UNIVERSITY OF BIRMINGHAM

THE JUBILEE CENTRE FOR CHARACTER & VIRTUES

VIRTUOUS PRACTICE

IN NURSING

RESEARCH REPORT

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Jubilee Centre for Character and Virtues

The Jubilee Centre for Character and Virtues is a unique and leading centre for the examination of how character and virtues impact on individuals and society. The Centre was founded in 2012 by Professor James Arthur. Based at the University of Birmingham, it has a dedicated team of 30 academics from a range of disciplines, including: philosophy, psychology, education, theology and sociology.

With its focus on excellence, the Centre has a robust and rigorous research and evidence-based approach that is objective and non-political. It offers world-class research on the importance of developing good character and virtues and the benefits they bring to individuals and society. In undertaking its own innovative research, the Centre also seeks to partner with leading academics from other universities around the world and to develop strong strategic partnerships.

A key conviction underlying the existence of the Centre is that the virtues that make up good character can be learnt and taught. We believe these have largely been neglected in schools and in the professions. It is also a key conviction that the more people exhibit good character and virtues, the healthier our society. As such, the Centre undertakes development projects seeking to promote the practical applications of its research evidence.

This report was launched by Professor Dame Donna Kinnair, Director of Nursing, Policy and Practice, Royal College of Nursing, on 28 September 2017, at the Royal College of Nursing in London.

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Virtuous Practice in Nursing

Research Report

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> 'I THINK THE ONE THING THAT PREVENTS YOU FROM BEING THE NURSE YOU WANT TO BE IS THE TIME PRESSURES, THE WORK LOAD. SOMETIMES THE CLINICAL WRITTEN STANDARDS ARE MORE IMPORTANT THAN THE PERSONAL.'
>
> **Experienced nurse**

Foreword
Sir Robert Francis, QC[1]

This valuable and thought provoking report makes a number of references to Florence Nightingale. My favourite quotation from her pioneering work is:

'what can't be cured must be endured' is the very worst and most dangerous maxim for a nurse which ever was made. Patience and resignation in her are but other words for carelessness or indifference – contemptible, if in regard to herself; culpable, if in regard to her sick. (1860: 132)

For me this stern expression of values essential to good nursing practice encapsulates the insight offered by the Jubilee Centre's work in promoting debate about values-based ethics in general and, here, nursing in particular. Some may be tempted to dismiss reference to values as opposed to rules and standards as 'soft' and lacking definition, but, on the contrary, a commonly accepted set of values has to be the foundation of professional practice to enable those with this vocation to navigate the ethical dilemmas they face on a daily basis. It is difficult to believe that the vast majority do not enter the nursing profession wanting to deliver compassionate care to patients or that they would wish to do less throughout their careers.

The evidence in this report indicates that this is indeed the case, but it contains both heartening and disturbing messages. On the one hand, there appears to be a general consensus among nurses of all levels of seniority as to what essential core virtues they possess, and need to possess. On the other, a large majority believe that their work hinders their ability to live by those virtues at least some of the time, mentioning the requirements of the job, the need to hide feelings, stress and lack of time.

Unfortunately the negative findings are not surprising considering recent survey results relevant to the morale and working conditions of nurses in the NHS in England. For example in 2016, 59% of staff reported working unpaid overtime each week, 59% felt able to deliver the care they aspired to, 37% reported work related stress, and 13% reported being bullied or harassed at least once in the past 12 months (NHS, 2016). In January 2017, a disproportionate 5.41% sickness absence rate was reported for nursing, midwifery and health visiting staff, 6.96% for healthcare assistants and other staff (NHS, 2017). The findings are also entirely consistent with a recent report suggesting an association between an increased rate of mortality in units and lower levels of registered nurse staffing (Ball et al., 2017).

This report's recommendations should be considered seriously by all those responsible for developing and protecting nursing standards in England. The report recommends those aspiring to join the profession should be assessed for character. The report rightly recommends various training and support measures to help nurses apply an ethical approach to decision-making amidst the complexities of modern healthcare provision. I recommended that nursing applicants should be assessed for, trained and supported in compatible values and compassion (see recommendations 185, 188, 191, 194 in Francis, 2013), and I believe that encouraging steps have already been taken to ensure that those recruited to the profession possess the values required, for example the Chief Nursing Officer's '5 Cs' campaign. The arising problems can no longer be tackled by reliance on instinctive responses, but require training and practice to address them ethically. However, it takes an understanding of virtues and how to maintain character in the face of adversity to enable nurses to remain true to their values. Just as importantly, nurses need continuous support from leaders in the workplace to face up to the challenges in the NHS of short staffing, increased demand and responsibilities. The more specialised nursing becomes, the greater the need to support nurses at all levels in serving their patients without having their values and compassion crushed out of them, a phenomenon which explains in part the tragedies of Mid-Staffordshire and similar scandals.

It is unlikely that a regulatory expectation of compliance with rules will diminish. I do not understand the report to be advocating that a virtues-based approach should replace rules-based decision-making in its entirety. I suggest, however, that a focus on character and values should lead to modifications in approaches to enforcing professional rules and standards. The current professional regulatory regime focusses its considerable resources on identifying the small minority of registrants whose non-compliance warrants imposition of a sanction, therefore deploying less time on ensuring that the majority of compliant professionals are provided with the means to fulfil their duties. I believe that character and values needed in nursing are not effectively supported by a professional regulatory regime of sanctions which are punitive whether or not this is the intention. Many of those who fail to reach the high standards required do so not because of inherent character flaws or an absence of fear of sanctions against lapses, but because of a lack of resilience in the face of mounting systemic pressures. It would therefore be constructive for professional regulators to consider how they can support the practical application of the necessary virtues in everyday practice. A culture of empowerment is likely to be more beneficial for patients than the culture of fear where that currently exists.

Finally, nursing is not work undertaken in isolation but as part of a team of professionals. The boundaries between the healthcare professions is continually changing as new ways of treating and caring for patients are developed, and new healthcare occupations emerge; work previously performed by doctors is now sometimes done by nurses and tasks previously in the nursing domain have moved elsewhere. All professionals who care for patients share many of the same challenges and aspirations, and the virtues they require are likely to be similar. Therefore, work to promote a virtues-based approach needs to be coordinated across the healthcare field as a whole.

For these reasons I am happy to commend this report as being an inspiration to those who would seek to engrain commonly agreed values and character traits in the invaluable work that all nurses do for their patients. I hope that it will lead to further work in this field to develop this approach.

Sir Robert Francis QC
Barrister, Serjeants' Inn Chambers, London

[1] Sir Robert Francis is a non-executive director of the Care Quality Commission but the views expressed in this preface are personal and are not necessarily those of the CQC or any other organisation with which he is associated.

Executive Summary

Motivated by the negative media coverage of the current state of nursing, this research project explored the ethical dimensions of contemporary nursing education and practice in the UK. Despite recent academic interest in virtue ethics, professional ethics in nursing continues to be studied through a rule-and-code focussed lens rather than a virtue ethical one. With this interdisciplinary project, drawing on insights from nursing departments, students, and practitioners, the aim was to refocus the lens and shed new light on nursing education and practice in the UK.

As a world-leader in rigorous academic research into applied virtue ethics, the Jubilee Centre for Character and Virtues operates on the assumption that good moral character is educable and practicable, and that professionals operate better when practising virtuously.

This report explores:

- the extent to which students and professionals in nursing draw on virtue-based reasoning when confronted with ethical dilemmas;
- the virtues that students and professionals in nursing report themselves as possessing and those that they regard as characteristic of the 'ideal' professional;
- the motivations of individuals seeking to pursue a career in nursing;
- the aids and the barriers that nurses experience in exhibiting virtuous practice;
- the recommendations that can be made regarding the ethical dimensions of nursing education and practice in the UK.

Key findings

The findings are drawn from survey and interview data from 696 participants across three cohorts: first-year undergraduates in nursing, final-year students about to enter employment at the end of initial training, and established professionals who had been in practice for five years or more, as well as from interviews with educators from UK Schools of Nursing. From the standpoint of virtue-based professional ethics, the findings of this report revealed some significant positive, as well as some concerning negative, findings.

Key positive findings

- The top six character virtues, personal and 'ideal', identified by respondents are appropriate for the profession, in particular kindness and honesty. Across the three cohorts there was a high level of agreement over the importance of these virtues within nursing practice. Four of the top six virtues were consistent across both lists (self-reported and 'ideal'), suggesting that students joining the profession develop a clear focus on the values of the profession during their initial training.
- Many nursing students and experienced nurses considered the profession to be a vocation. They had chosen to enter it for reasons that cohere well with the literature on the traditional ethical values behind nursing as a caring and compassionate profession.
- When faced with ethical dilemmas, respondents demonstrated an ability to integrate moral reasoning into their practice and to draw on a range of considerations to reflect upon and adjudicate ethical issues.
- Experienced nurses reported high levels of professional autonomy in their work and a capacity to remain emotionally involved in it (in line with their original motivations for joining the profession). They also experienced overall support from colleagues, which may aid retention.

Key negative findings

- While entrants to the nursing profession relied heavily on virtue-based reasoning, during the course of their studies those considerations were overtaken by rule-and-code-based reasoning. Worryingly, virtue-based reasoning was not found to pick up again among experienced nurses, in contrast to previous Jubilee Centre research into modes of reasoning by other professionals.
- Overshadowing positive findings about their work environment, various significant challenges to living out their character were identified by experienced nurses, due to lack of staff, time, and other resources.
- Organisational and psycho-moral barriers (e.g. workplace stress) to virtuous practice were greater than recorded in previous Jubilee Centre reports about challenges to other UK professions.

Recommendations

The report offers recommendations relating to the ethical dimensions of nursing education and nursing practice.

In relation to nursing education, the report specifically recommends that:

- moral role modelling be put at the heart of nursing education;
- more attention be paid to theoretical aspects of virtues and values by including ethical theory in the education of nursing students and helping them relate it to practice;
- a robust approach to character evaluation should be devised to assess the suitability of candidates for nursing, at the interview stage, and to monitor the development of their character throughout their studies.

In relation to nursing practice, the report specifically recommends that:

- educational institutions in the UK solidify the ethical core of nursing and make it more explicit in their Continuing Professional Development (CPD) provisions for experienced nurses;
- the quality of mentoring within practice is reinforced;
- professional bodies in nursing exert greater pressure on nursing departments to adapt their curricula to the needs of current nursing practice, many of which are identified in this report as ethical.


NHS

1 Purpose of the Report

This report explores the role of character and virtues in nursing education and the nursing profession in the UK. Its purpose is to illuminate issues that help, or hinder, the virtuous practice of nursing.

This report is timely for various historical and socio-moral reasons. Duties such as administration of medicines, application of dressings, avoiding medication errors, and the prevention of falls often were considered the major responsibilities of nurses in the past. Nursing is a demanding activity, requiring the provision of nursing care 24 hours a day, seven days a week, 52 weeks a year, and it is difficult to encapsulate what nurses do within the fields of work in any simple statement (Sellman, 2011). Although the above mentioned duties remain significant in the role, recent developments in the patterns of the delivery of care have improved the breadth and depth of the nursing profession. For example, Schneider *et al.* (2017), in *Mirror, Mirror* 2017, the most recent Commonwealth Fund Report, included some useful data on UK Health Care quality, where the UK was ranked first based on performance across the four subdomains of prevention, safe care, coordination, and patient engagement.

The nature of nurses' work is evolving. This evolution has been accompanied by renewed interest in the meaning and importance of the very idea of 'care'. Nurses are in a key position to improve the quality of healthcare in the current environment through various strategies. Titchen (2000) argues that nursing is essentially concerned with the care of vulnerable fellow human beings, and patients view nurses as skilled companions who discern their personal care needs and aspire to respond to them in a professional fashion. As Hunt (1992) describes, Higher Education Institutions have interpreted this aspect of professional formation as teaching student nurses ethical principles and decision-making skills, purely based on abstract moral theories, which is distinct from what nowadays is understood as character education in a professional context. While practitioners are familiarised with codes of practice during their professional training, such acquaintance is not sufficient to prevent professional malpractice. The education and training of professional practitioners requires something more than an acquaintance with codes of conduct, or even formal lessons in professional ethics (Jubilee Centre for Character and Virtues, 2016). One of the purposes of this report is to elaborate upon what this 'something more' could be.

Despite some recent interest in virtue ethics in the field of nursing (see Section 2), the actual moral practice of nurses more typically has been studied through a rule-and-code focussed lens rather than a virtue ethical one. The current project is one of three projects, which have explored the ethics of professionals, in the Jubilee Centre's second phase of work (2015–2017) following on the heels of three similar projects in the first phase of work (2012–2015), which involved medical doctors, lawyers, and teachers.

With entrants to the profession, this project investigated how the initial professional education of nurses is informed by conceptions of the virtues and how this education influences their values and beliefs. With experienced practitioners, the project examined the virtues they identify as important and influential for everyday nursing practice. An important aspect of the enquiry was the extent to which professionals rely – and are required to rely – upon codes of practice and guidelines in making decisions and how these interact with their own beliefs and conceptions of professional virtues. Recognising that professionals work within institutional, regulatory and disciplinary frameworks, which are meant to serve a 'public-protection' function, the project explored how these restrict and/or allow space for individual moral agency. The fieldwork undertaken in this project involved first-year undergraduates in nursing, final-year students about to enter employment at the end of initial training, and established professionals who had been in practice for five years or more.

The key research questions explored in this report are:

1) Which virtues are prized and upheld by nursing students and nurses, according to self-reports?
2) Which virtues do they associate with the 'ideal' professional?
3) What are the motivating factors for joining the nursing profession?
4) To what extent do nursing students and nurses draw upon rule-based, utility-based and virtue-based reasoning in responding to ethical dilemmas, and what does this tell us about the current ethical state of nursing?
5) What hinders or helps nurses in exhibiting virtuous practice?
6) What recommendations can be given to nursing educators about improving the teaching of professional ethics in the field?

