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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Nursing students' experience of learning ethical competence and person-centred care through simulation

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Abstract

Background: Ethics is a difficult subject for nursing students to grasp and learn but, like person-centredness, it has an important role in the relationship between nurses and patients. Simulation has been found to be a suitable method for learning nursing procedures and actions, and the researchers wanted to explore whether it could be a suitable learning strategy for acquiring ethical skills, which are a prerequisite for delivering person-centred care.

Aim: In response to the research question *How can nursing students develop ethical competence through simulation?* the study sought to consider how students could learn ethical reflection and decision making through simulated ethical dilemmas, and whether this could enhance their ability to deliver person-centred care.

Design: The study was qualitative and exploratory, and based on students acting in scenarios representing general ethical dilemmas in nursing. There were four focus group interviews with nine nursing students in their second year, during their clinical practice. Students were recruited by self-selection. Data were transcribed and analysed using Graneheim and Lundman's content analysis.

Findings: The students gained experience through participation and acting in simulation exercises. The shared experience was a good starting point for guided reflection on ethical and tacit knowledge, and the acquired experience led to knowledge that is transferable to similar situations in clinical practice.

Conclusion: This study shows that simulation is a valuable method for learning ethical reflection in nursing education. It found simulation to be suitable for developing ethical awareness that helps prepare nursing students to deliver person-centred practice. It has become a permanent learning strategy within nursing training at Nord University.

Implications for practice:

- Nursing students benefit from learning to practise critical ethical thinking as early as possible in order to become ethically aware and reflective during their training and later as nurses
- Simulation is a valuable way to practise personal relationships with patients and colleagues
- Simulated clinical scenarios improve competence in critical thinking and ethical conduct, and help prepare nurses to deliver person-centred practice. They can be used in all healthcare settings.

Keywords: Ethical skills, nursing students, simulation, reflection, active learning, person-centred care

Introduction

An essential aspect of nurse training is learning to make decisions skilfully with a deep respect for the patient. Ethics is the generic term for the different ways of understanding and examining moral life; in nursing, for example, it includes professionals' behaviour towards persons in their care. It concerns norms about right and wrong, moral principles, rules, rights and virtues. Beauchamp and Childress (2001) describe four ethical principles, of autonomy, justice, beneficence and non-maleficence, and argue that ethical dilemmas occur when there is a conflict between different moral commitments. In the nursing curriculum, proximity ethics, ethics of duty and consequence, and paternalism are essential aspects of ethical theory and nursing students must learn to reflect on their behaviour towards patients accordingly. The International Council of Nurses published the *ICN Code of Ethics for Nurses* in 2012 setting out standards for human rights, cultural rights, the right to life, choice, dignity and respect. The code is being updated this year to reflect the ethical dilemmas nurses face on a daily basis.

Reflection lies at the heart of the close connection between ethics and person-centred care. The ability to deliver person-centred care requires reflectiveness (McCormack, 2003), as does consideration of ethical factors during interactions with patients. Professional nurses often have to act in the best interests of patients and think critically to identify issues that can lead to ethical dilemmas. Therefore, minimising episodes of dissatisfaction with healthcare requires ethically skilled staff delivering person-centred care. Person-centredness is maintained by focusing on patients' wellbeing, respecting their autonomy, and recognising and cultivating their capabilities (Entwistle and Watt, 2013). We believe competence in ethical reflection gives nursing students a spirit of inquiry to get to know these aspects of the patient as a person. The literature describes the rationale behind person-centred care but we believe it must pervade both learning outcomes and teaching strategies in nursing training, and that this starts with understanding ethical reflection and self-awareness. As nursing educators, we have found this challenging. It has been difficult to help students understand the value and the complexity in ethical theory and reflection, and they often find it difficult to connect ethics theory to their own situated experiences and reflections.

The aim of this study was to consider the potential role of simulation in helping nursing students build the ethical awareness and competence that are such important aspects of person-centred care. The study has a qualitative, explorative design, using focus group interviews with students in basic nursing training. The study was conducted in 2018-19 at Nord University in northern Norway.

