WHAT PART DOES UNIVERSITY PLAY IN THE DEVELOPMENT OF A CARING CHARACTER DISPOSITION FOR NURSES? Some Theoretical, Historical, and Empirical Considerations

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This article explores how nurses learn to care and in particular, what higher education adds to that learning. Does it leave nursing graduates resentful of the more menial aspects of nursing, or "too posh to wash" (Beer, 2013; Hall, 2004) and if so, does that matter? Ultimately, the discussion reveals confusion over the role of the nurse in health care practice today, ambivalence from nurses themselves about the contribution higher education makes to their preparation for the caring aspects of their practice, and different conceptions of what it means to care in nursing. Grounding this discussion in a theoretical framework that links Tronto's ethic of care, Eraut's typology of knowledge and an Aristotelian understanding of *phronesis*, or practical wisdom, I argue for a greater emphasis within nurse education on the development and importance of character and virtue both in university and whilst on placement.

LEARNING TO CARE AT UNIVERSITY

This article explores how nurses learn to care and in particular, what higher education adds to that learning. Does it leave nursing graduates resentful of the more menial aspects of nursing, or "too posh to wash" (Beer, 2013; Hall, 2004) and if so, does that matter? The article begins with discussion of what it takes to be a "good" nurse, drawing upon a theoretical framework linking Tronto's ethic of care (1998), Eraut's typology of knowledge (1994, 2007), and an Aristotelian understanding of phronesis. In seeking to understand how nurses learn to care, I examine the context of nurse education, suggesting that the drive for higher (professional) status led nursing to

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Journal of Character Education, Volume 11(1), 2015, pp. 21–37 ISSN 1543-1223

move toward university-based education, with an associated shift in emphasis toward technical, scientific knowledge. Drawing upon narratives from four student nurses who form a small case study of student experiences in the early 21st century, I report their descriptions of their motivation to nurse, their understanding of how education prepares them for the caring aspects of nursing and how they viewed university as a site for learning in their profession. I conclude that though nursing is an intensely practical activity, it requires a highly knowledgeable, reflective, virtuous practitioner to be able to care well, and higher education, though ideally placed to nurture those capacities, has yet to convince the nursing profession of the importance of phronetic virtue in nurse education.

CURRENT CONCERNS: A LACK OF CARE?

Recent reports into poor care in United Kingdom hospitals and care homes (Department of Health, 2012a; Francis, 2010) have caused something of a moral panic amongst the public and popular press about the quality of nursing care. Yet it is unclear to what extent such failings relate to institutional factors such as staffing levels and time pressure, so-called "missed care" (Ball et al., 2013), highlighted in the Francis report (2010), or to a lack of care in the virtue of the individual nurse. Some have argued that nurses are now unwilling to provide basic care because they have been led to believe their role requires more clinical expertise than mundane tasks (Hall, 2004) and this is portrayed as a lack of care by nurses. In its response to the Francis report, the Royal College of Nursing argued "the National Health Service often sets up good people to do bad things, through constant change, chronic understaffing and unrelenting pressure staff have kindness and compassion eroded from them" before concurring with Francis on the need to recruit student nurses who "exhibit the right values, display a desire to deliver compassionate care and learn the technical skills essential to modern day nursing" (2013, pp. 5–6).

Established amid concerns that nurse education needed to change, the Willis Commission on Nursing Education in England found no obvious shortcomings in that education and reiterated the importance of moving to university-based education. It argued that although "some critics blame the problems explicitly on the move to degree-level nursing education," with its emphasis on technical and clinical expertise, nurses required both intellectual abilities *and* compassion. It went on to suggest strengthening higher education's engagement with nurse education, including promoting research and scholarship in practice and lifelong learning for nurses (Willis Commission on Nursing Commission, 2012, p. 8).

Therefore, we are left with confusion about how nurses can best be educated to meet the demands of the modern health service, what part compassion and care play in nursing and specifically how nurses learn to care. To address this confusion, I discuss what it takes to be a "good" nurse before tracing the development of nurse education, highlighting crucial influences that shape how nurses are prepared for practice.

WHAT DOES IT TAKE TO BE A "GOOD" NURSE?

A nurse in the 21st century needs to have practical competency, and propositional knowledge (Muller & Young, 2014), but these alone do not suffice. To nurse one needs to be able to offer compassionate care, and essential to this is the shift of attention away from oneself toward the interests of the patient. What is needed to complete the picture is a caring disposition, where a disposition is, along traditional Aristotelian lines, seen as a stable and permanent inclination incorporating emotion, motivation and action (Vanlaere & Gastmans, 2007, p. 761).

In this section I draw upon Tronto's ethic of care to fully understand what care in nursing might mean. I use Eraut's theory of learning in the workplace to understand the contribution university might make to good nurse education before discussing the contribution virtue ethics may make to fully describe the knowledge, personal dispositions and the relational capacities required to be a good nurse in the (highly technical) 21st century.

From the outset, it is important to be clear about how we use the term "care." In this article, care is used to denote the virtuous, compassionate thought, action and motivation by one individual toward another. What makes care in relation to nursing so specific is the motivation to relieve suffering, provide comfort and improve health, within a relationship that is at once unbalanced (in knowledge, resources and strength) and formalized (nurses are performing paid work as opposed to the unpaid care a family member might share).

Tronto (1998) uses the phrase "duality of care" to describe the mental disposition and the practices involved in care which she sees as a central feature of being human and aiming toward living well, or flourishing. She identifies four phases of care: caring about (by recognizing need), caring for (by accepting the responsibility to meet that need), care giving (actually responding to the need through action), and care receiving (getting feedback about your care actions). The latter highlights for Tronto the relational aspect of care, although others accept the centrality of the relational in care without accepting the need for "feedback" (e.g., van Hooft, 1999). Unlike other feminist care ethicists (e.g., Gilligan, 1982), who arguably have had significant influence in highlighting the importance of care (Kuhse, 1997), Tronto rejects the idea that women and men naturally care differently and thus she offers a stronger, broader analysis in the care debate.