This report coincides with well-documented NHS scandals, public disquiet about standards of hospital care, reports of low morale in nursing and a troubled picture of recruitment and retention of trainee nurses. Besides attempting to shed new light on the state of nursing ethics in the UK generally, this report answers the six questions above specifically, taking on board disciplinary insights from nursing, moral philosophy, and social science to interpret the data collected in this project.

2 Background

2.1 WHY STUDY ETHICAL PRACTICE IN NURSING?

Contemporary nursing is a complex field, featuring wide-ranging and diverse practices in various sub-fields. In the UK, nurses train to occupy specialised positions within four distinct fields: adult, children's, learning disability, and mental health nursing. These fields require them to develop distinct competencies and skills. However, while nurses play a variety of roles in the health professions, these roles are united in having the protection and promotion of patients' mental, physical and spiritual wellbeing as a focal aim. For some, working towards patient wellbeing is virtually synonymous with ethical nursing practice (Armstrong, 2007; Newham, 2015).

Caring for patients must be based on sound judgement and evidence-based practice. Although this care frequently involves making difficult decisions about the interests of patients and other stakeholders, such judgement also requires nurses to have a strong sense of which and whose interests should be prioritised, and what nurses should and should not do. While not always stated explicitly, it seems to be taken for granted that nurses capable of exercising good judgement should also demonstrate personal qualities such as trustworthiness, honesty, patience and kindness. These virtues are suggested to be crucial for the development of helping relationships and delivering high quality care. However, as these personal qualities are typically understood as moral virtues (Armstrong, 2006), the question arises as to what extent the nursing profession should be virtue-based, or at least informed by insights from virtue ethics.

The nursing profession as we know it today began to take shape in the mid-nineteenth century with the advance of modern medicine and institutionalised healthcare. From the beginning, early leaders of the field, such as Florence Nightingale, understood nursing to be a value-laden enterprise, requiring nurses to exercise certain virtues. From the days of Nightingale, who gave nursing a highly favourable reputation and became revered as the founder of modern nursing, there have been huge developments and changes in nursing education, including Project 2000 where ethics was mentioned as one of the core areas of training (Hunt, 1992). Nightingale considered moral training more important than academic education. Drawing on her definition of nursing, Scott and Hainsworth (1950) noted that nurse trainees and nurses working with Nightingale were expected to develop exemplary moral character and self-discipline. Nightingale also considered moral training more important than mere academic education.

The ethical complexity of nursing has only grown in recent years. In its early days, the practice of doctors and nurses was largely guided by a 'hierarchical' model, whereby the aim was treatment of the body according to the instructions of an authoritative physician. Nurses and patients alike were expected to defer to the expertise of the physicians, and the authority of patients, nurses or their families to make decisions was relatively limited. While nurses and patients could and did exercise agency within certain domains of decision-making, the influence of this model on early nursing ethics is reflected in Nightingale's partly outdated list of virtues, which includes a virtue of obedience to the physician (Hainsworth, 1949).[1] This model of treatment has gradually given way to a holistic or patient-centred model. In this model, the patient is viewed not just as a body to be medically treated, but as a 'more-than-ordinarily' vulnerable person, whose physical and psychological flourishing requires extra protection and support (Sellman, 2011; Armstrong, 2007). The interests of patients are understood to encompass emotional or even spiritual matters. Additionally, these interests ground a right to be actively involved in decision-making about their care and to control access to information about it (Thórarinsdóttir and Kristjánsson, 2014).

Empirical research on what patients want suggests that holistic nursing care is here to stay. One survey about the main aims and goals of mental health nursing, for example, found that patients want nurses who 'see the client as a person, encouraging them to identify their strengths' and 'develop a rapport and relationship to people' (Armstrong, 2007: 18). There is an expectation from both patients and professional bodies that nurses will not only be clinically competent, but also exhibit distinctive affective relations with the patients under their care (Bliss *et al.*, 2017). The question remains, however, whether holistic care can be delivered in reality.

For some, the imperative to supply holistic care calls for an expansion of the nurse's professional role, responsibilities and agency within institutionalised healthcare (Armstrong, 2007; Sellman, 2011). Practical duties and chores, such as those mentioned in Section 1, were often considered the major responsibilities of nurses in the past. Although these components remain significant in the role, the nature of nurses' work is changing. This has been accompanied by renewed interest in the meaning and importance of care. In this atmosphere, nurses nowadays are heavily involved in the management and coordination of all aspects of patient care (Corley, 2002). For example, a nurse in charge on an afternoon shift in an acute medical unit may be faced with an overwhelming amount of work on a daily basis. While a nurse is dealing with the demands of perhaps 25–30 acutely ill patients with various needs – palliative, on blood transfusion, with acute chest pain, on hourly observation, supervising agency care assistants, controlling drugs checks, auditing daily site checks, attending doctors' rounds, etc. – there is great danger of failing to provide the holistic care the patient deserves. Healthcare environments are frequently characterised by morally and emotionally charged issues for patients, families and providers (Nathaniel, 2006). When nurses are able to promote the psychological and emotional wellbeing of their patients, it will not only assist physical healing, but will also lead to better patient outcomes that will enhance the sense of purpose in one's work as a nurse.

Contemporary nurses need a moral compass to be prepared to deal with morally charged issues. Unfortunately, it is not clear that they are receiving adequate preparation – in training or through workplace support – to do so (Armstrong, Parsons and Barker, 2000; Lim, 2013). Indeed, one of the main aims of the current research project was to find out whether or not that is the case in the UK. A therapeutic nurse-patient relationship is achievable only if nurses have secured the moral and emotional sensibilities needed to respond to the demands of this role and have the resources and support

[1] While the historical and professional context has changed dramatically since Nightingale's day, it must not be forgotten that nursing is still a 'gendered profession', with 88.6% of registered nurses in the UK being female in 2017 www.theguardian.com/healthcare-network/2017/mar/01/why-so-few-male-nurses

required to enable them to spend enough time with patients. Nurses are increasingly under pressure, however, to do more with less. A survey for the Royal College of Nursing (2013) revealed that nurses are being prevented from caring for their patients because they are over-inundated with paperwork; 81% of nurses in the same survey said that having to complete non-essential paperwork prevented them from providing direct patient care.

More alarming are recent instances of nurses acting, either on their own or under institutional pressure, to harm rather than help. A nurse, who described himself as an 'angel turned evil', was convicted of a murderous spate at Stepping Hill Hospital in Stockport, Greater Manchester, in June and July 2011. He was charged, among other things, with three counts of murder and 24 counts of attempting to commit grievous bodily harm with intent. While the Stepping Hill murders may be attributed, perhaps, to the moral decline of a single individual, other cases reveal troubling institutional problems. In the first report on the failings at Mid Staffordshire NHS Foundation Trust, chaired by Sir Robert Francis QC, morale was found to be low and while many staff did their best in difficult circumstances, others showed a disturbing lack of compassion towards their patients (Francis, 2013). The decision by the Trust leadership to cut costs repeatedly, rather than maintain appropriate staffing, was cited as one of the key reasons why poor care took hold and was allowed to persist for so long. Therefore, it is important to consider the context in which nurses are working and its impact on their ability to flourish. For example, Newham (2015) has argued that one cannot experience compassion if one does not believe the agent is suffering, and one needs humane engagement to be compassionate, such as through listening to the patients' narratives and making sense of their expressed emotions; such engagement however requires both personal character qualities and resources such as time.

2.2 WHY FOCUS ON THE VIRTUES IN NURSING PROFESSIONAL ETHICS?

As indicated above, a study focussing on the virtues in the nursing profession is timely for a number of reasons. Nurses often face gruelling moral conflicts, more so than other healthcare professionals. For example, consider a nurse in charge of an acute respiratory unit who has received instruction to transfer a respiratory patient to a step-down rehabilitation centre for further management due to bed shortage. The nurse is fully aware that the patient needs further care that is very unlikely to be delivered at the less specialised rehabilitation centre. The nursing team is aware that this step-down move is impending and the patient has been in the speciality ward for the course of acute treatment. Here the nurse may be the indispensable link in advocating for the patient and wanting to practise according to the highest of ethical standards, yet struggling with the consequences of limited resources. As a result, the nurse may be confronted with situations of strong moral conflict, even more so than any other member of the healthcare team.

Scholars of nursing ethics used to turn to either deontological or utilitarian ethics in their thinking about how such conflicts should be resolved (Armstrong, 2007). In such approaches, professionals are to reason by applying one or more principles, such as 'Always treat others as ends in themselves and never as mere means only', a deontological principle, or 'Always act so as to maximise collective human happiness', a utilitarian principle. In the spirit of deontology, detailed rules and codes are often used to operationalise moral principles and safeguard adherence through sanctions of 'carrots and sticks'. The moral value of such strategies notwithstanding, an over-reliance on rules and codes among experienced professionals may be symptomatic of lack of professional autonomy and individual practical wisdom or *phronesis* (Schwartz and Sharpe, 2010; Jubilee Centre for Character and Virtues, 2016).

Appeals to deontological principles have fallen out of favour in recent professional ethics scholarship (if not necessarily professional practice). Their application to particular situations requires considerable interpretation and the principles themselves can point to conflicting courses of action. To date, no consensus has emerged on how such further conflicts should be resolved. Many nursing scholars agree, as a consequence, with abandoning the search for ever more detailed principles to guide ethical decision-making in favour of a quest to understand the virtues, especially the *phronesis*, judgement or practical wisdom nurses need in order to make good decisions themselves (Gastmans, 1999; van Hooft, 1999; Armstrong, 2007; Sellman, 2011). Others merge virtue ethical lines of thought to an older paradigm of care ethics maintaining that good nurses will establish caring attachments to their patients (Gastmans, 1999; van Hooft, 1999). While it is debated whether virtue ethics should replace or incorporate care ethics, virtue ethics is becoming the 'theory of choice' among scholars of nursing ethics (Tschudin, 2010: 130).

Virtue ethics forms a broad church, however, and current scholars often disagree in their approach. Derek Sellman (2011), for example, understands

nursing along the lines of philosopher Alasdair MacIntyre as a 'practice' through which virtuous nurses can achieve certain distinctive goods and advance their own wellbeing and the wellbeing of their patients. Doing so, however, requires the exercise of specific virtues, including trustworthiness, open-mindedness, and especially the virtue of 'professional *phronesis*', or wise professional judgement. Armstrong (2007) agrees that nurses need the virtue of *phronesis*; but, for him, the key nursing virtues flow from the demands of establishing a holistic, helping nurse-patient relationship, not from the goods nurses might achieve through excellent practices. He generates a somewhat different list of virtues from Sellman, including caring virtues needed to promote patient general wellbeing, virtues of courage needed to advocate for patients' rights and interests, and virtues of respect and trustworthiness needed to ensure that patients are empowered to make their own decisions.

The recent ascendance of virtue ethical thought in scholarly writing does not necessarily prove the suitability of virtue ethics for advancing the ethics of nursing (see for example misgivings raised by Holland, 2010 and Newham, 2015). Nor is it clear that nursing educators or professional nurses see the relevance of the virtues to their work or understand how to relate them to their practice. Do nurses themselves think in terms of virtue concepts? Does their understanding of those concepts reflect any particular way of thinking about the virtues? How do they conceive of their own virtues and the virtues of the 'ideal' professional? These are just some of the research questions motivating the present study, as was explained in Section 1.

Existing professional codes of conduct, such as the Nursing and Midwifery Council (NMC) codes in the UK, do call for nurses to exhibit good character. The NMC code for example, requires nurses to 'treat people with kindness, respect, and compassion' (Nursing and Midwifery Council, 2015: 4). Similarly, the International Council of Nurses Code of Ethics for Nurses states that the professional nurse 'demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity' (International Council of Nurses, 2012: 2). These codes are otherwise predominantly lists of principles, in a deontological sense, and what constitutes good character is not spelled out or much elaborated in them.

Available evidence also suggests that nurses in training, or practice, rarely receive direct instruction in character or virtue (Armstrong, Parsons and Barker, 2000; Parsons, Barker and Armstrong, 2001; Cooke, 2015). Numerous authors have defended a virtue ethical account of nursing ethics, recommended its integration into nursing education and suggested curricular and pedagogical strategies (Sellman, 1997; Vanlaere and Gastmans, 2007; Gallagher and Tschudin, 2010; Lim, 2013; Russell, 2014). However, few studies of whether nurses actually receive such training exist. Most studies of virtue-based healthcare ethics concern the training of medical doctors specifically, or healthcare professionals generally, and many of these focus on the development of professionalism, leadership or institutional 'virtuousness', not professional virtue *per se* (Gallagher and Tschudin, 2010; Laurenson and Brocklehurst, 2011; Coverdale and McCullough, 2014). Scholars, nurses and patients alike are also divided on whether the virtues needed for good nursing practice can be taught, or indeed, how (Armstrong, Parsons and Barker, 2000; Bramley and Matiti, 2014).

The early focus on nursing virtues in Florence Nightingale's era seems to be of less help in today's technologically complex healthcare systems. According to Edmonson (2010), nurses often find it difficult to respond to the moral conflict these systems generate in an appropriate way, consequently experiencing intense moral distress. Such distress often results from a conflict between a professional duty and personal beliefs, and as this is a well-known predictor of burn-out, the risk of distress may be an inevitable condition of contemporary nursing practice.

2.3 OVERALL EVALUATIVE GOALS

This project followed in the footsteps of a previous round of professional ethics projects conducted by the Jubilee Centre for Character and Virtues. The Centre's *Statement on the Character, Virtue and Practical Wisdom in Professional Practice* was developed in 2016, in collaboration with professionals, after the first round of projects, with the aim of opening up space for renewed debate, discussion and dialogue about the place of character, virtue and practical wisdom in professional practice.

