Theses

2020
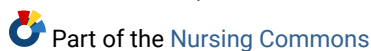
Moral competence in nursing: An exploration of the Giving Voice to Values Curriculum

Catherine Costa
The University of Notre Dame Australia

Follow this and additional works at: https://researchonline.nd.edu.au/theses

Part of the Nursing Commons

THE UNIVERSITY OF
NOTRE DAME
AUSTRALIA

Moral Competence in Nursing:

an exploration of the Giving Voice to Values Curriculum

Catherine Costa

Submitted in fulfilment of the requirements for the Degree of

Doctor of Philosophy

School of Nursing

University of Notre Dame Australia

Sydney Campus

December 2020

Declaration

To the best of the candidate's knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made.

This thesis is the candidate's own work and contains no material which has been accepted for the award of any other degree or diploma in any institution.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007, updated 2018). The proposed research study received human research ethics approval from the University of Notre Dame Australia Human Research Ethics Committee (EC00418), Approval Number #014146S.

Catherine Costa   15/12/2020

Abstract

Moral Competence in Nursing: an exploration of the Giving Voice to Values Curriculum

The development of moral competence is central to the profession of nursing and its practice. Nurses engage in moral decision making that impacts the health of people, families, and communities. It is important, then, to ensure that nursing graduates possess the necessary moral development for engaging in professional practice. To this end, research was conducted, the principle premise of which was to explore the use of the introduction of the Giving Voice to Values curriculum (Gentile, 2010) and its contribution to the development of moral competence in nursing. The Giving Voice to Values curriculum is a values-based methodology enabling students to find their voice, speak up, and act on their values effectively. The curriculum develops the students' confidence in identifying moral issues during their professional education. This research explored the use of the Giving Voice to Values curriculum as a component of an undergraduate nursing program in Australia.

The exploration of the Giving Voice to Values curriculum was undertaken within a wider investigation of moral theory, moral competence, and the profession of nursing. The research undertaken in this study analysed the perceptions and practices underpinning contemporary methodologies of moral competence in nursing, and the professional regulations that uphold and secure this. Using a mixed methods research design, this study draws on a collection of data from two sources: (a) a survey of first year nursing students' understanding of moral competence at the completion of the GVV Curriculum; and (b) semi-structured interviews of nursing experts and stakeholders' understandings of both moral development and the morally competent nurse.

Findings from this study demonstrated that the students' understanding of both the actions and influences of moral competence remained low on completion of the Giving Voice to Values curriculum. Specifically, the study revealed developments in students' ability to reason or to 'think ethically' or to recognise ethical anomalies, as well as an increase in actions taken to 'give voice' to their values; however, these findings were not supported by a noticeable development in students' capacity to identify their ethical position. Nonetheless, the study revealed a development in students' moral awareness, thereby providing a basis for the development of moral competence.

Nursing experts and stakeholders perceived moral competence in nursing as a circular developmental process that required solid foundations in moral theory and communication skills, as acquired and assessed throughout undergraduate nursing education. These participants proposed that a morally competent nurse must be able to uphold professional values, moral principles, and professional practices. They emphasised that the development of moral competence within nursing must be founded on the codes and regulations that govern and guide the profession. The participants also identified observed gaps between the theory and practice of moral competence, leading to weaknesses within professional practice and health care.

The Giving Voice to Values curriculum is not a moral theory in itself. The introduction of this curriculum within undergraduate nursing education must be based upon the teaching of both moral theory and professional ethics, as foundational for ongoing development of moral competence.

For my parents, Wal and Mary Scott

Sine qua non

Acknowledgements

This thesis is dedicated to my parents, were they still alive, I know their pride in me achieving this level of academia would have been immense.

To my husband Robert whose love, encouragement and support on every level has been enduring throughout the time this research has been going. Thank you for putting up with the books, the chaos and the 'just give me a minute and an hour later, what did you want? New adventures await us now.

To all my family for their support and love, a big thank you.

To my supervisors: Associate Professor Bethne Hart, a passionate and exemplary nurse leader who has been dedicated in her encouragement and support enabling me to discover what I could achieve, thank you. Thank you for guiding me, for being there and pushing me further. Reverend Anthony Crook, your supportive guidance, support, humour and encouragement kept me focused on the end goal. Dr Helen McCabe, you came into this research towards the end, but your enthusiasm and support, your help and encouragement have been unwavering. You have all been constantly generous in your support, guidance, and coaxing. I very much appreciated their approach, perceptive reviewing skills, and their time given to steering me to completion.

A big thank you to Brett Clarke who was always there to support and help me when I was stuck. To my good friends, Louise Boffa, and Sr Jan, you kept me going when I needed it, with your humour and prayers, thank you. To Laura, your help was immense. To my UNDA (Sydney) library colleagues, Morgan, Anusha and Michael thank you for your guidance and help throughout this study.

To the nursing students during 2015 and 2016 who became the study population, my thanks to you for taking the time to complete the survey, without your shared experiences, this research would not have been. Thanks also to the nursing experts and stakeholders who gave their time and thoughts to help me understand where moral competence sits in regards to nursing.

Table of Contents

List of Tables

List of Figures

Appendices

Chapter 1: Introduction

This doctoral research explored the intersections between moral theory, moral action, and professional practice in nursing. In particular, the researcher investigated both the concept of moral competence in nursing practice, as well as the process of moral development more generally. To this end, the researcher relied upon an account of moral development by Lawrence Kohlberg and Nel Noddings' ethic of care. The researcher will also look at the theories of Nel Noddings that are closely identified with the promotion of the ethics of care, and that caring should be one of the foundations for ethical decision making. The theories of Carol Gilligan will also be examined, Gilligan noted that care and justice perceptions exist in moral conflict, and during a person's growth process. Each perception, Gilligan noted, complements the other and encourages moral development and growth. In this thesis, theories are expanded upon in discussions on moral competence and nursing.

The ethics of nursing are influenced by moral development, as nurses must develop a strong system of morals in order to uphold the strict ethical standards required of them. In doing so, the researcher acknowledges that the use of the word competence/development implies both the knowledge and the skills that are essential to the integrity of nursing practice (Parsons, 2001).

1.1 Background to study

The researcher's interest and motivation in conducting this study was to evaluate the outcomes of introducing the Giving Voice to Values curriculum into an undergraduate nursing program in an Australian university. In particular, this study was designed to examine the extent to which the Giving Voice to Values curriculum enhanced the development of moral competence in undergraduate nursing students. Prior research was conducted within a School of Nursing in an Australian University examining the impact of the Giving Voice to Values curriculum in two units of study in 2013 (Lynch et al., 2013). Analysis of the data collected for the study

indicated the value of closer scrutiny into the broader domains of moral education, as well as the development of morally competent actions. The study established that the educational influence of simulation, and case study-based learning that is central to the Giving Voice to Values methodology, is a constructive and instructive initiative (Lynch et al., 2013).

1.2 Aim of research

This thesis presents a research study exploring nurse education in relation to moral competence in an Australian University. It is through a step by step progression in nursing studies that the student's moral competence evolves. Within each of these steps, students will encounter particular adaptations in regard to their practical skills, moral abilities and competencies.

This thesis challenges the hypotheses that nurses are essentially morally competent on graduation and, that the nurse graduate's moral competence is assumed rather than proven. Chapters 2 and 4 discuss the studies undertaken in regards to nursing morals with consideration given to the development of moral competence within the nursing curricula, through the work of Kohlberg, Gilligan and Noddings. The thesis looks at what might be added to curriculum through educational approaches to prepare nursing students to be morally competent. The premise underlying this research is that the application of the Giving Voice to Values Curriculum would strengthen and support the development of moral competence in nursing practice. Exploration of this premise also required exploring the context of nursing practice with nursing experts and stakeholders.

1.3 Research question

The research investigated the perspectives of a variety of nursing professionals in order to address the question: Can the introduction of the Giving Voice to Values curriculum contribute to the development of moral competence in nursing? The following sub-questions emerged:

1.   How is moral competence in nursing defined?

2.   What are the contemporary approaches utilised in nursing education towards the development of moral competence in the profession?

3.   What are the perceived and observed gaps in the development of moral competence in the nursing profession?

4.   Can these gaps be addressed by changes in the education of student nurses?

5.   What impact does the implementation of the Giving Voice to Values Curriculum have upon nursing students?

6.   How do nursing students perceive the effectiveness of the Giving Voice to Values curriculum?

These sub questions arose from discussions with nursing academics, nursing stakeholders and a pilot study led by the founder of the Giving Voice to Values Curriculum, Dr Mary Gentile, in a small number of undergraduate units of study. Sub-questions were chosen by a process of consensus, selecting those questions deemed salient by all contributors.

1.4 Significance of research

Nurses engage in moral decisions that impact the health of patients and their families, as well as the community, and they must uphold both the knowledge and practice enshrined in the professional Nursing and Midwifery Board of Australia (NMBA) Code of Conduct (NMBA, 2018) and International Council of Nurses (ICN) Code of Ethics (ICN, 2012).

The nurse engages with the patient when they are often at their most vulnerable; distress, fear and anxiety can accompany the experience of illness and injury. Indeed, nursing is largely premised on what Pellegrino (2001) terms the very 'fact of vulnerability'. For this reason, the moral character of the nurse is an essential safeguard against the exploitation of persons in the care of the nurse (Pellegrino, 2001). Further, if patients and, moreover, whole communities are

to seek care in a time of health care need, they have no choice but to trust that they are safe, cared for and cared about. They rely on the moral integrity of those who profess to be nurses.

As Jormsri et al. (2005) state, moral competence entails the knowledge and the skills required by the profession, whilst also assuming the capacity to apply that knowledge and skill. That is, competence goes further than simply knowing; it necessitates doing. Readiness to engage in nursing practice includes the possessing of confidence, competence, and courage in order to give voice to one's values when confronted with conflicts, whilst delivering healthcare with integrity and in a morally justifiable way (NMBA, 2018; Johnstone, 2015). In 2005, Jormsri et.al. conducted a study into moral competency in nursing and defined moral competence as an individual's capacity to live in a way consistent with a personal moral code and role responsibilities. The premise of the study was that nursing practice depends not only on knowledge, but also on pre-existing values, beliefs, and moral commitments, all of which shape a nurse's decision-making. Moral competence in nursing requires coherence of feelings with self-awareness, to be able to make decisions, and to be able to behave in a way that brings about the greatest level of support for those they care for.

1.5 Research objectives

The objectives of this research were to:

•	explore the implementation of the Giving Voice to Values curriculum in an undergraduate nursing program.

•	identify gaps in the teaching of moral competence to undergraduate nursing students.

Discussion of the implementation of the Giving Voice to Values curriculum within an undergraduate nursing program is discussed in Chapter 3 with Chapter 7 presenting the research findings of this implementation. A review of the literature demonstrated that in order for nursing students to develop moral competency learning experiences must be initiated in integrated steps continuously during their study, and that their development of moral competency goes hand in hand with their development of standards of practice. The Giving Voice to Values curriculum allows students to experience certain shifts in their own moral abilities through a step by step progression.

1.6 Research context

Preliminary research done by Mary Gentile (2010) in the Harvard Business School in the USA suggested that conclusions made in regard to the integration of the Giving Voice to Values curriculum into the business curriculum could also be applied within Schools of Nursing. Research was also undertaken at Bond University in Queensland (2013), under the leadership of Professor Ben Shaw, into the integration of the Giving Voice to Values Curriculum into units of study in a business curriculum. Preliminary evidence confirmed that the incorporation of the Giving Voice to Values framework worked well in the units of Business studies and indicated that the curriculum could be replicated into nursing curricula (Shaw, 2013a).

1.7 Conclusion

This thesis consists of seven chapters. The chapters will provide readers with an awareness of the research, research findings, implications, and conclusions.

Chapter 1 identifies the research questions, objectives and context.

Chapter 2 outlines the literature on moral competence in nursing, social theory, nursing ethics, values in nursing and nursing education. This chapter will look at the three moral theorists, Kohlberg (1973), Gilligan (1982), and Noddings (1984), and will critically evaluate the perceptions and practices underpinning contemporary educational methodologies in relation to the development of moral competence in nursing, and the professional regulations that uphold and secure this. The literature review demonstrated the challenges in preparing nurses for morally competent professional practice. This chapter will look at the challenges for nursing education and the strategies needed to support nurses in developing the moral competence required within this profession.

Chapter 3 examines the use of the Giving Voice to Values curriculum as a pedagogical framework for the development of moral competence in nursing. This chapter will look at its foundations, its relation to the development of moral competence, along with the strengths and weaknesses of the curriculum.

Chapter 4 details the research methodology, philosophical underpinnings and design used for this study and the ethical principles applied for its conduct. The mixed methods approach used and the techniques of data collection and analysis across the two phases of the study are also discussed. The use of a mixed methods research study allows for the measurement and exploration of the development of moral competence in nursing. Phase 1 allows the researcher to gain an understanding of the development of moral competence of the student participants following an integrated Giving Voice to Values curriculum and a dedicated Giving Voice to

Values Workshop. Phase 2 provides valuable data from nursing experts and selected nursing stakeholders, and allows the participants to voice their perceptions and experiences of the development of moral competence in nursing.

Chapter 5 presents the findings of the Student Survey (Phase 1), conducted following their completion of the Giving Voice to Values Curriculum in their first year of an undergraduate nursing degree program. Data will demonstrate an increase in the students' confidence, indicating that they perceived their development of moral competence in some elements more than others.

Chapter 6 will analyse the findings of Phase Two of this research, the qualitative semi-structured interviews undertaken with nursing experts and stakeholders. The analysis of Phase 2 will deliver added professional context and perspectives regarding the development of moral competence in nursing.

Chapter 7 summarises and evaluates the findings and concludes with recommendations for future nursing education. The findings in relation to the Giving Voice to Values curriculum demonstrate that it was a part of the processes of developing moral competence in nursing. The need for a moral context in which to situate moral development remains one of the crucial elements in curriculum planning

Chapter 2: Moral competence and nursing

2.1 Introduction

This chapter presents a critical review of the scholarly literature surrounding moral competence in nursing. Within this chapter, a foundation will be given to the research questions asked within this thesis, as well as looking at the central goal which was to explore the development of moral competence in nursing. The chapter also gives an overview of the moral theorists of Kohlberg (1973), Gilligan (1982), and Noddings (1984). This literature review critically evaluates the perceptions and practices underpinning contemporary educational methodologies in relation to the development of moral competence in nursing, and the professional regulations that uphold and secure this. This introduces the central conceptual foundations of this research study.

2.2. The literature review

Contemporary educators of undergraduate nursing students are very aware of the need for ethics to be taught within the nursing curriculum in order to prepare students to undertake the many moral decisions and actions that are required within their clinical practice. Most nursing curricula in Australia integrate studies of ethics, ethical principles and ethical decision making into units of study (Johnstone, 2015; Benner, 2001; Bickhoff, Sinclair, & Levett-Jones, 2017). The aim of this literature review was to identify and evaluate the central scholarly literature surrounding the development of moral competence in nursing. This section will report the literature search that has informed this review. Literature was gathered through searching the clinical databases: CINAHL, MEDLINE, Scopus, ERIC databases, as well as Google Scholar. The review was conducted using the key search terms 'moral competence', 'moral competence and nursing', 'moral competence and development', 'nursing education' to December 2016, yielding a total of 358 citations. The sole exclusion criterion was non-English language. The search was updated in December 2017 and yielded a total of 13 more citations. The search was

again undertaken in January 2019 with 8 citations included. After evaluating and analysing these articles, only those which had a defined approach to moral competence were considered. The literature search explored the intersections between moral competence, nursing, nursing education, and nursing practice.

Using the terms 'moral competence' and 'nursing' there were 101 results. These were assessed through scholarly/peer review, and appraisal by the research team. When completed, 34 articles were selected where moral competence was clearly aligned with nursing practice. Using the terms 'moral competence', 'nursing' and 'development' there were 17 scholarly articles. Using the terms 'moral competence' and 'social theory', six articles were found. The findings of the literature search are presented here and organised into these central themes: moral competence; moral competence and social theory, moral competence, and nursing - in nursing standards for practice, nursing ethics and nursing education.

The Literature Review evidenced moral competence scales in use by other researchers: Colby et al's. (1987) development of the Moral Judgment Interview, and Lind's (2012) Development of the Moral Judgment Test. These scales measured the individual's moral reasoning and are based on Kohlberg's theory of moral development. Rest (1994) developed the Defining Issues Test (DIT) which is also based on Kohlberg's theory; this test is a multiple choice, self-administered tool. Cassidy (1996), Ketefian (1989), Numminen & Leino Kilpi (2007) and Parker & Parker (1990) all challenged Kohlberg's account of moral reasoning which, they argue, was reflective of the ways in which men engage in moral reasoning. Instead, they argue that women reason differently in this regard. These authors proposed that Gilligan's (1982) theory be considered. Accordingly, the use of Kohlberg's Moral Judgment Interview (Thoma & Dong, 2014) and Rest's (1975) Defining Issues Test (DIT) were not selected for nursing research. Rest (1994) defined the MJI and the DIT as being focused on the individual's capabilities of moral decision making only. Rest went on to state that moral behaviour was

communicated through four psychological components: moral sensitivity, moral judgment, moral motivation, and moral character. Therefore, Rest's (1994) Four Component Model that defined moral behaviour was seen as a more valuable tool for the development of a Moral Competence Questionnaire for nurses. Whilst the researcher did not use Rest's (1975) work, they recognised modifications to Rest's 1994 work (the 4 component model) and saw it as a valuable tool.

Specifically, the measurement scale chosen differed from those found in the literature search. The reason for this difference is explained by the decision to use the same measure scale (Shaw's measurement scale), as it was used in a similar research project designed by the founder of GVV. That is, for the sake of consistency and comparability, Shaw's measurement scale ensured consistency in both research projects while, at the same time, accommodating salient ethical differences between the values of nursing and business students. These measurements were not in keeping with the research being undertaken. As stated, the use of Shaw's measurement scale was used as this was co-written by the founder of GVV. Questions were only slightly changed using nurse/nursing instead of Business as the survey was originally meant for.

2.3 What is moral competence

A moral action is one that is human and responsible and one that is done with knowledge and freedom (Parsons, 2001). Part of being responsible for one's actions is being aware of what one is doing and being aware that it is either right or wrong. Weinert (2001) stated that morality is about responsible behaviour; that is, morality is an understanding of one's actions in the sense of their moral meaning. Weinert also stated that the individual's actions are determined by the kind of reasoning one engages in, the circumstances that surround those actions, and the individual's principles. The focus of morality is on the type of action taken in its entirety, not only on the degree of personal moral responsibility, as Parsons (2001)

identified. That is, the individual must show that they have a sufficient amount of harmony and cohesiveness between their action, the circumstances, and their motivation.

To be able to define moral competence there must first be an understanding of competence. Weinert (2001) understood competence as a system of focussed capabilities, skills that were necessary in order to reach a specific task or goal. Kohlberg (1984) acknowledged that an individual's thoughts come first with their opinions stemming from these thoughts which were ideas the individual had about certain issues. Kohlberg also stated that it was the individual's thoughts that remained constant whilst their opinions remained active. Ma (2012) indicated that moral competence referred to the individual's emotional inclination to perform caring acts as well as the capability to judge moral issues logically. Alternatively, moral competence empowers nurses to think methodically, resolve moral difficulties, and to be able to make ethical choices as well as being able to act morally (Johnston et al., 2004). Park & Peterson (2006) discussed that emotions lay behind many challenging dynamics in both the healthcare field as well as an individual's own personal world.

An individual's moral competence could also be looked at in terms of good character, as a multidimensional form that comprises of many positive virtues that are obvious in the individual's beliefs, feelings, and behaviours. Park & Peterson (2006) stated that it could be said that both competence and character strengths are important components of human development. These authors observed that the structure and development of both competence and character are essential in their own right and suggestive of constructive growth. Aligned with this is the concept of the 'moral compass', referring to innermost beliefs and values that guide thoughts and actions; however, the possibility of objective measurement of the moral compass remains uncertain (Martin, 2010).

Moral competence in the context of professional nursing practice encompasses the capacity for the individual to acknowledge their own feelings (emotions) and to recognise the influence that

emotions have on personal perceptions of what is good or bad in certain situations (Jormsri et al., 2005).   These same authors also state that moral competence requires individuals to reflect on their feelings with self-awareness, to be able to make decisions, and be able to act in ways that bring about the highest level of benefit for patients.   Stated simply, a moral compass is the virtues that help the person communicate which path they should take when a decision has to be made involving right and/or wrong. A moral compass may also be seen as a set of values and ideas that guides an individual in their own ethical behaviours and decision-making (Martin, 2010).

It must be noted that an individual's moral compass may not point in the same direction as another individual's, in as far as right or wrong behaviour or beliefs are concerned. Rather, from a moral compass perspective, Martin (2010) stated that reasoning with regard to both good and bad actions is embedded in universal values and crosses over cultural barriers. Martin goes on to claim that each person maintains their values, but that influences can vary between each person and change as they develop through the lifespan.

Schwartz (1987) discussed the fact that research indicated individuals who have a healthy functioning moral compass appear to be more inspired, grounded, and comfortable with life, therefore more dynamic. Schwartz also noted that such individuals appear to have a more nurturing and positive relationship with people around them as well as their environment. Lennick and Kiel (2005) noted that a moral decision-making process was not dependent on demographic factors such as gender, race, nationality, or religious practice, but that judgment with deference to good and bad is deeply entrenched in universal principles across all cultural barriers.

2.4 Values and moral competence

An individual's personal values influences the way they interact, behave, and deliver care to their patients, As Rassin (2008, p. 614) stated "values lie at the core of the diverse world of

human behaviour and are expressed in every human decision and action". Hill (2006) and Halstead & Taylor (1996) both referred to the term values as principles. Hill (2006) went on to define values as the ideals and practices of a society whereby individuals have a genuine regard for them. On the other hand, they might also be seen as generic and valid across all cultures. Hill (2006) also stated that values may also be expressed as principles and standards that guide behaviour. Halstead and Taylor (1996) saw values as central beliefs, ideals and standards or life views that act as a general guide to behaviour. Behavioural theory holds that values can play an explanatory role and as Hechter et al. (1993) stated, it is values that are considered to be basic in the determinants of social action.

Schank & Weis (2000) contended that being able to provide opportunities for nursing students to explore their own values and those that would be expected of them once a registered professional, was important in their development within a person-centred culture. Smith and Godfrey (2016) identified nursing values as those of care, compassion, communication, competence, integrity, and commitment. Smith and Godfrey also noted that it was courage that enabled the nurse to be able to do the right thing for the patients in their care and to be able to advocate for them, which is an essential element within the caring relationship. Commitment is the cornerstone of nursing, of what nurses do, and it is on this cornerstone that they must build in order to improve the patients care and experience (Johnstone, 2015). Wright (1987) observed that values influenced ethical decision making in three ways: (1) values frame the dilemma and individuals look at a problem on the basis of the values that they bring to the situation; (2) values supply options that individuals contemplate as likely resolutions to problems, and are unwavering on the foundation of the values they relate to their possible actions; and (3) values guide conclusions or thoughts in resolving problems that are framed by what individuals wish to endorse or encourage.

In thinking about an individual's decision-making ability or competence, it can be recognised that the ability, or set of skills required in making decisions, also applies to one's own life. A significant feature of an individual's moral decision making is that they define their values (Wright, 1987). It must also be remembered that all values expressed by individuals might be seen as moral judgments and that these express a little of the values of that individual. Being able to understand one's values and morals requires research into what individuals' value most, and why they do so. Cline (2019) undertook studies that revealed there were three primary categories of values that individuals possess: preferential values, instrumental values, and intrinsic values. Each value played a significant part in the life of the individual but were not equal in the development of the individual's growth of their moral standards and norms. Cline (2019) understood preferential values as the expression of principles that individuals hold and respect, with some of these moral concepts not seen as important by other individuals. In relation to the instrumental value, Cline stated that an individual values this as it is a process of achieving something which they felt was important. This value is one where an individual's moral choice may lead to the best possible outcome for that person. The third value that Cline considered was that of an intrinsic value which was valued for itself and was not used as a means to another end or preferred above other possibilities.

Value pluralism must also be considered. Benner (1985) states that nurses received a lack of educational guidance to take on self-direction in relation to their own moral decision making.

McCarthy (2006) looked at the pluralist views of moral competence in nursing and stated that the pursuit of moral agreement or a distinctive moral framework for nursing could be replaced by working purposefully with different frameworks in order to develop the moral agency of nurses and to respond to the variety of views amongst nurses, patients and families. McCarthy states that a pluralist view can be seen as a non-aligned position on nursing ethics in relation to

moral frameworks. She sees this stance as being neutral vis-à-vis the conjectural theories underlying moral decision making.

The pluralist view, as McCarthy (2006) states, acknowledges that forming moral decisions can often be complex and that one's moral decisions are not certainties but are developmental over time and in response to professional experiences.

The task, therefore, within moral education in nursing curricula is to promote a range of moral competence and knowledge that will expand students' moral decision making in order to be able to consciously draw on what is most applicable for the situation at hand.

In examining current literature addressing how values make the individual morally competent, a gap appears to exist in this area of knowledge. Research undertaken by Enderle et al. (2018) stated that moral competence could be understood as an individual's capacity to be able to make choices and to interrogate moral decisions guided by their own inner values, and then acting in line with those decisions. Enderle et al. (2018) emphasised that one's principles might be seen from a cognitive viewpoint, and further, an individual's morality and their moral growth is not determined by their socialisation. The individual's principles must be seen as an attribute of their capabilities; thus, with this in mind, morality can be developed and enriched, so long as there are both developmental approaches and openings that allow for this development to happen. With added clarity, Haidt (2012, p. 270) defined morality as a system of "interlocking sets of values, virtues, norms, practices, identities, institutions, technologies, and evolved psychological mechanisms that work together to suppress or regulate self-interest and make cooperative societies possible". Haidt (2012) also acknowledged that the virtues an individual acquired were able to control their ability to react to moral situations in a spontaneous or anticipated way.

2.5 Moral competence and social theory

Social theory embraces broad methodologies that strive to discover and clarify the nature and changing aspects of social reality, as well as providing probing frameworks or patterns to analyse social occurrences and facts (Porter, 1998). Harrington (2005, p. 5) stated "social theory produces ideas about societies and social change, about the methods of clarifying social behaviour, about power and social structure, gender and ethnicity, modernism and civilisation, revolutions and utopias". Elliott (2014) observed that in contemporary social theory, some central themes take precedence over others; ideas such as the character of social life, the link between one's self and society, the structure of social groups, the role and expectations of social change, as well as themes such as gender, race and class. Archer (1995) discussed the fact that social theory had to be useful and practical and that it was not a means to an end. There were a number of theoretical approaches within social theory where the phenomenon of moral competence had been explored, these approaches included: psychoanalytic, behaviourist psychology, cognitive psychology, integrative psychology, and cultural-historical frameworks.

The central theorists contributing to moral competence literature and research examined in this chapter are Lawrence Kohlberg, Carol Gilligan and Nel Noddings. In looking at these three main theorists, a clear focus was on the changes observed across both time and experience in how people were able to understand right and wrong. Kohlberg presented a theory of moral development across the life span, congruent with Gilligan's theory of moral deliberation that has been espoused as reflective of the nursing profession's ethical orientation (Gilligan et al., 1990). Noddings' (1998) ethic of care was devised to guide the teaching of moral education in schools; subsequently, it was embraced by those involved in nursing education as well. Jorgensen (2006) examined the theories of moral development from both Kohlberg and Gilligan and stated that these theories were frequently used as theoretical frameworks in writings on the moral development of nurses.

2.5.1 Laurence Kohlberg (1927-1987)

Lawrence Kohlberg, an American developmental psychologist, unlocked the thinking of both psychologists and educators in describing the changes in people's moral thinking as they grew, and how these changes continued to follow the normal stages of the individual's development (Snarey & Samuelson, 2008). Kohlberg's 1984 stage theory was the most important theoretical contribution concerning moral development at the time. Although Kohlberg's theory had been critiqued at length (Dawson, 2002; Eddy, 1988), it still remains the foundation for social theory today.

Kohlberg developed methods of moral education by employing adult role models to exemplify interactions with colleagues. In turn, moral problems raised within those interactions formed the bases of discussion. Lawrence Kohlberg's key impact on moral education was his interpretation of the six stages of moral development. Kohlberg's theory emerged as being both philosophical and psychological (Rest, 1994). Looking at the theory from a philosophical perspective it can be understood that Kohlberg utilised culturally universal (Rest, 1994) stages of moral growth. Notwithstanding its individualistic focus, this approach was thought to be relevant to all culturally or socially defined groups, regardless of the individual's religion or beliefs which may otherwise influence their moral reasoning. (Rest, 1994). In describing his work as psychological, Kohlberg (1969) stated that an individual passes through consecutive stages of development across their lifespan. These stages can be both observed and developmental in that a person can be encouraged into development through the stages, each stage being more complex and thoughts more sophisticated (Kurtines & Gewirtz, 1995). In Kohlberg's (1969) model, moral development is the development of an independent self, capable of being encouraged by abstract values which could be understood as a kind of "mathematical" solution to conflicts of interest. This model was influenced by Western philosophical practice, predominantly the practices of Socrates and Kant. Kohlberg's work is

characterised by his concept of justice which he held to be the most motivating model of ethical good (Kohlberg, 1969). On further consideration, Hersh (1979) stated that like Kohlberg (1969), most forward-thinking moral reasoners believed that the value of life and the equality of one's human rights must take precedence over all other values, and they must try and resolve encounters that would end in injustice.

Kohlberg's theory had been the most significant among the modern moral development theories, but it has been criticised considerably and is limited to cognitive aspects of moral decision making (Dawson, 2002). Kohlberg (1973) stated that there was a difference between knowing what one ought to do, versus what one did. Kohlberg further states that moral reasoning may not necessarily lead to moral behaviour. Kohlberg saw the purpose of moral judgment as being a cognitive process which allowed individuals to be able to reflect on their own values and then amalgamate them into a rational order. Moral reasoning was based on traditional rational thinking. Kohlberg's theory embraced the idea that moral reasoning was the basis for ethical behaviour. The six developmental stages that Kohlberg presented were responsive to reacting to moral dilemmas. Kohlberg (1981b) observed the development of moral judgment in a broader age differential to that undertaken by Piaget, who also argued that reasoning and morality develop through constructive stages. Kohlberg (1981a) expanded on Piaget's work and determined that moral development was primarily concerned with justice and that this continued throughout the individual's life. Kohlberg offered a more comprehensive stage classification for moral reasoning than Piaget who discussed only two stages of moral reasoning with the second stage developing in early adolescence (Crain, 2010).

Kohlberg's cognitive methodology was in contrast to other theorists of the time, namely Freud and Mill, who theorised moral knowledge as a distinctive understanding of self. Kohlberg reached his theory through empirical research that was supported by Dewey in the late 1960's (Eddy, 1988). There had been significant examination of Kohlberg's moral belief including the

notion that a person's moral reasoning progressively changes over time, and that moral reasoning was primarily determined through cognitive processes. Duckett et al. (1997) stated that the development of a person's moral reasoning does not only develop as an individual gets older; they go on to state that an individual's level of moral reasoning increases when the person participates in formal education and, further, that moral reasoning influences a person's moral behaviour. Although Kohlberg identified that his moral reasoning theory was a modification of Jean Piaget's and John Dewey's approaches, Eddy (1988) suggested that Kohlberg had misconstrued Dewey's approach.

Piaget's (1997) theory regarding cognitive development. had a strong influence on future theories of development. Piaget argued that all children develop through three stages in which they develop concepts that assist understanding of the world around them. Eddy (1988) discussed the commonalities in studies undertaken by both Kohlberg and Piaget and the methods which indicated how Kohlberg demonstrated that not only did Dewey propose three levels of moral reasoning, but that these levels resembled his own three levels as well. Kohlberg (1975) adapted Piaget's work, verifying that the development of individuals reaching a certain level of moral maturity was longer and more gradual than Piaget had predicted (Eddy, 1988). In the late 1960's Kohlberg proposed that few people reach moral maturity. This can be seen in Kohlberg's (1969) data gathered mainly from boys who had experienced moral dilemmas, wherein Kohlberg speculated that a person held little ethical/moral reasoning until the age of thirteen.

Kohlberg was a close follower of Piaget, and Kohlberg's theoretical position on developmental change reflected those of Piaget. Crain (2010) stated that Kohlberg regarded his stages of development not as a formation of development that simply evolves as an inherited plan does, neither did he maintain that his developmental stages are a creation of socialisation, directed by parents and teachers. Instead, Kohlberg (1976) stated that the stages develop from an

individual's own thinking about a moral situation, and that social experiences promote

development by stimulating one's mental processes. As individuals develop through

discussions and arguments with others, they find their views questioned and challenged and, as

a result are motivated to come up with new positions (Kohlberg, 1976). Kohlberg spoke of

change arising through role-taking opportunities wherein people reflect on their points of view.

As individuals interact with each other they take on board different viewpoints and learn how

to categorise these thoughts through practice; through discussion and role play they are able to

develop their own ideas of what is fair and just.

Table 1: Comparisons of Kohlberg's Stages of Moral Development and Piaget's Stages of
　　　　Cognitive Development

Piaget - Stage	Age Range	Kohlberg – Level Stage	Age Range
Sensorimotor (Coordination of senses with motor responses, sensory curiosity about the world.)	0 – 2 years	Obedience/Punishment (No difference between doing one thing and avoiding punishment.)	Infancy
Preoperational (Symbolic thinking, Imagination and instinct are strong Complex abstract thoughts are still difficult.)	2 – 7 years	Self – Interest (Interest shifts to rewards rather than punishment.)	Pre School
Concrete Operational (Moral concepts attached to concrete situations.	7 – 11 years	Conformity and　Interpersonal Accord (The 'good boy/girl' level. Effort is made to secure consent and preserve friendly relations with others.	School Age
Formal Operational	11 years and older	Authority and Social Order (Positioning towards fixed rules. The purpose of morality is maintaining social order. Interpersonal consensus is extended to include the entire society.)	School Age
		Social Contract (Morally right and legally right are not always the same. Effective rules which make life better for everyone.)	Teens
		Universal Principles (Morality is based on principles that go beyond mutual benefit.	Adulthood

Source: adapted from Roervik (1981)

Although Kohlberg's stages of moral development are not direct equivalents of Piaget's stages

of cognitive development, it is clear that Kohlberg was influenced by Piaget's work. In

comparing both theories (see Table 1), it is clear that an individual's descriptive perceptions of

the world around them influences their sense of what they should do within that world, which involves their normative views (Kohlberg, 1976). From the viewpoint of both Piaget and Kohlberg, moral development can be seen as a change in reasoning patterns regarding moral issues, such as the person's perspective on rule breaking. In turn, moral development influences behaviour in response to facing moral dilemmas.   Kohlberg (1984) agreed that the possession of moral competence reflects not only how an individual thinks about moral dilemmas and how these might be resolved, but also about their own moral behaviour. Kohlberg (1981, p. 175) saw moral goodness, as being "firmly grounded in the human condition, in the reality of the moments and the interactions of our lives". Kohlberg (1984) proposed a developmental method of moving to higher levels of moral functioning; he set out a more defined model of stages. Kohlberg was neither concerned with what an individual was actually doing, nor with the individual's account about whether something was right or wrong, but how moral maturity had evolved from the reasons the person had given in regards to right and wrong (Kohlberg & Turiel, 1971).

Kohlberg determined that people were able to grow in their moral reasoning through a sequence of six recognisable stages classified into three levels, and he developed a set of general stages of moral thought "that can be defined independently of the specific content of particular moral decisions or actions." (Kohlberg, 1984, p.16). Kohlberg's theory emphasised the six chronological stages of change which can be seen within the three levels of moral development (pre-conventional, conventional and post-conventional) which he believed roughly classified how children, adolescents and adults view the world (Jenks, 2000). The first level of development, as described by Kohlberg, was the pre-conventional stage which demonstrated thinking which was concerned with rewards, negotiating, and anxiety and intimidation of reprimand. This stage appears from birth to about nine years of age. The second, or conventional level, spans the age range from 10 to 20 years. This stage deals with

the maintaining and following of directions and rules of the individual's family, group, or country. People in this age range become aware of social expectations as well as the purposes behind their actions that must be considered in their decision-making processes. The last level, the post-conventional level, ranges from the age of twenty onwards. Individuals at this level are capable of making moral judgments based on equitable thinking and shared ideals of right and wrong that are independent of beliefs and are able to balance the person's own moral values against what is best for the common good (Jenks, 2000). Kohlberg observed that people progress through these stages universally, whilst acknowledging that diverse societies hold different beliefs (Kohlberg & Gilligan, 1971). In summary, Kohlberg's (1981a) six stages are:

1. The individual observes rules to evade punishment. In this stage, egocentric thinking is used to develop the understanding of consequences.

2. The individual conforms to attain rewards, and in turn have favours repaid. Empathy and respect for others would only be exploited to achieve reward in this stage. Individuals at this stage identify that there is not just one correct view. Pleasure seeking behaviour is also noticeable in this stage.

3. The individual conforms to avoid disapproval and dislike by others. The individual is good in order to be perceived as being a good person by others. Therefore, reactions relate to the approval of others.

4. The individual conforms to avoid criticism by authorities and subsequent blame. The individual becomes mindful of the wider rules of society, so that decisions concerned with obeying rules are made in order to uphold the law and to avoid guilt. Kohlberg stated that here individuals accepted and followed rules without question with the aim to avoid any punishments from authority figures.

5. The individual conforms in order to retain the respect of unbiased onlookers. The individual becomes aware that while rules or laws might exist for the good of the greatest number, there are times when they will work against the interest of particular individuals. Rules and laws are tested and can be subject to change. An individual's rights and limitations are thought to define morality and values of society are held in greater respect than law and order.

6. The individual conforms in order to avoid self-condemnation. At this stage individuals are thought to have developed their own set of moral guidelines which may or may not fit the law. Kohlberg also stated that morality was grounded on the general ethical principles of moral behaviour, as individually determined.

