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PERSONAL EVALUATIONS OF MIDWIFERY STUDENTS REGARDING ETHICAL COMPETENCY

RESEARCH REPORT

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This report is submitted by the above candidate to The Steve Biko Centre for Bioethics, University of the Witwatersrand, in the above year in part fulfilment of the requirements for the Master's degree in Bioethics & Health Law.

DECLARATION

I, Moliehi Rosemary Mpeli, declare that this research report entitled **Personal evaluations of midwifery students regarding ethical competency**, which I hereby submit for assessment, in partial fulfilment of the requirements for the degree MSc (Bioethics & Health Law), is my own original work and has not been submitted before, for any degree or examination in any other institution of higher education.

Moliehi R Mpeli _____ 12 May 2018
SINGNATURE DATE

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ABSTRACT

Ethical competence, understood as the ability to identify and enact right actions within a specific spatial and temporal context, is ascribed to a nursing ethics educational approach that encourages self-reflection and guides toward personal growth. It is difficult for ethics educators to know whether the students who have undergone a specific training perceive themselves as confident and competent in handling ethical dilemmas. This knowledge is significant, especially for nursing and midwifery graduates who have undergone training that stipulates adherence to a code of ethics and professional norms. In the face of contemporary ethical challenges, the way that traditional codes of ethics or rule ethics are taught in midwifery practice without contextualization has been hotly debated by many authors. There is a consensus that rules or codes of ethics are inadequate in substantiating the moral decision-making of the practising nurses and midwives. This study argues that current strategies that rely heavily on Principlism and codes in teaching nursing ethics without appraising the context of an ethical situation are ineffective in fostering ethical competence amongst students. The acquisition of ethical competence amongst the midwifery students in terms of the current approach of teaching Principlism and codes of ethics may be described in terms of compliance and limited reflection.

This study makes use of a set of self-reflection reports in which the midwifery nursing students narrated their experiences in handling ethical issues. The reports detailing their experiences were analysed for evidence of ethical competence. The aim of the research report is twofold: first, to highlight the limitations of current nursing ethics education in fostering ethical competence; and second, to inform nursing ethics curricula regarding strategies to foster ethical competence amongst midwifery students, based on existing literature on the subject.

Analysis of the reflection narratives revealed that one of the three dimensions of ethical competence was limited. There was evidence of moral perception, moral action and substandard moral reasoning. The principles selected by the majority were limited to autonomy and beneficence. The findings support the argument that teaching Principlism and enforcing a code of ethics without contextualising it, obligates the student to conform without arguing their assertions. The current teaching approach that consist of abstract concepts of ethical framework, limit the acquisition of ethical competence. It is recommended that nursing education institutions should consider approaches that are aligned with the goals of care, and pertinent to the practice of nursing and midwifery, if ethical competence is to be attained.

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CHAPTER 1
CONTEXTUALISATION

1.1 Introduction

The aim of the research report is to highlight the limitations of current nursing ethics education in fostering ethical competence and to inform nursing ethics curricula regarding strategies that may be pertinent to the practice of nursing and midwifery and therefore capable of fostering ethical competence. In highlighting these issues, the study explores the evidence of ethical competence within a collection of narratives of midwifery students in which they describe and express their own experiences in handling ethical issues while placed in maternity wards. It is envisaged that the narratives should provide insight to these questions: How do midwifery students describe ethical competence; how are these descriptions compatible with the definite ethical competence, and how are these descriptions informed by the ethical outlook taught to these students?

I argue that ethical competence acquired within the realm of current strategies of teaching nursing ethics, which rely heavily on Principlism and codes of ethics without appraising the context of an ethical situation, is not effective in fostering ethical competence amongst students.

1.2 Background and problem statement

Midwifery training is crucial in the face of increased maternal and neonatal mortality in South Africa. However, the ethical issues within the practice of midwifery call for training that is not just aimed at academic achievement, but a training that also prepares one for the daily challenges in the practice of midwifery. When midwives are faced with ethical challenges which they have been insufficiently prepared for in their training, their uninformed decisions are likely to contribute to increased maternal and neonatal mortality. For example, prioritizing the autonomy of the pregnant mother without appraising the context in which this is happening could likely result in the death of either the mother or the new-born baby. Mannava, Durrant, Fisher, Chersich and Luchters (2015) conducted a systematic review of ethical issues in the practice of midwifery. Their review identified that negative attitudes and behaviour of midwives were undermining the efforts aimed at reducing maternal and neonatal mortality. Misconduct is likely to disrupt relationships that are essential for an ethical environment; this therefore necessitates ethical competence amongst midwives for the best interest of both healthcare systems and the community they serve. It is especially in disrupted relationships that the

midwives may fail to perceive the harms that are likely to be brought about by a decision made by the patient. Competency in ethics should be reflected in the attitudes and conduct of midwives.

As Bagheri (2012) confirms, a highly ranked health service is one that upholds the elements of human dignity from the perspective of the client. Observations of Mannava *et al*. (2015) suggest deficits in current strategies of ethics education, as a commitment to patient-centred care and respect for human dignity are evidently lacking in these cases of reported misconduct. It is therefore crucial to evaluate current ethics practice against contemporary issues within practice of midwifery and thereafter to reconsider new pedagogical models that match the ethical issues. As the majority of ethics modules make use of a code of ethics, it must be examined how effective such an approach is in preparing students to face contemporary ethical challenges in midwifery practice. Indeed, this has been a topic of debates among many authors. For example, Esterhuizen (1996) argues that codes of ethics are inadequate to guide the moral decision-making of practising nurses and midwives. Similarly, Pattison and Wainwright (2010) suggest that codes of ethics have a confusing and ambiguous terminology, with inconsistent ethical values that fail to give guidance on the ethical issues faced by midwives. Given the current demands of nursing care, Goethals, Gastmans and Dierckx de Casterlé (2010) are of the opinion that nursing ethics education should challenge the conformist way of reasoning and acting associated with rules.

The recognition of the deficits in current educational strategies raises the question: how can training for ethical practices in midwifery be geared towards acquiring the necessary ethical competence in students? This question is not peculiar to midwifery education and has been the subject of a range of different studies (Campbell, Chin & Voo, 2007). According to Dierckx de Casterle, Izumi, Godfrey and Denhaerynck (2008), the best approach to ethics education is one that encourages self-reflection and gives personal guidance towards ethical competence. Despite this commitment to fostering ethical competence, authors such as Grandy, Danis, Soeken, O'Donnell, Taylor, Farrar and Ulrich (2008), and Meine and Dunn (2013) highlight the difficulties of knowing whether the students who have undergone ethics training perceive themselves as confident and competent in handling ethical challenges. Without a clear understanding of how to measure ethical competence, educational reforms will continue to be hampered.

This study engages with this important issue, asking whether the current curricula which teaches ethics to midwifery students in a particular institution of higher education in South Africa fosters ethical competence. In response to this analysis the study examines where

current educational strategies could be improved. To achieve these goals, the study examined a collection of personal narratives of midwifery students in which they relate their experiences in dealing with ethical dilemmas during their placement in maternity wards in various hospitals. These narratives form the basis for a broader discussion about educating for the acquisition of ethical competence, and the ability to reflexively engage with the ethical issues.

1.3 The objectives

The objectives of this study are:

- To thematically analyse previously-collected set of self-reflective narratives from midwifery students at a South African higher education institution for evidence of ethical competence.
- To critically contrast the findings of this analysis to the style and content of the ethics instruction received by these midwifery students to identify key caveats.
- To suggest possible revisions and/or the development of the ethics course structure for midwifery students at the specific institution.

1.4 Layout of chapters

Chapter 1 provides the background and the problem statement, as well as the objectives of the study. Chapter 2 discusses the concept of ethical competence in detail. This chapter will also present discussions on teaching approaches as well as current strategies in ethics education, including current practice nursing and midwifery ethics training in South Africa. Chapter 3 describes the methodology used in analysing the previously-collected narratives for evidence of ethical competence. Chapter 4 provides an analysis of reflection reports. Chapter 5 identifies areas in which current strategies of ethics education can be strengthened for the development of ethical competence. Recommendations for ethics education of nurses and midwives will be drawn for dissemination to various institutions. Limitations and suggestions for further research are also presented.

1.5 Conclusion

The next chapter discusses ethical competence as well as the approaches aimed at facilitating the acquisition of this essential competence in the practice of midwifery. Thus, ethical competence as effected by the ethical framework of especially Principlism, as well as methods and strategies employed, characterise the ideal that students are expected to adhere to in their practice. Whether the midwifery students perceive themselves as having ethical competence remains to be seen.

CHAPTER 2
LITERATURE ANALYSIS AND CRITIQUE

2.1 Introduction

This chapter examines the concept of ethical competency in detail. The focus is therefore on how ethical competency can be best understood and taught. The chapter also discusses current strategies for teaching ethics to midwifery students in South Africa. In discussing these strategies, the chapter also considers some of the noted shortcomings of the current teaching of a Principlist approach as reported in existing ethics literature.

2.2 What is ethical competence?

Ethical competency, broadly speaking, is the ability to identify and enact right actions within a specific spatial and temporal context. The idea of a so-called ethical competence amongst individuals has a long history and can be traced to Socrates and Plato. According to Socrates' and Plato's dialogues, ethical competence is compared to an ability to philosophise; a technique that requires the use of the right tools and strategies to reflect and examine an idea, before discovering the right answers in a given situation (Pihlgren, 2008). In this way, acquiring ethical competence requires the development of skills to identify what tools to use in a specific situation. Similarly, within the practice of nursing and midwifery, Gallagher (2006) describes ethical competence as one's ability to use ethical knowledge in reflecting upon a perceived ethical situation and bringing about a good ethical behaviour. This is reiterated by De Schrijver and Maesschalck (2013) who describe ethical competence as a cluster of knowledge, skills, attitudes and abilities pertinent to a specific occupation. Thus, personal traits, as embodied in virtue ethics, the context of the ethical situation, and ethical knowledge are the right tools for reflecting critically and addressing ethical events in a justified manner.

The concept of ethical competence has recently made its way into discussions on nursing ethics. Johnstone (2015) argues that competence in nursing ethics goes beyond the essentials of moral sensitivity, moral awareness, and the character of the moral agent. It extends to how individuals engage with the dynamics of the social, cultural, political and institutional context in which the ethical issues take place. This emphasises the abilities of the nurse as a moral agent, who is expected to execute moral acts. According to Trobec and Starcic (2015) this calls for the co-ordination of personal, professional and social moral values, as well as the cognitive, affective and psychomotor skills of an individual.

In developing a better understanding of ethical competence, Kulju, Stolt, Suhonen and Leino-Kilpi (2016) conducted a study in which they investigated how this concept is analysed. The results of their concept analysis reveal that ethical competence is an attribute that is based on the traits of an individual, which are geared towards positive outcomes for the patient and profession, as well as the society. In addition, they identified that it has enabling factors such as ethical awareness, courage, willingness to execute ethical action, decision-making skills, as well as support from the organisation[1] .

Johnstone (2015) states that competence in ethics includes the complex ability to respect different moral perspectives that are in conflict with one's own. Besides taking cognisance of other moral outlooks, Jormsri, Kunaviktikul, Ketefian and Chaowalit (2005) indicate that ethical competence is also determined by one's ability to recognise and reflect upon the feelings that ascertain what is good and bad in a situation. In unfolding the concept further, Meine and Dunn (2013) indicate that various settings constitute diverse standards of ethical competence. Given the merits of these definitions, it is apparent that ethical competence as a complex ideal has to be made realisable for the purpose of ethics education. To make the definition of ethical competence more coherent, Jormsri *et al*. (2005) describe ethical competence in terms of multidimensional attributes that require the co-ordination of diverse skills, knowledge, and attitudes essential for ethical decision-making.

2.2.1 Dimensions of ethical competence

Within the context of nursing practice, Jormsri *et al*. (2005) identify three dimensions of ethical competence that may need to be evaluated in a given situation: the moral perception, moral judgment and moral behaviour. These dimensions are also mentioned by Lechasseur, Caux, Dollé and Legault (2016)

[1] Kavathatzopoulos (2002) suggests that issues relating to the ethical climate are as essential as the quest for acquiring and practicing ethically competent midwifery interventions. According to Auvinen, Suominen, Leino-Kilpi and Helkama (2004), the ethical climate is concerned with the environment that enriches and encourages a constructive manner of thinking in a moral situation. Functioning organisational structures are some of the factors that determine ethical climate. Combinations of these factors, with knowledge skills and attitudes of moral agents, demonstrates the complexity of this anticipated competence in the midwifery practice.

