Global Qualitative Nursing Research
Volume 4: 1–9

DOI: 10.1177/2333393617730208
journals.sagepub.com/home/gqn
SAGE

Informed Strangers: Witnessing and Responding to Unethical Care as Student Nurses

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Abstract

Nursing students occupy a unique perspective in clinical settings because they are informed, through education, about how patient care ought to happen. Given the brevity of placements and their "visiting status" in clinical sites, students are less invested in the ethos of specific sites. Subsequently, their perspectives of quality care are informed by what should happen, which might differ from that of nurses and patients. The purpose of this study was to identify predominant themes in patient care, as experienced by students, and the influence that these observations have on the development of their ethical reasoning. Using a qualitative descriptive approach in which 27 nursing student papers and three follow-up in-depth interviews were analyzed, three main themes emerged: Good employee, poor nurse; damaged care; and negotiating the gap. The analysis of the ethical situations in these papers suggests that students sometimes observe care that lacks concern for the dignity, autonomy, and safety of patients. For these student nurses, this tension led to uncertainty about patient care and their eventual profession.

Keywords

content analysis, qualitative analysis, descriptive methods, ethics / moral perspectives, nursing education

Received February 3, 2017; revised July 26, 2017; accepted August 4, 2017

As an applied discipline and profession, "doing it right" (Oberle & Raffin Bouchal, 2009, p. 3) is at the very core of nursing and a commitment to caring and to the patient. Right and wrong, should and should not, or "ought to or ought not to" (Oberle & Raffin Bouchal, 2009, p. 3), the core of ethics, move beyond the idea of what is technically right or wrong or what evidence suggests is best practice. Within nursing, our beliefs about right and wrong guide the application of technology and science, as well as how we see our duty to patients, as professionals, or for students, our duty as evolving professionals. As such, ethics guide every action that we take and hence the quality of nursing care that is delivered.

Although the delivery of care is essential to nursing, nursing cannot be merely doing care. Care is also about being, in which acts are not guided and informed by technology and science but also by how, which is the character of the nurse and an orientation that is respectful of the dignity of the patient (Yeo, 2014). *How* involves a deeply ethical and moral sense that is appreciative of the aims of science and technology in serving the needs of the patient in a caring manner. This sense does not address the *how* of what to do when the needs of the patient fail to be served well by science, technology, or poor quality nursing care.

Background to the Study

Poor quality nursing care can often be attributed to organizational factors such as lack of adequate resources, low staffing levels, workload, and interprofessional conflicts (Ball, Murrells, Rafferty, Morrow, & Griffiths, 2014; Park, Jeon, Hong, & Cho, 2014; Pauly, Varcoe, Storch, & Newton, 2009). In addition, quality of care has been found to be adversely affected by leadership where there is lack of respect for professionals and their concerns and failure to provide reasonable organizational policies that support nursing care (Gaudine & Thorne, 2012). Findings from these studies support the idea that nurses practice in situations where espoused ethical values such as the provision of safe, compassionate, competent, and ethical care (Canadian Nurse Association

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[CNA], 2008) cannot consistently be realized, which sets up conflict between what nurses have been socialized to value as the being or how of nursing and what actually occurs or the doing of nursing.

Similar findings can be found in studies that involve students. These studies have largely focused on issues that impact learning and the capacity of students to deliver safe and ethical person-centered care. Factors have included student–faculty interactions, student–nurse interactions, pressures to conform to the routine of the clinical unit, unsafe clinical settings, and the impact of academic learning on care that is delivered by students (Bradbury-Jones, Sambrook, & Irvine, 2011; Charalambous & Kaite, 2013; Grilo, Santos, Rita, & Gomes, 2014; Killam et al., 2012; Levett-Jones, Lathlean, Higgins, & McMillan, 2009; McGarry, 2009; Pearcy & Elliott, 2004; Pedersen & Sivonen, 2012). Research related to students' perceptions of the quality of care delivered by registered nurses is sparse and recent research in this area is especially limited. Specific factors in the nursing care observed by students suggest that task orientation, lack of communication with patients, and overwhelming concerns with documentation challenge the students' perceptions of what good nursing care entails (McGarry, 2009; Pearcey & Draper, 2008), but these studies have largely been a comment on the experience of students rather than a reflection on the direct patient care delivered by other nurses.