Of these six identifiable stages Kohlberg argued that they could be more generally classified into three levels where the first level is usually found at school, the second level generally found in society, and the third level not reached by the majority of adults (Barger, 2000). These stages Kohlberg saw as "planes of moral adequacy conceived to explain the development of moral reasoning" (Kohlberg & Mayer, 1972. p. 450). Kohlberg (1981, p. 16) developed these stages of moral thought "that could be defined independently of the specific content of particular moral decisions or actions" and that these stages were "process-oriented and as such are not guided by content specific virtues such as integrity and kindness which are the hallmark of the various value-relativist schools of thought" (p. 69). These stages appealed to a model of morality that was embedded in impartial values and not specific characteristics or directions. Kohlberg (1981, p. 19) gave an example stating that an individual should only act as though the act should become a universal law. Kohlberg (1981, p. 69) identified this as, "a guide for choosing among behaviours, not a prescription for behaviour, and as such was free from culturally defined content; it both transcends and subsumes particular social laws, hence it has universal applicability." In their review, Dierckx de Casterlé et al. (2008) indicated that when the application of Kohlberg's (1981) moral development stages were applied, there

appeared to be more weight attached to the third and fourth stages then to the post-conventional argument which were stages five and six. Kohlberg's model of the development of morality is valuable as it contains tangible situations, as well as ways to act in both the present moment and in the human and social world. Kohlberg (1981, p. 175) stated,

> "…In my view, mature principles are neither rules (means)
> nor values (ends) but are guides to perceiving and integrating
> all the morally relevant elements in concrete situations. They
> reduce all moral obligation to the interests and claims of concrete
> individuals in concrete situations; they tell us how to resolve
> claims that compete in a situation when it is one person's life
> against another's".

Kohlberg, like his European predecessors, believed that reason was the ability that people possessed by virtue of being human. He maintained that instinct and reason differed in important respects, and that reason was the reliable means for solving moral problems. This stands at the heart of Kohlberg's model of moral development and relates to an individual's cognitive development (Kohlberg, 1981).

For Kohlberg (1984), the moral person was a person who actively worked to develop both themselves and the society in which they lived, and in order to do this, people must refer to principles of morality that they identify through their ability to reason. Kohlberg et al. (1983) believed that individuals arrived at this point through the development of consciousness, which in turn, had its origins in the individual's conscience. Kohlberg (1981a) emphasises that an individual's reasoning occurs when the individual determines whether something they want to do is either right or wrong. The theoretical focus is on how that individual chooses to react to the moral dilemma and not what they essentially do (Kohlberg, 1976). In response, Crain (2010) stated that Kohlberg's stages of moral development could be described not as a one-way progression of emotional growth but as a classification of altered types of moral values. Overall, Kohlberg provided a complex theory of moral development including the integration of people's thoughts, feelings, activities, and growth (Turiel, 2008).

Gilligan (1982) claimed that Kohlberg's theory overlooked the ethical motivation that came from caring. In relation to care, Brown et al. (1995) stated that Kohlberg accepted the existence of a care viewpoint in a person's moral thinking, and that care had been incorporated into justice thinking, with the voices of both care and justice characterised in the post-conventional level (Bebeau & Brabeck 1987). Objections to Kohlberg's theory have been raised, such as by those who claim that while it was comprehensive, it was lacking in a range of respects. Overall, critiques of Kohlberg's theory stated that it was comprehensive but remained lacking (Bebeau & Brabeck, 1987; Fleming, 2006; Vozzola, 2014). Crain (2010) proposed that an inclusion of other influences, such as culture, religion and empathy would deliver a wider and far-reaching picture to the understanding of moral development. One of the most significant critiques of Kohlberg's theory was put forward by Carol Gilligan (1982). Her theoretical contributions have valuable relevance to the profession and practice of nursing.

2.5.2 Carol Gilligan (1936 -)

Carol Gilligan, a member of Kohlberg's research team, believed that Kohlberg's theory better described the moral decision-making processes of men than those of women (Barger, 2000). Gilligan (1982) stated that studies on psychological development, commencing with Freud, had been shown to primarily use men as subjects, and that when moral developmental theories were applied to women, women were seen as lacking and deviant. Gilligan (1982) went on to emphasise that it was not the women who were lacking but, instead, it was the grounding of research, exclusively, in the original investigator's male perspective. Gilligan proposed a stage theory of moral development for women emphasising that the transitions between the stages were fuelled by changes in the sense of self, rather than in changes in cognitive capability.

Gilligan et al. (1990) saw moral development as encompassing prosocial behaviour, such as caring, helping and altruism, along with characteristics such as honesty, fairness, and respect. In Gilligan's (1982) model, moral development could be seen as the development of a self-in-

relation, with morality being understood in terms of preservation of valuable human relations, and that progress from stage to stage was motivated by an understanding of human relationships. Gilligan's theory of the stages of moral development challenged researchers who had extrapolated findings from studies on developmental changes in boys to persons in general. Gilligan (1982/1993) maintained that women sometimes dealt with ethical problems differently than men. Therefore, when looking at any moral development theory that primarily focussed on boys, girls were seen as being less forward-thinking in their ethical reasoning than boys. Gilligan provided an important alternative to this view and felt that the moral development of women was not represented within the moral development theories of the time. Gilligan proposed that women's moral development was challenging to theorists because it did not reproduce the values of men. Women's experiences and how they lived their lives differed to those of men, and their moral voices differed, and a woman's experience of moral growth also differed from but paralleled that of men (Gilligan et al. 1988).

Gilligan (1987) maintained that the representation Kohlberg used to categorize styles of moral thinking in terms of cognitive competence mirrored a typically male tendency to highlight the value of impartiality when faced with a moral problem. Gilligan (1982) linked Kohlberg's theory with other philosophers and psychologists in Western intellectual thought (e.g., Augustine, René Descartes, Jean-Jacques Rousseau, and Sigmund Freud) who all portrayed the moral development of women as restricted, substandard and, even, childish.

In summarising the comparisons and differences between Kohlberg and Gilligan, it can be seen that Kohlberg developed his theory from Piaget's work and that Gilligan developed hers in response to Kohlberg's work. Both Gilligan and Kohlberg's models are progressive; an individual completes one stage before moving onto the next one. Kohlberg et al. (1983) claimed that his theory of Cognitive Moral Development encompassed both care and justice, but according to many commentators, Kohlberg assumed that justice was prior to care and in

order to be caring, a person needed, firstly, to be just. Gilligan would claim otherwise (Kohlberg & Gilligan, 1971). Nonetheless, Kohlberg and Gilligan's models both have a foundation in cognitive developmental theory.

Gilligan (1982) suggested that Kohlberg's theory did not define moral development in girls, arguing that female children pass through different stages. Men's development begins with self-centred, self-interest and moves in the direction of greater dependence on theoretical principles of justice. Whereas women's development progresses from self-interest toward a balanced concern for their own welfare and that of others (Gilligan, 1982). Gilligan (2014) distinguished that women's moral thinking centred on the needs of people, whereas Kohlberg granted prior place to a concern for individual rights and rules over and above that of caring within human relationships (Gilligan, 2014). In Gilligan's thinking the male voice highlighted individuality, or separation and responsibility for oneself, and the female voice emphasised interdependence or connection and responsibility to others (Gilligan & Attanucci, 1988). In their supporting research, Gilligan and Attanucci (1988) determined that both men and women are able to use both justice and care orientations, but that men tended to settle nearer a justice orientation, whereas women tended to settle nearer a care orientation. They further established that women appeared to be more willing or able to recognise the demands of justice than men were willing or able to recognise the requirements of care.

Gilligan asserted that just as the ethic of justice established a developmental structure, the ethic of care also did (Donleavy, 2008). Donleavy went on to state that Gilligan saw moral development as involving three main levels of care with two intermediate ones; from initial self-concern, moving to select other-oriented concern, to the final balanced concern for both self and others. Whilst there were differences in the moral development of men and women, these differences did not amount to deficits in women's moral development. Rather, Gilligan

(1982) argued that the characteristics of women's moral reasoning were strengths rather than weaknesses.

Gilligan's three-level stages of moral development (Gilligan & Attanucci, 1989) recognised different values and beliefs associated with each stage. She believed that women's development of a sense-of-self played a greater role in one's decision making than reasoning. The three levels are:

1) Pre-conventional stage: individuals make decisions in their own best interests irrespective of the needs of others; choices are made constructed on what is practical and best for themselves.

2) Conventional stage: During this stage, a female develops a sense of responsibility for others. Morality is associated with goodness and self-sacrifice.

3) Post-conventional stage: Achievement of this level of moral development sees women realise that their needs are equivalent to others. The focus shifts from being "good" to distinguishing worldwide truths (Gilligan, 1982).

Gilligan's contribution to the understanding of moral development has been recognised by Kohlberg and others (Levine et al., 1985; Marturano & Gosling, 2008), however, criticisms have emerged. Kohlberg argued that Gilligan overstated gender differences in moral reasoning. Reed (1997) observes that both Gilligan and Kohlberg offered concepts of moral development that were unclear and that Kohlberg's idea of compassion in the sixth stage was similar to Gilligan's mature stage. Gilligan (1982) also argued that both men and women reached different stages of moral development at different times. For women, morality centres not around privileges and rules but on interpersonal relationships and the ethics of compassion and care. She contrasted her morality of care with Kohlberg's morality of justice, critiquing his work as biased (Dubas et al., 2014). Further, Donleavy (2008, p. 815) believed that "moral behaviour is situational". Kohlberg understood Gilligan's position of care as expanding the social thinking of principles instead of rejecting the distinctive sphere of justice confined by

42

moral decision. Donleavy (2008) furthered identified that Gilligan concentrated on behaviour, whereas Kohlberg perceived this as being situational. Kohlberg's focus was on decision making which he believed to be cognitive and general and that it is brought to behavioural situations as a convenient method to use in different situations (Donleavy, 2008).

Gilligan's (2014) theory focused on both care-based morality and justice-based morality going on to propose the Stages of the Ethics of Care theory, which addressed the issue of what makes actions 'right' or 'wrong'.   Gilligan (2014. p. 101) stated that "it is difficult in this contemporary age to speak of an honest voice, and that cultural differences in today's world complicate the search for moral truth". Gilligan (2014, p. 101) went on to state that "care is a feminist, not a 'feminine' ethic, and feminism, guided by an ethic of care, is arguably the most radical, in the sense of going to the origins of the liberation movement". Her research defined a method through which women viewed the creating of moral choices in a dissimilar way and with a different "voice", the "voice of care". Voice, as Gilligan (2014) defined, was a sense of self and how one made meaning of the world.

In summary, notwithstanding similarities, there remain significant differences between Kohlberg and Gilligan's moral development theories. These differences, as synthesised through this literature review, have been drawn together in Table 2.

Table 2 Kohlberg versus Gilligan's stages of moral development.

Kohlberg's six levels of moral development (Ethics of Justice/Rights)	Gilligan's six stages of moral development (Ethics of care)

Pre-conventional level
  Stage 1: Deferring to authority
  Stage 2: Learning to satisfy one's
          own needs
	Pre-Conventional level
	  Stage 1: Caring for the self
	  Stage 2: Concern judged to be selfish

Conventional Level
  Stage 3: Conforming to stereotypical
          roles
 	
  Stage 4: Sense that individual roles
          contribute to social order
	Conventional level
	  Stage 3: Goodness is caring for others,
	          frequently equated with self-
	          sacrifice
	  Stage 4: Illogic of the inequality between
	          self and others become evident.
	          Search for equilibrium

Post-conventional level
Stage 5: Morality thought of in terms of
          rights and standards endorsed
          by society as a whole
Stage 6: Morality thought of as self-
          chosen, universal principles of
          justice.
	Post-conventional level
	Stage 5: Focus on the dynamics of
	          relationships, to eliminate the
	          tension between self and others
	Stage 6: Care is extended beyond personal
	          relationships to a general recognition
	          of the interdependence of self and
	          other, accompanied by a universal
	          condemnation of exploitation and
	          hurt.

2.5.3 Nell Noddings (1929 -)

Nell Noddings is an educational expert (Maxwell, 2014), whose work (1984) builds on the work of Gilligan to construct an ethic of caring which finds its highest ideal in her conceptions of empathy and kindness

Specifically, Noddings' ethic of caring is founded in the caring relationship (both carer and cared for) as distinct from the individualist perspective of the singular moral agent. In this sense, the ethic of care stands in noticeable difference to Kohlberg's theory. Noddings is not concerned with the value/virtue of care (the character of the carer) as such but, instead, with the strength of the caring relationship. Noddings (1984) stated that Kohlberg's moral theories rested on purpose and were lacking emotional aspects that formed part of a person's ethical decision-making. She believed that what was absent from Kohlberg's theory were the notions

of understanding, emotion, and compassion.   Noddings' work thematically complements that of Gilligan (1982), noting that caring is a major component of morality. Noddings does not construct a methodology for moral development but, along with Gilligan, does provide ideas on moral education (Swanger, 1993).

In her feminist model, caring was a comprehensive social practice that was the basis for good moral education (Crigger, 2001).   Noddings theorised this caring process into three phases: "fixation where the person chooses to direct mental attention to the other; emotional receptiveness toward the other ('sees through the other's eyes') and choosing to respond to the moral imperative to help the other" (Crigger, 2001, p. 616). The Ethics of Care Theory sees caring and attachment as foundational, in sharp contrast to the amalgamated position in Kohlberg's Stage 3 of Cognitive Moral Development. For Noddings, moral education has four major components – modelling, dialogue, practice, and confirmation. In using this framework, Noddings (1984) stated that it was not teaching principles and ways of applying them to problems, but rather a way of showing individuals how to care in their own relations. In Noddings' (1984) theory, there were two points where ethical choice occurs, the first occurrence was when an individual elects whether they do or do not want to become immersed in a situation. If the individual separates their self-concerns and becomes immersed with another, then they open themselves to being empathetic (Crigger, 2001). The second choice is informed by a decision to follow one's own interests or, alternatively, to act so as to meet the needs or concerns of the other (Crigger, 2001). In short, "to care is to act not by fixed rules but affection and regard" (Noddings, 1984, p. 245).

Noddings' contribution to a feminist ethic of care is substantial and she writes from her own viewpoint as an educator (Newman & Polinitz, 2005). Noddings' ethic of care ranges outside the area of family and significant others and goes into the public world of care for all individuals, plants, animals, the environment, instruments, and ideas (Noddings, 1984). For

Noddings (2002b), ethical caring was recommended for the establishment, renewing or development of the kind of relations whereby an individual reacts instinctively because they want to do so. She understood the ethic of care as being continuously open and amenable to the wants and needs of the other person in the relationship.

An ethic of care is a needs and response-based ethic that challenges many principles of customary ethics in moral theory (Newman & Polinitz, 2005). Noddings (1984) stated that one does not tell the individual how to care, but rather shows them, through creating caring relationships. Her ethics of care is different from the more traditional principles of ethics as she views the moral person existing only within relationships (Noddings, 2002a). For Noddings, caring is a relationship, not something that can happen individually (Crowley, 1994). Noddings' research revealed that the caring reaction was continually dependent on a move away from the self and stated that "at bottom, all caring involves engrossment" (Noddings, 1984, p. 17). Noddings (1984) acknowledged that caring was responsive and approachable, caught up in the moment, and that caring was a changeable response that was focused on the wants of individuals, rather than a response directed behaviour. According to Noddings (2013), caring is a moral practice, it is not imperative as to how an individual cared, *but that the individual did care*. It is this idea of caring for others that echoes the social nature of moral self-understanding. That is, belief in the need for the socialisation of moral feeling that:

> "…the ethical self is an active relation between my
> actual self and a vision of my ideal self as one - caring
> and cared-for. It is born of the fundamental recognition
> of relatedness, that which connects me naturally to the
> other, reconnects me through the other to myself. As I
> care for others and am cared for by them, I become able
> to care for myself" (Noddings, 1984, p. 49).

There were four main features noted in Noddings' (1984) Ethic of Care Theory. These aspects noted that moral decisions were part of everyday life; that individuals reacted to their own needs as well as those of others, there was definition of right from wrong and that there was understanding of the emergent views of others. Noddings did not abandon general moral principles altogether but found them to be limited when bearing in mind the moral decisions that are part of normal everyday life experiences. Noddings (1984) thought that acting sensibly in particular situations meant responding with care and empathy when deciding what to do and how to do it in the best way.-Acting sensibly in particular situations meant engaging in thinking along with care and empathy when deciding what to do and how to do it in the best way. Noddings (2002a) concurs with the Kantian "golden rule" that one was to do unto others as they would want done to themselves. It was important, moreover, to introduce the circumstances that would most likely uphold an ethical life, and that would produce situations where individuals would want to make moral choices, and where they might want to work towards a place where the majority of individuals would be morally good (Noddings, 2002b).

Noddings (1984, p. 72) emphasised the exchange in the caring relationship in the following way:

> "…the caring-one offers help, support, guidance for the cared-for
> one and the Cared-for one reciprocates by recognising the care
> and by responding to the Caring-one. The caring-one accepts
> the gift of responsiveness for the cared-one but does not demand
> it as that would be inconsistent with the notion of caring.
> The cared-for then, has the freedom to respond as themselves".

In regards to the continuing gender differences debate, Noddings stated "that it was whether or not women are by nature more caring than men is not the point, the point is that women have a tradition of care….care was a societal exercise and everyone wanted to be cared for or involved in the caring relationship" (Noddings (1984, p. 10).

2.5.4 Noddings and Kohlberg – contrast and congruence

Noddings (1984) stressed that Kohlberg's moral theories rested on reason and lacked an explanation of the role of emotions that colour an individual's moral decisions. Missing from Kohlberg's (1981) model was caring, empathy and feeling, Kohlberg (1981) suggested the presence of a shared capability, while Noddings (1984) believed that there was an innate capacity in everyone: the care response. That is, ethical caring was based on moments of natural caring. The moral theories of both Kohlberg (1981) and Noddings (1984) are both important contributions to theories of moral development.   Notwithstanding their significant differences, Noddings (1984) and Kohlberg (1970a) both acknowledged that individuals must discover purpose in their own lives before they are able to find it through helping others.

2.5.5 Gilligan and Noddings – contrast and congruence

The ethics of care was shaped in the early 1980s and both Gilligan and Noddings challenged the work of Kohlberg. This idea specifically incorporated a feminist perception of moral development, which explicitly emphasised the influence of personal relationships on observed responsibilities and obligations (Lachman, 2012; Sander-Staudt, 2011). Both Noddings and Gilligan highlighted the importance of the Ethics of Care, and their contribution contributed greatly to the feminist Ethic of Care Theory. Gilligan (1982) saw the male moral decision-making process as being concerned with justice, whereas women's moral decision-making process was concerned with relationships (Newman & Polinitz, 2005).   Gilligan also observed that if men are required to make a moral choice, they become focussed upon the rightness and fairness of the situation, whereas women would look at the same situation in light of how they could best preserve and nurture the particular human relationship (Newman & Polinitz, 2005). Gilligan (1987) saw care as a moral concept separate from justice and thought that moral development needed to include both justice and care.

The ethics of care is seen as a feminist theory, and this theory progressed from being thought of as a practice originating from women's morality that was supported by values such as empathy, agreement and protective love, to care being understood as a broad social practice.   Both Noddings and Gilligan's ethic of care theory relating to practice originated from the caregiver's knowledge and drive. For Gilligan this remained within the secluded sphere of family and friends, whereas Noddings's emphasised the importance of providing educational involvement that is entrenched in the theory of an ethics of care (Gilligan,1993; Noddings, 1984). Gilligan's concept of the ethic of care was connected to women's routines in daily life (Gilligan, 1990). Noddings (1984) on the other hand, stated that women had a tradition of care especially where that care was connected to practice in everyday life e.g. family and significant others as well as extending this care to global concerns. Noddings saw this care as social practice, or as a willingness to be open and welcoming to the needs or wishes of others. She also indicated that it was essential to be responsive to the needs or wishes of others acting on the basis of reason with compassion (Gilligan et al., 1990).

Card (2020), Hoagiand (1990), and Houston (1990) all stated that there had been criticism of Noddings' work which had come mainly from other feminist researchers. These criticisms were not levelled at Noddings' fundamental aspects of ethics, but were about the moral self being located or founded in relationships with others. Crowley (1994) stated that Noddings ethics spoke of the lived experience of women embracing features of the human situation that were significant to both women and men. Crowley (1994) identified that concerns had been raised by researchers that were based on their efforts to use Noddings' ethics within existing social, political, and economic contexts of both men and women. These researchers maintained that this perspective continued to be repressive for women, and they believed that Noddings had not sufficiently addressed this concern. Nonetheless, Noddings' (1984) acknowledges that a moral

theory useful to women should serve to eliminate, to a small degree, the repressive situations of their lives.

In summary, the models and theories considered in the development of moral competence are Kohlberg's Theory of Moral Development, Gilligan's Theory of Women's Moral Development, and Noddings' Ethics of Care. Kohlberg's understanding of moral development holds a prior place for the notion of autonomy; it equates physical maturity with moral maturity (McKenzie & Blenkinsop, 2006). Alternatively, Gilligan and Noddings both hold a central place for the notion of care in ethical evaluation. They also stress the gendered nature of moral reasoning, a matter of significance to nursing. Notably, the ethical codes and standards that inform nursing professionalism reflect the theoretical assumptions of both worldviews, where duties, principles and respect for individual autonomy are promulgated alongside the values of care, empathy and the moral significance of the caring relationship. Gilligan (1982) identified that the ethic of care represented the moral reasoning and values of women whereas the ethic of justice better characterised the moral thought and values of men. The gendered nature of nursing has close connections to Gilligan's work. Noddings' moral theory, the ethics of care, is another approach to moral education and the development of the caring relationship. The Ethics of Care is recognised today as thinking about care as the context, along with relationship issues as an important component of morality" (Skoe, 2014).

2.6 Moral competence in nursing

The nursing profession requires increasing competence of its practitioners at all levels because competent nursing practice in the pursuit of health is expected by society (Jormsri et al., 2005). According to Parsons (2001), competence signifies the application of knowledge and the skills required of nursing professionals. The developing and dynamic practice of nursing also requires nurses to have both professional and ethical competence and to deliver best care to all those they attend.

Many studies have been undertaken over the last 15 years in regards to nursing ethics, though these studies have not looked at the components of moral competency. These studies looked at the elements of knowledge and skills, along with the capabilities of the individual, all of which are essential to moral competency. Recent studies have explored the concept of moral competence and nurses (Zafarnia et al., 2017; Axley, 2008; Martin, 2010; Kulju et al., 2016; Jormsri et al., 2005; Ericson et al., 2007 and Mahasneh, 2014). For instance, Zafarnia et al., explored the scopes of moral competency of nurses, where the authors considered that "morality is teachable, that changes can be proposed and applied within nursing curriculum in order to demonstrate better moral competency" (Zafarnia et al. 2017, p. 2). They understood competence to include clinical, moral, and public competence, and that nurses would be better situated in contributing to decision-making processes through the development of moral skills during their undergraduate training. At an International level, the European Commission defines moral competency as the "meta-competency……an integral part of the knowledge and skills, and competence is an essential component for development of accountability and independence" (Zafarnia et al., 2017, p. 2). The World Health Organization also stated that moral competency must be seen as a fundamental skill of healthcare professionals (Axley, 2008).

Ericson et al's study in 2007 presented the argument that moral competency must comprise both morality and moral preparation, both of which necessitate the individual to have some ethical knowledge. Kulju et al's. (2015) study detailed that moral character and personality added to the individual's scope of moral competency, whilst Jormsri et al. (2005) identified the areas of moral perception, moral judgement, and moral behaviour as necessary aspects of moral competence. Mahasneh's (2014) study defined moral competence as a form of humanitarian behaviour and judgement which not only led to the delivery of quality care but, also, to nurses' own professional satisfaction. Martin's (2010) study also considered the

concept of moral competence as humanitarian conduct, having the moral qualities that enabled access to developed stages of acknowledgement and mental competencies. Jormsri et al. (2005) and Kulju et al. (2015) like Zafarnia et al. (2017) saw honesty as a part of the individual's moral character. Kulju et al. saw moral courage as an element of moral competency, and Lachman (2012) identified it as the individual's capacity to overcome fear and stand for their main principles.

It was seen as important for moral competencies to be applied in nursing ethics units of study as well as other units of study where the student would gain understanding of the importance of these competencies in nursing practice (Johnstone, 2015). By strengthening different areas of moral competence, nurses would be better able to care holistically for their patients and patient satisfaction would be attained. The making of moral and effective relationships with patients enabled safer care to be given (Mitchell et al., 2008). Johnstone (2015, p. 33) argued that moral competence:

> "…was the ownership of moral knowledge and the ability to
> value altered moral viewpoints, (especially those dissimilar
> to one's own) and, significantly, having the essential skills
> and capability to use these skills successfully to deal with
> morally challenging situations…… moral competence involves
> much more than and goes beyond mere 'moral sensitivity',
> moral awareness and being of 'good character".

The development of moral competence is central to the practice of nursing (Australian Nursing and Midwifery Accreditation Council, 2016). As nurses engage in moral decisions that impact the health of patients, families, and communities, they must uphold both ethical knowledge and practices as are enshrined in their professional Code of Conduct and Ethics. More succinctly, it is important that nurses develop moral competence and have the ability to apply this in practice (Johnston et al., 2004).

Duckett et al. (1997) outline several studies undertaken by Colby et al. (1987); Kohlberg (1976); and Rest (1975, 1986, 1994), that have examined the nurse's moral development.

These studies used the Defining Issues Test (DIT), a tool developed by Rest (1975) to explore moral development. Jormsri et al., (2005, p. 2) conducted a study into moral competency in nursing and defined moral competency as "the individual's ability to live in a manner consistent with a personal moral code and role responsibilities". These authors discussed a three-dimensional model with eight attributes that represented their model of moral competence within nursing practice. An individual brings their own values, beliefs and religion into the profession and these, the authors believe, are the basis for their moral growth. Jormsri et al. (2005) also identified that a person's own values add to the strength of their commitment to the nursing profession. Indeed, it is through the nurses personal, social, and professional values that they are able to develop their own set of nursing values and cultivate their moral competence. Through the growth of the nurses' moral insight, decision making and behaviour, nurses are able to deal with ethical issues that arise within their practice in a culturally sensitive way (Jormsri et al. 2005).

Jormsri et al. also state that an individual's moral competence is a mixture of three dimensions: the first dimension involves a person's awareness, or perception, of their own values and their ability to communicate these. The second dimension includes a person's moral judgment which involves the individual's choice of one value over another based on logical reasoning as well as critical thinking. The third dimension that Jormsri et al. (2005) discussed was that of an individual's moral behaviour which involved their use of values as well as their ability to recognise public encouragement for their preference. In support of this view, Taylor (1995) considered that nurses must be aware of their understanding of moral competence in order to be able to work through ethical issues that arise, as they relate to nursing values or values system within their profession. Nurses are required to act as effective patient advocates and mediate ethical conflict among patients, significant others, health care team members, and other interested parties. Therefore, nurses who have skills in moral competence can be trusted

to act in ways that advance the interest of patients (Jormsri et al. 2005).   Overall, the authors state that moral competence can be seen as a combination of three dimensions: (i) moral perception; (ii) moral judgment; and (iii) moral behaviour. The concept of moral competence within nursing practice, recognises that "competence implies knowledge and the skills required in a profession, while also presuming the ability to apply that knowledge and those skills" (Parsons, 2001, p. 321).

The Nursing and Midwifery Board of Australia has defined competence as: "the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession and that competence encompasses both confidence and capability" (NMBA, 2016, p. 16).   The essential competencies (skills, knowledge, attitudes, values and abilities) expected of registered nurses are organised into four domains: professional practice, critical thinking and analysis, provision and coordination of care, and collaborative and therapeutic practice (Johnstone, 2015). Scanlon and Glover (1995) stated that in nursing practice moral competence required understanding of, and commitment to nursing values. Nursing is a profession in which nurses make decisions that affect the health of patients. The environment in which nurses work is complex (Murray-Parahi et al., 2019). Contributing to this environment are factors such as: the nursing shortage, advanced technology, managerial imperatives, and diverse patient populations (Leners et al., 2006). It is these factors that often contribute to ethical dilemmas for nurses (Cohen & Erickson, 2006; Schank & Weis, 2000).

Patricia Benner (2001, p. 27) in her descriptive study of nursing, identified caring as "a committed, involved stance in nursing practice". Relying on the work of Benner and Wrubel, Edwards (2001) describes the basic activities of nursing as being there being there, listening, being willing to help and able to understand. These activities take on a moral dimension, indicating the obligation to pay attention, and not turn away from need.   Gilligan also

recognised that a willingness and capacity to consider someone's needs was reflective of a nurse's moral qualities (Benner, 2001).

Today's nursing profession is committed to developing and sustaining practitioners that are proficient in their field. Bickhoff et al. (2017) discuss that whilst moral courage can be taught, further understanding of this can inform the development of curriculum design and of moral competence. This emphasis on competence is mainly regulated by the nursing profession's commitment toward assuring the health and safety of the patient (Bickhoff et al. 2017). As Jormsri et al. (2005) stated the nursing profession requires increasing competence from its practitioners at all levels, because competent nursing practice in the pursuit of health care is expected throughout society. Zhang et al. (2001), Lenburg (2000) and Taylor (1995) all stated that nursing competence can be defined as the possession of basic nursing skills which includes the following: (a) clinical competence taking into account both assessment and interventional skills, clinical judgment, and technical skills; (b) general competence which covers communication, critical thinking, and problem solving skills; and (c) moral competence which is the individual's ability to live in a manner consistent with a personal moral code and role responsibilities. Today's nursing practice depends not only on technical knowledge and skills but also on values, beliefs, and ethics, which play a significant role in shaping decision making (Jormsri et al, 2005).

Johnstone (2015, p. 33) deliberated that:

> "…moral competence goes well beyond a person's perceived moral sensitivity, moral awareness and being of good character, ……. while these three components are important, one must remember that moral competence must similarly include ownership of their moral knowledge and have the capacity to respect diverse moral viewpoints and, importantly, as well as having the required skills and capabilities to be able to use these skills successfully in order to deal with morally challenging circumstances".

One way a student's moral development can also be explored through clinical agency. Clinical agency was defined by Benner et al. (2009, p. 60) as "the experience and understanding of one's impact on what happens with the patient and the growing social integration as a member and contributor of the health care team". The authors also noted that students may depend on the knowledge of others and may be directed by external factors such as standards of care, orders given by other nursing and medical personnel, as well as patient records. The moral knowledge that a nurse needs to have includes their knowledge and understanding of the different ethical concepts and theories that are pertinent in healthcare settings, and how these relate to their own nursing and healthcare practice (Johnstone, 2015). Johnstone goes on to identify that the nurse must also be able to understand the processes that will enable them to have sound moral reasoning and decision making skills, as well as being able to cope with common ethical issues that arise and affect nursing and healthcare practice. Nurses must be aware of the code of ethics and standards for practice that are relevant to nursing practice and to the facilities in which nurses work. Nurses must also be aware of the power dynamics of the social, cultural, political, legal and institutional environment in which ethical issues arise. (Johnstone, 2015). Johnstone also discussed the need for nurses to be able to apply their moral knowledge in a sound and valid way to address the problems at hand, and evaluate the success, or otherwise, of the outcomes of their interventions. Nurses then need to develop a set of moral skills so that they are able to demonstrate these skills as being morally competent nurses.

When looking at nursing curricula it must be remembered that ethical practice usually includes demonstration and practise of the reasoning process, its associated decisions, and the application of those ethical decisions (Blackwood & Chiarella, 2020). Ethical reasoning embraces the cognitive growth of reasoning which, in turn, leads to the individual's moral decision making and understanding of ethical behaviour; in other words, it involves "putting an ethical decision into practise" (Goethals et al., 2010, p. 636). Johnstone (2015, p. 33) stated

that "few would doubt the importance of moral competence as an essential component of responsible, responsive, safe and high quality ('excellent') nursing care. Moreover, it is appropriate to distinguish moral competence from the general professional competence." The morally competent individual takes their moral obligations seriously and endeavours to incorporate them into their mental and moral life (Jormsri et al., 2005). Moral competence moves consideration from cognition to action. Moral competence requires self-reflection and self-control (Smith et al., 2016).

Crowley (1994) stated that Noddings' ethics of care is projected as an example for moral training in nursing and argues that there are many individuals who do not approach moral situations initiated on set principles, but on the empathetic responses that Noddings labelled as worry for the individual. Noddings (1984, p. 16) stated:

> "…apprehending the others' reality, feeling what
> they feel as nearly as possible, is the essential
> part of caring from the view of the one caring.
> For if I take on the other's reality as possibility and
> begin to feel its reality, I feel, also, that I must act
> accordingly, that is, I am impelled to act as though
> in my own behalf, but on behalf of the other".

Gilligan places importance on both caring and relationships. This corresponds with nurses' shared experiences and this is reiterated in revitalised awareness found in nursing literature on the experience of caring since the mid-1970s (Harbison, 1992).

2.7 Moral competence and nursing ethics

Nursing ethics integrates the values and moral principles governing interactions between the nurse and patient, the patient's family, other members of the health professions, and the general public (Davis et al., 2010). Although nursing ethics shares core principles and general principles with bioethics (Beauchamp & Childress, 2013), this emphasis on relationships differentiates nursing ethics from other branches of applied ethics. A nurse's ethical

understanding and practice is a challenging and multifaceted development, whereby a complex network of both personal and related influences plays a significant role in both the individual's reasoning and behaviour practices (Davis et al., 2010).

Davis et al, (2010) go on to state that the focus of ethics in the early history of nursing was on that of the character of the moral agent. They discussed that even though nurses were being instructed in good conduct, it was seen primarily as what the nurse was, and not what the nurse did, that was of utmost importance, with the belief that good character would produce the right action. Davis et al. (2010, p. 32) identified that "it was the duty of the nursing school to shepherd the moral formation of the student, equipping them for patient care and for assuming a proper role in addressing the ills of society". These authors followed Nightingale in understanding nursing work as "*intelligent work*" (Davis et al., 2010, p. 32) and this view also ran in line with societal expectations, especially with women. Robb (as cited in Davis et al., 2010) held the premise that nurses also exercised a moral influence upon their patients and that it was this influence that added a burden on the moral development of the nurse's education. The authors proposed that character that was built on a foundation of kindness, and that this foundation of kindness was linked to aptitude, common sense and humour. Further, they upheld the Aristotelean view that character was rarely inherited but must be expanded by teaching and preparation. For this reason, Kohlberg's theory, as well as its academic relevancy in the direction of moral development establishes sufficient arguments for it to be considered in relation to nursing ethics.

As well, it is also the case that nursing embraces the concept of caring and accepts caring as integral to professional practice (Lachman, 2012; Mitchell et al., 2008). The ethics of care theory validates the link between ethical nurse practice and caring. Lachman (2012) elaborated upon the concept of care, using key illustrations to authenticate how the level of commitment varies depending on the level of emotional involvement: (a) strangers may not receive the same

level of care that may be afforded a family member, and (b) caring for a neighbour's pet while the neighbour is away differs greatly from caring for a dying family member in the home. Lachman went on to state that there are those that consider the ethics of care a practice or a virtue (linked to virtue ethics), and not a theory per se, where care involves maintaining the well-being of self and of those in the workplace. Although originally designed to address personal moral development, Sander-Staudt (2011) stated that the notion of ethics of care has informed a wide variety of ethical issues, and even used to frame political and social movements. Nonetheless, while an ethic of care captures some of the moral richness of the nurse's ethical relationship with those in her/his care, it lacks the necessary resources for guiding ethical deliberation in the complex context of nursing practice (Lachman, 2012).

Nursing is considered as an ethical endeavour, whereby nurses may come across ethical difficulties in their daily practice, which should be resolved for the pivotal good of the patient, pointing to nursing's moral culmination (Gastmans, 2016). To do this much requires, at times, the exercise of moral courage. Moral courage is a highly valued element of human morality and today a recognised quality in nursing care. When one speaks of moral courage, one means action taken for the right reasons, even though the possibility of unwanted consequences may arise (Gastmans, 2016). That is, courage is required to take action when one has doubts or fears about the consequences. Bickhoff et al. (2017) defined moral courage as an individual's ability to be able to rise above fear and take action that was based on their ethical beliefs, and that moral courage is the willingness to stand up and do the right thing. Moral courage connects the gap between an individual knowing their own personal values and responsibility and acting on these regardless of the risks of social exclusion, humiliation, or job loss (Clancy, 2003; Lachman, 2007).

A description of moral courage was given by Lachman (2007) as an individual's ability and capacity to overcome anxiety and readily support one's core values. Lachman also stated that

individuals must have courage in order to be able to deal with everyday reservations, and that they must be morally accountable in order to recognise and react to any inappropriate practices they observe. It is therefore important for nursing students and registered nurses to be aware that courage is an essential strength when it comes to communicating concerns. Lindh (2010) suggested that nurses must have the courage to be able to appreciate what is, have understanding into what could be and act on what should be.   LaSala and Bjarnason (2010) and Laabs (2011) considered the fact that to be able to demonstrate courage, nurses must put their patients' needs before any risk to themselves, and that they must have the courage to be able to stand up for what they think is the right thing to do despite what consequences they might endure both personally and professionally. In that way, in standing firm on what they believe is the right thing to do, nurses remain true to their professional values and commitments. Further, having the courage to act has a positive influence on the standard of care offered to the patient.

Advocacy is the means by which individuals can be permitted to express their views. Fry and Johnstone (2008) stated that advocacy is one of the ethical requirements that influence a nurse's decision making. Advocacy is generally acknowledged within nursing codes of ethics as a professional model and a strongly held principle. It was Gallagher (2006) who proposed that advocacy could enable patients who, for a multiplicity of reasons were not capable to state their needs. Nursing advocates safeguard the opinion of the patient in being heard and valued, promoting the rights of patients, and creating changes in the healthcare industry. Advocacy also plays a role in representing a positive image of the nursing community.   Nursing advocacy strives for improvement of patient-nurse-doctor relations as well as improving the patient's care on many levels (Kroll & Hansen, 2000). While there are nurses who work chiefly as advocates to progress these features of the profession, all nurses are to some extent patient advocates. It has been established (Bickhoff et al., 2017) that when nurses are challenged with

situations that may conflict with proper standards of patient care, they often remain silent as they lack the moral courage to intervene. Moral courage is considered to be an essential asset for nurses and being able to exhibit their moral courage when confronted with an ethical situation is critical to good practice. Research has shown that a principle/values-based approach provides sounder guidance than an ethic of care approach (Markey & Okantey, 2019; McLean, 2012).