2.2.1.1 The first dimension: moral perception

The first dimension is moral perception, through which one is able to recognise a moral issue (Jormsri *et al*. 2005). Moral perception is considered to be affective in nature, because it involves an experience of emotions, in which one becomes aware of values and its expression in a given situation (Jormsri *et al*. 2005). In clarifying this dimension, Lechasseur *et al*. (2016) illustrate that the ability to recognise an ethical issue and its aspects in a situation is influenced by one's ethical sensitivity, an aspect that is imbued by compassion. Wisnewski (2015) attests that there is involvement of sympathy, or an emotional perception that enables one to perceive a moral issue. According to Blum (1991) the ability to perceive ethical issues is a highly-esteemed component of ethical competence: without accurately identifying all the moral features in a situation, one's moral principles are in vain. According to Blum, it is in moral perception that one may construct and characterise a situation as moral milieu, and it is only after providing such a setting that an individual can bring in rules, principles or precepts to engage with the situation.

2.2.1.2 The second dimension: moral judgement

The second dimension is called moral judgement. According to Campbell (2007) moral judgement is a process that unifies a multifaceted state of expressions involving moral beliefs, moral motivation as well as emotions. It is within this process of judgement that the possible actions of an individual are evaluated as good or bad, with respect to the established norms and values or set of virtues informing a culture or subculture (Haidt, 2001). Thus, an established ethical framework – whether deontology or principlism – is essential for justified moral judgement. Haidt (2001) argues that the primary or initial source of moral judgement is intuition, as it involves a sudden affective value (good or bad, like or dislike) that lacks balanced evidence or diverse, thoroughly contemplated strategies. Saunders (2009) claims that this intuitive form of judgement is motivated by feelings, because in a given situation, the intuitive response is to refer to the internal representation of norms and values which are always laden with emotion (Prehn, Wartenburger, Meriau, Scheibe, Goodenough, Villringer, van der Meer and Heekeren, 2008, Jormsri *et al*., 2005). According to Blum (1991), one may act morally on the basis of emotion-based sentiments such as compassion, sympathy or fear. As Saunders (2009) substantiates, one can act morally on the basis of easy and immediate judgement that lacks conscious effort of reason. Such moral acts arising from perception and outside the reasoned moral judgement are called moral intuitions because of their lack of rational underpinnings of the judgement (Saunders, 2009, Haidt, 2001). Saunders (2009) argues that reflective equilibrium is a credible and acceptable normative model that is responsive to reason and may account for moral judgement in a given situation. Reflective

equilibrium values and emphasises the use of evidence and diversified strategies for bringing about coherence and soundness to the decision-making, especially in situations of competing values and norms. As Campbell (2014) attests, judgments about a particular case remains stable and consistent only if the process of reflective equilibrium is achieved, which is archived through harmonising the total set of principles and the empirical claims involved. Reflective equilibrium is defined as a process that "reasonably reconciles inconsistency between an intuitively plausible general principle and an intuitively plausible judgment about a particular issue in a given case" (Lechasseur *et al*., 2016). Reflective equilibrium seeks democratic deliberation of fair-minded persons capable of enhancing accountability for fairness and impartiality in ethical situations, in order to bring about a justified moral conclusion.

The importance of reflective equilibrium lies in reconciling ethics with social justice, in which empirical information is used to bring about consistency (Campbell 2014). Besides employing the process of reflective equilibrium, Prehn *et al*.(2008) assert that one must also envisage and establish the value of the possible outcome of his/her behaviour and also take into consideration the moral emotion experienced during the process. This therefore obliges a moral agent to have a post hoc justification[2], which involves a process of critical moral reflection and deliberation (Lechasseur *et al*., 2016; Prehn *et al*., 2008). For substantiating a moral assertion, such a justification will require moral discourse that must be based on logical reasoning and critical thinking as well as appraisal of values by all the stakeholders. As described by Lechasseur *et al*. (2016), this is a moral judgement that extends beyond the individual's normative knowledge, but also to the beliefs and values put forward by the other stakeholders within the context of the situation. Sher (2013) attests that deliberation is essential in any perceived moral issue, because any set of moral claims need scrutiny to attain a justified moral outlook. According to Sher (2013), cultivation of a moral outlook is likely to differ from one person to another. However, if a group of people were exposed to the same social determinants of moral outlook, their moral judgements are likely to reveal some traceable elements of the moral outlook that was taught. In addition to the taught moral outlook, Jormsri *et al*. (2005) state that values deriving from familial and religious upbringing as well as work experience in the context of nursing are likely to be used for justification of a moral action (Jormsri *et al*., 2005).

[2] According to Haidt (2001) a post hoc justification is an effortful process in which one searches for justification on already made judgement.

2.2.1.3 The third dimension: moral acts

Moral acts are rational activities or endeavours that may be considered to be morally right or wrong, and also judged to be morally good or bad by all stakeholders in a given situation (Spielthenner, 2005). Moral acts define the actor as a morally recognised person, both within and across fields of his/her practices (Tavory, 2011), which in this case will be the practice of midwifery. The moral act is reckoned to involve the application of the moral agent's values to the action, as well as the willingness of an agent to receive public affirmation or condemnation (Jormsri *et al*., 2005). Within the context of nursing and midwifery eliciting the type of behaviour conducive to resolving an identified ethical tension would constitute a moral act. This action would be based on deliberative reflection on acquired ethical knowledge, and a variety of alternative solutions, as well as their implications in promoting the welfare of the individual (Lechasseur *et al*., 2016). The application of a decision into action is aimed at receiving public affirmation. This affirmation or condemnation is considered to be the result of the moral discourse involved in justifying the assertions that consist of an unconfined variety of alternatives (Lechasseur *et al*., 2016).

2.2.1.4 Becoming an ethically competent individual

Ethical competence, thus, requires that ethical training be combined with skills, knowledge and professional requirements. This involves the development of cognitive and affective skills of the individual (Kulju *et al*., 2016). Only when one is able to draw on all three of these dimensions as described above can one be considered ethically competent. In midwifery, such ability must be based on the inculcation of a specific moral outlook pertinent to daily practice, and it must draw on high levels of personal and professional coherence.

Merging these dimensions of ethical competence is not an endeavour to be designated to a single academic discipline, as it involves a variety of knowledge, skills, attitudes and abilities that constitute the emotional, social, cultural and political aspects of life. Thus, it can be concluded that the effective co-ordination of personal abilities, midwifery knowledge and moral philosophical knowledge requires the involvement of other academic disciplines – including psychology and sociology.

2.3 Teaching for ethical competence

The purpose of this study is to ascertain whether the current ethics education enables students to reflexively engage with the ethical issues, as demonstrated in their narratives of ethical competence. Therefore, the discussion that follows will dwell on main approaches in the

teaching of ethical competence, such as the pragmatic, the embedded and the theoretical approaches.

2.3.1 The pragmatic approach

This approach is based on the pragmatism theory, whose originators are John Dewey, William James, Oliver Wendell Holmes, and Charles Sanders Pierce. It is based on the belief that an inquiry will be considered most when it originates from judgments that are objective, reliable and refined in application (Sorrell, 2013). Based on this approach, the codes of ethics are considered to be an absolute means for clarifying appropriate moral behaviour because they have gone through a process of inquiry (Hart, 2006). The process of inquiry is comprised of a discussion, negotiation, consensus and reflective evaluation (Hart, 2006). Because the moral principles in these codes have been deliberated upon and their practical consequences have gone through logical inquiry, they are considered to be just in serving as an absolute means for clarifying the truth and belief (Hart, 2006). A code of ethics is therefore considered as practical and appealing to medical ethics, as it is self-evident and self-justifying (Pellegrino, 2010).

The starting point in teaching within the pragmatic approach is to immerse students into expected behaviours of the profession, as these serve as absolute means for illuminating appropriate behaviour (Illingworth, 2004). Although Illingworth (2004) is of the opinion that the purpose of this approach is to socialise the students into the professional relevancy of ethics, Rappert (2007) argues that codes have advisory elements and may therefore serve as fostering moral agency and guiding moral actions.

According to Illingworth, the pragmatic approach introduces students to the framework of rules and procedures prescribed by the professional bodies for the maintenance of the standards of the profession (Illingworth, 2004). These standards serve as a set of externally imposed constraints or regulations that are enforced by professional sanctions, and in many cases are legally binding (Illingworth, 2004). These frameworks of rules are what Rappert (2007) describes as aspirational codes, as they aim to set ideal standards. However, Rappert (2007) is of the opinion that educational process of the codes should unpack the content messages of the codes and their formation to foster reflection. It is in unpacking their formation that the purpose and the merit of codes are expressed (Rappert, 2007). Accordingly, Pellegrino (2010) emphasises that these codes are valid and authoritative because they are constituted from other moral theories, such as social construction, categorical imperatives, utilitarianism, a *prima facie* justification, as well as the moral reflection of health care practitioners. Pellegrino (2010) indicates that these moral theories, the collective reflections of practitioners, and the

oath serve as the internal and external sources of authority that are expected to influence behaviour. Thus, proper education of this framework is likely to produce ethical competence.

2.3.1.1 Limitations and criticism of a pragmatic approach

Although the pragmatic approach may seem to be relevant and appropriate, there is inadequate account of how the acquisition of ethical competence may be achieved by ethics education, bearing in mind the cognitive, conative and emotional components of ethical competence. Doubtful about the ability of the pragmatic approach in developing ethical competence, Meine and Dunn (2013) indicate that the acquisition of ethical competence within the terrain ofa code of ethics is unfounded. It could be argued that such criticism would result from an undefined purpose of the code, because some such as advisory codes foster ethical reflection and competence (Rappert (2007), and this is an important aspect of ethical competence. Pellegrino (2010) and Thiroux and Krasemann (2009) indicate that codes of ethics are always endangered by both intentional and unintentional abuse, because some of their rules and obligations could conflict with each other and may lead to inconsistencies in their universal application. Furthermore, Pellegrino (2010) affirms that a code of ethics could stifle individual capabilities that prioritise character over conformity to rigid rules in supporting decision-making (Pellegrino, 2010). Indeed, it is believed that a code of ethics cannot comply with the changing characteristics of the modern world that is marked by multiculturalism, changing social mores and the bureaucracy in health services (Pellegrino, 2010).

These ethical codes are likely to deal in absolutes if proper content of the codes and the process of their formation are not made explicit, as indicated by Rappert (2007). Thus, lack of teaching time, limited contextual practices and improper implementation have led to contrasting claims regarding the usefulness of the code of ethics (Rappert, 2007). It may be concluded that the inability of the pragmatic approach to develop ethical competence is based on the fact that personal autonomy is undermined by conformity to the code of ethics and sanctioning stance of the relevant code.

Although this approach is criticised for seeing ethics as the eternal factors in influencing behaviour, Pellegrino, (2010), and Illingworth (2004), believe that this approach may still have some advantages of portraying the relevancy of ethics in easy terms and may be an evident example for the majority of students. The main purpose of the pragmatic approach is to raise awareness and maintain the standards that underpin the profession, and consequently, the code of ethics also defines the practical consequences that one is likely to endure if one ignores it (Illingworth, 2004).

Despite all these critiques, codes of ethics are still useful as they serve to maintain professionalism and public trust (Ki & Kim, 2010; Menzel, 2010; Illingworth 2004; Meine & Dunn, 2013). Furthermore, Singer (2010) and Hart (2006) indicate that these frameworks of rules and procedures prescribed by the professional bodies may be used as a starting point for ethics education, in conjunction with the integration of other ethical frameworks, such as the theoretical approach.