Understanding the nature of the dynamics between those involved in a caring relationship is therefore important and in medicine this relationship has been identified with a predominant ethos of detachment whereby the ideal of patient autonomy becomes synonymous with minimal interference (Martinsen, 2011). As nursing becomes more closely aligned with medicine, so this ethos endangers the ethic of care traditionally associated with nursing and underplays the importance of emotions in motivating the carer. Yet emotion alone is insufficient and differs from sentimentality (Gastmans, 1999), and a nurse who feels sorry for a patient may not be able to care for that patient in an appropriate way. While compassion is recognized for its importance in the health professions, it has been seen as showing compassion *toward* the patient, in a potentially paternalistic way, rather than a reciprocal balanced relationship. Of course, seeking balance in the relationship is problematic since the cared for is in a power relationship with the carer (Tronto, 1998) but a truly caring individual will be attuned to these dynamics and will account for them in her response to the identified needs of the cared for.

Nursing relationships are not reciprocal in nature, and are not based on previous kinship or friendship. The expectations of care placed on nurses extend beyond the mere professional duty of practical care. Therefore, care is seen as coming from within a person, as a stable disposition that has an essential moral dimension since it focuses on a good outcome for the cared for. Caring is seen as relational, based in respect for human flourishing, it is demonstrated in action and requires appropriate knowledge to inform that action. However, there are two potential misunderstandings that need to be highlighted. First, that care as a disposition is different from common understandings of care in practice. Goethals, Gastmans, and Dierckx de Casterlé (2010, p. 636) describe care as a "complex process of reasoning, decision-making, and implementation of the decision in practice" and this reminds us that caring is much more than undertaking "basic care" tasks, yet in public discourse examples of neglect of basic care duties is often seen as evidence of a lack of care in an ethical, moral sense of the term. While this is

undoubtedly the case, preventing neglect is a necessary, but not sufficient, condition of being caring. It may be possible to offer someone basic care for example to feed them, clothe them and attend to personal needs, without doing so from a caring disposition, although whether such a limited conception of care is sustainable over a long time and provides the same degree of comfort to the cared for is a different question. Only care in the dispositional sense can ensure sustained, ethical compassionate nursing practice.

Second, care in this sense differs from simply having an understanding of rules or even ethical principles since this may provide one with the knowledge of tasks and responsibilities, including setting norms of behavior, but does not necessarily generate good care (Vanlaere & Gastmans, 2007). What drives this difference is the motivation behind the act or thought. In nursing, this motivation has four aspects: to achieve the best outcome for the health of the patient, to empathize with the patient, and to aspire and strive to excellence in practice and a fundamental respect for the patient as a human (Woods, 2011). Yet this raises questions about how nurses learn the different knowledge, competencies and virtues needed for their role. Given the position of nurse education within higher education seems assured; it makes sense to consider the integration between learning theoretical and practical knowledge and where this learning might take place.

Learning to Nurse

For Eraut (1994, 2007), professional knowledge is held within the professional community itself, who determine its validity and may control access to the knowledge. Acquiring that knowledge happens through a process of socialization because it is taught by professionals who have, in turn, been taught by earlier professionals. He describes two types of professional knowledge: propositional knowledge (knowing that) and practical knowledge (knowing how). Propositional knowledge is underpinning knowledge, which enables professional action, but does not, on its own, ensure appropriate action. Practical knowledge is embedded within action, and is of increasing importance in professional practice, so in the next section I will explore "practical knowledge" more fully: what practical knowledge is, especially with respect to its moral aspects; how it is acquired, developed and used; and its contribution to nursing care. Nurses require practical knowledge and there are two settings in which they can gain this knowledge: the workplace and at university.

Learning in the Workplace

Eraut (2007) identifies key features of professional knowledge, including its tacit nature, the importance of implicit learning, and the complexity of situations in which it is needed. In highlighting the importance of tacit knowledge, he argues it is hard to articulate, and thus it is acquired through practice rather than explicit teaching. The accumulation of experience, through countless individual cases, builds into recognition and thus into knowledge of how to act.

However, it is the detail of Eraut's explanation of *workplace learning* that is of most relevance to this discussion. He describes a tripartite framework of (1) work processes with learning as a byproduct, (2) learning activities located within work and learning processes, and (3) learning processes at or near the workplace, but not necessarily directly connected to work. For learning as a "byproduct" of work processes, Eraut sees working alongside others as most significant, and thus the importance of working relationships is highlighted. Observing how others act, and most importantly explicit discussion of why they are acting as they are, both from a technical and moral point of view, is a highly significant part of the learning process which requires reflection, analysis and comprehension. In the second category, asking questions was an important element of learning activities located within work and learning processes,

but in his study, Eraut found that students nurses were not encouraged to ask questions in the workplace, and if they were so encouraged, they themselves were reluctant to expose a lack of (possibly vital) knowledge (2007, p. 415).

Learning at University

One of the problems with learning to be a professional at university is the separation of propositional and practical knowledge. Given the importance attached to the context in which knowledge is used, teaching practical knowledge away from the workplace is obviously potentially problematic. This has implications for the sequencing of learning too, because Eraut's research suggests professionals need to use propositional knowledge soon after acquisition or it is forgotten as irrelevant. The front-loading of theoretical knowledge within initial professional education may therefore be inappropriate and potentially wasteful. His solution to this problem is to suggest universities focus as much on how to use knowledge as they do acquiring that knowledge in the first place. Further, the people who hold expertise in practice are located within the workplace, and links between universities and workplaces are traditionally weak, particularly in knowledge exchange. Therefore, students may not be learning from those with the most up to date practical expertise within their field. This in turn may have implications for how students regard university teachers and may see practitioners as holding more relevant, valued knowledge.

Another concern for Eraut in professional learning at university is the highly codified technical knowledge that is prioritized in higher education, which, while conveying national and international recognition of a specialism, nevertheless limits the attention paid to practical knowledge (1994, p. 39). The danger is that between university and the workplace opportunities for acquiring either propositional or practical knowledge get lost, and Eraut's argument is that is therefore the job of higher education to enhance the knowledge *creating* capacities of individuals to allow them to apply their knowledge in practice. This is especially true of "moral knowledge." Many experienced practitioners expect students to arrive at the workplace with a set of already ingrained moral dispositions and some basic knowledge of moral theories from the university setting. Many university professors, however, expect student nurses to pick up moral knowledge relevant to their job during work placements and thus abdicate their responsibilities in this regard.