2.8 Values in nursing

In the profession of nursing, values reinforce all characteristics of professional practice especially that of decision-making. Further, values are spoken about as principles or beliefs (Horton et al., 2007) that influence one's behaviour. Rassin (2008) proposed that values characterised the "basic convictions of what is right, good or desirable and motivates both the social and professional behaviour and that values provided standards for living" (Rassin, 2008, p. 614).

A person's values are greatly impacted by their cultural background, as it is this culture that shapes the person's belief and values structures (Lewis et al., 2014). The core values of accountability and responsibility are imperative within the profession of nursing (Jakimowicz et al., 2017). It is essential for nursing students to be aware of the difference between their personal values and the professional values of the profession.

The personal values of the nurse play a vital role in their interactions within the healthcare setting, for instance, the nurse's personal values may be challenged if they decide not to follow directions given or requests asked with which they might disagree (Horton et al., 2007). Evidence also demonstrates the role that values play in nursing, and the impact that values have on workplace satisfaction and culture (Ingersoll et al., 2005; Maben et al., 2007). Nurses' mindfulness of their values and the result of these values on their behaviour is a core part of nursing care. Parks and Guay (2009) indicated that values are learned, socially recognised

beliefs, that reflect a version of one's own needs to what they considered acceptable in society. Jormsri et al. (2005) stated as well that one's personal values also represented a nurse's notion of what it means to be both a good nurse and how to act like a nurse. Rokeach (1973, p. 5) proposed that values were "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence". Rokeach acknowledged that while values were inclined to be steady, they could change or develop, and had cognitive, affective, and behavioural components attached to them. These components could be seen as what the person understood was desirable, what the person felt was desirable and the action that resulted from both these thoughts and feelings. Rokeach, (1973) also stated that while an individual's value structure may alter if and when they are exposed to new situations, their professional values are validated by their own professional group.

A nurse's professional values are the standards that direct their interactions with those they care for, as well as co-workers. It is these values that let nurses make the decisions needed when they come across a situation where an ethical dilemma has arisen (Jormsri et al., 2005), thus forming the foundation for good nursing care. In an article written by Schank and Weis (2000) the authors suggested that the growth of a nurse's professional values occurred along a continuum, which commences in their nursing training and carries on throughout the years of the nurse's clinical practice. Şenyuva, (2018) discussed the fact that both personal and professional values are not inborn, but that they are picked up during one's life, and affect their own personal viewpoints and behaviours whilst also being affected by socio-cultural circumstances. These values can vary from culture to culture and interact with the traditional practices created by the society they reflect. Jormsri et al. (2005) also stated that one's social values can be complex values that guide their behaviour in many ways, which might lead the nurse to take a specific stance in certain social circumstances. Horton et al. (2007, p. 717)

stated that "values could be viewed as what is important, worthwhile and worth striving for", and that they "also believed that values defined the individual, whilst on the other hand, society, culture, morals and beliefs may impact on how that individual demonstrates their values".

Values play an important role when working through ethical dilemmas, as they involve the individual's emotional side, understanding, thought, and finally their choice of how they are going to respond. Values, as we are aware, differ between individuals and because values oversee one's behaviour, they colour the way that person views and responds to the world around them (Vien, 1991). Individuals must appreciate the impact values have on their choices. While one's values can, and do, change over time, their values characterise a large section of their personality. It is through one's individual values that culture can be established, and they also provide comprehensive social guidelines for appropriate morals, thus it is these normal societal standards, or norms that influence how individuals make their choices.

In Viens' 1991 research, the basis of a nurse's values was shown to originate from both family and religious upbringing. These values grew as the nurse's clinical experience grew. Viens further stated that one's nursing values also influenced their views of goals attainable, strategies and actions, and could be considered as means to guide nurses when engaging in ethically competent practice and when confronting challenging situations. Jormsri et al. (2005) discussed the notion that nurses were responsible for upholding clinical purpose, with their core concern being the care of their patients. Nurses act on the values they know are important to them, and they form a framework in which they might evaluate their activities that influence their goals, strategies, and function (Viens, 1991; Jakimowicz et al., 2017). Jormsri et al. (2005) also acknowledged that an individual's values are the priorities as to how that person conducts their life, as well as developing the world in which they live, a person's values act as one of the utmost basic processes of human life. A nurse's awareness of their values, and the

consequence that these values have on their behaviour, is a principal part of how the patient is looked after as a whole person rather than merely an illness or injury (Viens, 1991). Ethical values are inseparable workings of both humanity and the nursing profession, and nurses must be aware of the value system and cultural beliefs of their patients/clients (Johnstone, 2015). Notably, Smith and Godfrey (2016) discussed that one of the most difficult aspects of moral education is not necessarily situated in the process of stating what values are most important, but in defining how to balance these values, and how to teach them to students, within the complex interactions of daily situations that occur within healthcare facilities, these can be the most difficult challenges that academics face.

Maben et al. (2007) identified that nursing values develop during undergraduate nursing studies and can be attributed to developing an understanding of the Code of Ethics and Code of Conduct. Fundamental values such as being ethically accountable and answerable are vitally important in the nursing profession. Cowin et al, (2019) stated that the Codes specify the expectations of nurses in regard to their legal obligations, behaviour and conduct once registered., they also stated that "it is this code of conduct which ensures structure and guidance for workplace values and principles" (Cowin et al. 2019, p. 2). Lui et al. (2008, p. 108) acknowledged that the code of conduct underlining the core values and standards would serve as a "compass to guide nurses to practice ethically and to make appropriate decisions in regards to their patients". The code of ethics is about a moral position, whereas the code of conduct guides an individual's actions and behaviours.

The Nursing and Midwifery Board of Australia is the regulatory body for all Australian nurses, and all nurses and nursing students must work within the professional standards set by this body. The professional standards defined by the NMBA outline the practice and behaviour of nurses and midwives, these include the Codes of Conduct, Standards for practice, and Codes of Ethics. In 2018 a revised Code of Conduct was introduced in Australia that stated the expected

professional principles in four domains that were supported by seven principles and values. In 2018, the Nursing and Midwifery Board of Australia's [NMBA] Code of Ethics for Nurses in Australia (2008) was replaced by the International Council of Nurses (ICN) Code of Ethics for Nurses (2012). The implementation of the ICN Code of Ethics was seen by Australian nursing professional bodies, the Australian Nursing and Midwifery Federation and the Australian College of Nursing, as delivering a high level of current governance with regards to moral practice (Blackwood & Chiarella, 2020). The values that are found in the ICN Code of Ethics and the Code of Conduct (2018) are there to guide nurses' behaviour, as well as to reflect their obligation to the nursing profession of their duty of care to those they will care for. These values need to be internalised, as this is paramount to the professional development of the nurse, as it provides the foundation for the nurses' behaviour (NMBA, 2018).

Over the last thirty years, competency standards in both Australia and internationally, have shifted from an indication of key knowledge outcomes which benchmarks entry to registered nurse practice (O'Connell et al., 2014), to criteria for other ranks of nursing, such as enrolled nurses or nurse practitioners, and other nursing specialties (Cashin et al., 2015; Edmonds et al., 2016). It was during the early 1990s, that the Australian Nursing and Midwifery Council (ANMC), now the Nursing and Midwifery Board of Australia (NMBA), adopted the first set of core national competency standards for registered nurses (NMBA 2008). Since then, these standards have undergone reviews and revisions, and they continue to provide a benchmark which assesses the competence of nurses to be able to practice in a range of settings and allow for the assessment of nurses to both obtain and retain their registration in Australia. The standards are also used to communicate to the public the standards it can expect of nurses, guide the development of nursing curricula, and assess the performance of students and new graduates (NMBA, 2018).

Amid the competency standards specified by the Australian Nursing and Midwifery Accreditation Council (2018) are competencies in ethical and moral decision making. These traditionally focussed on raising ethical awareness and developing skills of analysis and reasoning. It is known that in some settings, however less prominence is placed on developing students' capabilities to act on their own values. The Standards for Practice (NMBA, 2016), and Code of Conduct for Nurses (NMBA, 2018) have no direct reference to moral competence. The International Council of Nurses'(ICN) revised (2012) Code of Ethics for Nurses, has two citings in regards to moral competence. Firstly, nurses must be able to demonstrate the professional values of consideration, empathy, sensitivity, honesty, and veracity. Secondly, nurses must continue to be active in developing and nourishing their central professional values.

2.9 Moral competence and nursing education

The importance of moral competence as an essential component of responsible, responsive, safe and high quality nursing care must not be doubted. Gallagher (2006) stated that, moreover, it is appropriate to distinguish moral competence from the general professional competence expected of a registered nurse, since it cannot be assumed that ethical competence will inevitably emerge during the development of general professional competence. Lenburg (2000) and Taylor (1995) stated that nursing competence must include the three areas of competence being clinical, general, and moral and these all must be brought to the fore in the students' undergraduate curriculum. Johnstone (2015) defines moral knowledge that nurses require, as having the knowledge and understanding of different ethical theories relevant in healthcare settings, and an understanding of how these relate to nursing and healthcare. When thinking about teaching moral competence in the nursing curriculum, it is not possible to rely solely on an ethic of care for addressing ethical problems, such as decisions in relation to beginning and end of life care. Goethals et al. (2010) state that the significance of care in

nursing practice is an important part of all nursing practise. Nonetheless, nurses also must be able to reflect critically about the moral situation and have the capacity to employ a path to follow.

Noddings (2002a) stated that teaching the ethics of caring should include occasions where in students are able to explore their own moral awareness. Students would thus acquire the skills to question the procedures and values recognised by the profession (Crowley, 1994). Noddings (1984, p. 103) stated "the duty to enhance the ethical ideal, the commitment to caring, invokes a duty to promote scepticism and non-institutional affiliation. In a deep sense, no institution or nation can be ethical". Noddings contended that there are four elements involved in this model being: modelling, dialogue, practice, and confirmation. Modelling as Noddings (1984) saw it, involved the academic acting in thoughtful ways, providing students with an example of how they must act in order to establish caring relationships. Dialogue is also an important aspect in this process. Noddings also points to the importance of dialogue throughout this process, simply talking about caring and how this care is to be undertaken, along with feedback is a vital element within an educational framework.   The third element Noddings emphasised was that of practice, which is being able to provide opportunities within the educational setting, to be able to practice and reflect on how they care. The last element of confirmation is the assertion, positive reaction, and reassurance of others' and one's own caring behaviour that is characterised by an ethics of care. Again, one must remember the limits of solely using this approach in focusing on ethical problems when using case study-based learning.

2.9.1. Moral competence frameworks within nursing education

Benner (2001) provided a framework to analyse how well nursing education was preparing students for the 'real world' of nursing practice.   Benner describes the nursing student as a beginner with no experience in dealing with situations in which they would be required to make decisions. In the early stage of their education, it can be noted that their practice is

governed by rigid and limited directions where they have little understanding of the implications that are gathered from both their textbooks, lectures or clinical learning environments. It is when students are exposed to clinical environments that they are able to integrate and find meaning in the principles and theory learned in their teaching space (Benner, 2001). It is in this context, of being in real situations within a clinical environment with complex social and cognitive experiences, that Benner (2001) identified the development of the framework to be able to judge and understand what skills might be needed in certain situations. Benner (2001) used the Dreyfus Model of Skill Acquisition to describe how students' progress through different levels in their gaining of skills and incorporating ideas in regard to how students learn. The Dreyfus Model was developed by brothers Stuart and Hubert Dreyfus (1980). The model demonstrates how students gain skills through recognised curriculum. The model is founded on four qualities, those being: Recollection (either non-situational or situational), Recognition, Decision: (either analytical or intuitive) and finally Awareness (Benner, 2004). This model of proficient knowledge demonstrated a student's development through a sequence of five levels: novice, advanced beginner, competent, proficient, and expert. The model was a concept of philosophical discussion and phenomenological investigation and was initially adapted by Benner (2001) and other nursing educators to explain the development of nursing skills. Benner's work has been central to nursing education, however, moral education for nurses requires further development, and moral competence requires greater attention.

2.9.2 Caring and moral development within nursing

Noddings (1984) argued that caring should be at the heart of the educational system. Both Benner and Noddings defined caring as a "set of relational practices that foster mutual recognition and realisation, growth, development, protection, empowerment, human community, culture, and possibility" (Owens & Ennis, 2005, p. 393). Findings from studies of nursing students undertaken in Finland, reported that units of study incorporating elements of

moral development during nurse education were effective (Auvinen et al., 2004). Two other studies undertaken with Korean nursing students where elements of moral development were also incorporated, were similarly able to establish that the level of moral development was higher at the completion of nursing studies (Kim et al., 2004; Park et al., 2012).   Nonetheless, Bickhoff et al. (2017) found that when students were challenged with moral predicaments, they remained silent even though feeling that they had a moral responsibility to act; most nursing students lacked the moral courage to intervene or speak up when it was required.

2.9.3 Contemporary nursing education

Today's nursing profession is committed to developing and sustaining practitioners that are proficient in their field. Bickhoff et al. (2017) stated that moral courage can be taught, and that additional insight into these determinants will inform future curriculum design and hopefully foster moral courage in future nursing graduates. This emphasis on competence is primarily determined by the nursing profession's responsibility toward the health and safety of those persons in need of health care. The nursing profession requires increasing competence from its practitioners at all levels because competent nursing practice for the pursuit of health care is expected throughout society (Jormsri et al, 2005). In addition, Dierckx de Casterlé et al. (1998) suggested that an ethics of care model based on Gilligan's (1982) work may perhaps be an added perspective for learning as it is more consistent with both the historical and philosophical foundations of nursing.

The clinical environment must also have facilitators who are competent for the students' learning involvement (Forber et al., 2016). It is essential that these facilitators: follow the guiding principles for evidence-based nursing practice, have effective communication skills, and can take on the role of both teaching and socialising nursing students into the nursing profession (Bickhoff et al., 2017). Alarms have been raised within different domains of nursing education, where nurses may not be able to reach the expected moral competency standards required (Lyneham & Levett-Jones, 2016). In observing nursing curricula, it usually embraces

a professional ethics component, but the question remains as to whether the content communicated, along with the pedagogy used, is adequate to enable students to develop a greater understanding of the skills needed, knowledge, attitudes, values and abilities necessary to be able to show evidence of the moral competencies required (Johnstone, 2015). The author went on to identify that it cannot be presumed that all nurses will achieve the required moral competencies through their development of understanding of these competencies they are expected to grasp. This is one area that must be looked at closely in nursing studies as it has considerable consequences for both nursing practice and policy (Johnstone, 2015).

2.9.4 Teaching values within nursing

It has been identified that nurses' professional values are articulated in both national and international codes of nursing practice (Lyneham & Levett-Jones, 2016), and that these values are integrated into undergraduate curricula and taught in various ways, although a theoretical understanding of professional values does not always translate to practice. Liaschenko (1999) specified that the teaching of values necessitated a conscious link between the knower and the known. The student is then required to be able to relate the value-based concerns of importance within each area of study. Liaschenko also identified that academics are a significant influence on the moral character of each student through their particular approach to value-based teaching, and that both professional and personal values are incorporated into the student's curriculum and imparted in several ways. Professional values can be conceptualised as both values that define professional behaviour, and principles and models that affect moral decision making and give meaning and direction to clinical practice (Rassin, 2008; Meredith et al., 2012).

It is the student's own personal value system that originates from their lived experience, cultural situation, religious upbringing, and social group which enlightens their professional values (Chitty, 2005). As the student progresses through their undergraduate training, it is hoped that attainment of professional values might commence with an introduction to both

theoretical and scholarly understanding of the values that guide nursing practice and develop

on from the initial ethical thinking they brought to their course (Meredith et al., 2012). Chitty

(2005) argued that students identify and give thought to those values that resound with their

own views of the world, as well as their personal values and beliefs. Chitty also identified that

it is those values that are respected most highly by the individual that are internalised,

articulated, and assimilated into a student's behaviour and clinical practice. Lyneham and

Levett-Jones (2016) also stated that it is through life experiences that nursing students can

develop a moral conscience as well as a sense of right and wrong. Students can find

themselves apprehensive and disheartened when their personal and professional values conflict,

especially if they conflict with those of nurses they might be working with and learning from.

2.9.5 Preparation of nursing students for professional practice

The preparation of nursing students for ethical professional practice is a multidimensional

challenge. The profession of nursing legislatively requires safe and proper practice, with

continuing competencies in moral and ethical decision making, especially in regard to patient

advocacy, cross cultural competence, teamwork, collaborative care, social justice and critical

thinking (Chitty, 2005). Nursing students attain professional values through formal learning

and socialisation within tertiary institutions by attending lectures, through personal experiences

in health care settings, and via role modelling of faculty and nurses (Duquette, 2004). These

methods contribute to the socialisation of students into the profession of nursing, emphasising

the need to be aware of personal and professional values, and at the same time to care for

patients whose values they may not share (Blais et al., 2006). In discussing socialisation,

Hinshaw (1977) viewed this as a process whereby the students are learning new roles, values,

behaviours, and knowledge that was pertinent to this new social or professional group. Chitty

(1993) observed that this was occurring primarily during the time students were undertaking

their studies and continued after graduation, and into nursing practice. Professional

socialisation is enduring or, as Weis and Schank (2002) state, an aspect of enduring education that continues throughout the individual's professional experience.

Interest in the profession of nursing comes with the student having pre-existing views as to what this profession is, which may have been the result of media portrayal, as well as history (Ohlen & Segesten, 1998) or through personal experiences, such as family or friends being in the profession. There are times during the student's undergraduate studies when these views begin to change. Students become exposed to the values inherent in nursing during their studies whilst observing the behaviour of nursing academics and facilitators (Weis & Schank, 2002). It is these values that focus on the nurse-patient relationship and which also represent the "fundamental values and commitments of the nurse….and the duty and loyalty of the nurse" (Weis & Schank, 2002. p. 273).   Johnstone (2015) stated that nurses must develop their own moral skills, so that they are able to identify moral problems, appropriately recognise the nature of the problem at hand, and then be able to access the suitable means to help address the difficulty acknowledged. Johnstone also discussed the fact that nurses must be able to relate their own moral understanding in both a comprehensive and effective way to evaluate the problem and to gauge if their intervention was helpful. Nurses must also have good interpersonal skills both in communication, capacity to listen to others as well as the ability to be able to have effective problem-solving techniques for the situations at hand (Hinshaw, 1977).

As discussed earlier, diversity of patient needs, resource limitations, and complexity of healthcare settings contribute to ethical conflicts for nurses (Glen, 1999). Nurses are equipped for resolving conflicts by being made aware of the values of the profession through the cognitive domain when presented with the Code of Ethics for Nurses, and learning planned to augment ethical understanding. However, the emotional domain is also significant when integrating and adopting values (Brown et al., 2001). Birbeck and Andre (2009) emphasised

the importance of students understanding of their own motivations, attitudes, values, and feelings in relation to their behaviour as professionals and citizens. In exploring the role that emotions and feelings play in learning, Krathwohl (Miller, 2005) identified five levels within the affective domain: receiving/attending, responding, valuing, conceptualising/organising, and characterizing characterising by value. These levels are similar to the process of professional socialisation, as it progresses from awareness and interest, to reflecting on old and new information, to internalisation (Brown et al., 2001).

McLean (2012, p.161) defined a values-based curriculum as "one which recognised that one's own personal values, and the values or service users are inescapable and inextricably linked in every aspect of clinical practice and decision making". Thus, a values-based approach to curriculum identifies that the student must develop skills which will empower them to nurture an understanding and awareness of values, especially their own, and the skill to reason and work with their values. McLean (2012) also stated that a values-based practice requires the individual to be self-aware so that they can remain conscious of their own values and how these values direct their behaviour. The author developed a values-based enquiry model focusing on three prompt questions. These questions looked at the awareness of others, care and compassion and lastly awareness of self. These prompt questions nurtured a recognition that professional values of care and compassion may provide encouragement for learning (McLean, 2012). McLean went on to identify that students must be able to overcome obstacles to their own sense of personal worth which may obstruct their learning or practice, as well as improving their skills to be able to create or discover information which, in turn, supports and interrogates their own practice. The three prompt questions McLean (2012) developed were designed to nurture the behaviors of awareness that a nurse needs for practice through critical analysis skills: how can these questions be answered? Secondly, through fundamental motivation with the student thinking about what do I and others value? as well as what

knowledge, skills and attitudes must I develop? Lastly, looking at one's self-belief and self-efficacy such as "Do I have the self-belief to make a difference"? (McLean, 2012).

Students initially learn professional values in nursing in the educational setting of nursing faculties through prescribed learning and socialisation. Duquette (2004) found that the growth of proficient values in undergraduates was assisted through learning in formal lectures, experiences in the health care settings, and role modelling by the academics and other healthcare professionals. These approaches add to the professional socialisation of students into the nursing profession. The conclusive purpose of nursing education is to have students think and act like nurses, to enable them to look at the health care industry through the lens of nursing, and to develop their professionalism through both education and clinical experiences.

2.9.6 Curriculum development and review

Nursing education becomes even more effective when curriculum is developed to include more active learning approaches, so as to enable students to adjust to the responsibilities of a graduate nurse. Nursing students today now acquire the theory that lies behind activities, techniques and choices prior to acquiring and undertaking procedures, whereas preceding hospital training was based on the service needs of the hospital, and theory given by doctors, either on the ward or after one's shift. Procedures where taught and practiced on the wards under instruction from educators or senior nursing staff. Rosalia Hamilton (1995) recommended a nursing pedagogy that would enable students to learn the simple principles involved in ethical decision-making as well as training them to be able to apply those principles in the exploration and understanding of clinical events being undertaken. Hamilton went on to describe in depth, teachable moments in clinical practice that would allow the integration of clinical ethics and values in nursing curriculum. Hamilton also viewed ethics as an ongoing and repetitive theme that would allow the fundamental principles and values to be communicated to

the student, such as critical thinking, influence and practice concerns, as well as examination of what the patient may be needing at particular times.

The need for reviewing curriculum on a regular basis has been emphasised, ensuring that nursing curriculum reflects current health care practices. These reviews ensure that core nursing values and ethics in regard to complex nursing situations are able to be discussed with students in regard to their ethical decision-making (Hamilton, 1995). (Ranjbar et al. 2017, p. 584) stated that "the influential factors within nursing education that students are exposed to and how this relates to an unfolding evolvement of higher moral development have not been specifically identified."

In nursing today there are more demands on nurses than just the ability to be able to apply the right knowledge, undertake the correct skills and have the right attitude. Nursing demands that nurses have the capability to be able to reflect on what they do as well as the ability to be able to critically evaluate the care they give from a moral viewpoint in order to meet the particular care the patient requires (Johnstone, 2015). Students need to attain both knowledge and skill development that will empower them to analytically reflect on the care they give (Jormsri et al., 2005). Nurses must be empowered to contribute in moral decision-making situations. Nurses must be able to develop their professional moral responsiveness and their own idea of what good patient care means, as well as to be able to discuss any anxieties and struggles that might arise (Benner, 2001).

2.10. Conclusion

Through this literature review of moral competence and nursing, the challenges in preparing nurses for morally competent professional practice have been considered. Moral competence can be understood as a person's ability when faced with specific situations to be able to recognise how they feel and their understanding of what is right or wrong. The individual must then be able to reflect on their feelings, and their capacity to reason about the values and principles at stake. They must then act in a way that upholds professional ethical standards,

including commitments to the well-being of persons in their care. It has wide-ranging

multidisciplinary scope, which includes moral character, moral decision making and moral

care. A challenge for nursing education is to have strategies that will support nurses in

developing the moral competence required within this profession. Chapter 3 examines the use

of the Giving Voice to Values curriculum as a pedagogical framework for the development of

moral competence in nursing.

Chapter 3: The Giving Voice to Values curriculum and the development of moral Competence

3.1 Introduction

The previous chapter provided a synthesis of the current literature relating to moral competence in nursing. This chapter presents the Giving Voice to Values curriculum (Gentile, 2010), an innovative international program that is utilised within undergraduate professional courses for the purpose of developing ethical professional practice. The historical and philosophical foundations of the curriculum are presented, followed by the elements and practices of its implementation. The introduction of this curriculum into an undergraduate nursing program is outlined. The chapter concludes with an overview of the research that surrounds the Giving Voice to Values curriculum.

3.2 Historical foundations

Giving Voice to Values is an innovative, values-focused methodology devised for the purpose of guiding professional practice. It was pioneered by Mary Gentile in the late 1990's and has been trialled in business studies faculties in American colleges. The Giving Voice to Values curriculum is a values-focused approach, designed to guide individuals in identifying, clarifying, speaking up, and acting on their own values when conflicts arise in the workplace (Gentile, 2012; Gentile, 2019b). This curriculum differs from other approaches to teaching ethics and the development of moral competency as it is not an ethical theory as such; it avoids making determinations of good and evil, right and wrong. Instead, this approach provides strategies to assist individuals to address moral concerns which arise for them in their professional lives.

Gentile (2012) claimed that both experience and research suggest that professionals will hold values that conflict with those of their patients, clients, students, peers or managers. The Giving Voice to Values curriculum concentrates on how professionals raise issues of moral concern; it also focuses on what professionals must consider, and what they need to do and say, in order to

be heard when facing ethical conflicts in complex workplace settings (Gentile, 2010).   Mary Gentile, the curriculum developer, saw that there was a need to bring together a cross-disciplinary, action-oriented approach to curriculum studies in order to develop a person's skills, knowledge and commitment to ensure a values-based competence (Gentile, 2011b). She maintained that unethical conduct, such as corrupt business practices, were likely to be due to gaps in judgment or, moreover, to a lack of resolve on the part of individuals to speak up to prevent misconduct (Gonzalez-Padron et al., 2012).   Alternatively, Gentile proposed that, in regard to unethical or corrupt conduct, individuals do not always fully understand their own moral thinking when faced with diverse circumstances.

The Giving Voice to Values curriculum was developed to encourage students, as well as staff, to learn how to develop the capacity to express their values (Gentile, 2010). The Giving Voice to Values curriculum was first employed as a 'hands-on' method in business ethics education, but has been adopted more widely in the teaching of ethics (Gentile, 2010). This hands-on approach would be especially meaningful within the teaching of ethics within the profession of nursing. Gentile's (2010) approach shifts the focus of ethics education away from the teaching of abstract ethical theories to focus, instead, on the students own practical, values-based decision-making. Gentile (2012) did not suggest that the theoretical features of the individual's moral decision-making was not important; nonetheless, she observed that a growth in theoretical knowledge did not, of itself, lead to a change in the student's behaviour. That is, courses in ethical theory did not provide students with the practical skills and understanding necessary for effective moral behaviour

3.3 The founder of Giving Voice to Values

Mary Gentile holds a Bachelor degree in English from The College of William and Mary. Williamsburg, VA. USA; a Master of Arts in English from the State University of New York at Buffalo USA, and was awarded a PhD in 1983 in Film and English from the State University

of New York at Buffalo USA.   She is the Director and creator of the Giving Voice to Values Curriculum, and consults on management education, health professional education, and values-driven leadership (Gentile, 2019a).   Dr Gentile is currently Professor of Practice, University of Virginia Darden School of Business USA.   Previously she was Lecturer, Organizational Excellence through Diversity, Harvard Business School moving to Senior Research Scholar and Lecturer, Babson College, a private business school in Wellesley, Massachusetts USA. During her term at Harvard Business School she established and taught the first course in diversity studies, and facilitated the design and taught the first module on ethical decision-making. Gentile is a writer, consultant and educationalist and has authored and co-authored numerous articles, texts, chapters, and papers at conferences in regards to the Giving Voice to Values curriculum. She currently consults to many corporate and academic organisations on Giving Voice to Values, providing executive training, and curriculum and faculty development (Gentile, 2019a). Mary Gentile's (2011a) research undertaken in the School of Business in the USA, suggested that conclusions about the integration of the Giving Voice to Values framework could be applied to nursing studies; this led to international developments within this arena.

3.4 Philosophical foundations of Giving Voice to Values

The Giving Voice to Values curriculum offers the perspective that particular experiences or ethical values, are recognised by make-up rather than resolution (Gentile, 2012). The underlying assumption in Gentile's approach is that most individuals are wanting to act during times of ethical conflict, according to their own values. The methodology Gentile (2012) proposed was action-oriented, rather than the individual attempting to use either ethical theories or ethical decision-making models. Gentile noted that, traditionally, individuals have been able to identify their failures in ethical decision-making, but at the same time did not have the courage to voice their values in order to prevent the wrongdoing (Gonzalez-Padron et al.,

2012). The purpose of the Giving Voice to Values curriculum is to support individuals in

being able to recognise, clarify, speak out and take action on their own personal values when

situations arise within their work environment (Gentile, 2010). This curriculum is an

educational method that moves the emphasis away from traditional philosophical deliberation

to an ethics education process, highlighting developing capabilities in being able to express

one's views in a way that challenges activities that are contrary to the professional's values.

The Giving Voice to Values curriculum is a pioneering approach to values-driven moral

development and leadership (Gentile, 2010). The curriculum is about building moral

competence in order to make the ethical path seem less intimidating and more practicable.

This curriculum was developed to guide the student in thinking about what they wanted to do

in order to become an ethical professional. The Giving Voice to Values methodology also

enables individuals to rehearse how they might express their values in moral dilemmas, by

reflecting on their reasons and rationalisations and using enablers to voice their values (Gentile,

2010).

Among the competency standards specified by the Australian Nursing and Midwifery Council

(2018) for graduating students, are abilities in moral and ethical decision making, as well as

ethics education within the nursing profession. Traditionally, focus has been placed on

fostering moral awareness and developing skills of analysis and reasoning; however, ethics

education within tertiary settings has placed less importance on developing students' capacities

to *act* on their values.

The Giving Voice to Values curriculum highlights the significance for professional practice in

finding a values position between an individual's sense of purpose, and the purpose of the

facility they are working in (Bedzow, 2019). Tams and Gentile (2019) stated that the Giving

Voice to Values training combines reflection and action in the search of different ways of

looking at a situation, the people concerned, or the relationships involved in the situation.

Miller et al. (2020) stated that Giving Voice to Values enhances the individual's confidence in dealing with moral dilemmas or anomalies and their likelihood to try and resolve these concerns. The curriculum centres around students reflecting, planning and rehearsing how they might be able to voice their values within difficult settings (Gentile, 2012).

The Giving Voice to Values curriculum allows students to consider the question "What is the right thing to do?" when they are faced with ethical conflicts through a process of self-assessment and reflection. Gentile (2010; 2019b) drew attention to the significance of a shared set of values within the workplace. She also identified the presence of inhibitors that limit the individual's ability to voice and act on their values. Gentile (2010) gives the example of individuals finding themselves in situations where there may be the prospect of others being judgmental of feelings, ideas or language. Gentile (2010) stated that individuals want to find ways in which they are able to voice their values as well as act on them effectively. She also emphasised that there were times when a person believed they knew what the right thing to do was, but they were met with external influences which impeded them from undertaking this path. Individuals were also anxious as to what might happen to them as a result of acting on their values, especially through shared disapproval from others or rejection from work colleagues. Gentile (2010) suggested that individuals or organisations should not underestimate these inhibitors but be able to identify them and be mindful of both the individual's and organisation's values.

Understanding that values-base action encompasses choices (Gentile, 2010) is another way an individual may be able to act on their values. If an individual is able to embrace their own values, they are then able to choose whether they want to protect that value, thereby allowing for control over how to act, rather than seeing value-based norms as being imposed upon them (Bedzow, 2019). Gonzalez-Pardron et al. (2012) indicated that Giving Voice to Values was about giving the individual the tools, as well as a method to help them increase the time

between the moment they get that feeling that something was wrong and the arrival of preemptive rationalisations where they were able to discover possibilities rather than closing down. The Giving Voice to Values curriculum therefore implements an enabling approach, as distinct from the traditional teaching of students regarding ethical analysis does not create ethical behaviors and expertise (Gentile, 2012). Giving Voice to Values is about educating individuals in using action plans and practice, building the skills, the confidence, the moral muscle, and the habit of voicing one's values as well as the formation of the individual to act in different situations (Gentile, 2010).

The focus of Giving Voice to Values is that of a post-decision-making methodology, with the ability to be able to express the most appropriate action necessary when ethical dilemmas and conflicts arise (Gentile, 2012). The Giving Voice to Values curriculum develops ethical practice through the enactment of scripts addressing the ethical choices that may well be considered necessary. Gentile (2010) explains that it is the practice of enacting scripts that enables student to develop and gain self-confidence in their own capacity to examine, and respond to, values conflicts in the workplace

3.5 Giving Voice to Values and theories of moral competence.

It is important for this exploration of the Giving Voice to Values curriculum to locate its theoretical foundations in relation to the main understandings of moral competence and its development. The Giving Voice to Values curriculum models Kohlberg's theory of the development of moral competence (Bedzow, 2019), inasmuch as Kohlberg's theoretical conclusion was that moral thought and action were both developed from common-sense and directed by rule, and that thought, and action were a function of this moral development. Bedzow (2019) maintained that the methodology Giving Voice to Values uses was based on the premise that an individual starts with the notion that their own viewpoint has moral

strength, and that it is valuable in discovering the best way to respond to a given situation, and that the individual must follow a path of action that fits within their own outlook of self. The Giving Voice to Values methodology identifies that moral challenges require individuals to be able to recognise the different influences in the social context in which they must act (Bedzow, 2019). This includes the individual's understanding of the social bonds that may either help or hinder their actions. In using the Giving Voice to Values curriculum, students do not simply ask, "What would I do in this situation?", but "What values do I think I might use? What might I say or do?" (Gentile, 2012). Through the use of these questions it allows the student to be able to gain a better sense of how they might reply to ethical challenges that they come across. In practice, The Giving Voice to Values curriculum has the student imagine moral situations and then using these situations to develop the competencies and confidence required to be able to express their values. Bedzow's (2019) understanding of this methodology of moral decision making, reinforces the argument that students must develop their moral competencies in order to demonstrate their moral understanding.

Bedzow claimed that the Giving Voice to Values curriculum was aligned with Kohlberg's (1969) moral development theory in its position on learning how to act on one's own moral values, rather than reacting to a particular situation, copying mentors or simply gauging what colleagues might think. Bedzow (2019) also discussed the difference between Kohlberg's theory and that of Giving Voice to Values; Kohlberg's conceptualisation of moral development involved a change in the individual's sense of self, whilst the Giving Voice to Values curriculum required the individual to be able to build on their own sense of self.

Examining the Giving Voice to Values curriculum in relation to both Gilligan's and Noddings' moral theories, the curriculum could be viewed as aligning more with Gilligan's (1982) justification of care ethics as a technique of thinking that is both appropriate and expressive rather than planned and theoretical. Noddings' (1984) work was a demonstrative foundation

for an individual's moral conduct. Noddings also suggested a moral framework whereas the Giving Voice to Values curriculum does not consider ethical/moral frameworks. Kohlberg (1976) established a model of moral development, whereas Giving Voice to Values is a practical approach to responding, actively, to moral concerns. On the other hand, both Gilligan and Noddings questioned the hypothesis that moral behaviour was necessarily derived from a knowledge of academic theory and intellectual skill, they proposed instead that their new view of morality that was grounded in emotion and entrenched in relationships (Schwarz-Franco, 2016). In her work on moral reasoning, Campbell (2015) stated that Gilligan identified two models: the voice of care which prioritised relationships and required the individual to be focussed on the situations at hand. Secondly, the voice of justice which informed professional practice was grounded in fairness and objectivity as well as being concerned with rights and obligations. Gilligan (1982, p. 19) stressed that moral problems resulted from "conflicting concerns rather than from competing rights".

Noddings (1984) recognised that caring underpinned ethical decision-making and noted that natural caring is a moral attitude which comes with experience even though the ethics of care impacts both men and women, thus letting this natural caring be seen as a moral attitude which comes with experience. For Gilligan, ethical responsibility pertained to the particular (the obligation to care within interpersonal relationships) rather than to universal rights and principles. As Gillligan explained "for those listening to the voice of care, problems arise from conflicting responsibilities rather that from competing rights" (Gilligan, 1982, p. 19). Again, we are able to see a strong synchronicity between Gilligan and Noddings' work, and the Giving Voice to Values curriculum, with the Giving Voice to Values enabling the voice of care, combining both the conflicts of care with the situations.

3.6 The Giving Voice to Values curriculum

The principle premise of the Giving Voice to Values Curriculum is to develop moral

competence in a new and innovative way (Gentile, 2010), with Campbell (2015) stating that it

is not the structure of thought that makes the Giving Voice to Values curriculum different to

Gilligan and Noddings' thinking. While current methods of teaching aim to develop moral

competence by focusing on moral theory, the Giving Voice to Values curriculum is a post

decision making curriculum. (Gentile, 2010). It highlights practicable learning by allowing

students to reflect on their own past experiences and, then, to identify the common patterns and

actions that highlight practicable education through learning with encouragement allowing

students to undertake reflection of their own past experiences and then to identify the common

patterns and actions that have enabled or obstructed their moral actions (Gentile, 2012).

Undergraduate students often lack experience, even though they have encountered moral

conflicts already, and these experiences require reflection, insight, and analysis (Adkins, 2011).

Edwards et al. (2012) mapped the contemporary traditional ethics teaching model against the

Giving Voice to Values curriculum (Figure 1). This mapping presented the differences and

relationships between the Giving Voice to Values curriculum and contemporary approaches to

ethics education. The model shows that where traditional approaches centre on theoretical

examination and decision making, the Giving Voice to Values curriculum focuses on how to

act once an individual identifies a moral predicament.

Figure 1. Differences between Giving Voice to Values curriculum and contemporary ethics
  Approaches

Current Ethics Approaches   **Giving Voice to Values**

Current approaches focus

The use of ethical theories to analyse

The situation being analysed

Normalising ethical conflict/opportunity

Using decision making models

Decisions to be made

What will I say and do in this situation?

Consideration of options guided by codes of ethics and laws

Actions to be taken

Developing and practising strong replies

Giving Voice to Values focus

Edwards, M.G., Webb, D; Chappell, S. & Gentile, M. (2011)

Edwards et al. (2012) also explored the voicing of moral values through the Giving Voice to Values curriculum (Figure 2), in four key stages:

1. recognising the moral concerns that are involved be they challenging dilemmas or occasions for improvement

2. linking the individual's personal and professional principles and considering if choice is probable in the given situation

3. creating an action-oriented method whereby the moral dilemma can be tackled, and collecting data required in order to identify key stakeholders, and reflecting on what is at stake

4. creating and rehearsing helpful exchanges (Giving Voice to Values scripts) by identifying the influences that disable actions as well as identifying enablers that support the individual to realise their main intent.