Few studies have focused on the process of the development of ethical reasoning in nursing students and on their thinking and responses in situations that challenge their ability to behave ethically or to lead in ethical behaviors such as advocacy. In their study of ethical reasoning in students, Callister, Luthy, Thompson, and Memmott (2009) suggested that students, although aware of ethical dilemmas and issues, might lack the confidence to enact their ethical knowledge and awareness. Similarly, in their recent study, Ion, Smith, Moir, and Nimmo (2016) suggested that students were aware of ethical concerns in care that they observed, and the authors explored how students account for their failure to report poor care and ethical concerns arising. The observations of students about the care that is provided by nurses and seen during clinical placements are important to heed because they could provide a unique perspective of the clinical being of nursing and of patient care. In our review of the literature, we found no studies that explicitly articulated the care as perceived by students and delivered by nurses and how this influences the development of the ethical reasoning of students.

Nursing students occupy a unique perspective in the clinical setting because they are informed, through their education, about what ought to happen or what should happen in the clinical setting in patient care but might be less invested in the culture or ethos of clinical sites because of relatively brief attachments to specific sites. Subsequently, students offer a perspective that is informed about how quality patient care *ought to* be but one that is different from that of practicing nurses, who have considerable investment in their environments, or from that of patients, whose perspectives are influenced by personal needs and interpretations.

The purpose of this qualitative descriptive study was to identify predominant themes in patient care, as witnessed by students and the influence that these observations have on the development of their ethical reasoning. Specific research questions that were addressed were as follows:

Research Question 1: In what situations or events have students observed or participated in that suggest concern about the provision of safe, competent, ethical, and compassionate care?
Research Question 2: What ethical concerns emerge from these observations? and
Research Question 3: How do these observations influence the development of the students' ethical reasoning?

Method

Design and Setting

This is a qualitative descriptive study in which we have followed the approach outlined by Sandelowski (2000, 2010) and Neegard, Olesen, Andersen, and Sondergaard (2009) that seeks to provide minimally theorized (Sandelowski, 2000) description about events and situations. The aim of using qualitative description is to stay as close to the data as possible, with codes emerging that are data-derived. Data for the study was derived from papers completed by baccalaureate nursing students at a Canadian university who had been enrolled in a nursing ethics course and from in-depth interviews that were conducted after the initial analysis of the papers.

Ethical Considerations

After institutional ethics board approval, presently registered nursing students and program graduates who were enrolled or had been enrolled in a 4-year baccalaureate nursing program were invited to participate in the study by sharing a paper that had been submitted previously to the nursing ethics course in the program. The paper was an assignment that required students to critically analyze a clinical situation that had caused them moral distress, using the ethical decision-making framework outlined by Oberle and Raffin Bouchal (2009) and various ethical theories.

Recruitment

Through purposive and convenience sampling, participants were recruited by a research assistant who distributed a letter of information and invitation through the university's learning management system and social media. Interested persons were asked to directly contact the research assistant. Consent to participate in the study was implied if the participant notified the research assistant and gave permission to retrieve the

participant's paper from the course repository on Turnitin.com. Participants were assured through the letter that their participation was entirely voluntary. If the paper was not available through Turnitin, participants were instructed that they could email or send the paper to the research assistant. Once the research assistant accessed the paper and confirmed that it had been submitted to the ethics course, the paper was downloaded. All identifying information such as the participant's name, student number, and date of submission was electronically deleted before the papers were printed by the assistant, who kept a master list of the participants' names and emails for a follow-up draw as compensation for participation. This list was kept in a secure location only accessible to the research assistant and destroyed once the draw was made and study completed. Study identification numbers were arbitrarily assigned to the papers by the research assistant so that the researchers could identify the data during discussion and analysis.