The specific research questions underlying the current project were set out in Section 1. At a more general level, however, this research project was animated by a series of deeper evaluative assumptions and goals. The project was explicitly motivated by the assumption that contemporary nurses need a range of moral virtues as well as the capacity to exercise good judgement, and that preparing them, ethically and educationally, for the challenges of the profession is conducive both to their own flourishing and the wellbeing of their patients. The overall evaluative goals have to do with a facilitation of the understanding of the role that character virtues play in contemporary nursing practice in the UK. This study aimed to get a firmer grasp of the ethical terrain of the profession and the ways in which aspiring professionals are prepared for the ethical challenges they are likely to encounter. Finally, if it is the case that the concepts of virtue and character have been unduly neglected in nursing education, it may be hoped that the findings and subsequent recommendations in this report can play a part in remedying this shortcoming.

'SO IF YOU'RE GOING TO DO A LOT OF ADVOCACY, YOU HAVE TO BE AN ASTUTE JUDGE OF CHARACTER AND OF WHERE PEOPLE ARE AT – AND OF TRUTHFULNESS AND EVERYTHING.'

Experienced Nurse

3 Methodology

This section of the report introduces the research rationale, the methods applied in conducting the study, and its design.

3.1 RATIONALE

The aim of the project was to deepen understanding of the place of virtues and character in the education, training and practice of nurses. The project began with a scoping period, involving a review of relevant literature and discussions with a range of key experts in the field. This involved undertaking a thorough literature review to get a sense of the current state of play in virtue ethics in the nursing field more generally. More specifically, the research set out to provide insight into the research questions listed in Section 1.

3.2 METHODS, DESIGN AND INSTRUMENTS

To test the feasibility and the methods, a hardcopy survey was piloted with 25 nursing students at the University of Birmingham. The main aim of the pilot study was to test the questionnaire and to identify and resolve any potential problems or issues, especially with the presented ethical dilemmas. Following delivery of the survey, an open session was held with the research team, where students were invited to discuss and resolve any issues that they had encountered when taking the questionnaire. Apart from minor amendments to occasional terminology, the survey was considered ready to be administered to the larger group.

In the main study, a survey was administered to first-year and final-year nursing students at seven UK universities and to nursing practitioners with more than 5 years' of experience. Experienced nurses were identified and recruited through the alumni offices of participating universities, as well as via NHS Trusts. A list of participating institutions is provided in Section 3.3.

Surveys are widely accepted as a key tool for conducting and applying basic social science research methodology; however, for greater depth of understanding, interviews are often used to complement survey data. In semi-structured interviews, validity and reliability depend not upon the repeated use of the same words in each question, but upon conveying equivalence of meaning. To address the research aims of this project, a mixed methods approach was used, comprising a survey, complemented by semi-structured interviews with a selection of participants.

3.2.1 Survey

A survey[2] was completed online and in hard copy (where online was inconvenient) by first-year undergraduate students in nursing, by final-year students completing their initial nursing education, and by established practitioners who had been in practice for five years or more. In total, 696 participants completed the survey. As seen in Table 1, the distribution of completed surveys was evenly split between the three cohorts, so allowing for generalisations to be made and conclusions to be drawn within and across each cohort.

Table 1: Survey and Interview Participants

Career stage of participants	Number of completed surveys	Number of interviews conducted
First-year students	230	24
Final-year students	249	24
Experienced nurses	217	26
Educators	n/a	10
Total	696	84

The survey was designed to capture data from a large number of participants across multiple branches and sites. The online questionnaire consisted of five sections.

Section A - Ethical dilemmas:
The participants were presented with six ethical dilemmas, similar to those used in previous research by the Jubilee Centre (see Arthur *et al.*, 2015b). Ethical dilemmas were used as they (a) offered a potentially credible way to gain an insight into moral functioning and development, and (b) could be designed to activate more than simply moral reasoning skills, namely moral motivations as clues to potential moral action (Kristjánsson, 2015: chap. 3). These scenarios explored the role of character and virtues in decision-making processes in clinical settings and were designed by a panel of experts[3] drawn from the four main specialities of nursing education, i.e., adult, children's, learning disability, and mental health.

Section B - Your character strengths:
This section consisted of a list of 24 VIA-IS character strengths derived from the Values in Action inventory (Peterson and Seligman, 2004; Peterson and Park, 2009). The participants were given the opportunity to consider their own character strengths and to choose and rank six strengths which 'best describe the sort of person you are'.

Section C - About you: Participants were asked a set of demographic questions as well as to disclose the current stage of their education (students) or area of practice and experience in years (practitioners).

Section D - Your work environment:
These questions elicited participants' views regarding their work or study environment (only final-year students and practitioners, as the first-year students were yet to begin their initial practice placement). This section adapted questions from a Europe-wide workplace survey (Eurofound, 2012) with additional questions on ethical issues in the workplace.

[2] A copy of the online survey can be found at www.jubileecentre.ac.uk/nursing.
[3] Details of the members of the expert panel are given in the Appendix.

Section E - 'Ideal' nurse: The participants were asked about their views on the character strengths of an 'ideal' nurse. Here they were asked to identify and rank six character strengths from the 24 VIA-IS character strengths to 'best describe a good nurse', followed by an open question asking to describe their reasons for choosing the nursing profession.

3.2.2 Semi-Structured Interviews

The survey data were complemented by 74 semi-structured interviews[4], conducted with a selection of participants (at least 10% from each group) who had indicated a willingness to be interviewed when completing the survey. Additionally, 10 nursing educators were interviewed about their role in educating future nurses; how they assessed students for entry onto undergraduate courses; their views of a good professional in their field; how this view might have changed in the course of their career; whether the character strengths required for good nursing practice might change and why they might do so; what informed their teaching in relation to the virtues, and how much the NMC Code of Conduct influenced their teaching.

In the main, interviews were conducted face-to-face and lasted approximately 30–45 minutes. Where this was not possible, telephone interviews were undertaken. All interviews were recorded to ensure accuracy, although it is acknowledged that recording may affect answers (Scott and Usher, 1999). Audio recordings were transcribed, and then returned to participants for member checking (Lincoln and Guba, 1985) to allow for amendments and to ensure that data used offered a fair reflection of what the participant wanted to convey.

3.3 PARTICIPANTS

Data from undergraduate students were gathered at the following universities: Birmingham, Birmingham City, Buckinghamshire New, Dundee, Manchester Metropolitan, Northampton, and Greenwich. The participating universities provided a wide geographical spread across the UK. Students were contacted by email and provided with a link to the survey by the contact lecturer at each university, and through each university's online learning platform. The research team visited each site and introduced the project in lectures where students were given the opportunity to participate. A proportion of the data was collected via traditional pen-and-paper methods where email or online response was not deemed practical.

The experienced professionals were contacted initially through alumni offices at the Universities of Birmingham, Dundee, and Buckinghamshire New University. However, due to the low rate of responses, Chief Nurses/Heads of Nursing at hospitals and NHS Trusts across the UK were approached in order to request participation from nursing staff. Once agreement was in place, all nurses in each Trust were sent an invitation via NHS email requesting voluntary participation. Flyers were put up in departments to advertise the project and paper copies were handed out to be distributed to nurses who preferred to complete the survey on paper.

3.4 ETHICAL CONSIDERATIONS

The study received ethical approval from the University of Birmingham Ethics Committee. Some of the participating universities also gained approval via internal committees. Ethics approval from the NHS was not required for participating experienced nurses, as there was no discussion of patients or patient data. The research participants were fully informed of the scope and methods of the research through an information leaflet before participating. Once participants had read the information sheet, and given full consent to participate, they had the right to withdraw up to six months after the data collection phase had concluded. Participants' confidentiality was protected by anonymising survey responses and interview transcripts.

3.5 LIMITATIONS

The study was cross-sectional. Whilst a longitudinal design would have been ideal to chart the development of character through nursing education and practice, the time that it would take to track nursing students from university entry to more than 5 years' of practice excluded the possibility of such a design. Due to possible variations in the membership of the three cohorts studied, questions may be raised about exact comparability between the groups.

Response bias also limits the study. Participation in the study was voluntary and full participation by all who were invited to respond could not be ensured. This meant that only those participants who were disposed favourably enough to the topic (whatever their views on it) responded. Consequently, the survey and interviews represent the views of a self-selected group of people and not a perfectly unbiased sample.

3.6 DATA ANALYSIS

3.6.1 Analysis of the Survey Data

As mentioned above, data were collected using an online survey, as well as in hard copy. Data collected on paper surveys were entered into a database and then transferred to SPSS, version 23, to be checked, cleaned, and readied for analyses. Data collected via the online survey were exported to SPSS, version 23, and followed the same process. Analyses included descriptive analysis, cross-tabulation, and correlation. Analyses were also developed to deal specifically with the results of sections on respondents' views on character and ethical dilemmas.

3.6.2 Analysis of the Semi-Structured Interviews

Analysis of interview data was thematic, using a constant comparison method (Glaser and Strauss, 1967). A modified framework approach was adopted for this (Ritchie and Spencer, 1994). The research team independently analysed the data from the interviews and developed the themes and categories. Categories were refined and coding reviewed throughout the process.

[4] A copy of the interview schedule can be found at www.jubileecentre.ac.uk/nursing

4 Findings and Discussion

This section presents and discusses results from the survey and from the semi-structured interviews, relating to research questions 1–5 from Section 1. The aim of the project was to build up a picture of the role of character strengths and virtues in the professional lives of nurses by exploring them from a number of different angles, as indicated by the relevant research questions. Most importantly, the aim was to ascertain how UK nurses are able to apply the virtues in practice when they are faced with making crucial clinical/ethical decisions as part of daily patient management and care.

4.1 PERSONAL AND PROFESSIONAL VIRTUES

This first sub-section reports on findings from the survey regarding self-ascribed character strengths, as well as virtues ascribed to the 'ideal' professional. The well-known limitations of self-report surveys notwithstanding, salient information can, arguably, be garnered from the self-report surveys with respect to comparisons between self-reported and idealised virtues, and also with respect to differences and similiarities between nurses' reports and answers gleaned from other professionals. Findings from the survey are also elaborated upon and illustrated by drawing on deeper discussions from the semi-structured interviews.

Table 2: Personal Character Strengths as Reported by Each Cohort (%)

Personal character strengths	First-year %	Final-year %	Experienced %
Kindness	17.1	17.7	14.4
Honesty	15.0	16.1	17.1
Fairness	8.5	8.5	12.4
Appreciation of beauty	0.7	0.9	0.4
Zest	0.2	0.6	0.4
Prudence	0.7	0.1	0.3

Highest preference/Ranking Lowest preference/Ranking

4.1.1 Personal virtues

In the survey, Section B asked participants to reflect on their own character, by giving them a list of 24 character strengths (from Peterson and Seligman, 2004). The participants were asked to rank the six they considered to best capture their own personal character. Among all respondents, five character strengths were identified as common between the three cohorts: kindness, honesty, teamwork, fairness and humour. There was a slight difference in the sixth character strength between the cohorts; love was more common among students, whereas experienced nurses reported leadership as their sixth personal character strength. The least reported character strengths were prudence and zest.

Table 2 illustrates the total percentages and Table 3 shows the ranking of the personal character strengths. Table 4 displays the total scoring of the top six personal character strengths reported across all cohorts.

Participants in this study were recruited from various branches of nursing, in order to give breadth to findings, and allow for a more generalised view across the profession. When interviewed, participants gave very similar responses to findings from the survey when asked about the character strengths they find most important for them to be successful nurses. Participants were asked at interview what they felt their personal character strengths were as trainee or experienced nurses. The most common answers across the three cohorts were compassion, care, humility, patience, perseverance, integrity, and honesty.

Being honest with yourself, patients and colleagues, and standing up for what you believe is right, as opposed to just following the crowd, were also common responses to the interview question about their own character strengths. Experienced nurses suggested that these personal character strengths are not fully developed among new entrants to the profession; they need to be nurtured and mastered on the job. Therefore, teamwork and support from the working environment were highlighted as important for the professional development of the good nurse.

Table 3: Personal Character Strengths Ranking by Cohort

	Ranking		
Personal character strengths	**First-year**	**Final-year**	**Experienced**
Kindness	1	1	2
Honesty	2	2	1
Fairness	3	4	3
Teamwork	4	3	4
Humour	5	5	6
Leadership	12	8	5
Love of learning	9	10	7
Perseverance	7	11	9
Curiosity	8	9	12
Love	6	6	17
Social intelligence	11	13	13
Forgiveness	13	7	20
Judgement	14	19	8
Perspective	16	16	10
Hope	18	12	14
Creativity	15	15	16
Bravery	10	17	21
Gratitude	17	14	19
Self-regulation	21	19	11
Spirituality	19	21	15
Modesty	20	18	18
Appreciation of beauty	22	22	23
Zest	24	23	22
Prudence	22	24	24

Highest preference/Ranking Lowest preference/Ranking

> ‘NURSES DISPENSE COMFORT, COMPASSION, AND CARING WITHOUT EVEN A PRESCRIPTION.’
>
> **Val Saintsbury**

Among final-year students, compassion, empathy, and care were the dominant personal strengths reflected during the interviews. Patience was, for instance, considered as a strength by a final-year student when working as part of a team of healthcare professionals:

> *Because sometimes you want to give that care, you’re there to give that care, but sometimes you’re unable to because you’re waiting for somebody else, or something else has to happen first before you can provide that care.* – Final-year student, 3

Table 4: Top Six Personal Character Strengths Across All Cohorts

	Personal character strength
1	Kindness
2	Honesty
3	Fairness
4	Teamwork
5	Humour
6	Leadership

4.1.2 The Virtues of the 'Ideal' Professional

In Section E of the survey, the same 24 character strengths as in Section B were presented to the respondents and they were asked to rank the six they thought captured those of an 'ideal' nurse. First-year students ranked kindness as the most important character strength possessed by the 'ideal' nurse, whereas final-year students and experienced nurses reflected honesty as the top character strength. All cohorts reported kindness and honesty as either the first or second most important character strength. Teamwork, fairness, leadership, and judgement were considered next most important across all three cohorts. There was firm agreement across all cohorts on the top six 'ideal' strengths, with only a slight variation in the ranking order; similar to the ranking of personal character strengths. Table 5 illustrates the total percentage of preferences and Table 6 shows the ranking of the 'ideal' character strengths. Table 7 displays the total scoring of the top six 'ideal' character strengths reported across all cohorts. Spirituality, appreciation of beauty and zest were the three least important strengths ranked between the three cohorts.