Background: literature review

To achieve person-centred practice, nurses must deliver person-centred care (McCormack et al., 2017). The philosophy behind person-centred care brings to the fore the person's unique values, personality and history. Moreover, it highlights their right to respect and dignity, and to participate in choices about their life (Manley, 2017). Person-centredness in practice is something nurses must always strive to provide, giving prime consideration to those in their care and treating them as persons who matter and who have autonomous choices (Entwistle and Watt, 2013).

It is a challenge to find learning strategies that narrow the gap between theory and practice in order to make knowledge transformative for students. In nurse training, it is essential to teach clinical and moral responsiveness as nursing is unpredictable in terms of the range and type of situations encountered in practice (Benner, 2010). Simulation is a valuable way of educating people to be better prepared for situations where knowledge-based decisions are required, and it takes place in a controlled environment with no risk to patients (Khan et al., 2011). Situated learning happens when students are active in a training environment that replicates real-world practice (Lave and Wenger, 1991) and are able to generate meaning from negotiating the experience (Wenger, 1998). Students can experience learning from the perspectives of being an active participant as a patient, in a nursing role or as an observer (MacLean et al., 2019). The key to a good learning environment is confidence and supportiveness. Wagner and colleagues (2009) contend that facilitation is important, together with clear guidance for the observers and the opportunity to repeat the scenarios. Students taking

part in an innovative study featuring a simulation laboratory improved their level of confidence and their skills, crediting a combination of simulation and effective feedback (Wagner et al., 2009). Those authors conclude that the transferability of knowledge and skills is linked to the realism created in the simulation scenarios.

Debriefing is the educational feedback element of simulation and is considered by many to be an integral and critical part of the process (Levett-Jones and Lapkin, 2014). During debriefing, the positive aspects of the experience can be reinforced, and reflective learning encouraged (Jeffries, 2005). Shinnick and colleagues (2011) suggest knowledge gains from simulation are achieved only after debriefing, while Greco and colleagues (2019) argue that simulation together with guided debriefing develops and advances nursing students' skills in ethical reasoning. Schön (1987) emphasises that learning involves a dialogue between coach and student and that reflection helps students to be proficient.

A study by Bas-Sarmiento and colleagues (2019) evaluated the effectiveness of an intervention designed to improve nursing students' empathy, learning perception and understanding of the content as well as their acquisition of skills. They concluded that simulation improves the cognitive, emotional and relational dimensions of empathy. Learning empathy involves similar strategies to learning ethical reasoning. Buxton, Phillipi and Collins (2015) argue simulation has significant potential to enrich students' understanding of ethical concepts, especially in terms of encouraging ethical conduct in practice. Another study suggested embodied experiences of managing ethical dilemmas in simulation-based learning simulation can help medical students to smooth their transition into clinical practice (Lewis et al., 2016). The use of clinical simulation as a practical tool for learning about ethical problem solving was also considered by Díaz Agea and colleagues (2018), with students finding it to be a worthwhile strategy. Training students to care for a person with dementia using simulation increases their awareness of their own attitudes and gives them a better understanding of demanding situations in this area (Haugland and Reime, 2018). According to Kolb, writing about students' internal cognitive processes: 'Learning is the process whereby knowledge is created through the transformation of experience.' Kolb proposed a four-stage learning cycle of experience, reflect, conceptualise and test (McLeod, 2017), which aligns with learning through simulation, whereby the student reflects on the scenario and applies the resultant learning in new situations.

Our university designed learning activities using simulation to build competence in critical thinking and ethical reasoning. This study highlights the students' experience of this training.

Context

This study was conducted in the third semester of the second year of the students' training and followed 16 weeks of clinical practice. The two-week simulation programme was held on campus and started with an introduction to simulation. The students were then divided into groups of 10-12 and we started with icebreaking activities to help students and teachers get to know each other. Each group then participated in three scenarios, in which the teachers sometimes acted as patients and relatives to help guide the direction of the roleplay to fulfil the learning outcome. Videotaping was not used in these sessions.