Eraut's analysis of workplace learning is useful in highlighting the processes by which knowledge is learned and it is clear that nurses need both propositional and practical knowledge. Unfortunately, however, Eraut fails to draw a sharp distinction between practical knowledge as techné, on the one hand, and as phronesis, on the other, along Aristotelian lines (Carr, 2014). As we have seen, Van Hooft (1999) notes the range of knowledge a nurse needs and Eraut helps us to understand that knowledge and how it might be acquired. However, knowledge alone, of whatever hue, is not all that it takes to be a good nurse. As far back as the 19th century, Florence Nightingale argued "a woman cannot be a good and intelligent nurse without being a good and intelligent woman" (Bradshaw, 1999) yet technological developments (Goethals et al., 2010) and the dominant ethos of professional detachment in medicine (Martinsen, 2011) have combined to diminish the attention paid to the importance of caring in nursing.

Learning to Care

Since the caring disposition required for good nursing stems, as all dispositions, from within the person, doubt remains whether or how professional education, in university or elsewhere, can contribute to nurses learning to care. There are helpful parallels to be drawn between the development of dispositions and the development of virtues. Although the two are not the same, a person who is kind, honest,

virtuous, has the motivation to care and thus is likely to hold a caring disposition more readily than others. Annas (2011, p. 16) is helpful here. She likens the learning of virtue to the learning of a skill, with two key conditions: the virtue is learned through and within action, and virtuous development requires the motivation to improve and maximize the virtue (the "drive to aspire"). The important link between following rules and acting virtuously relates to the intentions of the person acting and the ability to articulate the reasons for actions. While strict rules of right and wrong might have their place, professional practice is too complex to be reducible to simple rules (Carr, 2012) and therefore understanding why something is right or wrong is required in order to be sure that the rule, if it is to be applied, is appropriate for the particular situation, to meet the (virtuous) intentions of the actor. So a child learns to be brave not simply by replicating a (courageous) action of a parent (Annas, 2011, p. 23) uses the example of a parent tackling a dangerous dog), but by understanding why the action was brave within the (dangerous) context in which it was taken. Translated into the nursing setting, a nurse learns to care not simply by copying the actions of other nurses. She first has to understand what care means in the context of the specific case she is dealing with, and she has to have the will to offer the best care she can within that context. Therefore, as Aristotle argued, virtue can be learned through a process of correct teaching and habituation, or through appropriate practice, with guidance. If the nurse is given the correct advice, conditions and space to practice, and she has the aspiration to excellence, her caring disposition will be nurtured and developed as she progresses through her work. You would not therefore expect the same level of excellence in caring from a new undergraduate (the novice) as you would from a more mature professional (Miller, 2006).

Recent developments in nurse education point to different ways of addressing at least the first of Annas' conditions by providing opportunities within the university setting for reflective, role-taking based education (Adam & Taylor 2014; Christiansen & Jenson, 2008). By placing the student in an, albeit simulated relationship, the student becomes aware of how patients may experience care and how her actions may provoke different reactions. Supported reflection on the activity can then be used to better understand the effect on emotions that actions and attitudes might stimulate. However, caution is needed in recognizing that reflection on practice is complex and requires more than simply providing space for that reflection (Clarke, 2014).

Further, the aim of nurse education should be to transform her to an ethical, caring agent, driven by excellence, but recognizing that this transformation will take place over time within a particular community (Gastmans, 2002). This process will involve role models (Miller, 2006) who embody the caring disposition required to achieve excellence. Here, the importance of university staff modeling a caring disposition, particularly in their pedagogical relationships with students is emphasized (Drumm & Chase, 2010) and paying explicit attention to values modeling between university and practice (Newton, 2010; Williams & Stickley, 2010). In practice, nurses need to learn within a caring community, where relationships are fostered and care is made explicit (Dewar, Adamson, Smith, Surfleet, & King, 2013). However, they also need to develop the capacity for critical thinking precisely because adherence to codes of practice, as we have seen, is insufficient to ensure good care. Vanlaere and Gastmans (2007, p. 759) describe this as "critical companionship," arguing that good nursing requires both a person-centered (practical knowledge-based) and evidenced (university propositional-based) approach. Van der Cingel (2014, p. 1253) suggests that the "missing link" between the two is compassion.

Although there is only limited agreement on the exact interpretation of the concept, practical wisdom is nevertheless an intellectual virtue, aimed at the cultivation of virtuous character, which ideally guides moral behavior

(Cooke & Carr, 2014). So a nurse may hold technical and propositional knowledge and they may have a caring disposition. However, they will still need to exercise practical wisdom when faced with a patient needing care in order to do the right thing in the right way. Little attention has been paid in the literature to how practical wisdom may be educated (Kristjánsson 2014) but there are lessons from philosophy that give an indication of what we should think about when designing moral nurse education.

The first condition for a person to develop practical wisdom remains the development of virtue itself. A nurse may need different virtues in various practice settings, but compassion is essential in a caring disposition. Yet knowing how to be compassionate in a given moment requires balancing compassion against other virtues, such as courage, honesty or justice, and practical wisdom performs this balancing function. Second, developing practical wisdom takes time, requiring practice, or habituation, to finesse (Kinsella, 2012). Since every situation we face is different to the last, we need to adapt our response to each eventuality. Yet there are common threads to those experiences, allowing us to learn something from each one that then informs our reaction to the next situation. But this learning only happens if we are able to reflect on our actions, the moral implications of which will help us to develop our wisdom for the next occasion. Finally, our actions and reflections on actions require a strong role model, who themselves demonstrate practical wisdom, to guide us and show us what practical wisdom is. This suggests that what is needed in nurse education is attention to the development of character, or virtue, opportunities for the habituation of virtue, and reflection and guidance on actions.

Understanding the historical evolution of nurse education helps to illustrate why the emphasis may lie elsewhere, on developing practical competence and propositional knowledge, rather than on the virtue of care or compassion.

FROM APPRENTICE TO GRADUATE: EVOLVING NURSE EDUCATION

The evolution of nurse education, from the apprenticeship model predating Florence Nightingale to the graduate of today, reflects the struggle to turn an occupation into a profession. Locating initial nurse education in higher education was not simply an *educational* decision (Brennan & Timmins, 2012), rather it was part of broader social, cultural and technological changes. Some would suggest that, as a result, the perception of nursing has changed, with consequences for both the practice and identity of nurses (Findlow, 2012; Harrison & Journeaux, 2011).

During the first half of the 20th century nursing was seen to be an important, respectable occupation for women from middle and upper middle class backgrounds described as "female vocationalism" (Miers, 2002, p. 34). After the World War II, the establishment of the National Health Service in the United Kingdom confirmed nursing within the institutional hierarchy in a subservient position to doctors, and nursing became seen as a job not a career, there to fill the gap between school and marriage (Miers, 2002), part of the process of the "gendering of care labor" (Brennan & Timmins, 2012, p. 748).

