questionnaire
Ethical Issues in Clinical Practice

General Information, Consent and Confidentiality

You are invited to participate in a research project being conducted by Jill Sinclair, a Master of Nursing student at the Eastern Institute of Technology.

The aim of this study is to develop our knowledge of ethical issues that nursing students face while in clinical practice. The title of the study is:

“New Zealand undergraduate nursing students’ experiences of ethical issues”.

This survey is anonymous. No one, including the researcher, will be able to associate your responses with your identity. Your participation is voluntary and you may choose to stop responding at any time during the survey.

The completion of the survey indicates your voluntary agreement to participate in this research project and your certification that you are 18 years of age or older at the time of the survey.

Ethical approval was granted by Eastern Institute of Technology Research Ethics and Approval Committee for 2 years from July 2012. Reference Number 25/12.

Questions regarding this study can be directed to Jill Sinclair at jill.sinclair@vodafone.co.nz or Professor Bob Marshall at bmarshall@eit.ac.nz

Preliminary Questions

1. Are you currently studying towards becoming a New Zealand Registered Nurse?
   - [ ] Yes
   - [ ] No

2. Are you registered with the New Zealand Nursing Council as an Enrolled Nurse or Nurse Assistant?
   - [ ] Yes
   - [ ] No

3. Have you attended clinical placement for a minimum of 2 weeks in the past 6 months?
   - [ ] Yes
   - [ ] No
Demographic Information

4. What is your gender?
   - [ ] Female
   - [ ] Male

5. Which category below includes your age?
   - [ ] 18-21
   - [ ] 22-29
   - [ ] 30-39
   - [ ] 40-49
   - [ ] 50-59
   - [ ] 60 or older

What ethnicity do you most identify with?
   - [ ] NZ Māori
   - [ ] NZ European
   - [ ] Pacific
   - [ ] Asian
   - [ ] New Zealander
   - [ ] Indian
   - [ ] Australian
   - [ ] American
   - [ ] Other
   - [ ] Other (please specify)

6. What year of your nursing degree are you currently in? (if your course of study will take longer than 3 years please indicate the year of the degree programme your clinical paper is run).
   - [ ] Year One
   - [ ] Year Two
   - [ ] Year Three

About the Questionnaire

The following questions outline pre-determined ethical issues that relate to patient rights and patient care. You will be asked to indicate how frequently you may have experienced these issues and the level of distress associated with these issues. If you have ‘never’ experienced the issues outlined in the questions you will not be asked the corresponding distress levels for that question.

Your ‘Experience’ of these situations or issues may mean that you have observed them or been involved either directly or indirectly. It is important that you recall situations or events that have happened while you were a nursing student. Please do not include situations that may have occurred in your personal or working life, for instance if you are also employed as a care worker or health care assistant.

It is expected that this survey will take approximately 10-15 minutes. However please take your time recalling your experiences - it is important that we learn what it is that you see and experience.
## Patient Rights

8. Have you experienced breaches of a patient’s right to confidentiality and/or privacy?

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9. What level of distress did you feel when you have experienced breaches of a patient’s right to confidentiality and/or privacy?

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<th>No Distress</th>
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10. Have you experienced information being withheld from a patient regarding diagnosis, treatment or prognosis?

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11. What level of distress did you feel when you have experienced information withheld from a patient regarding diagnosis, treatment or prognosis?

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12. Have you experienced medical or nursing care being provided where the consent given, in your opinion, was not informed consent?

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13. What level of distress did you feel when you have experienced medical or nursing care given without informed consent?

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14. Have you ever experienced discriminatory treatment of patients?

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15. What level of distress did you feel when you have experienced discriminatory treatment of patients?

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16. Have you experienced the use of chemical or physical restraints to control a patient's behaviour that in your opinion was not in the patient's best interests?

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<th>Rarely</th>
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17. What level of distress did you feel when you experienced chemical or physical restraints being used in situations that you felt were not in the patient's best interest?

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<th>No Distress</th>
<th>Some Distress</th>
<th>Moderate Distress</th>
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18. Have you experienced healthcare personnel making derogatory or disrespectful statements about patients?

