ETHICAL CHALLENGES AMONG NURSES IN SAMOA: WORKPLACE, PRACTICE AND PROFESSION

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ABSTRACT

This research explores and seeks to understand nursing perspectives/interpretations of ethical challenges within Samoan workplaces, and the impact on nurses' ethical decision making and their nursing practices. It is well known that nurses often encounter ethical challenges in their everyday practice, and researchers from developed countries explore these challenges and generate models and theories about ways to address these issues within the nursing profession. However much less is known about such issues in developing countries, and there has been little, if any, research on the ethical practices of nurses in the Pacific region, such as in Samoa. To perform the research as both theoretically sound and culturally appropriate as it could be, the Ietoga research model (a developing methodology that recognises the nuances of the Samoan context) in association with "Teu o le Va" and "Samoan Philosophy of Nursing" was incorporated during data collection and analysis.

The study is a mixed methods approach that employed a sequential exploratory design (SED). The two-phase design explores the topic by firstly using a qualitative method with twenty-one participant nurse experts, through interview techniques. Thematic analysis was used to extract themes that were later used to develop a survey questionnaire. The quantitative method phase used the purposively made survey questionnaire to collect 221 responses from nurses' respondents that was analysed by using descriptive analysis. The findings from both analyses of the study were transformed into a conceptual model (called the *Sulu* Model) that is presented as a symbolic representation of Tuiga, a cultural headdress. The model presents the viewpoints of nurses' concerning ethical knowledge, ethical challenges and ethical decision making in Samoa by means of five main key findings. First, fa'asamoa (culture) as a foundational and collective perspective of the meanings of ethics as perceived within Samoa, and by Samoan nurses in particular. Second, perspectives of socio-cultural knowledge relating to nursing ethics and education. Third, the attempted integration of western perspectives of nursing ethics in nursing education. Fourth, the experiences of ethical challenges in nursing practice, and lastly, decision making considerations and approaches to these ethical challenges. The study therefore contributes a particularly Samoan approach to the existing knowledge of nursing ethics and methodological approaches to research from socio-cultural, contextual and professional perspectives. The study concludes with implications and recommendations for nursing education and practice, for quality assurance, and also ideas for improvements to quality (ethical) patient care within the Samoan health care organisational culture.

DEDICATION

This thesis is dedicated to

my dear aunty

Musi Fa'asalaina Iulio

And to the

Queen of my Heart, Nana/Grams

Fa'asulu Sefo Fa'asalaina.

With a heavy heart, may you rest in love,
I love you both very much,
Until we meet again

"Faafetai Tina, ua sili ofe tautai o le fua, ae fati magalo le āva i Tāga

Ua matou sopoia mauga, ua lē pōnā, ua matou folau i vasa, ua lē souā

Aisea? Na e aputiputi ma apelepele i matou, i le lotofou ma le mamā.

E lē o le tamāo'āiga ia malomaloā, ia manatua ala, na naumati ma gaoā

Faasulu, le La'au sa matou malu ai, alu atu ia i le fiafia o lou matai".

(Lemalama Ta'aloga Fa'asalaina)

.

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Psalm. 28:7

" Therefore, my heart exults, and with my song I shall thank Him."

O LAU PULE LEA, UA FAAFETAI.

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GLOSSARY

Aumaga	Untitled men – both single and married, and both men of the village and those married into the village.
Aganu'u	culture
Aiga	family
Aitu	thoughts and mental process
Alagaupu	phrase or saying
Ali'i	Chief
Alofa	love, kind, generous, compassion
Apia	Capital city of Samoa
Atua	God
Atunu'u	Country
Aualuma	The association of women who are specifically daughters of the village. It excludes women who are married into the village.
Ekalesia	church or congregation
Fa'aaloalo	courtesy, respect and politeness
Fa'afetai	Thank you
Fa'alavelave	Family events or obligations such as weddings, funerals, church openings, bestowal of titles.
Fa'alupega	Constitution of chiefly titles and honorific addresses.
Fa'amaoni	Honesty
Fa'a-Samoa	Samoan culture, Samoan lifestyle, Samoan way
Faioa	wealth maker
Faipule	council, member of Parliament
Fale	house
Falema'i	health centre or hospital
Faletua ma Tausi	wives of chiefs and orators
Fanau	Children
Fatu	essence, heart
Feagaiga/Tamaitai	sacred covenant in the sister-brother relationship, daughters, girl children
Fesili	ask, question
Fono	meeting
Gagana	language

galulue fa'atasi	work together
Itumālō	district
Ma'i po o gasegase	illness, health problem
Maloloina	well health or optimal health
Matai	titled man (and now woman), chief or orator
Mauli	intellect, vision, dreams, insight, telepathy, intuition, spiritual, inner being
MT2	Malietoa Tanumafili 2, Transfer hospital of Samoa
Nu'u	village
Ola	living, alive, physical life, birth, rest and peaceful death
Ositaulaga	leader in worship, a sacrifice
Pae ma Auli	peacemaker
Pule	authority
Pulega matai	chiefly system
Pulenu'u	mayor
Savaii	largest island of Samoa
SPN	Samoan Philosophy of Nursing; is the conceptual cultural framework that guides the quality of care provision and culturally competent and proficient health care.
Tamaiti	children
Tapu	sacred
Tapuaiga	worship or well wisher
Taulasea	a healer
Taulelea	young untitled men
Tautai	fisherman or captain of a boat
Teu le Va	to value, nurture and tidy up/act, social and sacred relational space
Tofa saili	the search for wisdom
TTMII	Tupua Tamasese Meaole II, main hospital of Samoa
Tu	Stand
Tulafale	Orator
Upolu	Main island of Samoa
Va fealoa'i	space between relational arrangements
Va tapuia	sacred relational space
Va	Relationship, space.

"`Ua ala mai i pu'e o manu"
"You are coming with the fortune you have caught"

Chapter 1: INTRODUCTION

Introduction

This research explores and seeks to understand nursing perspectives and interpretations of the ethical challenges that nurses face when delivering health care within Samoan workplaces, and how they affect the nurses' ethical decision-making and practice-based experiences. This introductory chapter provides the background and general overview of the research, starting with the rationale of the study which is then followed by the research question and aim of the study. This is followed by an introduction to Samoa, where I am from, and an outline of the cultural context which helps position myself in a way that is relevant and appropriate for the settings of my research data collection and throughout the research process.

The proverb as mentioned earlier of the chapter "Ua ala mai i pu'e o manu" means "you are coming with the fortune you have caught". It refers to the wealth of experience and understanding that I have gained as a nurse in my pursuit and search for knowledge about ethical challenges among nurses in Samoa. This chapter provides the background, aims, and context of the study, and introduces concepts of caring, nursing, morality, and ethical challenges. It also describes a detailed account of the methodological approach to the study and its contribution to nursing knowledge, policy implementation and practice. The significant of the study and thesis content are outlined at the end of the chapter.

Rationale

I started my career as a registered nurse in the outpatients and emergency department of the main hospital, Tupua Tamasese Meaole II (TTMII) in Apia, the capital of Samoa. As an advocator for patient safety, my priority was to ensure that nursing practice adhered to cultural and religious values, the International Council of Nurses (ICN) Code of Ethics (2012), nursing standards in relation to patients' care, and correct medical procedures and treatments. However, the application of good practice can be problematic in the reality of nursing in Samoa due to a number of issues beyond the nurse's control, such as limited

resources and shortages of nursing staff. For instance, some years ago, I encountered a difficult cultural and clinical situation during a busy shift where a caregiver reported me to the principal nurse because she thought that my nursing practice was unethical or not up to nursing standards, and that I was therefore behaving in an unprofessional manner. She stated that I should not be a nurse, did not do my job well. She said that I, was rude and she questioned my qualification. I was angry and scared, not because of the caregiver but because I had to report to the principal nurse to explain the incident. The meeting between myself, the caregiver and principal nurse had a good outcome because I was able to explain how I used the ICN code of ethics to provide quality care for the client. It was the first time a caregiver has ever questioned my nursing practice, but since this incident, my understanding of the code of ethics and nursing ethics in the provision of nursing care has been strengthened considerably.

Following that incident, over the years of working as a nurse, I endeavoured to apply relevant clinical decisions and ethical judgements to different clinical situations and treatments to improve patient care. Yet sometimes I found that it was difficult to exercise good ethical judgements in nursing care and treatment because of the shortages of staff, limited resources and external influences such as pressure from families, the demands of Samoan culture and its hierarchical system, and difficulties within the organisation and health system environment. There were many times when I asked myself: “How do other nurses make their ethical and practice-based decisions if they are under pressure under these working conditions?” I have no doubt that other Samoan nurses have gone through, and are going through the same challenges, and subsequently I am aware that they, like me, are subject to similar criticisms from both other members of the nursing staff and the general public alike. Indeed, ‘poor nursing attitudes’ are one of the most common complaints heard on radio and seen in newspapers in Samoa. A report from the office of the Ombudsman and National Human Rights Institution survey (2015) stated that respondents viewed nurses as treating patients negatively and complained of poor service skills. Such statements question professional accountability as applied to both patients and community. Feagaimaalii-Luamanu (2018) reported on our own prime minister at the time, speaking of his disappointment with nurses’ performances, and he spoke of nurses’ “unprofessional behaviour”, claiming that this was not the first time he had been informed of nurses’ “unprofessional behaviour” towards

patients, telling nurses “to stick to their profession and stop telling-off patients.” These experiences, and the anecdotal stories of other nurses in Samoa, have led me to pursue my study topic on nursing ethics.

Aim and research question of the study

The aim of this study is to explore and develop an understanding of the concept of ethical challenges and decision-making among Samoan nurses when delivering patient care in their nursing profession. It focuses on identifying ethical challenges within the workplace that nurses in Samoa are experiencing and their responses to these challenges. Therefore, the research question for this study is “*What are Samoan nurses’ perspectives of ethical challenges within their workplaces and how do these perspectives affect their decision-making about patient care and their profession?”*

Objectives of the study

The objectives of the study were to

1. Gain an understanding of the perspectives of Samoan nurses about nursing ethics and its relevance to nursing practice.
2. Identify and understand ethical challenges and decision-making in nursing practice that impacts on patient care in Samoa.
3. Understand methods that Samoan nurses use to resolve and address ethical challenges within their workplaces or the health system.

Background of the Study

In background preparations for this study, it became apparent that certain ethically related elements were going to be essential aspects of both the research project and in the subsequent writing up of the thesis. These main elements required that sufficient attention be paid to contexts (and the context of care in particular), nursing as a moral obligation, the meaning of ‘good’ nursing care, the problems of ethical challenges and dilemmas, and, especially because the research involved those ethically related aspects of nursing care in Samoa, the importance of socio-cultural aspects of care. They are now briefly introduced in this chapter as a beginning guide to the background of the study.

The context of caring

In general, caring is considered as relating oneself to another in a precise way with attention to maintaining and developing others and self in a relational context, and caring in nursing has been described as a foundational normative concept in nursing ethics that plays a vital role (Gastmans, 1999). In this aspect, nursing care is not limited to a single moment, nor is it a guarded situation, but one that adopts a sympathetically vulnerable position that allows nurses to experience what the patient is going through. Demanding continuity of involvement and care in nursing therefore expresses the nurse's solidarity, and willingness to identify with patients' pain and suffering and desire to do everything possible to relieve the patient's situation (Gastmans, 1999). Thus, caring is about people, and it is a basic concept of human existence that is characterised by qualities such as compassion, competencies, confidence, conscience, and commitment as well as sharing and mutual respect (Cronqvist, Theorell, Burns, & Lützén, 2004b). This allows the development of ideas of care ethics, which in a basic sense, can be simply considered as a universal ethical task (Lachman, 2012) and most certainly a major nursing task. Nursing is a hands-on job of everyday practice where its work shapes nurses experience, emotion, affection, and relationship (Gallagher, 2015; Tschudin, 2003a). Therefore, in nursing, caring is essential from infancy to the end of life, and it connects people in a unique relationship (Vanlaere & Gastmans, 2011). In Samoa, this unique relationship is to be found in the *Fa'asamoa* context and involves 'Teu le Va' (honouring the space to respect each other; this will be discussed in detail in Chapter 3).

This relationship leads nurses to experience patients' suffering which demands moral knowledge and judgement (Cerit & Dinç, 2013), and subsequently several nursing sources refer to nursing care as an ethical enterprise that has an obligation to care for those who are unable to care for themselves (Cronqvist et al., 2004b; Noddings, 2013; Tschudin, 2003b; Vanlaere & Gastmans, 2011) This care occurs within interpersonal relationships that Bergum (2004) claims to be 'a moral space', i.e. where one acts for the benefit of others through (moral) responsiveness and reasonability. Indeed, Nortvedt (2001) refers to the nurse-patient relationship as the place that generates moral responsibilities and professional duties, rather than merely paying lip service to them. These relationships and interactions involve a complex network of mutual dependencies between patients and nurses, among nurses, other health workers, and also the relationship of the nurse with the context of practice (Doane & Varcoe,

2007). In this way, the context of practice involves caring for others which makes caring a relational concept or a human relation that asks vital questions such as "how to live and what to do" that Gilligan (1982) regards as a basic question of human living within a variety of contexts. It is an explanation that is based on the belief that people's lives are psychologically, economically, and politically connected. In such connections, there is a therefore also a 'relation space' that not only suggests a moral space, but ratifies it (Doane & Varcoe, 2007). Thus, although care develops (or is inhibited) on different levels within many and various relationships, it remains critical in care practices (Gallagher, 2020). Therefore, it is important to consider ethics in every situation, and every encounter with every patient.

Nursing as a moral obligation

Caring is the practice of taking responsibility for another person in a process of responding to one who is vulnerable, providing them with contact, value and community within networks of social relationships. This is especially important to a person whose capacities of reasoning and energy are minimal and who is vulnerable in body and mind. This is where care connects the person who is taking ethical responsibility with the individual who is receiving care, and it therefore holds a moral obligation, which is not an external requirement but an internal one. Caring is a part of being a human and not caring diminishes the sense of being human as well as those who are vulnerable (Vanlaere & Gastmans, 2011). According to the American Nurses Association in 2015 (as cited in Stokes & Palmer, 2020), caring is an essential characteristic, expectation and moral obligation of the nursing and caregiver professions. Thus, a moral obligation occurs once the relationship is formed between the nurse/caregivers and patients and continues as long as is necessary. Within this relationship, nurses must negotiate everyday practices that always have ethical meaning, i.e. some nursing care practices and procedures might seem simple and basic or small, but they could potentially cause harm to others. Hence, most nursing practices are significantly moral ones, and they will always have moral meaning within the relationships between the carer and the cared for. Subsequently, an ethical point of view underpins the nursing practice and the attitude or conduct of the nurse (Johnstone, 2019). Therefore, the moral obligation of nursing not only looks at the nurse's ability to carry out nursing care, but also at the moral attitude of the nurse when attempting to match care with the morally beneficence acts, or 'doing good'.