The three scenarios were designed to relate closely to the students' experience of the clinical practice they had just completed. The simulation room was set up as an authentic domestic kitchen and a typical patient's room in a nursing home, and the scenarios all followed the same person, 'Jane'. The first was situated in the kitchen in Jane's home, with community health service staff present. The next scenario took place in her room in the nursing home shortly after she arrived, and the third was in the nursing home after she had lived there for some time. The purpose of this progression was to allow students to get to know Jane and support better understanding of her situation, background, history and needs. This gave them the possibility of discovering wider perspectives related to the person. Getting to know the patient as a person is one of the basic premises of person-centred care (McCormack and McCance, 2017).

The simulations were each divided into three phases: briefing, action and debriefing:

- **Briefing:** The groups were given descriptions of the scenarios, their topics and purpose, in order to clarify the learning objectives. This was to create confidence and avoid surprises, and to enable the students to prepare themselves for the scenario and for the reflection in the debriefing afterwards. They were encouraged to imagine different outcomes to the situations, and to discuss how they might handle them. The students also received suggested reading linked to the scenarios.
- **Action:** The student groups decided in advance on the distribution of roles and who should be observers. As many of the students as possible were encouraged to experience acting in one of the roles. The observers were seated in the same room during the simulation. The surroundings and the facilitators were well known to the students. This phase lasted five to 10 minutes.
- **Debriefing:** A facilitator led the debriefing, conducting a guided reflection with open questions. Through mutual dialogue, ethical dilemmas and perspectives were illuminated. The debriefing always started with a deep reflection over what had happened and what the group had experienced. Both actors and observers were encouraged to convey their experiences of the simulation and reflect on them. The observers were given specific learning objectives to focus on during the scenario. The scenarios are described in Table 1.

Table 1: The three scenarios

Scenario description	Ethical focus
Scenario 1: The person who doesn`t want to shower Jane lives on a remote farm and gets help from the home-nursing services every second week for showering. She has one son who is very busy and lives in another town. Two students appear at her house, alone, for the first time. They meet Jane, who is nice and friendly but is dressed in shabby, not too clean clothes. The house looks a mess. Old food is on the table and the room smells nasty. As the students speak, Jane tries to distract them from the question of a shower, arguing that she has just had one. The students have been told the bathroom is in the basement, to highlight that it would be awkward to get her there if she was reluctant. Jane has only socks on her feet and appears to have an unsteady gait, using a walking frame. There is a big shaggy carpet on the floor. The students face a dilemma between their duty to give healthcare according to the working schedule, the person's autonomy and the consequences of the different solutions considering the person's health condition.	• Ethics of duty • Consequence • Autonomous choices
Scenario 2: The 'difficult' relative Jane has now moved into the local nursing home. Her room is quite bare, with just a bed, a table and four chairs. Two nursing students are in her room to engage in an introductory conversation to gain an overview of her situation, needs and wishes. Her son is also present and tends to take over the conversation, constantly answering for his mother. He makes all kind of comments about her, some quite compromising. The students attempt to maintain a proper conversation with Jane, trying to keep their focus on her and maintain equality and human dignity for Jane and her son, but the son's behaviour is clearly disturbing them. The students must deal with the relative's need to tell their story while protecting the person's dignity. They must take into consideration ethical obligations and consequences, and follow ethical principles in choosing how to respond.	• Ethics of proximity • The four principles (Beauchamp and Childress, 2001)
Scenario 3: A need for privacy Jane has now been resident in the nursing home for some months. She has settled in well, seems happy and looks well. Now she wants to have a conversation with her nurses in charge (played by two students). She says she is satisfied with life and reveals that she has got a boyfriend in the home. She insists she wants to be able to have some privacy with him and demands a lock for the door to her room. She complains that her son does not seem to approve of the relationship. Then she tells them she wishes to buy her friend a small electric car as a gift, so her son or others can take them out driving – she wants the opportunity to get away from the home from time to time. The students must sustain this conversation and maintain dignity and autonomy for Jane, and consider ethical obligations and consequences in their attitude and communication.	• Autonomy • Paternalism

Research method

The design of the study was qualitative and exploratory. Data were collected by conducting focus group interviews with nursing students and the chosen analytical method was Graneheim and Lundman's qualitative content analysis (2004). The research question was: *How can nursing students develop ethical competence through simulation?*

Sample

The study participants were nursing students in the third semester of their second year. After completing eight weeks of clinical practice in nursing homes and a further eight weeks in home-based services, the students took part a two-week simulation programme on campus to simulate cases with critical reflection.