Table 7: Top Six 'Ideal' Character Strengths Across All Cohorts

	'Ideal' character strengths
1	Honesty
2	Kindness
3	Teamwork
4	Fairness
5	Leadership
6	Judgement

Students who were ready to commence their professional journey as nurses seemed to be most outspoken in interviews with regard to the qualities required by an 'ideal' nurse. One of the final-year students, who was about to take up the role of a staff nurse, mentioned that she struggled to rank six out of 24 as she felt that they were all necessary for nurses to have, but that salience is relative to the situation in which they find themselves:

Definitely being kind and caring, I think, would come at the top of the list. Then honesty definitely has to be one. And humour, I think. More so because I think humour's important everywhere because I think without it we'd always just be quite upset about things. It can really be quite therapeutic when applied appropriately. Leadership, I think, being a nurse is definitely a privileged position and using that position with good leadership I think can allow not only yourself and your colleagues and your patients, but everyone to flourish and do better. I think judgement is definitely quite key. It's something you have to use in your assessments of someone. You have to use it in day-to-day life, your judgement of individuals, and your judgement of conditions – Final-year student, 13

Table 5: 'Ideal' Character Strengths as Reported by Each Cohort (%)

'Ideal' character strengths	First-year %	Final-year %	Experienced %
Kindness	18.3	15.9	17.8
Honesty	15.7	17.9	17.9
Teamwork	11.8	12.6	12.7
Zest	0.2	0.4	0.6
Appreciation of beauty	0.2	0.5	0.3
Spirituality	0.1	0.4	0.3

Highest preference/Ranking Lowest preference/Ranking

Table 6: 'Ideal' Character Strengths Ranking

	Ranking		
'Ideal' character strengths	First-year	Final-year	Experienced
Honesty	2	1	1
Kindness	1	2	2
Teamwork	3	3	3
Fairness	4	5	4
Leadership	7	4	5
Judgement	6	7	6
Bravery	5	6	11
Humour	10	10	8
Love of learning	13	8	7
Perseverance	9	15	9
Hope	14	9	12
Love	8	12	16
Perspective	12	11	15
Self-regulation	15	13	10
Social intelligence	11	14	14
Curiosity	16	16	12
Creativity	18	18	17
Forgiveness	20	17	20
Gratitude	17	19	21
Prudence	19	24	18
Zest	23	22	19
Modesty	21	20	24
Appreciation of beauty	22	21	23
Spirituality	24	23	22

Highest preference/Ranking Lowest preference/Ranking

4.1.3 Comparisons Between Nurses' Self-Reported Personal and Professional Virtues, and Those Reported by Other Professionals

The responses from participants, especially within Section B and Section E of the survey, confirmed that there was a strong agreement across all cohorts on personal character strengths and their perceptions of the character strengths of an 'ideal' nurse. Table 8 represents a comparison in rankings between the personal and 'ideal' character strengths split across each cohort.

> 'THE CHARACTER OF A NURSE IS JUST AS IMPORTANT AS THE KNOWLEDGE HE/SHE POSSESSES.'
>
> **Carolyn Jarvis**

Table 8: Comparison Between Personal and 'Ideal' Character Strength Rankings for Each Cohort

	First-year ranking		Final-year ranking		Experienced ranking	
Character strength	**Personal**	**'Ideal'**	**Personal**	**'Ideal'**	**Personal**	**'Ideal'**
Kindness	1	1	1	2	2	2
Honesty	2	2	2	1	1	1
Appreciation of beauty	22	22	22	21	23	23
Teamwork	4	3	3	3	4	3
Love of learning	9	13	10	8	7	7
Social intelligence	11	11	13	14	13	14
Fairness	3	4	4	5	3	4
Perspective	16	12	16	11	10	15
Zest	24	23	23	22	22	19
Perseverance	7	9	11	15	9	9
Creativity	15	18	15	18	16	17
Gratitude	17	17	14	19	19	21
Love	6	8	6	12	17	16
Hope	18	14	12	9	14	12
Leadership	12	7	8	4	5	5
Prudence	22	19	24	24	24	18
Modesty	20	21	18	20	18	24
Humour	5	10	5	10	6	8
Self-regulation	21	15	19	13	11	10
Spirituality	19	24	21	23	15	22
Curiosity	8	16	9	16	12	12
Forgiveness	13	20	7	17	20	20
Judgement	14	6	19	7	8	6
Bravery	10	5	17	6	21	11

Highest preference/Ranking Lowest preference/Ranking

Table 9: Top Three Personal and 'Ideal' Character Strengths, Combining All Cohorts for Each Profession

Character strengths	Business and Finance	Nursing	Medicine	Law	Teaching
Top three personal character strengths	Honesty Fairness Teamwork	Kindness Honesty Fairness	Fairness Honesty Kindness	Fairness Honesty Humour	Fairness Honesty Humour
Top three 'ideal' character strengths	Leadership Judgement Teamwork	Kindness Honesty Teamwork	Fairness Honesty Judgement	Judgement Honesty Perseverance	Fairness Humour Love of learning

Table 9 shows a comparison between five professions that have been studied by the Jubilee Centre[5].

It is noteworthy that perceptions of both the 'ideal' character strengths of a nurse and their own personal character strengths coincided almost completely in the case of nurses. As revealed in interviews, these results indicate that the majority of nurses join the nursing profession after thinking through what their character strengths are and whether they match those of an 'ideal' nurse. The journey, thus, often begins with a personal motivation to be the sort of nurse that one perceives as an 'ideal' nurse. Many nurses talked about the influence of colleagues and role models on the development of a good nurse, as discussed in later sections.

4.2 MOTIVATIONS FOR ENTERING THE PROFESSION

This section explores participants' motivations for joining the nursing profession.

The participants were presented with an open-ended question in the survey on their motivations for wanting to become a nurse, and the semi-structured interview started with the question: 'Why did you choose nursing as a career?' The responses from both surveys and the interviews yielded multiple reasons. Some respondents reported more than one reason such as wanting to care for others, and family influence, in their process of making nursing their career of choice. For example:

> *I loved the idea of helping to care for people. I grew up in a very health-professional family. My mum is a nurse and midwife, my dad was a mental health nurse. – Final-year student, 6*

In most cases, however, one dominant reason emerged. Being able to provide care for others was the dominant reason for the majority of participants to join nursing; it could be called a 'master-theme'. Around the core concept of caring revolved five different conceptions, however, which are analysed as follows.

1) Vocation: 'nothing but nursing'

Several participants identified that they entered nursing because they were 'cut out' for the profession. The impression from the responses under this theme was that they have a duty to care for patients, had been a 'people person' since childhood, and just enjoyed helping people, as illustrated by a few anonymous responses from the surveys:

> *It is a vocation I have always felt drawn to.*

> *I feel it is something I was made for. It is my vocation.*

> *I was aware of a sense of calling to nursing. Other members of my family were or are involved in healthcare professions.*

> *It chose me.*

2) Caring: personal character trait and job satisfaction

The sense of caring and altruism as personal character traits were major motivators emerging across all cohorts:

> *I have always wanted to care for people in need. My nature and values have always led me to the caring profession. – Survey response*

> *Caring. I wanted to help people. – Experienced nurse, 19*

> *I want to be the person that sits on the end of someone's bed and comforts them when they're going through a tough time, and be there for support. It's just one of those things that I just knew I wanted to do and it's all I wanted to do. – Final-year student, 5*

> *I felt it was a job well suited to my character and a job that would give me real enjoyment and satisfaction. – Survey response*

3) Personal experience

For some, the personal experience of a family member being cared for and looked after by nurses was the chief motivator, namely, a desire to emulate caring encounters:

> *After witnessing the care my grandfather received whilst in hospital I was inspired to practice. – Survey response*

> *I have spent much time sat at hospital bed sides throughout my life, the nurses who have taken care of loved ones always drew my admiration. Many of my family members are nurses, I have witnessed the commitment that the role involves, which has sparked an interest in the profession. – Survey response*

> *My sister has a disability, she has cerebral palsy, and she was in hospital when we were younger, and I was with her in hospital. When I went to visit, and go in, I'd see the nurses and they were always just amazing, and they always helped. So, it stemmed from there, I think. – First-year student, 19*

> *I think it all came from an episode I had in hospital when I was about 14 years old. That opened my eyes to nursing; I'd never contemplated it before that. So, it was a personal experience, I feel. – Experienced nurse, 10*

In a few instances, however, negative experiences of encounters with nurses became a motive for, so to speak, reverse emulation:

> *I had a personal experience where I had to go to hospital – not quite an emergency, but an acute episode. And at the time there was a nurse there, and I didn't feel she was particularly caring or supportive when I was there. And I always thought, 'Do you know*

[5] See Arthur *et al.*, 2014; 2015a; 2015b; Kristjánsson *et al.*, 2017.

what? I could do better than her'
– Experienced nurse, 8

4) Family background: a source of inspiration

Family members in the healthcare profession were perceived to be great motivators for numerous participants, particularly where at least one or more family member was a nurse. They had grown up with the idea of caring for others, professionally, or becoming a nurse, specifically, from an early age and did not think of anything else when it came to choosing a career:

So in my family, we…are like nine nurses. So the family conversations were always about nursing. – Experienced nurse, 20

I had aunties who did nursing, I had cousins who did nursing, everybody in my family did nursing, so it was always going to be something I did. – Final-year student, 7

5) Making a difference: helping people and making an impact on the NHS

In some cases, the master-theme of caring was instantiated not so much by reference to matching personal characteristics or personal experiences but the intense desire to make a difference to the current state of the NHS:

Desire to make a difference.
– Survey response

Being courteous and compassionate to them. Giving them the best care – which they deserve. Making their families happy, just trying to do your best for the patient. All the patient-centred care. – Final-year student, 6

I chose the nursing profession as there is a large margin for improvement in the NHS and I hope to help end the stigma surrounding minority patients. I also believe it will be hugely rewarding and allow me to exercise my best qualities plus better myself.
– Survey response

I decided to become a nurse as I want to be part of the NHS's future. I want to help promote good health…and also help an individual maintain their health whatever their health status may be.
– Survey response

A sixth theme, which was more difficult to categorise under the umbrella of caring, is described below:

6) Career change and prospects

The sixth theme that emerged from the analysis was considered to be more about nursing being seen as a promising career for a young student or an older person who considered a career change:

At first, I went into nursing because I wanted to leave home and I wanted a career which gives me accommodation and a job.
– Experienced nurse, 16

I didn't set out to be a nurse, and I didn't… I wasn't a child that always had a career path, but when I left school I was in…I think I did a secretarial course for about a year and I wasn't satisfied, and I knew I wanted something else. And my friend was applying for nursing, so I applied at the same time.
– Experienced nurse, 26

I went from working as a waitress to working in a healthcare setting. It was here I found a passion for helping people and was devoted to systematically being able to help people.
– Survey response

The motivations of participants in this study, when considered in comparison to responses about job motivation in other professions studied by the Jubilee Centre for Character and Virtues, were seen as more uniform across the three cohorts. Caring emerged – as could have been expected from the literature canvassed in Section 2 – as a master-theme. It is reasonable to hypothesise, therefore, that recruitment and retention of nurses, and their job satisfaction, will depend to a great extent on how this overarching motivation can be satisfied on the job.

4.3 VIRTUES, RULES AND CONSEQUENCES INFORMING REASONING ABOUT ETHICAL DILEMMAS IN NURSING PRACTICE

The actual decision-making and clinical judgment process cannot be explored completely through a self-report survey. Therefore, six scenarios were designed by an expert panel as 'situational judgement tests'[6] to understand the relative use of virtue-based reasoning in the process of dealing with the ethical dilemmas, as distinct from reasoning based on deontological or formalistic rules and codes, on the one hand, and considerations relating to the best consequences, on the other. The focus of interest in the dilemmas was not so much on the course of action chosen (among two given options in each case), but rather to challenge the participants to justify their choices, in particular to recognise the place of virtue-based reasoning in that process. Some theorists have argued that dilemma tests are more likely than mere self-reports to predict moral responses in actual situations (Kristjánsson, 2015). Be that as it may, dilemma tests at least give some indication of the sort of moral reasoning strategies, or 'moral scripts', that are most readily available to participants. Chart 1 brings together responses from the three cohorts across the six dilemmas.