Good nursing care

Gastmans (2006) suggested that "good care demands more than good intention; good care, is a practice of combining attitudes, and knowledge of the situation" (p. 137), i.e. care involves more than showing affection and emotional awareness towards the needs of another person. Good care has two main concerns, firstly, about providing for another human being with personal needs. Secondly, about maintaining the (human) dignity of another person, i.e. providing the normative foundation of good care where dignity shows itself in the caring relationship of the patient and the nurse. Respect for the person and their identity are shown as characters of good nursing care especially when a person is unable to respond, e.g. unconscious or barely conscious (Vanlaere & Gastmans, 2011). Therefore, good care is the care that not only provides for the basic care needs of others but does so by promoting the dignity of the person through attention to the meaning of 'doing good' in an ethical sense. In this regard, Wiechula, Conroy, Kitson, Marshall, Whitaker & Rasmussen (2016) maintain that nurses need to be mindful of their behaviour and attitude towards patients, noting that the nurse's attitude or behaviour should aligned with what the patient values within the relationship (between the nurse and the patient). Considering and responding to a patient's values within a relationship is also a part of the process of doing good or 'good caring'. However, the relationships between nurses and those they care for can be shaped by a multitude of contextual forces an several positive and negative way, and so it can be argued, a nurse's good (i.e. moral) intentions may not always be enough.

Ethical dilemmas/challenges

According to Johnstone (2019), an ethical dilemma is defined as, "a situation requiring choice between what seem to be two equally desirable or undesirable alternatives; it may also be described as an 'awful feeling of being stuck'" (p.110). Nurses experience ethical dilemmas in different ways, such as having conflict between the practice and the ideal of care, while another may involve a nurse feeling compelled into a situation where they must decide to either compromise or act against the perceived values of the profession. Such conflict among values, norms and interest can cause tensions within the institution which hinders desirable actions. Thus, resolving these seemingly intractable ethical dilemmas often results in compromising personal and professional values, as well as compromising the ability to provide

high-quality and compassionate care, (Haahr, Norlyk, Martinsen, & Dreyer, 2020). As Lillemoen and Pedersen (2013) stated, ethical challenges are common in health care service with a rising interest in their consequences within the field of ethics in health care. It is well known that nurses often encounter ethical issues and dilemmas in medical practice every day, i.e., disagreements between health care workers and patients/families, access to adequate resources, disagreements about end of life treatments, and others (Almoallem et al., 2020; Chen, Lee, Huang, Wang, & Huang, 2018). Some of these issues are common within the Samoan health services, and Samoan nurses face similar concerns frequently. Other scholars mention the dominance of ethical dilemmas in nursing practice that are capable of leading to considerable ethical and moral distress (Huffman & Rittenmeyer, 2012; Rainer, Schneider, & Lorenz, 2018; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014). However, little is known about the necessary guidance to support and help Samoan nurses to address or resolves these ethical dilemmas. Samoa, as a developing country with strong cultural and religious practices, has limited strategies in place to address or resolve ethical challenges in nursing practice. This is especially noticeable when the vast scope of dilemmas varies so much across different cultures and specialities (Almoallem et al., 2020)

Cultural context

The application of good practice can be problematic in the reality of nursing in Samoa due to, for instance, cultural and religious values, limited resources, and shortages of nursing staff. This is exacerbated in part by difficulties in knowing how to best respond to these problems. That is, while Samoan nurses may recognise ethical issues within their practices, the professionally inspired responses that are offered to them to act as appropriate guidelines and protocols, and related ethical concepts are often taught within nursing education, may not be entirely suitable in the Samoan context. These guidelines and protocols are often inspired by internationally focussed ideals, as are the ethical theories and concepts that are taught in the classrooms, as for instance in the widespread use of the ICN Code of Ethics (2012). However, there is a marked degree of conflict between the ethical standards and values that are encouraged and taught in nursing education in Samoa that do not always easily align with cultural values and practice of Fa'asamoa (see later discussion).

My study is inspired through my nursing experience and the Samoan culture. The way Samoans make sense of one's identity and explains why they behave or act in a certain way is called Fa'asamoa (The 'Samoan Way'). Therefore, in order to make sense and understand indigenous behaviour and act accordingly within my chosen topic, and remain mindful of the setting and participants, the fa'asamoa must be integrated in all components of the research. It emphasises the context and process of the research, methods and data collection and particularly the role and relationship between myself as the researcher and the participants. The study's purpose is to explore ethical challenges that nurses face within a Samoan context and how it affects their moral decision-making. This study is therefore influenced by a Samoan inspired research methodology that honours Samoan culture and values, and the participants of the study. The study is important because it provides evidence of how moral decision-making in Samoa differs from Western countries such as New Zealand or Australia. Thus, this study provides new knowledge from a social-cultural perspective to the discourse of nursing ethics that could also be relevant to countries in the Pacific region that have similar social and cultural similarities.

Methodological approach

The decision of selecting a methodological framework and approach for this study was determined by factors such as the sensitivity of the topic of the study, the research question, the context (social and culture) of the study, the participants, and also the position of the researcher herself. The approach was influenced by existing Pacific research models and approaches such as Kakala, Vaka, Ta va, Teu o le Va and Tivaevae that have emerged in education and the social sciences (Vatuvei, 2017). There were also authors such as Anae, (1998); Fairbairn-Dunlop (1998), Meleisea (1992); Mulitalo-Lauta (2000), and Seiuli (2015) who have already used or considered Ietoga and Lalaga as a major aspect of the overall structural approach to research both in writing style and methodology. The Ietoga research framework was used by these authors as the methodological framework with the conceptual framework of Lalaga (or 'weaving') to ensure the cultural appropriateness of the study. Subsequently, in this study, the use of the lalaga concept caters to the research question by weaving together experience and perspectives of Samoan nurses, western research theories and cultural perspectives regarding the ethical challenges of nurses in Samoa. This symbiosis

of both traditionally inspired and contemporary reflective research methodologies is therefore a major aspect of this study

As a result of the previously outlined approach to the research in this study, the use of the *Ietoga* research framework is strengthened by two other conceptual sources of ethical knowledge, namely the Samoan Philosophy of Nursing and *Teu o le Va*. This is a deliberate choice which is designed to safeguard respect, trust and good relationship with participants and enhance the fine art of the 'weaving' experience and perspectives of ethical challenges and discourses in Samoa. This overall design led to utilising a mixed method approach through the use of an overall sequential exploratory design[1] for the research procedures. The methodological research framework of *Ietoga* privileges Samoan, cultural, social, and political values of the research topic, context, and participants (N.B. These major approaches within this research project will be further explained and discussed in greater detail in Chapters Two and Four).

Significance of the study

It is well known that nurses often encounter ethical challenges in their everyday practice, and that these challenges often lead to moral distress for nurses. Researchers from developed countries in the South Pacific region have explored these challenges and generate models, theories or recommendations about ways to address these issues within the nursing profession (Burston & Tuckett, 2013; Woods, 2020; Woods, Rodgers, Towers, & La Grow, 2015). However much less is known about such issues in developing Pacific countries, and there has been very little, if any, ethical analysis of nursing viewpoints and practices in the Pacific region, such as in Samoa, a small Pacific nation and a developing country.

To my knowledge this is the first study undertaken in Samoa that focuses on the ethical challenges that nurses encounters at their workplaces and in practice. Although the topic of ethical challenges is more adequately addressed and researched by western countries, no research has been done in Samoa or any of the Pacific Islands. Ethical issues or challenges

[1] N.B. In this thesis, the terms 'Sequential exploratory design (SED)' and 'Exploratory sequential design' are sometimes used interchangeably. This reflects a trend in the usage of these terms that has occurred within the last decade or so, but basically the research within this thesis is 'Exploratory Sequential Mixed Method Design.'

faced by health care providers differ from one country to another so the research and results from Western countries cannot easily be generalised when applied to the Pacific Islands (Almoallem et al., 2020). There is at least anecdotal evidence that what is happening in Samoa probably applies in many, but perhaps not all, ways in other Pacific countries such as Fiji, Tonga, Papua New Guinea and other island nations displaying similarities with social hierarchical systems. Therefore, this study may possibly shed light on shared ethical challenges that nurses face in the Pacific region, and also perhaps those ethically related challenges that nurses in other countries with similar societal structures, i.e., those with compatible socially and culturally developed backgrounds, may face. The study provides evidence of perspectives and experience that shows quite clearly how ethical knowledge and moral decision-making in Samoa is significantly different from western countries. These differences may be of considerable interest and of relevance to nurse ethicists and nurse educators everywhere.

Thesis content outline

Chapter 2: Contextual Background, the next chapter provides an overview of the setting of the study. This chapter presents a profile of the country of Samoa, outlining demographic, social, cultural and health system information. In addition, this chapter includes a brief history of nursing education and the practice of nursing within a social context that strongly relies on cultural beliefs and practices, especially religious beliefs.

Chapter 3: Literature Review, describes strategies that were used to search for studies in the field of ethics and a nursing ethics discourse. Studies that were later used to discuss gaps and areas that guide the development and arguments within the research are presented. This chapter not only discusses western perspectives of ethics but challenges within the culture, religion and practice of developing countries, and especially developing countries that have a similar context and economic status to Samoa.

Chapter 4: Methodology, outlines the research methodology and methods that enabled the development of new knowledge on the chosen topic. This chapter discusses the philosophical stance that guides the research, the use of the mixed methods research approach by employing sequential exploratory design. This includes a discussion of the Pacific research

framework and Samoan cultural concepts as a conceptual framework with great consideration of ietoga as an adjunct to the overall methodological research approach.

Chapter 5: Qualitative Findings, presents results from the first phase of the study's data collection which is analysis of the one-on-one interviews. These interviews were performed with a selection of key participants and concerned their viewpoints on issues relating to nursing ethics in Samoa. The resulting data were subsequently analysed, and the main themes and sub-themes extracted from that data are presented in this chapter. A discussion of survey development using identified themes from interviews is also included in this chapter.

Chapter 6: Quantitative Findings, outlines result of the second phase of the data collection analysis. The chapter presents the interpretation of results using descriptive analysis, how the data was coded, and a detailed account of the survey sample such as the discussion of demographic and professional characteristics of respondents, professional variables, ethical challenges, Likert scale results and additional comments from respondents.

Chapter 7: Results/Integration, offers the integration of findings from the thematic and descriptive analysis within a conceptual or framework model called the *Sulu* model. The model summarises in detail perspectives and experiences of nurses' ethical knowledge, ethical challenges and ethical decision consideration and approaches in Samoa. This chapter therefore outlines and explains the main aspects of the model and offers an understanding of perspectives and interpretations of Samoan nurses' ethical knowledge and decision making.

Chapter 8: Discussion, detailed the study's key findings and their significance, paying particular attention to those findings that offer an alternative perspective on a type of nursing ethics that is associated with what may be described as a form of 'social ethics'. It also considers the implications of the study, its strength and limitations, as well as the contribution of the study to the existing knowledge of ethical challenges among nurses in Samoa, and by extension, in other Pasifika nations. The discussion therefore adds to contemporary, discourses of nursing ethics in general, and concludes by offering suggestions for future research.

"Ia seu le manu ae tagai i le galu"
"Catch the bird, but watch out for the waves"

Chapter 2: CONTEXTUAL BACKGROUND

Introduction

The ethical challenges that nurses face are well discussed and researched in developed Western countries, but there are few contributions from researchers or research in developing countries. Yet there is a belief that the range of these ethical challenges and dilemmas varies considerably across cultures and specialities (Almoallem et al., 2020). This emphasises the importance of the context of the situation that surrounds participants, which in this case are Samoan nurses. '*Ia seu le manu ae tagai I le galu'* is translated as "catch a bird but watch out for the waves." The proverb tells a tautai (fisherman) to be cautious about the waves when he set over the reef to catch a type of seagull used for baiting. In connection to the researcher and the study, in this chapter, the fisherman (researcher) tried to catch a bird (knowledge, perspective and experience of nurses) over the reef (context) however the researcher needs to watch out for the waves (obstacles of the context and the research topic). Hence, the fisherman (researcher) needs be aware and be cautious of the context and be mindful of obstacles (waves) in the way of the study setting, context, participants and process of the research while exploring and catching new knowledge about ethical challenges in the social cultural context and environment of Samoa. Therefore, the context is particularly important in search for knowledge and gaining understanding that prepares the self for any obstacles along the way of the study. Elliot (1992) discussed that "ethics does not stand apart. It is one thread in the fabric of society, and it is intertwined with others."

This chapter introduces Samoa, the island that was once known by many names such as the Navigator Islands, Pearl of the Pacific, the heart of Polynesia and Cradle of Polynesia. The study presents a brief trip to its unique cultural and system of chiefs that governs and guides its people, the Samoan way of social order, communal lifestyle, and collective society. Included is a detailed discussion of social-cultural etiquette and the influence of religion on a Samoan Self. This chapter also introduces the publicly funded health system which has the main objective of improving the quality of life for all people of Samoa. The nursing history and nursing education in Samoa is included in this chapter.

Historical Background of Samoa

Samoa is a native name of the volcanic islands group in the centre of Polynesia, that were long known as the "Navigator Islands" (Turner, 1884). According to archaeological evidence, settlers from Samoa reached the Marguersas Islands about 300 A.D. and Polynesian settlers spread to Tahiti, New Zealand, Hawaii and Easter Island directly while others went indirectly (M. Meleisea & Meleisea, 1987). As it is known nowadays, Samoa was the 'cradle' of distinctive Polynesian culture. The "Cradle of Polynesia" with Savaii being the legendary island of Hawaii, the original home of Polynesians who later explored the Pacific from Hawaii to Easter Island (Samoa Bureau of Statistic, 2017).

A Dutchman named Jacob Roggerveen in 1722 was the first European who sighted and made brief contact with people of Manu'a (another Samoan island governed by America in the U.S territory of American Samoa). However, it is believed that sailors, whalers, beachcombers, and escaped convicts were the first white people who settled in Samoa, many of whom landed there by chance (Samoa Bureau of Statistic, 2017). Missionaries were the first notable major agents of change in 1830, and subsequently Samoans were quickly converted to Christianity. This was especially the case after the arrival of John Williams of the London Missionary Society in 1830, followed by the arrival of several recognised Methodist and Catholic missionaries.

There was extended interest from countries such as Germany, the United States and Great Britain on the island groups from 1840s onwards that resulted in those countries being able to exert great influence in later years. The growing influence of the larger countries as rivals impacted Samoans (physically, mentally, culturally and spiritually) to seek support from foreign powers which led to the arrival of naval ships from all three nations in 1889 to settle the problems of sovereignty (Samoa Bureau of Statistic, 2017). Later, the German administration announced its official institution in Samoan affairs (i.e., as an administration) in 1900 (Hempenstall, 2016). Despite some initial problems, German governance was relatively stable, and Samoa prospered at the time. However, during the First World War in 1914 New Zealand claimed occupation of Samoa following a suggestion by the British government for New Zealand to act as 'a great and urgent imperial service'. Later in 1919,

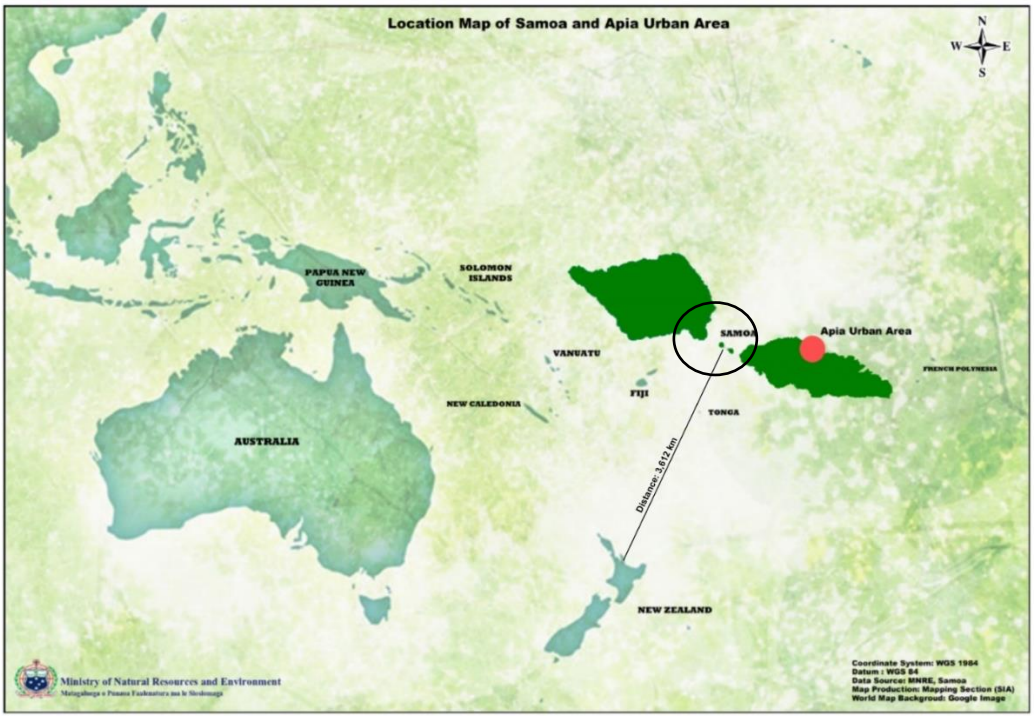
New Zealand received an approval of the 'League of Nations' mandate to administer Samoa (Boyd, 1968).