To recruit participants, we sent out an information letter to the classes, encouraging students to sign up. Students were also informed about the project during class. Each participant signed an informed consent sheet, stating that they participated voluntarily and understood they could withdraw from the study at any time. The participants (n=9) were full- and part-time students aged between 23 and 49 years, from two different campuses at our university. We received approval from our university and from the Norwegian Centre for Research Data. We ended up with four focus groups. Participants have been anonymised; an overview of their gender and age is presented in Table 2.

Table 2: Overview of the participants – gender and age

Group 1: Two students F1 (female, 43) F2 (female, 45)
Group 2: Three students M1 (male, 49) M2 (male, 40) F3 (female, 29)
Group 3: One student* M3 (male, 28) **The other Group 3 students were unable to attend so we proceeded with one*
Group 4: Three students M4 (male, 25) F4 (female, 23) F5 (female, 26)

Ideally, a focus group should have six to 12 participants (Stewart et al., 2007), but because the method benefits from a supportive group (Stewart et al., 2007), we decided to have focus group interviews with fewer participants who knew each other, rather than having an ideal group size.

We had jointly designed a semi-structured interview guide, which was validated by an external expert. Focus group interviews are a method whereby data are collected in a group setting; the usefulness and validity of the data is influenced by the degree to which participants feel comfortable sharing their thoughts and ideas (Stewart et al., 2007). We felt this comfort could be better achieved among students of the same cohort. All students in each group were located on the same campus. With one exception, focus group interviews were held in the teachers' break room, which offers a more familiar atmosphere than the university's meeting room. The remaining interview had to be conducted in the researcher's own office with another interviewer participating via videoconference.

This study was conducted by a team of four researchers who had also been the teachers in some of the simulations. In order to maintain as much distance as possible, both in the focus group interviews and in the research process, all groups were interviewed by two researchers. Each researcher participated in two interviews, with a different co-researcher each time. We chose this method to strengthen the research-ethical standard and because a close relationship between researchers and participants can create role difficulties and power imbalances (Beck, 2013). The use of external interviewers would have been beneficial in this respect but was not possible to arrange this.

The interview guide was designed with 10 questions on the topic, moving from general to more specific. The focus group interviews lasted between 45 and 70 minutes. We found the participants willingly spoke about their experiences from the simulation. The interviews were recorded on audiotape and the data material was anonymised and treated confidentially.

Analysis

The audiotaped interviews were transcribed, and the data analysed using Graneheim and Lundman's (2004) qualitative content analysis. This is a method that gradually derives units of meaning from the actual words used; these units are then interpreted and analysed to form subthemes and themes.

We each transcribed one interview and shared it with the rest of the team. Each team member read each of the transcripts thoroughly and identified units of meaning from the texts. We then had a two-day project meeting at which the transcripts were shared between all four of us. The units of meaning were compared and merged into subthemes. The group then analysed subthemes further into themes, an example of which is shown in Table 3.