2.3.2 The embedded approach

The teaching and learning of ethics may be embedded within the core objectives of the module as an essential section of a larger area of concern, with a significant ethical component (Illingworth, 2004). The module for midwifery may very well necessitate ethics awareness during teaching and learning. Thus, ethics becomes an entity that is embedded in their core module through the objectives or teaching strategies to be followed (Illingworth, 2004:35). On being embedded in objectives, Illingworth (2004:35) states that “ethics may be presented as a component of fitness for practise, a concept that defines ethical obligations that accompany the duty to care”. Fitness within the practice of midwifery would therefore entail upholding good standards of care for the mother and the child as well as the family. The specific knowledge, skills and attitudes pertinent for midwifery practice may be infused with ethical issues such as fitness to practise. Illingworth (2004) explains that ethics may be embedded through reflective practice, drama practice and the use of narratives. These modes of teaching may be used to present ethical issues that are embedded in a specific objective of the course.

As in the pragmatic approach, the embedded approach introduces students to the notion of professionalism and behaviour constrained as agreed by the code of conduct. However, this approach goes further to interpret professionalism in terms of the student’s emerging sense of self-identity (Illingworth, 2004). The purpose of this sense of identity is to encourage the student to reflect on practices that are aimed at exploring what it means to be a ”professional” or to be “fit for practice” in a specific profession (Illingworth, 200). As much as students deal indirectly with ethics in their specific core module, the notion of being ethical is scrutinised theoretically, so as to encourage explicit awareness of some level of overt use of ethical concepts (Illingworth, 2004). In the scrutiny of “being ethical”, the students are not just familiarised with the code of ethics, but also to the interpretation of the professional code of ethics in practice (Illingworth, 2004).

Besides embedding ethics through the interpretation of the code of ethics, another aspect of embeddedness is within the strategies for teaching of ethics. As Illingworth (2004) attests, reflective practice as strategy for the teaching of ethics encourages students to take

cognisance of the overt and conscious moral implications of their behaviour. They are encouraged to pay attention to the judgement of their performance against some broader notion in which ethical values are embedded. Various ways in which reflection practices as a strategy may be done include reflective essays, presentations, group discussion, self-evaluation, and more complex outputs, such as the preparation of a learning portfolio (Illingworth, 2004). Self-reflective narratives as part of a portfolio of evidence were used in this study.

Teaching and learning of ethics may be accomplished through the embedded approach, as demonstrated by the objectives of the course module (Illingworth, 2004), and it has become the preferred method of teaching ethics at many South African universities, including the institution pertinent to this study. In the case of the embedded approach, the institutions of higher education interpret ethics as a vertical strand within the curriculum in which students in their first year of study are introduced to a code of ethics and ethical principles. After the first year of study, ethical issues are aligned with and discussed within the objectives of the modules or course such as psychiatric nursing or midwifery. The embedding of ethics is progressive over the period of training, and the acquisition of ethical competence may be assessed at all stages of training through tests and examinations (Illingworth, 2004). Nonetheless, it has been proven that ethical competence goes beyond knowledge and skills and therefore, tests and examinations alone cannot prove competence (Bertolami, 2004).

2.3.3 The theoretical approach

The starting point in the theoretical approach is the conceptualisation of the key moral theories, principles and concepts, before they may be applied to real-life ethical situations (Illingworth, 2004). Many reasons are cited for this approach to ethics education. For example, Illingworth (2004:9-10) indicates that this approach encourages the students to acquire the language of moral discourse. “This enables students to apply moral theories such as, virtue ethics, consequentialism or Kantian deontology to real-life situations” (Illingworth 2004). Besides enabling the development of critical reasoning faculties, this approach helps with the “identification and analysis of morally challenging situations, while at the same time allowing students to be aware of multiple perspectives on contested issues” (Illingworth, 2004).

The theoretical approach to ethics, although seemingly founded on the objective viewpoint of ethics education, helps students to present arguments in a coherent, reasoned, and structured manner (Illingworth, 2004). However, it, has met with concerns from a number of ethicists. As Lawlor (2006) argues, the theoretical approach entails an excess of complex work for students, who are not expected to be moral philosophers, who should rather apply ethics to

their specific healthcare professions. Lawlor (2006) asserts that this has resulted in a simplified caricature of the moral theories presented to students, with no or little benefit at best. Accordingly, Allmark (1995) contends that moral theories compete with each other, and as such, ethics educators in nursing are uncertain about which theory to teach or to leave out in the development of ethical competence. Indeed, the theoretical approach is challenged by other approaches. As Bertolami (2004) points out, "knowledge-based ethics education courses have accomplished little by way of ensuring exemplary ethical conduct, because there is a disconnect between knowing what's right and doing it, and understanding the principles of ethics at an intellectual level and applying them in daily life" (Bertolami, 2004).

It is clear from the discussions above that ethical competence within the frameworks of the theoretical, embedded and pragmatic approaches is questionable. In this regard, many authors within the realm of nursing ethics have proposed pedagogical models that can be used in addition to the approaches described by Illingworth (2004).

2.4 Ethics education of nurses and midwives in South Africa

Many nursing education institutions in South Africa follow curricula consisting of 8 credits or 80 notional hours of ethics teaching (South African Nursing Council, 2013). Many nursing education institutions follow both a pragmatic and a theoretical approach to ethics education. The basis of the theoretical approach is the four principles comprising the ethical framework named Principlism as advocated by Beauchamp and Childress. Furthermore, the South African Nursing Council (2013) has developed a code of ethics which nurses/midwives are expected to subscribe to upon completion of their training. This code of ethics holds professionals to roles of advocacy, accountability and consistent application of standards of nursing and midwifery practice in the care for patients and their families (Nursing Act 33 of 2005). It is essential to discuss Principlism, as this will highlight the fact that Principlism may in ideal circumstances facilitate the acquisition of ethical competency.

2.4.1 Principlism

For the purpose of clarifying the use of four principles in ethics education for nurses and midwifery, it is essential to briefly describe how these four principles came into the practice of midwifery and nursing.

2.4.1.1 Background of Principlism

Principlism is a framework of general principles that forms a starting point for biomedical ethics, which is in agreement with most classical theories and traditional medical ethics

(Beauchamp & Childress, 2013). As moral theory, Principlism originates from the 1979 Belmont report which prompted guidelines for the protection of human subjects during research such as the Tuskegee syphilis study that ran from 1932-1972 (Gordon, 2011).

It was first used as a three-principle guideline (respect for persons, beneficence and justice) for the resolution of ethical problems in research involving human subjects (Gordon, 2011). After examining the moral judgements and the way the moral beliefs coincide, Beauchamp and Childress formulated the four cluster moral principles, namely autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2013). According to Beauchamp (1995), the choice of the moral principle as a framework derives from the health professionals' obligations and virtues that contextualise the commitment to provide medical care.

2.4.1.2 The aim of Principlism

The framework aims at producing benefits that can compensate for any harm that could be introduced in the process of healing, and again to enable equal access of health resources by all deserving individuals (Beauchamp, 1995). The underlying purpose of this model is to promote the autonomy of patients, while at the same time protecting them from injury or harm due to disease and system failure (Beauchamp, 1995). These obligations concur with the understanding of ethical competence in midwifery, as the patients, new-borns and their families are rightfully expected to benefit from a good standard of care, and to be protected from harm and unjust practices. The principles are considered an easy, measurable outcome for competence-based ethics education, as students are expected to understand and apply them in their midwifery practice. Although considered to be easy, the intensity of these principles may become apparent if taught properly.

2.4.1.3 Underlying principles and their application

According to Beauchamp and Childress (2001), the four principles of respect for autonomy, beneficence, non-maleficence and justice, express common values and their underlying rules, and therefore define a set of norms shared by people devoted to morality. The people committed to morality in the case of midwifery practice are the students and the team of other healthcare professionals, as well as the patients and their families. Thus, what will be called morally good must be common across all these core participants in the practice of midwifery. Common morality is drawn from universal norms shared by all people in all places, and it contains universally admired traits of character, as well as endorsed human rights and moral ideals that are esteemed in many cultures (Beauchamp and Childress, 2001). Bulger (2007:) claims that Principlism is easy to effect in the interdisciplinary and pluralistic environment

because of its inter-subjective agreements and its oblivion of epistemic differences of various philosophical perspectives. It may be from this stance that nursing and midwifery training institutions adopted Principlism as an ideal ethical framework for the teaching of ethical competence.

The respect for autonomy requires that the moral agents involved in a specific situation acknowledge the value and the decision-making rights of other autonomous persons (Beauchamp and Childress, 2013). Beauchamp and Childress (2013) relate beneficence to all deeds of mercy, kindness and charity which an agent is obligated to contribute towards the welfare of all the patients under his/her care. Non-maleficence requires the intentional avoidance of actions that can cause harm. According to Beauchamp and Childress (2013:249-251), "justice refers to fair practices and the appropriate distribution of benefits and burdens as determined by norms that structure the terms of social cooperation".

Beauchamp (1995) observes that Principlism is expounded in W.D Ross's model of *prima facie* duties, which spell out that principles are always binding unless they are in conflict with other obligations. In such a situation of conflicting norms, the framework suggests some sort of balance or harmony; otherwise one norm will have to supersede the others (Beauchamp and Childress, 2013). As Brooks and Sullivan (2002) attest, the strength of Principlism is found in this *prima facie* duty: if all principles were absolute duties or obligations, it would be unethical not to follow them. According to Beauchamp and Childress (2013), the norms rely on rules that are specific in content and restrictive in scope. It is from the backgrounds of conflicting norms in a given situation that the practical, sanctioning and procedural rules are defended, and principles are appraised to bring harmony to the competing norms (Beauchamp & Childress, 2013).

Information regarding the four principles is easily available in the literature, and use of such knowledge is considered to be a norm within the practice of health professions. The concepts used in literature to illustrate the simplicity of Principlism include basic principles and four pillars of medical ethics, as well as basic principles of medicine in books such as *Medical Ethics for Dummies*. The purpose of these illustrations is to demonstrate that these principles are important and easy to incorporate into the daily health care practice. However, such a simplistic approach to these principles may undermine their proper application in cases of competing norms. The following discussion will therefore deal with moral justification in Principlism, as a way of demonstrating that mere knowledge of principles is not adequate. As mandated by the proponents of Principlism, moral agents must demonstrate capability when principles are competing.

2.4.1.4 Moral justification in Principlism

Justification in ethics is concerned with an ability to demonstrate that one's assertions are right and permissible because there is sufficient evidence and reason claiming that such a confirmation or conclusion went through moral discourse (Beauchamp & Childress, 2013). There are different approaches to justifying moral judgement. For example, Beauchamp and Childress (2013) present one approach that involves applying a principle, rule, idea, right or other norm to the case in supporting an inference or justifying the moral conclusion, while Viafora (1999) spells out that justification in Principlism may rely on the following elements: i) that a decision may be ethically justified when it falls under general criteria of evaluation; ii) the evaluation is the result of a process, in which the concrete case is subsumed under continually higher levels of generalisation; iii) the method demonstrates that a particular decision obeys certain rules, which in turn obey even more general criteria .

Unlike applying principles or rules, which may be parallel to applying a personal and professional codes of ethics, Viafora's argument is founded on the process that is deductive in nature, instead of application of principles from codes that dictate what to do and what not to do. For example, Armstrong (2015) describes autonomy and beneficence as moral obligations for nurses, aimed at benefiting the patient in relating to the context of South Africa. Described as obligation, one may feel compelled to fulfil all duties pertinent to these principles, sometimes to the disadvantage or ignorance of the patients 'desires. Beauchamp and Childress (2013) warn that the adaptation of such an approach is likely to ignore facts regarding beliefs, cultural expectation, the impact of other rules and principles, as well as various possible outcomes of a situation. These specifics are considered determinants of acts that are too abstract and complex in wide-ranging moral issues (Beauchamp & Childress, 2013). Beauchamp and Childress (2013) caution against the expression of beneficence as an obligation for the best interest of the patient, as this may at times carry a paternalistic justification.

As a process for moral reasoning, "Principlism posits that particular judgments are justified by moral rules which are justified by cardinal principles, which in turn are endorsed by ethical theories" (Beauchamp & Childress, 2013:14-15). In irreconcilable situations, these principles are to be balanced and specified. With the process of specification, the scope of relevant norms has to be narrowed down in such a way that the where, when, why, how, by what means, to whom, or by whom the action to be done or avoided are made explicit (Beauchamp & Childress, 2013).