The New Zealand authorities raised challenges over the years, especially with the matai (chiefs), the traditional leaders who formulate an organisation, establishing a peaceful movement to advocate for independence which was known as the Mau movement. There were failed attempts to crush this movement, but it was recognised as a 'Legitimate Political Party' in 1936 when the Labour party was in power in New Zealand (Samoa Bureau of Statistic, 2017). The preparation for independence transition was started in 1953, and it was obtained in January 1962, thus making Samoa the first independent nation in the South Pacific Island Nations.

Samoa

Samoa was previously known by the name Western Samoa however the word 'Western' was removed from its name in 1997 and it is now known as Samoa. It is a very small independent country that is near Fiji and Tonga in the South Pacific Ocean. The independent state of Samoa is located 2,900 kilometres north from New Zealand and 4,300 kilometres northeast from Australia (Samoa Bureau of Statistic, 2017).

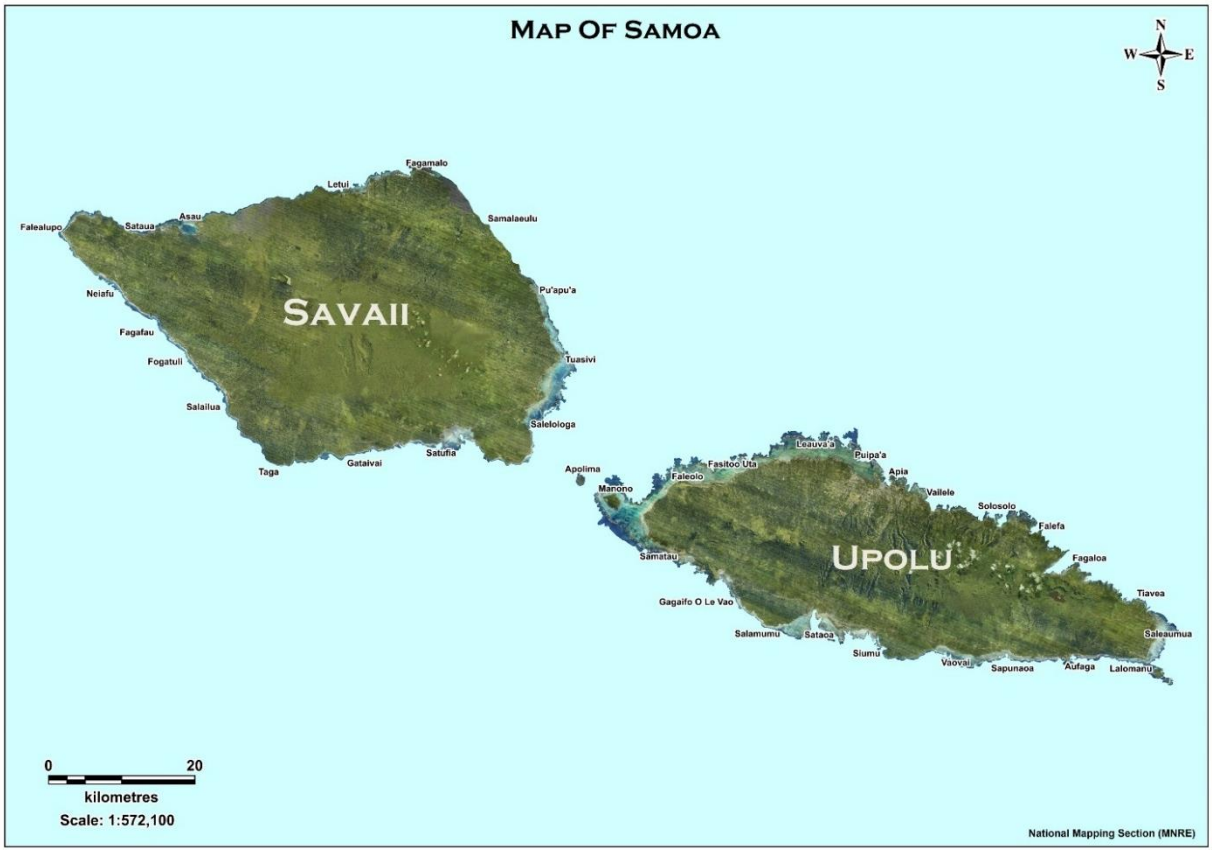
Figure 1: ***Location of Samoa in the South Pacific (a blown-up Map of Samoa)***



Source: Ministry of Natural Resources and Environment, 2020

The islands are of volcanic origin, consisting of two main islands; Savaii, and Upolu; with eight smaller islands: Apolima, Manono, Fanuatapu, Namua, Nuutele, Nuulua, Nuulopa and Nuusafee. Savaii is the largest island with an area of 1,700 square kilometres while Upolu Island is the second largest with an area of 1,100 square kilometres. The main island of Upolu is where the capital city, Apia is situated.

Figure 2: ***Map of Samoa***



Source: Ministry of Natural Resources and Environment, 2020

The total population of Samoa stood at 195,979 as recorded in the population and housing census of 2016 (Samoa Bureau of Statistic, 2017). Upolu has a total population of 151,439 which represents 77 percent of the total population of Samoa. While 22 percent of the population (43,560) resides in Savaii, and 0.5 percent (980) reside in Manono and Apolima islands (Samoa Bureau of Statistic, 2017). Samoan and English are the two official languages used in the country. Samoa has a tropical climate with significant rainfall, the average temperature ranging from 22 to 30 degrees Celsius. There are two major seasons, the wet season - from November to April, and the dry season - from May to October (Samoa Bureau

of Statistic, 2017). Samoa is a developing country with tourism, agriculture, and fishing industries being major drivers of Samoa's economy. However, opportunities for Samoa's development are constrained due to high frequency and intensity of natural disasters and expected risks intensified by climate change as well as small local markets and a degree of detachment from large markets and foreign suppliers (World Bank Group, 2019).

Matai, Aiga ma Nu'u (Chief, Family and Villages)

Samoans, by their customs live in an extended family system that is led by their matai. The matai (a titled man or woman) is appointed by the consensus of the aiga (family) and he or she is the head and chief of the family. There are two distinct types of matai titles, the 'Alii' or high chief and the 'Tulafale' or orator/talking chief. The Alii title is of higher rank and status than the Tulafale title and holds different obligations and responsibilities (M. Meleisea, 1987). The matai titles are the essence of Samoan culture that are bestowed by the extended family and acknowledged by other matai, village councils and districts. The matai serves as the matriarch or patriarch and is responsible for the family (Tavila, 2010). Their position holds responsibilities such as directing the use of family land and other assets that belong to the aiga (Samoa Bureau of Statistic, 2017). In addition, the matai promotes the unity and prestige of the family and manages all aiga affairs. They act as mediator to settle disputes within their aiga, as well as an advocator for family members in village and church activities (Tavila, 2010).

Samoans live a communal lifestyle and operate in a collective society. Aiga or extended family is the central element and primary social unit of Samoan life (Tavila, 2010). The aiga as headed by the matai, consist of many members from parents, children, grandparents, aunts, uncles, and cousins as well as in-laws. Adoption is also common within aiga, with individuals treated the same as genetic family members. Interpretation of aiga (family) in Samoa is not merely a biological group as Europeans would understand the term family to mean (Kerslake, 2010). Instead, the term applies to kin group, shared blood or relatives, extended families that "conceived of as tino e tasi (one body) and toto e tasi (one blood), and principles of tautua (service), fa'alavelave (obligations), alofa (love, compassion), and fa'aaloalo (respect) in kinship relations" (Lilomaiava-Doktor, 2009, p. 7). It was rare during traditional times for families to live as a nuclear unit. Most families lived together with extended family members

which remain the norm in traditional Samoan society, and it is still practised in modern Samoan society today.

Within the family, directions come from the hierarchy of above the age-grade or older towards younger ones, never the other way around. Therefore, the younger members of the family respect and serve those who are older. There is a common saying that is still heard nowadays, within family that is very fundamental, and it guides the conduct of not only the young ones but also applies to someone older which is “Tu i lou tulaga” (Stand at your post). The word tulaga (post) refers both to a position and to a role, within family or village according to one’s status and rank (title). It is a metaphor that is equivalent to behaving respectfully in performing one’s role according to his/her status and rank in the group (Mageo, 1998).

Chiefs of each family join in the council of chiefs (fono) which governs villages (nuu/afioaga) (Fairbairn-Dunlop, 1998). Villages consist of many families with all different ranks of matai titles they hold. The villages are part of wider districts (Kerslake, 2010). Even though Samoan society is based on unequal rank or titles and status, it does not affect the distribution of resources, i.e., everyone has access to food and other important resources such as land. Although there is government and freehold land, the majority of the lands are customary lands (Kerslake, 2010). Fa’asamoa is the social and organisation system that underpins and guides Samoan life.

Aga, Loto ma Amio *(*Persona/Self)

Self as the substance of things, not least the self is indicated by the term Aga in Samoans sociocentric context. Freeman (1984) translated Aga as nature in the sense of essential character that also means persona, a social mask, face, or role. The Samoan term indicates that the person’s roles are constitutive of their nature, but Samoan's interpretation of the term simply means “behaviour.” Also understood as performance that believed to be forming part or existence of the person or thing in question, that makes its character a relating nature of its performance. Thus, aga is a social role or persona that interpreted as the basic aspect of self in Samoa and can also be interpreted as a face one wears. The term persona is an English word that is derived from the Latin word for the masks (and roles) of theatre (Mageo, 1998)

so this expands the meaning of the *aga* to a social role or persona and face or mask/roles that individuals wear and perform within society.

Samoans use of the term aga (persona) suggests that people are role players and role-playing grounds toss a shadow over inner life. It is a vague and generally known as loto, a shadow territory. The loto is a depth of the person that refers to a small deep lake or lagoon within a person. It is a term that has a comprehensive meaning pertaining to any personal thoughts, feelings, and decisions. The loto also inspires all discomforting sentiments such as behaviour resulting from arrogance to envy, to gushes of grief that cannot be accounted for by social roles. Therefore, Mageo (1998) argues that the moral vocabularies are dual, by highlighting the virtue territory and the shadow territory as the source of bad behaviour. Virtue and vice were translated by Pratt as a form of amio. Thus, amio is behaviour that stems from the *loto* that is the individual's own will (Mageo, 1998), while Samoans speak only of behaviour when there is a social consequence (Duranti, 1984).

The society of Samoa is sociocentric and hierarchical, its context is not constituted on relations to the subject but by group type such as peer groups (informal) or hierarchy (formal). The essence of the Samoan formal context, such as ceremonies and the vital virtues of morality *lingo* is the performance of fa'aaloalo (respect) and alofa (generosity), such as one member giving a flattering speech while another makes a generous presentation. These acts symbolically convey these values i.e., flattery and presentation. These act measures are measures of social achievements rather than morality however in the contextual discourse that the culture associates with achievement and public recognition (Mageo, 1998).

Va (Relational Space)

Va means space between, a space that is not empty but a space that relates; a space that holds together distinct entities and things, a space that is contextual, a space that gives meaning to things (Wendt, 1999). Va is also defined as 'distance, a space between two people, places, or things' (Milner 2003). The term brings a mutual respect in a sociopolitical setting that fosters relationships between people, places, and the social environment (Lilomaiava-Doktor, 2009). Accordingly, with different interpretation of Va there are also many natures or types of Va. There is a Va o Tagata that refers to relational space between people; Va fealoai refers to the

protocols of meeting; Va fealofani refers to the brotherly and sisterly love that people should show one another; Va fealoaloa'i, the respectful space and Va tapuaia, the worshipful space (Tuagalu, 2008). Where Lilomaiava-Doktor (2009) refers to Va tapuia as sacred spaces and taboo relationships that established boundaries in sociopolitical and spiritual arrangements. The term Va that refers to Va fealoaloa'i is the social space that arise from the social organisation and differs from Va tapuaia that is a space that stresses on spiritual reasoning for the social organisation (Tuagalu, 2008).

The Va guides appropriate behaviour, acts of reciprocity, and sustained connections and interactions between people and places. Cultural behaviour of propriety and impropriety is characterised by Va. Lilomaiava-Doktor (2009) added food division and distribution, sleeping and sitting arrangements, and the language use in private and public spaces are all being considered through va. The social space remains as a moral imperative that has a profound influence on relationships among Samoans (Lilomaiava-Doktor, 2009). The division of Samoan society (matai (chief), aumaga (untitled men), tamaitai (unmarried ladies), faletua ma tausi (the wives of matai), tamaitai (children) not only have set roles, functions, and obligations of their own but it also determines the relationships in which individuals engage both within and outside their social groupings. The va is determined by the interplay of the roles and functions of the individuals engaging in va relationships. It is in a village context that people know their fa'asinomaga (identity) and learn about the va relationships (Tuagalu, 2008). Relationships in Samoa are holistically considered within the spiritual, social, economic, and political context (Lilomaiava-Doktor, 2009). There is a strong influence of Va or relationship in nursing profession in Samoa, because of its integration in the Samoa Philosophy of Nursing as discussed in chapter 4.

Teu le Va is a well-known Samoan expression that means cherish/nurse/care for the va, the relationships. A crucial aspect in a communal culture that values group unity more than individual (person/creature/thing) in terms of relationships where the meaning can change when the relationship and context changes as well (Wendt, 1999). The Samoan sense of self is relational and communal which are influenced by social space (Lilomaiava-Doktor, 2009). Tamasese et, al (2005) elaborated that an individual does not exist in Samoa but "there is myself and yourself. Through you, my being is contextually meaningful and whole. Through

myself, you are given primacy in light of our collective identity and fa'asinomaga (places of belonging), our genealogy tupu'aga (lineage), and our roles and responsibilities and tofiga (heritage)" (p. 28). Va is a way of thinking about self, identity, and place. In the connecting web of social networks, institutions, and cultural ideologies however, the Va spiritual, cultural, economic, political, and social implications also gives consideration to place, legitimacy, and belonging (Lilomaiava-Doktor, 2009).