Table 3: An example of condensing meaning units

Units of meaning*	Subthemes	Theme
'It's reassuring to be two, then. It's great to support each other' 'Working in teams, working together and communicating in teams, at least I had benefit from that'	• It was safe to be two students in action	• The value of the group
'It's a very good arena for practising communication, because you get feedback on how you are in the situation. And there are things maybe I miss very much in practice, and at work, that you don't get feedback on who you are as a nurse' 'That's what was good about the simulation, we got to see each other's different methods'	• Small groups provide good learning	
'I found it very useful observing, reflecting and talking about what happened afterwards, what we could have done and what was good and what was bad... I thought it was amazing because I've used it in clinical practice since'	• Good experience of working in a team with regard to communication	
'We reflected on different things then... so I thought that was awesome. I learned a lot' 'I have learned a lot after being in two clinical practices and using simulation' 'So there are several ways to learn'	• Different competences in the group • Learn from other students' and teachers' reflections	

**The entries in this column are reproduced verbatim, translated by the authors*

Results

After analysis of the transcriptions, the data clustered into three main themes. The themes are presented below.

1. Personal experience comes through participating and acting in learning ethical reflection

The participants said the opportunity to be both actors and observers had been valuable. They described the learning experience of being situated within the scenario and being able to explore their own feelings in connection with what was happening: *'It kind of gives you a real experience to reflect over later'* (F2). They described the experiences in simulation as being similar to real clinical practice, and spoke of taking in the complete situation through different senses. Some described sensory impressions they experienced as actors – for example touching a sticky hand, the smell, the mess around the patient and in the room – and as observers, being able to witness reactions and body language closely. Each experience contributed to understanding the complete situation: *'We use our eyes and ears; we get it all!'* (F3). Some participants said being observers sitting close to the actors allowed them to feel the atmosphere of the scenario.

The chance to view clinical scenarios from the perspective of the patient, experiencing the communication and activities being done around the person was described as useful: '*We learn from switching roles, and we learn from acting as patients'* (F4). They said the sense of the possible threat to dignity and the feeling of being invaded was important: *'We try to immerse ourselves in the different roles, this gives us unique experiences'* (F4). The participants said every element of the scenario was a learning opportunity, especially listening to the input of others.

In the focus group interviews, the participants said it was helpful to learn how to conduct themselves professionally in a variety of situations: *'I need to learn to perform in any situation without expressing myself badly by revealing my own bad body language'* (F3). They noted that self-awareness can be improved by noticing, and being aware of, other people's body language, and that it was valuable to practice and reflect on this. Some said it was useful to be able to practise this in safe surroundings where they could build their self-confidence. The students experienced the simulation scenarios as realistic and transferable to real-life clinical situations; later, when they found themselves in similar situations, they found that the scenarios had provided something to draw on. This made it easier to feel prepared for unexpected developments within practice situations: '*It made me more courageous'* (M3).

The participants all agreed they would like more learning through simulation in their training, describing it as especially useful for improving personal skills, in particular awareness of ethical behaviour. One said learning through simulation made remembering easier and referred to this as information *'saved in a personal file'* that was easier to recall than similar information gained from books: *'I can recall every detail from that scenario, it still goes like a movie in my head'* (M3).

2. The value of the group and of shared experience

Shared experience is a starting point for common ethical reflection and learning. The participants appreciated the reflection in the debriefing sessions. Observing in the same room as the acting provided a close and conscious common experience and a shared basis for the reflection:

> *'We learned a lot by listening to each other's views and interpretations and suggestions for solutions'* (F2).

> *'It kind of opened up your horizon to listen to all the other perspectives and interpretations – it is easy to think in a limited way when you are on your own. I feel it was very useful for my learning process to listen to the others, and to the teacher's views. It was enlightening to reflect on whether other solutions could have been chosen, and what the different outcomes might have led to'* (F1).

> *'You will bring all these reflections with you into clinical practice, and they will provide you with like a 'bank' to harvest from when you suddenly find yourself in similar situations later in real life'* (M3).

While the participants confirmed they had learned a lot, it was sometimes difficult for them to describe exactly what had been learned. Some mentioned that, as beginners, there was so much they had not yet seen so it could be difficult to connect and relate the curriculum to actual situations and persons who need care. They did feel it was easier to bring reflections and theory back to clinical practice as connected experiences and to use them, and that it became easier to reflect on their own. The participants described the learning process as ongoing and stated that they continued discussing the scenarios with each other: *'We even continued discussions later and after class'* (M1). *'We shared experiences and learned a lot from each other this way'* (M3).