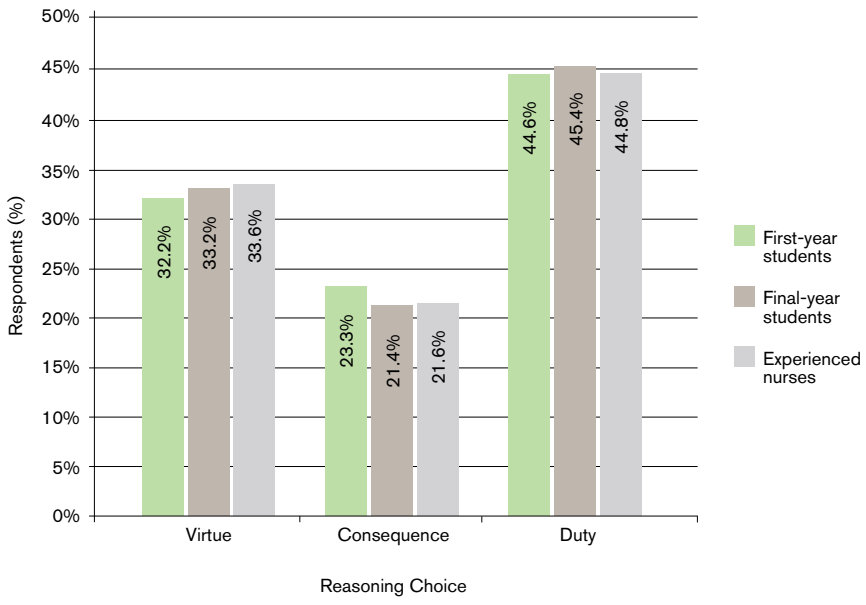
Together, a majority of respondents across all career stages cited deontological reasons as the motivation behind the options chosen: 44.6% of first-year students, 45.4% of final-year students, and 44.8% of all experienced nurses. Among those motivated by virtuous reasons for their choice were 32.2% of first-year students, 33.2% of final-year students, and 33.6% of experienced nurses. Considerations of consequences, however, ranked lower than both virtue-based and duty-based reasoning, as can be seen from Chart 1.

The prevalence of deontological reasoning was greater than in any of the professions studied by the Jubilee Centre for Character and Virtues (see e.g. Arthur *et al.*, 2015b). Especially noteworthy is that reliance on deontological reasoning increased, if anything, with experience. In most of the previous studies into professional ethics, a U-curve emerged with respect to the prevalence of virtue ethical reasoning (i.e. reasoning relying on the professional's own moral character and critical reflection). Entrants to the professions tend to rely heavily on such reasoning, while during the course of studies those considerations are overtaken by rule-and-code based reasoning, in line with the formal requirements of the profession that students are being taught. After five years or more on the job, virtue ethical reasoning picks up again, however, once professionals realise that many ethical dilemmas are uncodifiable and not amenable to clear-cut duty-based decisions. In this study, however, no such U-curve was noted. Rather, duty-based modes of reasoning remained the most common ones throughout nurses' careers. From the point of view of those theorists who consider virtue ethics the most appropriate moral paradigm for nursing, this is a worrying finding. There was no sign of virtue ethics having become the 'theory of choice' (Tschudin, 2010: 130) among nursing professionals.

NMC codes in the UK (published 29 January 2015, effective from 31 March 2015) do call for nurses to exhibit good character by displaying a personal commitment to the standards of practice and behaviour set out in the Code, and to be models of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, other healthcare professionals, and the public. Although nurses will presumably have gained a foundation for autonomous practice through their training and education, the responses generally suggest that obligations and principles, which are external to the person, are enforced upon people from the outside, for example through professional obligations from the NMC (2004), rather than being intrinsically motivating.

There is no space here to explore responses to all six dilemmas in detail. Rather, three have been singled out for further consideration because they best illustrate how reasons to do with virtues, rules and consequences influence nursing students' and experienced nurses' moral decision-making. Dilemmas 1, 6, and 4 were chosen because in Dilemma 1 deontological reasoning was the popular choice made by all respondents over consequentialist and virtuous reasons. In Dilemma 6, the majority of the respondents did identify virtuous reasons as their motivation to choose their preferred option. Dilemma 4 illustrates a very close conflict between duty-based and virtue-based reasoning among the participants.

Chart 1: Overall Reasoning Across All Ethical Dilemmas (%)



[6] See Patterson, F. and Ashworth, V. (2011) *Situational Judgement Tests: The Future of Medical selection?*, [Online], Available at: http://careers.bmj.com/careers/advice/Situational_judgment_tests%3A_the_future_of_medical_selection%3F_ [Accessed: 8 September 2017].

4.3.1 Dilemma 1: Elderly Patient

In Dilemma 1, participants were presented with the following scenario:

> Elderly patient:
> 'You are a staff nurse who enjoyed working in the elderly ward. But recently you feel the job is not as rewarding as it was before because new changes prevent spending much time with the patients. You are frustrated with your new conditions and feel sorry for the patients as sometimes the changes have compromised fundamental care. In the worst case, an elderly patient died without anyone around him. The management is ignoring all requests for more staff but subtly pressurising staff to manage with fewer staff so that they can meet their financial targets. *What would you do?*'

Respondents were offered the below two options:

1. Just live with the new policies and attempt to operate as effectively as you can within them.
2. Speak to your matron and alert higher authorities if things do not improve.

Under each option, six reasons were provided (see Figure 1).

Most participants (92%) responded that they would speak to the matron and alert higher authorities if things do not improve. Only 8% chose to just live with the new policies and attempt to operate as effectively as possible within them. Chart 2 shows the results for all participants.

As already explained, the choice between Options 1 and 2 was not meant to tease out morally relevant differences. Rather the aim was to show how the reasoning informing each option relied on virtue-based, deontological or consequentialist considerations. Since only 8% of participants chose Option 1, only responses to Option 2 are analysed below.

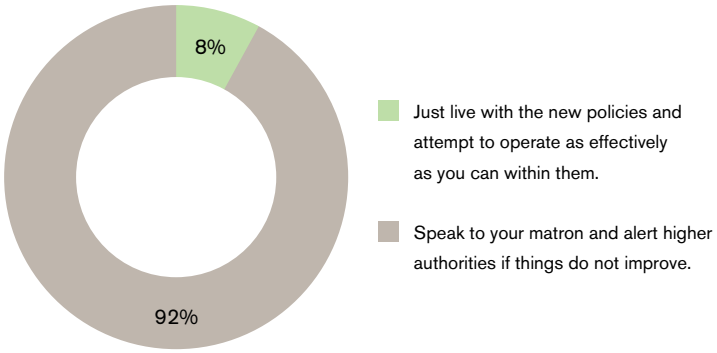
Option 2

This option provided a typical example of raising concerns or whistleblowing in a clinical environment. However, the reasons offered were virtue-based, duty-based, or consequence-based. Among the 92% of respondents who chose Option 2, to speak to the matron and alert higher authorities if things do not improve, duty-based reasoning scored much higher than virtue-based or consequentialist reasons.

Figure 1: Options for Ethical Dilemma: Elderly Patient

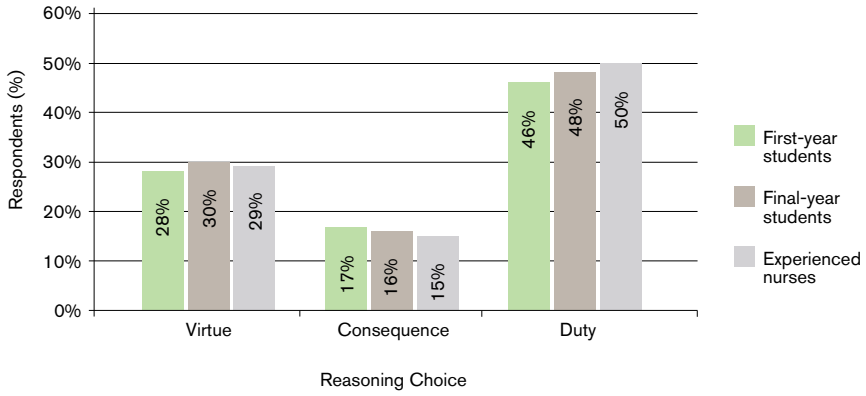
Reasoning Choice *What do you consider to be the three best reasons for your decision?*	**Option 1: Just live with the new policies and attempt to operate as effectively as you can within them.**	**Option 2: Speak to your matron and alert higher authorities if things do not improve.**
1	Things are like this everywhere and you are hopeful and optimistic that it will improve.	Everyone will be better off in the long run if you speak up.
2	You do not believe that you will have any luck influencing management, so it is better to keep quiet.	You have a duty of care to your patients.
3	You have a duty to continue helping your patients.	This is the compassionate thing to do.
4	You want to avoid trouble for yourself or others.	If you or someone close to you were in the patients' position you would want the staff to take action.
5	You are a determined person and want to continue to be there for your patients as much as you can despite the forces working against you.	You are a courageous person and if there is a shadow of doubt in your mind about the care given, you will escalate your concerns.
6	You are expected to follow management rules.	If any more of these incidents happen, you will feel guilty.

Chart 2: All Participants' Responses for Dilemma 1



> 'BOUND BY PAPERWORK, SHORT ON HANDS, SLEEP AND ENERGY… NURSES ARE RARELY SHORT ON CARING.'
>
> **Sharon Hudacek**

Chart 3: Reasons for Choosing Option 2 by Cohort (%)



Some 46% of first-year students, 48% of final-year students, and 50% of experienced nurses ranked duty-based reasons as their justification for selecting Option 2, as shown in Chart 3. Notably, increased reliance on duty-based reasons is seen with increased experience.

Some 28% (first-year students), 30% (final-year students), and 29% (experienced nurses) selected a virtue-based reason for Option 2; the virtues underpinning this reason were courage and compassion. Preserving safety is one of the fundamental elements in abiding by the NMC Code (2015). Raising concerns or escalating a problem as soon as it is identified, or when a person is vulnerable or at risk, is one of the main steps nurses need to follow in practice. Most respondents seemed to have this consideration inculcated in them. However, rather than being grounded in a habituated or reason-informed sense of professional virtue, the reasons for the choice to raise concerns seemed to follow duty-based considerations more than virtue-based ones.

Results showed that, at least for this response to Dilemma 1, when there were clear rules or policies regarding how professionals should behave, direct appeal to such rules was offered by a large number of respondents (Chart 3) as the reason for their choice. It would be unwise to lose sight of the influence that explicit rules do – in morally legitimate ways - have on nurses' thinking about ethically challenging situations. In some cases of this sort, it could be argued that rules should, indeed, trump all other considerations. Nevertheless, as part of the overall picture emerging from this study, the prevalence of duty-based reasons over other considerations is striking.

4.3.2 Dilemma 6: Friendly Patient

In Dilemma 6, respondents were presented with the following dilemma and options:

> Friendly patient:
> 'You get on very well with Pat, a patient you have been looking after for a while. Pat has multiple health problems and is frequently admitted to hospital for management of exacerbations. You have discovered that you share an interest in environmental issues and that Pat has been running an online campaign to highlight the plight of Dolphins being caught in fishing nets. This is a cause particularly close to your heart. Pat lives near to you and has suggested you meet up when Pat is discharged from hospital and that you exchange contact details and become Facebook friends. *What would you do?*'

Respondents were offered the below two options:

1. You accept the invitation.
2. You decline the invitation.

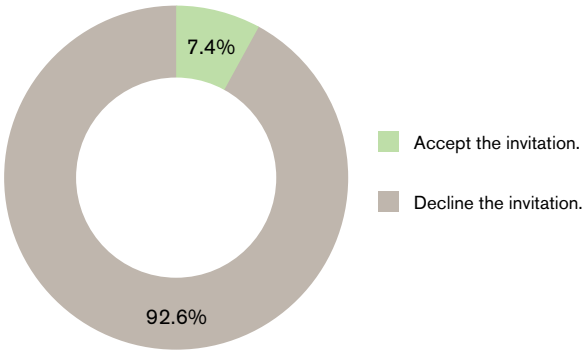
Under each option, six reasons were provided (see Figure 2).

The vast majority of respondents (92.6%) selected Option 2 as the correct course of action; that they would decline the invitation. Only 7.4% chose to accept the invitation (Option 1). Chart 4 shows the responses from all participants. The second option is elaborated upon in further discussion.

Figure 2: Options for Ethical Dilemma: Friendly Patient

Reasoning Choice *What do you consider to be the three best reasons for your decision?*	**Option 1: You accept the invitation.**	**Option 2: You decline the invitation.**
1	You get on well with Pat and care about the friendship.	It is generally imprudent to become friends with your patients.
2	Nothing in the professional code of conduct forbids getting involved in campaigns run by patients.	Befriending patients is forbidden by professional codes of conduct.
3	A just and caring person would take every opportunity to advance the cause.	It would be unfair to both you and Pat to begin a friendship you may later have to end for professional reasons.
4	This is an opportunity to do some good for a cause which is close to your heart.	You want to avoid trouble or criticism with your colleagues and employer.
5	There is nothing wrong with making new friends.	You have a personal rule never to befriend your patients.
6	You do not want to appear rude by refusing.	It could lead to problems if Pat is admitted in the future.

Chart 4: All Participants' Responses for Dilemma 6



'A KIND GESTURE CAN REACH A WOUND THAT ONLY COMPASSION CAN HEAL.'

Steve Maraboli

Option 2

When considering the reasoning behind the decision-making of those who opted to decline the invitation, 47% of experienced nurses chose a virtue-based reason. Further, 39% of first-year students and 38% of final-year students (Chart 5) also indicated that they would decline the invitation for virtue-based reasons, stating that either it is imprudent to become friends with patients or it is not fair on oneself or the patient to start a relationship, considering its future. Deontological reasons for this option were: befriending patients is forbidden by professional codes of conduct and you have a personal rule never to befriend your patients. Out of the total respondents, 32% of first-year students, 34% of final-year students and 28% of experienced nurses selected either of the above two reasons for their choice.

The least frequently selected reasons were consequence-based reasons such as the problems it may cause if Pat is admitted in the future, or the avoidance of trouble or criticism with your colleagues and employer. The future consequences of participants' choice of reason appeared to be the least salient of their concern for this option.

The interesting overall finding here, as shown in Chart 6, was that this is the only dilemma of the six where virtue-based reasoning ranked higher than deontological reasoning among all the cohorts.