Tapu (Sacred/Taboo)

Tapu is a Polynesian term that generally means both 'sacred' and 'taboo.' Tapu has a sacred essence which is why it is taboo. A sacred essence underpins man's relation with all things, i.e., the gods, the cosmos, the environment, other men, and self (Efi, 2007). Tapu is believed to permeate through different dimensions of Samoan life from pathways to land and light, to village and entities such as chiefs due to its common occurrence. The awareness of the connectedness and sacredness of all things and their origins makes people responsible and take responsibility to protect, respect and appreciate without presuming to know God (Plessis & Fairbairn-Dunlop, 2009). The term Va tapuia that has its roots in the word tapu refers to the sacred (tapu-ia) relationship *(*va) between man and all living and non-living things. The sacred relation between all things encompasses all Samoan indigenous people where hereditary relationships are drawn to all things living or dead (Efi, 2007). Therefore, pursuing knowledge involves collective decision making and relational thinking thereby recognising human vulnerability, humility and a strong sense of equality and empathy in relation to all things living or dead (Du Plessis & Fairbairn-Dunlop, 2009). The approach therefore requires attention to sacred or tapu parts of relatedness.

Faamatai (Matai System)

The faamatai is a conceptual division that some call the 'sociometric wheel' that Samoan society turns to. It sets an individual in their 'place' based on the rights and duties of each within a collective, rather than individualistic, society. For instance, men's responsibilities are often to look into political affairs, defence and warfare and food production whereas women are mainly focused on moral authority, ceremony, and hospitality (P. S. Meleisea, 1979; Schoeffel, 1999). Thus, each of the five organisations, i.e., chiefs and orators (matai), wives of chiefs and orators (faletua ma tausi), untitled men of the village (aumaga), ladies of the village

(tamaitai) and children (tamaiti), are important to Samoan society, and each must fulfil their responsibilities according to roles of the faamatai. This concept as it is applied to family is also exercised in the institution of the village fono. The men of the village are termed aumaga (untitled men) whereas the women of the village are the faletua ma tausi (Fairbairn-Dunlop, 1998). Differing from most parts of Polynesia, Samoan society's social and cultural institutions are strong and more intact. Its village government system is well-organised and coherent and is the focal point of a network of social relationships that provide honour and prestige to its members (Samoa Bureau of Statistic, 2017). As a system of authority, the fa'amatai is of greatest significance to the fa'asamoa which is very difficult to challenge and would be even more difficult to change. As it was argued by Meleisea in 1987, there could be an acceptance and incorporation of new practices, ideas, and knowledge into this system, but its fundamental premise remains unchanged (Tavila, 2010). Therefore, the faamatai is still an integral part of the modern government system of Samoa (Tui Atua, 2009).

Fa'asamoa (the Samoan Way)

The term 'fa'asamoa' translated into English as *'the Samoa Way'* has been interestingly discussed and explained by many authors and it will be of considerable importance in this thesis. It is a term that was referred by (Kallen, 1982) as a phenomenon, a complete worldview, a way of life, a valued heritage, and a set of structured principles of social life order in Samoa. It is the way that a Samoan makes sense of one's identity and it defines why they behave or act in a certain way (Mulitalo-Lauta, 2000). Fa'asamoa is an expression that reflects language, identity, beliefs, values, and traditions of who Samoan people are and what they do. Tagaloa (2010) describes fa'asamoa as a social interconnected web. Mulitalo-Lauta (2000) stated that fa'asamoa is a strong bond that links and holds people of Samoa through the generations, to their culture, including alofa (love), fa'aaloalo (respect) and their aiga (family) or nu'u (village). According to Efi Tui Atua (2009) alofa and reciprocity continually drives fa'asamoa across generations. It is the foundation of the Samoan worldview that is directed by traditions and culture (tu ma aganu'u). Fa'asamoa revolves around native traditions such as the chief (matai) system, religious belief (talitonuga), dietary habits (mea'ai), and family or a village's fa'alavelave (social functions/obligations) such as funerals, weddings, and bestow ceremonies (saofa'i) (Puaina, Aga, Pouesi, & Hubbell, 2008). In addition, Anae (2016) added

that Samoan people's display of hospitality or love is one of their key values by providing food and gifts during celebrations or occasions illustrating their tu ma aganu'u.

The fa'asamoa or the Samoa Way is used to govern family and village life, it is a social and organisational system that is ruled by chiefs and is based on rights and obligations of all members of the family with shared rights to family resources such as land and family titles. Thus, members of the family will use and work the social system to achieve goodness for the wider family (Fairbairn-Dunlop, 1998). The fa'asamoa or the Samoan Way places a great emphasis on the group's dignity and collective achievement rather than on individual members (Samoa Bureau of Statistic, 2017). Division of power, status, labour, and expectation is what the system is built on, but the main force of motivation is protecting the status of the family. The expectation that is built on rank and precedence is determined by daily behaviour which is symbolised by their tautua (service) and mamalu (respect) (Fairbairn-Dunlop, 1998). The chief is the head of the family, who represents the honour and esteem of the family. Essentially, this aspect of the fa'asamoa links back to the belief of the creator deity that is the authority and control of chiefly power, the combination of human and supernatural. Features of sacred and secular are still seen nowadays, where chiefs are served by those who are untitled, and sisters are protected by brothers (Fairbairn-Dunlop, 1998).

The relationship and obedience to authority is important in Samoan structures, where appropriate guarding is equivalent to moral conduct. The guideline for behaviour starting from early in life, is simply obeying parents and elders in the aiga (family). The standards of conduct are not equally applied to all in Samoa. However, questioning any actions or someone of a higher rank or status is considered impolite. Therefore, aiding children by teaching proper social conduct by giving more practice in service and following instructions without questions, and by whipping if failing to obey is the sense of alofa (love) in Samoan beliefs (Mageo, 1998). When it comes to evaluating someone, who has done wrong, attitude plays a major role unlike in western culture where the driving force is motive. Whether the deed is serious or small, motive is more important in western culture, however in Samoan culture, attitude of the person who did something wrong is vital. These different interpretations of what is wrong branch from the differences of identity between western and Samoan culture. It is believed that western identity is based on *ego*, an idea of oneself as a unique person, apart from others

(Freud, 1961) and ego is constructed from the inner world of the subject. These subjective inner events, such as motive, are considered to be fundamental. Whereas, Samoan identity is based on *persona* or self-image according to Jung theory (1966). This derives social relations where social events, such as attitude is all important (Mageo, 1998).

Religion

Samoa was referred to by outside observers, the Rarotongans (fellow Pacific islanders) as 'Godless Samoa' because there was no sign of an established or formalised religion such as temples, idols or a powerful priesthood when the pioneer missionary John Williams reached Samoa in 1830. However, Samoa in fact had an established religion which was polytheistic in character (Palenapa, 1993). Samoans believed in three types of gods/deities which were Atua[2], Aitu[3] and Tupua[4]. Atua was the supreme Tagaloa (creator of the universe, earth and humanity). However, Aitu was more than one god. It was believed that every Samoan would come under the protection of a particular aitu from birth, meaning each person had their own aitu. The matai as believed to be the descendant of Tagaloa, and therefore played a significant role as a family mediator for the gods and decision maker in family matters. It symbolised the close affinity that existed between the secular sphere and the religious sphere in Samoans lives before Christianity, which to some extent, still exists nowadays (Palenapa, 1993).

Religion plays a vital role in Samoan life and it is both sacred and secular, which clearly portrays strong faith in the Samoan motto 'Faavae I le Atua Samoa' that translates as 'Samoa is founded on God'. The majority of the people are strong believers in the Christian faith (Samoa Bureau of Statistic, 2017) largely because Christianity was wisely integrated within the fa'asamoa by missionaries, an approach that included matais' assistance in spreading the gospel around villages. There were many Samoan ministries by the late nineteenth century and their deliverance of the 'good news' was in accord with the fa'asamoa (the Samoan way) (Mageo, 1998). Thus, appointing the matai as deacons and traditional leaders of the church extended

[2] a superior non-human origin, Tagaloa a supreme Atua, resided either in the *Lagi* (the heavens) or in Pulotu (the afterworld)
[3] human origin and usually took the form of animals, birds, humans or often natural objects, i.e., war-gods, family-gods, tutelar deities (various trades and employment)
[4] deified spirits of dead chiefs or deceased persons of high rank, the duty was usually conducted by the matai (chief). It was believed that matai was Tagaloa's descendant.

their leadership not only socially and politically but also religiously. Indeed, the core success of the missionaries work in Samoa was the inclusion of matai in the advent of the ministry. Christianity has therefore been part of the social structure of Samoa and has had a profound cultural, educational and religious impact on the lives of its people (Tavila, 2010).

Health care system of Samoa

The health care system of Samoa is made up of public and private health sectors that include public and private-sector practitioners, dentists, pharmacists, alternative therapists, physiotherapists, traditional healers, and traditional birth attendants. Non-government organisations (NGOs), academic institutions, community-based organisations, and development partners also play a role in providing health care services. The Samoan health service is publicly funded, and the main objective of the health system is to improve the quality of life for all people of Samoa (Samoa Bureau of Statistic, 2017). This reflects Samoa's value of health, as a critical component of well-being and quality of life and ensures that it remains a priority area of social policies with one of its outcomes being 'A Healthy Samoa and Well-Being Promoted' (World Bank Group, 2019)

Samoa has recorded the highest life expectancy and the lowest infant mortality rates in the Pacific, progressively improving on health outcome indicators in the past three decades (World Bank Group, 2019). Life expectancy has increased from 65 years in 1990 to 75 years in 2015, where women had a life expectancy of 78 years, compared to men at 71 years. The mortality rate for under-five year olds, declined from 37 per 1,000 live births in 1985 to 18 per 1,000 in 2015. The infant mortality rate has halved since 1985, down to 15 per 1,000 live births in 2015 (World Bank Group, 2019). In general, these indicators are favourable outcomes for the country's income level compared to East Asia and the Pacific region. However, compared to Pacific Island Countries, these outcomes are average overall (World Bank Group, 2019). Yet regardless of the health outcomes being optimistic; Samoa faces challenges in relation to the millennium development goals agenda for immunisation and non-communicable disease (NCDs). The rate of immunisation of 68 percent of the population is still below full coverage (World Bank Group, 2019). The pattern of morbidity and mortality identified an increasing number of NCD (non-communicable disease) diagnoses becoming the top cause of mortality. This resulted in a total disease burden of 75 percent in 2016 and more than half of all

premature deaths in Samoa. In addition, a major driver of overseas medical treatment and diseases such as diabetes, ischemic heart disease, cardiovascular disease, asthma, chronic obstructive pulmonary disease, and cancer are major NCDs that are affecting Samoa (World Bank Group, 2019).

Health care reforms

In the late 1990s the Samoa Ministry of Health undertook a number of health care reforms. There reforms focused on national policies and strategic plan development, financing health care, resources of allocation and strengthening refurbishments and institutions. The National Health Service (NHS) was established in July 2006, one result from the health sector reforms. The newly developed National Health Service took over the health care service delivery except for health promotion and prevention services. The reforms directed National Health Service (NHS) plans to manage urban and rural areas. While the Ministry of Health primarily looks at strategic roles of regulating and monitoring the health sector, strategies such as setting policy directions, establishing health services standards, and assuring health promotion and preventive service. The reforms shift the focus from operational management of the public health service to providing overarching strategic leadership in the health sector. A national plan was formulated to strengthen partnership with various health sectors, including formal and informal private health sectors, the community-based organisation, Non-Governmental Organisations, the Ministry of Health, and other governmental ministries (Samoa Bureau of Statistic, 2017).

However, it was argued that the separation of Ministry of Health (MOH) and National Health Service (NHS) decades ago actually weakened the focus on public health and primary care and added intensified constraints on human resources (World Bank Group, 2019). For instance, the separation of medical treatment and public health services as well as nurses and doctors resulted in poor team coordination of care delivery. Health was facing challenges of increasing rate of Non-Communicable Disease prevalence which leads to mortality rates amongst young people, increasing cost of corporate structures and fragile public health. These are some of the reasons that overall, shed light on the need for more focus on primary and secondary preventative care than the focus on inpatient and curative care. In response, the Government of Samoa has recently taken the critical step of merging the MOH and NHS together, which is

now regarded as a landmark reform. Therefore, on the 29 January 2019, the Samoa Parliament passed the Ministry of Health Amendment Act, 2019 (Amendment Act) which legally constituted the merger (World Bank Group, 2019).

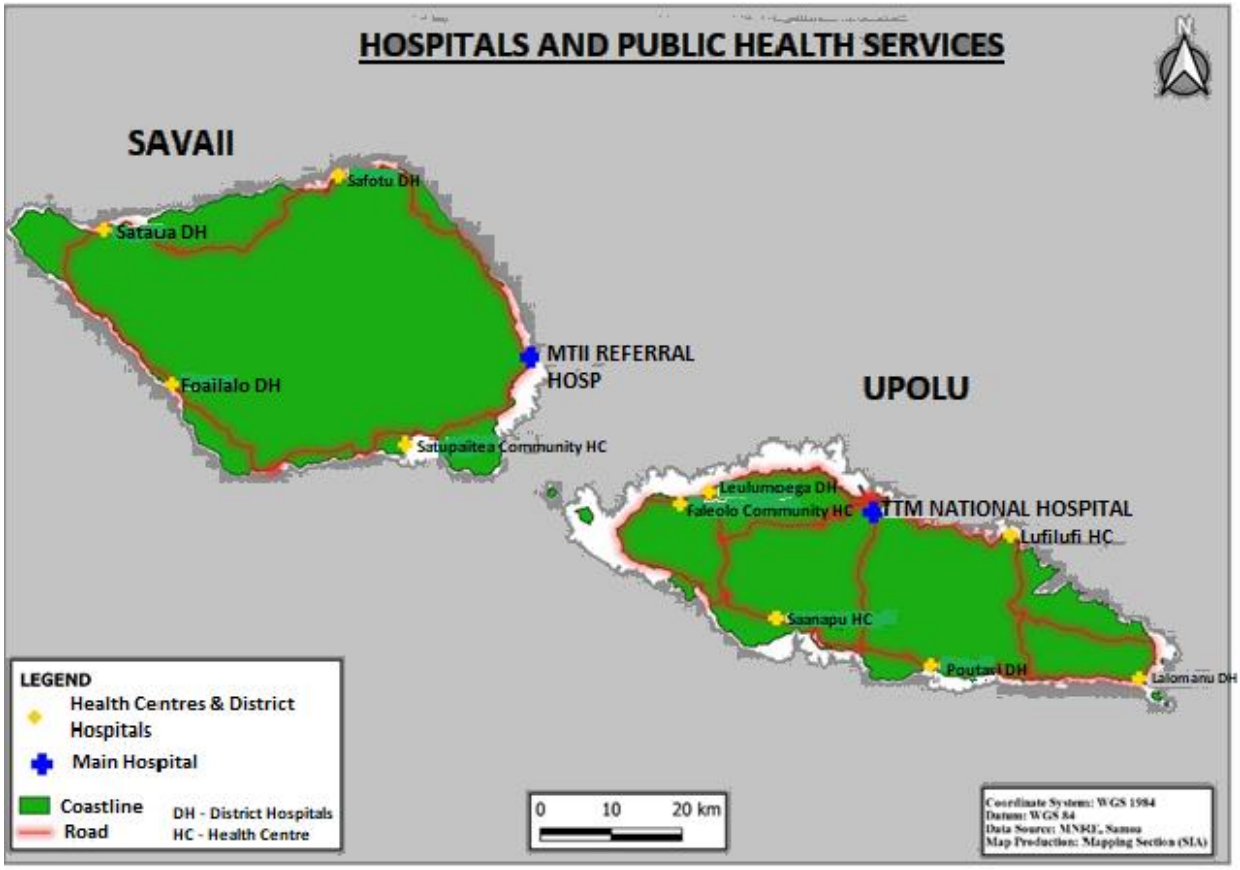
The Samoan health service delivery system

In Samoa, there are three levels of health care service, Primary, Secondary and Tertiary. The primary health care service focuses on prevention of disease, antenatal care, delivery assistance and family planning services that are delivered by district hospitals (World Bank Group, 2019). The district hospitals operate 24 hours and 7 days a week delivering services such as outpatients' clinics, inpatients treatments, and emergency services; antenatal, postnatal, and delivery services; family planning services; immunisation services; community and school outreach program; home care and home visits for directly observed short courses treatment (World Bank Group, 2019). However, the community health centres also provide outpatient clinics, emergency services, antenatal and postnatal services, family planning services and immunisation services. The community health service operates from two to five days a week which varies between facilities but are only open during standard business hours (World Bank Group, 2019).