3. The acquired experience gave professional and personal knowledge in advance with which to prepare for similar situations in clinical practice

The discussions and feedback the participants got from the debriefing left them feeling more self-confident. They commented:

> *'If you had not had the experience with simulation, it would have been much more difficult to know how to perform and navigate in situations with persons and their relatives'* (M2).

> *'I feel I am much more aware of my own appearance and how I talk and the way I ask questions, for instance. I felt more confident in similar situations in practice later, because I knew I had been in this before, with fellow students and an audience, and that gave me a feeling of managing and coping' (M3).*

Some described an increased awareness when deciding whether or not to intervene in situations when they felt the urge to do so. One described working through uncertainty over whether or not to tidy up the messy kitchen at the patient's house in the first scenario (Table 1): *'I realised that it was not exactly my standards that should rule, but the balance between safety and her autonomy'* (M1).

'I learned a lot by watching the others' (M1). The sharing of the experience facilitated subsequent discussions between participants. They said the simulation had helped them to think differently, despite their lack of real-life experience – that sharing perspectives had boosted their confidence. They felt they had gained a new approach to putting theory into practice, better knowledge of what to look for and better skills at retaining learning as competence.

Discussion

Learning by creating an understanding

Teaching person-centred practice to nursing students starts with creating awareness of the importance of a focus on respect and compassion for the person. High-level skills in ethics and ethical decision making contribute significantly to this awareness, so it is valuable to understand how to identify and connect ethics to real situations. Learning strategies that involve activity and participation from students can help achieve this. Benner (2010) describes a need for interactive teaching – teaching that not only integrates the classroom and the clinical, but that helps students integrate knowledge, skilled know-how and ethics. Buxton and colleagues (2015) underline that simulation offers the opportunity to connect ethics to practice, helping students to synthesise their knowledge and encouraging ethical conduct. In this study, the opportunity to play the role of the patient in the scenarios increased the students' understanding of that perspective, which we believe could improve the ability to provide person-centred care. The students said simulation made understanding possible in a way that clinical practice cannot. One described the importance of reflecting on the situation he was in, when he stood and reached for the door handle while talking to the patient. The reflection afterwards made him aware of the possible effect of this action.

In response to interview questions about identifying ethical dilemmas and situations, the participants said they found it challenging to relate to and describe ethical terms and theory. This is a natural stage early in training, and the students need to develop a system for understanding (Schön, 1987). Benner (2010) suggests nursing education stands out from that in other professions by its stronger emphasis on clinical practice. When the students get caught up in the various duties nurses must perform, they can often forget the person in the bed. To maintain person-centred practice, the students need to develop an understanding of a caring relationship with the patient (McCormack et al., 2017), and this understanding can be learned through reflection.

Ethical reflection is a prerequisite for learning to act professionally as a nurse but, as Gropelli (2010) points out, ethical decision making in healthcare is a complex area. She argues that simulated clinical scenarios during education encourage nurses to critically examine their thoughts and feelings in relation to making such decisions. Benner (2010) concurs, saying nursing students benefit from being introduced to clinical situations early in their training as this will help them to integrate science and human knowledge. In this study we noted that the students acted ethically, even though they were not yet capable of describing their dilemmas. This highlights the complexity involved and underlines the importance of starting simulation training with ethical topics early on in the degree programme.

Learning how to think critically, and to identify dilemmas and apply sound decision making to these issues will gradually enhance confidence (Gropelli, 2010; Greco et al., 2019). By participating in simulation, the students get the opportunity to use their imagination and learn in lifelike situations in safe surroundings on campus. In this way they can build competence that they can transfer to clinical practice, as confirmed by one participant: *'It made me more courageous in real situations later'* (M3).