Elsewhere, notably in the United States and Canada, nurse education was moving into higher education. However, in the United Kingdom, despite calls dating back to 1895, there was resistance to moving nurse education into university because of what Brooks and Rafferty (2010) describe as ambivalence from within both nursing and universities. The reasons for this ambivalence included a lack of political confidence within nursing, in part arising from the differential status of nursing and medicine; a concern that only matrons could judge the character of a person and their suitability for nursing, and a fear that intellectual nurses would not be "practical" (Rafferty, 2010, p. 582). Hardy's view (1943) that nurses needed "common sense, courtesy and kindness

in that order," rather than intellectual acumen, prevailed.

Despite this ambivalence, there were counterpressures to include nursing in higher education. The subservient position of nursing in relation to medicine, together with low academic entry requirements, led aspiring "professional" women to reject nursing as a career option (Miers, 2002). Placing nurse education within an expanding higher education would improve this image. Second, broader social and cultural changes in the second half of the twentieth century regarding women's role in society led to demands for female dominated occupations (including teaching and nursing) to be seen as lifelong choices rather than filling time until marriage and child rearing. At the same time, health care was facing two potentially contradictory pressures, which continue to shape demand today: increasingly complex technological expertise needed to keep pace with advances in knowledge and treatments, alongside an expanding, increasingly elderly population requiring basic personal care over prolonged periods of time (Watson, 2006). Ever more technological approaches to health care, together with unfavorable international comparisons, were undermining the status of nursing in Britain (Brooks & Rafferty, 2010), which, it could be argued suffered from "status anxiety" (Becher, 1989).

The move from hospital-led to university education was facilitated by changes to higher education in the second half of the 20th century. Policy drives to increase the number of participants, as well as broadening the representation of previously underrepresented groups, created space for a different kind of higher education (David, 2010). Where previously the polytechnics were seen as the site for practical, technical learning, their overnight conversion to university status brought new subjects within the university sector, changing the traditional view of what constituted "higher" education (Smith & Webster, 1997). However, expansion and widening participation has not been unproblematic, with concerns about differential access (Archer & Hutchings, 2000; Callendar, 2008), both elite and lower status institutional provision (Crozier, Reay, Clayton, Colliander, & Grinstead, 2008; Furlong & Cartmel, 2009) and employability and pay inequities (Adnett & Slack, 2007; Cranmer, 2006) remaining.

Nursing, as a new discipline within university provision, found itself located often in newer institutions, carrying less academic status, with higher numbers of mature and "non-traditional" students than traditional, elite universities. The move suited the change from female vocationalism to "professionalism invested in service to the newly established National Health Service" (Miers, 2002, p. 34). Resistance to framing nursing as an intellectual practice stemmed, in part, from the ambivalence of nurse educators themselves. Findlow found lecturers concerned about a "mismatch" between student nurses and university education because "their aspirations were being falsely raised" (2012, p. 124). In her study, lecturers argued that students were attracted by recruitment literature that emphasized a high status, university-educated profession only to find themselves expected to engage in practical, often menial tasks while on placement. Increasingly complex technological and interventionist medical care, together with the need to meet rigorous standards of *higher* education have shifted the focus from nursing 'as a practical art, grounded in women's practical skills' (Miers, 2002, p. 215) to a competence based "client advocate, educator and manager" (American Society of Registered Nurses, 2007). In this process, the emphasis on the caring role of the nurse has shifted to one of competency and knowledge. However, if nursing is seen as primarily competency and knowledge based, this raises the question of who attends to the need for an ethical and moral practice in nursing?

Therefore, the task of nurse education is to offer the right combination of knowledge and competencies while at the same time developing a caring disposition that will underpin nursing practice and ensure that knowledge and competencies are used for the right

purposes. This may take place in university, out on placement, or both. To help understand these issues more clearly, I now turn to the narratives of student nurses themselves to see how they describe their learning journeys toward professional registration.

NURSES TALKING NURSING

Here I present data from a small study of students' perspectives on learning in higher education in England in the early 21st century (Cooke, 2012) to explore how conceptions of nursing shape understandings of the caring role, how caring dispositions may or may not be developed, and how the interplay between theory and practice can contribute to the development of those dispositions. The wider study from which these narratives are drawn sought to understand the learning journeys of students in English higher education through regular and extended semistructured interviews. Set within the wider study, a group of four nursing students at an elite university were interviewed four times over the three year period of their undergraduate, professional degree in nursing to understand their motivations for choosing nursing and how their teaching and learning changed their understandings of what it was to be a nurse. In this study, student stories are used because they give an insight into how students experience university, how they see themselves as undergraduate learners and choose to present themselves to others. They allow me to describe individual experiences set within large organizations, national policy frameworks, and broader social, cultural, and economic structures. As Bathmaker argues, "they reveal ambiguity rather than hide it away" (2010, p. 2) and may allow me to "call into question dominant narratives that do not match the experience of life as lived" (2010, p. 3) by the students themselves.

Critics of the use of narratives in research argue the approach is too subjective, relying on one perspective at a moment in time, in a given setting, presented in a selective way, open to interpretation that can change or distort the intention of the original account. Although not offering the same scientific rigor that randomized control trials and other measurable research designs purport to do, the use of personal narratives remains an essential data-gathering method in the researcher's repertoire in helping to understand deeply subjective, personal experiences. I draw upon these narratives to illustrate and strengthen my argument, not to prove facts. A more extensive study would offer further development in this area.

Interviews were recorded, transcribed and member-checked with participants before being coded thematically using NVIVO software. Codes were developed through the research questions and focus on motivation, personal development and the link between theory and practice. Students' names and distinguishing features have been changed to protect anonymity.

Motivations to Nurse

Here I present nurses' descriptions of their motivations in choosing nursing as a career and in so doing I reveal their understandings of the nursing role, the place of care within that and what they understood "care" to mean. Within the narratives of the four nurses, the difference between academic, technical, career focused, and caring, practical nursing was explicit.