Figure 2: Giving Voice to Values curriculum and moral values

THE PROCESS OF FINDING AND GIVING VOICE

The Giving Voice to Values curriculum aims to increase the student's consciousness and capability in acting effectively within moral value conflicts at the individual, relational, structural, and universal levels (Gentile, 2012). Gentile avoids specific characteristics of moral debates, particularly regarding the foundations of moral values; however, she emphasises that colleagues of the educated professions share certain values: honesty, respect, responsibility, fairness and compassion (Lynch et al., 2013). The learning goal of the Giving Voice to Values curriculum is to embrace moral imagination and the capacity to move from thinking to acting which can be seen in Figure 2. Edwards et al. (2012) considered this to be a decision-making competence that could be learned. The Giving Voice to Values curriculum is not about influencing an individual's ethical thinking but begins with the intent that many individuals want to act on their values, and that they can do this capably (Gentile, 2016). Being a post-decision-making methodology, Giving Voice to Values places importance on individuals

developing their confidence to act on moral decisions within their multifaceted workplace or within their social setting (Bedzow, 2019).

The Giving Voice to Values curriculum takes its foundations from the observation that individuals within a professional workplace are able to recognise a conflict of values, but may not be able to convey or act on their own values (Gentile, 2010). As Gentile stated, the curriculum focuses on demonstrating ways of being successful in finding a way to voice individual values and, further, to express or uphold those values within their working environment. The curriculum also emphasizes the importance of finding an orientation between one's own awareness of purpose, for example, one's strength, and that of the facility where they are working (Gentile, 2012). Gentile is also concerned with building and practicing responses to the often-heard explanations as to why we do not act on our values. Giving Voice to Values entails learning how to deliver and receive peer feedback in order to improve the effectiveness of voicing one's values (Gentile, 2010). Gentile also stated that Giving Voice to Values does not focus on how to be ethical, but rather its purpose is to empower individuals who already act or want to act on their values to be better at doing so. This focus is the key difference between the Giving Voice to Values curriculum and Kohlberg, Gilligan and Noddings' moral theories. The Giving Voice to Values framework focuses on action rather than exploration and allows students to prepare for a situation where they feel they have been asked, or indeed feel they are expected, to do something that is in conflict with their values (Gentile, 2012).

The focus of the Giving Voice to Values framework is to give students positive examples of ways in which they can act on their values within the health care setting. The curriculum's purpose is to have students think about the choices they would make if they were able to give voice to their own values. It allows students to consider different questions, such as what is the right thing to do when faced with morally contentious situations (Gentile, 2011a). The

curriculum helps the student understand the different ways in which they might be able to express their values, and that some ways may work better in certain situations. The curriculum also allows the student to feel comfortable using one method over another, recognising that work areas may have a strong impact on the ways they are able to express their values, and undertaking ways to voice their values powerfully. The curriculum, if implemented within units of study in Nursing, would be located over the three years of nursing study. It would commence with students understanding the theory of the curriculum in first year, with exercises coming into second year units of study and finally, the use of case studies in the students third year of study.

In the Giving Voice to Values curriculum Gentile (2012) has maintained a belief that a shared reason for not voicing one's view is that the individual may feel a novice in the workplace and that they should be in a more senior or powerful role in order to voice their values and make a difference. Some individuals who are not familiar with the Giving Voice to Values curriculum may jump to what is called pre-emptive rationalisations, for example: "maybe that's not so wrong", or "maybe this is standard operating procedure in this facility", or "maybe I just do not understand", or "maybe it is wrong but it is not my role/responsibility/right to address it", or "maybe it is wrong but I will do more harm than good" (Gentile, 2012). The Giving Voice to Values curriculum maintains that the student's moral thoughts and capability to move from thinking to acting is a competence that can be acquired. It provides students with both a theoretical background and practice for them to act on their values in situations of ethical conflict.

The methodology of the Giving Voice to Values curriculum includes the use of case studies which focus on the ethics of everyday professional situations where challenges may be difficult (Gentile, 2012). Students are faced with ethical questions when in the workplace, thus the Giving Voice to Values curriculum would enable them to have a better understanding of the

interactions they may have with colleagues, patients or carers who may have differing ethical views to them. Gentile (2010) stated that Giving Voice to Values embraced the capacity to modify the foundational expectations on which the teaching of professional ethics was based, and to prepare the student to not only know what was right, but how to make it happen. The framework concentrates on giving students positive examples of ways in which to act on their values within the health care setting, and highlights the importance for practice in being able to find an individual's sense of purpose, along with that of the institution through a practice of self-assessment and reflection.

3.6.1 The 'Seven Pillars'

The Giving Voice to Values curriculum is constructed around Gentile's (2010) 'Seven Pillars', which explore the ways individuals act or refrain from acting. These pillars are essentially perceptions or observations that Gentile (2010) explored where individuals acted or did not act on their values. Gentile's (2012) pillars are:

1. Values: looks at what values are, the different set that each person has and certain shared values

2. Purpose: looks at what is important to the individual and how they can voice and act on their values, defining their personal and professional purpose

3. Choice: this is at the heart of the Giving Voice to Values curriculum. It affirms that all individuals have a choice as to whether to act on their own values and that all are able to identify concerns which would either enable or disable them from doing so.

4. Normalization: encourages individuals to see moral dilemmas as normal, and to manage them calmly and proficiently, recognising that facing values conflicts is unavoidable.

5. Self-Knowledge and alignment: asks the individual to reflect on their own strengths and weaknesses whilst under pressure to act within values conflicts.

6. Voice: looks at the importance of practice and the ability to develop the skill and habit of speaking up with ease and appropriateness to the situation.

7. Reasons and Rationalisations: draws attention to the typical and anticipated reasoning that is presented for failing to act morally and encourages counterarguments.

3.6.2   The 'Tale of Two Stories'

The 'Tale of Two Stories' is an introductory task within the Giving Voice to Values curriculum. This task demonstrates the integration of both exploratory learning, encouraging students to observe as well as explore new information for the purpose of forming alternative narratives. The 'Tale of Two Stories' encourages students to engage in reflective observation where the student is able to observe others as well as developing observations about their own experience. During this exercise, students present their own understandings followed by discussion of the relevant Giving Voice to Values pillar of 'Choice'. For students to have a greater understanding of The Giving Voice to Values curriculum, they begin with an exercise which builds their confidence and skills. Participants write about two situations, one where they spoke up and acted in order to resolve a moral dilemma that was in keeping with their own values, and the second when they did not speak up and act.

Using the 'Tale of Two Stories', students reflect on a time where they came across a values conflict and were asked how they were able to voice it and act effectively on their perceived values. Students were asked to consider what motivated them to do so, what was it that made things easier for them (enablers), and then what made it harder for them (disablers). Once the students were able to understand both the enablers and disablers, they were then asked how they felt about that experience. Students were then set an exercise where they were to think of a time when they encountered a values conflict, and they were not able to act of their own values and how they handled it. They were then asked what they would do differently now. Debriefing and discussion of the importance of confidentiality was undertaken after the

exercise within the group setting. The 'Tale of Two Stories' exercise allows students to move beyond logical thinking and discussion, to practicing for the time a conflict may arise in their working life.

3.6.3 Case studies in the Giving Voice to Values Curriculum

The use of case studies has been found to be a very effective technique for integrating the Giving Voice to Values curriculum into units of study; it has been found that students learn better from case studies than from theoretical principles (Dunne & Brooks, 2004). Dunne and Brooks further discussed how the use of case studies allowed students to think about things within their control such as: with which of (or who among) my colleagues am I able to discuss ethical dilemmas, who can I get to help me, questioning before making any statements, collaborating, reframing problems as an opening collaboration, questioning expectations and rationalizations and engaging common values. In presenting case studies, students might be asked to consider certain questions: What is the issue? What is the goal? What is the context of the problem? What key facts should be considered? What alternatives are available? What would you recommend — and why? (Gentile, 2010).

Students are able to role play the parts of those involved in the case studies, thus allowing them to understand the viewpoints of the case study and those involved. Case-studies have been used to assess students' understanding as well as adjusting the learning requirements and objectives of the units of study that have the Giving Voice to Values Curriculum integrated into the content (Dunne & Brooks, 2004). The Giving Voice to Values curriculum, through case studies, explores both internal and external factors that shape an individual's responses to value conflicts as well as allowing students to understand both their own moral values and those of others within different settings.

3.6.4 Scripting in the Giving Voice to Values curriculum

The Giving Voice to Values methodology supports the individual to act according to their own values despite conflicting pressures from others. Students are able to acquire skills to confront moral predicaments through pre-scripting or rehearsing responses to situations that they may come across. Gentile (2016) stated that the key stage in this process was the development of an informal script in reply to the question 'If I were to act on my values in this situation what would I say and do?' This exploration engages the student in problem solving in relation to values conflicts, as they arise in various situations. It also requires the student to identify the correct action to take in such situations.

3.6.5 Implementation of the Giving Voice to Values curriculum

In late 2010, an Australian university began to examine the teaching of ethics in its professional disciplines programs with the aim of supporting and improving its curricula and student outcomes. A core group of academics established a Giving Voice to Values curriculum initiative, incorporating a pilot study of the implementation of this framework into the undergraduate nursing curriculum. This pilot study was led by Dr Gentile with workshops held for the academic staff. The initiative was supported and promoted by a central ethics unit within the University.

Evaluation of the implementation of the Giving Voice to Values Curriculum methodology was undertaken by Lynch et al. (2013) within the undergraduate nursing curriculum. From the evaluation of this implementation, the vision was that the Bachelor of Nursing Program become a more values-based curriculum, from which graduates would emerge ready for practice within the profession of nursing through a curriculum dedicated to values-based competency. From this initial project a new curriculum was written with a values-based core unit of study and the integration of the Giving Voice to Values curriculum into further units of study. The project explored the way in which the Giving Voice to Values curriculum aligned

with a model of ethical decision-making which had been used within the Nursing School and in nursing ethics education generally. Gentile's (2010) curriculum was implemented to assist students and academics to explore, script and rehearse responses which built upon their competencies to respond to complex workplace situations in which they face conflicts of value and belief.   The Project implementation saw course objectives being set that enabled students to overcome uncertainties they had regarding their own professional values, as well as learning how to voice their values within a health care context (Lynch et al., 2013).

This Giving Voice to Values curriculum initiative was introduced as a pioneering, action-oriented, pedagogical approach to developing the skills, knowledge and commitment requisite to values-based practice and leadership within nursing (Gentile, 2010). Importantly, the Giving Voice to Values curriculum does not focus on compelling students or practitioners to be ethical; rather, its aim is to empower action on values by supporting the development of moral competence (Lynch et al., 2013). This Australian School of Nursing has progressively integrated the Giving Voice to Values curriculum into their nursing curriculum. The decision to incorporate this curriculum was to increase the student's development of moral competence.

In 2012/13, the Giving Voice to Values curriculum for ethics education was integrated within two units of study within the Bachelor of Nursing Degree.   In 2012 academic staff completed a Giving Voice to Values curriculum workshop run by Dr Mary Gentile to support this curriculum project. The two selected units of study for the integration of the Giving Voice to Values curriculum were 'Legal and Ethical Issues in Nursing' a 2nd year unit, and a third-year elective unit – Rural Remote Nursing. Evaluation outcomes from this curriculum integration investigated student commentary, with students maintaining that they felt the learning through the Giving Voice to Values curriculum was a positive and powerful 'rehearsal' for the realities of nursing practice. The second-year student cohort reported that the Giving Voice to Values curriculum gave them knowledge and skills in dealing with values conflict situations by

enabling them to speak/act on their values and have the courage to speak up because they had a method in place. Students saw Giving Voice to Values as simplifying their ethical decision making, with an emphasis on actions. Students also identified difficulties in applying Giving Voice to Values in situations where they felt they held different views to colleagues, with some students stating that they had difficulty with some values conflict situations and were not sure how to respond. Evaluations by the third-year student cohort of the benefits and weaknesses of Giving Voice to Values demonstrated that they felt more able to speak their mind with a method in place that enabled action. Some students also felt that it supported critical thinking and added value to their own beliefs. Students also saw it as an addition to decision making and another way of embedding ethical decisions.

The Giving Voice to Values curriculum was further embedded within the Bachelor of Nursing Program in the new curriculum in 2015. The curriculum commenced with first year students being introduced to the program in units of study and with a Giving Voice to Values Workshop post clinical placement.   Staff development sessions were also given so that staff had a greater understanding of the curriculum and how it could be used within their units of study. This pilot Giving Voice to Values implementation project demonstrated that the educational power of simulation, experiential, or scenario-based learning central to the Giving Voice to Values methodology was a valuable pedagogical initiative. The School of Nursing facilitated the systematic integration of the Giving Voice to Values framework throughout the School's revised curriculum.

3.7 Research and evaluation of the Giving Voice to Values curriculum

Though research surrounding the effectiveness of the Giving Voice to Values curriculum is in its infancy (Miller et al., 2020), research and evaluation are central to the Giving Voice to Values methodology (Gonzalez-Padron et al., 2012). As the focus of Giving Voice to Values is post-decision making, it is presumed that students would be able to identify ethical issues

and respond to the situations. The focus of the Giving Voice to Values curriculum recognises individuals starting with their own values and then building the skills, confidence and "moral muscle" to be able to voice their values (Gentile, 2010).

Developments in nursing education have resulted in nurse academics seeking alternative means of educating, with the aim of liberating nurses as learners (Greenwood, 2000). In this way historical, traditional, and normative frameworks of education are reconsidered surrounding moral competence (Marturano & Gosling, 2008). Adkins (2011) reflected that if the Giving Voice to Values curriculum was too theoretical it would miss the link to individuals' own lived encounters. Adkins (2011, p. 387) also stated that "in learning from different situations an individual is able to understand these experiences through two dialectically related methods, concrete experiences and abstract conceptualisation thus altering the experience through two dialectically related modes: reflective observation and active experimentation". Bedzow (2019) stated that traditional moral and ethical teaching posed two questions for students which sat outside the Giving Voice to Values post-decision methodology, the first question being, "Is there a moral obligation that is independent of our own personal wants, desires, or beliefs?" Bedzow (2019, p. 40) discussed the fact that:

> "…there are ethical theories that deny the existence of moral obligations outside of our own personal wants, desires, or beliefs. Yet, for the most part, ethics and moral decision-making presumes that what one should do is not always what one wants to do, though it may be the case that a person always wants to do the right or good thing".

This statement by Bedzow acknowledges that a person's moral responsibilities are not merely grounded on specific needs, wants or feelings, and that this should not deviate from the central question of "How can I act on my values?", but must be seen as a way to commence thinking on how one may possibly act. The second question that Bedzow (2019, p. 40) asks is "how can I fulfill that obligation in the best way possible" suggesting that "the answer to this

question includes not only what you choose to do and your intention to do so, but also the consequences that may result and how the choices you make help shape your identity". These two questions can be seen as speaking to both the decision-making process as well as the student's ability for moral action. The ability to consider ideas in this way, generates different ways in which the student would be able to express things. Bedzow (2019, p. 41) believed that:

> "…the right choice may not lead to good outcomes,
> unless you define the appropriateness of a choice
> by the goodness of its consequences, therefore, the
> individual needs to understand how each framework
> would approach a given issue, how it ranks social facts
> and moral values, and then reflection as to how the
> different frameworks could be used together to come
> up with the most ethical solution".

If values are to be taught, then consideration must be given to the way students acquire and communicate values and principles (Aspin, 2000). Arsenio and Lemise (2001) stated that it is essential that all student cohorts study and relate values and qualities within their profession in an attempt to change unacceptable behaviours towards others. As Tams and Gentile (2019, p. 7) stated "Giving Voice to Values is designed as a mechanism to enable participants' moral agency, to empower them to translate moral reasoning into moral action, and, in so doing, activate and stimulate the social practice of generating and maintaining shared social norms".

3.8 Strengths of the Giving Voice to Values curriculum

The focus of the Giving Voice to Values curriculum on action and communication is suited to the application of ethical responsibilities across different social levels (Edwards et al., 2012). The Giving Voice to Values curriculum endorses personal responsibility in order to represent the individual's core values within their area of work. The Giving Voice to Values curriculum provides a structure for the introduction of moral conversations, and it is through these conversations that questions related to the voicing of moral values can be explored.

At Bond University in Australia, research had been undertaken under the leadership of Professor Ben Shaw (2013) into the integration of Giving Voice to Values into Business Studies. Preliminary evidence from this study confirmed that the integration of the Giving Voice to Values structure worked well within units of Business Studies, and Professor Shaw believed that this could be replicated into nursing curricula. The use of the Pre and Post Evaluation developed by Professor Shaw (2013a) was quite adaptable to a nursing focus; these amendments were undertaken by the researcher. The new adaption of the evaluation was then an easy process for nursing students to undertake and was compliant with curriculum learning objectives. Shaw saw the evaluation as a good approach in regards to a student's understanding of their own values, and the design of the pre and post questions giving an insight into students' understanding as well as an assessment of their learning.

Bedzow (2019) stated that current methods of teaching aimed to develop moral competence, and even though Giving Voice to Values is primarily a post-decision methodology, it was also thought that it could be expanded to improve the individual's ethical decision making as well. In support, Moen (2017, p. 35) stated the "Giving Voice to Values curriculum is designed to overcome the need for expertise in moral philosophy in order to ask questions applicable outside of scholarship". Bedzow (2019) also stated that this method fits with the idea of what an individual can do to inform themselves as to what should be done in a given situation, as well as empowering the individual to think of their own values in acting rather than using the theoretical principles to apply to the situation. While the Giving Voice to Values methodology integrates a post-decision method producing strategies for effective moral action when individuals are confronted with a choice to act, these individuals must also reflect on whether the decisions they are making are in fact allowing them to voice their values or whether they might be providing rationalisations for not voicing them (Bedzow, 2019).

Adkins (2011) stated that by creating links between an individual's experience and the learning environment, academics must emphasise the importance of feedback, and the Giving Voice to Values curriculum facilitates such a learning experience. Adkins also noted that through the sharing of stories, students were able to benefit from a range of experiences and learning platforms, as well as different strategies and scripts that they might be able to use in situations they may possibly come across.

Holmes (2015) discussed that the Giving Voice to Values curriculum could be seen as a way of familiarising students with the understandings of social ethics, as well as presenting a chance for the student to explore how they could enable themselves to act on their values when challenged with a moral situation. Mintz (2016) supported the argument that in using the Giving Voice to Values curriculum there was a greater role for moral exploration than envisaged when individuals were able to clarify that their original values-based views may be flawed. Gentile (2013; 2019b), however, proposed that Giving Voice to Values assumed that this consideration had already been undertaken. Gentile maintained that Giving Voice to Values focused not only on the questions of 'what's the right thing to do?' but also on the ethical question of 'how do we get the right thing done?' Mintz (2016) saw Giving Voice to Values as being a practical and reflective method that would assist students to go beyond "the why" of moral action and embrace techniques to achieve the goal and knowledge by doing.

3.9 Weaknesses of the Giving Voice to Values curriculum

Gonzalez-Padron et al. (2012) acknowledged that the Giving Voice to Values methodology could play a role in the individual's understanding of moral competency in nursing, but that it was not a replacement for long-established moral/ethics education. The authors observed that Gentile (2010) stated that preparation and an instructive emphasis on theory and ethical reasoning models could be unclear, as theoretical foundations such as utilitarianism and duty-based deontology (Gonzalez-Padron et al., 2012) were needed to define what is correct or right

when challenged with moral dilemmas. The authors also stated that the Giving Voice to Values curriculum brought a new outlook to the opportunities and challenges in identifying moral decision making within different situations, but little academic research had been undertaken to assess the effect of the Giving Voice to Values curriculum on individuals. Gonzalez-Padron et al. (2012) cautioned those proposing to embrace the Giving Voice to Values curriculum, that they must understand how it might fit into units of study, and stated that they were apprehensive that Giving Voice to Values and moral investigation were not simply distinguishable. Gonzales-Pardon et al. (2012) also stated that informative research findings may be able to determine if the addition of a Giving Voice to Values component to undergraduate nursing training might develop a moral culture and, therefore, lessen the frequency of wrongdoing. The fundamental question posed by Gonzales-Padron et al. (2012) was 'does the Giving Voice to Values curriculum improve the individual's self-confidence in ethical decision making? and could it be evaluated through the use of a pre-test/post-test measure related to moral self-efficacy. The authors maintained that while the Giving Voice to Values curriculum has great potential in improving moral decision making within healthcare facilities, there needs to be more research about the integration of this method to evaluate its learning outcomes.

In a paper presented by Dr Iain Benson (2017) as part of The Christopher Dawson Centre for Cultural Studies' 2017 Colloquium on the theme "Liberal Education: Restoring the Notion of Education as the Basis for Living the Good Life", Benson critiqued the use of the Giving Voice to Values curriculum. Benson implied that the Giving Voice to Values curriculum appeared to alter the individual's primary concepts concerning the teaching of moral insight in understanding what is right, and how the individual might be able to make this happen. Benson (2018) identified that in his analyses of the Giving Voice to Values curriculum, Gentile (2010) had omitted the terms ethics and morals from the development of this curriculum, and that she had stated:

> "…values are said to be different from both ethics and
> morals as they are non-judgemental and self-aspirational
> rather than judgemental and self-disciplinary, and that
> these are essentially based upon feelings and the list of
> such things as honesty and self-respect and fairness can
> be seen as widely shared values but not in any way
> related to common starting point of virtues" (Benson, 2018, p. 21).

Benson acknowledged that the removal of both morals and ethics from this curriculum, might give the individual the idea that assertions concerning morality or moral views might be seen to be personalised into mine and not yours. Benson felt that there was a sense of avoiding connections to the classification of morality. He also claimed that the Giving Voice to Values curriculum used language and approaches that appeared to lack any conformity to moral principles.

Benson (2018) stressed that the Giving Voice to Values curriculum could be seen as having very little in the way of virtues and that the curriculum was not really about virtues. Benson discussed the fact that he believed the Giving Voice to Values curriculum presumed that students undertaking the program already had an understanding of their own personal values, and that they were capable of being able to voice these values. On this point one could ask the question; Do students actually have an ethical or moral viewpoint at this stage of their life? Benson (2018) also acknowledged that he felt the Giving Voice to Values curriculum did not consider moral principles, but that it was a program for individuals in which they were able to give voice to their personal values and that the moral significance of what was being considered could be avoided. Benson also believed that the Giving Voice to Values curriculum wavered between virtues and values, and mistakenly defined them as the same thing; evidence of this can be seen in the index of Gentiles (2010) Giving Voice to Values: How to speak your mind when you know what's right, where she writes: "virtues: see values".

Benson (2018) saw the Giving Voice to Values curriculum as attempting to replace tangibility with procedure, thereby focussing on the development of the individual's skills with no real

guidance given, and that the curriculum did not appear to start at the beginning or have a finish. Benson (2018, p. 35) went on to challenge the fact that the Giving Voice to Values curriculum did not address:

> "…the profound requisites of the failure of ethics in today's world … the replacement of genuine moral languages with the subjectivised language of the will that is values language … moral language must engage in what is right in all disciplines that are understood as moral choice of the individual towards shared moral purposes and the language of preference cannot be merely relied on … it is pseudo-moral language or anti moral".

Benson (2018) also observed that the approach Giving Voice to Values takes disconnects ethics and morals, identifying them as being judgments that should not be a part of the assessments of moral dilemma and action. He holds that this approach is unreasonable and irresponsible.

Haidt (2014) explores the evidence regarding the impact of the Giving Voice to Values curriculum. He indicates that Gentile (2019) has stated that there is not conclusive evidence but there are four levels of important outcomes. The first level of evidence suggested by Gentile, points to research outcomes that suggest that the rehearsal of values-based actions was an effective way to influence professional practices. The second level was of anecdotal evidence from staff involved in the teaching of the Giving Voice to Values curriculum, along with organisations who have undertaken the curriculum reporting it to be effective. The third level of evidence was in research of pre/post survey design of students, in particular the work of Ben Shaw (2013) at Bond University, Australia. The last level of evidence that Gentile anticipated, was a longitudinal study demonstrating Giving Voice to Values training impacts on voice/enacting their values effectively. Overall, Gentile states the Giving Voice to Values curriculum does not take a convincing or advocating position, but an enabling one, with the objective to work with the student's best instincts instead of working against their worst (Haidt, 2014). However, the level of evidence for outcomes of the Giving Voice to Values curriculum remain low and under-developed.

3.10 Conclusion

The Giving Voice to Values curriculum aims to contribute to the development of moral awareness within nursing education. Nurses will encounter conflicts of values in their working lives and circumstances where their own values might conflict with the expectations, decisions and actions of those around them. The Giving Voice to Values curriculum is an innovative curriculum that can be positioned as an alternative methodology to traditional ethics frameworks and their teaching. The focus of all moral frameworks is the development of moral competence; the challenge arises around the enactment of this which is addressed by the Giving Voice to Values Curriculum.

The Giving Voice to Values curriculum has synergies with the theoretical frameworks of both Gilligan and Noddings. The critiques of the Giving Voice to Values curriculum are focused around its non-attention to moral foundations, and its possible misrepresentations of its outcomes. The curriculum does appear to develop moral competence through the development of awareness, and the strengthening of actions towards values-based work and care. The Giving Voice to Values curriculum's representation as an alternative framework to the development of moral competence is partly endorsed. Its value within the worlds of nursing education and practice are found in its strengthening of the nurse to act.

This chapter has presented arguments for the educational advantages of the Giving Voice to Values curriculum, along with concerns that some educators and moral theorists have. The next chapter will present the research design and methodology for a study of the outcomes of an introduction of the Giving Voice to Values curriculum within an undergraduate nursing program. This study of outcomes is contextualised and magnified within a further exploration of the perceptions of nursing experts and stakeholders regarding the development of moral competence.

Chapter 4:   Research Methodology

4.1 Introduction

The previous chapter presented an overview of the Giving Voice to Values curriculum, taking into account its historical and philosophical foundations, its implementation in a school of business, and its integration into undergraduate nursing programs. This chapter provides a discussion of the mixed methods research approach used for this study. This thesis has presented a literature review focused on the development of moral competence, and the consideration of the Giving Voice to Values curriculum. The research study was developed with explorative and analytical aims; it sought to understand the development of moral competence in nursing in general and, as well, its development in a cohort of nursing students following the implementation of the Giving Voice to Values curriculum. This chapter details the study's design arising from the aims of the research project, its philosophical underpinnings, and its methodology. The approaches used to gain research data presented in this chapter are the use of a questionnaire and semi-structured interviews. The last section of the chapter describes the data analysis methods for both the questionnaire and the semi-structured interviews. Methodological limitations and ethical considerations are also discussed.

4.2 Aim of the study

The aim of this research study was to explore the development of moral competence in nursing, through the exploration of the Giving Voice to Values Curriculum.

4.3 Research question

The research project sought to identify how the introduction of the Giving Voice to Values Curriculum contributes to the development of moral competence in nursing.

4.4 Theoretical foundations

Kohlberg's (1969) theory of moral development, Gilligan's (1982) theory of moral development and Noddings' (2002b) Ethic of Care provided the theoretical underpinning and framework for this investigation. It was proposed that Gilligan's theory of moral development finds resonance in the philosophical and historical features of nursing theory, as does Noddings' Ethic of Care (Noddings, 2002b). Indeed, the core of nursing theory and practice is founded on the therapeutic relationship between the nurse and the patient, calling for the nurse to be responsible for the person in their care. This necessitates nurses to critically reflect on their practice within this caring context.

Kohlberg's (1969) theory of the development of moral competence has some relevance here, as it is a theoretical and practical model for the exploration of a nurse's moral reasoning from which their practice flows. Kohlberg's model is structured on: the interaction of self and environment, the critical evaluation of one's behaviour, and a scaffold to look at the way individuals think and make decisions in diverse situations. Kohlberg's theory provides a framework for exploring how nurses articulate moral decision-making processes, as well as how they reflect on their own practice. Kohlberg (1969) developed a tool termed, the Moral Judgment Interview this was developed to explore his theory of Cognitive Moral Development. Kohlberg's (1969) technique involved the interviewing of individuals after they had been presented with situations concerning moral dilemmas, leading to an understanding of their moral reasoning, beliefs about right and wrong, and the way these beliefs were understood in order to attain and validate moral conclusions. However, Kohlberg's (1969) work did not include a therapeutic relationship – a caring relationship – which is the essence of nursing theory and practice, therefore the use of the MJI tool was not used by the researcher in this analysis.

The works of Gilligan (1982) and Noddings (1986) led to an increase in literature in regards the importance of care, relationships, reliance, and the moral experiences of women. Both Gilligan and Noddings rejected the moral theories that had guided earlier moral philosophies, and Gilligan and Noddings claimed that proper acknowledgement of women's experiences meant a strong and sympathetic study of relations, emotion, and other neglected themes in moral theory (Walker, 2007). Noddings' (1998) concept of natural caring referred to care for another, and the desire to care for the other. Noddings' maintained that an individual does not always feel motivated to act, nor does the individual become engaged when they should. By definition, Noddings (1998) asserted that the latter is morally wrong, but the former may be morally permitted or reasonable. She was also open to the possibility that individuals might become immersed in the world of someone who is doing something morally wrong. Noddings' (2002a) thinking was that care was not care unless it met a need, and an ethics of care required an individual to recognise if exchanges of care had been recognised, sustained or improved.

Moral development in Gilligan's (1990) eyes embraced pro-social behaviour, such as caring, helping and selflessness, along with behaviours of honesty, fairness, and respect, with empathy being seen as a strong basis for creating pro-social behaviour. In Gilligan's (1982) model, moral development was seen as the development of a 'self-in-relation', and that morality was understood in terms of safeguarding of valuable human relations. Gilligan was acknowledged as expressing the view that one's moral actions integrated their moral position of care (Skoe, 2014). Skoe indicated that this signified Gilligan's thinking that the individual was concerned with responsibility and agreement while preventing harm within the relationship. In distinction from Noddings, Gilligan (along with Kohlberg) emphasised the significance of justice and rights in a morally integrated person, as well as with concerns relating to equality, fairness and one's own rights (Skoe, 2014).

In looking at the three theorists central to this research, the following intersections are evident:

- the practice of moral competence in nursing is developmental, as moral competence develops across the life span (Kohlberg, 1969)

- the nursing profession and its practice upholds and embeds moral reflection (Gilligan, 1990)

- The ethics of care has given a foundation for the moral education of nurses as it represents a growing understanding of individual relationships that are based on the perception that people are interconnected. (Noddings, 2002a)

Additionally, the gendered nature of nursing has close alliances to both Gilligan's and Noddings' work. Noddings' (1998) moral theory, the ethics of care, was an approach used in the development of a student's moral education within nursing curriculum as well as their development of a caring therapeutic relationship. Kohlberg's (1969) theoretical contributions are represented through the moral education methods now used in the implementation of role models and peer interactions within moral problem-solving discussions using case studies and clinical practicums. Kohlberg (1969) saw the moral person as one who enthusiastically works to develop both themselves and the society in which they live and work; this is clearly supported by the professional standards of the health professions. All three theorists are central in the moral education of the nursing profession, with moral competence being understood as a reasoned, cognitive, emotional, and relational ability (Kohlberg, 1969; Gilligan, 1982; Noddings, 2002). Formal development of moral competence commences as the student progresses through their undergraduate curriculum. The Giving Voice to Values curriculum has emerged as a practical approach for furthering or enhancing the development of moral competence for nursing students. There is a need to assess the merits of the claim that the Giving Voice to Values curriculum enhances the development of moral competence within nursing curriculum.

4.5 Methodology of the study

The objectives of this two-phase, mixed methods research project were to explore the development of moral competence through two lenses – the initiation of the Giving Voice to Values curriculum, and the wider view of nursing and moral competence. The use of a mixed methods design allowed the researcher to quantify and explore these two perspectives, that of nursing students undertaking the Giving Voice to Values curriculum, and nursing experts and stakeholders leading the development of moral competence in their profession. Both groups formed a focus for the research investigation. As Creswell (2015) stated, the most significant advantage of a mixed methods investigation is that both quantitative and qualitative methods can be used to strengthen research. In using this mixed methods research design, there was flexibility in the collection of data and enhanced validity through both types of data gathering undertaken. The research design allowed the researcher to view the two different perspectives and to develop an understanding from these different perspectives.

The sequential design allowed the researcher to investigate moral competence using tools which provided a more in depth understanding of the phenomenon, than just using quantitative or qualitative methods alone (Creswell, 2005; Tashakkori & Teddlie, 1998). The combination used in the mixed methodology allowed assessment of the processes and outcomes [quantitative and qualitative data gathering] (Creswell, 2005). Creswell (2018) and Plano-Clark (2017) indicate that mixed methods research incorporates both quantitative and qualitative research data which obtains fundamental data but also balances the differences and strengths of each method allowing the researcher to better understand multidimensional research problems.

The practical philosophy of mixed methods research enabled the researcher to study what was of interest in the variety of ways that the research question and aim required (Tashakkori & Teddlie, 1998). Bazeley (2019) stated that mixed methods research was a methodological approach whereby the researcher is able to integrate different types of data, as well as different

ways of analysing this data for specific studies. Data and preliminary results, arising from different methods of data collection, were combined during the analysis phase and results and conclusions were drawn on the methods used. Bazeley (2019) has stated that the mixing of research data gained through the use of a mixed methods investigation is more valuable and offers challenges in integrating data to support a broader level of exploration. Bazeley also acknowledged that the approaches for mixed methods research include: the construction of an integrative structure that identified patterns and differences in related data, and the integration of mixed data dealing with differences and inconsistences.

Understanding mixed methods research necessitates a knowledge of its historical development. In the late 1980s researchers from many research fields instigated discussions about the advantages of combining both quantitative and qualitative methods in response to a growing complexity of difficulties arising from research, as well as the justification of qualitative analysis and the need for more data in research investigations (Creswell & Plano Clark, 2018). Bazeley (2019) stated that in the mid 1990's, mixed methods research was seen as a way of explaining research designs, that combined data, firstly in the realm of education followed closely by health research. She went on to identify that the label of mixed methods was not generally used until the 2000's. Creswell (2018) also described mixed methods research as requiring a focused mixing of approaches in data collection, analysis and understanding of data collected. Creswell (2015) indicated that mixed methods research was an approach that integrated particular features of the qualitative and the quantitative approaches. The idea of incorporating these two approaches allowed the researcher to develop a more detailed picture of the issues in question, by means of gathering insights established on the combined strengths of both sets of data, in order to understand the research challenge (Creswell, 2015). Bazeley (2019) stated that integration comes about due to the way different data features and approaches come together to become co-dependent in reaching a common research goal. This

approach delivers outcomes that were greater than the total of the parts. The challenges of integration were obvious, when results from data collection of mixed methods research were described individually, with detailed results coming from different origins of the study that were similar but did not fulfill the task of combining them (Bazeley, 2019).

The research design for this study comprised two sequential separate phases; completing each phase systematically, then using the outcomes to inform the next phase of the investigation. The quantitative phase employed a questionnaire which was completed and analysed. This informed the researcher of the development of themes and questions for the qualitative semi-structured interviews; thereby integrating the two methodologies (Greenwood & Terry, 2012). The use of the questionnaire was chosen for its effectiveness in obtaining large amounts of data efficiently and effectively (Bazeley, 2019). This quantitative approach allowed the researcher to explore responses from a survey undertaken by nursing students, with analysis of data through statistical evaluations describing occurrence, means and relationships between data factors (Creswell, 2015).

The qualitative phase of this study aimed to gain information from nursing experts and stakeholders' experiences of moral competence and its development, with the objective of establishing rich data coming from their knowledge, expertise and leadership perspectives. This qualitative method of semi-structured interviews led to informed questioning around the phenomenon under investigation, being the development of moral competence in nursing.

The integration of focused data enabled the researcher to gain a better view of data gathered from these diverse perspectives and through differing lenses. Bazeley (2019) suggested that mixed method research could be particularly useful in uniting the strengths of the two methods whilst minimising the limitations. Mixed methods are able to develop validity, however, the appropriate use of mixed methods research can be challenging in its delivery.

In using a mixed methods approach for this research, the mix of quantitative and qualitative methods provided a greater breadth and depth of understanding, than using a singular approach. As a methodology, mixed methods research incorporates varied perspectives, as its distinct characteristics combine methods, philosophy, and research design (Creswell & Plano Clark, 2018). The mixed methods methodology used in this study was most appropriate as the research question directed the researcher toward the collection of both quantitative and qualitative data. A central strength in using this mixed methods research design was the exploration of both quantitative and qualitative data towards the if's and the why's of the research question (Creswell & Plano Clark, 2018; Creswell, 2015).

However, weaknesses may arise in the use of a mixed methods design through limitations in research data when data collected differs. The dominant concern raised within mixed methods research design lies in the connection between the segments of evidence and facts (quantitative data), and the exploration of the phenomena (qualitative data) that were collected (Bazeley, 2019).

In this study, the researcher drew on the work of Jack et al (2010) to develop a rigorous research design. The areas pertinent to this study were: sample representation, validity of measurements, bias and confounding factors. This cohort design had sample representation characteristic of first year nursing students who had undertaken an integrated Giving Voice to Values curriculum and a Giving Voice to Values workshop. This study sample would be typical of the wider target audience to whom the research might apply in future studies. The survey method held validity through its use of a valid instrument to measure the impact of the Giving Voice to Values curriculum on nursing students. Two types of validity (Jack et al, 2010) were looked at: face and content validity. Face validity (Jack et al, 2010) ensured that, on exploration, the variables of interest, the students' knowledge of their ethical values, their awareness and understanding of different ethical issues and their ability to communicate, was

able to measure what was intended to be explored. Content validity (Jack et al, 2010) involved comparing the content of the acquired data from the survey against the known literature; this validated the use of a Giving Voice to Values impact measurement after the implementation of a Giving Voice to Values curriculum.

The potential for bias (Jack et al, 2010) was also identified during data collection and analysis. Areas of concern were that of participant bias - whether the participant understood the statement based on what they thought the right response might be or if it was socially acceptable, rather than responding to the statements authentically. The second area of potential bias was that of researcher bias, where unintentionally, the researcher interprets data to meet their assumptions, or they incorporate only the data they think is significant. These areas of bias have been minimised within the research design; anonymous and graded responses were used, and the researcher's data analysis was constantly scrutinised by supervisors. The last criterion was that of confounding factors (Jack et al, 2010) wherein another factor/s have influence upon the measurements outlined in the study, these were also considered in the research design. Overall, using quantitative methodology allowed for the collection and analysis of empirical data about the impact of the Giving Voice to Values curriculum upon nursing students.