The secondary health care service tier is provided by the national hospital called Tupua Tamasese Meaole hospital (TTM) located on Upolu Island and Malietoa Tanumafili II (MTII) on the island of Savaii (as indicated by blue crosses on both islands in the map see figure 3). Secondary health care service focusses on diagnosis and treatment at TTM and MTII as well as for patients' dialysis treatment at the Samoa National Kidney Foundation (Samoa Bureau of Statistic, 2017). The location of these primary and secondary level health care services is illustrated in Figure 3.

Samoa has two referral hospitals; the main national referral hospital is Tupua Tamasese Meaole (TTM) hospital, located in Apia, Upolu and Malietoa Tanumafili II (MTII) hospital located in Savaii Island as mentioned above. There are eleven rural health facilities including six district hospitals (three on Upolu Island and three on Savaii Island) and five community health centres (three on Upolu Island and two on Savaii Island). The locations of rural health facilities were strategically sited according to population size and distance (See Figure 3).

Figure 3: ***Hospitals and Public Health Service in Samoa***



Source: Mapping Section of the Ministry of Natural Resources and Environment, 2020.

Contracted hospitals in New Zealand and Australia provide the tertiary level health care service required, through Samoa's Overseas Medical Treatment Scheme (SOMTS). The government of Samoa developed this initiative to facilitate Samoan's access to required medical services that are not available in Samoa (Samoa Bureau of Statistic, 2017). However, despite having both primary and secondary services, Samoa's current health care service delivery system is heavily centred around the two referral hospitals which has resulted in patients ignoring the primary health care (PHC) delivered by district hospitals and overcrowding the main national referral hospital in Apia (World Bank Group, 2019). This phenomenon reveals a series of challenges in the service delivery system that have a significant impact on nurse's professional and moral ability to provide quality care. Contributing to this is the lack of drugs at primary health care facilities, availability and inflated cost of drugs, disruption of clinical service access, limited numbers and health care personnel that delays provision of care and concentrated numbers of doctors at hospital levels (Fraser-

Hurt et al., 2020). These challenges affect nurses' ability to do good and limits care provision and attention to health in Samoa.

The majority of resources such as personnel, equipment, supplies, infrastructure, and vehicles are mostly allocated to the TTM national hospital leaving the primary health care facilities under resourced and short-staffed. There is an insufficient number of staff to cater to the increasing number of the population as well as the uneven distribution of staff to facility in rural areas. Most of the doctors are concentrated in the main hospital in Apia while the other eleven health facilities are staffed predominately by nurses. There is an estimation of 400 nurses in Samoa while the number of doctors is less than 100 however physicians from the main referral hospitals visit most of the district hospitals although infrequently. In rural health facilities, there is a lack of basic infrastructure, diagnostic equipment, and competencies which leads to poor capacity to diagnose and manage chronic NCDs. For instance, all laboratory samples for testing and final diagnosis are actually transported to the main hospital by the visiting physician. The shortage of staff at the primary care level impacts the rural district hospitals' abilities to identify NCD cases, provide consultation and treatment, as well as necessary health education services for the patient and prevention (World Bank Group, 2019).

The history of nursing in Samoa

Development of Nursing

The first national hospital was built and staffed by the Germans in 1912 during the German administration (Stanley, 2004). The hospital was formally known as the Government Hospital, Apia, where nursing training started in 1917 with four female students aged twelve and fourteen recruited from the Papauta Girls School (Maiava, 2019). Nurse training and coaching on the job were conducted by few doctors who also had to work around the clock to attend to their patients. This arrangement was clearly insufficient, and the New Zealand administration at that time brought over nurses and doctors from New Zealand to work and staff the hospital. Furthermore, the occurrence of the influenza epidemic that spread and killed many people in Samoa in 1918 highlighted the importance of having local nurses and motivated the movement to train more local nurses. This development showed the commitment of the New Zealand administration to develop primary health care within Samoa.

As a result, health departments were set up as well as a nursing school (Mataia-Milo, 2017; Schoeffel, 1978). The first significant milestone of nursing development in Samoa came when the first four locally qualified students that started nursing training graduated and became the first western Samoan trained nurses in 1921 (Barclay et al., 1998). After the Mau movement (a local revolutionary movement for independence in 1928) and World War Two began in 1939, the first Samoan public health nurse was appointed in the 1930s to work in health education with the women's health committees. This initiative was started by one of the first Samoan medical graduates who organised women's associations in villages to promote environmental sanitation and maternal and child health program (Schoeffel, 1984). By the year 1940, all villages of Samoa had a women's committee as explained in the latter part of discussion of this chapter. The Western Samoa Nurses Association (WSNA) was later established in 1952, with the aim of looking after the collective nurses' welfare. In 1953, the first Samoan nurse trained and registered in New Zealand and returned to serve in Samoa. The nursing staff went on strike over staff reductions and remuneration in 1956. Fiji accepted the Samoan-trained nurses for the first time in 1960, to undertake nursing training in Fiji (Barclay et al., 1998).

The New Zealand era of administration ended in 1965. 'Samoanisation' of Nursing then began under the leadership of Martha Lam, a Samoan nurse who went on to become the first Samoan matron of Apia National Hospital (Maiava, 2019). Furthermore, in the same year, the Western Samoa Nurses Association worked on developing its own nurses' constitution which was passed in Parliament as the Western Samoan Nurses Act in April of 1969. Another important historical development in Samoan Nursing happened in August of the same year when the Board of Nursing was established, and a position of Superintendent of Nursing was created. At the same time a Division of Nursing was established in the Health Department (Barclay et al., 1998). There was a categorisation of the Nursing division made in 1973, dividing the division into three sections: National Hospital Nursing Service, Public Health, and District Nursing Services; and a School of Nursing. The Two of the divisions already had candidates to fill positions however the principal of the nursing school was appointed later in 1974. Developments within nursing escalated in 1974 when nurses went on strike to gain recognition of their midwifery status and demand better work conditions (Barclay et al., 1998).

The Western Samoa Nurses Association developed international affiliations and became a member of the Commonwealth Nurses Federation in 1975, and International Council of Nurses (ICN) in 1977 and were admitted to these bodies during the Tokyo Congress. Development continued with the first midwifery course that was offered in the same year (1977) for local midwives. In 1980, the first Director of Nursing was appointed, an American registered nurse, followed by the development of the first official career and salary structure for nurses in 1981. A local registered nurse took over the position of Director of Nursing in 1981 and the appointment was officially formalised in 1983. There was a separation of the Department of Health into two separate Ministries, in 2001 to 2002, which had a significant impact on the structural and organisational status of nursing leadership and authority. However, nursing leaders came together in 2007 to review the Nursing and Midwifery Act. The Samoan Nurses Association celebrated its 100 years of nursing in Samoa in 2017. In 2019, a brief ground-breaking ceremony was held for the construction of the Nurses Hall during the Memorial Ceremony for those who died in the 1918 Influenza Epidemic and a plan for building of new hall for the Samoa Nurses Association in 2020 was announced.

The history of Samoan nursing is a story of courage, determination, and immense achievements. Over many years, nurses fought for equality of educational opportunities, salaries and better working conditions. These struggles culminated in one of the most significant strikes and marches to parliament by nurses in 1988 for nursing education. Through their persistence and commitment, the Samoan nurses succeeded in bringing about changes to their level of professional development and as a result of their higher education, to the delivery of health care in Samoa (Maiava, 2019).

Komiti tumama and primary health care

The program called Komiti Tumama (cleanliness committees) brought together the three female status groups recognised in Samoan village organisation: the aualuma, (female members of the village descent group), the faletua ma tausi (in-laws marrying wives of chiefs and orators), and lastly, ava taulelea (wives of untitled men). Women health committees were formulated by women in villages, and they were called a 'Komiti Tumama' (a cleanliness committee). The original task of the committee was to organise grass cutting and weeding at a specific dwelling, collecting and removal of rubbish i.e., breeding grounds for flies and

mosquitoes. There are sub-committees within these committees that carry out inspection tours of the village to checks on dwellings' conditions and hygiene i.e., proper thatching on houses, good conditions of blinds, households' cleanliness (free of weeds and rubbish), households adequate kitchen utensils, sheets, linens', towels, mats, and mosquito nets for the family, and that each possesses a proper latrine. The committee also has the responsibility for guarding the village drinking and bathing water supplies from the village springs and bathing pools. Monitoring the use of the water and ensuring that the water is not polluted by people or rubbish (Schoeffel, 1984).

The Komiti Tumama (Women's committee) further extended their function into more multi-functional institution by absorbing the aualuma roles within the village, the utilitarian and fundraising activities of the church's wives, and a variety of new functions such as fundraising activities for community projects and maintenance of community facilities i.e., district hospitals and schools, village piped water supplies, the churches, electricity generators, pastors' houses, and women's meeting houses. Every Samoan village had a women's committee by the year 1940. Therefore, women committees' functions and activities that target a great population varies from one village to another (Schoeffel, 1984).

However, the most important function of the women's committee is organising monthly clinics for pregnant women and children's health assessments. Check-ups, immunisation program and appropriate treatment take place under the care of a district public health nurse. The planning of primary health care in Samoan villages has been worked around the district hospital and nursing station networks where both curative and medical services, follow up and stand by services are available to the public. The health nursing staffs uses these facilities (district hospitals) as an operational base to work and prepared their monthly visits to villages committees. The public health nurses enable the committees to undertake most of the primary health care fundamental work by guiding, educating and encouraging or advising village women's committees on health matters. The initiative has been a highly effective approach hence, already well-established traditions and customs were used to build the backbone of Samoan primary health care. Primary health care in Samoa is not seen as a modern agent but a cultural institution that is deeply rooted in the pattern of life the same as the Council of Chiefs and Christian churches (Schoeffel, 1984). The majority of nurses at the

time (1978) were between 40 and 60 years old and claimed to be well respected due to their rank in their home villages and were experts in Samoan etiquette and ways of communication (Schoeffel, 1984). This appears to be lacking nowadays in nurses and needs to be strongly emphasised and encouraged.

Hospital-based training (under New Zealand administration)

The hospital-based training of nurses was based on the main concept of caring for an individual (Individualised caring) (Maiava, 2020). There was a set entry criterion for the nursing school during the New Zealand administration with criteria such as the minimum of achieving lower five which is equivalent to year 11 in school nowadays, two references to be provided, one from a church leader and one from any person of the family or village and an interview to determines passing rate. There were two intakes per year into the nursing program under the old curriculum, therefore once the student passed the first entry criteria stage, then they would be added in the next intake of the nursing class either in January or June of the same year (Maiava, 2020).

The program was a three-year program that began with three months orientation to nursing training. Within these three months, a basic introductory course was taught including principles of practice and anatomy of the human body. It was claimed that many nurses dropped out from this preliminary period. After three months in the preliminary class, then there was a six-month period of each classes (Maiava, 2020). The preliminary class together with the following six-month period is considered to be the first-year students of nursing. It was an intensive theory period, meaning students were just in the classroom receiving theoretical teaching with no shift work or practical elements. This first year was followed by a final theory exam. There followed two periods of education each comprising six months that made up the second year, with another final exam after six months and a demanding practice component at the hospital, scheduled as shift work with salary. The third-year class also had two six months blocks, but at the end of the first of these, there was a state final examination on theory set by nurse educators that determined the student's progression into the next and final period of education. There was another final exam after this, that was set by nurses in practice because it was based on testing practical skills (Tapuvae, 2020).

The curriculum that was used at the time was formulated by the nursing educators during the New Zealand administration. Thus, most of the nursing educators were Europeans of New Zealand origin, and there was an emphasis on mirroring the New Zealand methods of nurse education, i.e., the implementation of medical models and content that was mostly disease driven, at the time. Teaching was therefore based more on empirical knowledge with little emphasis on humanities or social sciences, including subjects such as ethics and law. The theory-based teaching only made up 30 percent of the education period and 70 percent of the nursing training was clinical hours of practice. After completion of preliminary class, the student nurse took shift work at the hospital and got paid fortnightly by the Ministry of Health (Maiava, 2020). Hence, during the hospital-based training, ethics was integrated into aspects relating to performing nursing procedures, but not taught as a theoretically separate topic. This approach was strongly supported going into the clinical environment with the belief of practicing the ethical component alongside practice. Furthermore, in the hospital-based training, which was a westernised approach, there was no integration of culture in teaching and training. However, cultural understanding was expected of students and nurses when talking to patients, especially in rural areas, communities, and villages during home care services (Tapuvae, 2020).

Nursing education in Samoa

Development of nursing education

It has been 104 years since nursing education was established in Samoa. The training for nurses started in 1917, initially under German administration with four young girls from Papauta School as mentioned earlier. The education was delivered by doctors at their available times for two or three hours a day. Training was on measuring temperature, blood pressure and other basic nursing tasks, all of which were task oriented to cater for the given needs of the service at that time. From 1917 to 1965, nurses were trained under the New Zealand Administration, which was more on western ideas of nursing training. It eventually took 56 years for Samoan nursing leaders to take over nursing education which resulted in both hospital-based training and a higher education level of nursing tutelage period in Samoa.

Nursing training, as it was then known, was continued by western leaders until 1965 when local nurses, trained overseas, returned, and served in Samoa. This is known as the beginning of the Samoanisation of nursing leadership after the first New Zealand trained Samoan nurses returned to serve their country. However, even with the shift of leadership in 1965, the nursing education was still hospital-based training until 1992. The focus of educational development of nurses was noticed in 1983, which resulted in offering the first basic community health nursing program. In 1985, the first locally trained Samoan nurses were accepted to undertake the Advanced Diploma of Nursing course in New Zealand leading up to Samoa hosting the South Pacific Nurses Forum Conference in 1986 (Barclay et al., 1998).

More emphasis on nursing education was strengthened when nurses marched on strike again in 1988, standing and marching together to Parliament, lobbying for nurses' educational development. This movement resulted in curriculum preparation for tertiary level education for nurses and ended the three years hospital-based program with the last intake in 1989. Later in November of the same year, the Director of Nursing and the President of Samoa Nursing Association (previously called Western Samoa Nursing Association) were reinstated and returned to work. Flinders University in Australia assisted in the preparation of the curriculum and provided nurse lecturers through distance education (Barclay et al., 1998). Opportunity was offered not only by distance education but also from Flinders lecturers visiting Samoa for practical lectures and coaching local nurse educators to be nurse lecturers. There were five students who first enrolled in the Bachelor of Nursing in Samoa and the last group of nurses trained under the hospital-based program graduated in 1992. In 1992 local nurses' leaders of the nursing division planned and prepared to elevate nursing education from hospital based to a university level of education. The transition to the National University of Samoa changed the focus on nursing to a higher education of nurses with a family-oriented and more culturally responsive approach to deliver nursing care. It was not an easy transition with curriculum and staff preparation. The initial suggestion to the National University of Samoa was for the nursing program to start with the Bachelor of Nursing however, the National University did not approve the request but instead began with an offer of a Diploma in Nursing. Therefore, the first intake to this nursing program was with the Diploma in Nursing in 1994.