Besides specification of, the principles, rules, obligations and rights need also to be balanced (Beauchamp and Childress, 2013). Balancing is a process of finding reasonable weights and strengths of different moral norms for supporting norms that should prevail in a given situation (Beauchamp & Childress, 2013). Beauchamp & Childress, 2013) state that specification and balancing give authority to the norms, because these processes involves the use of tools for refining and correcting ambiguities. In addition, specification and balancing, give room for further specification of principles, rules and rights, which will lead to the formation of more moral guidelines (Beauchamp & Childress, 2013). It is in specification and balancing that reflective equilibrium is implemented, so as to test and adjust the moral belief, and it is in this process that a particular moral belief and general moral principles become justified (Hine, 2011). Reflective equilibrium is a procedural model that entails the testing and adjustment of moral principles to the practical contexts, so as to render them as coherent as possible to a particular decision, in order to be universalised to the possible, but unanticipated situations (Degrazia & Beauchamp, 2010). Reflective equilibrium is considered a tool in the process of moral reasoning and justification, as it substantiates claims that a particular act or practice is permissible or impermissible (Van den Hoven & Kole, 2015). The strengths of reflective equilibrium lie in its ability to engage both the personal and professional moral insights in an ethical situation (Van den Hoven & Kole, 2015). The strengths of reflective equilibrium have prompted Van den Hoven and Kole (2015) to advocate the significance of this exercise in ethics education as a model for moral development in all the professions. The question is whether nursing institutions do equip their students regarding the aspects of Principlism, including reflective equilibrium, as this would encourage the development of smooth moral conclusions.

It is, however, appropriate to understand the theory first in order to apply it properly. Lawlor (2006) attests that a simplified theory will never yield satisfactory results of developing the ethical competence of students. As Illingworth (2004) illustrates, the context of ethical encounters has an influence on the student's perception of the subject and its relationship to professional values and behaviour.

From the discussion above it is obvious that ethical competence is a multifaceted concept that requires the nursing education institution to pay careful attention to the coordination and alignment of the ethical framework with the teaching approach. It is through proper teaching of the ethical frameworks that students may acquire the expected process of ethical competence.

2.5 Conclusion

This chapter provided insight into the meaning of ethical competence. It illustrated that ethical competence is a multi-dimensional concept that requires the coordination of ethical knowledge, skills, and attitudes by the individual moral agent. The chapter also gave an overview of how ethics education may facilitate the acquisition of ethical competence. The next chapter will focus on the methodology that informed this study in formulating the claim that the current teaching approach of ethical framework may inhibit acquisition of ethical competence.

CHAPTER 3
METHODS AND MATERIALS

3.1 Introduction

The chapter first introduces the background of the method followed in analysing the reflective narratives about ethical competence and impetus for using personal evaluation for reporting ethical competence. Secondly, the chapter discusses the research designs found relevant for this study. Lastly, the trustworthiness of the study, as well as the ethical considerations that were employed are described.

3.2 Background of the method followed

This study was designed to investigate evidence of ethical competence amongst midwifery students who have undergone a specific ethics training. The midwifery students designated for this study, besides being introduced to the prescribed codes of ethics by SANC, were trained within the pragmatic and theoretical approach of ethics education in which principles such as autonomy, beneficence, non-maleficence and justice were highlighted as well as the code for ethics. The narratives of midwifery students' ethical competence are likely to reflect these ethical principles. The study conducted a textual analysis of the self-reflection portfolios collected from midwifery students as part of their portfolio of evidence regarding ethics training.[3]

3.2.1 Description of data set

The students were asked to collect this portfolio of evidence as they were being placed in different midwifery clinical facilities. For the purpose of describing their evidence regarding ethical competence, they were asked to keep a journal of their experiences during their placement in maternity wards with the following instructions:

- Write a reflection report of about two pages and narrate a critical incident in which you think you were ethically relevant in your provision of care.
- Identify the skills you employed while dealing with this incident and make note of any person, course or module, that assisted you in the accomplishment of this competence

[3] The researcher, under the supervision of the head of education portfolio at the school of nursing, piloted the use of portfolio of evidence in 2013 and 2014, based on the essential competencies for basic midwifery practice (International Confederation of Midwives [ICM] 2010). The portfolios were contributing towards achievement of competency in midwifery practise.

- Discuss your overall impressions of your placement in this area as compared to your earlier impressions of other placement during your training.

As the portfolio of evidence was not meant for academic achievement, some of the students made no effort to complete them, as this was just a pilot and they were also informed that their reflection reports might be used for research and publication. For this reason, the reflection reports were written anonymously by those who completed the portfolios.

The study was therefore retrospective in nature, as it made use of existing data that were collected to pilot portfolio of evidence. Nimon and Allen (2007) affirm that retrospective studies are essential for self-reporting measures across a wide variety of knowledge and skills, and that such studies may be used to assess the effectiveness of programmes. As Hess (2004) indicates, retrospective studies may be used in cases of pilot study data. However, upon the completion of such projects, prospective studies are anticipated (Hess, 2004).

3.3 Study population

Out of the ninety (90) students who were enrolled for the midwifery training in 2013 and 2014, sixty (60) handed in their portfolios. Thus, only sixty (60) midwifery students volunteered to pilot the use of essential competencies for basic midwifery practice (ICM, 2010). As the portfolios were just a pilot and not meant for academic achievement, students wrote the reflection reports anonymously as they were informed their reflection reports will be used for research and publication.

3.3 1 Sample

The sample was drawn from the 60 portfolios that were submitted. Streubert and Carpenter (2011) indicate that the sample size cannot be determined beforehand in qualitative research; instead, saturation of data should be used as a determining factor. Fifteen (15) portfolios were selected as a sample size to critically assess the acquisition of ethical competence and the efficacy of ethics education.

3.4 Study design

This study conducted an analysis of the self-reflective narratives that were part of portfolio reports collected from the midwifery students. The assessment of ethical competence envisaged to generate subjective view and a process of moral development as an outcome. It was therefore necessary in this study to use content analysis within the paradigm of qualitative inquiry.

3.4.1 Qualitative inquiry

The phenomenon of interest, ethical competence, is the human phenomenon with diverse and multiple realities that may be expressed in words rather than numbers, and this is the reason the study was qualitative in nature. In focusing on human realities, qualitative research aims at reaching a better understanding of human endeavours, which are mostly intrinsic in nature for the individuals involved and are also responsive to the context in which they happen (Polit & Beck, 2012). The study was therefore aimed at understanding how the students' main ethical concerns were resolved, as well as the meaning they ascribe to these resolutions. Accordingly, Creswell (2013) notes that such meaning may be constructed through situations that forge interaction and discussion with other persons. As Polit and Beck (2012) attest, this entails discovering a basic social process that is usually influenced by personal, cultural, political and historical experiences. The discovery of the ethical competence within the complex environment of midwifery practice offered another perspective for social interaction that was necessary for developmental learning and exchange of knowledge among the midwifery students. It is through this social interaction that students were able to derive their diverse variety of meaning regarding their ethical competence (Berg, 2007). This variety of perspectives on meaning are important for the formulation of theory (Berg, 2007). It was for this reason that the grounded theory was chosen rather than phenomenology.

3.5 Data analysis

The study made use of Strauss and Corbin's (1990) systematic set of procedures that were aimed at developing an inductive theory about the ethical competencies of the midwifery students. The analysis of data followed the three-phase process of open, axial, and theoretical/selective coding as described by Streubert and Carpenter (2011). According to Streubert and Carpenter (2011), open coding entails line by line examination of the concepts and conceptualisation of the underlying patterns of the identified idea. Although constructionist theory would be recommended for deriving the categories pertaining to ethical competence, the codes that were used in this study were based on the definition of Jormsri *et al*. (2005), which identifies ethical competence as an ability to perceive, act and justify one's actions based on ethical knowledge, skills and attitudes, as well as the recognition of one's own and others feelings involved in the incidence, as described by De Schrijver and Maesschalck (2013). The phrases or concepts from the self-reflective narratives that portrayed the ability to perceive, act and justify intentions to achieve a good midwifery outcome were used for the illustration of the codes and categories that were used to build theory.

Axial coding is the second phase of the process, and its purpose is to reassemble the data that were fractured by open coding, and to link the concepts from open coding to the theoretical coding process (Streubert and Carpenter, 2011:158; Saldana, 2013). Axial coding was used to determine dominant codes to select the most representative ones and remove the redundant ones (Saldana, 2013). Hence some of the information that was not relating either to the three dimensions of ethical competence, or Principlism and codes of ethics, was not considered. In this manner, the codes used in this study, achieved the best fit within the identified three dimensions of ethical competence and Principlism as a normative standard. As a result, the initial codes were reduced and sorted according to the dimensions of ethical competence: ability to perceive, act and justify one's assertions. According to Charmaz (2006:61), axial coding identifies the properties and features of a category and therefore build uniformity and consistency of relationships around the connection of a category. As Streubert and Carpenter (2011) suggest, memoing was also done in order to generate a hypothesis. According to Charmaz (2008), memoing is about capturing ideas in process for the purpose of providing a framework for exploring, checking, and developing ideas. In this study, the idea of responding to the expressed vulnerability of the client was captured during memoing, and was therefore the foundation for the recommendations in this study.

The last phase of the coding process (selective coding) Charmaz (2008) was done so as to evaluate which codes best explain or interpret the empirical phenomenon, and after this process these codes become tentative theoretical categories. As advised by Charmaz (2008:165), there was comparing of data to data, so as to clarify the codes and therefore develop the focused and refined code. There was also constant comparison with other transcripts for the purpose of ensuring consistency, and this also assisted with the identification of negative cases. This was essential for deciding which codes to raise to theoretical categories (Charmaz, 2008:165). With this final stage of coding process, the core category; ability to identify moral issues, ability to act and ability to justify one's action based on ethical knowledge, skills, and attitude were pulled together by the concepts that best explained ethical competence.

The writing up of the theory necessitates integration with existing theories so as to show relevance, fit, and/or extension as commended by Goulding (2005). Thus, the developed categories of ethical competence were integrated with Principlism framework, so as to identify relevancy or fit or extension. Accordingly, Leget and Borry (2010) affirm that empirical results embody factual normativity and should be tested against normative principles and theories. Therefore, the theoretical framework from data was tested against Principlism to critically

clarify and support the decisions for ethics teaching and training that will be geared towards ethical competence. It was identified that ability to perceive the moral issues in a given situation, did not fit with Principlism, and though moral justification was considered relevant, it happened in a limited manner. It is from these junctures that recommendations to the ethics curriculum designers in nursing were made.

3.6 The trustworthiness of the study

The following criteria are recommended for ensuring trustworthiness in qualitative research; credibility, transferability, dependability and confirmability (Polit & Beck, 2012). In ensuring confirmability, Brink, Van der Walt and Van Rensburg (2012) indicate that the researcher should ensure that the results and decisions are proven by data and that there is understanding between the researcher`s interpretation and truthfulness in the data. The researcher made use of the co-coder to increase the reliability of the findings. The co-coder was a nurse educator who has a PhD in nursing and is also facilitating the post basic diploma in professional practice and ethos for nursing students at the same institution designated for this study. After the co-coder and researcher analysed the narratives independently, a meeting was set up to discuss and reach consensus regarding the identified themes and categories. Transferability was also ensured, and according to Polit & Beck (2012), this refers to the extent to which the results will have meaning to others in similar situations. This was ensured by in-depth description of the methodology and metadata. In this way, it will be easy to duplicate the study and to contextualize data appropriately as advised by Brink *et al.* (2012).

3.7 Ethical considerations

Participants clearly understood the purpose of writing the reflective narratives, voluntary involvement of participants, and anonymous writing of these reports. This was to respect their autonomy as persons. The participants were aware that the immediate benefits, were only limited to the self-evaluation, as this was expected to encourage further moral development. Emotional risks were possible. However, the benefits outweighed the risks, given that they were soon going to practise as independent midwives. The narratives were analysed after ethics approval was obtained from the Human Research Ethics Committee (Medical) of the University of the Witwatersrand. This is a retrospective study, in which verbal consent was obtained from the participants. This being a retrospective study, the researcher had a discussion with the Chair of the Human Research Ethics Committee (Medical), in which a sample of the portfolio and narratives were presented for discussion. After inspecting the documents, the Chair of the Human Research Ethics Committee (Medical) consented and requested that the descriptions be written anonymously. Thus, it was concluded that there

would be no need for a written informed consent. However, for the purpose of confidentiality, no data would be traceable back to the student, nor will the institutions where students were placed be linked with the data. The narratives are stored securely by the researcher to safeguard the confidentiality and privacy of the participants.