Data Analysis

Twenty-seven papers were submitted for consideration by the research team. The papers were divided among two teams, each with two researchers. The teams read and reread the transcripts for the who, what, and where of situations in which ethical concerns arose; the what of ethical concerns; and what impact these situations had on developing ethical awareness and reasoning. Consistent with qualitative research methodology, initial codes were developed from the transcripts by each of the four researchers, which described patient care situations, ethical concerns, and impacts. The researchers then brought the initial codes to the team as a whole. These codes were refined in discussions among the team and a working set of codes evolved through consensus.

In-depth interviews were conducted with three participants who provided consent during the initial recruitment phase for follow-up interviews. Interview questions were developed from the working set of codes for in-depth interviews with the participants who had volunteered for further follow-up. The intent of these questions was to expand, confirm, and disaffirm (if appropriate) the initial codes and descriptions that had been developed by the research team and to contribute to rigor within the research process (Noble & Smith, 2015). The interview questions were as follows: *How has your perception of patient care changed since you completed the nursing ethics course? What have you learned about the ethical practice and treatment of patients in the clinical setting? From the perspective of a student nurse, what do you think should be done to ensure patient care is delivered ethically?*

The telephone and face-to-face interviews were conducted and transcribed by two members of the research team and reviewed within the context of final analysis and writing of the themes by all members of the research team. Each interview was approximately 20 to 30 minutes in duration and were digitally recorded on an external device. Notes were taken during each interview to record context. Throughout the process of individual review of the student papers, group review and discussion, and interviews, notes were kept by each member of the team and of the group discussions that reflected individual thoughts and ideas and those of the group as a whole. These notes also provided an audit trail throughout the research process.

Findings

The papers that the students submitted represented a wide range of clinical situations and settings that they had encountered while in the nursing program. Given that students were asked to write about situations in which they experienced ethical distress, the papers reflected ethically troubling situations and by their very nature, tended to reflect on patient situations in which there were problems with care. Twenty papers, or the majority, described situations in which students witnessed care enacted by others, often for patients for whom the students were also caring, and about which students perceived ethical concerns. The remainder of the papers involved care that the students themselves provided and largely involved uncertainties as to whether what had occurred was ethical or not.

Through a process of critical analysis, the students explored care situations in their papers, using legal concepts and a variety of ethical theories, which were mainly Kantian ethics, relational ethics, and utilitarianism. At times, although the rich description of the situation overtook its analysis, the vividness and detail of which suggested a high degree of involvement with the situation at hand and a dissonance between what students knew to be right and what was presented as care in the clinical setting.

The knowledge acquired during their educational program enabled students to enter the clinical setting, where they were peripheral to care and the nursing team and thus, perhaps, less invested in the culture of the unit and more objective. Subsequently, their involvement was more as an informed observer or witness to care, which led to the overriding theme of *student as informed stranger*, as evidenced in an interview that followed after the review of the papers. The term witness, which came out of Old English and commonly came to mean to *see or know by personal presence, observe* in the late 1500s ("Witness," n.d.) seems especially appropriate within the context of these informed strangers, who observe and in the words of Paley (2013) are bystanders in care but see care through an intentional presence that is neither uncaring or necessarily naive.

> In clinical placements, I learned that the client's role in their own health can be dictated by staff with little to no input from the client, which shows limited respect . . .
>
> So, it's unethical care . . . that's what I witnessed in the clinical practice setting. (Interview Participant 3)

Table 1. Hierarchy of Themes.