You learn also by being an observer

By participating as actors or observers, the students gained shared experience of interpreting meaningfully the situations that arose. This is in line with the findings of MacLean and colleagues (2019) in underlining the ability of shared experiences to extend the learning experience. In clinical practice, students conduct reflection sessions individually and in groups. The main difference between that reflection and the post-simulation debriefing is that the simulation session provides the same situation experience for everybody, giving a common context for reflection. Teaching students to discover and identify ethical perspectives for themselves is a major aim of our work with simulation and we would argue that this ability will bring a better understanding of the importance of person-centred care. As revealed in the focus group interviews, the extended learning outcome applied to the actors and the observers; the observers described learning from watching the acting, thinking about their own solutions and participating in the guided reflections afterwards. As an acting experience, the student who felt the urge to tidy up after touching the person's sticky hand and sitting in the smelly, untidy kitchen (Figure 1) was able to reflect as he talked to her that he was a visitor in her home where her standards should prevail. He managed through his reflection to focus on her autonomous self, and understand that it would not have been person-centred to impose his values in her home. *'I realised that it was not exactly my standards that should rule, but the balance between safety and her autonomy*' (M1). In the debriefing, he shared how difficult that dilemma had been, and how close he came to starting to tidy up. Doing so would have triggered a conflict between non-maleficence, beneficence and autonomy (Beauchamp and Childress, 2001). This led to an interesting discussion among actors and observers. Person-centred practice is not something that is always achieved but it must be continuously sought; this entails sustained reflection and awareness (Entwistle and Watt, 2013; McCormack et al., 2017).

Debriefing is crucial for understanding and learning

Debriefing is the crucial part of the simulation exercise (Shinnick et al., 2011) and helps students learn to link their behaviour to ethical theory. A part of the knowledge in nursing is tacit, and tacit knowledge is difficult to uncover. However, being part of, and sharing in, the construction of meaning helps reveal tacit elements and this is central to learning (Wenger, 1998; Benner, 2010). Putting thoughts into words makes them obvious to others and to oneself and, as Schön (1987) emphasises, is essential in creating a dialogue for learning. This is what took place in the debriefings, as students offered and listened to discussion and opinions around their shared experiences. This knowledge then became easier to transfer to clinical practice. One student described an experience with death in clinical practice after the simulations: she was situated in a hospital room with a person who had just died, a nurse and the person's relative. She described how her practice supervisor preferred to focus on technical routines around death, not on the reactions of the relative. The student disagreed with this priority and her learning from the debriefings gave her the courage to communicate with the relative, so she chose to focus on that instead. In this case she showed how she managed to transfer what she had acquired in simulation to a similar dilemma in clinical practice. She showed how she trusted and used the experience she had gained to focus on the relative as a person and treat her with recognition and respect. Treating persons with recognition and respect are core concepts of person-centred practice (McCormack, 2004).

In the debriefings, the students shared feelings, frustrations, difficulties and their experiences of inadequacy. As teachers, we discovered that the new insights they shared led to a wider understanding. Moreover, the exploration of different reasons and solutions offered fresh perspectives on the patient's life, her self and her social world. Such enlightenment can be obtained and enhanced through clinical supervision, critical companionship or peer support and challenge (McCormack and McCance, 2017). By guiding the reflection further, facilitators can support students in learning to connect experiences to the ethics theory in the curriculum. In-depth reflection leads to insight – for example, how to meet a person with respect and how to deliver person-centred care.

The students revealed that they kept on discussing the simulations and different options with each other long after the sessions, both in and outside class. To take the initiative and continue to reflect ethically on their own shows a growing independence and self-efficacy – a vital part of the transition from student to nurse. Moreover, this process gradually helps reveal the tacit elements, giving the students a wider understanding of person-centredness and what it means. The participants said the simulation made them feel better prepared for encounters in clinical practice. For example, one commented: *'Now I feel prepared to meet a situation like this'* (M2). The reflection in the debriefing had taught him to think critically about how to act ethically with patients – an experience he described as much easier to remember and to transfer to real situations that learning derived from reading.