3.8 Conclusion

In this chapter, the methodology followed in gathering and analysing the reflections were discussed, including criteria for trustworthiness and ethical considerations that were followed. In the next chapter, the findings will be discussed.

CHAPTER 4
RESULTS

4.1 Introduction

This chapter is devoted to discuss the findings of themes of the three dimensions of ethical competency that were coded from reflection reports. These themes are discussed within the context of the literature, as Strauss and Corbin (1998) attest that literature control may be used as an analytic tool in fostering conceptualization of the results.

4.2 Data analysis

The findings are based on students' experiences during their placement in maternity wards regarding the incidences in which they thought they were ethically relevant in the provision of their care. Data were thematically grouped around the definition by Jormsri *et al.* (2005), which identifies ethical competence as an ability to perceive, act and justify one's actions based on ethical knowledge, skills and attitudes, as well as the recognition of own and others' feelings involved in the incidence, as described by De Schrijver and Maesschalck (2013). These themes were therefore evaluated against the four principles as this signifies the acquisition of and commitment to nursing values.

After following the steps of coding, the self-reflective narratives were arranged thematically to distinguish the three dimensions of ethical competence as presented by Jormsri *et al.* (2005). The themes identified were:

- Moral perception
    - ability to identify moral issues
- Moral action
    - ability to act
- Justification for moral action
    - Ability to justify one's action based on ethical knowledge, skills, and attitude
    - Portrayal of principles and values for justification of acquired nursing ethics education.

Saturation of data was reached after 9 reflective narratives were evaluated, however four additional reflection reports were analysed to see whether there was no emerging information.

The descriptions below in Table 1 show how the moral issues were identified and how the moral actions were implemented and justified.

Table 1 Framework of analysis

Categories	MORAL PERCEPTION	MORAL ACTION	JUSTIFICATION FOR MORAL ACTION (Knowledge, skills, and attitude)	PRINCIPLIES AND VALUES USED FOR JUSTIFICATION (Acquisition of nursing values)
1	I met the mother who did not attend clinic because she believed that the iron tablets that were given to treat anaemia with her previous pregnancy caused her miscarriage.	I gave her information regarding the medication and importance of antenatal care, as well as the possible causes of miscarriages.	I wanted her to be informed about antenatal care for the purpose of future pregnancy, I respected her cultural values but at the same time I wanted her to make informed decisions in the future	Respect for autonomous decisions.
2	We admitted a woman with hypertonic uterus because of the traditional medicine she used to quicken the labour progress. Although at first the foetus was alright, I was worried that the uterus will rupture. Later on, the foetus became distressed due to infection	I however, did not blame or judge her when the foetus was distressed. I offered my help by giving her pethidine and aterax for pain.	There was no time or space to teach the mother what is right and wrong, I had to help as quickly as possible. I learned from sociology and psychology that we have diverse cultures and we should not judge.	Beneficence and non-maleficence
3	There was mother who had previous caesarean section and she had uterine contractions just before going to theatre. Because the foetus' feet were out, she was made to give birth normally without being informed about what was happening to her baby. She had a fresh stillbirth because the head delayed to come out, because she also did not want to push the baby out.	I catered for the emotional needs of the mother, and I gave her all the information	I believed that a patient should be treated holistically and be informed	Respect for persons
4	I saw the midwife that was assisting with the birth of a baby with severe prematurity, and she told the mother that the baby is dead, while the baby was still gasping, and I asked the doctor if there are no other possible solutions in situations like this. After a few hours the baby was taken to high care for palliative care as it was said he was too premature to survive.	I asked the doctor if there are no other possible solutions in situations like this. The baby was later taken to high care for palliative care as it was said he is too premature to survive.	I was advocating for the mother, I felt it was not right	Beneficence, human dignity even in preterm babies
5	I was admitting the Asian woman refused the support of the husband as well as to eat specific food while in labour because of her culture	With great curiosity, I asked her why refused the support of the husband as well as to eat specific food while in labour and listened. I did not judge her and I respected her choice	I knew ethically I have to respect her choices	Respect for persons

6	As I was conversing with the husband of one of the mothers, I learnt that he has never witnessed the birth of his children, because he didn't know how to go about it as is not a normal practice in his culture.	I made arrangements for father who wanted to support his wife and witness the birth of his children. It was the father's right and he was not aware of it	It was the father's right and he was not aware of it	Facilitating autonomy and human rights
7	I saw that the resuscitation of the preterm baby was not effective, and I thought the mother's presence is essential. I witnessed the preterm baby dying on the chest of the mother.	I asked the Dr. if I could go and call the mother, as her preterm baby's condition was deteriorating despite the resuscitation. After death of the baby I asked if she would like some privacy with the baby. She agreed and placed the baby on her chest (skin to skin). I closed the curtains and allowed them to be on their own. After a while I came back and I used the mother's cues to offer support.	I wanted her to have a role in the situation. I was empathetic and felt I should provide hope to the hopeless,	Virtues or care ethics Respect for persons Beneficence
8	We were attending the mother with imminent eclampsia was reluctant to sign an informed consent for termination of pregnancy. The mother didn't want to terminate the pregnancy because, this was her first pregnancy, the only one after six years of marriage. She asked the doctor whether she could have a second opinion of another doctor, despite the fact that her life was in danger, and that termination was meant to save her life, instead of the foetus.	We provided her with all the information and allowed her to ask questions. We phoned her husband and family to ask them to come and support her.	I understood her reasoning, but I wanted her to be more knowledgeable regarding the complications. We wanted the family to assist with decision-making.	Respecting her autonomy and relational autonomy
9	I was in the labour ward when a patient with obvious uterine contractions walked in, and we were trying to communicate with her, but she couldn't speak either English or Afrikaans	I used a little bit of Sesotho I learned while in primary school, but, I also requested assistance from one of my colleagues, though we were not best friends.	It was obvious that the language was a barrier to good care for the woman.	Doing one's duty of Beneficence
10	There was an incident, where I was told by the head midwife the leave a patient who was 9cm dilated about to give birth and attend other patients in the first stage of labour. Nearly the patient gave birth alone	I went and I was back in few minutes because the patient's husband came to call me back. I help the mother and I went back to the midwife to report. She did not respond and I was upset with the midwife	There were enough people to look after the patients in the first stage and I told by MrsAAA our lecturer that we cannot leave the mothers during a birth process.	Doing one's duty of beneficence, as well as justice
11	I experienced a horrific incident in first day at work in the labour ward whereby the patient went to shock due to internal bleeding and no one noticed, when I entered the room the patient was lethargic and called for help and no one came, I went to tea room and dragged the sister to the patient. When the sister saw the patient she called the	Though I was angry when I was blamed for not finding required equipment from the emergency trolley, I did not respond to the sister's anger, their shouts as well as blaming me even though they did not orientated me to their ward	I learned in psychology that I should not confront people if they are angry and I must wait until they are calm	Doing one's duty

	doctors and as they were resuscitating the mother, we discovered that tha the emergency trolley was empty. The sister shouted at me			
12	The woman that I helped to give birth sustained vestibular tear that were bleeding. I wanted to suture them, but the sister told me that they need no suturing as they will heal. I did a follow up on her in postnatal ward	While the mother was already in postnatal ward, I went to assess and see how she was doing because I was worried about the tear. I found the woman soaked in blood and I took her back to labour ward to be sutured.	I was worried about postpartum bleeding as this is the thing that kills our mothers and yet it is preventable.	None-maleficence, , beneficence and scope of practice
13	The day was very busy and all the midwives on duty, skipped tea and also lunch. As we were about to go and eat, a patient came walking with complaints of abdominal pains and ruptured membranes, the midwives told her that they are too hungry to respond to her complaints and needs,	I admitted the mother	I felt that it is not right and it was not the patient's fault that it was too busy and they had to skip meals"	Beneficence and Human rights

4.3 Findings and discussion

CATEGORY 1

4.3.1 Moral perception or ability to identify moral issues

The ability to see or recognise that a specific situation presents an ethical issue is considered to be the first step in responding to a given ethical problem (Gallagher, 2006). According to Wisnewski (2013), identifying moral issues entails that a person should be able to discern the features of morality in a given situation. Some messages carrying principles such as presence of the harms or benefits, autonomy, justice, and the proximity of the feelings of the moral agents to those affected were coded to show moral perceptions.

4.3.1.1 Obligation to beneficence and non-maleficence

Moral perception depicting the presence of harm and a student being moved by an obligation to do good (beneficence), were evident in most of the reflective narratives. The students gave their views like this:

> 12. *"The woman that I helped to give birth sustained vestibular tear that was bleeding. I wanted to suture it, but the sister told me that they need no suturing as they will heal. I did a follow up on her in postnatal ward."*

10 "There was an incident, where I was told by the head midwife to leave alone a patient who was 9cm dilated and about to give birth and attend other patients in the first stage of labour. Nearly the patient gave birth alone."

7. "I saw that resuscitation of the preterm baby was not effective, and I thought the mother's presence was essential. I asked the doctor, If I could go and call the mother, as her preterm baby's condition was deteriorating despite the resuscitation. I thought the mother's presence is essential. I witnessed the preterm baby dying on the chest of the mother."

4. "The midwife that was assisting with birth of a baby with severe prematurity, told the mother that the baby is dead, while the baby was still gasping."

These transcripts show that the ability to perceive the situation as being ethically charged, was based on the moral judgement grounded in beneficence and respect for persons. This was an obligation to do well as stipulated in the code of ethics for nursing practitioners, as well as Principlism. The above transcripts illustrate as Jormsri *et al*. (2005) indicate, that commitment to professional values is necessary for the awareness of moral issues. The students were committed to the principles of beneficence and non-maleficence. Besides professional values, empathy or being in the shoes of the mothers compelled the student above to call the mother while the other one felt it is not alright to leave the mother alone during birth and these were considered essential. These processes above indicate, as stated by Jormsri *et al*. (2005), that the affective and cognitive domains of an individual become involved in moral perception. The use of affective domain in moral perception is affirmed by Wisnewski (2015), who argues that patients' distress and anxiety is a fundamental embodiment that induces sympathetic moral perception. This claim by Wisnewski (2015) concurs with Emmanuel Levinas' view that the "face of the Other expresses vulnerability, and therefore challenges us to respond" (Gracia, 2010). The reflective narratives of the midwifery students demonstrate that the identification and perception of the patients' vulnerabilities, called for moral actions that were significant for the high standard of care.

These extracts demonstrate that the perception of ethical issues, though differing, were filtered through sympathetic concerns. These sympathetic concerns concur with Gastmans' (2013) argument that the ethical essence of nursing is the provision of care in response to the vulnerabilities of the patients.

As one of the narratives show, the narrator felt there was a need to respond to the vulnerability of the mother and the new born, when *she/he saw that the new-born is being declared dead to the mother while still alive (4)*. This was also demonstrated by one participant who *identified*

that the resuscitation efforts were failing and he/she therefore felt the presence of the mother was essential (7).

Although these *(4, 7)* may be deemed as translating from beneficence, sympathy was beyond the obligatory precepts. Wisnewski (2015) argues that sympathy is a cognitive mode that enables one to perceive a moral issue. The ability to relate with someone or "being in their shoes" is a personal value that is highly prized in nursing and midwifery practice. According to Gastmans (2013), a threatened dignity, whether in its fundamental form of intrinsic dignity or relational human dignity, is in constant request for restoration. The above narratives illustrate that there was threat to fundamental dignity that was perceived by the narrators. The ability to identify the moral issue in which the mother whose baby was severely premature and declared dead while still gasping, translates into seeing the baby as having human dignity and also empathising with the mother.