The Diploma in Nursing involved a four-year period of training and preparation for lecturers. The Faculty of Nursing was officially established in the following year in December 1995, under the National University of Samoa in December. Followed by the establishment of the first orientation program in 1998, a one-year program for new nurses who just finished training from the University (Maiava 2020). During the second year of the program, the Faculty of Nursing was officially established in 1995 also under the National University of Samoa. This followed by the establishment of the first orientation program in 1998, a one-year program for new nurses who just finished training at the university. This was a practical one-year period for nurses to train as a staff nurse before gaining his or her registration as a registered nurse to be able to work as a nurse in Samoa.

Development within nursing education was strengthened with an official launching of the 'Grow your Own' initiative in 2018. This new program was designed to provide opportunities for nurses to pursue higher educational studies in collaboration by a Memorandum of Understanding between Victoria University of Wellington, New Zealand, and the National University of Samoa. With all the development for nursing education, the implementation phase of the merge between the National Health Service and the Ministry of Health in 2018, impacted on the structural, organisational and leadership in nursing. The Nursing structure within the health system altered the leadership position and roles, functions and responsibilities within the organisational structure.

Transition to university level of nursing education (under Samoa leaders)

The transition of nursing education to university level, not only involved changing the setting and curriculum but also the approach and focus of nursing education and practice. The focus was shifted from individualised caring to a collective approach, or as it was called, a family focuses approach, and (finally) the inclusion of the Samoan culture. The innovative approach used a participatory model with definitions of person, community and environment taken from the Samoan Philosophy of Nursing. The Samoa Philosophy of Nursing (discussed in chapter 4) is a family focused structure that was integrated with the conceptual framework (Figure 5) to create the current curriculum in nursing education (Maiava, 2020). A noticeable difference and positive aspect of this framework was acknowledging and allowing family members to help with the care, something that was hitherto not usually considered. The

University curriculum of higher education for nurses was not the same as the hospital-based training, where the classroom hours are 70 percent of the entire curriculum, and only 30 percent was allocated for clinical practical hours. The program is sponsored by the Ministry of Health with financial assistance provided for students, with the expectation of shift work only after completing three years of the training or degree.

In 1989, the Nursing Regional Adviser for the World Health Organisation in the Western Pacific Region sent a Malaysian consultant to assist Samoa with developing the curriculum. When the newly developed curriculum was presented to Samoan nurses it was believed that the consultant did not consult or collaborate with any nurse. The consultant wrote the curriculum at the time most senior nurses and respected nurses were on suspension and it was completed without most seniors and respected nurses' input or review. The curriculum document was not approved and rejected by local nursing leaders with the belief that "it was not theirs." The curriculum presents old training curriculum components and there were no views or input of local nurses in the document (Barclay et al, 1998). There was a hope of change and integration of culture in the curriculum review however the consultant failed to identify and address it.

The Samoan nurses strongly believed that the curriculum should be based on the integration of the Samoan way of life and the model of health care. As the curriculum was still designed around a western curative model of illness and disease it contradicted with the requirement of integrating fa'asamoa (culture) to the development of nursing in Samoa (Maiava, 2020). A nurse expert from Australia helped local nursing leaders with the development of the new curriculum which captures fa'asamoa and was accepted by the Samoan nurses as it was based on Samoans' understanding of health and care.

In preparation for the transition of nursing training to the new curriculum, new intakes were on hold for five years (1992 – 1997) which further impacted on the industry shortage. Reduced intake followed later that resulted in severe shortages of nurses while at the same time older nurses retired from the profession every year but there was no output from nursing education for nurses. Thirty years after nursing education moved to the National University of Samoa, there was a shortage of nursing output for recruitment to the service. Some of the reasons

were due to the entry criteria and migration factors, making the intake numbers low and the drains of qualified local nurses moving overseas for a better future.

The decreased number of nurses output from the nursing school and general shortage led to closing of some sub centers around Samoa. The 2008 intake to nursing education, was the biggest class of 30 students since the transition, followed by the intake in 2013 started an increase, which in turn started to stabilise some areas of the nursing service however there is still a need for more nurses (Maiava, 2020). The severe shortage of nurses was the major ethical challenge resulting in the introduction of long working hours (12 hours shift) for nurses, that led to overworked nurses, potential burnout, and unsafe practices. Nurses are currently much more aware of ethical principles and challenges than during the old curriculum. The nursing education and practice is believed to be getting better; the number of students entering nursing education has increasing since 2013; and the quality is improving in terms of knowledge and practice (Maiava, 2020).

Nursing education curriculum change: New era

During the transition period of nursing education to the National University of Samoa, the new curriculum was widely accepted as an appropriate framework for nursing education as it was based on fa'asamoa understanding of health and care. It was claimed to be a moving and memorable moment for nurses, i.e., to be finally able (after a century) to combine the Samoan culture with nursing philosophy for the first time (Barclay et al, 1998). This curriculum design is still in place and used in nursing education today. The Samoan Philosophy of Nursing (SPN) as shown in *Figure 4* below (discussed in Chapter 4) complements the conceptual framework (*Figure 5*) of nursing in the design of nursing courses.

The Samoan philosophy of nursing (Figure 4) is a conceptual framework that is culturally rooted and with the belief that nursing starts in the person, and it enhanced by the culture to which that the person and society belongs and lives in. It is a conceptual framework and account of beliefs and values that underpins nursing care to achieve appropriate health outcomes. The SPN conceptual framework was used to guide the development of the nursing curriculum conceptual framework thereby making sure that the cultural context is well

considered and integrated in the development of the nursing curriculum. Thus, it reflects on the nursing practices' drive to achieve appropriate health outcomes and ensure culturally proficient practice within the healthcare context of Samoa.

Figure 4: ***Samoan Philosophy of nursing conceptual framework***

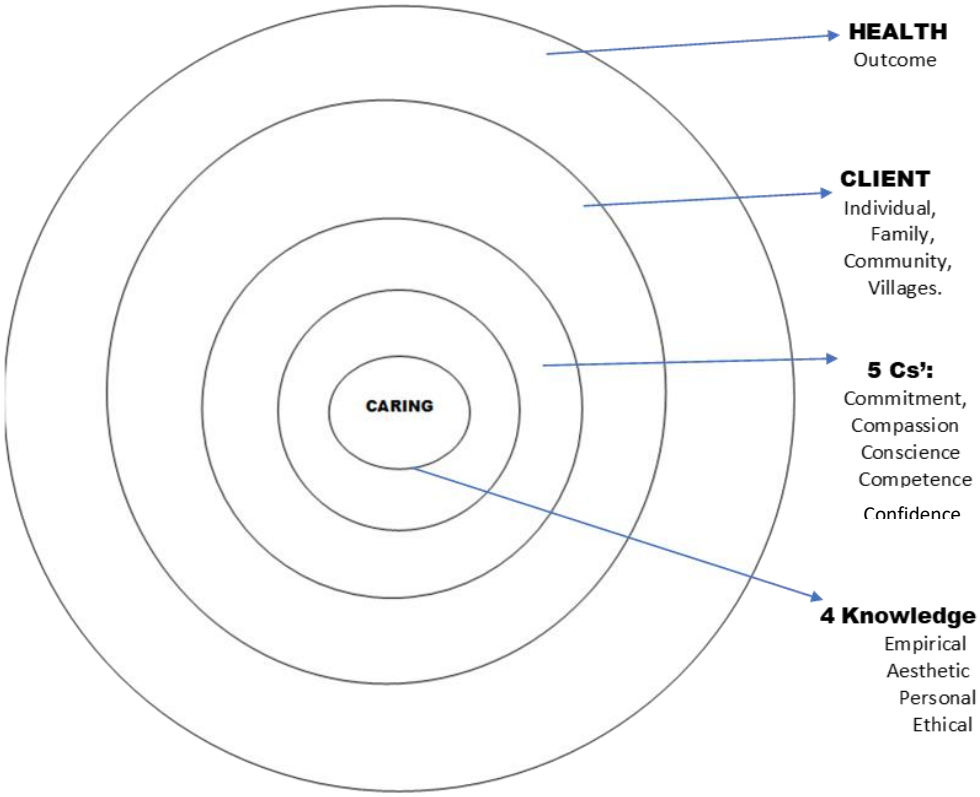
Individual	*Society*	*Health*	*Nursing*
We believe that each individual (*Tagata Ola*) consists of three parts: 1. *Mauli* – intellect, vision, dreams, insight, telepathy, intuition, spiritual, inner being and *masalo* (suspect) 2. *Aitu* – thoughts and mental processes 3. *Ola* – living, alive, physical life, birth, rest and peaceful death Deviation from any of the three parts will result in *Tagata Vale* (disordered person). The absence of *Ola* will result in *Tagata Oti* (deceased person)	We believe that Samoan society is holistic in nature. It consists of five guilds: 1. *Matai* (chiefs, heads of family) 2. *Faletua* and *Tausi* (wives of chiefs and orators) 3. *Feagaiga/Tama'ita'i* (daughters, girl children) 4. *Taulele'a* (young untitled men) 5. *Tamaiti* (children) These five guilds are all interrelated, not only through their *faiā* (relationship) but also through political, social, economic and spiritual forces that provide the dynamics of society.	We believe that: *Soifua Maloloina* is optimum wellness. It is a concept that is all encompassing and includes: life or living, birth, resting, health, or recovery from ill health or passing away peacefully. *Soifua Maloloina* enables individuals at any age to move towards their full potential relative to their total development and that of their society. Impairments in an individual's *Soifua Maloloina* will influence their dignity and quality of life.	We believe that the role of the *feagaiga* (a sacred covenant) characterizes professional nursing in Samoa. *Feagaiga* includes both male and female roles. Samoan nurses are known for their caring cultural roles that form the foundation of professional nursing. These roles include being a: 1. Taulasea (a healer) 2. Fai'oa (wealth maker) 3. Ositaulaga (leader in worship, a sacrifice) 4. Paema Auli (peacemaker)
Nursing, as both a human science and an art, is a discipline which needs to be based on a sound body of knowledge. It is concerned with the health of the individual, family and community, and takes place in a variety of settings, irrespective of race, creed or status. The process of nursing facilitates health in a caring relationship by: 1. promoting responsibilities for the development of healthy life cycle; 2. helping the individual to identify and meet one's health needs; 3. nurturing the person who has continuing health deficits; 4. supporting the dying; and 5. comforting the grieving. Nurses work as independent and interdependent members of the healthcare team contributing to the provision of optimal health care and the attainment of *Soifua Maloloina*, optimum wellness. (Source: Samoa Nursing Division, 1990)			

(Source: The Samoan philosophy of nursing by Enoka, I S., Petrini, M A., & Turale, S. (2014). Samoan Philosophy of Nursing: A basis for culturally proficient care and policy, *International Nursing Review*, 61, 416-426.)

The figure above shows Samoan beliefs and values of four major components of individual, society, health and nursing that the nurses should consider in nursing practice. For example, the individual is believed to consist of three parts, which is mauli (intellect), aitu (thoughts) and ola (physical life). Society is holistic in nature that consists of five guilds which is Matai (chiefs/head of the family), Faletua ma Tausi (wives of chiefs and orators), Feagaiga or Tamaitai (daughters), Taulelea (young untitled men) and Tamaiti (children). Health is an optimum wellness that starts from birth to death stages, and impairment of health influences their dignity and quality of life. Nursing is characterised by caring roles of the feagaiga such as taulasea (healer), fai'oa (wealth maker), ositaulaga (leader in worship, sacrifice) and pae ma

auli (peacemaker) (Enoka, Petrini, & Turale, 2014). The SPN reflects core principles of nurses' manner of communication, identity, language and etiquette that was used for the development of the nursing curriculum. It infuses the western knowledge of nursing around a culturally grounded conceptual framework.

Figure 5: ***The Conceptual Framework of Care (Dynamic Wheel)***



Source: Personal Communication, 2019

The Dynamic Wheel of Care framework (*Figure 5*) was formulated and used to focus on the health needs of Samoan society. Ensuring nursing education is socially, culturally, and professionally relevant as well as locally and internationally accepted. The Dynamic Wheel of Care (*Figure 5*) is the integration of Carpers 4 ways of knowing, Roach's 5 Cs and the Samoan philosophy of nursing framework that culturally re-defined individual, societies, health, and nursing. The conceptual framework was formulated by local senior nurses and leaders of Samoa. The five wheels, starting from the middle consist of Caring, the 4 Knowledge by Carper, and the 5 Cs by Roach, Client and Health (Maiava, 2020). The SPN framework from the Samoan perspective encourages socio-cultural knowledge to the four ways of knowing, reminding core

principles of nurses' manner of communication, identity, language, and etiquette to the 5 C's of commitment, compassion, conscience, competence, and confidence of caring. Thus, it re-defines a person, community, and environment as in client and outcomes of health that should be family satisfactory.

Nursing School

The School of Nursing was formerly a faculty itself in 1992 when the school entered the National University of Samoa. Until the end of 2012, the School of Nursing moved to the Faculty of Applied Science due to staff development issues, poor growth of nursing student enrolment and graduates' overtime. Nursing then became one of the three main schools to form the new Faculty of Applied Science. A review was later made and showed development in the School of Nursing in terms of professional development of staff and an increased number of enrolled students in the program. The School of Nursing later, relocated to the Faculty of Health Science, together with the newly developed school of Medicine in 2017 where it still is today.

The School of Nursing have five programs, i.e., Health Preparatory year (one year), Foundation Certificate in Nursing (one year), Diploma in Nursing (two years) , Bachelor of Nursing (three years) and Postgraduate Diploma in Nursing (Midwifery, Mental Health, Primary Health Care) however, only the Postgraduate Diploma of Midwifery is offered due to the availability of lecturers. The health preparatory year and foundation certificate program targets graduates from colleges and high schools while the bachelor's in nursing is offered to students who successfully passed eight courses of the Foundation Certificate program. There are twenty-four courses in the bachelor's in nursing program and six courses for the postgraduate diploma in midwifery program. It is believed that all courses (from the preparatory year program to postgraduate diploma program) of nursing program have nursing ethics components in them however there is a specific course that covers the discipline of ethics and its historical development. The course is a compulsory course for third year nursing students of the bachelor program called Ethico-Legal Aspect of Nursing.

Teaching ethics and ethical decision making.

The Ethico -Legal Aspect of Nursing provides an introduction to students about the Samoan Code of Ethics for nursing and midwifery practice and the integration of the International Council of Nurses Code of Ethics in the development of codes for professional practice. It discusses legislations affecting nursing education and professional nursing thereby enabling students to develop a deeper understanding of ethics and the legal aspects of professional nursing and assist in discussion of conflicts and informative ethical dilemmas. The course also promotes understanding of the legal and ethical principles affecting nursing practice; application of ethical principles to analyse ethical issues, ethical dilemmas and moral decisions and making moral judgments in professional practice.