Liamputtong (2013) identified four principles to validate research accuracy in qualitative studies: reliability, transferability, dependability and confirmability. In the qualitative phase of this research project, credibility was ensured in the semi-structured interviews by using pre-set themes and audio recording of the interviews. The themes asked of every participant were designed to stimulate dialogue, as a means to respond to the themes in relation to the research question and in response to the phase 1 survey data. Using this method, the researcher was able to clarify themes and responses (Bazeley, 2019) with the participant, and explore for more inclusive data. Transferability was reached by selecting key nursing experts and stakeholders

from both educational, clinical and regulatory bodies, thereby ensuring findings that could be further applied. Dependability related to the research proposal and research design, the aim was clearly identified at the outset and the sample size was representative of the studied group. Information obtained was different from data which would have been obtained if a questionnaire only had been used (O'Leary, 2014). Confirmability was obtained by the use of semi-structured interview themes arising from Phase 1 data and the Literature Review, which assured that the participants were being asked relevant exploratory themes. The researcher provided transparency of purpose (Liamputtong, 2013) before the start of every interview, and reviewed data on completion of every interview.

4.6 The Research study

The research study had two phases:

4.6.1 Phase 1: Survey of nursing students

A survey of first year undergraduate nursing students was undertaken at the end of years 2015 and 2016. The students were invited to complete the survey at the end of their first year of study after an integrated Giving Voice to Values Curriculum and a Giving Voice to Values Workshop. A Pre and Post Comparisons survey was utilised, which had been sourced from another Australian University (Dickenson, 1996; Shaw, 2013). Shaw designed the survey - Current Knowledge, Ability and Skill: to evaluate the effect of Giving Voice to Values in his Giving Voice to Values-related business ethics subject in the School of Business. This survey assessed course related knowledge, skills, abilities and characteristics of the students undertaking this Business degree. In Shaw's (2013) study, the Pre, Post and Then design (Appendix 4) measured the business students' comments in the first week of their semester and they were again surveyed in their last week of semester (12 weeks duration). This survey had students responding to the measurement items twice: the NOW test of knowledge, skills and characteristics obtained by the last week of the semester, followed by the THEN test. Shaw

(2013) saw the Then measure as allowing for a more advanced evaluation of change or lack thereof of the student. Shaw's questionnaire was used as a literature search gave no evidence of a survey instrument particular to nursing, nor emerging from specific theoretical moral frameworks. Shaw's work emerged through a collaboration with Mary Gentile, the founder of the Giving Voice to Values curriculum. Shaw's study indicated that the integration of the Giving Voice to Values curriculum had positive outcomes within units of study in Business Studies, and that this could be replicated within nursing programs.

Shaw presented his findings in a presentation "Assessing the Impact of a Giving Voice to Values-enhanced undergraduate ethics and CSR Course" at a Giving Voice to Values Conference in 2013 with Mary Gentile. Shaw found that the survey was an easy process for the students to undertake, that it was adaptable to other learning objectives within the course, and that it shed light on the students' experience during their semester. Shaw (2013) indicated that the survey was certainly not an absolute method of measuring students understanding and learning, but that it was able to give an understanding of students thinking. He noted that the Then and Post (Now) measures were more strongly correlated with measures of behaviour change than Pre-Post measures (Shaw, 2013). After discussion with Shaw (2013) the researcher adapted the survey statements to a context more relevant to nursing students. The survey was entitled "Becoming an Ethical Nurse" (Appendix 5). Three open ended questions were added to the end of the survey.

Permission for the recruitment of student participants to undertake this research was obtained from the Dean of Nursing at the University the study was being undertaken in. One week prior to the Giving Voice to Values workshop, an email was sent to the students by the School of Nursing Administration staff, with the Student Participant Information Sheet (Appendix 1) that introduced students to the research study and invited survey participation. Nursing students completed a Giving Voice to Values workshop and at the completion of this workshop hard

copy surveys were distributed by administration staff with the researcher not being present. Participants were instructed where to deposit their surveys on completion. Students were asked to fill out the survey indicating how much of the knowledge, skill, ability or characteristics of moral thinking they believed they had 'NOW' (Column A) compared to the beginning of the year (Column B) 'THEN'. Using the 'THEN' measure both the participant and the researcher was able to note reported changes.

Using a Likert scale to gather the data for this Phase, the researcher was able to measure participants views and recognise responses to given statements (Jamieson, 2004). Likert scales gather responses to statements through descriptive points in order to assemble a range of responses (Maranell, 2017). Through the use of this scale, the survey increased simplicity, transparency and focus for the participants completing the survey. The participants' demographic data including age and gender were also collected at the beginning of the survey. The participants identified their understanding of each statement in the survey using a Likert 6 point scale ranging from 1 – 6 with 1 = Almost None, 2 = Very Low, 3 = Low, 4 = Moderate, 5 = High and 6 = Very High.

Twenty-seven (27) statements in total were presented in the survey. Each statement required the students to give a Now and Then response. The survey asked students to think about how they saw themselves at the end of twelve (12) months of study after completing a Giving Voice to Values Curriculum unit of study and the Giving Voice to Values workshop. They were then asked to compare themselves to when they began the year. Data from the survey demonstrated the students' awareness of ethical issues that may arise within their nursing practice, their ability to resolve ethical conflicts in workplace situations, as well as their ability to appreciate the different ethical and value orientations of their colleagues. Students were asked to look at their awareness of their own ethical values and how these might affect their actions within the workplace. They were also asked how they might 'give voice' or 'act' on their values when

115

confronted with unethical behaviours or attitudes. Lastly, participants were asked to think about the likelihood of how they might express their moral values in a work setting, as well as their own understanding of personal ethical values and beliefs.

At the end of the survey, participants were presented with three (3) open-ended questions that sought further information. These questions were: What is Moral Competency (in your own words); What are your values? What does Giving Voice to Values mean to you?   The use of these qualitative questions allowed the participants to give greater detail about their understanding and reasoning regarding moral competence using their own specific words and ideas (Jack et al, 2010).

4.6.2 Phase 2: Semi-structured interviews with nursing experts and stakeholders

Requirement for the recruitment of stakeholders was highly focused. Identification was undertaken via a Stakeholder mapping exercise in order to identify stakeholders. A mapping exercise was undertaken in order to look at experts and stakeholders that could be considered from areas such as those currently working in a clinical area, stakeholders in leadership roles, current academics in the nursing field and regulatory areas.

The second phase of data collection used semi-structured interviews with key nursing experts and stakeholders from educational, clinical and regulatory bodies across Australia. These interviews allowed the researcher to explore these professional leaders' understanding of the development of moral competence in nursing. The semi-structured interviews also attempted to gain the nursing experts' and stakeholders perceptions and observations regarding the strengths and gaps in nursing education in regards to students' preparation for being morally competent in the work place. Information was also gathered from the participants in regards to their understanding of the curriculum demands that intersect with the development of moral competency within nursing undergraduate programs.

Eight interview participants were purposefully selected from the key areas of clinical leaders, regulatory leaders, academic leaders and graduate leaders, with initial letters being sent. The clinical leaders were those who focused on the improvement of quality and safety outcomes for patients or patient populations. Experts in nursing regulation were involved in the development of standards, codes and guidelines for the nursing profession. Academic leaders were selected for their influence in and teaching of nursing ethics and moral development, and the graduate leaders were those who had undertaken their nursing studies within the last five years – thereby clinical leaders. An academic participant information sheet (Appendix 2) as well as an Informed Consent sheet (Appendix 3) were sent to each of the participants and signed consent forms were returned to the researcher by email. Participants were contacted on receipt of the consent forms and interview times were scheduled and confirmed at a mutually convenient time and place.

The sampling method for this research was purposive convenience sampling. This method was used to identify and select participants for the semi-structured interviews that were specifically experienced and knowledgeable within the nursing profession and would bring a depth of understanding to the research (Cresswell & Plano Clarke, 2018). The availability and willingness to participate along with the ability to communicate their experiences and opinions was also taken into consideration. The semi-structured interview themes were constructed following the completion of the literature review and Phase 1 survey.

4.7 Study participants

4.7.1 Nursing student participants

The source of participants was from a School of Nursing at an Australian University. Potential participants were given an invitation by a third party to participate in the surveys. Invitations were distributed to first year students at the end of 2015 and 2016. These students were enrolled in a three year fulltime undergraduate program. All invited participants had

completed an integrated Giving Voice to Values Curriculum within an Ethics subject and had

completed a one day Giving Voice to Values Workshop immediately prior to the survey

distribution. The surveys were anonymous, and completion was voluntary.

4.7.2 Nursing experts and stakeholders

In gathering data for this research, it was important to gather information from nursing experts

and stakeholders, both male and female, who were directly involved in areas where the

development of moral competence in nursing was observed, led and carried out. The

perceptions, experiences and expertise of these participants were gathered through a onetime

in-depth semi-structured audio taped interview. These nursing experts and stakeholders had

different roles within the professional areas of nursing: clinical leaders, regulation leaders,

academic leaders and graduate leaders as seen in Table 3. A small representative sample of

these professional leaders was purposefully invited to participate. It was anticipated that this

small group would be able to provide rich and meaningful explorations and perceptions for this

study. In support, Patton (2002, p. 245) stated that "validity, meaningfulness and insights

generated from qualitative inquiry have more to do with the information richness received than

with the sample size".

Table 3: Professional Areas of Nursing Experts and Stakeholder Participants

ID	Expert & Stakeholder Areas			
	Clinical Leader	Regulation Leader	Academic Leader	Graduate Leader
A				X
B		X		
C			X	
D		X		
E			X	
F	X			
G				X
H	X			

Interview participants were initially contacted via email. Participants willing to participate in the interviews were then sent an information letter and consent form which were then sent back to the researcher prior to a time being set for the interview. The interview themes were identified as:

- Definition of a morally competent nurse

- Phases of development of moral competency in nursing

- Preparation of nurses to be morally competent

- Contemporary approaches or frameworks utilised in nursing education in Australia in regard to the development of moral competence within the nursing profession.

- Curriculum demands that intersect with the development of moral competency within nursing studies

- Perceived or observed gaps within the development of moral competency in the nursing profession.

For consistency, the researcher conducted all interviews. Three of the interviews were conducted face to face, whilst the other interviews were conducted over the phone. Each interview lasted approximately one hour and were transcribed shortly after the interview was completed. Telephone interviews were utilised when travel constraints and geographical

distances hindered face-to-face interviews. The telephone placed on a loudspeaker enabled recording using the same method as the face-to-face interviews. The recording of the semi-structured interview commenced following an initial introduction with the participant's consent. Clarification of the aims of the study and the purposes of the interview were again presented to the participant. The participant was given time to ask any questions they may have in regards the interview prior to commencing.

The interview was designed to build rapport and clarify responses to the themes that had been sent to the participants prior to the interviews. The researcher invited all participants to speak informally in regard to the themes asked. Field notes were completed after each interview. The interviews were undertaken in 2018.

4.8 Data Analysis

4.8.1 Phase 1 – Nursing students

Analysis of the quantitative survey data preceded the qualitative, semi-structured interviews. Quantitative data from the student surveys was analysed using the Statistical Package for the Social Sciences (SPSS) Version 26.0, to perform descriptive and correlational analyses. Qualitative data from the surveys was coded for each question. Analysis from this survey provided insight into the development of themes for the qualitative phase of the research study.

Content analysis of the three open-ended questions provided a methodical and unbiased process of explaining and calculating trends through a process of categorizing the data into themes and key concepts (Elo & Kyngas, 2007). These responses gave insight into students' understanding and the development of moral competence through the Giving Voice to Values curriculum learnings over the academic year.

Question 1 asked for the participants' understanding of Moral Competence in their own words. Six (6) categories were used to classify and collate the students' responses:

- Students' awareness of their action/influences/doing/being

- Students' awareness where there was no action/doing/being

- Limited awareness or knowledge was exhibited

- Students' incomplete awareness where knowledge needed to be developed

- Question misunderstood or student was unsure of question

- Question was left unanswered

Question 2 asked the participants their understanding of what values they held. The answers were categorized using clusters of the values identified by the participants.

Question 3 asked the students to reflect on what the Giving Voice to Values curriculum meant to them. Answers were again coded using words or phrases given by the students that represented important or recurring themes in the responses. Common themes and concepts were measured using thematic analysis.

4.8.2 Phase 2 – Nursing experts and stakeholders

The semi-structured interview design was utilised as it allowed the researcher to target various aspects of the concept of moral competence, as well as the development of moral competence in nursing through the use of open-ended exploratory questions. Interviews with nursing experts and stakeholders were transcribed and thematically analysed. The transcribed interview data was evaluated focusing on the research themes in order to identify patterns of thought and practice that provided answers. A rigorous process of data analysis, data coding, theme development and revision was undertaken with oversight and objectivity from Research Supervisors. The researcher independently collated data and developed an interpretive summary identifying themes and examples from the data. When consensus had been reached, this analysis of data provided an accurate interpretation of information gathered.

4.9 Ethical considerations

This study held ethical risks for participants, therefore the ethical rights of all participants were upheld during the design and implementation of this research. The primary ethical concern was the relationship between the researcher and the participants. The existence of a power differential was acknowledged, as the researcher was a Senior Academic at the University, involved in the teaching and assessment of nursing students. It was essential to assure the participants that the study would take place outside the researcher's academic influence, as a hierarchical power relationship may introduce coercion into the research process (Seidman, 2019). All participant recruitment and data collection processes were separated from the researcher, and the survey respondents were anonymous, consequently the researcher could not identify participants or non-participation.

Confidentiality and privacy principles were upheld by the researcher throughout the entire process of the research. The participant information sheet was integrated into the survey, and completing the survey and submitting it, implied consent to participate. Confidentiality of all interview participants was upheld. Participants were given a coding at the commencement of the interview so that only the researcher was aware of who was represented in the data collation and analysis.

Phase 1 Consent was indicated by the completion and return of the survey, with the distribution and return processes of the survey clearly stated. The Survey Information form outlined the rights and responsibilities of the participant and the researcher, as well as the goals and methods of the research study. Participants were informed that they were under no obligation to take part in the study. Informed consent for Phase 2 as stated by Alby et al. (2014) was achieved through the acceptance of voluntary consent which was gained from the research participants for interview participation and recording. A full and comprehensible explanation by way of a Participant Information Sheet was provided along with information regarding the

research study. Autonomy, via the participants' right to withdraw from the study was respected and observed. No identifying data regarding interviewees was recorded or reported in the study, nor will be in subsequent publications. Interviews took place at sites and times mutually convenient to both researcher and participant. The interview participant had the lead role in determining where they would like the interviews to be undertaken.

On conclusion of the interviews, data was gathered, and each interview had been given an alphabetical coding that assured confidentiality. All survey documents and transcribed interviews were stored securely in accordance with the University's Policy on the Code of Conduct for Research on the researcher's password protected computer. All data was stored in an electronic database in the researcher's academic office. Folders were clearly labelled identifying: notes, documents, questionnaires, and interview transcripts. It was essential that the data be kept in order, with clear evidence showing the links between themes, data collected, and the conclusions drawn (Yin, 2009). This record provided a formal accounting of gathering of evidence, distinct from the final conclusions, which could be used in an appraisal trail by other researchers for further exploration. On completion of the study all participant data inclusive of interview notes and memos was to be stored securely at the University for a period of 5 years. The researcher and supervisors were the only people permitted access to the data. The Dean of Nursing gave approval for the study to be undertaken within the student cohorts, and the University's Ethics Committee provided ethics approval: HREC Reference Number: 014146S.

The study conformed to the University's Research Integrity Statement and the National Statement on Ethical Conduct for Research Involving Humans as well as the National Health and Medical Research Councils Ethical Code of Conduct (National Health and Research Council, Australian Research Council, & Australian Vice-Chancellors' Committee, 2007). The

researcher upheld the values of integrity, respect for persons, autonomy, beneficence, and justice. Every stage of the research was monitored by the supervisor and co-supervisors.

4.10 Research bias and limitations

This study was limited in that it only looked at nursing students on one campus of the University where the research was undertaken. The researcher had worked in the School of Nursing for 13 years and was part of the initial introduction of the Giving Voice to Values Curriculum within the School of Nursing. This closeness of the researcher to the study could be considered a limitation, however, any bias was reduced through critical reflection, field notes and discussion of methods and findings with the supervisors. The researcher, being mindful of the perceived bias, continually looked for alternate views and demonstrated this within the analysis and conclusions of the study. Leading and framing were deliberately avoided during the interviews to allow the participants to put their understanding forward without reservation. The participants – as professional leaders – were empowered to present their perceptions and observations with full confidence.

The 'Becoming an Ethical Nurse' survey was a self-report design, which in itself has advantages and disadvantages. One of the prime benefits of self-report data is that it is easy to obtain (Rosenman et al., 2011). Using a self-report can be undertaken reasonably quickly with results quickly to hand, they can be made in private and can be anonymised in order to protect information and encourage honest responses. Limitations in the use of self-reporting tools are that individuals may feel biased in reporting their own experiences and may either knowingly or unintentionally be motivated by what they think they should say and may be more likely to report experiences that they considered to be what the researcher was wanting to hear (Rosenman et al., 2011).

4.11 Conclusion

This chapter has detailed the research methodology, philosophical underpinnings and design used for this study and the ethical principles applied for its conduct. This mixed methods research study allowed for the measurement and exploration of the development of moral competence in nursing. Phase 1 allowed the researcher to gain an understanding of the development of moral competence of the student participants following an integrated Giving Voice to Values curriculum and a dedicated Giving Voice to Values Workshop. Phase 2 provided valuable data from nursing experts and stakeholders within different areas of nursing to voice their perceptions and experiences of the development of moral competence in nursing. The mixed methods approach allowed for investigation of the development of moral competence from different viewpoints, providing meaningful results. The approach measured and explored the reported outcomes of nursing students completing the Giving Voice to Values Curriculum, as an introduced model for the development of moral competence. Chapter 5 and Chapter 6 will go on to review the findings of both Phase 1, the student survey, and Phase 2, the semi-structured interviews with nursing experts and stakeholders respectively.

Chapter 5: Research Findings of Phase 1: Student Survey

5.1 Introduction

The previous chapter defined the design used for this study providing discussion in relation to the approaches used. This chapter presents the findings of the Student Survey (Phase 1), conducted following their completion of the Giving Voice to Values Curriculum in their first year of an undergraduate nursing degree program. Phase 1 allowed the researcher to acquire an understanding of the student participants' perception of Giving Voice to Values. This phase also allowed the researcher to gain an understanding of how the students understood the concept of moral competence, what their values were, and what Giving Voice to Values meant to them. This phase followed from the students undertaking an integrated Giving Voice to Values curriculum and a dedicated Giving Voice to Values Workshop. The surveys were undertaken at the end of the students' first year of studies in 2015 and 2016, with the total number of submitted surveys being 346. The overall response rate was 54%. The survey gathered information about the students' perceptions of moral competence, their understanding of their own values and the perceived impact of the Giving Voice to Values curriculum upon their learning outcomes. The data collected was analysed to establish the levels of students' awareness, skills, and abilities towards moral competence. A quantitative approach was used by the researcher in this phase of the research study and SPSS (Version 26.0) was utilised to analyse the data that was obtained.

5.2 Participant data and demographics

The survey targeted nursing students at the end of their first year of study. 9.5% of participants were male and 57.2% female with 33.3% not stating their gender. Most participants were aged between the years of 15 to 30. Table 4 provides the gender and age profile of respondents by survey year and overall.

Table 4 Participant Demographic Data

	First cohort (N = 163) n (%)	Second cohort (N =183) n (%)	Total (n = 346) N (%)
Gender			
Female	90 (55.2)	108 (59.0)	198 (57.2)
Male	17 (10.4)	16 (8.7)	33 (9.5)
Missing gender data	56 (34.3)	59 (32.3)	115 (33.2)
Age			
15 – 20	84 (51.5)	103 (56.3)	187 (54.0)
21-30	38 (23.3)	49 (26.8)	87 (25.1)
31-40	4 (2.5)	6 (3.3)	10 (2.9)
41-50	1 (0.6)	4 (2.2)	5 (1.4)
51-60	2 (1.2)	4 (2.2)	6 (1.7)
61-70	0 (0)	1 (0.5)	1 (0.3)
71-80	2 (1.2)	0 (0)	2 (0.6)
Missing age data	32 (19.6)	16 (8.7)	48 (13.9)
Total	163 (100)	183 (100)	346 (100)

5.3 'Then' and 'Now' responses to survey items

Data collection consisted of two parts. The first part consisted of twenty-seven (27) statements where the student was asked to respond, giving their own self-assessment of their moral competence, using a Likert scale to select their response to statements at a particular time. Column A ('Now') indicated the student's perceptions at the end of the year after undertaking an ethics unit of study with an integrated Giving Voice to Values Curriculum, and a Giving Voice to Values Workshop. Column B ('Then') indicated the student's perception of their status prior to undertaking these Giving Voice to Values curriculum studies. The survey statements asked the student to assess their awareness and understanding of ethical issues that may arise in their nursing practice. Statements also asked the students to consider their abilities in resolving ethical conflicts, appreciating different ethical and value orientations of others, and being able to accept these differences. The students' perceived ability to be able to act on their values as well as raise ethical issues with team members, other healthcare professionals or patients was also measured. The survey also asked students about their ability in understanding situations from a values perspective, which may not be aligned with their own

viewpoints, as well as their understanding of why people act the way they do in particular situations. Students were asked to consider influences on their own behaviour, their ethical values and beliefs, and their ability to influence others to act ethically in value conflict situations. Table 5 presents the mean score for each of the Giving Voice to Values statements for the "Then" and "Now" responses. The difference and the level of significance is displayed in order of the greatest difference between item means. All 27 comparisons showed a significant difference at $p < 0.0001$

Table 5. Mean item scores for 'Then' and 'Now' Analysis

Statement No:	Giving Voice to Values Statements	Pre-Semester (Then)	Post-Semester (Now)	Difference	Significance
1	Awareness of ethical issues	3.18	4.93	1.75	P <0.0001
22	Give voice to values in a work setting	3.33	4.82	1.50	P <0.0001
26	Likelihood that I would express my values in a work setting	3.48	4.94	1.46	P <0.0001
24	Ability to use persuasive and appropriate ways to influence values and behaviour	3.32	4.73	1.41	P <0.0001
6	Give voice to own values when confronted with different values	3.27	4.67	1.40	P <0.0001
14	Effectively communicate my point of view	3.43	4.80	1.37	P <0.0001
17	Understanding of factors in a workplace that lead to unethical behaviour	3.54	4.90	1.37	P <0.0001
7	Raise ethical issues with colleagues, patients and carers	3.26	4.62	1.35	P <0.0001
16	Articulate ethical principles	3.47	4.80	1.33	P <0.0001
8	Needs to be said and done in an ethical dilemma	3.34	4.65	1.31	P <0.0001
12	Understanding of corporate social responsibility in healthcare environment	3.31	4.59	1.29	P <0.0001
18	My ability to ask for advice when I need help	3.76	5.04	1.28	P <0.0001
13	Understanding of environmental sustainability in a healthcare environment	3.22	4.48	1.26	P <0.0001
5	Knowledge of my own ethical values	3.72	4.98	1.26	P <0.0001
10	Correct existing course of action that is unethical	3.46	4.73	1.26	P <0.0001

Statement No:	Giving Voice to Values Statements	Pre-Semester (Then)	Post-Semester (Now)	Difference	Significance
19	Knowledge of common reasons people use to justify unethical behaviour	3.56	4.82	1.26	P <0.0001
23	Understand how emotions, cognitions and instincts can influence ethical behaviour	3.82	5.07	1.25	P <0.0001
25	Communicate effectively about ethical issues	3.78	5.02	1.23	P <0.0001
2	Win-win outcomes in resolving ethical conflicts	3.18	4.37	1.19	P <0.0001
21	Understand why people may act the way they do in a work situation	3.74	4.93	1.18	P <0.0001
11	Influences others to behave in an ethical way	3.73	4.89	1.17	P <0.0001
27	Understanding of my own personal ethical values	4.07	5.23	1.16	P <0.0001
9	Understand a situation from a value perspective other than my own	3.91	5.05	1.14	P <0.0001
20	Empathise with a person who has a different set of values	4.04	5.14	1.09	P <0.0001
15	Commitment to acting ethically	4.15	5.22	1.07	P <0.0001
3	Appreciate different ethical and value orientations	4.00	5.06	1.06	P <0.0001
4	Accept different ethical and value orientations	4.25	5.20	0.96	P <0.0001

5.3.1 Results of survey data

The Shapiro-Wilks test for normality was used to test normality of data assumptions, and this showed that all of the Giving Voice to Values survey items violated the normality assumption. Therefore, the Wilcoxon signed rank test was used. The Wilcoxon signed rank test is used in place of the paired sample t-test when data is not normal. The Wilcoxon signed rank test detects whether a directional change occurred between the "Then" and "Now" scores. Because of the number of comparisons that were carried out (n = 27), the Bonferroni correction for multiple comparisons was applied. Thus, a significant p value of <0.001 was set. All analyses were completed using SPSS Version 1.0.0.1298.

5.3.2 Highest areas of student development

The highest areas of student development reported were:

- Understanding of ethical issues

- Ability to speak up

- Ability in articulating their values within a work setting

- Ability to influence other individuals' values and behaviours

- Ability to voice one's own values when challenged with different values

These areas of student development are all in essence, communication skills.

5.3.3 Lowest areas of student development

The areas of least student development reported were:

- Acceptance of different ethical and value preferences

- Understanding of their own personal moral values

- Appreciation, commitment and empathy to those who have different value sets

- Appreciation of diverse moral thinking, dissimilar moral and value positions

- Understanding of emotions, perceptions and instincts and how this influence moral behaviour

- Ability to ask for advice when needing help in dealing with moral encounters

These areas of least development require critical reflection, self-awareness, developed moral competence and collaboration with others.

Figure 3 demonstrates the changes as documented by the students after completion of the Giving Voice to Values curriculum. The graph shows that there has been a significant increase in awareness of ethical issues and in the ability to speak up within a work setting.

Figure 3. Mean scores 'Then' and 'Now' for the 27 survey items
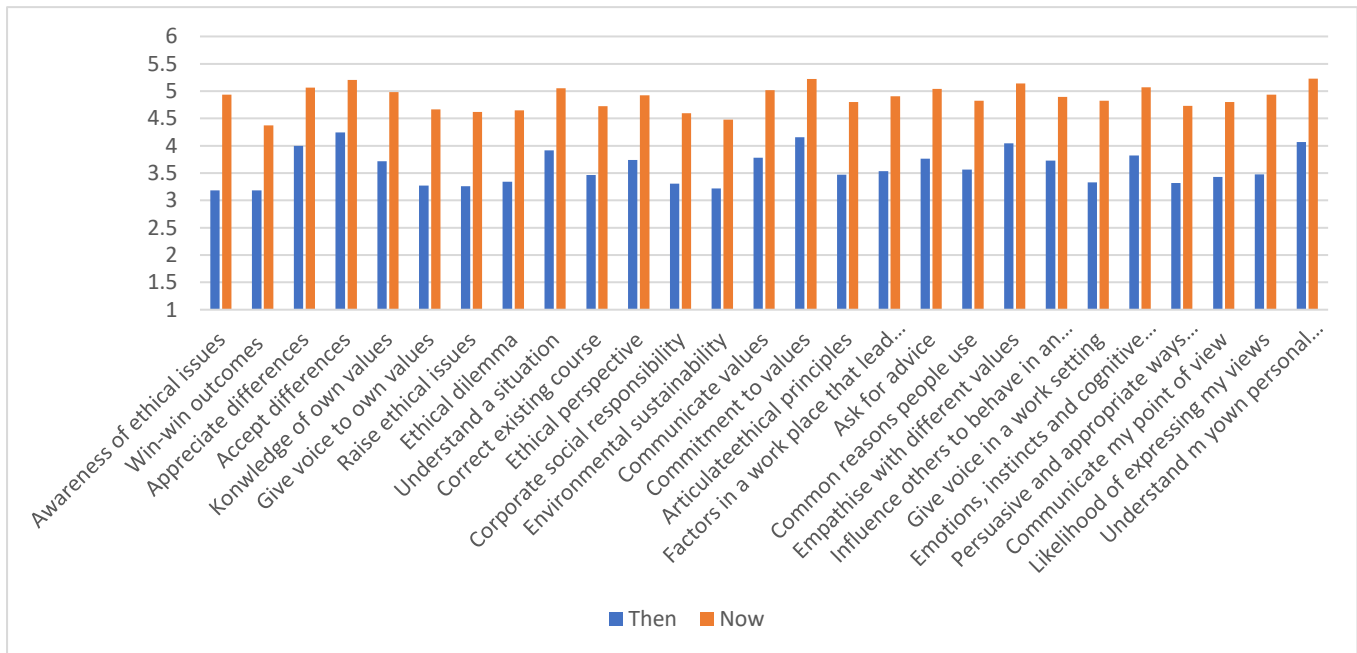
All survey item responses have indicated a perceived increase in students' ability, capacity, skills and awareness, after the completion of the Giving Voice to Values curriculum.

5.4 Qualitative responses

Following on from the 27 statements within the Survey, students were asked three open-ended questions to answer in their own words.

5.4.1 Question 1: What is moral competence?

This question invited the students to present their own understanding of moral competence. The responses given by the students were grouped (Figure 4) according to the students' level of displayed knowledge and were categorised as:

- Incomplete knowledge of moral competence

- Incomplete knowledge with ability to identify one aspect of moral competence

- Developing knowledge of moral competence

- Comprehensive knowledge of moral competence

- Question unanswered / did not know.

Figure 4: Knowledge of moral competence.
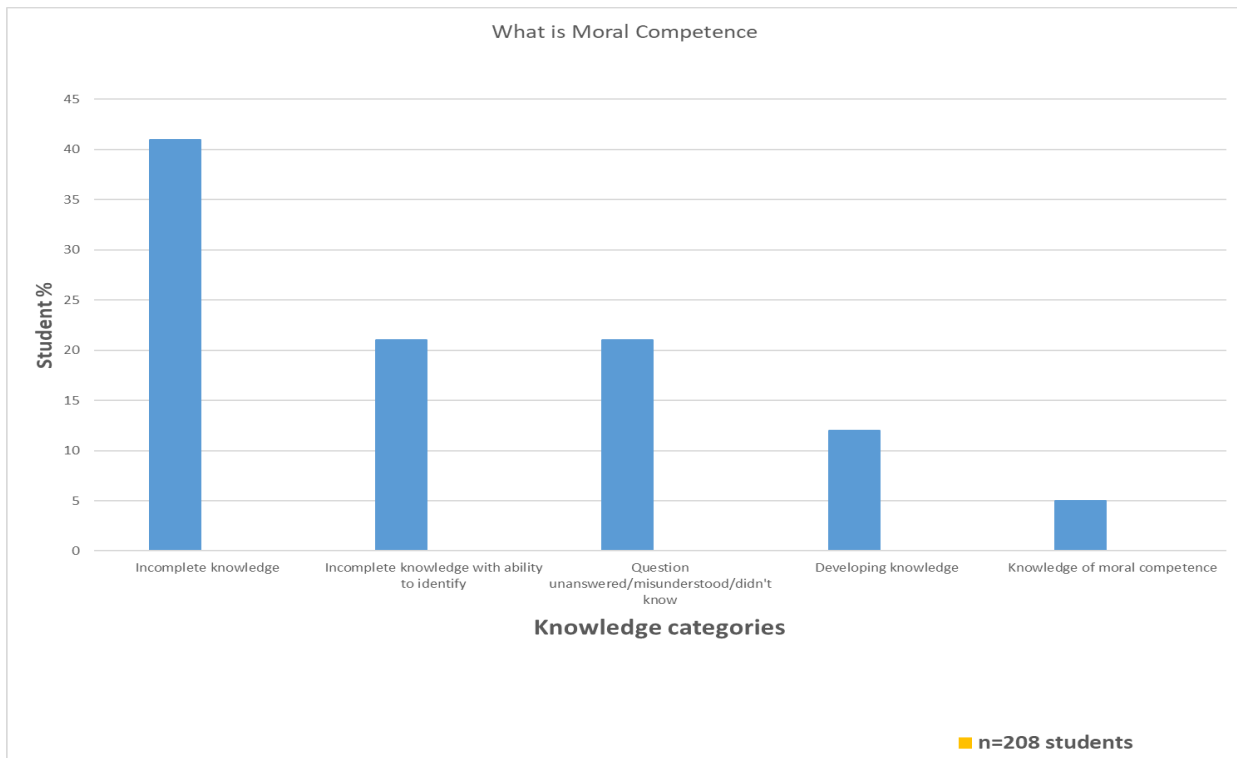
Figure 4 reveals that 41% of students undertaking the survey demonstrated incomplete knowledge of moral competence, whereas 21% demonstrated the ability to be able to identify one aspect of moral competence. 12% of students demonstrated that they had a developing knowledge of moral competence, with 5% of students demonstrating that they had a comprehensive knowledge of moral competence. 21% of students left the question unanswered..

In summary, data revealed that students primarily saw moral competence as a cognitive capacity, with some students indicating they were aware of moral competence but had limited understanding. Moral competence as awareness, respect, and the ability to identify one's values were the main themes throughout the responses, that demonstrated a developing knowledge of moral competence. Students also stated that moral competence was being able to make decisions and to understand what was right or wrong if they were faced with a conflict.

The survey undertaken by the students demonstrated that they perceived a limited but developing knowledge of moral competence. Students were able to show that they recognised the communication skills of moral competence, but they were not yet clearly recognising affective, cognitive reflective and analytical elements of moral competence.

5.4.2 Question 2: What are your values?

This question asked students to identify their values. Their responses were collated numerically; n=231. Table 6 presents the most reported values; Table 7 represents other values students identified with Table 8 demonstrating values that were the least identified by the students.

Table 6. Most Cited Values by student participants

Most Cited Values by student participants		
Respect (92)	Honesty (81)	Empathy (35)
Compassion (37)	Kindness (35)	Integrity (15)
Dignity (25)	Loyalty (25)	Trust (21)

Table 7: Other Values Cited by Students

Other Values Cited by Students		
Justice (14)	Understanding (14)	Equality (14)
Truthful (9)	Patience (11)	Fairness (8)
Beneficence (7)	Love (7)	Happiness (6)

Table 8: Least identified values noted by students

Values least identified by the students		
Advocacy (4)	Sincerity (1)	Individuality (2)
Acceptance of difference (1)	Open minded (1)	Selflessness (2)
Professionalism (1)	Choice (1)	Transparency (1)
Willingness (1)	Self-knowledge (1)	Autonomy (5)
Patient-centered care (3)	Courage (2)	Non-Maleficence (1)
Forgiveness (1)	Charity (2)	Strength (1)
Duty of Care (1)	Freedom (2)	Openness (1)
Morality (4)	Intelligence (1)	Genuineness (1)
Commitment (2)	Hope (1)	Acceptance (1)
Diversity (1)	Tolerance (2)	Truth (5)
Humility (3)	Responsibility (2)	

The most often cited values are congruent with professionalism and the nursing profession. The breadth of responses indicates values diversity, with congruence across a values spectrum indicating the development of self-awareness within a pathway towards a values-based profession and practice.

133

5.4.3 Question 3: What does 'Giving Voice to Values' mean to you?

This question asked the students to express what 'Giving Voice to Values' meant to them after the completion of the Giving Voice to Values Curriculum. The responses to this open-ended question were collated into thematic clusters (see Figure 5).

Figure 5: Students' perception of 'Giving Voice to Values'
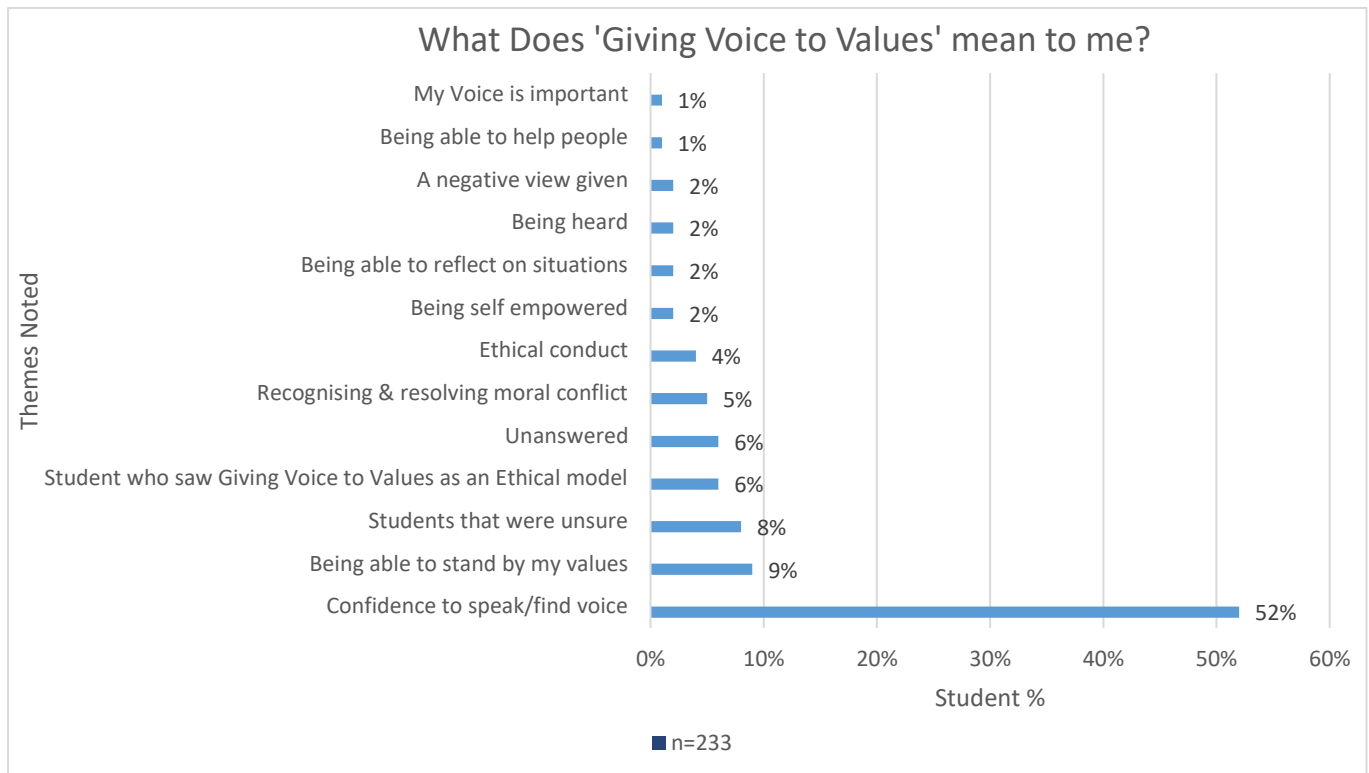
The main content clusters collated from the student responses were:

- Ability to speak up and find their voice

- Ability to recognise and resolve moral conflicts

- Knowing their voice is important

- Ability to reflect

- Feeling self-empowerment through helping people

- Standing by one's values.