Carol was a young woman who came from a family steeped in higher education experience, with high expectations of academic success. In her first year she described her motivation to choose nursing as a career based in subject interest, particularly biology, the career prospects on offer and the diversity of pathways through her potential career. She saw success in her course being directly linked to achieving high grades in her academic work. By the end of her third year she described impatience with the sociocultural learning she had undertaken at university, which she saw as being at the expense of propositional, clinical

knowledge. She reiterated that she did not choose nursing "because I really wanted to hold someone's hand" and commented about her choice of nursing as a career "I know it's involved with people." For her, nursing seemed to be primarily a clinical role and yet she was highly defensive of nurses in the face of criticisms of their caring role, arguing:

> When people say that elderly people in hospital are being starved to death by nurses, I get really annoyed because they don't understand that you can't force someone to eat and a lot of people aren't dying because they're not eating, they're not eating because they're dying.

In contrast to Carol, Helen described having known from a young age she wanted to do medical-related work, encouraged by her father being a family doctor, or general practitioner and mother a radiologist. However, she chose nursing as "more hands on" and offering "more patient contact" than medicine, because she wanted to do "basic care" and to have time to build relationships with patients. She said she was "very interested in caring for people". In her first year she recognized that what she described as the "idealistic" view of nursing may have been wrong, and that this was a commonly held misconception of nursing. In her experience:

> You don't go around wards swanning about with a clipboard in a clean dress. You are dirty, you are toileting people, you talk to people a lot more. You are dealing with people when they are not at their best. So it's not always pretty.

She described nursing on a surgical ward:

> It was too fast paced for me and too like conveyor belt nursing. You have a procedure, you're out. Whereas medical, you have more time to build a relationship with your patients, which I prefer.

Throughout her 3 years training, caring was foremost in her narrative and by the end of her course she thought that "a lot of nursing is people telling you their story or their problems." She questioned whether nursing should focus on promoting itself as a profession since this requires it to foreground academic and research knowledge, perhaps at the expense of basic care.

Lucy had personal experience of caring for relatives having cared for her dying grandad and disabled mother. From the start, her view of nursing was shaped by those experiences, "I always had quite a caring way about me … I can kind of see it from the point of view of the patients." Unlike Carol, her perception of nursing was grounded in relationships rather than technical expertise and she recognized the balance in duties often tipped toward the personal care needed by patients:

> I did want to be a doctor for a long time, but I changed to nursing because it is more hands on and more patient contact.… I quite like helping people and I don't get bothered by all the disgusting stuff like sick and all that.

Janice was another example of someone who chose nursing specifically for the focus on caring and working with people it offered. At the start of her course she argued:

> If anything, nurses could be seen as the more important role, because they have the more contact with the patient and they are the ones that are actually doing all the normal caring stuff for the patient.

Throughout her narrative she emphasized the need for her to understand patients' needs, and for her, it was the nursing that "really, really matters" rather than academic success. By the end of her course she reflected that nursing was becoming more paperwork based "and the higher you progress up the career ladder, the less patient contact you have and this is not what you go into nursing for." She commented that she probably had an "idealized" view of nursing "where everything is helping the poor and needy," and the reality is not like that.

These contrasting narratives illustrate the confusion over the nursing role in modern healthcare. For some, nursing offers good career prospects and an opportunity to develop their clinical, propositional knowledge, while for others, it offers the chance to work with people in a caring and practical environment. How these two paths are combined is the crucial question, because both are necessary: a good nurse needs up to date clinical knowledge alongside caring and empathetic dispositions. The question posed relates to the balance between the two extremes and whether in the drive to label nursing a profession, the emphasis has not shifted too far in one direction.

Developing Dispositions

In interviews, students were asked how they thought they had changed as *people* as a result of their time at university, specifically in relation to those dispositions needed to become a good nurse. A common theme in the descriptions related to personality traits, such as confidence and assertiveness although some did give a broader insight. Carol described how her confidence had increased, and related this to the growth of knowledge from her learning. However, she reflected on the kind of person she needed to be:

> I don't know who I am, I don't know what I'm doing. Sometimes I'm questioning myself: 'Am I that kind of person or am I more like that?' I try not to think about it too much but it does make me think 'Well what kind of person am I'?

Helen saw nursing as being inextricably linked to whom she was as a person and contrasted this with other disciplines:

> It is not necessarily part of who they are, whereas I think that's more true for nursing. It's firmed up the qualities in myself that are tied in with nursing, the caring.

Alongside mentioning confidence and assertiveness, Helen also described humor as an essential attribute:

> I don't think you can be a nurse if you've got a dull personality. You just wouldn't get through the day, because you need humour. Cancer is a serious subject but you need appropriately to put a bit of humour in, lightness into life, because these people are in a traumatic situation, they need some light.

Rather than describing specific dispositions and how they had developed them, most of the students' testimonies related to maturing, or even improving as a person as a result of the course. It was unclear whether this was simply part of the usual process of growing up that all students experience to some degree, or what part was particularly related to nursing. Lucy definitely saw this as a profession-specific development:

> I think I've learned that with this profession, you can't be somebody who sits back and let's things happen even if you know it's wrong. You've got to speak up and say something.

Alongside understanding the need to speak up for what was right, Lucy also described how nursing had taught her the virtue of perspective:

> I'm less judgmental of people now. Now I think okay, maybe they're like that for a reason. You kind of look at them as a whole picture rather than picking one thing out.

Janice pointed to the responsibility inherent in nursing as a key factor in her maturing:

> Obviously as a nurse, you've got a lot of responsibility when you're working with other people … so you do have quite a lot of responsibility and that obviously helps you grow as a person.

These examples illustrate the kind of reflection that these nurses were engaged in, so although they focused on what they thought they needed or had learned, with some focus on the caring aspect of nursing, the emphasis tended to be on the performance aspects of their development and the place of confidence.

Learning Theory for Practice

In Eraut's typology, there is a potential gap when propositional and practical knowledge is learned in different settings. Universities offer formal teaching of predominantly propositional knowledge and placements within the hospital or community setting offer largely informal learning of practical knowledge. The nursing student has to work out how the two relate to one another and Carol offered a good example of how this can be done. She described how placements had "cemented" the knowledge in her head, illustrated by the case of a patient with diabetes. She argued that her experience of seeing how the patient, presenting in accident and emergency, was treated allowed her to relate propositional knowledge:

> Now every time I think about that particular problem I think about that patient and what medicines they gave him, how he acted, what his blood pressure was doing and that's really helped me in my learning.

Yet not everyone experienced this synergy. Janice described her confusion when practice on placement had not reflected teaching at university even in her first year on the course:

> That's happened a few times when we've been on placement and come back, and said you taught us to do this, but actually none of the nurses do it that way, so which is the right way?