Major Theme	Definition	Minor and Sub Themes
1. Good employee, bad nurse	Focus on self within the context of the organization and work relationships	i. Comply with organization ii. Organization versus patient iii. Get tasks done iv. Belonging is important
2. Damaged care	Potential or actual harm done to the patient as a result of nursing actions or neglect	i. Too busy to care ii. Unfulfilled patient needs iii. No choice for patients iv. Compliance through fear
3. Negotiating the gap	How nursing students and eventual graduates react to the ethics and care that they witness being provided and how they make sense of it	i. Protecting self: Now and in future ii. Doing just what a professional would do iii. Growing a backbone

Through analysis of the papers, we identified three themes which came out of the student's experience as an informed stranger: (a) good employee, poor nurse; (b) damaged care; and (c) negotiating the gap (see Table 1).

Good Employee, Poor Nurse

Although patient-centered care is considered an ideal within current health care (Engel & Prentice, 2013), the accounts of care that the students shared indicated that the needs of the patient were sometimes relegated to a lower priority behind the needs of the nurse and the organizational practices and policies.

Comply with organization. Many of the students wrote about situations in which care to patients was compromised because of organizational directives and constraints that resulted in deficit care. In one situation, the student described how staff were so few in a long-term care setting that the residents did not receive their evening snacks and that those who had baths scheduled had the baths canceled. Other activities on the shift were also cancelled and evening care was "rushed or missed." Although it was unclear whether staff might have been available if the registered nurse in charge had called them, lack of staffing and subsequently the care was an intentional decision.

> A personal support worker from the day shift offered to stay, but the manager would not allow the worker to stay because she would have to pay him overtime. (Participant 5)

In another situation, staff tolerated an ongoing situation for patients in a ward room where half the patients had curtains around their bed and half did not.

> There were no curtains for two out of 4 patients, which lacked dignity and privacy.
>
> Patients received bathing, toileting without curtains. (Participant 8)

Organization versus patient. Occasionally, students described situations in which the rules and policies of the unit and institution overrode the individual decisions or needs of the patients. For example, a student worried that the freedom of her voluntary patient on the psychiatric mental health unit might be curtailed by rules as to when patients can leave the unit, regardless of the physician's orders that allow her to do so and that is "the way the hospital functions" (Participant 6).

> No one, voluntary or involuntary, is allowed to leave the unit after 2030.

Get tasks done. In observing care for a patient with pain, Participant 14 noted that it was more important to "get tasks done" than to provide attention needs for pain control of patient who was recently postsurgical and who had previously abused drugs. The completion of tasks, rather than safety whether physical or psychological at least sometimes, took precedence in the care of patients.

> The nurse with whom I was working had five patients . . . four of whom had been diagnosed with Clostridium difficile . . . I noticed that . . . my nurse would perform care without using any PPE (Personal Protective Equipment) or consistently sanitizing her hands between client rooms. The nurse told me that I was "slowing her down" by constantly putting on and taking off PPE during client care. She told me, "in the real world, nurses do not have time for all that attire. Besides most of my clients are infected anyway." (Participant 25)

Belonging is important. For others, the need to get tasks done was placed within the context of pleasing others and belonging to the work group rather than complying with system, organizational, or patient needs. While observing a nurse complete a sterile dressing near the completion of a shift, it appeared to Participant 10 that the nurse was more concerned about the disapproval of a colleague who was coming in on the next shift than about taking time to complete the dressing safely.

> The nurse had not noticed the order until ten minutes prior to the end of her shift.
>
> She did not want to upset her colleague coming in for the next shift [sic] quickly grabbed a sterile dressing kit and began the change. She opened the tray on the patient's bed, abandoning her sterile dressing technique almost immediately after she began. (Participant 10)

Damaged Care

Situations in which care was observed to be less than adequate ranged from failure to observe standards of care to neglect, withdrawal of care, coercion, and lack of respect for the dignity and rights of patients. The care that was provided was seen by the students as actually harming the patient or as having the potential to harm patients. The harm done included physical, emotional or psychological, or spiritual aspects and included the erosion of dignity. For example, one of the participants described with great detail, a lack of attention to the dignity of a patient who had recently died.