Students reported that the study of 'Giving Voice to Values' enabled them to discover their voice and be able to speak up with confidence. Students perceived 'Giving Voice to Values' as enabling them to be able to stand by their values as well as being heard and identified 'Giving Voice to Values' as an "ethical model", forming a part of their undergraduate nursing education.

There is correspondence between the responses to this question, and the earlier survey results identifying the students' self-assessment of their moral competence. Students acknowledged having more awareness of their own moral competence as well as being more aware of ethical issues and being able to speak up as their highest qualities in their self-assessment. Data from this question indicated that the students were able to demonstrate an understanding of 'Giving Voice to Values' and its contribution to their development in speaking up.

5.5 Conclusion

Overall, the survey results identified and explored the nursing students' self-assessment of their moral competence, their values, and their understanding of 'Giving Voice to Values'.   The data indicated that the students' self-assessments noted increased development in all elements measured in the survey. Data showed increases in the students' confidence, indicating that they had developed their moral competence in some elements more than others.   The strongest elements of change were the students' reported acquisition and development of skills in moral communication; however, they reported a lower development of their moral understanding. Students stated the implementation of Giving Voice to Values into their studies had a positive influence upon their developing skills in being able to speak up.

Data also demonstrated that the Giving Voice to Values curriculum facilitated improvement in confidence to speak up and voice their values, but did not increase appreciation and awareness of value differences, orientation to others or the values of other cultures. Data and responses from the survey demonstrated the student's perceptions as to their professionalism, their

empowering of self, knowing that their voice matters and is important, and reflecting on what they understand. Students having undertaken a unit of study incorporating the Giving Voice to Values curriculum were able to demonstrate an increase in their knowledge, skills, abilities and characteristics that were present at the start of their studies (Then) to what they perceived them to be at the end of the first year (Now).

Chapter 6 will analyse the findings of Phase Two of this research, the qualitative semi-structured interviews undertaken with nursing experts and stakeholders. The analysis of Phase 2 will deliver added professional context and perspectives regarding the development of moral competence in nursing.

Chapter 6:   Research Findings of Phase 2: Nursing Expert and Stakeholder interviews

6.1   Introduction

The previous chapter discussed phase one of the study design. This chapter analyses the findings from Phase 2 of the research study. Semi-structured research interviews were undertaken to understand moral competence and its development in nursing from the perspective and experiences of nursing experts and stakeholders. Questions used in these interviews were informed by the student survey results. The use of semi-structured interviews was undertaken as it allowed the researcher to have structure, but also allowed for more in-depth probing of responses given by participants. The interviews were undertaken with nursing experts and stakeholders from clinical, leadership, academic and regulatory areas. The data gathered provided a rich picture of the participants' opinions and experiences regarding moral competence and its development, both in the educational and clinical contexts, and along the professional pathways of nursing. Central themes emerged that were recurring, reaching data saturation. This chapter presents the findings of the interviews (phase 2).   The thematic analysis explored the five central themes undertaken in the semi-structured interviews, these being: (a) what is a morally competent nurse, (b) the development of moral competency in nursing, (c) the preparation of nursing students towards moral competence, (d) gaps in the development of moral competence in nursing and (e) intersecting demands within the development of moral competency in nursing students. These central areas for exploration were informed by Phase 1 of this study, the survey of nursing students.

6.2   Data analysis process

Data from interview transcripts was read, collated, and grouped thematically. Contemporaneous notes were made by the researcher in order to compare thoughts and findings, these were then explored and examined with the principal supervisor in order to decrease the bias of preconceived ideas.

6.3 Theme One: What is a morally competent nurse?

This theme explored the nursing experts and stakeholders understanding and perceptions of what a morally competent nurse is. Most participants stated that they found this theme difficult to immediately answer and had to think twice whilst talking about this theme. The defining of a morally competent nurse was not simply given. Participants generally acknowledged that a morally competent nurse varies, and that nurses are influenced from both their internal concepts, as well as external happenings both of which clarify and inform the development of the individual. The following themes emerged from the data.

6.3.1 Moral competence as observed in its absence

Participant A stated: *"you can tell from the person's behaviour, the way the individual speaks to people, the tone of their voice, how they communicate about others when they thought no-one was listening, and how competent they were both morally and ethically"*. Participant B indicated: "as a member of the profession it is easier to say what it is not, then to rely on a definitive definition. It may rely on the situation at hand before one can say if one is morally competent or not". Participant C thought moral competence was: "someone who is aware of whatever system of moral and ethical decision making that they use however, primitive or advanced it may be" and a person "able to explain why they took the path that they took". All participants were unable to readily define this concept of the morally competent nurse. This challenge was clearly captured by Participant F stating: "it is difficult to define the idea of a morally competent nurse, as moral competence involves the individual's moral awareness, abilities, outlooks, motivation and reasoning ability". Participant G indicated: "when working in a clinical environment nurses must be able to make decisions through both theoretical and clinical knowledge".   Participants more readily explored moral competence as a way of being and doing; as seen in the practice of nursing.

6.3.2 Moral competence as observed in nursing practice

There were a range of attributes and attitudes that were seen as constituting a morally competent nurse. Participant A stated that they believed a morally competent nurse was: "one that had personal empathy for all those around them, not just the patient but for the healthcare team as well as family". Participant G spoke about a nurse being able to: "think holistically about how to care about their patients not only clinically but in all facets of their care". Participant E found it simpler to define a morally competent nurse through the use of examples as to what one would expect a morally competent nurse to do, that is: "…to act in a fashion that is ethical, and to do the right thing in the right circumstances, for the right reasons". Participant H stated:

> "…as a beginning clinician I see it as a basis of not breaking confidentiality, of not putting down other members of the 'team' they are working with…. not taking short cuts i.e. 'radar observations'… not ticking the boxes of things like handover check list or patient safety checklist just because everybody else does without checking the patient or whatever else they are supposed to be checking".

Participant D added that they believed that a morally competent nurse must be able to: "manage conflicts when they arose…. they must be able to reason through these conflicts …. be able to distinguish which values are being used in these conflicts". This participant went on to comment that: "nurses must be able to recognise nursing dilemmas…. be able to make good decisions and judgments that are based on their values whilst maintaining the regulations that direct them". Participant G identified that the nurse: "has influence, responsibility, and accountability for their nursing practice …they make decisions and take action that is consistent with their duty in the provision of best patient care". This participant also made mention that they believed it was also about the professional commitment to being able to

practice competently: "it is essential that accountability for all aspects of care is supported *with the nurses responsible decision making processes*". Participant F acknowledged that they understood a morally competent nurse to be: *"showing a standard of behaviour that they maintain in respect to what is and what is not appropriate in nursing practice"*. Participant C stated: "nurses must have a high level of regard for all whom they care for, and acknowledge self-respect in regards to their dealings in both the care and communication given to patients…the same treatment and respect be given to the patient's families". This participant also noted:

> "…nurses are accountable for their clinical purpose…their main responsibility is to take care of their patients who deserve suitable and safe care", and that "a nurse's actions are centered on the values they have chosen, and it is these values that form a framework in which they are able to evaluate their actions that might influence their goals, approaches, and purpose".

Participant E acknowledged: "moral practice was the foundation of ethical thinking for nurses as they will be dealing with moral issues on a daily basis, and that these dilemmas occur as the nurse cares for their patient". This participant went on to state that these dilemmas may: "sometimes conflict with the Code of Ethics or with the nurse's own moral values and that nurses are advocates for their patients ….nurses must be able to find a sense of balance at the same time as providing good patient care".

6.3.3 Moral competence as observed in the regulation of nurses

Most participants stated that The Code of Conduct (NMBA, 2018), Standards for Practice (NMBA, 2016) and the ICN Code of Ethics (2018) influence nurses' views, goals, strategies and actions, and that these regulations guide nurses to be morally competent nurses. Some participants looked towards the professional standards and Code of conduct that regulate the nursing profession, to ascertain moral competence; however, they felt that they could be seen

as lacking.   Participant B stated they felt that these professional statements and documents were: "incredibly broad and that you could drive a truck through them".

This participant went on to state:

> "…that within the accreditation standards there are areas
> which are mandatory in learning: Code of Conduct, Standards
> of Practice and the Code of Ethics…. but how these are
> delivered to students is up to the Unit Coordinator (educator),
> it is these standards that provide nurses with a reference
> point where they are able to reflect on their conduct as well
> as guide their ethical decision-making and practice."

Participant F remarked that: "the competency standards are resourceful in their example of what registered nurses are required to have, know and/or do…. with descriptive rather than wide-ranging examples of different types of practice". This participant also indicated that they thought a morally competent nurse was: "able to live in a way that was in balance with their own personal moral thinking as well as their responsibilities as a nurse". Participant D saw the regulation of moral competence as:

> "…incorporating all the ethical principles in being a
> nurse …. students/nurses have to understand and do
> what is good and right …. registered nurses take an oath,
> or did, to do no harm and all people should be treated
> accordingly, … nurses today must be able to manage
> conflicts, they must be able to reason through conflict,
> to discern which principles are working here…. To ask
> the question what do I think??... What do others think??....
> Overall, today's nurse must be able to deal with moral
> problems through their own understanding of values".

Further explorations from participants upheld the view that the regulatory Standards and Codes were foundations only; exemplified by Participant E stating: "there should be some assessment of the integration in regards to the Code of Conduct and /Code of Ethics throughout clinical placement … the Code of Ethics must be seen as just a starting point in their understanding of moral standards".

6.3.4 Moral competence observed as nursing knowledge

Participants located moral competence within the specific professional discipline of nursing knowledge which is central to the question of professional accountability. Students must have the capacity to be able to recognise a moral issue and then be able to understand any conflict of values that they might have. Students/nurses must be able to recognise the relationship between their personal and their public ideas of life, as well as recognising that we all share some significant values. Participant G stated: "being a morally competent nurse could be seen in the realms of coping…..allowed the person to be better able to cope with difficult situations/experiences/interactions and can give one a little more of an edge if moral competence is better understood". Participant C looked at moral competence as a nurse's own awareness and self-reflection and stated that a morally competent nurse: "was aware of whatever system of moral and ethical decision making that they use however, primitive or advanced it may be…..was able to explain why they took the path that they took with something more articulate then … because I thought…" Participant C also added that they thought that moral competence might also be: "a person who was able to explain their actions or their inactions, the things that they were actively able to move forward with and the things that they might resist within a nursing context and for these to be done in a consistent and contextual way".

Participant F explored competence and morality separately as distinct entities to begin with, they went on to identify a nurse as:

> "…someone working within a particular framework…
> has an advanced knowledge and understanding of
> various processes … is aware of what the regulations
> say… with a morality in the sense that nursing is seen
> as an ethical practice that requires courage to be
> moral, taking tough stands for what is right, and
> living by one's moral values …. nurses need moral
> courage in all areas and at all levels of nursing".

Participant E summed up their thoughts saying: "to have a nurse that would do the right thing, in the right circumstances for the right reasons" would be their understanding. Participant H, saw developmental knowledge as: "having some basics but that moral competence changes over time for some people… there has to be a base line level and the person's basic understanding that they have of ethics that they have derived from education and home life". Participant H also indicated:

> "…the acquisition of nursing values is explored through the study of professional values as well as one's own personal and social values …. exploration of professional values allows the student to understand the value of being accountable to the patients they are caring for, the healthcare team around them as well as for themselves".

6.4 Theme Two: The development of moral competence in nursing

This theme explored the participants' understanding and perceptions of the development of moral competence in nursing.

6.4.1 The foundations of moral competence

Many participants identified values and morals as the foundations of moral competence and its development. Participant A stated:

> "...a person's values are the foundation in the development of moral competence … nursing students need to be guided especially in the values of the facility in which they are undertaking their studies… these values are human values, they do not have to be put into a religious framework … these universal human values that guide you [sic]".

Participant B indicated:

> "…that if an individual does not fundamentally stay true to their values they will never get it…. from an education perspective it is about bringing those

143

values to the forefront and saying that this is where
we are coming from and that it is applicable to one's
practice…. people do not go into nursing with the
wish or desire to not hold onto those values but
clearly some people lose their way".

This participant also expressed: "it is the individual's maturity that helps them understand

values... the more they understood what their values are the better they will be able to act in a

morally competent way … as the individual gets older the better their understanding should

hopefully become". Participant B also identified the fact that: "professional values that are

fundamental in providing direction to the nurse, but nurses must have insight into these values

and be able to align them with their own values".

Participant G stated:

"…moral competence might also be defined as the
capacity of the individual to be able to identify their
own feelings in the way these feelings guide their
understanding to what is good or bad in particular
situation…the individual must then be able to think
about these feelings in order to make choices and then
be able to act on them."

This participant also stated: "one's values and feelings are derived from our culture which

includes religion, personal experience, …this in turn leads on to further learning in the nursing

profession". Participant D focused upon moral awareness:

"…nurses today are morally competent, but they may
not be adept in understanding the moral surroundings
that they are placed in …people who want to do nursing
usually want to do the right thing as a rule and are
usually, generally, morally inclined but it is more about
becoming morally aware and knowing how to apply morals
to specific situations".

Participant E gave the example of the complexity of this moral development:

"…one's instinct is not to hurt people but sometimes you
have to hurt people to cure them, or restraining a patient
with a mental health condition in order to protect them
from themselves, although your first instinct would be
to let them do what they want or how they feel but

sometimes you need to override your morals …. it is understanding when a greater need or greater right overbears what your natural moral compass is….it is about adjusting your understanding of what is right and what is the wrong thing to do and knowing that sometimes there are situations where what you feel is correct is not the right thing at that moment".

An individual's characteristics are a significant factor of moral competence with characteristics such as awareness, understanding, abilities, and skills being essential for the person to be morally competent.

6.4.2 Moral competence developed over time

There was uniform agreement that moral competence developed over time. Participant F considered the development of moral competence of nursing students: "commenced from a novice status…. that being one who was fairly new to the exposure of nursing situations and then moving to a level of advancement whereby they understood a certain level of moral thinking". Participant F also identified that this development of moral competence: "progresses over three phases from novice, intermediate to a more advanced thinking level". Participant C expressed a lengthier picture of this development in regards young adults commencing nursing studies and compared them to nurses who are five or ten years post registration in leadership positions: "their moral decision making process has become more complex to when they first began their studies, …. they are now aware of the multiple nuances that happen in situations". For a beginning nurse, Participant C considered that:

> *"...*it can be said that moral competence develops across a lifespan and is influenced by the individual's capabilities, moral competence might also be influenced by their behaviors when faced with moral concerns through the various phases of their physical and cognitive development. Moral development can be further developed through the individual's thoughts, behaviors, and feelings regarding standards of right and wrong as they progress through nursing studies".

6.4.3 Moral competence developed through education

All participants explored the processes of education in developing the moral competence of nurses.

Participant C considered the point that: "morality is teachable" and that "changes might be able to be suggested and related within nursing curriculum in order to have nurses display enhanced moral competency". Participant E believed that nurses today were: "more morally aware than their counterparts were ten years ago due to the effort in current tertiary education to ensure that ethics is promulgated throughout the education of tomorrows nurse". Participant D discussed the use of case studies to help in the development of moral competence within nursing education: "the use of case studies helps students to understand bad decision making and how these decisions and the consequences of such might impact, as well as how the outcome might be different through exploration of these case studies". Aligning students' education with the clinical world was seen as extremely important and challenging.

Participant H stated:

> "…student nurses appear to ask more questions when on clinical placement and students are more aligned to the clinical aspects of what they have to do having been taught during their undergraduate studies and are not really thinking of what they are doing in a moral sense …. I have been approached many times by students during their clinical practice asking questions which indicated their lack of understanding of the moral thought behind the skills they were undertaking".

This participant went on to acknowledge:

> "…if facilitators were able to emphasise the moral reasoning behind skills students may have a better understanding of why something was being done in the way it was...….the student nurse relies very heavily on modelling…. classroom teaching does not really prepare students for some of the moral situations that arise in the ward or other areas".

Participant H also recognised that:

"…students should have tutors who model moral thinking
along with their clinical teaching so that the student is
exposed both in the teaching area along with the moral
thinking which needs to be explicit and engaging, hoping
that the student will model this on the floor … I have had
students were posing questions during their clinical placements
about what they should be doing such as …. I see that
others are doing this, should I be doing that?' and that
questions were also posed in relation to what the right thing
to do was and why what others were doing was wrong …
sometimes they felt compromised as they were doing what
they were taught, but registered nurses were telling them
that this is what you do in the real world…. I have observed that
nurses at the beginning of practice were much more diligent,
later becoming less mindful in their moral competence".

Participants A and G were both involved in academic teaching and discussed the core units of

ethics study at universities; they believed that the core units helped students understand where

they were positioned on both moral issues and personal values. Participant A commented that:

"…students must understand where they were coming from,
who they were and what they stood for, as without
this it is difficult for them to then be able to stand up
and advocate for others on moral grounds, i.e. having
moral competence …. units of study in ethics help students
understand morals, the morals of other people and
how and why people do and say what they do …a
basic unit must be undertaken to begin with and then
areas woven into other units of studies over the next
three years".

Participant G considered that:

"…academically all universities do not explore the
development of moral competence …there is not
enough talk about morals/values in any universities
and students should be educated in what is the right
way to talk to someone and to upskill them in having
the right tools to go about it as well as reflecting on
how to do it and why".

Participant H believed: "students must be challenged to grow in their thinking and understanding*"*, however, the diversity of students was also a factor in their development and this participant furthered stated:

> "…it really depends on the individual, some students
> need that light bulb moment …some students coming
> back from their first or second clinical placement were
> seeing the world through very different eyes as their life
> experience has not been great and that being exposed to
> challenging situations, getting them out of their comfort
> zone can be quite confronting for some students".

Participant C stated:

> "…it should not be assumed that an individual will be able
> to develop their moral competencies through the
> study of professionalism as well as professional nursing
> ethics alone, it should be integrated into all facets
> of nursing curriculum for the student to have a greater
> understanding as well as insight into their own values
> and how these might impinge on their nursing practice".

Overall, the interview data demonstrated that the development of moral competence was perceived to be linear, beginning with the novice student who required formal instruction as a strong foundation to further integrated learning. It would be hoped that through education in regard to moral development, the nursing student would hopefully become more developed, independent, responsible and have a more mature moral consciousness. Case study learning, and lessons from the clinical field, were seen as central contexts for learning through demonstration and exploration. The internalisation of acquired professional values – above and beyond personal values – could be seen by some of the nursing experts and stakeholders as a required component in the development of moral competence. Participants deliberated the fact that the use of effective methodologies might encourage students to better understand and further their own critical thinking and decision-making process. This might be undertaken through skills being implemented whereby the student becomes the central means allowing

them to understand how they saw themselves interacting through their moral actions. The use of effective methodologies such as the implementation of a practice, whereby the student becomes the central means in their own development and learning was deliberated as an option to encourage the students' self-understanding. It was also felt that this would further the student's critical thinking and decision-making processes in areas of moral actions.

Overall, the findings of "what is a morally competent nurse" demonstrated that it was seen in nursing knowledge and nursing practice, and that it was regulated by and through the profession. Moral competence could also be seen in the nurse's behaviour, awareness, and abilities. The majority of participants identified that a morally competent nurse must be able to recognise what is happening, as well as having a good understanding of what to do, and the ability to respect the other individual's moral viewpoints. Participants on the whole thought that moral competence was more than just basic understanding, and that the individuals needed to have the skills required as well as the capacity to use those skills successfully in order to work through the morally challenging situations that arose within the workplace. All participants implied that they have a moral relationship of trust with patients and those they worked with, and that they expected nurses to have and maintain moral standards of practice within the nursing profession,

6.5 Theme Three: The preparation of nursing students towards moral competence

This theme explored the participants' understanding and perceptions of the preparation of nursing students towards moral competence

6.5.1 Education towards moral competence

A number of participants stated that a student's grounding in moral competence actually starts before entering University to undertake nursing studies, and that moral competence must be a process of continuous assessment from Day 1 of study and continue there on. Many

participants suggested that the best way to apply moral thinking, was to begin analysing bad outcomes or non-competent situations, then developing principles towards moral thinking and practice. The valuable use of clinical reasoning through case reviews and the introduction of moral concepts using case studies was highlighted by Participants F, H, C and E.

Participant E indicated:

> *"...*it must be remembered that an academic cannot teach clinical decision making/clinical reasoning without having an understanding of the moral aspect of things included e.g. not taking short cuts …. moral thinking really comes in around the teaching of how to care for the patient and why that is really important".

Participant E further deliberated: *"there should be some assessment of the integration of* studying and applying the Code of Conduct and Code of Ethics throughout clinical placement". This participant remarked the Giving Voice to Values curriculum was a good framework to follow:

> "…Giving Voice to Values curriculum should be brought into the students first semester units as well as introducing models of ethical decision making that might be used in certain curriculums, so that students would have been exposed to a couple of frameworks through early discussion and through engagement with them…… students should be encouraged to try and develop their own framework for ethical thinking that they might use during their studies…. hopefully, students would understand and use this model when they needed to … moral thinking and competency had to be interwoven throughout the curriculum in order for the student to gain a developing understanding… however, this progressive developmental education is not always visible….it is evident in some units of study but it is not always overtly stated that this is the right thing to do… and that… faith-based institutions have a watershed level that one cannot go below, not to say that this is not said for all institutions".

This participant also acknowledged Aristotle's thinking in regard to practicing virtue, stating that Aristotle quoted: *"the more you practice, the better you become, the more it becomes innate in who you are."*

Participant C shared their view that one way to go forward was:

> "…at the start of their studies to bring to their attention some disastrous moral and/or ethical decisions that people have made and what were the consequences of these decisions... if the academic starts off by saying at the beginning of a unit of study what is ethical thinking? most students will see it as 'mundane speak' and think that we will never use this, whereas, if they were given some very recent situations where mistakes had been made, discussion takes place and then discussion on how the situation could have been different…some people do things because they think they can get away with it but do not have a framework to work outside of, therefore, one way of starting ethical conversation is by looking at different scenarios and seeing how people's lives have been ruined".

In regards to moral frameworks, Participant E saw the Code of Ethics as: "just a starting point…..students must be aware that there are ethical rules that flow from the Code of Ethics and must be adhered to." From their viewpoint:

> *"...*it was not apparent that there was a structured ethical framework for students in most ethical texts for nurses …. most texts describe what ethical theories are, such as this is ethical decision making, these are bio-medical principles, but there appears to be no real standardized framework…. some prescriptive models demonstrate to the students that any decision made must be ethical and that things can be ethical but not legal or legal and not ethical…. these models indicate to the student that one must make the ethical decision before the legal decision, …the use of an advocacy framework such as the Giving Voice to Values curriculum would supplement this teaching. In using this framework students are making their own decisions and then voicing them…. it must be instilled in students that following the professional rules is ethical".

Participants believed that while nursing curricula encompassed a professional ethics component, it may be questioned whether the content taught, as well as the methods used to teach, were adequate to enable students to develop more than a cursory understanding of professional ethics. The skills, knowledge, attitudes, values and abilities necessary to be able to demonstrate the moral competencies expected may not be adequately taught. Participant H stated that: "*confronting students with ethical dilemmas, makes them think and reflect. It would be hoped that they would reflect on their values as they work through the case*". This participant also expressed: "reflecting between reason and emotion, the code of ethics as well as common sense might prompt moral thinking, and it might be said that this internal reflection of values gets the student to think morally".

6.5.2 Moral competence through reflective practice

The second recurring observations from participants about the development of moral competence in students emphasised the value of reflective practice. Participant H stated: "the lack of moral thought in any decision making can see someone fail to communicate something on time", with Participant B pondering:

> "…reflective practice must be integrated throughout practice
> whilst undertaking clinical preparation…. case studies are
> excellent tools as there is so much that one can explore,
> and they are very real as they are the nature of what a
> nurse does…. by breaking the case study down into
> various components it is very valuable…. these studies
> are real and students can explore their own ethical thinking
> and say why they would do this or that as well as
> learning from what others say".

Participant B believed that this causes students to: "look at their own values, values in relation to society, application of values to those in their care, dealing with more complex ethical issues then going into social justice and equity". Participant A thought: "asking students to reflect on any moral distress they might have encountered, as well as articulating on what might have

been ethically or morally challenging about a situation, and what kind of feelings it brought up in them to build on their understanding of self…*"* this participant also saw clinical supervision as a good way to develop moral thinking within the workplace: "this could be achieved through discussion of positive and challenging situations that might arise or had arisen during the students' clinical placement… through the process of problem solving in a group and listening to how others might or might not resolve the problem or situation, is an excellent way of learning and peer mentoring"

The freedom to be able to analyse and reflect critically through realistic case studies presents different situations with real problems in learning approaches, which is not always available in nursing settings. Having students reflect on these case studies helps develop a questioning atmosphere for decision making.

6.5.3 Frameworks to develop moral competence

Some participants explored the presence and need for the development of moral competence to be undertaken through a particular framework.

 Participant C stated:

> "…students need to be able to discern how they make decisions, and this is where simple frameworks come into play to guide them…it is about developing the students understanding of the ways of dealing with complex issues and strategies, of pitting one value against another value and how to work through these issues".

Participant B focussed on the accreditation standards that were mandatory in nursing education, these being The Code of Conduct, Standards of Practice and the ICN Code of Ethics for Nurses. This participant also stressed that how this framework for professional practice is taught to students is dependent upon the academic staff. This participant also emphasised that

communicating this framework and principles to students required skill as well as

understanding:

> "…educators cannot just hand students a piece of paper
> and say once you have read this you will understand
> what moral competence is…. this type of learning does
> not lend itself to instant learning, it is about re-visiting
> these topics over the three years of study within various
> units of study".

One strategy presented by Participant B:

> "…I feel that first year students should be given a basic
> understanding of moral competence by planting the
> seed, and then knowledge and understanding is increased
> over the next two years as they mature both in
> themselves and with clinical knowledge… thus expanding
> their knowledge that has come through exposure to
> the clinical environment through reflective practice….
> in units of study students would be asked to reflect about
> what are the underpinning values here and revisiting
> all the time…. by embedding and using reflective practice
> as well as critical thinking, about how values have
> guided them is a good way to ensure the student
> has a good understanding of where they are sitting in
> reference to moral competence in the workplace".

Participant C discussed the need for a simple decision-making framework so that students:

> "…understand that there are frameworks and that they are
> able to apply those schools of ethical decision making to
> actual case studies, in order for them to see how that
> looks on the ground…. and that as time moves on, nurses
> might adopt a framework of their own, or an academic could
> encourage them to develop a model of their own that is then
> applied to case studies".

The majority of participants agreed that frameworks/approaches must be built around the

Standards for Practice (NMBA, 2016), ICN Code of Ethics for Nurses (2018) and the Code of

Conduct (NMBA, 2018) which are the basis of "the doing" in nursing. Overall, participants

suggested that there should be an integrated, continuous, experiential and reflective practice

approach to curriculum in regard to moral competence. Through the use of different

approaches and more representative simulations in the teaching/learning process, students may develop their moral competencies through active participation with the help of reflective and critical assistance from the academic. Along with teamwork, this approach would hopefully lead to students obtaining both knowledge and skills by furthering their thinking in both their actions and moral outlooks.

6.6 Theme Four: Gaps in the development of moral competence in nursing

This theme explored the participants' assessment of the gaps that occur in the development of moral competence in nursing.

6.6.1 Gaps in teaching

Most participants observed that there were gaps in the teaching of nursing students that weakened their development of moral competence. Participant A discussed the fact that in the studies undertaken by students they:

> *"...*must be aware and taught that there are respectful ways of dealing with patients, with other healthcare staff, with families, as well as their communication with others…. they focus on the academic side, on the skills side, but what happens to the personal side, the side of speaking to my patient and not worrying about time management…. until they have an understanding of where the patient is at*".*

Participant B discussed the changing norm of nursing studies in contemporary nursing practice. This participant thought: "there may be a conflict of person, where values that are defensible to self but not to others, come up within nursing studies and that opportunities must be made available for students to question conflicts in a safe and secure setting". Participant C indicated that students might have difficulty at times understanding areas of their own moral capabilities within different situations: "academics must have a good grasp and understanding of moral issues so that the subject can be taught correctly". This participant also stated: "it is imperative

that moral and ethical situations must be looked at and discussed during undergraduate studies". Participant D noted that students: "need to be taught how to deal with moral distress…. they felt this was not really being undertaken in some universities" and that "students need to be able to identify and manage moral distress". This participant went on to say that they believed: *"the gap between theory and practice, of what is acquired through curricula and what is experienced in the clinical environment, has at times been a key dilemma within clinical education".* Participant E felt: "there were gaps in curriculum as everyone has their own framework they work and teach from with their own ethical values…. leading to an incomplete education across the profession". Participant H thought that the gaps in teaching were that students did not fully understand what was acceptable or not acceptable:

> "…students were not sure of where the bar was set, what
> was normal or not quite knowing what was over the line
> and that what is morally acceptable is changing over time ….
> nursing education today does not really impart what is the
> right way and what is an acceptable level of practice….
> the integration of the Code of Conduct into some units of
> study does not really impart or cover the range of things
> that moral competence covers…. there are gaps around
> mentoring and modelling in relation to the development
> of moral competence in nursing".

6.6.2 Gaps in skill development

Participants observed that there were particular skills that were not developed towards moral competence. Regulation leaders discussed the changing norms within the profession and their practice settings, with participant D stating: "students must be taught to deal with moral distress…. given a framework early in their studies so that they fully understand how the process might work, how choices are made, what do I do/do not do…how do I reduce that". This participant went on to give examples of how students may not have the skills in certain situations: "let me give you an example of bullying…. or people becoming disengaged or follow the leader because it is easier". Participant E felt that there were gaps in curriculum:

"unit coordinators, lecturers and tutors have their own frameworks from which they work and teach…. even if the framework is presented the way its presented is coming from that academics own ethical values". Participant C indicated: "it is imperative that moral situations be looked at and discussed during undergraduate studies…. in some cases, these situations are only touched on". Participant A believed that: "it is essential to emphasise concerns on skills and knowledge as well as values and moral competence in today's nursing education". This participant also indicated: "*the ability to be able to undertake various nursing skills has the ability of encouraging the students' developing moral competence*". This participant expanded by saying that: "it allows them to be able to consider their own values that will support their actions and decisions to enable them to develop their moral competence within units of study*"*.

6.6.3 Gaps in the regulation of the nursing profession

Participants observed that the rules and regulations of the nursing profession did not completely introduce and support moral competence. Participant H thought the gaps were: "that students and nurses just do not fully understand what is acceptable or not acceptable….not sure of where the bar is set, what is normal or not quite knowing what is over the line…..and what is morally acceptable is changing over time". This participant also raised the point that:

> "…access to social media really stretches peoples
> boundaries, many times people are uncertain
> about what is acceptable… what is morally okay
> and what is not, and the changing norms are
> a problem for young people today in knowing what
> is right or wrong…. for young, registered nurses coming
> into the profession they need to know what is the right
> way and what is an acceptable level of practice…. the
> Code of Conduct does not really impart or cover all
> of the range of things that moral competence envelops".

This participant also believed that gaps around mentoring and modelling in the workforce could be improved:

"…healthcare is very task driven today and some students
are not quite understanding of what is required of a nurse...
it is difficult to teach clinical decision making/clinical
reasoning…. the student needs to have a good grasp of
the moral aspects of nursing, especially why short cuts
must not be taken".

Another challenge put forward by Participant H towards the students' development of moral competence was time: "it can take longer for a nurse to do the right thing, say the right thing, remedy a problem because morally it is the right thing to do, but then, it is much more time consuming". This participant also identified the fact that some nurses have stated: "it is not the task I was allocated to do, so then 'y' and 'z' which might make the patient feel a lot better goes out the door".

Many of the participants saw that it was the academics' responsibility to instruct students in moral reasoning, through their own knowledge and life experience. Students are then able to strengthen their knowledge through theoretical activities and clinical practice, it is this connection and integration that provides an environment promoting and nurturing the development of moral competence.

6.7 Theme Five: Intersecting demands within the development of moral competency in nursing students

This theme explored the participants' understanding and perceptions of the intersecting demands in the development of moral competence in nursing.

6.7.1 The overloaded curriculum

Several of the participants when asked whether current nursing curricula might be overloaded, discussed the fact that the development of a student's moral competence cannot be done in isolation from the clinical world and other knowledge. The sheer volume of what students had to learn was a challenge, and the curriculum appeared to place demands on clinical skills and nursing science - Participant A stating: "where does moral competence fit in as the focus of

study today, the focus appears to be predominantly on the skills to be achieved". Another area of concern discussed by Participant A was that: "the newly registered nurse was expected to come out as a fully formed practitioner, but they still did not have a grasp on fundamental things. … older nurses would address this as 'why is that not added to the curriculum', 'what are they teaching you" with Participant B adding: "the curriculum is already overloaded with content".

6.7.2 The disintegrated curriculum

Participants were concerned that the development of moral competence was fragmented throughout the curriculum, as well as in continuing education. Both participants C and H discussed the fact that they could see nursing ethics units of study as just an added unit of study that was required to be incorporated into the nursing curriculum. Participant C stated that they thought that there was: "always the probability that in nursing education, nursing ethics may still be deemed by some to be no more than yet another topic to be slotted into the curriculum", with Participant H stating that they felt that: "the unit of study was seen as a topic that needed a significant amount of time allocated to it within a well-planned and presented curriculum, but due to time constraints and other units that had to be incorporated into curriculum topics would only be touched on". Participant H also believed: "there was more importance placed on the repetition of acquiring of skills versus respectful ways of nursing practice" and concluded that it might be: "likened to the doing of things against one's best work through the use of clinical reflection".

Participant A noted that students are: "busy caught up on skills and tasks but not on self or respectful ways of practice". Participant D thought that there was: "too much pushed into curriculum and information that was required was forever changing…..the Code of Conduct and ICN Code of Ethics for Nurses must be integrated into all units of study and assessed along with clinical skills, but I do not see this happening…….one's morals change over time but not

as fast as information". Participant D indicated: "people need to work to survive, they are time poor and it comes down to studying versus surviving, so the student will only take in what is important in their eyes". Participant G felt that at university level the area of moral competence was not explored enough and stated: "clinical situations especially in regards to thinking about what is the root cause? or how do I handle this? .... understanding should be woven through all units of study for reflection especially through exposure to clinical scenarios". Participant E felt that unit content was: "centered on what the academic wanted to teach that aligned in some way to curriculum". Participant F discussed a further limitation: "…students stated that they felt bored during classes because they had heard the 'same old, same old' theme in units of study previously…. students should be told this is why moral competence is important, especially in clinical placement settings and explain the why and what, it must go hand in hand, theory and clinical work must align together."

6.7.3 The integrated curriculum

All participants in response to this theme believed that the answer may well be to weave moral thinking and action through units of study. This could be undertaken through case studies within the given subject with Participant C stating that:

> "students need to be able to think critically through all
> facets of study….the thing to do is to keep revisiting, it
> is the experiential learning that is repeated that helps
> build the foundation…..when we think about it, what
> you learnt yesterday as opposed to today after you have
> reflected on it, thought about it and done some more
> learning about the situation, one's opinion evolves and
> matures -   it cannot be done in isolation".

Participant B considered the fact that:

> "…clinical facilitators need to be brought in and have
> a good debrief/ critical think at the end of clinical
> placement where they can be challenged over issues
> that may have arisen, and how they got the students

to reflect and act…. this would need to be undertaken
by someone with good skills who could guide the
discussion so that it does not become a fight over you
should have done this or you should have done that….
or be criticised by others because they think it was not
handled in the correct way or was right…. students go
onto the floor with high ideals about the right way
to do things and sometimes feel pressured by registered
nurses to take short cuts…. they come back questioning
as to why we teach them "the wrong way" this is then
an area that can be explored".

Participant B also stated in reference to curriculum:

"…if it was done holistically such as weaving it through
curriculum and acknowledging this as something that is
very important... especially through case studies... and asking
the question what is the right thing to do and why would
you do that, it would soon become part of the students
thinking whilst they were undertaking a task or involved
in a situation with a patient".

Participant E believed that: "moral ethics should be articulated much better within a School of

Nursing….a core curriculum including an ethics unit that all students from all disciplines had

to undertake, was a valuable model of integration both educationally and professionally".

Participant B also maintained that students need to see further than:

"…it is just a unit that needs to be done…. they need to
be able to cross that bridge and see that this is really
important to my future nursing career…. a core unit
of ethics would enable students to look at different
situations and how those beginning theories are put into
place, they also stated that looking at the curriculum
demands that might intersect in the study of nursing,
is that you could not study the sociology of nursing
without some ethical flags becoming apparent such as
Palliative care, Sociology of Nursing and Public Health
units of study…. at the core of this is our own
ethical and moral thoughts about the person as that then
determines how we move with the person   and their
healthcare…. units of study that looked at general
management and professionalism must also involve
the student in understanding what the ethics/morals
behind these units are as well".

Overall, participants thought that there should be better integration of moral competence skills into all units of study. Participants stated that there is a possibility that nurses may not be able to attain moral competency through the current ways of teaching and learning. A number of participants identified the fact that it cannot be assumed students will be able to develop the moral competencies required to be morally competent as a registered nurse. It can be thought that through the development of these skills the students' overall capabilities of understanding situations will develop and not be in conflict with their values. Failure to ensure that this is undertaken may have repercussions for nursing practice and policy in the future.