The course covers introductory knowledge to the discipline of ethics and its' historical development both (locally and internationally in the profession. It also addresses legislations in relation to nursing practice and the nurses' obligations that vary among clients, co-workers, society, nursing practice and professional nursing. Topics ranges from value formation and value conflicts, the discipline of ethics, principles of ethics, ethical concepts for nursing practice, ethical responsibility of the nurse, framework for decision making. It includes standards for ethical behaviours and the code of ethics for nurses and midwives of Samoa. The course has been designed in accordance with the National Standards for Nursing and Midwifery practice (Ministry of Health, 2007). The underpinning skills that the course encourages and develops include critical thinking and ethical decision-making skills, problem solving and conflict resolution skills and analytical skills in addressing ethical dilemma. Such skills are taught by utilising lectures, tutorial and interactive methods such as group work and discussion. However, there is a delivery of presentation cases that also encourages interactive and participatory method in the course with an assessment method of 60% coursework and 40% Final examination.

Summary

As the opening phrase of the chapter stated, ‘catch the bird and watch out for the wave’, is a call to a fisherman to be aware of the waves. It sheds a light on the context of the fisherman, to not to forsake other factors surrounding the bird that he is aiming at for his bait but makes sure to understand and know the time of the next wave. So, that the fisherman can be prepared and stay out of danger. It is the same understanding applied to this research, i.e., the understanding of the context of participants, the culture, the community, the research topic and healthcare system and nursing education system are big waves that I (the researcher) need to be aware of while catching the understanding of ethical challenges among nurses. Valuing the context the participants, the culture that the participant belongs to, and the society in which they live in therefore, gives a broader understanding of the essential aspects of social context that is so necessary to prepared an appropriate research approach and subsequent use of an appropriate methodology and method.

"E fesili Muamai i a Mulimai"
"Those who have just arrived must ask
those who have arrived first"

Chapter 3: LITERATURE REVIEW

Introduction

In nursing, maintaining and respecting the dignity and integrity of the individual derives from a comprehensive approach that includes an ethical obligation (Haahr et al., 2020). The opening proverb of the chapter derives from one of heritage stories of Samoa. It tells a story of a couple who travelled from Fiji to Samoa with the bird of the Fijian king/chief. When they reached the coast of Samoa, Tagaloa the Samoan king/chief greeted them. While Samoan birds flew by, the bird of the Fijian king spread his wings and tried to fly to the Samoan birds to fight. However, Tagaloa advised the couple not to release the bird because the Samoan birds might attack and kill the bird of the Fijian king/chief. From that, the couple understood that Samoan birds might look tiny but are very strong. The man name 'Muamai' instructed his wife 'Mulimai' to ask first if she wanted to release the bird. However, when Muamai arrived home, Mulimai had already released the bird and it had been killed by the Samoan birds. Muamai told Mulimai *"na ou fai atu foi e fesili Mulimai i a "Muamai"* meaning "didn't I tell you *Mulimai* to ask Muamai" as the phrase is commonly used nowadays. It is the expression that significantly points out the importance of asking and seeking permission or approval first from those who come before you. The word "Muamai" itself means 'arrived first' and "Mulimai" means 'arrived last.' Hence *those who have just arrived must ask those who have arrived first*, is the phrase or expression that encapsulate the intention of the researcher in this chapter.

Therefore I, the novice researcher, have been asking questions and seeking literature on what already exists about the topic before I make any statements. This has involved seeking the wisdom of the Muamai, as in cultural experts, academics, researchers, who firstly explored and discovered the research topic, and consulting literature. Yet as a Samoan researcher, I first need to seek wisdom from my culture, i.e., where I am from, to find appropriate strategies to approach my research topic and participants. The purpose is to build an understanding that will strengthen the study and look at ways that this study can contribute to the body of knowledge and expand ethical issue discourse to provide awareness among nurses with the

vision of promoting better working environments, quality care and service. Subsequently, this chapter discusses the general global views about ethics, nursing ethics, and ethical challenges within the nursing profession, workplace issues, and the impact of ethical challenges on patient care and decision-making, ethical challenges within socio-cultural change and scope of practice.

Search strategy

Finding literature related to the research topic from Samoa and even the Pacific region was difficult. It is one of the challenges that slowed the search, which was later discussed in meetings with supervisors, resulting in the development of an approach to find literature elsewhere to help with the research topic. That approach was to redirect the search to the nearby Pacific Island countries that shared a similar Polynesian background and way of life. Therefore, literature was sought from the wider Pacific region such as Fiji, Tonga, Solomon Islands and Vanuatu. Literature with relevant components of patient care, workplace, religion, culture, indigenous language, limited resources which related to Samoa and the research topic, was highlighted even though the main topic differed. I extracted and made use of the similarities with consideration to cultural sensitivity and ways used to address certain issues that might be relevant to the context of Samoa, the research topic, and participants. The search for literature did not stop there; it was expanded to literature from developing countries and countries who shared some similarities with Samoa's indigenous culture, religion, and economic status. These widened search methods helped to construct an understanding of how other developing countries code and identify similarities of health care contexts with Samoa.

Literature for the research topic was retrieved from the cumulative index to nursing and allied health literature complete (CINAHL), Medline, PubMed, Sage Knowledge, and Scopus search engines The keywords used to find literature for the research were *ethics, nursing ethics, ethical dilemmas, ethical challenges, ethical issues, ethical decision-making, nursing, developing countries, Samoa, Pacific islands.*

Ethics verses morality

'Ethics,' 'morality,' 'rights,' 'duties,' 'obligations,' 'moral principles,' 'moral rules,' 'morally right,' 'morally wrong' and 'moral theory' are common terms used in the discussion of ethics. The use of these terms by nurses may be at times due to life event discussions and practical situations that are related to moral or ethical dimensions. Johnstone (2019) claimed that the terms are not correctly used sometimes, i.e., that sometimes they might misrepresent the discussion of ethical issues which results in a rising problem and complication that did not exist before. Johnstone continued by providing an example of the use of the word 'duty' and 'right' in one of the views that "nurses have the 'right' to practise within their codes of ethics and law governing their practice and the 'right' to act as patients' advocates" (p. 12). In this case, the use of the two words is synonymous but duty and rights may be different by nature, where in fact, the term 'right' in the example should be read as 'duty' (practise within their code) (Johnstone, 2019).

Differentiating between the terms 'ethics' and 'morality' was another common error that Johnstone (2019) noted. Referring to 'morality' as a personal or private value set, such as 'personal morality,' where 'ethics' is related to well formalised, public and universal value sets like 'professional ethics' (Rainer et al., 2018). Yet the two terms are often used interchangeably have no significant difference and differentiating ethics and morality claims are pointless and confusing (Johnstone, 2019). This basic task of understanding the definitions and differences between ethics and morality provided me, the researcher, with an awareness of the common mistakes to be avoided and an emphasis to be very careful when formulating the research topic and question.

Understanding of Ethics

The term ethics originates from the Greek word *"ethos"* which means custom, tradition, and habit (Johnstone, 2019; Özel & Akyol, 2014). Whereas 'morality' derives from the Latin word *moralitas* that means 'custom' or 'habit,' a translation nearly identical to that for the term ethics. Therefore, according to overall meaning and theoretical discussion, the terms can be used interchangeably (Chaloner, 2007b; Cronqvist, Theorell, Burns, & Lützén, 2004a; Johnstone, 2019; Milliken & Grace, 2017). Thus, it may be argued that giving freedom to an

individual on which term ethics or moral to use in the discourse of ethics, may be a matter of personal preference rather than philosophical debate. This rationale supports the interchangeability of the terms ethics and morals in this research.

As a general term, ethics refers to numerous ways of thinking about, understanding and examining how best to live a moral life (Beauchamp & Childress, 2012). However, to be more precise, ethics is the study of the underlying values of people's relationships, the character of good or bad morale, right or wrong and fundamental philosophical values of interpersonal relationships (Özel & Akyol, 2014). Chaloner (2007) explains it simply as a branch of philosophy that determines the right or wrong decisions and actions of people. Shapira-Lishchinsky (2009) stated that it is the "relationship between the right and good" (p. 1602) and defines good in relation to human principles or standards of well-being and defines right in relation to the justice of allocation and distribution of rewards that do not harm other people. Ozel and Akyol (2014) added another definition of ethics as the logical reasoning of the thinking process that creates valuable decisions on human actions which (Voyce, 2017) refers to as moral conduct, characteristic, motivation, and determination of what is good to or valued by people. Furthermore, Johnstone (2019) contributed to the definition as related by Beauchamp and Childress (1983) by stating that ethics is comprised of a critically reflective activity that is related to systematic examination of living and moral act that intends to illustrate what one ought to do by asking questions to reflect and reconsider our initial actions, decisions, and reasons. It is a definition that strengthens the ability of reflection on top of values, the character of good and bad, logical reasoning and interpersonal relationships, as previously noted authors generally maintained.

Nevertheless, the understanding of ethics nowadays still owes some deference to ancient Greek philosophers such as Socrates (born 469 BC), Plato (born c. 428 BC) and Aristotle (born 384 BC) and their influential works. These ancient Greek philosophers influenced the view of ethics as a branch of philosophical inquiry, and this influence remains to the present day. For instance, what is to be considered as morally acceptable and morally unacceptable requires a composed and rational explanation and reasoning of the basic assumption and beliefs that people hold. Furthermore, philosophical inquiry still requires people to ask why they considered a particular right and wrong, what was the reason for their decision and whether

it is a correct decision. Thus, this influential view remains significant nowadays and its value is still considered in the ethics mainstream discourse despite the (postmodernist) controversies over the past decades (Johnstone, 2019).

Nursing ethics

Ethics has been an important part of nursing since the beginning of modern nursing and often tracing its values back to Florence Nightingale (Nightingale, 1856,1969). During the Crimean War era, Nightingale stressed the importance of listening to patients, prioritising patients' needs and maintaining confidentiality. She considered these actions to be of considerable value. These aspects are still described as important ethical actions today (Silén, 2011). Ethics equip the nurse to understand moral duties and expected rules of caring that are trusted to help enhance ethical behaviour (Hafez, Mohamed, & Sobeh, 2016). Therefore, these continue to be vital duties and principles of the nursing profession that nurses in the present time need to maintain to improve the quality of patient care. Nevertheless, the sheer complexities of moral choice and ethical pressures challenge nurses all over the world, including Samoa, and this has a significant impact on the integrity of nursing practice (Ulrich et al., 2010).

Forrester (2005) called nursing ethics a "distinct discipline" within the field of nursing due to its aspect of independence and accountability. The acknowledgement was made in relation to the development and implementation of the professional codes of ethics for nursing which structures and directs the practice of nursing in a morally necessary way. Examples include the International Council of Nursing (ICN) Code of Ethics (2012) that the Samoan nursing profession is currently using. Nursing ethics requires underlying ethical principles, knowledge of practice and awareness of the implications for patients' care (Forrester & Griffiths, 2014). Nursing ethics is not just about finding answers to moral problems that have occurred, it is also about being a good nurse in everyday practice (Wright & Brajtman, 2011). According to Wright and Brajtman (2011), the fundamental normative nature of nursing is delivering good care in terms of "comfort, dignity and quality of life", and at the same time preventing ill effect such as "pain and suffering" (p. 23). In such environments of practice, nurses stand out in the role of being a facilitator of "humanisation, meaning, choices, quality of life and healing" which develops ethical knowledge to express and influence the interprofessional care of patients and their families who receive health services (Wright & Brajtman, 2011, p. 23).

However, the responsibility to do good and prevent harm does not only require practical skill and knowledge but it also needs a value system that will underpin the provision of care (Forrester, 2005). Horton et al. (2007) clarified the importance of understanding nurses' values of their practice to achieve good nursing practice since values define good nursing. Therefore, nurses must be aware of their ethical responsibilities regarding their duty of practice and obligation to deliver appropriate health services. According to Osingada et al., (2015) it is suggested that knowledge of ethics will change attitudes and the approach of nurses to high quality nursing care. This is an area that needs to be strengthened among Samoan nurses to achieve quality nursing care and service. Thus, if good nursing in practice I promoted, patient and public satisfaction will be achieved. Therefore, there is a need to enhance and strengthen ethical knowledge among nurses in Samoa.

Nurses ethical knowledge and decision-making

Numminen, Arend, and Leino-Kilipi (2009), and Osingada, Nalwadda, Ngabirano, Sewankambo and Nakanjako (2015) point out that nurses' often lack sufficient knowledge about ethics, codes of ethics, and their uses, especially in developing countries. They maintain that nurses in lower to middle income countries tend to have a poor understanding of the basic concepts of ethics such as informed consent, confidentiality and veracity, principles of ethics, ethical theories, value clarification, and general aspects of the code of ethics, which in their case is Uganda. The authors also indicated that nurses who have diplomas and a higher level of education are more knowledgeable about ethics than nurses with only a certificate level of education in nursing training. Osingada et al., (2015) argue for the need to raise nurses' knowledge of ethics because it would change nurses' attitudes and approaches to the delivery of quality nursing care in Uganda. By extension, this may also be thought to be true about nurses in Pacific nations, Samoa included.

Some studies claim that nurses are supportive of the application of nursing codes of ethics because of their similarity to their personal values; it also supports the identity of the profession and monitors practice (Numminen et al., 2009). Therefore, it is argued that codes of ethics are one aspect of ethical knowledge that assist in nurses' ethical decision-making,

guiding high-quality ethical care and informing nurses' missions, values, and standards (Shahriari, Mohammadi, Abbaszadeh, Bahrami, & Fooladi, 2012). Donkor and Andrews (2011) also recommend the implementation of a professional code of ethics because it is considered to be a major cornerstone of nurses' ethical knowledge. The evolution of nursing development and nurses' roles also places an emphasis on the relevance of codes of ethics for nurses (Shahriari et al., 2012). However, according to Aitamma, Leino-Kilpi, Puukka, and Suhonen (2010), a code of ethics has limited value in some important areas of health care delivery and their relationship with effective nursing care, e.g., allocating resources, stating that there should be a drawn guideline for nursing management personnel to monitor ethical decision-making when allocating resources, economic activities, and high care quality. Being aware of health care resources and the context that nurses practice ethical care are as important as ethical knowledge and following an ethical code. The majority of nurses' ethical decision-making relies on their personal, practice and environmentally related experiences. Hafez et al. (2016) supports the argument that age, years of experience, and work settings influence nurses' ethical knowledge but claims that their personal character does not influence their practice. According to Woods, Rodgers, Towers, La Grow (2015), nurses understand what to do, but constraints hold nurses back from doing the right thing and most of the constraints are associated with external factors outside of the nurse's control. This, and the previously outlined resources problem, are most certainly regarded as some of the issues that may relate to the Samoan nurses' context.

An ethical understanding is particularly important in the provision of professional care that requires developing reasoning skills, understanding of principles and concepts that will help in the ethical analysis of nursing practice (Chadwick & Gallagher, 2016; Chaloner, 2007a). Furthermore, ethical knowledge is significant to clinical training, practice related issues, and to areas of professional nursing development to improve the quality of nursing care. Thus, nursing practice is often governed by previously recommended ethical principles wherever the nurse practices and helps the nurse to make ethical decisions regarding patient care. It may be reasonably assumed that this is an area that needs to be encouraged in Samoa for quality focussed (and ethical) practice.

Suitability of western ethics in developing nations

The International Council of Nurses formalised and launched its Code of Ethics in 1953, and it has gone through several revisions since that time (ICN, 1953). In this code, recommendations are made as to how nurses should respond to moral issues, but nonetheless, most nurses respond more directly to laws and regulations on a national level (cited in Silen, 2011). Subsequently, nurses must navigate between the different ethical values of stakeholders such as patients, organisations, the profession, and society, whilst at the same time being mindful of the law and its regulations. With all these considerations, nurses are required to take a stand on how to deal with a moral issue when stakeholders' values are threatened or clash (Silen, 2011). Hafez et al. (2016) agreed, adding that even though nurses enable individuals, families, and groups to maintain, restore, and improve their health status, nurses encounter ethical challenges regardless of the nurse's speciality.