> The RN said that she needed to "crack the window open" to get rid of the odor in the room . . . there were no last rites and the patient was not bathed.
>
> When the family visited, the family asked where the teeth were.
>
> When the RN and I were stuffing the body in the body bag with a soiled Depends, the RN said "there's those teeth," (Participant 3)

Too busy to care. Lack of time for care resulted in situations in which patients sometimes were subjected to care in which basic needs were partially fulfilled or fulfillment even compromised. Participant 4 described a situation in which a staff member tried to force hot soup into the mouth of a patient who was being fed because the patient was "taking too long to chew." When the patient refused, the food tray was removed from a patient's table before the patient had fully finished eating. In another situation, a patient's expressed wish to die was ignored because of its low priority in busyness.

> The nurses were very task oriented with her and they thought she was dramatic when it came to her depression and busyness. One day, she [patient] told me she wanted to die.
>
> The nurse did not appear shocked or concerned. She [nurse] told me she was too busy with patients who were "more sick" than my patient. (Participant 15)

Unfulfilled patient needs. The students' accounts detail several instances in which the rights of the patient were neglected or not respected either in relation to consent to care or in relation to information that the patient was providing or requesting. In one situation described by a student, a patient was made to sit at lunch despite an expressed need to use the toilet.

> M. was seated in her spot, ready to eat, when she got up and headed to her room. When the nurse asked her where she was going, M. said she had to use the bathroom. The nurse responded by leading her back to the table, saying M. should eat lunch first and she was "just confused." During lunch, I noticed M. was not eating and looked uncomfortable. When I asked M. what was wrong, she whispered she needed to go to the bathroom . . . I helped her to her room where M. went to the toilet. (Participant 20)

No choice for patients. Participant 16 described a situation in which an elderly patient asked not to be put to bed at the time designated by her caregiver. Despite the wishes of the patient, who was competent to make this decision, the patient was taken to bed. When she protested because of a painful transfer, she was placed in restraints. In a similar situation, an elderly patient wished to refuse her evening dose of Ativan because it made her too drowsy. Despite the wishes of the patient, the medication was offered to her and when the patient asked whether the tablet was Ativan, the nurse reassured her that it was not.

> A particular patient we had been assigned to was very lively and would stay up late and disturb other patients, but was cognitively present. When the nurse took the dose of Ativan out I asked her what that was for and she informed me that she gives Ativan to this patient unknowingly so that she would not have to deal with her disturbing other patients. I asked if she told the patient she was receiving this medication and she said that she did not tell her because she'd always refuse it. (Participant 11)

In this instance and in other situations, intentional denial of information might have limited the choice and involvement of patients in their own care. For Participant 12, not sharing information about weight might have limited the participation of a patient in the treatment team regarding her own care, although the decision of the team was related to the anorexic disorder of the patient.

> JS was weighed weekly but the team all agreed not to show her the weight amount. JS believed that it was a "human right" to know how much she weighed.

Compliance through fear. Although threats were rarely mentioned by students as a way to gain adherence to care, occasionally the use of negative or unwanted consequences by health care providers was witnessed by student nurses as a means to bring about the wishes of caregivers. Although the full legal or health contexts and implications of the situation may have been unknown to the student, Participant 13 described how gaining the compliance of family became a practice of fear, rather than of exploration of options. In this situation, the student described how the parents of a young suicidal patient who preferred the approach of medication

over hospitalization were threatened with being reported to social services if they did not agree to admission of their daughter and how nurses became complicit in the threat.

> The doctor ordered Nurse S. to set up a family meeting and obtain informed consent for M.'s treatment . . . M.'s parents and two daughters came to the meeting where Nurse S. and I explained the care plan decisions and need for informed consent. The parents refused . . . and asked to speak to the psychiatrist. When Dr. R. came . . . the parents expressed their concerns . . . and insisted their daughter be cured through religious means . . . Dr. R. stated to the parents that if they didn't give informed consent, he would contact Children's Aid. Due to fear . . . the parents signed the consent papers. Nurse S. began the treatment order.