Chart 5: Reasons for Choosing Option 2 by Cohort (%)

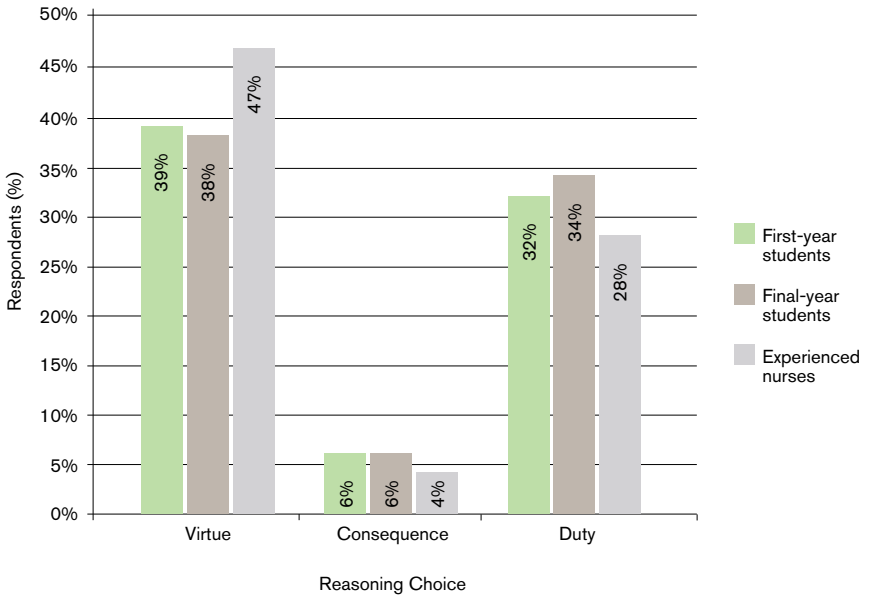
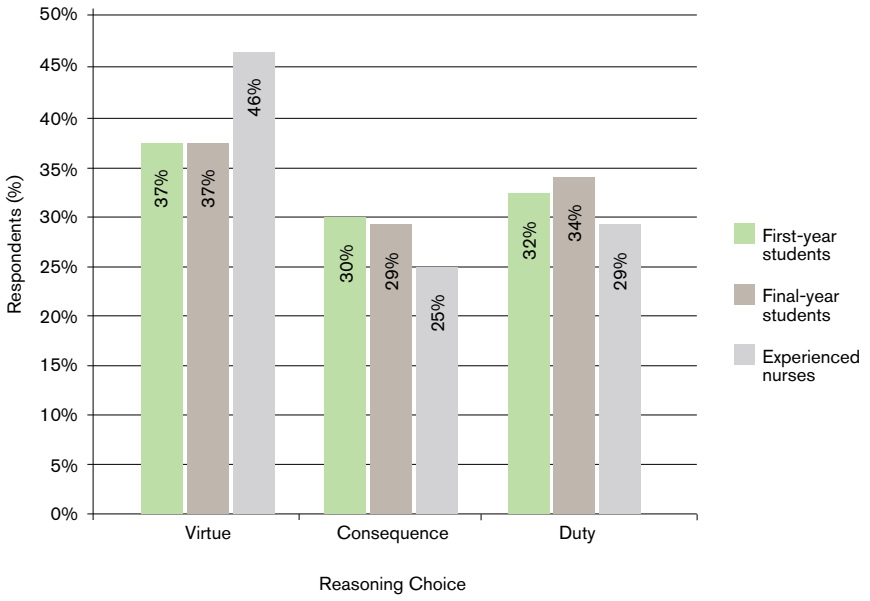


Chart 6: Overall Reasoning for Dilemma 6, Including Both Options 1 and 2 (%)



4.3.3 Dilemma 4: The Difficult Patient

In Dilemma 4, respondents were presented with the following dilemma and options:

> The difficult patient:
> 'It is the weekend and a patient, Mr. Jones, who is labelled 'difficult', is in pain. The regular analgesia has just been reduced in dose and so the volume is also reduced. The nurse prepares the new, reduced dose but makes the volume the same as the previous higher dose so that Mr. Jones cannot tell the difference. *What would you do?*'

Respondents were offered the below two options:

1. Continue this practice.
2. Refuse to follow this practice.

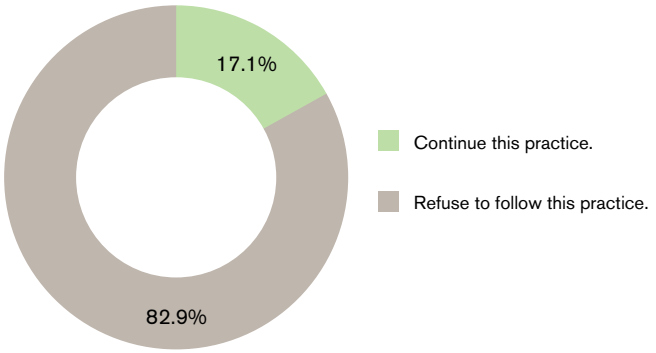
Under each option, six reasons were provided (see Figure 3).

In their responses, 82.9% indicated that they would refuse to follow this practice and 17.1% reported that they would follow this practice. Chart 7 shows responses for all cohorts to Dilemma 4.

Figure 3: Options for Ethical Dilemma: The Difficult Patient

Reasoning Choice *What do you consider to be the three best reasons for your decision?*	**Option 1: Continue this practice.**	**Option 2: Refuse to follow this practice.**
1	It is wiser to keep Mr. Jones in the dark given everything else the staff must deal with.	Trust between nurses and patients would be grievously damaged if nurses always deceived their patients like this.
2	The deception spares you a pointless squabble with Mr. Jones.	It is wrong to infantilise and manipulate patients like this.
3	Reducing the dosage is the doctor's orders.	It is unwise to get into the habit of misleading people, even when it seems harmless.
4	The deception ensures that all staff members are free to assist other patients with real problems.	You may get into trouble if your deception is discovered.
5	You have a duty to help other patients with real problems, not squabble with Mr. Jones over his dosage.	You want to be truthful to your patients about their care.
6	It is only kind to spare Mr. Jones from having to deal with both the pain and accept that he is not permitted a higher dose.	You are professionally obligated not to deceive your patients.

Chart 7: All Participants' Responses for Dilemma 4

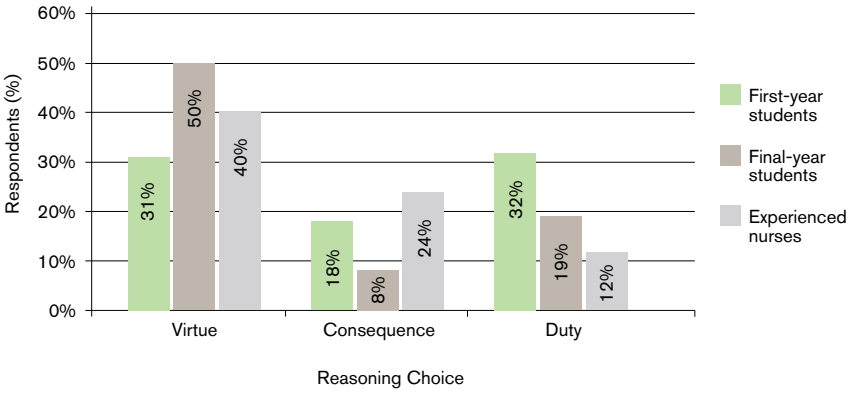


Option 1

In selecting from the six reasons available for Option 1, to join your colleague and continue the same practice, 31% of first-year students, 50% of final-year students and 40% of the experienced nurses chose to do so, using virtue-based reasons, as shown in Chart 8. What is especially striking here is that the 50% of the final-year students who chose Option 1 indicated that they did so based on either being kind to the patient by sparing him from having to deal with the pain and accept that he is not permitted a higher dose, or it is wiser to keep the patient in the dark, given all the other issues staff must deal with. Duty-based reasons for this option by the same cohort (final-year students) were only chosen by 19%. Only 12% of experienced nurses selected deontological reasoning, whereas 32% of first-year students selected either of the duty-based reasons as their priority. It was notable that out of the 32% of those first-year students, 25% indicated that it was their duty to follow the doctor's orders. These responses indicate that a sizable number of entrants to the nursing profession think that there is an obligation to follow the doctor's orders uncritically. The first-year students who took part in the study, having only recently begun their undergraduate studies, had not received any teaching input with regards to being patients' advocates or questioning actions which may compromise patient safety. It came across in the interviews with highly experienced nurses that being an advocate for patients was proving difficult earlier on in their nursing career. One interviewee for instance noted:

> *I got into some trouble for bossing doctors around to change times of painkillers – to try and get things that worked better. I think I probably overstepped the mark a good few times.* – Experienced nurse, 13

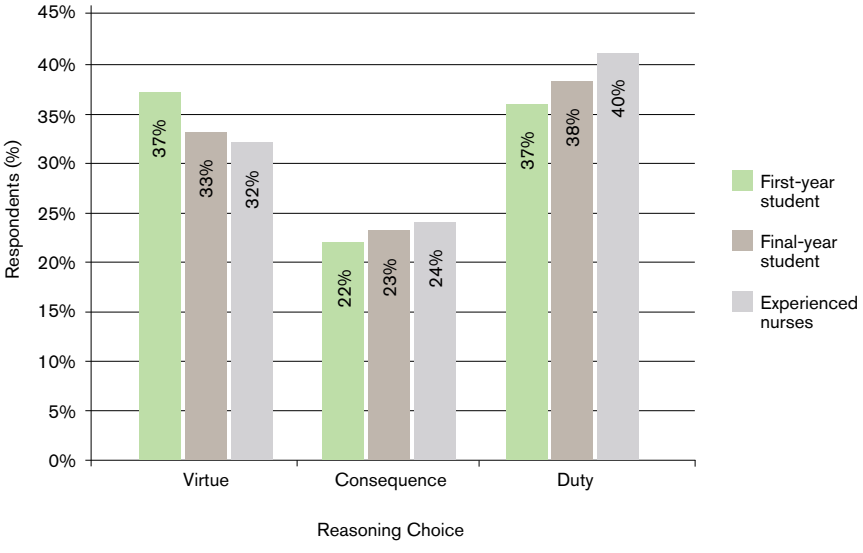
Chart 8: Reasons for Choosing Option 1 by Cohort (%)



Option 2

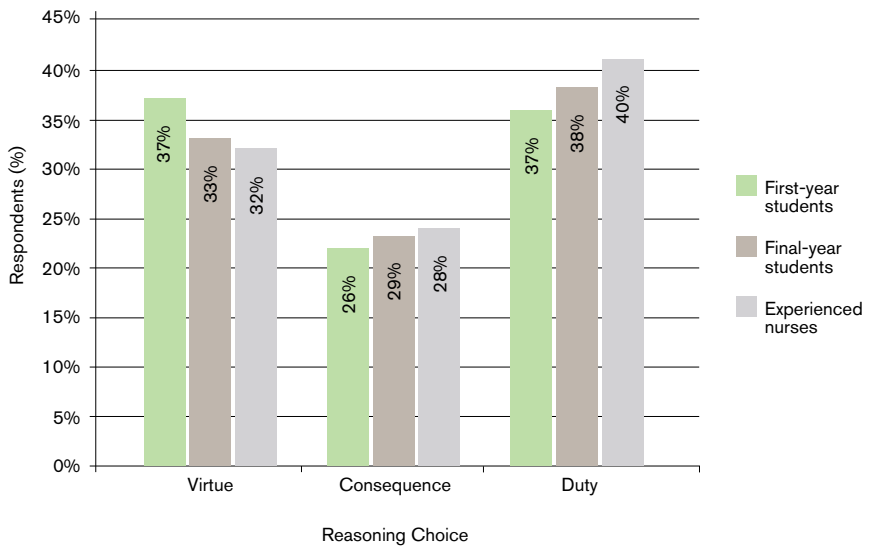
For Option 2, 37% of first-year students, 33% of final-year students and 32% of experienced nurses indicated that they would refuse to follow the practice for reasons of being prudent and honest to their patients, as shown in Chart 9. First-year students were slightly more inclined (37%) to be prudent and honest to their patients compared to final-year students (33%) and experienced nurses (32%). However, 41% of experienced nurses chose deontological reasons for their choice of this option, i.e. either it is wrong to infantilise and manipulate patients like this, or they are professionally obligated not to deceive patients. They were joined by 38% of final-year students and 36% of first-year students. Again, the ranking of consequential reasoning (trust between nurses and patients would be grievously damaged if nurses always deceived their patients like this, or one may get into trouble if deception is discovered) was much lower than that of virtue- or duty-based reasons. The slightly dominant cohort who chose one of the two consequential reasons were experienced nurses (24%), closely followed by final-year students (23%), and first-year students (22%).

Chart 9: Reasons for Choosing Option 2 by Cohort (%)



When both options were put together and weighed up against the three different reasoning modes in this scenario, 37% of first-year students, 38% of final-year students, and 40% of experienced nurses opted for duty-based reasoning, as shown in Chart 10. Yet the virtue-based reasoning scores were only slightly lower than those for deontological reasoning, with 37%, 33%, and 32% for first-year students, final-year students and experienced nurses, respectively. Here can be seen, therefore, a dilemma in which two sorts of moral reasoning modes are competing closely for allegiance.

Chart 10: Overall Reasoning for Dilemma 4, Including Both Options 1 and 2 (%)



4.4 PRACTISING VIRTUES IN THE WORKPLACE

The above dilemmas were intended to gain an understanding of nurses' and nursing students' reflections on particular situations, and how they try to reason out a solution in context between the sometimes conflicting requirements of virtues, duties, and consequences. However, even if nurses believe that they have reached the best possible solution in theory, they may feel frustrated that they cannot carry it out in practice because of various workplace barriers. Interviews with 10% of participants addressed the influence of the workplace and afforded an opportunity to consider in more depth which features of the workplace have an impact on virtuous practice.