Keeping up to date with new knowledge was an issue as Lucy described: "you can read one book which was published last year and it's already out of date." The students clearly felt that practice kept abreast of new developments faster than the theoretical knowledge they were learning at university.

Nevertheless, at university students were reminded to think more deeply about what they were doing in practice and this helped them to develop a moral imperative to their work. Helen discussed how learning clinical skills at university reminded her to respect the dignity of the patient, because "time with a patient is just as important as actually what you are doing for them." Implementing what was learned at university allowed students to experience the reciprocity of a caring relationship, as Lucy described:

> It's so rewarding, because even the little things you do, people are so grateful for, so for a patient who is in a lot of pain to say thank you to you, that's a really nice feeling.

Yet not everyone experienced the same level of interest in this aspect of nursing. Carol described her frustration at how her course at university had "focused on other bits," including learning about the impact of bereavement, or culturally specific needs of patients, "we think we've had quite enough of the cultural stuff." She understood 'it's all holistic care in nursing' but this was not what she felt was useful knowledge—preferring to focus on physiology and propositional knowledge in her studies. She was being taught about how to behave as a nurse within a separate module called "professional development," described as irrelevant by all four of the students to a greater or lesser extent. This irrelevance seemed to relate to the subject matter of the module which, rather than focusing on relational aspects of nursing, seemed to concentrate on "professional" behavior:

> Professional development, I find it confusing to link. I know that there is a very simple link there, they're teaching me what is involved in being a professional and obviously I'm going to be one, but it is hard.

What seemed to be happening was a separation of propositional and practical knowledge, which in themselves were further separated from developing caring dispositional capacities.

However, it was not simply the type of knowledge that caused a potential gap. There was a constant theme in the students' narratives that teachers at university were more credible where they were practitioners in the

field, brought in for explicit sessions. Lucy described:

> It feels more relevant because they're not a lecturer who used to nurse, it's like you've got more respect for them because they're still out in the field doing it.

The issue of the credibility of the practical knowledge of the university teachers was significant, with specialist experts attracting greater respect.

University as a Site of Professional Education

University has traditionally focused on both vocational and academic learning, from its earliest origins in educating doctors, priests and lawyers. However, "new" vocational higher education has faced considerable political resistance. The four nursing students in the study described very pragmatic reasons for being at university, namely it was simply where you learned to be a nurse. With the possible exception of Carol who emphasized her academic motivations, the other students took the view that doing a nursing degree would help them progress in their career. There was an element of resignation about that choice, since the profession was becoming increasingly graduate-only entry, as Janice discussed when comparing degree and diploma nurses:

> I think it is a bit sad … you don't need to be academic to be a nurse … if you make it degree only … that's going to be a lot of people that you're going to cut out of the profession.

Students experienced a real separation between learning propositional knowledge at university and practical knowledge on placements. The physical separation of sites of learning created additional barriers in linking theory to practice, as Helen reflected:

> It feels irrelevant: it's more theoretical than it is practical. Theory's great but not if you can't relate it to practice … it's just knowledge, but you're not doing anything with it … so it doesn't seem useful to me.

As Catharine remarked, "There are things they can't teach you at university." It was their experiences of interacting with people while on placement that students described offering learning a more personal, nuanced approach to their work. As Helen described:

> It's the relationship that you build with them (the patients), because that helps to treat people, not just giving them what they need, medication wise, actually building a relationship with them.

Thus, what placements offered, in contrast with university based learning, was the opportunity to develop the relational capabilities required to foster a caring disposition. These may or may not have been theoretically embedded in university teaching but the students clearly only understood them and recognized them in the practice setting.

In summary, there were different attitudes to the nursing role among the students, most of whom saw nursing as predominantly relational caring, while Carol saw nursing in more technical, expertise ways. Students described a disjuncture between university learning and their placements and frustration with those aspects of the course that focused on personal development.

LEARNING TO NURSE AT UNIVERSITY

It seems from both the literature and data from students' narratives that there are three important capacities for a modern nurse to hold in order to offer high quality care. She must have a high level of propositional knowledge that she can bring to her work as well as the critical engagement to identify salient features of any situation. She needs to have practical, technical knowledge and competence to be able to execute procedures safely and effectively. And she needs to have compassion so she can deliver care "through a relationship based on

empathy, respect and dignity" (Department of Health, 2012b, p. 13). This is the "right combination of critical judgment, practical skills and values/virtues" (Willis Commission on Nursing Education, 2012, p. 6). But how are these best developed?

University education offers nursing a number of things. First, it promotes a view of nursing as a (female-dominated) profession worthy of recognition in comparison with the high-status (male-dominated) medical profession. Second, it offers the space and resources to develop propositional knowledge within the classroom to ensure that nurses are equipped with the understanding to operate within a highly technical, scientific health care model. Third, it offers the capacity for individuals to develop critical understanding and moral insight to allow them to question practices seen in the practical sphere that diverge from theoretical understandings.

The practical interaction in placements offers extensive opportunities to learn informally, on the job, to complement and cement knowledge gained in university. Indeed, in the case of the nurses reported in this article, that practice came to dominate their experiences and severely limited their engagement with the broader university. It caused them to reflect on practice they saw and where that diverged from theoretical knowledge learned at university they were required to question and reformulate their thinking to incorporate practical knowledge shared by others in the workplace.

However, what was less obvious was how nurses learned about caring, in the virtue or disposition sense described earlier in this article, or indeed where that fitted into the role of the nurse in modern health care. Nurses still need to care and for many it is the caring incentive that attracts them to nursing in the first place. Yet there is confusion in the literature, public discourse and the nurses' testimonies themselves between care as disposition, embedded within the person as motivator, and care as basic, personal task, without which neglect occurs.

Nevertheless, successive reports have highlighted the importance of university-based nurse education, rejecting suggestions that this left nurses ill equipped for caring. What was absent in the students' descriptions of their higher education experiences was satisfaction with how their university based education had really taught them to *nurse* in the traditional, caring sense. Indeed, there was little evidence that this happened, leaving it up to informal mentoring in the workplace to ensure such education took place at all. This then left nurses learning care from those they worked with, in highly pressured workplaces. If Annas is correct, paying attention to the caring virtues in both formal and informal aspects of their education may help nursing students to develop, nurture and implement compassionate care with appropriate understanding of the reasons behind that care. Universities may be able to provide that guidance and nurturing but it is unclear whether there is sufficient priority paid to it in current nurse education.