Negotiating the Gap

The gap between what was sometimes seen as what ought to happen and what should not happen in practice was described in the papers by the participants and in the interviews through three primary perspectives. In each description, the students identified as coming to the situation as strangers: informed, but not part of the group. *A stranger*. A stranger whose voice is not necessarily welcomed or acknowledged because of the nature of the short-term clinical placement. A stranger, who is often viewed as a visitor to the clinical floor versus being a member of the clinical staff and team. Making sense of what was witnessed in care was influenced by the students' growing awareness of ethics and of the clinical setting.

Protecting self: Now and in future. Anticipation and fear of retribution or negative consequences influenced one description, which was characterized by avoidance and silence, an ethical gap that had potential for continuance. The chasm between what ought to have happened and what actually happened was resolved by the student in a way that hints at what the student might do, even as a graduate nurse. As an informed stranger, aware but not part of the clinical staff, the student saw both the wrong in the nursing action and in the potential resolution but anticipated the difficulties in staying outside what the group or organization expects or supports.

> In the circumstance and being a student, even if I was a newly graduated RN, I would be fearful of what could happen to my position on the unit, and be afraid my job could be suspended or worse. I know I should be the best advocate for the patient . . . but I cannot say that I would be the first of the working staff to come out with my opinion and make a choice . . . As I have learned through my placements, most nurses take measures to protect themselves in case of any legal issues. It seems to be that the fear of losing one's job over a moral issue is not worth it. (Participant 6)

Stories of negotiating the gap from the participants who were interviewed about their clinical nursing experiences as students and the role that their ethics course had in the development of their ethical practice suggest that this education provided valuable knowledge about ethical practice and the responsibility to uphold it as a professional. The knowledge that was gained was also discomforting because it resulted in an uncomfortable gap or tension when the nurses to whom the students looked for guidance in actual practice failed to uphold the accountability that is considered foundational to nursing. Witnessing was a difficult experience in which the ethical dilemma was essentially whether to respond in a way that was consistent with the knowledge gained about ethical behavior or in a way that was consistent with the perceived ethos of the clinical setting, if it was perceived as unethical.

Doing just what a professional would do. A second perspective on negotiation was one in which the student behaved in a way that was comfortable for the student in advocating for the patient. This was an act that the student thought was not in any way "going above and beyond" but instead a professional responsibility that was *just what a competent nurse should do*.

> I had a patient in . . . I think it was third year, and he was in a lot of pain and the doctor came in and assessed him and said, "ok, well . . ." and he didn't have adequate PRN medication or anything like that, like, he had some but it wasn't managing it properly and it wasn't really managing that type of pain he had, it was more nerve pain that he was having and it was . . . yeah . . . so the doctor was like, "well . . . um . . . if, if you're still in pain tomorrow, then we'll do something, then I will find out what to do . . ." and I felt more confident being like, "no he needs something now because you haven't seen it because you haven't been with him all day, but he is in a lot of pain and he can't deal with this for another 24 hours or however long until you decide to show up . . . like, not that it's an option of whether you are going to do certain things that are ethically . . . like, advocating or things like that, like that's an actual responsibility that you have to do it if you're going to call yourself a professional. (Interview Participant 1)

Growing a backbone. A third perspective involved a gap between student nurse and practicing nurse where there was an expectation to *find their voice*, because a nurse should stand up to others who are not acting in a professional or ethical way. There is an expectation as a student, you should have this skill. As Interview Participant 1 points out, the space as a student allows the development of this *voice* as a skill even though it is a skill that might not be fully realized.