This section, therefore, looks at the impact of work environment factors on actual nursing practice; these include the physical environment, organisational structures and resources. This section may also help promote an understanding of the conditions that encourage or discourage nurse retention, which is vital in the current situation within the NHS. Since the students surveyed were either at the beginning or end of their initial nursing education, they were not included in this part of the survey, and therefore the responses reported on here are only from experienced nurses. In Section D of the survey, the participants were presented with a 15-item questionnaire exploring practising nurses' views of their workplace. These 15 items were classified into four factors previously identified in the *Virtuous Medical Practice* report by the Jubilee Centre for Character and Virtues (Arthur *et al*., 2015b: 24-26); namely, 'autonomy', 'involvement', 'support', and 'challenges'. Comparisons between the two projects lead to some interesting conclusions.

4.4.1 Autonomy

The first factor analysed in this section was autonomy, where the following two items from the survey were joined together after factor analysis:

> 'I am able to act in the best interests of my patients.'
>
> 'I have the resources to do my work to a standard I believe is right.'

Some 211 experienced nurses responded to these questions and of those 94% (38% *always* and 56% *mostly*) said they were able to practise autonomy in their workplace (Table 10).

Table 10: Experienced Nurses' Views of the Degree of Autonomy they are Accorded

Autonomy					
N=211	Never	Rarely	Sometimes	Mostly	Always
Mean=4.1	1	2	3	4	5
%	0	1%	5%	56%	38%
I am able to act in the best interests of my patients I have the resources to do my work to a standard I believe is right					

Only 6% of nurses felt they were either only *sometimes* (5%) or *rarely* (1%) able to act as autonomous agents in their workplaces.

Many participants indicated during interview that they experienced autonomous agency and self-determination in practice when making a patient assessment independently; when they make a clinical decision and clinical judgment which is right for the patient; when they educate a patient; and so on. In everyday practice, nurses indicated that they have a sense of autonomy and authenticity when acting as advocates of patients under their care. Most of the interview responses were in favour of the professional autonomy given to nurses today, through which they are seen as equal to other healthcare professionals, as opposed to previous times when they were seen as merely 'handmaidens' of doctors (see one of the below quotations from Experienced nurse, 9):

> *I think the profession has changed…It has changed positively; we are seen in a greater professional manner by our medical and AHP colleagues. In a lot of circumstances, I think we are seen as equals within the multidisciplinary team rather than before when a consultant would go through the ward round and just leave a list of jobs for the nurses to do.* – Experienced nurse, 5

One nurse noted that the introduction of evidence-based practice has helped nurses to provide better care to patients:

> *So, I think from that point of view, things are much better, much stricter on making sure that we are giving the best care but also keeping us right as professionals as well, we're making sure we are practising with what's the best practice for this patient. So I think professionally we can absolutely hold our head up high.*
> – Experienced nurse, 6

The support and guidance from the senior staff in the clinical area had opened up ways for developing autonomy, personal as well as professional:

> *I was given the autonomy to make assessments and kind of develop into what modern nursing field would like to be and what it strives for its students just now. What I mean is in the olden days, nurses were very much…you know, you used to hear people talk about nursing being the handmaiden, the doctors make the decisions and then the nurses do what they're told, whereas now, nursing I believe to be more of a profession in its own right with quite a distinct skill set and I think that… well, initially, my first job, I was given the autonomy and the confidence and be quite assertive and confident in what I was doing and I realised that my skills and my assessments and my specialities were different to others and just as valuable.*
> – Experienced nurse, 9

While these findings seem to paint a positive picture of the autonomous status of the nurse, some reservations were already made in the discussions of autonomy – and those carried over into discussions of workplace barriers, explored under 'challenges' (Section 4.4.4):

> *I think certainly the pressure on the NHS, the time constraints, have certainly made nursing a lot harder over the years.*
> – Experienced nurse, 4

One nurse even noted a recent professional backlash with regard to the status of nursing:

> *I feel again that there has been a loss of confidence. I feel like nurses' voices aren't being heard as much now, so I think it makes it harder for nurses to feel that they are being listened to.*
> – Experienced nurse, 7

4.4.2 Involvement

Table 11: Experienced Nurses' Emotional Involvement in Their Work

Emotional involvement in their work					
N=214	Never	Rarely	Sometimes	Mostly	Always
Mean=4.24	1	2	3	4	5
%	0	1%	4%	37%	58%
I am emotionally involved in my work I have the feeling of doing useful work I am motivated to work to the best of my ability					

To analyse the factor 'emotional involvement in work', the following three items in the survey were added together after factor analysis:

'I am emotionally involved in my work.'

'I have the feeling of doing useful work.'

'I am motivated to work to the best of my ability.'

Of the 214 experienced nurses who participated in the survey, 95% felt that they are always or mostly emotionally involved in their work as shown in Table 11, which was similar to the findings of the *Virtuous Medical Practice* project (98.2%) (Arthur *et al*., 2015b). Only 5% of experienced nurses expressed that they either *sometimes* (4%) or *rarely* (1%) felt involved emotionally in their work.

During the interviews, the common themes that unfolded as reasons for emotional involvement were empathy and having a clear focus of the role they are in; this enabled them not to lose sight of their purpose as a nurse. For example, one of many nurses who considered compassion as the fundamental element of nursing stated:

> *I think despite all the difficulties we have, I don't lose compassion. I mean, it's a difficult job because we are so short staffed, but compassion would be the last thing that would go.* – Experienced nurse, 19

Feedback from patients and relatives was also considered a positive influence to get emotionally involved in the work, as one nurse expressed:

> *I think the biggest thing that keeps me going now is the feedback patients give me on an average day.* – Experienced nurse, 24

Having had role models in practice also had an impact:

> *I think positive role models make a big difference, when you see a nurse that's doing things how you think things should be done, and you model yourself on them.* – Experienced nurse, 25

There were significant similarities between the answers collocated under the heading of 'emotional involvement' and the responses about motivations for becoming a nurse, discussed earlier. The moral and emotional involvement which drove students to enter the profession does materialise in the workplace, which must be considered a positive finding.

4.4.3 Support

The following five items were combined, after factor analysis, to examine the support nurses get from the work environment and which can be understood as facilitating virtuous practice:

'My colleagues help and support me.'

'I am treated fairly.'

'I am able to apply my own ideas in my work.'

'I am able to influence decisions that are important for my work.'

'I feel 'at home' in my workplace.'

Of the 213 responses for these five items, 92% of the experienced nurses felt they are *always* (33%) or *mostly* (59%) supported in the work environment, as shown in Table 12. Only 8% of the experienced nurses reported that they only received support from the work environment either *sometimes* (7%) or *rarely* (1%). While this factor scores even more highly than with the equivalent cohort of experienced doctors in *Virtuous Medical Practice* (Arthur *et al.*, 2015b), there seems to be no shortage of collegial support and fellow-feeling in nurses' UK workplaces. Teamwork was also ranked highly as both a personal and an 'ideal' character strength of nurses. High levels of teamwork and collegiality are thus represented among UK nurses, despite the perceived shortage in staff, funding, and time: factors which have been shown to have an impact on job satisfaction and offset possible barriers (Kalisch, Lee and Rochman, 2010). This finding may explain why more nurses have not yet left the profession despite the significant challenges described in the next sub-section.

The interview data mentioned 'support' as a driver to carry on when feeling overstretched, overworked, and undervalued. Some nurses with leadership roles have found ways of rewarding their team members by sending them on courses in their favourite areas of expertise. Being motivated by colleagues and managers gives nurses the opportunity to be involved in work and to perform better:

Table 12: Experienced Nurses' Views of the Supportiveness of the Work Environment

Supportiveness of the work environment					
N=213	Never	Rarely	Sometimes	Mostly	Always
Mean=3.87	1	2	3	4	5
%	0	1%	7%	59%	33%
My colleagues help and support me I am treated fairly I am able to apply my own ideas in my work I am able to influence decisions that are important for my work I feel 'at home' in my workplace					

When I got my first staff nurse job, I had a senior charge nurse who was excellent at developing her staff and she saw people that were interested and motivated and one of the big things that's helped me in my career is that I was given the autonomy to kind of lead my own development.
– Experienced nurse, 9

An experienced nurse who worked in private practice said:

I am very lucky for the organisation I work in, I'm given a lot of time, I'm given a lot of support and I've been allowed to develop and used to develop my career.
– Experienced nurse, 10

There was a sense of confidence that emerged from the interviews that, against all the adversities and at times when staff morale became low, the support from colleagues and ward managers were the drivers which kept them moving forward:

Good support from other nurses in the ward; yeah, yeah, I would say.
– Experienced nurse, 8

One of the interviewees, whose role was a team leader, said:

Within the team itself I've got a more managerial role, as well, so I care about staff that I work with, the team. And not only gain good relationships with the staff, but ultimately improve standards for the patient, but also be sort of accepted as a team, part of their team, as well.
– Experienced nurse, 6

Working together as a team, not only the nursing team but as a whole multidisciplinary team, has enabled nurses to be mutually supportive and to learn from each other:

I think nurses are very much like - it's like a family group on a ward situation. I think you learn from each other and I think that breadth of experience, not just from nurses but you gain so much from the other people. We spend a lot of time on, we had physios, OT, the medics doing, you know, treating people as a person and seeing the whole thing. It was the whole infrastructure around it that I think really helped in nursing.
– Experienced nurse, 2

4.4.4 Challenges

The generally positive responses recorded under the three factors above notwithstanding, some reservations were expressed in interviews about those factors, concerning recent reductions in staff, heavier workloads, and an increase in administrative tasks, keeping nurses away from patients' bedsides and preventing them from getting emotionally involved in their work. The final sub-section on work environment looks at the challenges nurses face to living out their character in their workplace; what barriers do they face in staying authentic and true to their moral character and personal values? The following five items factored together under the subsection 'challenges':

> 'My work involves tasks that are in conflict with my personal values.'
>
> ´My work requires that I hide my feelings.'
>
> 'I experience stress.'
>
> 'At work it is difficult to do the right thing.'
>
> 'I do not have time to do my work to a standard I believe is right.´

Of the 214 experienced nurses who responded to these questions, only 17% said that it is *rarely* (16%) or *never* (1%) a challenge to live out their own character, as shown in Table 13. However, an overwhelming majority reported it as a challenge (83%), ranging between *always* (2%) *mostly* (18%) and *sometimes* (63%) to act in a way they want to in their workplace.

While disconcerting findings had already emerged from Jubilee Centre for Character and Virtues' research on medical doctors regarding this factor (Arthur *et al*., 2015b), the findings recorded here are much more negative and must count as causes of great concern. A range of issues emerged from interviews to explain this finding, and while most of those have appeared in recent media coverage of the state of the NHS, the gravity of those concerns and the significant extent to which they seem to disaffect nurses must raise alarms.

Many nurses felt their moral obligations to the patients had to be compromised due to the time constraints and staff shortage:

> *I think sometimes your values not quite get lost, but when you're in an environment you have to incorporate the values as well, if that makes sense? And sometimes there might be a little bit of conflict. For example, you would always want to give as much time as possible to your patients and you're under time constraints. I think sometimes there may be a little bit of compromise.*
> – Experienced nurse, 4

One respondent said that in a busy clinical area where there are drug rounds, discharges and admissions all going on at the same time, as a nurse you are doing your best, in the face of adversity, and trying not to look flustered, carrying on with a caring and compassionate approach:

> *And the consultant comes round or something like that, that's when the caring, compassion goes out the window, no matter what you're thinking.*
> – Experienced nurse, 5

Many nurses said often there have been times when they come away from patients feeling they did not do as much for those patients as their hearts dictated and that the patients did not receive the care they deserved due to low numbers in staffing:

> *So the retention of staff is a continual barrier to actually working in the way that you would want to work.* – Experienced nurse, 9

Institutional pressures, such as bed management and discharging patients unsafely, were discussed as concerns by the interviewees. These seem to play a major role in preventing nurses from being the caring professionals they want to be. One of the nurses explained this with an example:

> *Constant bed managing that interferes enormously with being able to be compassionate. Being expected to move patients out of their bed and into the chairs, so that they can get the next patient into that bed. Moving people late in the evening to the discharge ward when you know that that's not going to work and they end up coming back to you two days later because they never did get home. And, you know, we are not treating the patients compassionately when we do that. Collectively we're not. I don't believe I am, because I still do it with the concern that I…but the institution is making us behave in that way.*
> – Experienced nurse, 19

One of the nurses felt that it is quite frustrating that lack of attention and contact with patients is becoming part of the normal culture of nursing:

> *I don't get in contact with patients the way I should and I must admit, at the end of those days, I haven't enjoyed my job so much because I feel it's all been just dealing with the symptoms and doing the paperwork and I don't feel I've spent enough time with my patients. But I've learnt to accept that's part of the environment I've chosen to work in just with the pressures on the emergency services at the moment. But it is frustrating some days. That's what stops me getting to be the nurse I want to be is those days when you can't get near the patients.*
> – Experienced nurse, 18

One of the nurses reported bullying as a serious work environment concern, due to which nurses are tempted to discontinue their current practice even though they want to make positive changes:

> *Because you come up against quite a lot of bullying really, when you do try to make changes. And you can sort of see why people's attitudes change, and they think, I am not going to bother doing it anymore now, because you get complaints made against you.* – Experienced nurse, 3

Many of the above concerns can be summarised by the following two quotations:

> *So to think of the barriers that stop me, is literally money, staffing, lack of equipment, lack of time.* – Experienced nurse, 23
>
> *I worry that lots of good nurses are leaving the NHS because the stress of a permanent fulltime NHS post means that you're stuck with mountains of*

Table 13: Experienced Nurses' Perceptions of Challenges to Living out their Character

Challenges to living out their character					
N=214	Never	Rarely	Sometimes	Mostly	Always
Mean=2.67	1	2	3	4	5
%	1%	16%	63%	18%	2%
My work involves tasks that are in conflict with my personal values My work requires that I hide my feelings I experience stress At work it is difficult to do the right thing I do not have time to do my work to a standard I believe is right					

paperwork – budgets, computer work, that pulls you away from patient care. I think there is very good care, and very genuine care being given throughout the NHS, but people are struggling to be able to deliver that in the way that they want to. – Experienced nurse, 13

The dangerous slide from workplace stress and moral disengagement, on the one hand, to possible burn-out, on the other, came to the fore in some interviews:

We still try it – and that's a thing I like in nurses is we know it's difficult, but we never give up, and we always push ourselves to do more. But unfortunately that has a downside too, because people kind of know that, so they push us to the edge. – Experienced nurse, 11

In sum, the negative factors recorded here under 'challenges' seemed to outbalance the positives which had been foregrounded earlier in the interviews with many of the participants.