The importance of true-to-life scenarios

Ethics can seem clear when you read about them, but this is not often the case in the middle of a situation where an instant action or decision is needed. Simulation is an ideal learning method for confronting such potential uncertainty (Lewis et al., 2016). By building the scenarios to reflect reality as closely as possible, we wanted to ensure the acting could provoke authentic feelings and sensory impressions in the students. Experiencing moral distress and how it can influence your decision making is an important way of learning how to respond. Simulation facilitates this learning safely without involving any real patients and can be done without disturbing elements of real-world practice, such as disruptive surroundings and patient distress.

The scenarios we used were designed to follow 'Jane' in three different situations. The aim was to facilitate the nursing students' focus on the patient as a person, to show how the person's need for support changed and progressed, and highlight that insight into the context and history was important to meet the person's needs and build a relationship. The students reported that the lifelike scenarios gave them the skills to think more clearly in a situation and better understand the patient's needs. We wanted to foster in the students the desire to explore patients' background and history in order to be able to deliver person-centred care as nurses in the future.

To prepare students to meet real ethical dilemmas, the simulations must be experienced as recognisable in terms of culture, norms, language and setting. Realistic practice-like scenarios engage the students and create mutual engagement for action (Lave and Wenger, 1991). One of the particpants related how in later clinical practice, he faced a situation with a person and their relatives similar to the simulation we had practised. He said he recognised the dilemma with beneficence and autonomy for the persons involved, and was able to do a quick reflection and deal with the situation immediately. He felt confident to act to keep his focus on the patient and assume leadership: *'I knew I could, I had been through it before in front of my group at school, so now I dared to take control'* (M3). Schön refers to this as reflection in action, saying this reflection must be connected to practice situations to enable learning (Schön 1987).

Conclusion

This study set out to explore how simulation could be used as an active learning method in nursing education to teach ethical competence and person-centred care. Through participating, both as actors and observers, the students developed their own awareness and gained a greater understanding to take into similar situations in practice. The experience helped them to identify and address ethical dilemmas.

For the students, putting their own experience into words, identifying and describing ethical dilemmas in the debriefing sessions clarified the tacit dimensions of the scenarios. Listening to each other's reflections provided insight into how they could develop ethical competence and self-awareness to enhance their ability to provide person-centred care.

The guided reflections in the debriefing helped the students to connect their own experiences to ethics theory and revealed a wider understanding of the patient's perspective and self. The data from the focus group interviews show the students could apply the ethics in their actions, but found it

difficult to describe this process. This study shows that it takes time for nursing students to integrate ethics theory as personal knowledge and so be able to explain their actions. Therefore, it is preferable to start to connect ethical theory and practice as early as possible in nursing training. Students need guidance to connect ethical theory to situations and care for patients, relatives and co-workers, and to learn to think critically in identifying and analysing dilemmas.

The study shows guided reflection is crucial in nurse training in order to develop professionally equipped nurses with the ability to interpret situations and make confident ethical judgements. We suggest that critical thinking and active ethical reflection through simulation can contribute to the development of professionally competence, which is a prerequisite for person-centred practice. Introducing simulation early in the curriculum would contribute to the teaching of person-centredness from the outset of nurses' training.

Universities are encouraged to use learning methods that involve student interaction, and this study shows how simulation has an important potential role in supporting nursing students in constructing their ethical and personal competence.

Ethical research considerations and limitations

Since we, as researchers and teachers, were so close to the participants and the whole research process, we chose to share the findings with an external expert to get a more objective view. She gave us the feedback that our initial findings were too wide ranging in respect of the research question. That led to a second reading of the transcripts with a specific focus in mind, and thereafter new meaning units emerged.

The sample in this study is very limited. When we started the project, we were unable to find other nursing courses that used simulation in ethics education in Norway, which could have been included to expand our project. Limited samples like this can never be used for generalisation (Beck, 2013). However, the goal of qualitative nursing research is not to produce generalisable data but rather to explore, and this study required researchers who were insiders (Beck, 2013). The results show the experience of the participating students, which may be of interest to other nursing schools. In our university this use of simulation has now been implemented in the area of mental health as well as basic nurse training. We believe the results offer the basis for further research in the future.

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