6.8   Conclusion

In summary, participants all noted that an individual's moral character, moral decision making, and moral care are the key characteristics of moral competency in nurses. Moral competency was seen by the nursing experts and stakeholders as a developmental process, emerging through clinical practice, and founded upon ethical knowledge and training, and requiring specialised communication skills. Moral competence must be aligned with standards of nursing practice. Participants thought that the undergraduate curricula completed by nursing students appeared to hold weaknesses in preparing nurses to be morally competent in the complex workplaces and work relations of current health care. These weaknesses in preparation also diminished the moral competence of nurses in care relations with their patients, families and communities.   Chapter 7 provides a discussion and review of the significant findings of the study.

Chapter 7:   Discussion, Summary and Recommendations

7.1 Introduction

The aim of this study was to explore the development of moral competence in nursing through the introduction of a Giving Voice to Values Curriculum within an undergraduate nursing program. The preparation of nursing students for morally competent practice was considered in relation to a literature review of moral development theory. A central challenge is in introducing to the student the moral principles and theories that are foundations to nursing practice. In addition to the challenges of introducing moral principles and theories into student learning, the other challenge is the consideration and integration of ethical concerns and dilemmas into the curriculum.

The main focus of the Giving Voice to Values curriculum was to develop the moral competence of nursing students. It was anticipated that the curriculum would enable students to understand, explain, communicate and act on their values when challenges arise, with emphasis being put on the ability of the student to raise concerns in an effective way, and to articulate professional values when moral situations arise. The fundamental direction of the Giving Voice to Values curriculum is developing the students' confidence and competence to deal with moral conflicts by developing 'moral muscle', enabling students to be able to respond with integrity to the situation (Gentile, 2010).

The research from surveys undertaken by students after completion of the Giving Voice to Values Curriculum, and semi-structured interviews of nursing experts and stakeholders has been presented in chapters 5 and 6 respectively. This chapter integrates the research outcomes through a discussion that responds to the central findings of the literature review reported in chapter 2. The chapter then makes recommendations towards the development of moral competence within nursing students, with reference to the Giving Voice to Values curriculum.

7.2 Discussion of data findings

The central question to be answered was: Can the introduction of the Giving Voice to Values curriculum contribute to the development of moral competence in nursing? The sub-questions were:

1. How is moral competence in nursing defined?

2. What are the contemporary approaches utilised in nursing education towards the development of moral competence in the profession?

3. What are the perceived and observed gaps in the development of moral competence in the nursing profession?

4. Can these gaps be addressed by changes in the education of student nurses?

5. What impact does the implementation of the Giving Voice to Values Curriculum have upon nursing students?

6. How do nursing students perceive the effectiveness of the Giving Voice to Values curriculum?

The following sections respond to these questions separately, with a final summation of the findings regarding the Giving Voice to Values curriculum and its contribution to the development of moral competence in nursing.

7.2.1 What is moral competence?

Students' understanding of moral competence centered around awareness of their values and being able to deal with moral conflicts. Overall, students saw moral competence as a cognitive phenomenon that began with their awareness of moral concerns and continued with more developed understanding. Students' abilities to acknowledge both the action and influences of moral competence at the completion of the Giving Voice to Values curriculum was low.

Students primarily saw moral competence as a cognitive capacity, with students indicating they were developing awareness and knowledge of moral competence but had limited understanding. The main themes demonstrated by students as to their understanding of moral competence were that it entailed an awareness and ability to be able to identify their values. It was also demonstrated by students that in their understanding moral competence was the ability to make decisions and to understand right or wrong when faced with a conflict. Overall, the research findings demonstrated a limited recognition and understanding of the ethical foundations of moral competence.

Nursing experts and stakeholders found it difficult to define moral competence in nursing, noting it was easier to define moral incompetence. Most expressed the view that moral competence involved being aware, having communication abilities, understanding professional values and being sensitive towards the diversity of moral values. It was also expressed that a morally competent nurse must uphold professional values, moral principles and professional practices. It was noted that nurses are accountable for all aspects of care through their processes of moral decision making.

Kohlberg, Gilligan and Noddings maintain that moral awareness and moral thinking are essential elements of moral competence. In summary, these theorists consider moral competence as the individual's capacity to make choices and to question moral decisions, guided by their own inner values. In turn, the individual is able to act according to those decisions (Enderle et al., 2018).

Communication was also seen as an important aspect of moral competence, especially in regard to moral discussion and decision making. Moral competence in nursing practice requires an understanding of, and a responsibility to, nursing values. Students identified the fact that they were able to recognise the communication skills that moral competence required, but data showed that the students were not yet clearly able to recognise the affective, cognitive,

reflective and analytical foundations of moral competence. Fundamentally, students were developing communication skills to articulate their position, without the development of moral knowledge and moral competence. Further to this, interviews with nursing experts and stakeholders highlighted that moral competency was a developmental process that emerged through its integration with clinical practice, and was founded upon ethical knowledge and training, alongside specialised communication skills.

7.2.2 Values and moral competence

The breadth of the responses from the nursing students' survey in Question 2 indicated values diversity, with congruence across a values spectrum indicating the development of self-awareness towards a values-based profession and practice. Values that are core to moral competence such as advocacy, transparency and ethical responsibility were not identified by students.

The most often cited values are congruent with professionalism and the nursing profession. These were respect, empathy, honesty, compassion, kindness, dignity, loyalty, trust and integrity which are all values of the profession of nursing, and cornerstones of the Australian profession's Code of Conduct (NMBA, 2018), ICN Code of Ethics (2018) and Standards for Practice (NMBA, 2016).

Nursing experts and stakeholders identified that students' values were the foundations of moral competence and that the students must be guided to integrate their values with those of the profession of nursing. They also endorsed that case studies led students to grow in their thinking and understanding of different health care situations and that being able to discuss and confront moral dilemmas enables students to think and reflect on their values. Discussion of moral dilemmas would allow students to reflect upon their reasoning and values, thereby strengthening moral development.

The literature underpinning this research on values and moral competence revealed some uncertainties. Behavioural theory holds that values are considered to be basic in the determinants of social action, and that being able to provide opportunities for nursing students to explore their values and those of the profession was important in their development within a person-centered framework (Hechter et al., 1993). It was also demonstrated that values shaped ethical decision making, that values contribute to the choices that individuals consider as likely problem resolutions, are the basis of actions, and that values guide conclusions or thoughts in resolving ethical problems (Hill, 2006).

The values the nursing students upheld reflect the values reported in other studies of moral competence in nursing (Schank & Weis, 2000; Jormsri et al., 2005; Lynch et al., 2013). Being able to provide opportunities for nursing students to explore their values and the profession's values was important in their moral development. In short, values provide direction for nursing practice. A methodology was required to enable students to be able to develop their moral competence, to voice the profession's values, and to reflect upon values, conflict and moral competence.

The Giving Voice to Values curriculum (Gentile, 2010) promotes the awareness of values, the development of decision making, and the articulation of reasoning and values positions. The gap appears between the aforesaid awareness and actions, and the development of moral knowledge. The link between values, knowledge and actions appears to be weak. Discussion of moral dilemmas would allow students to reflect upon their reasoning and values thereby encouraging moral development. However, the knowledge of moral theory is also an essential foundation (Johnstone, 2015; Parsons, 2000).

7.2.3 Moral competence and social theory

The Giving Voice to Values curriculum reflects Kohlberg's moral development theory of the individual acquiring skills through developmental phases (Bedzow, 2019). The introduction

of the Giving Voice to Values curriculum leads students to an awareness of values and brings the ability to act on values when faced with moral challenges (Gentile, 2010). Giving Voice to Values assists students to perceive themselves as being competent to act on their values (Bedzow, 2019). The ongoing development of moral competence was highlighted by nursing experts and stakeholders; it was a continuing, never completed, integration of knowledge and practice, influenced and mentored within the profession. Kohlberg's (1969) theory brings alignment to this conceptualisation of moral development. Within this context, the Giving Voice to Values curriculum is an important contributor within this developmental process.

The difference between Kohlberg's (1983) theoretical contributions and the Giving Voice to Values curriculum is that Kohlberg's theory of moral development (1969) requires a change in how individuals view themselves, while the Giving Voice to Values curriculum (Gentile, 2010) involves the development of self-awareness and empowerment to act.   Kohlberg's (1984) moral competence is moral reasoning that is ultimately realized in moral judgment. The Giving Voice to Values curriculum reflects this developmental approach of moral competence.

Gilligan (1993) saw Kohlberg's (1969) theories to be insufficient, unfinished and biased against women's understanding and did not feel that these theories were an acceptable reflection of women's moral reasoning (Gilligan & Attanucci, 1988). Alternatively, Gilligan's theory was said to be uncharacteristic of the rules and principles that are unsupported by moral theory. In this regard Gilligan's theory differs from the principled approach characteristic of bio-ethics approaches (Skoe, 2014). Instead, the ethic of caring within the nursing profession is seen as a moral practice in itself. McKenzie and Blenkinsop (2006) state that Gilligan's ethic of care has been an influence in nursing education. In relation to Giving Voice to Values, the ethics of care can inform the recognition and understanding of ethical requirements to speak up and act upon professional values. Nodding's ethics of care theory is an example of moral education for nurses; it approaches moral situations avoiding set principles and rules and

focuses on relationships of care. This care theory can provide a moral context within which the Giving Voice to Values curriculum can be situated. As Crowley (1994) identified, Nodding's ethic of care was seen as another example of moral education within undergraduate nursing studies.

7.2.4 Moral competence in nursing

The research findings from expert nursing experts and stakeholders provided a context for the exploration for consideration of the Giving Voice to Values curriculum. The development of moral competence was seen to be framed by the Australian profession's Code of Conduct (NMBA, 2018), Standards for Practice (NMBA, 2016) and the ICN Code of Ethics for Nurses (2018); providing values, principles, and practices that constitute the profession. Moral competence was observed in moral decision making and practices. Moral competence was identified as central to nursing knowledge and upheld through professional regulation. Nursing experts and stakeholders identified awareness of professional values and moral theory as the foundation for nursing students' development of moral competence, which was continuously developed over time through education and clinical experience – and never completed nor fully achieved. A core finding was that nursing experts and stakeholders saw the development of moral competence as being linear; that it grew as they continued their nursing studies and integrated learning with clinical skills. They observed that this integrated development of moral competence was not well accomplished within undergraduate degree programs nor within continuing professional development.

The required competencies for nursing practice are seen in the three domains of professional practice, critical thinking and analysis, provision and coordination of care, and collaborative and therapeutic practice (Johnstone, 2015). Moral competence requires understanding of, and responsibility for nursing values. Parsons (2000) identified that moral competence signified the knowledge and skills required within the nursing profession, whilst also assuming the students'

capacity to be able to apply that knowledge. Competence within professional nursing requires that students develop their awareness and abilities to become morally competent.

The methodology of the Giving Voice to Values curriculum requires students to combine their academic knowledge with practical actions and professional obligations. The Giving Voice to Values curriculum encourages students to identify their own values and to apply the skills required to voice those values. In this regard, the Giving Voice to Values curriculum supplements academic nursing curricula with emphasis on developing the students' moral and professional character. As Gentile (2010) stated, the Giving Voice to Values curriculum presents students with the context to develop skills and understanding to enable them to become successful in voicing their values.

7.2.5 Moral competence and nursing education

Nursing experts and stakeholders indicated that content within the nursing curriculum must center on the ICN Code of Ethics (ICN, 2018), The Code of Conduct (NMBA, 2018) and Standards for Practice (NMBA, 2016). The Giving Voice to Values curriculum could well be integrated into this content and would be an effective strategy towards the development of the student's moral competence. Nursing experts and stakeholders also acknowledged that the codes and standards governing the nursing profession – whilst broadly stated - remained the foundation and starting point for nursing students to develop an understanding of the moral standards required of them. The Giving Voice to Values curriculum cannot fulfil this developmental task on its own; instead, it focusses on the skills that are needed to implement such developmental achievements (Edwards et al., 2011). Fundamentally, nursing experts and stakeholders observed weaknesses in nursing curricula; a failure to embed standards and codes, and to integrate these into professional practice. The gap between theory and practice, of knowledge and skills obtained through curricula and what is experienced in the clinical environment, is a major challenge within nursing education. Additionally, the identification of

observed gaps within the development of moral competence within the nursing profession was universally perceived by the nursing experts and stakeholders; they believed that this led to weaknesses in professional practice. Nursing experts and stakeholders asserted that those teaching and guiding the development of moral competence must have foundational knowledge of moral theory and the ability to disseminate this understanding to their students. The learning of moral theory within undergraduate nursing curricula is therefore a fundamental requirement for professional practice.

Research findings also demonstrated that students noted an increase in their development towards moral competence after completing the Giving Voice to Values curriculum. Students stated that the implementation of Giving Voice to Values into their studies had a positive influence upon their developing skills in being able to reflect and speak up. Research findings also demonstrated that students reported that their appreciation of diverse moral thinking and dissimilar moral views along with their understanding of their own emotions, perceptions and instincts were areas that had been least developed after their completion of the Giving Voice to Values curriculum. This is of significance as these are at the 'meta' end of the moral competence scale. The moral competence required of a nurse has broad dimensions being those of moral integrity, moral decision making as well as moral care, thus being a 'meta' competency (Zafarnia et al., 2017).

As Goethals et al. (2010) discussed, the moral dimensions of care are an important part of nursing practice and the development of moral competence within the nursing curriculum cannot be limited to particular ethical problems. Instead, exposing students to situational clinical settings allows them to integrate the principles and theory learnt within the teaching space, and it is in this context of real situations that the student is able to develop their moral competence. Bickhoff et al 's. (2017) study identified that when students were confronted with moral dilemmas, they appeared to remain quiet even though they felt they had a moral

responsibility to speak up. Specifically, the authors found that students lacked the 'moral nerve' to speak up when it was necessary. It is here that the Giving Voice to Values curriculum holds a strong and central role. Through the implementation of the Giving Voice to Values curriculum within nursing curricula, the student's moral development was seen to evolve. The use of different steps within the Giving Voice to Values curriculum allowed the students to experience certain shifts in their moral abilities. The students' development of moral competency would go hand in hand with their development of standards of practice as becoming registered nurses. In order to enable this progress it must be ensured that learning experiences the students are exposed to during their three years of study continuously further their development of moral competence.

One of the challenges for nursing educators is the development of strategies supporting nurses in their development of moral competence required within the profession. Through curricula there should be development of both knowledge and moral muscle allowing the student to feel less fearful when they are confronted with these moral situations. Most nursing curricula embrace ethics teaching; it remains a significant question as to whether stronger foundations in student's moral knowledge would strengthen their abilities to speak up and more able to take moral action.

7.2.6 The Giving Voice to Values curriculum

The majority of students who had completed the Giving Voice to Values curriculum reported developments in their thinking and abilities. The most significant developments were reported in the students' ability to be able to 'give voice' to their values. However, this was not supported by any significant development in identifying or knowing their ethical position. It can be understood from the data that the students felt empowered to articulate their position but seemed unsure of their position. Students reported that the Giving Voice to Values curriculum enabled them to be able to stand by their values with confidence; it enabled them to be heard,

to be able to speak up and to find different ways in which they might be able to address diverse situations which may be opposite to their own beliefs or manner of practice. Fundamentally, these are all communication skills. Areas of least development require critical reflection, self-awareness, and collaboration with others.

The Giving Voice to Values curriculum strongly develops moral communication skills but does not develop knowledge and understanding of moral theory and moral action.   Previous studies evaluating the Giving Voice to Values curriculum have demonstrated beneficial outcomes for students. The Lynch et al. (2013) study demonstrated that using the Giving Voice to Values curriculum within units of nursing study enabled scripting and rehearsal of responses to moral challenges and supported their awareness of their own values.   Bedzow (2019), Mintz (2016) and Gonzales-Padron et al. (2012) all supported the use of the Giving Voice to Values Curriculum stating that those using this method found enriched perception in regards to the importance of professional values in nursing.

Integrating the Giving Voice to Values curriculum into nursing curricula was undertaken to support nursing students in responding to the moral issues within their nursing practice and their profession. The methodology of the Giving Voice to Values curriculum lies in facilitating the recognition of professional moral challenges and developing knowledge, skills and awareness through the use of case studies which have come from clinical encounters (Edwards et al., 2012). The Giving Voice to Values curriculum enables students to develop their moral communication but it has not demonstrated evidence that other aspects of moral competence are similarly enhanced.

It is this enabling that Gentile (2010) maintains presents the student with the chance to be able to construct and practice their skills in expressing their values. This understanding and practice enables the student to identify that they are able to act on their values and use these skills when faced with difficult situations. The Giving Voice to Values approach is a post-decision making

methodology; creating approaches and responses for successful moral encounters, the student must consider whether the choices they are making are moral choices (Gentile, 2010). However, the theoretical foundation underpinning moral choices are not found within this curriculum.

Gentile (2012) has stated that the Giving Voice to Values approach is justified through research findings, that the practice and rehearsal of moral action is a purposeful way to affect professional behaviour. The nursing student survey demonstrated the development of communication skills and confidence, but not strong development of knowledge or moral competence. They were able to identify the communication skills of moral competence but were not yet able to recognise the affective, cognitive reflective and analytical elements of moral thinking. The positioning of the Giving Voice to Values Curriculum can therefore be employed as a specialised component within the central communications of moral education and practice within contemporary nursing.

7.3 Summary: Giving Voice to Values curriculum within nursing undergraduate curriculum

The Giving Voice to Values curriculum should not be seen as a central model in the teaching of moral development. It can be seen as a communication and reasoning template underlining the voicing of values within the nursing profession and its practice, requiring integration within units of nursing study. The Giving Voice to Values curriculum does not provide a theoretical foundation for moral competence. Instead, it is a method that develops skills within a practical ethics education framework, as it endeavors to move the importance of moral learning from a theoretical enterprise to a methodology of moral actions.

The Giving Voice to Values curriculum within a nursing program develops moral awareness, therefore enabling students to develop moral competence. Nursing experts and stakeholders ask for more time spent in understanding moral situations, preparing and influencing nurses

when they are faced with moral dilemmas in clinical areas. Moral development is a continuing process; it is not set or merely dependent on what students learn and develop during their nursing studies. Further, it continues to develop as professional practice continues. The newly registered nurse depends significantly upon the expertise of others around them and they will also be guided by the Standards for Practice (NMBA, 2016), as well as through the interactions they have with the patients they care for. Nurses must reflect on their moral competence and their development of moral knowledge. All members of the nursing profession have crucial roles in developing the moral competence of nursing students.

This study has explored both nursing students and nursing experts and stakeholders' understandings of moral competence and its development. The Giving Voice to Values curriculum is an enabling element to nursing curricula allowing students to find their voice and speak up as well as acting on their values effectively. The Giving Voice to Values curriculum aims to develop the student's confidence in dealing with moral issues and their ability to be able to speak out

The Giving Voice to Values curriculum develops moral decision making in nursing education through its integration into nursing units of study. But this is its scope, and more is required. As indicated earlier, a weakness of the Giving Voice to Values curriculum is its assumption that the individual's values are already established enabling them to be able to make moral decisions. The distinction between one's personal sense of right and wrong and the professional values required within their professional work setting may not overlap. Nonetheless, it supports students to recognise their values and clarify how these values underpin moral decision making, gaining self-confidence. It differs from the traditional teaching of professional ethics in that it concentrates on action over knowledge. However, it does not lessen the requirement for nurses to be able to recognise and assess moral challenge.

The Giving Voice to Values curriculum is in line with pedagogical principles inviting students to think about when and why they, and their peers, act on their values, or why they might not, along with reflection on the reasons that might enable or hinder them from doing so. This would be best achieved in a nursing curriculum through the use of case study learning, as incorporated within the GVV curriculum.

7.4 Limitations of research findings

The literature review underpinning and forming this research study was inclusive of scholarship on the development of moral competence in nursing. This excluded other domains of professional practice and educational theory and research. This led to a focussed consideration of the research findings and recommendations for future education and research. This is a limitation on the possible interpretation of findings, as a broader consideration of other professions and the development of moral competence could place nursing within a comparative contextual framework. The study explored nursing education in relation to moral competence within an Australian University

The scope of the research undertaken for this study was limited to first year nursing students who had completed the Giving Voice to Values curriculum at one University. The researcher had also worked within the School of Nursing and was part of the initial introduction of the Giving Voice to Values Curriculum in the School which could be perceived to be a limitation. Bias was lessened through the use of critical reflection, theme notes, as well as discussion of methods and findings with the supervisors. The researcher continually considered alternate views which was demonstrated within the conclusions and the analysis of the study. The student survey was a self-report method, and these findings were juxtaposed within the views and experiences of nursing experts and stakeholders. The method of self-reporting provides space for bias as students may respond in a way they perceive as desirable to the

researcher. Another limitation is whether the students know themselves sufficiently well to provide data that might help the researcher evaluate the concepts in the statements.

7.5 Recommendations from this study

From the findings of this study, the following recommendations are made for the development of moral competence in nursing:

7.5.1 Recommendation 1.

The development of moral competence must be underpinned by an awareness of moral theory.

7.5.2 Recommendation 2.

The development of moral competence in nursing students must be aligned with the ICN Code of Ethics for Nurses (2018), Standards for Practice (NMBA, 2016), and Code of Conduct for Nurses (NMBA, 2018), in order to cohere with the profession's values.

7.5.3 Recommendation 3.

The development of moral competence in nursing students should be the focus of further longitudinal studies in order to inform the development of curriculum in the teaching of ethics to undergraduate nursing students.

7.6 Conclusion

This study explored the introduction of the Giving Voice to Values curriculum within an undergraduate nursing program. It contextualized this exploration with the perceptions of nursing experts and stakeholders regarding the development of moral competence within nursing. The findings from this study have also illustrated that the Giving Voice to Values curriculum is an insightful and reflective method for helping students to acquire techniques to be able to voice their own values. The Giving Voice to Values curriculum is a methodology for moral action. It is not a moral theory in itself. The integration of Giving Voice to Values

within nursing education must be based upon the teaching of moral theory and professional

ethics. The development of moral competence in nursing is ongoing; integrating knowledge,

experience and the development of capacity. It provides the foundation for future studies to

determine the usefulness of Giving Voice to Values in nursing curricula.

REFERENCE LIST

Adkins, C. P. (2011). A pathway for educating moral intuition: Experiential learning within the giving voice to values curriculum. *Journal of Business Ethics Education, 8*(1), 383-391.

Alby, F., Zucchermaglio, C., & Fatigante, M. (2014). Beyond the written words of informed consent: What participants would like to know about research. *Nordic Psychology, 66*(2), 71-93.

Archer, M. (1995). *Realist social theory: The morphogenetic approach*. Cambridge University Press.

Arsenio, W. F., & Lemerise, E. A. (2001). Varieties of childhood bullying: Values, emotion processes, and social competence. *Social development, 10*(1), 59-73.

Aspin, D. N. (2000). Values, beliefs and attitudes in education: The nature of values and their place and promotion in schools. *Education, Culture and Values, 14*, 197-218.

Australian Nursing and Midwifery Board (2018) *The ICN Code of Ethics for Nursing:* https://www.icn.ch/sites/default/files/inlinefiles/2012_ICN_Codeofethicsfornurses_%20eng.pdf

Australian Nursing and Midwifery Board (2018) *Code of Conduct for Nurses*. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-   standards.aspx

Nursing and Midwifery Board of Australia. (2016). *Registered nurse standards for practice*. http://www.nursingmidwiferyboard.gov.au/Codes-GuidelinesStatements/Professional-standards.aspx

Auvinen, J., Suominen, T., Leino-Kilpi, H., & Helkama, K. (2004). The development of moral judgment during nursing education in Finland. *Nurse education today, 24*(7), 538-546. https://doi.org/10.1016/j.nedt.2004.07.005

Axley, L. (2008). Competency: A concept analysis. *Nursing forum (Hillsdale), 43*(4), 214-222. https://doi.org/10.1111/j.1744-6198.2008.00115.x

Barger, R.N. (2000). *A summary of Lawrence Kohlberg's stages of moral development.* University of Notre Dame. USA

Bazeley, P. (2019). *A practical introduction to mixed methods for business and management.* SAGE

Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). Oxford University Press.

Bebeau, M. J., & Brabeck, M. M. (1987). Integrating care and justice issues in professional moral education: A gender perspective. *Journal of Moral Education, 16*(3), 189-203. https://doi.org/10.1080/0305724870160304

Bedzow, I. (2019). *Giving voice to values as a professional physician: an introduction to medical ethics* (1 ed.). Routledge. https://doi.org/10.4324/9780429425400

Benner, P. E. (2001). *From novice to expert: excellence and power in clinical nursing practice* (Commemorative ed.). Prentice Hall.

Benner, P. (2004). Using the Dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education. Bulletin of science, technology & society, 24(3), 188-199.

Benner, P. E., Tanner, C. A., & Chesla, C. A. (2009). *Expertise in nursing practice: caring, clinical judgment & ethics* (2nd ed.). Springer Pub.

Benson, I. (2017). Understanding the purpose and drift of contemporary cultures. Paper presented at the *Christopher Dawson Centre for Cultural Studies' 2017 Colloquium* on the theme "Liberal Education: Restoring the Notion of Education as the Basis for Living the Good Life", Hobart Australia. Audio retrieved from https://cradio.org.au/cradiotalks/talk-lecture-series/dawson-centre/purpose-drift-contemporary-cultures/

Benson, I. (2018). "Values language": A cuckoo's egg or useful moral framework? In D.

Daintree (Ed.), *Creative subversion: The liberal arts and human educational*

fulfilment (pp. 1-43). Connor Court Publishing Pty Ltd.

Bickhoff, L., Sinclair, P. M., & Levett-Jones, T. (2017). Moral courage in undergraduate

nursing students: A literature review. *Collegian (Royal College of Nursing, Australia),*

24(1), 71-83. https://doi.org/10.1016/j.colegn.2015.08.002

Birbeck, D., and Andre, K. "The affective domain: beyond simply knowing" *ATN*

Assessment Conference 2009, RMIT University.

http://emedia.rmit.edu.au/atnassessment09/sites/emedia.rmit.edu.au.atnassessment09/files/215.

pdf

Blackwood, S., & Chiarella, M. (2020). Barriers to uptake and use of codes of ethics by

nurses. *Collegian (Royal College of Nursing, Australia), 27*(4), 443-449.

https://doi.org/10.1016/j.colegn.2019.11.005

Blais, K., Hayes, J. S., Kozier, B., & Erb, G. L. (2011). *Professional nursing practice:*

concepts and perspectives (6th ed.). Pearson.

Bouhmama, D. (1984). Assessment of Kohlberg's stages of moral development in two

cultures. *Journal of Moral Education, 13*(2), 124-132.

Brown, L. M., Tappan, M. B., & Gilligan, C. (1995). Listening to different voices. In W. M.

Kurtines & J. L. Gewirtz (Eds.), *Moral development: An introduction*. Allyn & Baco

Brown, D. L., Ferrill, M. J., Hinton, A. B., & Shek, A. (2001). Self-directed professional

development: The pursuit of affective learning. *American journal of pharmaceutical*

education, 65(3), 240-246.

Campbell, T. (2015). Voicing unease: Care ethics in the professionalization of social care.

The New Bioethics, 21(1), 33-45.

https://doi.org.ipacez.nd.edu.au/10.1179/2050287715Z.00000000065

Card, C. (2020). Caring and evil. *Hypatia, 5*(1), 101-108.

    https://doi.org/10.1111/j.1527-   2001.1990.tb00393.x

Cashin, A., Buckley, T., Donoghue, J., Heartfield, M., Bryce, J., Cox, D., Waters, D., Gosby,

    H., Kelly, J., & Dunn, S. V. (2015). Development of the nurse practitioner standards for

    practice Australia. *Policy, Politics, & Nursing Practice, 16*(1-2), 27-37.

Cassidy, V. R. (1996). Moral competency. *Annual Review of Nursing Research, 7*, 173– 195.

Chappell, S., Webb, D., & Edwards, M. (2011). A required GVV ethics course: Conscripting

    ethical conversations. *Journal of Business Ethics Education, 8*(1), 308-319.

Chitty, K. (1993). Professional socialization. In K. Chitty (Ed.). *Professional nursing:*

    concepts and challenges (pp. 136–155). Jossey-Bass.

Chitty, K. K. (2005). *Professional nursing concepts & challenges*. Elsevier Saunders.

Clancy, T. R. (2003). Courage and today's nurse leader. *Nursing Administration Quarterly,*

    27(2), 128-132.

Cline, A. (2019). *Ethics, morals, and values: how do they relate*?

    https://www.learnreligions.com/ethics-morals-and-values-4003787

Cohen, J. S., & Erickson, J. M. (2006). Ethical dilemmas and moral distress in oncology

    nursing practice. *Clinical journal of oncology nursing, 10*(6), 775-780.

    https://doi.org/10.1188/06.CJON.775-780

Colby, A., Kohlberg, L., Speicher, B., Hewer, A., Candee, D., Gibbs, J., & Power, C. (1987).

    The measurement of moral judgement: Volume 2, *Standard issue scoring manual* (Vol. 2).

    Cambridge university press.

Cowin, L. S., Riley, T., Heiler, J., & Gregory, L. (2019). The relevance of nurses and

    midwives code of conduct in Australia. *International nursing review, 66*(3), 320-328.

Crain, W. C. (2010). *Theories of development: Concepts and applications* (6th International

    ed.). Pearson Education.

Creswell, J. W. (2015). A concise introduction to mixed methods research. Sage Publications

Creswell, J. W., & Plano Clark, V. L. (2018). Designing and conducting mixed methods research (3rd ed.). SAGE.

Creswell, J. W. (2020). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research, Global Edition*. Pearson Education.

Crigger, N. (2001). Antecedents to engrossment in Noddings' theory of care. *Journal of advanced nursing, 35*(4), 616-623. https://doi.org/10.1046/j.1365-2648.2001.01878.x

Crowley, M. A. (1994). The relevance of Noddings' ethics of care to the moral education of nurses. *The Journal of nursing education, 33*(2), 74-80.

Davis, A. J., Fowler, M. D. M., & Aroskar, M. A. (2010). *Ethical dilemmas & nursing practice* (5th ed.). Pearson.

Dawson, T. L. (2002). New tools, new insights: Kohlberg's moral judgement stages revisited. *International Journal of Behavioural Development, 26*(2), 154-166.

De Casterlé, B. D., Izumi, S., Godfrey, N. S., & Denhaerynck, K. (2008). Nurses' responses to ethical dilemmas in nursing practice: meta-analysis. *Journal of advanced nursing, 63*(6), 540-549.

Dickenson, C., Fisher, C., Shaw J.B. & Southey, G. (1996). Teaching HRM and managerial skills with the 'living case'. *Asia Pacific Journal of Human Resources, 33*(3), 39-52

Donleavy, G. D. (2008). No man's land: Exploring the space between Gilligan and Kohlberg. *Journal of business ethics, 80*(4), 807-822.

Dreyfus, S.E & Dreyfus, H L. (1980). *A five-stage model of the mental activities involved in directed skill acquisition*. Storming Media.

Dubas, K. M., Dubas, S. M., & Mehta, R. (2014). Theories of justice and moral behaviour. *Journal of legal, ethical and regulatory issues, 17*(2), 17-36.

Duckett, L., Rowan, M., Ryden, M., Krichbaum, K., Miller, M., Wainwright, H., & Savik, K. (1997). Progress in the moral reasoning of baccalaureate nursing students between program entry and exit. *Nursing Research, 46*(4), 222-229.

Duquette, L. (2004). *Effects of nursing on the formation of professional values*. *Retrieved February, 29*, 2017.

Dunne, D., & Brooks, K. (2004). *Teaching with cases*. Society for Teaching and Learning in Higher Education,

Eddy, P. (1988). Kohlberg and Dewey. *Educational theory, 38*(4), 405-413. https://doi.org/10.1111/j.1741-5446.1988.00405.x

Edmonds, L., Cashin, A., & Heartfield, M. (2016). Comparison of Australian specialty nurse standards with registered nurse standards. *International nursing review, 63*(2), 162-179. https://doi.org/10.1111/inr.12235

Edwards, S. D. (2001). Benner and Wrubel on caring in nursing. *Journal of advanced nursing, 33*(2), 167-171. https://doi.org/10.1111/j.1365-2648.2001.01649.x

Edwards, M. G., Webb, D. A., Chappell, S., & Gentile, M. C. (2012). Giving voice to values: A new perspective on ethics in globalised organisational environments. In *Ethical Models and Applications of Globalization: Cultural, Socio-Political and Economic Perspectives* (pp. 160-185). IGI Global.

Elliott, Anthony. (2014). *Contemporary social theory: an introduction*. (2nd ed). Routledge https://doi.org/10.4324/9780203519929

Enderle, C. d. F., Silveira, R. S. d., Dalmolin, G. d. L., Lunardi, V. L., Avila, L. I., & Dominguez, C. C. (2018). Teaching strategies: promoting the development of moral competence in undergraduate students. *Revista Brasileira de Enfermagem, 71*, 1650-1656.

Ernsberger, D.J., & Manaster, G.J. (1981). Moral development, intrinsic/extrinsic religious orientation and denominational teachings. *Genetic Psychology Monographs, 104*, 23-41.

Fleming, J. (2005). Piaget, Kohlberg, Gilligan, and others on moral development. *Psychological Perspectives on Human Development, 7*, 1-25.

Forber, J., DiGiacomo, M., Carter, B., Davidson, P., Phillips, J., & Jackson, D. (2016). In pursuit of an optimal model of undergraduate nurse clinical education: An integrative review. *Nurse education in practice, 21*, 83-92.

Fry, S. T., Johnstone, M.-J., & International Council of, N. (2008). *Ethics in nursing practice: a guide to ethical decision making* (3rd ed.). Blackwell Publishing.

Gallagher, A. (2006). The teaching of nursing ethics: content and method: promoting ethical competence. In AJ Davis, V Tschudin & L de Raeve (eds). *Essentials of teaching and learning in nursing ethics: perspectives and methods.* Churchill Livingstone/Elsevier.

Gastmans, C. (2016). A fundamental ethical approach to nursing: some proposals for ethics education. *Nursing ethics, 9*(5), 494-507. https://doi.org/10.1191/0969733002ne539oa

Gentile, M. C. (2010). *Giving voice to values: How to speak your mind when you know what's right*. Yale University Press.

Gentile, M. (2011a). Giving voice to values: an innovative approach to values-driven leadership. *The GLRI Partner Magazine. Global responsibility No. 4.*

Gentile, M. (2011b). Giving voice to values. *Global Focus*: *The EFMD Business Magazine, 5*(1), 34-38.

Gentile, M. C. (2012). Values-driven leadership development: Where we have been and where we could go. *Organization Management Journal, 9*(3), 188-196.

Gentile, Mary C. (2013), *Educating for values-driven leadership: Giving voice to values across the curriculum*. Business Expert Press.

Gentile, M. (2016). Listening for values. *Humanistic Management Journal. 1*. https://doi.org/10.1007/s41463-016-0005-3

Gentile, M. (2019a). Mary Gentile curriculum vitae.

https://www.darden.virginia.edu/faculty-research/directory/mary-gentile

Gentile, M. (2019b). Balancing differing views in decision-making. *People & Strategy*,

42(3), 50–52.

https://www.darden.virginia.edu/sites/default/files/inline-files/CV-Gentile- February2019.pdf

Gilligan, C. (1982). *In a different voice: psychological theory and women's development*.

Harvard University Press.

Gilligan, C. (1987). Moral orientation and moral development. In. Held, V. (1995). Justice

and care. Routledge. https://doi.org/10.4324/9780429499463

Gilligan, C. (1993). *In a different voice: Psychological theory and women's development*.

Harvard University Press.

Gilligan, C. (2014). Moral injury and the ethic of care: Reframing the conversation about

differences: Moral injury and the ethic of care. *Journal of social philosophy, 45*(1), 89-

106. https://doi.org/10.1111/josp.12050

Gilligan, C., & Attanucci, J. (1988). Two moral orientations: Gender differences and

similarities. Merrill-Palmer Quarterly, 34(3), 223-237

Glen, S. (1999). Educating for interprofessional collaboration: Teaching about values.

Nursing ethics, 6(3), 202-213. https://doi.org/10.1177/096973309900600303

Goethals, S., Gastmans, C., & de Casterlé, B. D. (2010). Nurses' ethical reasoning and

behaviour: A literature review. *International journal of nursing studies, 47*(5), 635-650.

https://doi.org/10.1016/j.ijnurstu.2009.12.010

Gonzalez-Padron, T. L., Ferrell, O. C., Ferrell, L., & Smith, I. A. (2012). A critique of

giving voice to values approach to business ethics education. *Journal of academic*

ethics, 10(4), 251-269. https://doi.org/10.1007/s10805-012-9168-1

Greenwood, J. (2000). *Nursing theory in Australia: development and application* (2nd ed.).

Prentice Hall Health.

Greenwood, M. D., & Terry, K. J. (2012). Demystifying mixed methods research: Participation in a reading group 'sign posts' the way. *International Journal of Multiple Research Approaches, 6*(2), 98-108. https://doi.org/10.5172/mra.2012.6.2.98

Haidt, J. (2012). *The righteous mind: why good people are divided by politics and religion* (1st ed.). Pantheon Books.

Haidt, J. (2014, Feb 6). *Research on the giving voice to values curriculum*. https://www.ethicalsystems.org/research-on-the-giving-voice-to-values-curriculum/

Halstead, J. M., & Taylor, M. J. (1996). *Values in education and education in values*. Psychology Press.

Hamilton, R. (1995). A seamless integrative approach to the teaching of ethics: teachable moments. Presented at the "*Ethics in America*" conference, Long Beach, CA.

Hanmer, T. J., Gilligan, C., Lyons, N., & Emma Willard, S. (1990). *Making connections: the relational worlds of adolescent girls at Emma Willard school*. Harvard University Press.

Harbison, J. (1992). Gilligan: a voice for nursing? *Journal of medical ethics, 18*(4), 202-205.

Harrington, A. (2005). *Modern social theory*. Oxford University Press.

Hechter, M., Nadel, L., & Michod, R. E. (1993). *The origin of values*. Aldine Transaction.

Hersh, R. H. (1979). *Promoting moral growth: From Piaget to Kohlberg*. Longman.