> Growing a backbone . . . some people just can't find their voice. Know who you can go to immediately, so teaching them to talk to either their clinical instructor, the charge nurse . . . being able to say "that's ok" you know, if you don't have that voice at the time, then be able to do that, that would be your second best option. (Interview Participant 3)

> If like you feel confident talking to your instructor, then it's not . . . then there's not a lot of risk because you don't fear that you will be reprimanded for speaking up but sometimes if you don't feel

> comfortable then, you might think that there's risks, then that, in itself, causes risks because you're not bringing up issues that need to be brought up for patient care. (Interview Participant 1)

The student nurses who participated in this study share common stories related to feeling "informed" and possessing some knowledge of ethical practice and principles, as well as feeling like a "stranger" in that they perceived themselves as outsiders or as feeling different from other nurses who were accepted in the clinical setting. The student participants were able to discern the differences between a good employee, a nurse who simply follows the rules and timelines of the clinical sites, and a good nurse, one who consistently provides safe, compassionate, and ethical care. The damaged care that they witnessed evoked moral distress and cognitive dissonance to which the students tended to respond by attempting to negotiate the gap between how they have learned care ought to be provided and how nursing care was sometimes provided in current clinical environments. The negotiation of the transition from being an informed stranger to a graduate nurse emerges as a potentially critical point in the development of ethical reasoning.

Discussion

The incidents reported by students in their papers arise out of a gap between what they expect in terms of patient care and what they have seen in the clinical setting. Although what the students reported in their papers might lack full knowledge of the context in which care occurred, students' perceptions of what takes place is potentially meaningful to them and their development of quality care practices. It is also, potentially, of significance to patients and others who manage or deliver care. The gap between what is seen and what is believed to be ethical care is important, because as Timmons and deVries (2014) suggested, discrepancy between two meaningful and inconsistent ideas that are encountered at the same time sets up cognitive dissonance, which is uncomfortable. The discomfort that is encountered leads to efforts to reduce it. Within the context of nursing care, Paley (2013) suggested that efforts to reduce discomfort that occur when care inadequate or organizational cultures fail to support good patient care can result in improved care. If, however, care has already occurred and cannot be reversed, then rationalization of care occurs as a strategy to diminish negative feelings.

It is entirely possible that the experiences reported in the papers reflect social desirability in that students might have overreported or underreported details in their experiences either to fit the situation to what their professors might favor or to fit with what students believed were prevailing norms (Marquis, 2015) within good patient care and nursing practice. Even if this was a predominant orientation in the papers, an orientation that would undoubtedly affect analysis, the papers suggest that the students differentiate good care from bad care and that this recognition produces dissonance, which is uncomfortable and sometimes distressing. This dissonance arises out of what students think is good care and what is sometimes provided but also out of intentional learning about ethics, in which students are sensitized to moral thinking. For example, Interview Participant 3 suggested that "this course actually opened my eyes . . . changing my perspective . . . nothing's how I thought it was."

Through the lens of increased ethics knowledge, students perhaps become even more aware of unethical situations or *gray areas* (Interview Participant 3) in nursing care and begin to examine where and how they are positioned in relation to moral agency or taking action (Oberle & Raffin Bouchal, 2009), or even if action is possible. The gap between being ethical and doing care becomes attenuated as students perhaps begin to realize that the practice into which they are entering might not always involve ethical care.

There are important implications in this study related to the quality of care sometimes perceived by students and how this quality of care potentially influences moral action and the care that the students will deliver as graduates. Their position between their knowledge and the realities of clinical practice enables a mindfulness of inappropriate care to patients and an awareness of appropriate care that might be ignored or given less priority related to personal professional or institutional constraints. This awareness, however, occurs at a time when students might feel constrained morally by a lack of confidence or by a lack of mentorship in education or in the clinical areas in how to address poor care. Lack of mentorship raises issues about whether we know how to address poor care and moral dissonance within nursing. Despite the proliferation of knowledge and evidence about what good practice entails, the continued existence of poor care witnessed by students who are informed and yet strangers in the clinical areas suggests that we know about good care and what moral should be but that we still do not know how to deal with situations in which care is inadequate or immoral.