4.3.1.2 Obligation to support autonomous decision

Respect for autonomy was one of the principle illustrated by the students. The students believed that disclosure of information would capacitate autonomy of their patients and family. The students gave their supports in this way:

> 8. "*The mother with eminent eclampsia, was reluctant to sign an informed consent for the termination of pregnancy, she asked the doctor whether she could have a second opinion of another doctor, despite the fact that her life was in serious danger and that termination was meant to save her life, instead of the foetus."*
>
> *6. "As I was conversing with a husband, I learnt that he has never witness the birth of his children, because he didn't know how to go about it as is not a normal practice in his culture".*

The excerpts from the narratives also reveal the experiences of the students in dealing with certain issues in midwifery practice. For example, the support of husband to a mother is an essential practice in midwifery, and so is the need for a second opinion. This is likewise highlighted by Wisnewski (2015) who describes moral perception as a phenomenological character of a moral experience. Wisnewski (2015) indicates that an experience is an essential embodied phenomenon which, when attentively engaged with the environment, constitutes the capability of moral perception (Wisnewski 2015). This occurrence of moral experience was also explained in one of the narratives:

> *13. "The day was very busy and all the midwives on duty, skipped tea and also lunch. As we were about to go and eat, a patient came walking with complaints of abdominal pains and ruptured membranes, the midwives told her that they are too hungry to*

respond to her complaints and needs, and I felt that it is not right and it was not the patient's fault that it was too busy and they had to skip meals."

It is obvious that the complaints of vulnerability of the patient triggered different moral perceptions for the midwives who were on duty on that day. For this particular student, there was interplay of emotions, obligation to help and protect the rights of the patients that triggered a moral perception and influenced the way the student executed his or her action. On the other side, the midwives that were on duty were influenced by the context of the moral issue. For these midwives, their well-being was seen as a determining and important factor rather than the best outcome of the patient in need. The narrator above reflected consciously upon the phenomenon of the process of birth and its outcomes. By making sense of his/her experiences of failure or success it was possible to respond to the needs of this particular patient, and he or she was able to identify a moral issue. Nonetheless, the experiences of the other midwives may present a different reality based on their long exposure in the practice of midwifery. This is explained by Wisnewski (2015), who indicates that it is through attentiveness and directedness of the emotions that one may capture the structure and quality of the experience.

Besides the involvement of emotions and experiences in moral perception the self-reflective narratives also portrayed the interaction of personal, social and professional values in a given situation, as stipulated by Jormsri *et al*. (2005). The quotes such as the ones below have an interplay of values from diverse perspectives:

13. "*I felt that it is not right"*

7. "I was empathetic and felt I should provide hope to the hopeless"

5. "I knew ethically I have to respect her choices"

The quotes show that the personal, social and professional values and beliefs were explored and were influential in perceiving the moral issues in their midwifery practice. For one to feel obliged to be empathetic comes from a general moral duty which derives from our nature of being human (Agich, 1980). This interplay is considered to be significant in nursing practice because it ends up being a way of knowing (Jormsri *et al.* (2005). Thus, knowledge, experience, commitment to the upheld values, as well as cognitive abilities played a role in the identification of moral issues in this study. It is cited that unless one perceives a moral situation as a moral situation, or perceives moral character accurately, the highly appreciated moral principles and skills for deliberation that are esteemed in ethical competence are likely to lead one astray (Blum, 1991), and this ability was a prerequisite for moral action.

CATEGORY 2

4.3.2 Moral action

According to Mahan (1840), moral actions are deliberative and voluntary actions that give answers to the notion of right and wrong, which one's rationality demands that it ought to be done. According to Tavory (2011), moral actions are self-definitional actions experienced by the actor as being right, or that she/he expects others to perceive as being right, and to have predictable emotional reaction.

4.3.2.1 Obligation to beneficence and non-maleficence

The principles of beneficence and non-maleficence were also mentioned by the students as an ethical framework that guided their right actions. Some of the excerpts of the moral actions from narratives included:

> *7. "I asked the Doctor. If I can go and call the mother, as her preterm baby's condition was deteriorating despite the resuscitation. After death of the baby I asked if she would like some privacy with the baby. She agreed and I placed the baby on her chest (skin to skin). I closed the curtains and allowed them to be on their own. After a while I came back and I used the mother's cues to offer support"*
>
> *4. "I asked the doctor if there are no other possible solutions in situations like this. The baby was later taken to high care for palliative care as it was said he is too premature to survive".*
>
> *2. "I however, did not blame or judge her when the foetus was distressed. I offered my help by giving her pethidine and aterax for pain".*
>
> *9. "I used a little bit of Sesotho I learned while in primary school, but, I also requested assistance from one of my colleagues, though we were not best friends".*
>
> *12." While the mother was already in postnatal ward, I went to assess and see how she was doing because I was worried about the tear. I found the woman soaked in blood and I took her back to labour ward to be sutured".*

The transcripts portray the principles of beneficence and none-maleficence, and these represent the ethical framework that was taught. The fact that the students felt obliged to help despite their feelings, indicates that they did good even though their feelings which portrayed their personal values were not congruent.

Although the student exercised the principle of beneficence, the narrative clearly shows that the student was responding to the vulnerability of the mother. The mother's response in

complying with the request of a student without questioning could be portrayed as paternalism. However, the support and the sympathy offered showed concern for the wellbeing of the other.

4.3.2.2 Obligation to support autonomy

Some of narratives clearly demonstrated that the students were respecting the autonomous position of their patients, such as the following:

> *1. "I gave her information regarding the medication and importance of antenatal care, as well as possible causes of miscarriages".*
>
> *6. "I made arrangements for father who wanted to support his wife and witness the birth of his children."*
>
> *8. "We provided her with all the information and allowed her to asked questions and we phoned her husband and family to come and support her".*
>
> *5. "With great curiosity, I asked her why she refused the support of the husband as well as to eat specific food while in labour. I listened, I did not judge her and I respected her choice".*

The transcripts indicate that the students were respecting the self-determination of the patients and their clients. They capacitated the patient to be autonomous by providing information, where they felt that lack of information is likely to infringe the self-determination. A limited number of the narratives show that the narrators were not acting morally out of habit, but they considered different knowledge such as human rights and midwifery practice. This was made explicit by the following quotes:

> *1. "I understood her reasoning but, I wanted her to be more knowledgeable regarding the complications".*
>
> *3. "I believed that a patient should be treated holistically and be informed."*

CATEGORY 3

4.3.3 Justification for moral action

Moral justification is concerned with how one substantiates the moral assertions of a particular act or practice, as to determine whether those practices are good or bad, or permissible or impermissible (Scanlon, 2013). According to Jormsri *et al*. (2005) the ability to justify ones' moral action in nursing practice entails using principles and values that frame what one wishes to uphold or promote in directing judgment or resolving a problem.

4.3.3.1 Justification of autonomous decision

In justifying the autonomous decisions of the patients, the excerpts such as these were included and these also show that the students were motivated by the teaching of codes of ethics principlism:

> *1. "I knew ethically I have to respect her choices I understood her reasoning but, I wanted her to be more knowledgeable regarding the complications".*
>
> *3. "I believed that a patient should be treated holistically and be informed."*
>
> *5. "I knew ethically I have to respect her choices."*
>
> *6. "As I was conversing with the husband, I learnt that he has never witnessed the birth of his children. I made arrangements for father to support his wife and witness the birth of his children, I felt that It was the father's right and he was not aware of it".*

The narratives indeed reveal that the narrators considered and also applied the normative precepts that were relevant to the situation. This is a model that Beauchamp and Childress (2013) call a top down model, that relies on application of precepts in an obligatory way rather than determining what could have been permitted or prohibited. This demonstrates that students reflected on the codes of ethics and Principlism, while justifying their moral action. Some of the excerpts illustrate that there were cases where autonomous decision making was deemed to be limited and the narrators felt obliged to facilitate it. Respect for autonomy is concerned with honouring the rights of the patients to self-determination or informed decision (Dhai & McQuoid-Mason, 2011). To be autonomous, the theory asserts that the individual must be free from coercive powers and must have the capacity for intentional actions that are free from conflicting wants and desires (Beauchamp & Childress, 2013). Thus, one would be rendered non-autonomous if one has not reflected on his/her wants or desires (Beauchamp & Childress, 2013), although these were not made evident within the reflection reports.

4.3.3.2 Justification for beneficence and non-maleficence

Some of the assertions that were used to justify the beneficence action include the following:

> *9. "It was obvious that the language was a barrier to good care for the woman."*
>
> *7. "I was empathetic and felt I should provide hope to the hopeless."*
>
> *13.* "*I felt that it is not right."*
>
> *4. "I was advocating for the mother."*

The narratives that entail the acts of beneficence, were however, lacking a dialogue between the student and h the patient, and therefore, the students' moral acts seem to provide a one-sided form of information. Quotes such as I felt that it was not right or I was being empathetic,

can be seen in the light of intuition response emanating from the internal representation of norms and values. This concurs with Haidt's (2001) claims that such judgements are laden with emotions and have sudden affective valance with no balanced evidence or thorough searched for diverse strategies into the situation. Although the narrators gave an explanation for their moral actions, their sources of knowledge were limited in nature. The principles that were used to justify ethical actions were the respect for persons and beneficence

For the student to justify her actions of advocating for the mother or capacitating the knowledge of the client, it could have been reasoned properly, if the mothers' opinions regarding their needs and desires were given. And this was not the case in these situations. The excerpts above show that beneficence and respect for persons were the only principles that were used to justify moral actions. There narratives do not display a set of principles that were involved and so the diversified strategies to bring about logical argument to the conclusion. Campbell (2014) indicates that a justified decision must have evidence or facts from the event as well as diversified strategies for bringing about coherence and soundness to the decision making, especially in situations of competing values and norms. Although some of the quotes reveal that there were competing norms, one would expect the use of diverse strategies. This claim is demonstrated by the following:

> *5. "The Asian woman refused the support of the husband as well as to eat specific food while in labour because of her culture. I knew ethically I have to respect her choices*."
> *8. "The mother with imminent eclampsia was reluctant to sign an informed consent for termination of pregnancy. I understood her reasoning, but I wanted her to be more knowledgeable regarding the complications. We wanted the family to assist with decision-making".*

Excerpts like these call for dialogues, as there are competing norms between the patient and the health care provision. These excerpts depict compliance to principles as rules or obligations. Conforming to these principles is, as Meine and Dunn (2013) clarify, too simplistic to assert that there is ethical competence, if what is necessitated is the application of principles, law and formal rules. Instead competence should also entail communication and argumentation skills, and confidence and emotional intelligence in dealing with views that are different from one's own (Meine & Dunn, 2013). As described by Beauchamp and Childress (2013) a post-hoc judgement and final analysis is needed where one practices reflective equilibrium, in which one is expected to critically analyse his or her behaviours against a whole range of moral knowledges, skills, and attitudes as to give his or her moral assertion a claim. In such cases Lechasseur *et al.* (2016) suggest that there is a need to employ the process of reflective equilibrium which will assist in harmonising the total set of principles and the

empirical claims involved. Jormsri *et al.* (2005) further indicate that moral reasoning must be not merely be defined by mastering principles that are found in the codes of ethics, but there must capability in analysing the situation and reflecting on feelings, intuitions, and experiences of others.

4.3.3.3 Logical justification

A number of the narratives met this requirement, as demonstrated by the following excerpts:

> *6. "I saw that resuscitation of the preterm baby was not effective, and I thought the mother's presence was essential. I asked the doctor. If I can go and call the mother, as her preterm baby's condition was deteriorating despite the resuscitation. I wanted her to have a role in the situation. I was empathetic and felt I should provide hope to the hopeless."*
>
> *4. "The mother was told that the baby is dead, while the baby was still gasping, and I asked the doctor if there are no other possible solutions in situations like this, as it was said he is too premature to survive."*

The basis of the extracts above fall within Gallagher's (2006) notion of ethical competence, which stipulates that nurses are to demonstrate critical reflection about what they know; who they are; and what they do, in order to bring about an ethical practice. Even though the decisions made above can be viewed as translating from moral intuitions and emotions as suggested by Haidt (2001), the narrator considered the context and the other stakeholders before calling the mother when the child's condition was deteriorating. Furthermore, the narrator asked the doctor whether there were no other alternatives of care for new-borns facing death. This reveals that the discussion with a doctor was asking for consensus to be reached before calling the parent. It is clear that there was involvement of emotions and intuition coming from experience and obligation to do good, while at the same time the feelings of others were envisaged. These two quotes demonstrate a reasoned moral action, even though it can be argued that the whole scenario concurs with Singer (2010), who indicates that if a being is suffering, there would never be disagreement on the decisions aimed at alleviating the suffering of such person.

The excerpts from the previous narratives, excluding the immediate two above, demonstrate that the judgements that persuaded the narrators to act were restricted to the principles of beneficence, respect for autonomy, as well as advocacy. It can therefore be concluded the application of Principlism and a code of ethics were limited to the use of beneficence, respect for autonomy, as well as advocacy.