Hill, B. (2006). *Values education in schools: issues and challenges.* Emeritus. Professor of Education, Murdoch University. http://www.curriculum.edu.au/verve/_resources/ve_acsa_paper.pdf

Hinshaw, A. S. (1977). Socialization and resocialization of nurses for professional nursing practice. *NLN publications* (15-1659), 1.

Hoagland, S. L. (1990). Some concerns about Nel Noddings' caring. *Hypatia, 5*(1), 109-114.

Holmes, V. (2015). 'Giving voice to values': enhancing students' capacity to cope with ethical challenges in legal practice. *Legal Ethics, 18*(2), 115-137.

Horton, K., Tschudin, V., & Forget, A. (2007). The value of nursing: a literature review.

Nursing ethics, 14(6), 716-740.

Houston, B. (1990). Caring and exploitation. *Hypatia, 5*(1), 115-119.

Ingersoll, G. L., Witzel, P. A., & Smith, T. C. (2005). Using organizational mission, vision, and values to guide professional practice model development and measurement of nurse performance. *The Journal of nursing administration, 35*(2), 86-93. https://doi.org/10.1097/00005110-200502000-00008

Jack, L., Hayes, S. C., Scharalda, J. G., Stetson, B., Jones-Jack, N. H., Valliere, M., Kirchain, W. R., & LeBlanc, C. (2010). Appraising quantitative research in health education: Guidelines for public health educators. *Health promotion practice, 11*(2), 161-165. https://doi.org/10.1177/1524839909353023

Jakimowicz, S., Perry, L., & Lewis, J. (2017). An integrative review of supports, facilitators and barriers to patient-centred nursing in the intensive care unit. *Journal of clinical nursing, 26*(23-24), 4153-4171.

Jamieson, S. (2004). Likert scales: how to (ab)use them. *Medical education, 38*(12), 1217-1218. https://doi.org/10.1111/j.1365-2929.2004.02012.x

Jenks, D. A. (2000). Social developmental theory: An integrative approach. *The Justice Professional, 12*(4), 507-532. https://doi.org/10.1080/1478601X.2000.9959565

Johnstone, M., Da Costa, C., & Turale, S. (2004). Registered and enrolled nurses' experiences of ethical issues in nursing practice. *Australian Journal of Advanced Nursing, 22*(1), 24.

Johnstone, M. J. (2015). Moral competence in nursing. *Australian Nursing and Midwifery Journal, 22*(10), 33.

Jorgensen, G. (2006). Kohlberg and Gilligan: duet or duel? *Journal of Moral Education, 35*(2), 179-196.

Jormsri, P., Kunaviktikul, W., Ketefian, S., & Chaowalit, A. (2005). Moral competence in nursing practice. *Nursing ethics, 12*(6), 582-594

Ketefian, S. (1989). Moral reasoning and ethical practice. *Annual review of nursing research, 7*(1), 173-195.

Kim, Y.-S., Park, J.-W., Son, Y.-J., & Han, S.-S. (2004). A longitudinal study on the development of moral judgement in Korean nursing students. *Nursing ethics, 11*(3), 254-265.

Kohlberg, L., & Goslin, D. A. (1969). *Handbook of socialization theory and research*.

Kohlberg, L., & Gilligan, C. (1971). The adolescent as a philosopher: The discovery of the self in a postconventional world. Daedalus, 1051-1086.

Kohlberg, L., & Mayer, R. (1972). Development as the aim of education. Harvard educational review, 42(4), 449-496.

Kohlberg, L., & Turiel, E. (1971). Moral development and moral education. In L. Kohlberg (Ed.), Collected papers on moral development and moral education (pp. 410-465). Moral Education & Research Foundation.

Kohlberg, L. (1970a). *Education for justice: a modern statement of the platonic view. moral education* (pp. 56-83). Harvard University Press.

Kohlberg, L. (1975). The cognitive-developmental approach to moral education. *The Phi Delta Kappan, 56*(10), 670-677.

Kohlberg, L., & Lickona, T. (1976). Moral stages and moralization: The cognitive developmental approach in moral development and behaviour. *Moral development and behaviour, Holt, Rinehart & Winston, New York*.

Kohlberg, L. (1981). *The philosophy of moral development moral stages and the idea of justice*. Harper and Row Publishers.

Kohlberg, L. (1981b). *Essays on moral development, Vol. I*: The philosophy of moral development. Harper & Row.

Kohlberg, L., Levine, C., & Hewer, A. (1983). *Moral stages: A current formulation and a response to critics.* Harper & Row.

Kohlberg, L. (1984). *The psychology of moral development: the nature and validity of moral stages* (1st ed., Vol. 2.;2;). Harper & Row.

Kohlberg, L. (2010). The claim to moral adequacy of a highest stage of moral judgment. Moral psychology: historical and contemporary readings, 2010, 40-47.

Krøll, V., & Hansen, H. (2000). The competence of the newly qualified nurse now and in five years–seen from an empirical and professional perspective. *Nursing Science and Research in the Nordic Countries, 20*(4), 10-16.

Kulju, K., Stolt, M., Suhonen, R., & Leino-Kilpi, H. (2016). Ethical competence: A concept analysis. *Nursing ethics, 23*(4), 401-412. https://doi.org/10.1177/0969733014567025

Kurtines, W. M., & Gewirtz, J. L. (Eds.). (1995). *Moral development: An introduction.* Allyn and Bacon.

LaSala, C. A., & Bjarnason, D. (2010). Creating workplace environments that support moral courage. *The Online Journal of Issues in Nursing, 15*(3).

Laabs, C. (2011). Perceptions of moral integrity: contradictions in need of explanation. *Nursing ethics, 18*(3), 431-440.

Lachman, V. D. (2007). Moral courage: a virtue in need of development? *Medsurg Nursing, 16*(2), 131

Lachman, V. D. (2012). Applying the ethics of care to your nursing practice. *Medsurg Nursing, 21*(2), 112.

Lapsley, D. K. (2018). *Moral psychology.* Routledge.

Lenburg, C.B. (2000). Promoting competence through critical self-reflection – a portfolio development: the inside evaluator and the outside context. *Tennessee Nurse. 63*(3): 11, 14-15.

https://www.researchgate.net/profile/Carrie_Lenburg/publication/267362753_Promoting_Competence_through_Critical_Self-Reflection_and_Portfolio_Development_The_Inside_Evaluator_and_the_Outside_Context/links/54d92cf60cf2970e4e7ae6a0.pdf

Leners, D. W., Roehrs, C., & Piccone, A. V. (2006). Tracking the development of professional values in undergraduate nursing students. *Journal of Nursing Education, 45*(12), 504-511.

Lennick, D., & Kiel, F. (2007). *Moral intelligence: Enhancing business performance and leadership success*. Pearson Prentice Hall.

Levine, C., Kohlberg, L., & Hewer, A. (1985). The current formulation of Kohlberg's theory and a response to critics. *Human development, 28*(2), 94-100. https://doi.org/10.1159/000272945

Lewis, J. M., DiGiacomo, M., Currow, D. C., & Davidson, P. M. (2014). Social capital in a lower socioeconomic palliative care population: a qualitative investigation of individual, community and civic networks and relations. *BMC palliative care, 13*(1), 30.

Liamputtong, P. (2013). *Research methods in health: foundations for evidence-based practice*. Oxford University Press.

Liaschenko, J. (1999). Can justice coexist with the supremacy of personal values in nursing practice? *Western Journal of Nursing Research, 21*(1), 35-50.

Lind, G. (1998). An introduction to the moral judgment test (MJT). *Unpublished manuscript. Konstanz: University of Konstanz. http://www. uni-konstanz. de/ag-moral/pdf/MJT-introduction. PDF*.

Lindh, I.-B., Barbosa da Silva, A., Berg, A., & Severinsson, E. (2010). Courage and nursing practice: A theoretical analysis. *Nursing ethics, 17*(5), 551-565. https://doi.org/10.1177/0969733010369475

Lui, M. H. L., Lam, L. W., Lee, I. F. K., Chien, W. T., Chau, J. P. C., & Ip, W. Y. (2008).

Professional nursing values among baccalaureate nursing students in Hong Kong. *Nurse education today, 28*(1), 108-114. https://doi.org/10.1016/j.nedt.2007.03.005

Lynch, S., Hart, B., & Costa, C. M. (2014). Giving voice to values: An undergraduate nursing curriculum project. *Collegian (Royal College of Nursing, Australia), 21*(4), 367-373. https://doi.org/10.1016/j.colegn.2013.09.004

Lyneham, J., & Levett-Jones, T. (2016). Insights into registered nurses' professional values through the eyes of graduating students. *Nurse education in practice, 17*, 86-90. https://doi.org/10.1016/j.nepr.2015.11.002

McCarthy, J. (2006). A pluralist view of nursing ethics. Nursing philosophy: an international journal for healthcare professionals. 7(3), 157-164. http://doi.org/10.1111/j.1466-769X.2006.00272.x

McKenzie, M., & Blenkinsop, S. (2006). An ethic of care and educational practice. *Journal of Adventure Education and Outdoor Learning, 6*(2), 91-105. https://doi.org/10.1080/14729670685200781

McLean, C. (2012). The yellow brick road: A values based curriculum model. *Nurse education in practice, 12*(3), 159-163. https://doi.org/10.1016/j.nepr.2011.11.002

Ma, H. K. (2012). Behavioural competence as a positive youth development construct: a conceptual review. *The Scientific World, 2012*, 568272-568277. https://doi.org/10.1100/2012/568272

Maben, J., Latter, S., & Clark, J. M. (2007). The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study. *Nursing inquiry, 14*(2), 99-113. https://doi.org/10.1111/j.1440-1800.2007.00357.x

Mahasneh, A. M. (2014). The level of moral competence among sample of Hashemite university students. *Middle East journal of scientific research, 19*(9), 1259-1265. https://doi.org/10.5829/idosi.mejsr.2014.19.9.11888

Maranell, G. M. (2017). *Scaling: A sourcebook for behavioural scientists*.

https://doi.org/10.4324/9781315128948

Markey, K., & Okantey, C. (2019). Nurturing cultural competence in nurse education through

a values-based learning approach. *Nurse education in practice, 38,* 153-156.

https://doi.org/10.1016/j.nepr.2019.06.011

Martin, D., & Austin, B. (2010). Validation of the moral competency inventory measurement

instrument. *Management Research Review, 33*(5), 437-451.

https://doi.org/10.1108/01409171011041884

Marturano, A., & Gosling, J. (2008). *Leadership: the key concepts*. Routledge.

https://doi.org/10.4324/9780203099643

Meredith, P., Murray, J., Wilson, T., Mitchell, G., & Hutch, R. (2012). Can spirituality be

taught to health care professionals? *Journal of religion and health, 51*(3), 879-889.

Miller, M. (2005). Teaching and learning in affective domain. *Emerging perspectives on

learning, teaching, and technology.*

Miller, W. F., Shawver, T. J., & Mintz, S. M. (2020). Measuring the value of integrating

GVV into a standalone accounting ethics course. *Journal of Accounting Education*,

100669.

Mintz, S. (2016). Giving voice to values: A new approach to accounting ethics education.

Global Perspectives on Accounting Education, 13(1), 37-50.

Mitchell, G., Murray, J., & Hynson, J. (2008). Understanding the whole person: life-limiting

illness across the life cycle. *Palliative Care: A Patient-Centered Approach*. Radcliffe.

Moen, D. (2017). The leader-investigator: Using leadership studies as a model for

conscientization through adaptive leadership, the four frames approach, giving voice

to values, and the competing values framework. *Journal of thought, 51*(3-4), 22-37.

Murray-Parahi, P., DiGiacomo, M., Jackson, D., Phillips, J., & Davidson, P. M. (2019).

Primary health care content in Australian undergraduate nursing curricula. *Collegian*

(*Royal College of Nursing, Australia), 27*(3), 271-280.

https://doi.org/10.1016/j.colegn.2019.08.008

Newman, L., & Pollnitz, L. (2005). *Working with children and families: professional, legal and ethical issues*. Pearson Education.

Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education.* University of California Press.

Noddings. N. (1986). *Caring: a feminine approach to ethics and moral education*. University of California Press.

Noddings, N. (1988). An ethic of caring and its implications for instructional arrangements. *American journal of education, 96*(2), 215-230.

Noddings, N. (2002a). *Educating moral people: a caring alternative to character education.* ERIC

Noddings, N. (2002b). *Starting at home: caring and social policy*. University of California Press.

Noddings, N. (2013). *Caring: A relational approach to ethics and moral education*. University of California Press.

Numminen, O. H., & Leino-Kilpi, H. (2007). Nursing students' ethical decision-making: A review of the literature. *Nurse education today, 27*(7), 796-807. https://doi.org/10.1016/j.nedt.2006.10.013

O'Connell, J., Gardner, G., & Coyer, F. (2014). Beyond competencies: using a capability framework in developing practice standards for advanced practice nursing. *Journal of advanced nursing, 70*(12), 2728-2735. https://doi.org/10.1111/jan.12475

O'Leary, Z. (2010). *The essential guide to doing your research project* (2nd ed.). Thousand Oaks, Calif.; London: Sage Publications.

Öhlén, J., Segesten, K., Sahlgrenska, a., Institute of, N., Göteborgs, u., Gothenburg, U., Institutionen för, o., & Sahlgrenska, A. (1998). The professional identity of the nurse:

concept analysis and development. *Journal of advanced nursing, 28*(4), 720-727. https://doi.org/10.1046/j.1365-2648.1998.00704.x

Owens, L. M., & Ennis, C. D. (2005). The ethic of care in teaching: An overview of supportive literature. *Quest (National Association for Kinesiology in Higher Education), 57*(4), 392-425. https://doi.org/10.1080/00336297.2005.10491864

Parks, L., & Guay, R. P. (2009). Personality, values, and motivation. *Personality and individual differences, 47*(7), 675-684.

Park, N., & Peterson, C. (2006). Moral competence and character strengths among adolescents: The development and validation of the values in action inventory of strengths for youth. *Journal of adolescence (London, England.), 29*(6), 891-909. https://doi.org/10.1016/j.adolescence.2006.04.011

Park, M., Kjervik, D., Crandell, J., & Oermann, M. H. (2012). The relationship of ethics education to moral sensitivity and moral reasoning skills of nursing students. *Nursing ethics, 19*(4), 568-580. https://doi.org/10.1177/0969733011433922

Parker, R. S. (1990). Measuring nurses' moral judgments. *Image: the journal of nursing scholarship, 22*(4), 213.

Parsons, R.D. (2001). *The ethics of professional practice*. Allyn & Bacon.

Patton, M. Q. (2015). *Qualitative research & evaluation methods: integrating theory and practice* (Fourth ed.). SAGE.

Pellegrino, E. (2001). The internal morality of clinical medicine: a paradigm for the ethics of the helping and healing professions. https://academic-oup-com.ipacez.nd.edu.au/jmp/article/26/6/559/853110

Piaget, J. (1997). *The moral judgement of the child*. Simon and Schuster.

Plano Clark, V. L. (2017, 2017/05/04). Mixed methods research. *The Journal of Positive Psychology, 12*(3), 305-306. https://doi.org/10.1080/17439760.2016.1262619

Porter, S. (1998). *Social theory and nursing practice*. Macmillan International Higher Education.

Ranjbar, H., Joolaee, S., Vedadhir, A., Abbaszadeh, A., & Bernstein, C. (2017). Becoming a nurse as a moral journey: A constructivist grounded theory. *Nursing ethics, 24*(5), 583-597. https://doi.org/10.1177/0969733015620940

Rassin, M. (2008). Nurses' professional and personal values. *Nursing ethics, 15*(5), 614-630. https://doi.org/10.1177/0969733008092870

Reed, D. R. C. (1997). *Following Kohlberg: Liberalism and the practice of democratic community*. University of Notre Dame Press.

Rest, J. R. (1975). Longitudinal study of the Defining Issues Test of moral judgment: A strategy for analyzing developmental change. *Developmental psychology, 11*(6), 738-748. https://doi.org/10.1037/0012-1649.11.6.738

Rest, J. R. (1994). Background: Theory and research. *Moral development in the professions: Psychology and applied ethics*, 1-26.

Roervik, H. (1981). A comparison of Piaget's and Kohlberg's theories and tests for moral judgement. *Scandinavian journal of educational research, 25*(3), 99-124. https://doi.org/10.1080/0031383810250301

Rokeach, M. (1973). *The nature of human values*. Free press.

Rosenman, R., Tennekoon, V., & Hill, L. G. (2011). Measuring bias in self-reported data. *International Journal of Behavioural and Healthcare Research, 2*(4), 320-332.

Sander-Staudt, M. (2011). *Care ethics*. Internet Encyclopedia of Philosophy.

Scanlon, C., & Glover, J. A., (1995). Professional code of ethics: providing a moral compass for turbulent times. *Oncol Nurs Forum. 22*: 1515-1521.

Schank, M. J., & Weis, D. (2000). Exploring commonality of professional values among nurse educators in the United States and England. *Journal of Nursing Education,*

39(1), 41-44.

Schwartz, B. (1987). *The battle for human nature: science, morality, and modern life.*

Norton.

Schwarz-Franco, O. (2016). Touching the challenge: Embodied solutions enabling humanistic

moral education. *Journal of Moral Education, 45*(4), 449-464.

https://doi.org/10.1080/03057240.2016.1230052

Seidman, I. E. (2019). *Interviewing as qualitative research*. (5th Ed.). Teachers

College Columbia University

Şenyuva, E. (2018). Intergenerational differences in the personal and professional values of

nurses. *Nursing ethics, 25*(7), 939-950. https://doi.org/10.1177/0969733018784688

Shaw, B., (2013). *GVV Pre and Post workshop questionnaire*. Faculty of Business,

Bond University. QLD: Australia.

Shaw, B. (2013a). Assessing the impact of a GVV-enhanced undergraduate ethics and CSR

course. Bond University QLD Australia.

Skoe, E. E. A. (2014). Measuring care-based moral development: The ethic of care

interview. *Behavioral development bulletin (Philadelphia, Pa.), 19*(3), 95-104.

https://doi.org/10.1037/h0100594

Smith, K. V., & Godfrey, N. S. (2016). Being a good nurse and doing the right thing: a

qualitative study. *Nursing ethics, 9*(3), 301-312.

https://doi.org/10.1191/0969733002ne512oa

Snarey, J., & Samuelson, P. (2008). Moral education in the cognitive developmental tradition:

Lawrence Kohlberg's revolutionary ideas. *Handbook of moral and character education*,

53-79.

Swanger, D. (1993). The arts, empathy, and Aristotle. *The Journal of aesthetic education,*

27(1), 41-49. https://doi.org/10.2307/3333340

Tams, C. & Gentile, M. (2019). Giving voice to values: responsible

management as facilitation of ethical voice. In: Laasch, O., Jamali, D., Freeman, R.E. & Suddaby, R. *Research handbook of responsible management*. Edward Elgar Publishing.

Tashakkori, A., Teddlie, C., & Teddlie, C. B. (1998). *Mixed methodology: Combining qualitative and quantitative approaches* (46). Sage.

Taylor, C. (1995). Rethinking nursing's basic competencies. *Journal Nursing Care Quality 9*(4): 1-13.

Thoma, S. J., & Dong, Y. (2014). The Defining Issues Test of moral judgment development. *Behavioural development bulletin (Philadelphia, Pa.), 19*(3), 55-61. https://doi.org/10.1037/h0100590

Turiel, E. (2008). The development of children's orientations toward moral, social, and personal orders: More than a sequence in development. *Human development, 51*(1), 21-39.

Viens, D. C. (1995). The moral reasoning of nurse practitioners. *Journal of the American Academy of Nurse Practitioners, 7*(6), 277.

Vozzola, E. C. (2014). *Moral development: theory and applications*. Routledge.

Walker, M. (2007). *Moral understandings: a feminist study in ethics*. (2nd ed). Oxford University Press.

Weinert, F. E. (2001). Concept of competence: a conceptual clarification. In D. S. Rychen & L.H. Salganik (Eds.), *Defining and selecting key competencies.* Hogrefe & Huber Publishers.

Weis, D., & Schank, M. J. (2000). An instrument to measure professional nursing values. *Journal of nursing scholarship, 32*(2), 201-204. https://doi.org/10.1111/j.1547- 5069.2000.00201.x

Weis, D., & Schank, M. J. (2002). Professional values: Key to professional development. *Journal of professional nursing, 18*(5), 271-275. https://doi.org/10.1053/jpnu.2002.129224

Wright, R.A. (1987). *Human values in health care: the practice of ethics*. McGraw- Hill.

Zafarnia, N., Abbaszadeh, A., Borhani, F., Ebadi, A., & Nakhaee, N. (2017). Moral

competency: meta-competence of nursing care. *Electronic physician, 9*(6), 4553-4562.

https://doi.org/10.19082/4553

Zhang, Z. x., Luk, W., Arthur, D., & Wong, T. (2001). Nursing competencies: personal

characteristics contributing to effective nursing performance. *Journal of advanced*

nursing, 33(4), 467-474. https://doi.org/10.1046/j.1365-2648.2001.01688.x

<u>**Appendix 1: Student Participant Information Sheet**</u>

PROJECT TITLE:	**An Investigation of Moral Competence in Nursing**
CHIEF INVESTIGATOR:	**Associate Professor Bethne Hart**
STUDENT RESEARCHER:	**Catherine Costa**
STUDENT'S DEGREE:	**Doctor of Philosophy**

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

The research project explores the intersections between moral theory, moral action and the profession of nursing. It will examine the concepts underpinning contemporary approaches and regulations designed to help develop moral competence in graduates of nursing schools. The Giving Voice to Values (GVV) Curriculum, a recent approach towards the development of moral competency in nursing students – will be particularly emphasized.

Who is undertaking the project?

This project is being conducted by Catherine Costa and will form the basis for the degree of Doctor of Philosophy at The University of Notre Dame Australia, under the supervision of Associate Professor Bethne Hart.

What will I be asked to do?

Your participation in this research project will involve the following:

- As a current nursing student, you are invited to complete this questionnaire.

How much time will the project take?

This questionnaire will take participants around 10 to 15 minutes to complete.

Are there any risks associated with participating in this project?

There are no foreseeable risks to participants. However, we encourage you to contact the University Counselling service sydney.counselling@nd.edu.au if you need to discuss any concerns or experience distress associated with completing the questionnaire.

What are the benefits of the research project?

The preparation of nursing students for ethical professional practice is a multidimensional challenge. The profession of nursing legislatively requires safe and proper practice, with continuing competencies in moral and ethical decision making, and particularly in patient advocacy, cross cultural competence, teamwork, collaborative care, social justice and critical thinking (ANMC, 2008). This research project contributes to knowledge regarding the preparation of nursing students to reach moral competence.

Can I withdraw from the study?

Participation in this study is completely voluntary. You are not under any obligation to participate. However, those students undertaking the questionnaire will be unable to withdraw after submission of the questionnaire. It will be non-identifiable. Non-participation by students or withdrawal will not affect their ongoing studies in any way. Please return the questionnaire into the Return Box provided. This is an anonymous questionnaire – your completion, or otherwise, will not identify you.

Will anyone else know the results of the project?

Information gathered about you will be held in strict confidence. This confidence will only be broken in instances of legal requirements such as court subpoenas, freedom of information requests, or mandated reporting by some professionals.

Storage of data will be secured, and all data will be non-identifiable. Participant data will be securely stored at the University, where only the researcher and the two identified supervisors of this research will have access to these documents. Computer based information will be stored on the primary researcher's password protected computer to which only this researcher has access. All research data

will be destroyed after a period of five (5) years. No participant will be identified in any nursing or ethics publications or thesis and only aggregated data will be published.

Will I be able to find out the results of the project?

The outcomes of participants' contributions will be published in nursing/ethics journal papers and the researcher's thesis.

Who do I contact if I have questions about the project?

If you have any questions or concerns in regard to this research you can contact:

Catherine Costa   (T) 02 8204 4285 or email: cathy.costa@nd.edu.au

Associate Professor Bethne Hart (T) 02 8204 4294 or email: bethne.hart@nd.edu.au

What if I have a complaint or any concerns?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 014164S). If you wish to make a complaint regarding the manner in which this research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au
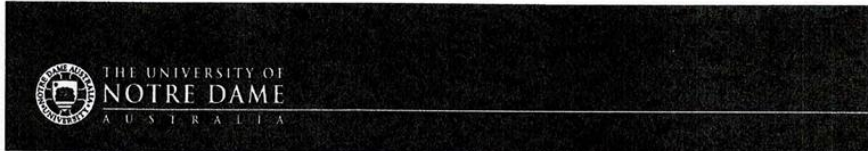
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

Yours sincerely,

Supervisor:

Researcher:

Appendix 2: Information Sheet: nursing experts and stakeholders

ACADEMIC PARTICIPANT INFORMATION SHEET

PROJECT TITLE: **An Investigation of Moral Competence in Nursing**
CHIEF INVESTIGATOR: **Associate Professor Bethne Hart**
Co-INVESTIGATOR: **Mr Anthony Crook**
STUDENT RESEARCHER: Catherine Costa
STUDENT'S DEGREE: **Doctor of Philosophy**

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?
The research project explores the intersections between moral theory, moral action and the profession of nursing. It will examine the concepts underpinning contemporary educational approaches and regulations designed to ensure the development of moral competence in graduates of nursing schools and the perceptions of nursing educators regarding the success of current education in relation to the development of moral competence in nurses. In particular, it will explore current educational approaches towards the development of moral competency in nursing students emphasizing one recent approach: the Giving Voice to Values (GVV) Curriculum.

Who is undertaking the project?
This project is being conducted by Catherine Costa and will form the basis for the degree of Doctor of Philosophy at The University of Notre Dame Australia, under the supervision of Associate Professor Bethne Hart and Mr Anthony Crook.

What will I be asked to do?
Your participation in this research will involve the following:
A semi-structured interview either face-to-face or via telephone at a mutually convenient time and location. These interviews will be taped. Participants will be asked to reflect on the following themes:
- The definition of a morally competent nurse
- The phases of the development of moral competency in nursing
- The preparation of nursing students for moral competency
- The contemporary approaches or frameworks utilized in nursing education in Australia toward the development of moral competency in the nursing profession. The approaches or frameworks undertaken in their units of study in this area.
- The curriculum demands that intersect with the development of moral competency in nursing studies
- The perceived/observed gaps in the development of moral competency in the nursing profession.
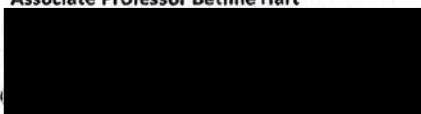
PARTICIPANT INFORMATION SHEET
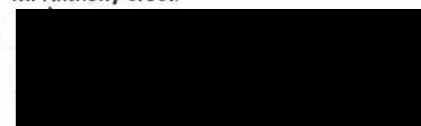
I want to participate! How do I sign up?
If you wish to participate in this project please send an email to Catherine Costa at cathy.costa@nd.edu.au confirming your participation in this research. You will then be sent a consent form which you sign and then return.
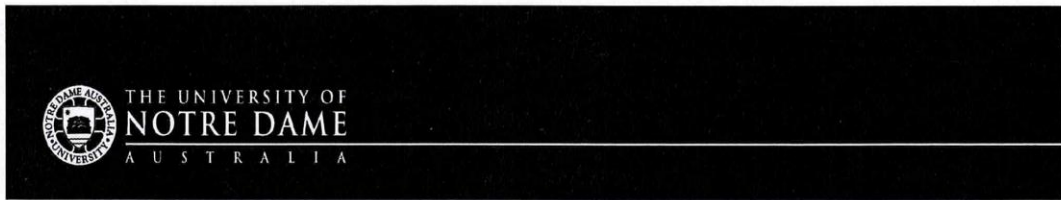
Yours sincerely,

Associate Professor Bethne Hart

Mr Anthony Crook

Catherine Costa

Appendix 3: Informed Consent: nursing experts and stakeholders

THE UNIVERSITY OF
NOTRE DAME
AUSTRALIA

CONSENT FORM

An Investigation of Moral Competence in Nursing

INFORMED CONSENT FORM

I, *(participant's name)* _____hereby agree to being a participant in the above research project.

- I have read and understood the Information Sheet about this research and any questions have been answered to my satisfaction.

- I understand that I may withdraw from participating in the research at any time without prejudice.

- I understand that all information gathered by the researcher will be treated as strictly confidential, except in instances of legal requirements such as court subpoenas, freedom of information requests, or mandated reporting by some professionals.

- I understand that the protocol adopted by the University Of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to and relevant sections of the *Privacy Act* are available at http://www.nhmrc.gov.au/

- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

- I understand that I will be audio-taped.

PARTICIPANT'S SIGNATURE:		DATE:	

RESEARCHER'S FULL NAME:	MS. CATHERINE COSTA		
RESEARCHER'S SIGNATURE:		DATE:	

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au

Consent Form Template Version 2012.2

Appendix 4: Shaw's Survey

Knowledge, Ability and Skill You Have NOW and What You Really Had THEN

PRINT YOUR PERSONAL SECRET ID NUMBER HERE _____

Using the scale below, please place the number that best represents the amount of skill, knowledge, ability, or level of a characteristic you <u>CURRENTLY</u> have in the following areas:

<u>Scale</u>: 1 = Almost None   4 = Moderate

2 = Very low   5 = High

3 = Low   6 = Very High

Rating

#		Rating
1.	My understanding and knowledge about the kinds of ethical issues that may affect business decisions.	
2.	My ability to develop "win-win" situations when there is conflict about values within a particular work situation.	
3.	Ability to appreciate and accept different ethical and value orientations among people.	
4.	Knowledge of my own ethical values and how they might affect my actions in a business environment.	
5.	My ability to "give voice" to my values when I am confronted with a situation that is in conflict with those values, i.e., my ability to effectively deal with and behave acceptably in those situations.	
6.	My ability to raise ethical issues in an effective manner in a work situation.	
7.	When faced with an ethical dilemma in a work situation, my ability to say and do what needs to be said and done.	
8.	Ability to understand a situation from a value perspective other than my own.	
9.	My ability to correct an existing course of action in my work environment when I think that it is unethical or violates important personal values.	
10.	From an ethical perspective, my ability to understand why people might act the way they do in a particular work situation.	

11.	My understanding of corporate social responsibility and how this concept applies within a business environment.	
12.	My ability to establish productive ethical norms and role expectations among the people with whom I work.	
13.	My understanding of environmental sustainability and how it applies within a business environment.	

Scale: 1 = Almost None   4 = Moderate

          2 = Very low   5 = High

          3 = Low   6 = Very High

Rating

		Rating
14.	My ability to communicate effectively with my workmates about ethical issues and values.	
15.	My level of commitment to act ethically in all work settings and activities.	
16.	My ability to apply ethical principles when making work decisions.	
17.	My understanding of the factors in a work situation that may contribute to unethical behaviour.	
18.	My ability to learn from my mistakes when attempting to deal with ethical conflicts in the workplace.	
19.	My knowledge of the reasons and rationalizations that people often use to justify actions I perceive as unethical.	
20.	My ability to empathise with another person who has a different set of ethical values than myself.	
21.	My ability to influence others to behave in an ethical manner in work situations.	
22.	My knowledge of different ways to "give voice" to my values in a work setting.	
23.	My understanding of how emotions, instincts, and basic cognitive processes influence our level of ethical behaviour.	
24.	My ability to choose the most persuasive and appropriate ways to influence the actions of others in values-conflict situations.	
25.	My ability to communicate my point of view effectively in a values-conflict situation.	
26.	The likelihood that I would express my moral/ethical values in a work setting.	
27.	My understanding of my own personal ethical values and beliefs.	

Knowledge, Ability and Skill You Have NOW and What You Really Had THEN

PRINT YOUR PERSONAL SECRET ID NUMBER HERE _____

Using the scale below, please place the number that best represents the amount of skill, knowledge, ability, or level of a characteristic you have in the areas listed below. In COLUMN A indicate how much of the knowledge, skill, ability or characteristic you have NOW. In COLUMN B, indicate how much of the knowledge, skill, ability or characteristic you really had AT THE BEGINNING OF THE SEMESTER (Then).

Scale: 1 = Almost None   2 = Very low   3 = Low

4 = Moderate   5 = High   6 = Very High

		A Rating NOW	B Rating THEN
1.	My understanding and knowledge about the kinds of ethical issues that may affect business decisions.		
2.	My ability to develop "win-win" situations when there is conflict about values within a particular work situation.		
3.	Ability to appreciate and accept different ethical and value orientations among people.		
4.	Knowledge of my own ethical values and how they might affect my actions in a business environment.		
5.	My ability to "give voice" to my values when I am confronted with a situation that is in conflict with those values, i.e., my ability to effectively deal with and behave acceptably in those situations.		
6.	My ability to raise ethical issues in an effective manner in a work situation.		
7.	When faced with an ethical dilemma in a work situation, my ability to say and do what needs to be said and done.		
8.	Ability to understand a situation from a value perspective other than my own.		
9.	My ability to correct an existing course of action in my work environment when I think that it is unethical or violates important personal values.		

10.	From an ethical perspective, my ability to understand why people might act the way they do in a particular work situation.		

GO TO NEXT PAGE →

		A	B
Scale: 1 = Almost None 2 = Very low 3 = Low		Rating	Rating
4 = Moderate 5 = High 6 = Very High		NOW	THEN

		A Rating NOW	B Rating THEN
11.	My understanding of corporate social responsibility and how this concept applies within a business environment.		
12.	My ability to establish productive ethical norms and role expectations among the people with whom I work.		
13.	My understanding of environmental sustainability and how it applies within a business environment.		
14.	My ability to communicate effectively with my workmates about ethical issues and values.		
15.	My level of commitment to act ethically in all work settings and activities.		
16.	My ability to apply ethical principles when making work decisions.		
17.	My understanding of the factors in a work situation that may contribute to unethical behaviour.		
18.	My ability to learn from my mistakes when attempting to deal with ethical conflicts in the workplace.		
19.	My knowledge of the reasons and rationalizations that people often use to justify actions I perceive as unethical.		
20.	My ability to empathise with another person who has a different set of ethical values than myself.		
21.	My ability to influence others to behave in an ethical manner in work situations.		
22.	My knowledge of different ways to "give voice" to my values in a work setting.		
23.	My understanding of how emotions, instincts, and basic cognitive processes influence our level of ethical behaviour.		
24.	My ability to chose the most persuasive and appropriate ways to influence the actions of others in values-conflict situations.		
25.	My ability to communicate my point of view effectively in a values-conflict situation.		

26.	The likelihood that I would express my moral/ethical values in a work setting.		
27.	My understanding of my own personal ethical values and beliefs.		

Appendix 5: Becoming an Ethical Nurse.

Becoming an Ethical Nurse

Knowledge, Ability and Skill You Have NOW and What You Really Had THEN – Post-Workshop Questionnaire

(adapted from Shaw, 2013)

Using the scale below, please place the number that best represents the amount of skill, knowledge, ability, or

level of a characteristic you have in the areas listed below.

In **COLUMN A** indicate how much of the knowledge, skill, ability or characteristic you have **NOW**.

In **COLUMN B**, indicate how much of the knowledge, skill, ability or characteristic you really had **AT THE**

BEGINNING OF YOUR DEGREE STUDIES (THEN).

Scale: 1 = Almost None   2 = Very low   3 = Low   4 = Moderate   5 = High   6 = Very

High

Circle your age group: **Circle your Gender**:

15-20   21-30   31-40   41-50   51-60   61-70   71-80   Male   Female

		A Rating NOW	B Rating THEN
1.	My awareness and understanding of the kinds of ethical issues that may arise in nursing practice.		
2.	My ability to achieve "win-win "outcomes in resolving ethical conflicts in workplace situations		
3.	My ability to appreciate different ethical and value orientations among people.		
4.	My ability to accept different ethical and value orientations among people		
5.	My knowledge of my own ethical values and how they might affect my actions in a healthcare environment.		

6.	My ability to "give voice" to or act on my values when I am confronted with a behaviour or attitudes that are in conflict with those values, i.e., my ability to effectively deal with and behave in accordance with my values in those situations.		
7.	My ability to raise ethical issues with colleagues, patients or patients' families in an effective manner in a work situation.		
8.	When faced with an ethical dilemma in a work situation, my ability to say and do what I think needs to be said and done.		
9.	My ability to understand a situation from a value perspective other than my own.		
10.	My ability to correct an existing course of action in my work environment when I think that it is unethical or violates important personal values.		
11.	From an ethical perspective, my ability to understand why people might act the way they do in a particular work situation.		
12.	My understanding of corporate social responsibility and how this concept applies within a healthcare environment.		
13.	My understanding of environmental sustainability and how it applies within a healthcare environment.		

GO TO NEXT PAGE →

Scale: 1 = Almost None   2 = Very low   3 = Low   4 = Moderate   5 = High   6 = Very High

		A Rating	B Rating
		NOW	**THEN**
14.	My ability to communicate effectively with my workmates, patients and patients' families about ethical issues and values.		
15.	My level of commitment to acting ethically in all work settings and activities.		
16.	My ability to articulate the ethical principles that underlie my decision-making in either workplace settings or elsewhere.		
17.	My understanding of the factors in a work situation that may contribute to unethical behaviour.		
18.	My ability to ask for advice when I need help in dealing with ethical conflict at work.		
19.	My knowledge of the common reasons and explanations that people often use to justify actions that others perceive as unethical.		
20.	My ability to empathise with another person who has a different set of ethical values than myself.		
21.	My understanding of what it is that influences others to behave in an ethical manner in work situations.		
22.	My knowledge of how to "give voice" to my values in different ways in a work setting, depending on the particular situation.		
23.	My understanding of how emotions, instincts, and basic cognitive processes influence our capacity to behave ethically.		
24.	My ability to choose the most persuasive and appropriate ways to influence others to act ethically in values-conflict situations.		
25.	My ability to communicate my point of view effectively in a values-conflict situation.		
26.	The likelihood that I would express my moral/ethical values in a work setting.		
27.	My understanding of my own personal ethical values and beliefs.		

Adapted from: Shaw, J.B., (2010). GVV Pre and Post Workshop Questionnaire. Faculty of Business, Bond University. QLD:

Australia.

GO TO NEXT PAGE →

Please answer the next three questions.

What is Moral Competency? (in your own words)

_____

_____

_____

_____

_____

_____

What are your values?

_____

_____

_____

_____

_____

What does "Giving Voice to Values" mean to you?

_____

_____

_____

_____

_____

_____

THANK YOU FOR YOUR CONTRIBUTIONS