Educational Implications

For some students, there is a rationalization of inaction and they muse about the power and possible retribution of nurses in the clinical settings where they observe care. This musing might extend into future practice, where these students perhaps find themselves considering the risk of being moral, and if the risk is seen as too great, begin considering justifications for their behavior. Timmons and deVries (2014) suggested that the shift toward justification is dangerous because once established, future observances of lapses of care or participation in poor care will become less uncomfortable. The justifications of some students related to moral inaction have implications for nursing education in that the future of moral agency in nursing practice might have roots in the moral sensitivity or ability to recognize moral aspects of situations

(Oberle & Raffin Bouchal, 2009) early in the education of students. Furthermore, as an interview participant suggested in the study, students need to be provided with strategies to intervene when confronted with unethical practice.

An implication that arises out of the findings of this study is that the role of the clinical instructor is significant. As previously recommended by Gazarian, Fernberg, and Sheehan (2016), it is important to provide an environment for discussion when care is seen to be potentially compromised. It is also important either to provide additional context for the care witnessed or to address strategies for tackling poor or insufficient care while providing feedback and support. This is an environment that can be established by the clinical instructor who is near at hand both to the student and the situation. The findings of this current study are consistent with those of Gazarian et al. (2016), which suggest that moral thinking can be fostered through formal grounding in ethics. Action can be supported through open and nonpunitive environments, which is consistent with the findings by Rathert, May, and Chung (2016) who also suggested that the development of moral action and thinking is possible within educational and nonpunitive environments, which has important implications for nursing education.

Managerial Implications

Although the findings of this study are based on student-only perceptions of care, there is perhaps value in seriously considering student perceptions of care delivery. Despite not being intentionally witnesses or informed observers in the care of patients, students encounter a variety of situations during clinical rotations and bring to these situations a growing knowledge and expertise and yet less investment in specific unit and organizational cultures. This knowledge might be limited by inexperience and lack of appreciation of day-to-day realities and contexts. It, nonetheless, offers a point of view that might enable an even fuller and richer perspective on the care that is provided to patients and could be valuable in informing quality initiatives and is worthy of consideration and investigation.

Limitations of the Study

The researchers in the study relied on papers in which students were asked to write about clinical situations in which there were ethical issues. Given the requirements for the assignment, the accounts of clinical situations involved problems in care and the number of patient situations are limited, which influenced the analysis. Nonetheless, the mere occurrence or presence of problematic and unethical care in clinical areas remains a concern not only for students but also for patients, nurses, and those who lead and administer in clinical areas.

Conclusion

Student nurses occupy a unique position in clinical settings in that they have information about what is right or ideal related to patient care and patient needs and yet they are not fully invested in the culture of specific clinical settings. Their obligation and experience are different from those who provide care within particular workspaces in which particular norms and values influence the practice of those who work there. Perhaps the obligation of student nurses is toward their evolving knowledge base, which is merged with their personal experience and an evolving awareness of what occurs within clinical settings. This unique position enables students to evaluate care differently than those who submerged in the culture of units and even differently from patients, who have personal knowledge but might lack knowledge of proper care or the agency to change what occurs. Like patients, the students in this study thought that they were constrained in their moral agency, but unlike patients, they had more awareness and knowledge of what proper care should be and an expectation that they should be able to do something about improper care. The knowledge of good care is especially difficult for students. As witnesses to poor patient care, who are less invested clinically, they particularly experience moral dissonance and even more troubling without strong role models in the delivery of good care and in how to address instances of poor care, and might learn that being a good employee is more important than being a good nurse.

Acknowledgments

The authors thank the nursing students who shared their papers (and clinical stories) with the authors.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Individual institutional research accounts of the authors were used to support authorship and publication of this article.

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