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19. What level of distress did you feel when healthcare personnel made derogatory or disrespectful statements about patients?

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<th>No Distress</th>
<th>Some Distress</th>
<th>Moderate Distress</th>
<th>High Distress</th>
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20. Have you ever experienced a health care professional not respecting a patient's dignity?

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<th>Rarely</th>
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21. What level of distress did you feel when you experienced healthcare personnel not respecting a patient's dignity?

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<th>No Distress</th>
<th>Some Distress</th>
<th>Moderate Distress</th>
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22. Have you experienced medical or nursing treatment given against a patient's wishes?

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<th>Rarely</th>
<th>Sometimes</th>
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23. What level of distress did you feel when medical or nursing care was given against a patient's wishes?

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### Patient Care

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<td>24. Have you experienced unsafe healthcare practices that place a patient at risk?</td>
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<td>25. What level of distress did you feel when you have experienced unsafe healthcare practices that place a patient at risk?</td>
<td></td>
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<tr>
<td>26. Have you experienced working conditions that you consider unsafe; i.e. low staffing levels, lack of resources or equipment, lack of staff training?</td>
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<tr>
<td>27. What level of distress did you feel when you have experienced unsafe working conditions?</td>
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<tr>
<td>28. Have you been asked to provide care, without supervision, that you did not feel competent to provide?</td>
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<td></td>
</tr>
<tr>
<td>29. What level of distress did you feel when you were asked to provide care you did not feel competent to provide?</td>
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<tr>
<td>30. Have you ever provided care to a patient that has put your own personal safety at risk?</td>
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<tr>
<td>31. What level of distress did you feel when you have provided care to a patient at risk to your own personal safety?</td>
<td></td>
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</tr>
</tbody>
</table>
32. Have you experienced a medication or treatment error that was not reported?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

33. What level of distress did you feel when a medication or treatment error was not reported?

<table>
<thead>
<tr>
<th>Level of Distress</th>
<th>No Distress</th>
<th>Some Distress</th>
<th>Moderate Distress</th>
<th>High Distress</th>
<th>Very High Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

34. Have you experienced a 'Do Not Resuscitate Order' being implemented by medical staff without consultation with a patient or their family/whanau?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

35. What level of distress did you feel when you experienced a 'Do Not Resuscitate Orders' being implemented without consultation with a patient or their family/whanau?

<table>
<thead>
<tr>
<th>Level of Distress</th>
<th>No Distress</th>
<th>Some Distress</th>
<th>Moderate Distress</th>
<th>High Distress</th>
<th>Very High Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

36. Have you ever experienced caring for a patient who you suspected may have been abused or neglected?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

37. What level of distress did you feel when you have cared for a patient who you suspected may have been abused or neglected?

<table>
<thead>
<tr>
<th>Level of Distress</th>
<th>No Distress</th>
<th>Some Distress</th>
<th>Moderate Distress</th>
<th>High Distress</th>
<th>Very High Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
Your Say

This is your opportunity to note any other ethical issues you have faced in clinical practice as a nursing student. Please write the issue in the space provided, then indicate the associated frequency and distress levels.

**38. What other ethical issue have you experienced in clinical practice?**

<table>
<thead>
<tr>
<th>Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**39. How frequently have you experienced the stated issue?**

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td></td>
</tr>
<tr>
<td>Very Often</td>
<td></td>
</tr>
</tbody>
</table>

**40. What distress level did you experience in relation to the stated issue?**

<table>
<thead>
<tr>
<th>Distress Level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No Distress</td>
<td></td>
</tr>
<tr>
<td>Some Distress</td>
<td></td>
</tr>
<tr>
<td>Moderate Distress</td>
<td></td>
</tr>
<tr>
<td>High Distress</td>
<td></td>
</tr>
<tr>
<td>Very High Distress</td>
<td></td>
</tr>
</tbody>
</table>

Thank You

Thank you for taking the time to complete this survey.

If this survey has raised issues or caused you to recall situations that are distressing to you that may require debriefing, please contact Student Support Services at your Educational Institute for assistance.