4.5 OVERALL FINDINGS

This sub-section summarises the most notable findings from the present section.

On personal and 'ideal' virtues

Respondents across the three career stages rated their most prominent character strengths as follows:

- Kindness
- Honesty
- Fairness

Respondents across all three career stages reported that the following virtues are important in the 'ideal' nurse:

- Kindness
- Honesty
- Teamwork

The top professional virtues (both personal and 'ideal') as identified by respondents seem appropriate for the profession. Across the three cohorts there was also a high level of agreement about the importance of these virtues. Four of the top six virtues were identical in both lists, which may suggest that students joining the profession have a clear focus on the profession and its values.

On motivations

Many nursing students and experienced nurses considered nursing a vocation. They have chosen it, often as a direct result of personal experiences or family background, for reasons that cohere well with the literature on the traditional ethical philosophy behind nursing as a caring profession. The notion of 'compassion' as a driver to pursue nursing came up in many interviews.

On ethical dilemmas

When faced with ethical dilemmas, the respondents demonstrated an ability to integrate moral reasoning into their practice and to draw on a range of considerations to reflect upon and adjudicate ethical issues. Various subtle justifications and lines of ethical argument emerged from the interviews. Regarding responses to the survey only, however, an unusual picture emerges with respect to previous Jubilee Centre reports on professional ethics: namely, the absence of a U-curve where virtue-based reasoning picks up steadily with experience after a dip during years of formal education. There is little change from one cohort to another, and duty-based modes of reasoning remain the most common ones throughout the career of UK nurses (recall Chart 1); from the point of view of virtue ethics, this is a disconcerting finding.

On the work environment

Important factors influencing nurses' ability to demonstrate virtuous practice in the working environment were identified as:

- autonomy;
- emotional involvement in their work;
- support; and
- challenges to living out their character.

The positive findings were that experienced nurses reported high levels of professional autonomy in their work and a capacity to remain emotionally involved in it (in line with their original motivations for joining the profession). They also experienced overall support from colleagues and managers to a level that may be beneficial to the overall retention of nurses within the profession. Overshadowing those findings, however, were various significant challenges to living out their character due to lack of staff, time, and other resources. These organisational and psycho-social (eg, workplace stress) barriers to virtuous practice were found to be greater than recorded in any previous Jubilee Centre reports about challenges to other UK professions.

5 Conclusions and Some Recommendations

Given the somewhat bleak findings about the current psycho-moral state in which many UK nurses seem to find themselves, recommendations can be made for improvements both to nursing education and nursing practice. As stated in the Compassion in Practice (DH and NHS England, 2012) document, training and development of all staff reflecting the 6Cs[7] and embedding it throughout career pathways – including recruitment, education and training, organisational culture, and the appraisal and development of staff – is a way forward. The recommendation below expands on this core suggestion, in light of the present findings.

5.1 NURSING EDUCATION

5.1.1 Role Models

This report demonstrates the need for nursing professionals to have an education that is able to support the development of virtues and character strengths: helping them to flourish in order to deliver holistic care and to operate effectively in today's multifaceted, ever changing healthcare environments. In the past, nursing education involved considerable patient-centred bedside teaching on patients' conditions, bedside manners etc., which helped nursing students to internalise proper displays of behaviour and character from role models (predominantly from nurses on placements or mentors). This teaching has been reduced at some universities to a brief discussion in the classroom about ethics, advocacy and whistleblowing, and by putting materials on e-learning platforms to read.

In default of a clear understanding of this emulative aspect of nursing education, nurses will find it difficult to make phronetic choices when faced with an array of options about what to do in particular situations. In the absence of adequate role modelling, the tendency will be, as seen in this report, to 'go by the book', circumventing individual reflection and responsibility and doing uncritically whatever the rules or standards of practice say. To be sure, nursing education in the UK today does at least pay lip service to the ideals of developing ethical values and designing learning experiences that foster the development of students' abilities to practise. However, at the same time (according to interview data), the role of students' role models as exemplars to emulate has been reduced in nursing education. The interviews showed how important nursing students find role models for influencing their practice. This was also put into sharp focus by one of the educators:

> *I think the role modelling with relation to practice has got a big influence for us working in education. Us being able to role model. Us being able to role model the qualities that we would like to see in students...I think that's really important. So if we're looking for students to communicate effectively with us, then we have to be communicating effectively with students. If we want students to…you know, setting expectations and us role modelling positive traits and attributes ourselves.*
> – Educator, 3

The report recommends, therefore, putting moral role modelling at the very heart of nursing education.

5.1.2 More Attention Paid to Theoretical Aspects of Virtues and Values

Whilst the development of appropriate professional virtues takes place primarily during placements and through role modelling, the theoretical aspects of nursing ethics cannot be ignored with impunity. All medical schools and departments in the UK include at least a small module on medical ethics. The provision and quality of nursing ethics are more mixed across UK universities. From the perspective of virtue ethics, it is of the utmost importance to integrate ethics within the rest of the curriculum. Giving students the space to reflect upon ethical dilemmas within core nursing modules, and hence develop their professional *phronesis*, is often seen as the best way to do this, for example by drawing attention to scenarios involving virtue conflicts:

> *They give more priority to professional values and they don't really look at personal values and how that might conflict with the scenarios that you've…I think more of those scenarios could be good as well, in education. It gives students a broader knowledge.* – Final-year student, 18

Such reflections, however, cannot take place constructively in a theoretical vacuum. All nursing students need basic knowledge of the core tenets of the main ethical theories, as those theories relate to their practice. Various helpful introductory texts about virtue ethics (eg, Annas, 2011) would help nursing students bridge the theory-practice gap with respect to the ethical core of their profession. The lack of attention to theoretical aspects of nursing ethics stands in sharp contrast to the increasing focus on the science side of nursing, aiming at competence in areas such as pathophysiology and pharmacology:

> *I think it's helpful for student nurses to have some input, in terms of values and ethics, and ethical dilemmas, and how to approach ethical dilemmas, and things to think of, and you know, thinking around those kinds of thorny issues. I think that is helpful, because you will meet those over your career.*
> – Experienced nurse, 17

Another interviewee pointed out, however, that the tendency to want to 'elevate' nursing to the level of 'hard science', through the obsession with 'evidence-based practice', had undermined the intuitive artistry needed to be a good nurse:

> *Evidence-based practice can actually reduce the standard of care because it's almost… It's not anti-rational, it's almost anti-thinking, in that I'll go over to the shelf and get my guideline, or I'll get my review, we seem to be getting a catalogue of them. But each time in a way it stops me thinking as a nurse.* – Educator, 5

The report recommends that, in order to modify the impression that some nurses seem to have of ethics as 'soft' and 'subjective', they should be taught some ethical theory and helped to relate it directly to practice. This is especially true with respect to the theory of virtue ethics which, as seen in Section 2, connects well to the traditional ethical core of nursing.

[7] The 6Cs: Care, Compassion, Competence, Communication, Courage, Commitment.

5.1.3 Strengthen the Criteria for Selection and Recruitment

The healthcare sector in the UK is suffering from a well-documented nursing shortage; currently, there are around 24,000 vacant nursing positions in the NHS. While getting more students into nursing programmes and avoiding drop-out is crucial, the recruitment process needs to be tightened up and correct decisions made to recruit the right candidates, with the right character. The themes that emerged from Section 4.2 about nurses' motivations are potentially useful for addressing current issues of shortage in the nursing workforce as they may be used to improve recruitment strategies in the future. Considering the high levels of psycho-moral stress involved in current nursing practice, both students and patients are being done disservice by admitting candidates into the profession who do not possess an appropriate psycho-moral mindset to flourish. Questions of the 'right character for nursing' are obviously sensitive, and some discussions of this topic seem to assume – incorrectly from the point of view of virtue ethics – that character is set in stone and not educable. Nevertheless, it remains true that students possessing certain character traits (such as an instrumentalist, performance-driven mindset) are not good candidates for nursing, although they might prosper in other areas of professional practice. However, those issues usually do not come up until fairly late in training for clinical practice:

> *When it's flagged up in clinical practice, it could potentially stop the student's progression on the course, quite dramatically actually, quite dramatically. And we've certainly had students leave the course purely because their mentors in clinical practice feel they don't have the right character.* – Educator, 7

Some interviewees suggested that red flags should ideally be raised earlier. Some recommended that every student be interviewed or even 'character tested' prior to admittance onto a nursing programme. One nurse mentioned an even earlier juncture:

> *Get the right people, recruit the right people. But even before people have submitted their supporting statement to the universities, I think it needs to be got earlier. I think you need to be talking to young people at 12, 13, and 14 about thinking about working within the caring and health professions, and getting them to start thinking about themselves. Because that's when their character is developing – at that time.* – Experienced nurse, 15

A recommendation to be drawn from this is that a robust approach to character evaluation should be devised to assess the suitability of candidates for nursing, at the interview stage, and to monitor the development of their character throughout the programme.

5.2 NURSING PRACTICE

5.2.1 Ethics at the Heart of Practice

When examining the quality of the work environment, an increase in the number of nursing staff may address the problematic issues in the workplace, identified in the present report, to some extent. In today's value-driven healthcare marketplace, staffing changes alone cannot, however, be a solution for all the problems the nursing workforce is facing. Nurses face daily ethical challenges in delivering care to their patients and maintaining the nurse-patient relationship. Some interviewee nurses said they were being reduced to tears regularly. In many interviews, there was a sense of an overwhelming feeling of sadness at failing to deliver the care patients deserve. It is time that the healthcare system prioritised creating a healthy work environment that prevents compassion fatigue in nurses and enables them to practise effectively. The present study indicates that the best way to do so is by explicitly placing professional ethics at the heart of working practice: in other words, by foregrounding the moral core of nursing in education, training, continuing education, and workplace ethos. The report recommends, therefore, that educational institutions in the UK solidify the ethical core of nursing and make it more explicit in their continuing development provisions for experienced nurses.

5.2.2 Quality Mentoring Within Practice

Students look for role models in their mentors who exemplify best practice (Price and Price, 2009). The report mentioned earlier the need to strengthen the role of the nurse as a moral exemplar *vis-à-vis* students; the other side of the coin is that no nurse can assume that role if overwhelmed by sadness and disaffection:

> *If we don't look after the mentors a bit more, no university input will make any difference.* – Educator, 8

Importantly, the role of the mentor should not be limited to that of students as mentees. Once fully qualified, nurses continue to need more experienced colleagues to look up to and learn from. This report recommends that the continuing role of the experienced nurse as a mentor be formalised in the workplace and reinforced through CPD programmes. The contents of these programmes would focus on issues around nurse-patient relationships, reflecting upon patient experiences, working with scenario-based ethical dilemmas, and thinking through the main issues that seem to affect the psycho-moral mindsets of nurses, many of which have been identified in this report. Emphasis should be put on preparing mentors who are confident decision-makers and advocates for patients and able to encourage colleagues – no less importantly than students – by initiating discussions and providing clear feedback, particularly in areas involving character virtues and how those impact upon practice.

5.2.3 The Role of Professional Bodies in Nursing

The impact of professional bodies and practitioners on the ethical ethos of nursing in the UK cannot be overlooked. An increased emphasis can be noted on moral values, such as the so-called 6Cs introduced by NHS England, among established professional bodies. This report encourages those bodies to exert even greater pressure on nursing departments to adapt their curricula to the needs of current nursing practice. This report shows that many of those 'needs' have strong ethical connotations – as evidenced by interviews with the practitioners themselves. Professional bodies can also encourage healthcare institutions to add ethical components to their employment criteria. The present study has revealed a disconcerting tendency among experienced nurses to reduce ethical norms to codifiable rules. If this understanding does not reflect the view of professional bodies in nursing, it is incumbent on those bodies to make an alternative voice heard.

On a positive note, the NMC's new education consultation launched in June 2017 gives patients, the public, and healthcare professionals the opportunity to shape the future of nursing. The current review that the NMC is undertaking also sets out proposals for a new education framework for nursing and midwifery education. This framework details a range of new outcome-focussed standards for education institutions and practice placement partners. The authors of the present report hope that its findings will feed into the ongoing consultation process.

This report has shown that, given the challenges of nursing in the UK today, there is an increased pressure on nurses to get each decision right, under constraints of time and resources. To choose the option that is the best clinical one for patients, but also ethically correct, requires careful deliberation and the capacity to exhibit professional *phronesis*. The ability of the nurse to make such decisions on behalf of patients goes right to the core of what it means to be a nurse, whose first responsibility is to the patient. This study has highlighted ways in which shortcomings in the working and learning environments limit trained nurses' and nursing students' development of core values for nursing practice. It has offered practical recommendations for improvement and paved the way for a fuller discussion of issues that are likely to be with us for quite some time.

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‘BE KIND, FOR EVERYONE YOU MEET IS FIGHTING A HARDER BATTLE.’

Plato

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FOUNDATION

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