4.4 Summary

In this chapter, results were presented and the applicable and available literature was used as a control. The narratives show that students can identify moral issues in instances of vulnerability experienced by the patients and this prompted the response to care initiatives. Moral intuition as described by Haidt (2001) was more evident in most of the decisions, except for the two narrators who demonstrated a moral judgement that was based on reason. Almost all the reflective narratives demonstrated that the moral judgement lacked critical reflection that was supposed to take into account all other principles, as well as the emotions of others. In addition, the justifications lack diverse strategies and the description of the context as other factors necessary for ethical competence. The questions are therefore: Can it be alleged without contradiction that students demonstrated ethical competence in their reflective narratives on the basis of three students who applied all the dimensions of ethical competence? Can acquisition of that ethical competence be attributed to the current approach of ethical framework teaching and training?

The next chapter will present a discussion of the findings, the conclusions and recommendations.

CHAPTER 5
DISCUSSION OF THE FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 Introduction

The previous chapter gave the results and literature control. In this chapter, the ethical competence of the midwifery students will be discussed and the conclusions, recommendations will also be drawn from these discussions. Lastly the limitation of the study and propositions for further research will be presented.

5.2 Discussion of findings

The students' narratives regarding own ethical competence were analysed to check whether ethics education played a significant role. The following categories will be discussed: the ability to identify moral issues; the ability to act morally; and the ability to justify the moral actions based on ethical knowledge, skills and attitude, as a portrayal of acquired nursing principles and values.

5.2.1 Moral perception.

The ability to perceive moral issues and to engage with some values espoused in a specific situation was obvious from the self-reflective narratives. The narratives revealed that the midwifery students were able to perceive that certain situations carry either morally sound or morally wrong practices. There was no mention of the principles enshrined in Principlism, however, various ethical issues became evident when the patients were considered vulnerable and when the best interest of the patient was at stake. The moral perceptions identified could be said to be motivated by empathy translating from the vulnerable position of the patient as the reasons provided were based on being an advocate for the patient and providing hope for the hopeless. Bishop (2013) points out that empathy co-exists with observations, and within the practice of nursing or midwifery care. Thus, vulnerability of the patient could have been a source of a judged observation that prompts the students to perceive the situation as being moral and therefore seeking responses. According to Haidt (2001) one may make moral observations based on a quick flash of emotions while Wisnewski (2015) acknowledges sympathy as being significant in enabling one to perceive a moral issue in a quick flash of time. Wisnewski (2015) sees sympathy as an obligation that needs to develop within the realm of ethics education. The question therefore is, can the current ethics education approach, develop the empathetic attitude of the students, given the fact that

empathy is a character or trait related to virtue ethics? This question is based on Beauchamp and Childress' (2013) claim that even though empathy is a noteworthy moral excellence within the realm of Principlism, it does not serve as a standard that has authority to judge or direct a human belief, reasoning or behaviour.

Given the fact that these midwifery students had a duty to look after the vulnerable sick patients and their empathetic judgement compelled them to respond to the situation. It may be argued that this moral excellence shown by the students translates from the personal values or from the duty to care as stipulated in the code of ethics. The question is, how could institutions of nursing education give dichotomous views on empathy, given the fact that Principlism and codes of ethics for the nursing practitioners in South Africa do not explicitly state empathetic attitudes as the ground for the ethical response? The implicit stance of Principlism regarding empathetic attitude is further demonstrated by Beauchamp and Childress (2013), by stating that although feelings are part of human interaction, within the practice of common morality, they may not be generalised to the entire context, as this may be harmful or offensive to others. As Mordacci (2015) attests, the inconsistency in the application of emotions and lack of a unifying concept, may leave room for unspoken presuppositions and hidden theoretical assumptions. Thus, this may be confusing for the midwifery students. This raises the important question: why is ethics education in nursing solely reliant on this approach of teaching, especially if the empathetic care is pertinent and significant to nursing care.

The findings revealed that the narrators were moved by the vulnerabilities, such as a new-born being declared dead to its mother while still alive. The response to vulnerability was also demonstrated by one participant who identified that the resuscitation efforts were failing and he/she therefore felt the presence of the mother was essential. While the other student saw the vulnerability of the father who did not know his rights in being a support system during the birth of his child, others identified lack of knowledge from a woman who believed that the iron tablets that were given to treat anaemia caused her miscarriage. Lack of knowledge as a vulnerability was also seen in one mother who used traditional medicine to enhance labour, but to the detriment of her life and unborn baby. Even though the act of beneficence was exhibited, the trigger to initiate may be from compliance to do one's duty or the presence of a vulnerable situation.

It can be argued that the vulnerabilities of the patients triggered the sympathetic response of the students. These statements from the narratives concur with Gastmans (2013) argument that the significance of ethics within the realm of nursing care is the provision of care in

response to the vulnerabilities of the patients. As Gastmans (2013) states, illness is a vulnerability that destabilises our human existence, as it threatens our fundamental dimensions of being human, and it is in such states that good care becomes an essence of nursing, a moral essence more than just a duty. According to Pellegrino (2006), the goal of medicine is to enhance the patients' ability to act for their own best interest and to make truly self-determined human decisions. This goal is the obligation of health professionals such as nurses or midwives (Pellegrino, 2006). In almost all the narratives, the vulnerabilities of the patients were factors that initiated an ethical response.

In this study, the best interests of the patients were promoted and protected through balancing the knowledge of midwifery practices (professional competence), understanding of human rights and personal values. The narrators recognised certain practices or activities in the patients or the senior midwives that were likely to be in contradiction with the midwifery practice, and these were perceived as having a moral issue. However, such a perception was one-sided, as it lacked the reflective feelings and views of other stakeholders in a moral situation.

What was intriguing about the narratives was the use of personal outlooks that probably translate from personal values and these were charged with emotions and attitudes. Most of the moral issues perceived, portrayed how the students placed themselves in the patient's shoes. The statements regarding what was considered right or wrong were laden with personal judgements that were embedded in their compassion to care. This was consistent with Wisnewski's (2015) argument, that sympathy is a mode through which a moral issue may be perceived. Wisnewski (2015) holds that cultivation of such a mode of moral perception involves cultivating one's reaction to certain kinds of situations, and that it is through experience that one can cultivate sympathetic moral perceptions. One question raised by this study is, how can ethics education that is founded entirely on competing principles (Principlism) allow involvement of personal values, feelings as demonstrated in this study? Could it be that the principles were taught in an abstract way for the student to comprehend and name them in their assertions? The findings of this study could not provide answers to this question, as it was a retrospective study and it was not possible to have follow up questions for the students. Another question is how could the institutions of nursing or midwifery education enhance further the development of empathy amongst the students as empathy manifests in this study?

5.2.2 Moral action

Although students did not mention Principlism as their normative grounding, their moral actions testified to some of the principles. The principles that were underlined were respect for autonomous choices, beneficence and none-maleficence. Even though the students were drawn to the perceived vulnerabilities that were limiting the patient's well-being, their actions point to doing good to the patients. The vulnerabilities of the patients compelled the students to perceive the moral issues and therefore to act in the best interest of the patients. Their definition of an ethical issue was based on their understanding of best interest of the patient, as well as their experiences regarding the care of the susceptible patients. As Wisnewski (2015) attests, reliance on principles, may run a risk of habituation, in which the ability to detect and respond to ethical situations becomes limited to particular values that are found to be most appealing to the moral agents. This may explain why beneficence and respect for persons were highly favoured in this study.

The findings show that these values (respect for autonomous choices, non-maleficence and beneficence) were combined with sympathetic emotions. According to Meine and Dunn (2013), sympathetic emotions are essential in ethical competence, as ethical behaviour is beyond the adherence to rules and principles, but involves feelings of those involved in the situation. The feelings of other stakeholders in an ethical situation were not mentioned, and it might be as Wisnewski (2015) indicates, that ethics education that puts much emphasis on rules and principles cannot develop sympathetic perception. Wisnewski (2015) describes empathy as an enhancing mode for moral perception. Indeed, many nursing education institutions in South Africa rely on teaching of rules and principles for acquisition of ethical competence of their students.

It became obvious from the results that midwifery students relied mostly on their personal values, beliefs and experiences in perceiving moral issues. Most of them used statements such as "I felt it was not right" or "I felt I need to provide hope". Wisnewski (2015) is of the opinion that ethics training in medical professions should not only give preference to the moral theories, but should extend its attention to the emotional morality that derives from our nature of being human. If considered, such an approach would undeniably be consistent with Levinas' moral philosophy.

According to Levinas (in White, 2012), the suffering of the Other initiates a certain subjectivity in the humans, and this calls for responsibility and compassion, which is given in the face of the Other. According to Zembylas and Vrasidas (2005), the nature of existence compels one to responsibility. The face of the other, which within the context of nursing and midwifery

practice is a suffering face, calls for a specific response, as it happened in this study. As Levinas asserts, the proper response to the Other is to remove misery and to give aid. Whether the response was the provision of information to facilitate autonomous decision-making, or implementing the acts of mercy towards the mothers in maternity wards, the vulnerable face of the Other influenced the ethical acts of the students in this study. The question is, therefore, can the foundation of nursing ethics from the perspective of Principlism enable one to respond in the face of vulnerability without reverting to paternalism?

Bergo (2015) questions the understanding of ethics from rationalist self-legislation and freedom as pertinent to deontology, or the calculation of happiness, as relevant to utilitarianism, as well as the cultivation of virtues as underlined by virtue ethics. Given the doubts raised by Bergo (2015), it maybe suggested that there is the need for reconciling the moral theories such as Principlism, care ethics virtue deontology, as well as utilitarianism within the notion of enhancing of human dignity, as the ultimate goal of ethical competence in nursing. This will be relevant to what Kulju *et al*. (2016) calls the ultimate goal of ethical competence in nursing, which is the positive outcome of the patient. Whether the outcome is to solve a conflict or to increase the good standards of care in midwifery, all is for the benefit of the patient and good name of the profession.

Ethical competence from the view point of Principlism is therefore uncertain, as it became evident in this study that emotions for judgement were employed in perceiving the moral issues and executing the moral actions. It became uncertain because Beauchamp and Childress (2013:85) claim that although emotion is a moral excellence, it cannot serve as a standard that has authority to judge or direct a human belief, reasoning or behaviour. This uncertainty is raised by the fact that ethical competence requires not just knowledge of principles, but esteems the acknowledgement of feelings in a situation.

5.2.3 Moral justification

Although moral perception and moral actions were manifested, there were no epistemic reasons given as to why they felt that their assertions should be believed as having moral worth. The assertions from the narrative were not in accordance with Beauchamp and Childress' (2013) description of reflective equilibrium process, in which the background principles and theories were supposed to have been brought into harmony as to maximize the coherence of the overall set of beliefs, acceptable to a reflective evaluation. Instead, the findings reveal an empathetic moral intuition. According to Saunders (2009), moral intuitions are easy, and immediate judgements are made without any conscious effort. Taking empathy

into account, it may be said without doubt that moral intuitions used in this study were based on consciously held principles that may be modified if the need arises as stipulated by Saunders (2009). However, it must be understood that though valuable, moral intuitions are unreliable and subject to all kinds of biases (Brun, 2014).

The questions from this study are therefore, how should ethics education engage and encourage an extension into rational justifications, as the narratives demonstrated that there is a gap? How should reflective equilibrium be taught in curriculums that allocate limited time for ethics education? The findings revealed that there is an emerging ethics of responding to the face of the Other; the face that is authentically vulnerable as discussed by Levinas' ethics, as well as a caring attitude. The challenge is therefore, should this be reconciled through ethics education for nurses, and what about the limited credits allocation?