It could be argued that the apparent absence of formal "education for character" (where character is seen as appropriate dispositions) can be linked to the gendered nature of nursing as a profession. This article has argued that the development of nursing was shaped by gendered expectations of women in the workplace. In addition, the care ethics tradition has centered on feminist perspectives that women care differently from men (Gilligan, 1982), thus fostering an assumption that care comes "naturally" to women and cannot be taught. While it may be true that an uncaring nurse may not respond to ethical, reflective, practical education, research suggests that such teaching is missing in nursing (Webb & Warwick, 1999) as well as in other professions including teaching (Sockett & LePage, 2002).

Examples do exist elsewhere (see, for example, Goldie, 2008; van Mook et al., 2009), and there is evidence that universities can contribute to ethical development in students. For example, in medicine, understanding how attitudes change as a result of education is problematic (Jha, Bekker, Duffyi, &

Roberts, 2007), in part because of the difficulties in measuring dispositions. Traditional modes of developing appropriate values in Doctors have centered on the "hidden curriculum" through role modeling (Goldie, 2008), although recent calls for a more specific focus on teaching medical ethics suggest that this would help create "good doctors" with appropriate dispositions (Stirrat, Johnston, Gillon, & Boyd, 2010). However, as Kristjánsson (2014) has argued, virtuous practice is informed by a comprehensive, universal ethical theory before profession specific capacities are needed. Thus, the aim of professional ethics teaching at university has first to focus on the habituation of good or virtuous dispositions more broadly before students can apply those in their practice. Secondly, a comprehensive approach to character education more generally is required (Berkowitz, 2011), including paying attention to the learning environment, role modeling, interactional practices and professional development for the teaching staff. These features are relevant to education for caring professions at university equally as they are to character education in schools. Therefore, if nurses are to learn to care from their university education, a broader, embedded approach to teaching for caring is required, paying greater attention to the development of appropriate virtuous dispositions and offering the opportunity to habituate these dispositions in a practical environment.

So what would good education for nurses look like and what part could university play in it? University can provide both knowledge and the ability to reflect and interpret practical situations, but only if there is a strong and secure link between theory and practice in teaching. Of course, initial professional training is just one step along the route, and we would not expect nurses to be fully fledged mature, moral professionals from day one. University can create appropriate expectations to care, and provide foundational knowledge and understanding of that care. Once in practice the nurse will learn more about appropriate care through a process of continued professional development, role modeling, professional reflection and most importantly through building caring relationships with patients and colleagues in the clinical setting. Nevertheless, the evidence from this article and research elsewhere suggests that what is needed is a greater emphasis on explicit education for caring and virtue, through a holistic, integrated education in university and in practice. At present this emphasis would appear to be missing.

Acknowledgments: I am very grateful to the anonymous reviewers for their insightful and helpful comments on two earlier drafts of this article.

REFERENCES

Adam, D. and Taylor, R. (2014) Compassionate care: Empowering students through nurse education. *Nurse Education Today, 34,* 1242–1245.

Adnett, N., & Slack, K. (2007). Are there economic incentives for non-traditional students to enter HE? The labour market as a barrier to widening participation. *Higher Education Quarterly*, *61*(1), 23–36.

American Society of Registered Nurses. (2007, December 1).The real public perception of nurses. *Journal of Nursing*. Retrieved July 25, 2014 from http://www.asrn.org/journal-nursing/249-the-real-public-perception-of-nurses.html

Annas, J. (2011). *Intelligent virtue.* Oxford, England: Oxford University Press.

Archer, L., & Hutchings, M. (2000). Bettering yourself? Discourses of risk, cost and benefit in ethnically diverse, young working-class non-participants' constructions of higher education. *British Journal of Sociology, 21*(4), 555–571.

Ball, J. E., Murrells, T., Rafferty, A., Morrow, E., & Griffiths, P. (2013). 'Care left undone' during nursing shifts: Associations with workload and perceived quality of care. *BMJ Quality and Safety*. doi:10.1136/bmjqs-2012-001767

Bathmaker, A. M. (2010). Introduction. In A. M. Bathmaker & P. Harnett (Eds.), *Exploring learning, identity and power through life history and narrative research* (pp. 1–10). London, England: Routledge.

Becher, T. (1989). *Academic tribes and territories.* Milton Keynes, England: Open University Press.

Beer, G. (Ed.). (2013). *Too posh to wash: Reflections on the future of nursing.* London, England: 2020health.org.

Berkowitz, M. (2011). What works in values education. *International Journal of Educational Research, 50,* 153–158.

Bradshaw, A. (1999). The virtue of nursing: The covenant of care. *Journal of Medical Ethics, 25,* 477–481.

Brennan, D., & Timmins, F. (2012). Changing institutional identities of the student nurse. *Nurse Education Today, 32,* 747–751.

Brooks, J., & Rafferty, A. M. (2010). Degrees of ambivalence: Attitudes towards pre-registration university education for nurses in Britain, 1930–1960. *Nurse Education Today, 30,* 579–583.

Callender, C. (2008). Does the fear of debt constrain choice of university and subject of study? *Studies in Higher Education, 33*(4), 405–429.

Carr, D. (2012). Values, virtues and professional development in Education and Teaching. *International Journal of Educational Research, 50*(3), 171–176.

Carr, D. (2014). Professionalism, profession and professional conduct: Towards a basic logical and ethical geography. In S. Billet, C. Harteis, & H. Gruber (Eds.), *International handbook of research in professional and practice-based learning* (pp. 5–27). Netherlands: Springer International.

Christiansen, B., & Jensen, K. (2008). Emotional learning within the framework of nursing education. *Nurse Education in Practice, 8,* 326–332.

Clarke, N. M. (2014). A person-centred enquiry into the teaching and learning experiences of reflection and reflective practice—Part One. *Nurse Education in Practice, 8,* 1219–1224.

Cooke, S. (2012). *Perspectives on the learning journeys of students in English higher education* (Unpublished doctoral thesis). University of Birmingham, Birmingham.

Cooke S., & Carr, D. (2014). Virtue, practical wisdom and character in teaching: In search of further clarification. *British Journal of Education Studies, 62*(2) 91–110.

Cranmer, S. (2006). Enhancing graduate employability: Best intentions and mixed outcomes. *Studies in Higher Education, 31*(2), 169–184.

Crozier, G., Reay, D., Clayton, J., Colliander L., & Grinstead, J. (2008). Different strokes for different folks: Diverse students in diverse institutions—Experiences of higher education. *Research Papers in Education, 23*(2), 167–177.

David, M. (Ed.). (2010). Introduction to the dilemmas of widening participation in higher education. In *Improving learning by widening participation in higher education* (pp. 3–27). Abingdon, England: Routledge.

Department of Health. (2012a). *Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report*. London, England: Author.

Department of Health. (2012b). *Compassion in practice: Nursing, midwifery and care staff: Our vision and strategy*. London, England: NHS Commissioning Board and Department of Health.

Dewar, B., Adamson, E., Smith, S., Surfleet, J., & King, L. (2013). Clarifying misconceptions about compassionate care. *Journal of Advanced Nursing, 70*(8), 1738–1747.

Drumm, J., & Chase, S. K. (2010). Learning caring: The student's experience. *International Journal of Human Caring, 14*(4), 31–37.

Eraut, M. (1994). *Developing professional knowledge and competence.* London, England: Falmer Press.

Eraut, M. (2007). Learning from other people in the workplace. *Oxford Review of Education, 33*(4), 403–422.

Findlow, S. (2012). Higher education change and professional-academic identity in newly 'academic' disciplines: the case of nurse education. *Higher Education, 63,* 117–133.

Francis, R. (2010). *Independent inquiry into care provided by mid Staffordshire NHS Foundation Trust January 2005–March 2009*. London, England: The Stationery Office.

Furlong, A., & Cartmel, F. (2009). *Higher education and social justice*. Maidenhead, England: SRHE/OU Press.

Gastmans, C. (1999). Care as a moral attitude in nursing. *Nursing Ethics, 6*(3), 214–223.

Gastmans, C. (2002). A fundamental ethical approach to nursing: some proposals for ethics education. *Nursing Ethics, 9,* 494–507.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Goethals, S., Gastmans, C., & Dierckx de Casterlé, B. (2010). Nurses' ethical reasoning and behaviour: A literature review. *International Journal of Nursing Studies, 47,* 635–650.

Goldie, J. (2008). Integrating professionalism teaching into undergraduate medical education in the UK setting. *Medical Teacher, 30*(5), 513–527. doi:10.1080/01421590801995225

Hall, C. (2004, May 11). Young nurses 'too posh to wash.' *The Daily Telegraph*. Retrieved May 24, 2014, from http://www.telegraph.co.uk/news/uknews/1461504/Young-nurses-too-posh-to-wash.html

Hardy, G. M. (1943, May). A quest for qualifications. *British Journal of Nursing, 50.*

Harrison, J., & Journeaux, M. (2011). Promoting nursing and midwifery as a potential career for school leavers. *Nursing Standard, 26*(9), 35–40.

Jha, V., Bekker, H. L., Duffyi, S., & Roberts, T. E. (2007). A systematic review of studies assessing and facilitating attitudes towards professionalism in medicine. *Medical Education, 41,* 822–829.

Kinsella, E. A. (2012) Practitioner reflection and judgement as phronesis: A continuum of reflection and considerations for phronetic judgement. In E. A. Kinsella & A. Pitman (Eds.), *Phronesis as professional knowledge: Practical wisdom in the professions* (pp. 35–52). Rotterdam, Netherlands: Sense.

Kuhse, H. (1997). *Caring: Nurses, women and ethics.* Oxford, England: Blackwell.

Kristjánsson, K. (2014). Phronesis and moral education: Treading beyond the truisms. *Theory and Research in Education, 12,* 151–171.

Martinsen, E. (2011). Harm in the absence of care: Towards a medical ethics that cares. *Nursing Ethics, 18,* 174–183.

Miers, M. (2002). Nurse education in higher education: Understanding cultural barriers to progress. *Nurse Education Today, 22,* 212–219.

Miller, J. F. (2006). Opportunities and obstacles for good work in nursing. *Nursing Ethics, 13,* 471–486.

Muller, J., & Young, M. (2014). Disciplines, skills and the university. *Higher Education*, *67,* 127–140.

Newton, V. (2010) Teach students compassion by being an excellent role model. *Nursing Practice, 106*(39), 10.

Royal College of Nursing. (2013). *Mid Staffordshire NHS Foundation Trust Public Inquiry Report: Response of the Royal College of Nursing*. London, England: Author.

Smith, A., & Webster, F. (1997). Changing ideas of the university. In A. Smith & F. Webster (Eds.), *The postmodern university? Contested visions of HE in society*. Buckingham, England: SRHE and OU Press.

Sockett, H., & LePage, P. (2002). The missing language of the classroom. *Teaching and Teacher Education, 18,* 159–171.

Stirrat, G. M., Johnston, C., Gillon, R., & Boyd, K. (2010). Medical ethics and law for doctors of tomorrow: The 1998 Consensus Statement updated. *Journal of Medical Ethics, 36,* 55–60.

Tronto, J. C. (1998). An ethic of care. *Generations, 22*(3). Proquest Nursing and Allied Health Source.

van der Cingel, M. (2014). Compassion: The missing link in quality of care. *Nurse Education Today, 34,* 1253–1257.

van Hooft, S. (1999). Acting from the virtue of caring in nursing. *Nursing Ethics*, *6*(3), 189–201.

van Mook, W. N. K. A., van Luijk, S. J., de Grave, W., O'Sullivan, H., Wass, V., Schuwirth, L. W., & van der Vleuten, C. P. M. (2009). Teaching and learning professional behavior in practice. *European Journal of Internal Medicine, 20*(5), e105–e111. doi:10.1016/j.ejim.2009.01.003

Vanlaere, L., & Gastmans, C. (2007.) Ethics in nursing education: Learning to reflect on care practices. *Nursing Ethics*, *14*(6), 758–766.

Watson, R. (2006). Is there a role for higher education in preparing nurses? *Nurse Education Today, 26,* 622–626.

Webb, J., & Warwick, C. (1999). Getting it right: The teaching of philosophical health care ethics. *Nursing Ethics, 6*(2), 150–156.

Williams, J., & Stickley, T. (2010). Empathy and nurse education. *Nurse Education Today, 30,* 752–755.

Willis Commission on Nursing Education. (2012). *Quality with compassion: The future of nursing education: Report of the Willis Commission on nursing education*. London, England: RCN on behalf of the Independent Willis Commission on Nursing Education.

Woods, M. (2011). An ethic of care in nursing: past, present and future considerations. *Ethics and Social Welfare*, *5*(3), 266–276.