5.3 Conclusions

It can be concluded that the ideal, which is the ethical competence as informed by the ethical framework that was taught to the midwifery students is partially reflected within the narratives that presented the actual clinical practice. There were some limitations in meeting the ideal ethical competence, as presented in chapter 2. And these are stated by the objectives of the study below:

- Grounded theory for the analysis of self-reflective narratives collected from midwifery students, for evidence of ethical competence was done. Although the students perceived themselves to be competent in handling ethical issues, the reflective narratives reveal that such competence was limited. It was limited because the self-reflective narratives did not demonstrate all three dimensions of ethical competence applicable to nursing and midwifery practice. These include the moral perception, moral judgment and moral behaviour as described by many authors (Jormsri *et al.*, 2005: 586; Lechasseur et al., 2016; Gallagher, 2006). The narratives reveal that there was no argument, as the students were conforming to the principles and personal values of their choice.
- The role of ethics education in aiding the acquisition of ethical competence was assessed. The self-reflective narratives demonstrate that Principlism and a code of ethics as an ethical framework for ethics education, came out in a limited way. The role was limited, due to the fact that the choice of principles used, was limited to beneficence and autonomy, even where other principles were permissible to be used. Furthermore, other aspects of Principlism such as a justification of moral action were limited to the level of intuition. The process of reflective equilibrium, as a higher level

of moral reasoning was not even initiated. It may be argued that Principlism and a code of ethics as an ethical framework, restricted the acquisition of ethical competence because these frameworks obligate one to either conform or obey and not argue one's assertions.

- The findings and recommendations will therefore be disseminated to the designated training institution, as to inform curricula planning/revision and ethical module development for nursing and midwifery training.

Given the three moral dimensions of ethical competence; the moral perception, moral behaviour and moral judgment as described by Jormsri *et al*. (2005), it can be concluded that the acquisition of ethical competence was limited among the midwifery students that were trained under the ethical framework of Principlism and code of ethics. The ability to perceive moral issues and to act morally, as well as the recognition of own and others feelings involved in the incidence as stated by Jormsri *et al*. (2005), Gallagher (2006) were explicitly stated; however, there was no justification of one's assertions. It may be assumed that the justification of moral perception and moral action was impacted by habituation to specific values as described by Wisnewski (2015). Regarding sympathetic perception demonstrated in the narratives, it may be concluded that students made use of their prior learning, which were prevalent in their own personal values. It is therefore suggested that ethical abilities that were demonstrated by the narratives were limited as students were mostly adhering to rules that were translating from the ethics education offered. However, there was an emerging notion of responding to the vulnerabilities of the patients and their families, which translates from the personal values that are underpinned in many cultures.

5.4 Recommendations

Based on the findings and conclusions, it is clear that students make use of limited principles, as they appear in Principlism and a code of ethics for nurses. However, this may be because of the abstract way of teaching the principles to the students. It could also be argued that the chosen ethical framework is inconsistent with the goals of good midwifery care, therefore, it was difficult for them to reconcile these in making a plausible moral justification. It may also be argued that there were some incompatibilities between the principles and the students' personal values, and this may have contributed to moral justification being limited to an intuition level. Although moral intuitions are considered to be essential in a moral situation, they may however be considered subjective, as their justifications are always not appealing to the facts, logical reasoning, and the context of the situation. As it is revealed by the findings of this study, the use of other moral principles alternative strategies, and the evaluation of the

context of the moral issue were not considered, and this could have been helpful. It also became evident that there was an emerging ethics of responding to the vulnerability of the patients, as well as the caring attitude. Thus, there are three issues that need to be addressed by the training institutions.

The emerging of ethics of responsibility, in which one responds towards the vulnerable Other, is integral to care ethics and translates from the values that are underpinned in many cultures, and this appeals to the essence of human existence as described by Levinas.

- There must be discussion amongst the institutions of nursing education regarding moral theories, in particular, to examine whether to indulge students in diverse moral theories and run the risks of limited knowledge, or to select and study in-depth, the theories that are essential to nursing care.
- Regarding the emerging ethics of responsibility, it is recommended that the ethical competence of midwives and nurses be geared towards moral theories that are pertinent to this innate notion of caring. This therefore calls for ethics of care within the theory of Levinas. Thus, moral philosophy from the view point of Levinas, must be the basis for ethics education in nursing
- However, if the need is to stay with the current curricula for nursing ethics education it is then recommended that the principles be discussed fully and not be given as abstract concepts. There must be a model that will reconcile all the values pertinent to patient-centred care, as the suffering face of the patient was the trigger for ethical response in this study. If Principlism is a preferred ethical framework, the emphasis must also be given to moral justification of one's decisions, especially when there are competing principles. Additionally, the process of reflective equilibrium, as model for cohesion and consistency of moral acts must be taught to the students. Because reflection equilibrium, request a search for diverse strategies as to bring about harmony to situations with conflicting ethical principles.

5.4.1 Contemporary frameworks for acquisition of ethical competence

There are diverse ethical frameworks and pedagogical models aimed at the acquisition of ethical competence. While some of them contain a professional ethics component, the question that remains is whether the content and teaching methods enable students to develop the knowledge, skills attitudes, values and abilities necessary to demonstrate the competencies expected. While some of these may indeed demonstrate the required dimensions of ethical competence, others may only accomplish a superficial understanding of

professional ethics. Table 2 gives a few examples of ethical frameworks that are currently utilised within the ethics education for nurses. Some of the frameworks have been discussed under the approaches above and will therefore not form part of the discussion.

Table 2. Examples of models for an ethical framework

Authors	Country	Pedagogical framework	Defining attributes
Chris Gastmans (2013)	Belgium	Dignity-enhancing nursing care: A foundational ethical framework	Specifies vulnerability as a lived experience that should inform care as an ethical framework in enhancing human dignity
Bob Rankin (2013)	UK	Emotional intelligence: Enhancing value-based practice and compassionate care in nursing	Introduces emotional intelligence within the realm of values that prioritises quality standards, rules and regulations that govern nursing practice

Some of these ethical pedagogical trends entail exposing the trainee to real life situations, where they can test their conceptualised theoretical underpinning of ethics and reflectively analyse their growth in ethical responsibility (Molewijk, Abma, Stolper & Widdershoven, 2008). Accordingly, Young and Paterson (2007:146) affirm that real-life situations allow the students to explore the richness of human experiences and the complexities of the context, as compared to the use of case scenarios. Thus, workplace environments where students interact with the clients and the team of other health professionals are considered to be a good avenue for the process of ethical competence acquisition.

In developing ethical competence, Kristofferson and Friberg (2014) highlight the value of self-understanding in dealing with ethical issues, which entails exercising control, determining oneself and shaping one's life. In affirmation, Bertolami (2004) indicates that ethics courses must allow students to synthesise their own personal values by borrowing from different sources of values, while simultaneously assimilating the aspirations of the professions. Beside these models, there is one that falls within realm of care ethics. This model establishes care within the anthropological foundation and the context of care, so as to demonstrate normativity

of care ethics (Vanlaere & Gastmans, 2011). This model is called dignity-enhancing nursing care and proposes a foundational ethical framework.

5.4.2 The dignity-enhancing nursing care as a foundational ethical framework

Dignity-enhancing nursing care as a foundational ethical framework is proposed by Gastmans, is based on existentialist moral philosophy and the Louvian tradition of the personalist theory (Gastmans, 2013). Based on Emmanuel Levinas' view, human beings are responsible for their existence, and because we share a common humanity and sentience, the "face of the Other demands further thought and responsibility" (Gracia, 2010). Because the face is infinite, it expresses vulnerability, and therefore, challenges and commands us through its nakedness to respond (Gracia, 2010:64). The personalist theory is based on the moral theology of Louis Janssens, which states that the human being is a totality that unifies all actions undertaken in all dimensions of a human person (Vanlaere & Gastmans, 2011). According to Vanlaere and Gastmans (2011) the fundamental dimensions a human persons are interconnected and characterise the human person as being:

1) A subject, capable of acting freely and responsibly.
2) A subject in corporality, and therefore belonging to the material world and subjected to the physical laws. Thus, this body is marked by meaning giving dynamics and is therefore subjective.
3) Essentially directed towards others, and is therefore always in relation to other persons. Thus, a person is a relational being even though he may be free and autonomous.
4) A part of a larger social world. The human is therefore reliant not only on other persons and family, but also on the community, including larger structures and institutions.
5) Just as the human person relates to other persons and social groups, is in relation with God, and is therefore spiritual.
6) A historical being that is marked by time, and is a succession of several phases characterised by specific possibilities he must seize throughout his existence and develop towards integrity and wisdom
7) A human person is fundamentally equal with other human persons, but at the same time each is an originality. Thus, all humans have intrinsic dignity that can never be lost throughout their life span.

According to Vanlaere and Gastmans (2011), vulnerability may affect a human person in all these dimensions, and, as a result, human dignity may become threatened. Thus, nursing care becomes more meaningful when a patient is respected in all of these dimensions (Vanlaere & Gastmans, 2011). According to Gastmans (2013), "the ethical essence of nursing

care is to respond to the vulnerabilities of the patients by providing care that will enhance the dignity of that patient."

Gastmans (2013) indicates that this model of care is based on the following three pillars: 1) vulnerability as a profound lived experience bound to all of us as human beings; 2) care as a dialogical interpretative process that should be based on the ethical decision making of all involved in the care including patient, family and society; and 3) dignity as a normative standard to answer questions such as, what exactly does it mean to be ethical, how can we evaluate the people's behaviour ethically, and what actions are right or obligatory?

According to Gastmans (2013), the lived experiences that confront us as humans should inform the ethical framework, instead of abstract constructions such as autonomy and beneficence, as these are limited to the process, attitudes, daily care and relationships, which are essential to nursing care. The dialogical interpretative process is based on searching for appropriate and adequate care, as agreed upon by all the stakeholders concerned (Gastmans, 2013). As Gastmans attests, care within the dignity enhancing model is a dynamic process based on specific contextual relationships, is value-laden and responsive to the needs of the patient. It is marked by a sequence of interpretative dialogues regarding caring decisions (Gastmans, 2013). It is in such caring processes that ethical behaviour may be evaluated and reconstructed to an agreed standard of good care that will serve as the normative standard that respects and enhances dignity of the patient (Gastmans (2013). Gastmans (2013) explains that this model appeals to and is consistent with the aim of nursing care and is therefore likely to advance the ethical development of the nursing students. According to Gastmans (2013), teaching may therefore be geared towards helping students to:

- Enter into a caring relationship with a patient, so as to understand the fundamental dimensions of personhood that would be threatening the dignity of the patient.
- Be concerned about the vulnerable state of the patient that demands of the nurse to be attentive and to clarify the profound lived experiences of the patient and the family, as the patient is a relational being.
- To interpret the reflective lived experiences of all those involved in the care including the healthcare team.
- To search jointly with the patient and family for the most adequate and appropriate care. As it is in this joint adventure that the ethical responsibility and competence of nursing care, which is responsiveness in nature, may be achieved.

As the study aimed at determining how those that were trained under a specific ethical framework describe their own ethical competence within the context of South Africa, the discussions therefore described the ethical framework embraced by the midwifery students designated for this study. The discussion began by stating the prescription of the South African ethics education for nurses, and went on to the four principles (Principlism) as a theoretical approach and a basis for decision-making for dealing with ethical issues in nursing and midwifery.

5.5 Limitations and further research

This was a small-scale study conducted in one institution and with a limited number of participants, and as such, it cannot be generalised to the entire population of student midwives and nurses in South Africa. Furthermore, it was also a retrospective study in which a follow-up with the participants for further explanation of certain issues mentioned in the narratives was not possible. It is therefore essential that another study be conducted in which both quantitative and qualitative data may be generated from all the institutions of nursing education in South Africa. Such a large study would give a bigger picture of the state of nursing and midwifery practice regarding training for ethical competence. It is suggested that recommendations mentioned above be piloted for efficiency and usability by the training institutions.

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APPENDIX A: ETHICS CLEARANCE CERTIFICATE

R14/49 Ms Moliehi R. Mpeli

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M150773

NAME: (Principal Investigator)	Ms Moliehi R. Mpeli
DEPARTMENT:	Steve Biko Centre for Bioethics Steve Biko Centre For Bioethics
PROJECT TITLE:	Personal Evaluations Of Midwifery Students Regarding Ethical Competency
DATE CONSIDERED:	31 July 2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Louise Bezuidenhout
APPROVED BY:	Professor A Woodiwiss, Co-Chairperson, HREC (Medical)
DATE OF APPROVAL:	17/08/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**

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CHAPTER 1
CONTEXTUALISATION

1.1. Introduction

1.2. Background and problem's statement

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pERSONAL EVALUATION OF MIDWIFERY STUDENTS REGARDING ETHICAL COMPETENCY

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