Furthermore, as Ulrich et al. (2010), and Zakaria, Sleem, and Seada (2016) maintain, ethical issues are different among age groups and years of experience in the nursing field. For example, younger nurses with fewer years of experience encounter a higher occurrence of ethical issues compared to senior nurses with more experience. Ethics is important to nursing as they practice in both traditional (e.g., disease based) and expanded nursing roles (e.g., health based) to assist in ethical decision-making (Hafez et al., 2016). While providing health care, nurses face various problems affecting the results of the care due to the structure of a community and consumers' increasing demands of care (Özel & Akyol, 2014). George and Grypdonck (2002), and Wolf and Zuzelo (2006) define ethical challenges as the situations that involve choices between two or more options of reasons or priorities and responsibilities without a satisfying solution. It therefore refers to conflict that requires ethics in decision-making, as Kopala and Burkhart (2005) note when they refer to issues such as not causing harm and preventing harm to others (Shapira-Lishchinsky, 2009). Thus, as Wilson-Barnett (1986) claimed some decades ago, nursing's ethical issues should be viewed within the context of professional integrity, and within the team of different disciplines that nurses work with, and within the socio-cultural situations that nurses have contact with most of the time, an approach that is frequently made by more contemporary commentators on nursing ethics in countries around the world (Abbas, Zakar, & Fischer, 2020; Almoallem et al., 2020; Woods, 2010, 2012). Therefore, gaining understanding of ethical issues in nursing does not stop at the

nursing profession itself but also other disciplines and stakeholders that are working with the nurse. The points raised above lead to several significant issues and questions, i.e., what are the areas that need to be explored among all nurses, and for the purpose of this thesis, Samoan nurses in particular. Furthermore, whether ethical knowledge and context are considered in their decision-making of patient care. The use of ethics such as ethical principles i.e., causing or preventing no harm are well stated, however this requires more explanation because of its context and application. In a similar way, the notion of individual autonomy that is so prevalent in western ethics is often seen as a misnomer in other, non-western countries, i.e. where the notion of collective or 'relational' responsiveness tends to be more prevalent (Gómez-Vírseda, de Maeseneer, & Gastmans, 2019; Woods, 2010). Other researchers suggest the context of professional integrity should be viewed more closely, because of its relation to moral excellence and moral resiliency in practice (Crigger & Godfrey, 2014). Therefore, mindful of considerable differences that exist between both explanations of ethical principles and the vast differences in context, it is argued that nursing ethics from the western perspective is not fully appropriate or does not capture ethical challenges that are encountered by nurses in developing countries. In developing countries such as Samoa, a highly relational and communal country, there are many factors or areas that the nurse needs to consider, thus supporting Wilson-Barnett suggestion of a closer exploration of the social and physical contexts.

Nursing ethics in Samoa

In developing nations, the application of such a western approach to ethics (as in the use of major moral principles) presents several problems and challenges (Woods, 2012). For instance, Botswana as a developing country follows European practices (such as in the UK (United Kingdom)) due to its past colonial experiences (Akinsola, 2001). These changes are reflected in nursing responses to ethical problems and dilemmas relating to socio-cultural changes, new and advancing technology, and highly scientific-based practice. Yet, as in Samoa, some of these changes may not be entirely valid or even appropriate. Samoa also experienced major colonial influences (by Germany and Britain under New Zealand administration) in the last century. Thus, foreign customs and institutions that were incorporated into Samoan practices during that time including health care delivery (in institutions such as the hospitals) and nursing training (Barclay et al., 1998). However, it may be posited that such manoeuvres

were never of any great benefit to the population, i.e., they were not always appropriate for the given population, and nor were they always socially or culturally mindful. As a result, some years after becoming an independent nation in 1962, changes occurred when Samoan professional nursing adopted the fa'asamoa or Samoan Way of nursing practice, where Primary Health Care practices were emphasised above previously institutionalised ones. This shift reflects what Woods (2010) argued when discussing culturally appropriate nursing responses, essentially that nursing needs to shift its focus from individual insights and actions to collective social orientation to enhance the notion of cultural safety. Woods (2012) later continued that the social, cultural, and political context of peoples' existence needed to be incorporated and well understood for nurses' ethical responses to be effective. From a Samoan perspective, this also reflects care based on morals and fa'asamoa (chapter 2) as a collective rather than as the individually focussed responses so common in Western nations. This significant idea is what Samoan nurses' leaders considered 30 years ago, resulting in a complete overhaul of nursing practices, and certain developments in nursing education.

Briefly, in nursing education in Samoa, the ethics education of nurses' remains in what might be described as ongoing developmental stages, i.e., its importance is being increasingly recognised, but there are still gaps in the nursing curricula and reviews of specific content issues within the ethics curricula and future directions are ongoing (as previously outlined on pages 41-42). In some ways (but not entirely) this is a similar picture to the ongoing development of nursing ethics in other countries where numerous debates have occurred in relation to the best ways to teach nurses ethics that has sufficient meaning and usefulness to enable nurses to more critically reflect on the ethical aspects of their nursing practice (Hoskins, Grady, & Ulrich, 2018; Vanlaere & Gastmans, 2007; Woods, 2005)

Ethical challenges among nurses in Samoa

Patient care problems.

Care is basic to human existence. It is essential for the development of humanity, and although it often primarily focuses on meeting physical needs, it often goes well beyond. For instance, caring connects people into a relationship system (Vanlaere & Gastmans, 2011), and it is through such relationships that care may flourish. Gastmans (2006) suggested four dimensions of care when he stated, "good care demands more than just good intention; good care…is a practice of combining activities, attitudes, and knowledge of the situation" (p.137). Therefore, care can be either considered as purely an ethical task, or an added weight of things to do or consider as an obligation, as in being attentive and actively involved in patients' needs (Lachman, 2012). Nurse's obligation towards being attentive and providing time for patients is therefore one factor that defines quality of care. In addition to this, staff numbers and equipment on the ward, nursing staff skills, collaboration and satisfying the needs of the patient are additional components for consideration when determining quality of care (DeKeyser Ganz & Berkovitz, 2012). These factors show areas that measure quality of care within the context of nurses' working environment which is especially important, and it needs to be considered when developing an improved quality nursing service in any nation, and in this instance in Samoa in particular. It is believed that nurses tend to lose sight of the significance of these relationships and the obligation to be attentive due to increasing population demands and limited resourcing. Samoa is certainly not an exception to these issues; indeed, Samoan workplace issues for nurses tend to abound.

Workplaces issues

Nurses work in a complex environment that consists of highly demanding medical and technical interventions which can make nurses lose track of their priority of establishing caring relationships with their patients. Thus, making it hard for nurses to practice according to their ethical values or give voice to ethical issues within the team due to a variety of factors, i.e., a complex work environment, practical circumstances, and in some cases, situational factors (Goethals, Gastmans, & de Casterlé, 2010). As previously maintained, there is a significant connection between the ethical domain and clinical domain in nursing. The two domains are intertwined to equip nurses to be ethically sensitive and clinically competent to deliver

personalised care, an essential element for effective and safe care. However, organisational structures and the workplace culture of where the nurse is situated can either empower, improve, or inhibit a nurse's ability to be competent and deliver humanised care. Nurses and the institution in which the nurse works, establishes a relationship with patients that can either be good or ill as a human being. It is the fact that leads or links nurses to the ethical domains of nursing practice (Scott, 2017). Other factors such as pressure from either supervisors or managers, referring doctors, family and friends, or combination of any of these, can impact on a nurse's decision-making (Oerlemans et al., 2015). From my personal experience as a clinical nurse, I can easily claim that I have faced similar external pressures and factors and can confidently confirm it is happening in the workplace of nurses in Samoa. Furthermore, the context or the environment, that includes the workplace, plays a significant role in nurturing ethical knowledge and supporting ethical decision-making that needs to be addressed and strengthened in Samoa. This is one of the reasons why the workplace context and the constraints for nurses within it, is essential to include in the exploration of the research topic, as is the case in this thesis.

Constraining factors

Hamid, Kanwal, Bajwa, Khalid, and Mubarak (2016), authors writing about the ethical issues that are faced by nurses in another developing nation (Pakistan), argue that nurses are powerless to fully apply ethical codes and are not included in decision-making in many situations due to constraints, even though they are aware of ethical codes. It is claimed that nurses are viewed as merely assistants in their work environment with insufficient equipment and instruments, "shortage of staff, stereotypes of [the] nursing profession, poor management and poor support to address the issues" (p.307). This leads to distress and stress, conflict, poor professional care, compromised nursing care, and code violations because nurses do not feel valued or respected in the role they play (Hamid et al., 2016). Other authors have made similar claims when addressing those constraining factors on nursing ethical decision making that arise within what is essentially a difficult 'ethical climate' (Humphries & Woods, 2016; Koskenvuori, Numminen, & Suhonen, 2019; Olson, 1998). Woods (2014) generally concurred with the views of the these authors when he wrote that "a lack of organisational support across all levels, indifferent and unsupportive organisational cultures, poor leadership, recruitment and retention issues, government interference and uncertain

policies" all contribute to these constraints (p.128). Furthermore, as Woods (2014) also argues that the effect of having to work in a difficult ethical climate that entails power, trust, and human interaction often leads to situations where a nurse will do their best but can within limiting circumstances. These limitations affect nurses' abilities to exhibit a sound moral ability to do the right thing according to their professional and ethical values. This definitely mirrors nurses' experiences in Samoa, as will be shown.

A lack of resources and infrastructure are major challenges for the delivery of quality care in any country, and in Samoa in particular, when these environmental limitations are more pronounced. A study on leadership and the influence on patient care in Fiji, a country that is similar in many ways to Samoa, shed light on ethical issues in one of the islands of the Pacific region. The study's findings indicate that the context of the ethics of patient safety in this developing country where a lack of resources and infrastructure seriously challenges optimum provision of patient care is as important as other considerations (Stewart & Usher, 2010). This is because nurses may be educated in ethical theory, principles, and codes of practice, but still might not be able to make a satisfactory moral decision because of the lack of infrastructural support. This result from Fiji represents ethical dilemmas that nurses may also face in other Pacific Islands such as Samoa.

As identified in Steward and Usher's (2010) research in Fiji, which is quite likely similar in Samoa, replying to another staff member or voicing a concern is uncommon in the nursing profession in these countries. Henriksen and Dayton (2006) found "fear of retaliation" and lack of confidence to get involved in the dilemma were reasons behind patient safety issues, but there are other reasons why such actions are less common in nations such as Fiji or Samoa due to its social and cultural context. These brief examples of the consequences of unresolved ethical dilemmas in nursing may easily lead to moral distress. According to Ulrich et al. (2010), moral distress can make a person afraid and hesitant to talk about what is happening because it represents an impassable ranked system of care. Another example of the problem associated with nursing ethics in developing countries, was identified by McIntosh and Stellenberg (2009) in a study in Africa. The authors claim that a shortage of nurses and lack of professionally skilled staff contributed to poor care practices and are major barriers to delivering quality of care in health care workplaces. Such barriers also hinder ethical decision-

making because it puts nurses under moral distress (Stellenberg & Dorse, 2014). Shortage of nurses and economic crises, the demands on nurses' provision of competent and compassionate care resulted in moral distress as it makes nurses feel unaccomplished, and unable to meet the expectations of others as well as themselves (Ghebrehiwet, 2012). However, Campbell (2004) believes that there is a possibility that developing countries can take part in improving the quality of care for patients regardless of not having enough resources (cited in Steward & Usher, 2010). This, Campbell suggests may be achieved by changing the ethos and attitudes at both head offices and local levels to develop a culture of patient safety. This would then address the patient as the centre of a health service that puts patient safety to the forefront and creates a positive environment i.e., in interpersonal interactions, and adds to the notion of putting patients as main or equal partners in health care. This may well be one of the lessons that need to be repeated frequently for Samoan nurses when creating a culture that centralises the patients to all levels of the nursing profession. This notion will therefore be pursued within this thesis.

Clearly, contextual factors are some of the constraints that affect nurses' ability to decide on how they act, and it is evident in the literature that this phenomenon is reinforced by a common threat of powerlessness. Woods (2014) stated that powerlessness is one of the crucial causes and the main component of moral distress experienced while short staffing is one of the environmental factors that limit nurses' ability to fulfil their ethical obligations. As a result, and following appropriate research, Humphries and Woods (2016) claimed that compromised patient care is one of the most commonly perceived main ethical issues that nurses face every day in practice. In an equivalent way, short staffing issues claim to be the most common issues that affect the ethical practice of nurses in many countries, and most certainly in my experience, it significantly affects the work of Samoan nurses every day.

Summary

Searching for literature about ethical challenges among nurses in Samoa was a very challenging task indeed because such literature is extremely scarce. However, the use of contextual similarities such as culture, economic status, nursing workforces, demographic factors and other similarities with other developing countries were some of the terms that helped yield relevant results in the search for suitable literature. The review has shown that according to research, and to other associated literature, there are still a number of debates or uncertainties relating to an understanding ethics and morality in regard to meaning and application, i.e., how ethics might be perceived and applied to the work of nurses in different countries, Samoa in particular. This discussion extended to not only distinctions between ethical dilemmas and social more, but to those associated ethical challenges are common in health services and nursing practices. It is also argued that researchers are finding it difficult to identify effective ways to successfully resolve ethical challenges encountered by nurses. In this aspect, it is maintained that there is an awareness of ethical knowledge and decision-making, however ethical challenges (and often ethical responses) may vary considerably among different culture and specialties. These thoughts and observations therefore helped to guide the development of this thesis, and to underpin its methodological progress which led to the formation of a sound approach to an appropriate research method, both of which will now be discussed in the next chapter.

Chapter 4: METHODOLOGY

Introduction

This study was devised to explore ethical challenges among Samoan nurses regarding those aspects that relate to their profession, care, and workplace. This task is often perceived as being quite demanding because ethics can mean many different things to different people, and in the case of this research, nurses in particular. This was certainly found to be the situation when conducting research within Samoa, where (as previously indicated in Chapters 2 and 3) concepts such as morality, ethics, and social etiquette and norms are often interchangeable. To respond to the need for socio-cultural flexibility, an approach that is intended to reflect both ontological and epistemological differences in interpretation of morality and ethics within the Samoan culture, both research methodology and methods had to be carefully chosen. Another consideration was the practicality of performing research among very geographically spread and often hard to reach group of nurses in Samoa. Subsequently, the underpinning methodologies used in this research was generally interpretivist, although certain elements from within the transformative paradigm were also incorporated, as well as a necessary positivist perspective (i.e. when using a survey). The interpretivist methodology comprised gathering rich information from key participants about the ethical issues faced by nurses in Samoa, and the latter positivist methodology took the form of a survey distributed amongst a broad representation of Samoa's approximately 450 nurses. The transformative aspect, albeit a secondary one, represented the desire to assist Samoan nurses to both further their appreciation of ethics in nursing, and eventually to advise Samoa's nursing leaders to be able to make future recommendations for change within Samoan nursing practice and education. Hence, to undertake the research in a theoretically sound *and* culturally appropriate manner, the Ietoga framework and a *mixed methods approach* that employed an overall sequential exploratory design (SED) was adopted.

The methodological chapter for this study is divided into two major parts. Part one focuses on the methodological frameworks that this research uses to guide the research and the researcher. It also discusses cultural approaches that the researcher found necessary to carry out the research within the Samoan community. In part two, a discussion is presented that covers the methods that the researcher uses to explore ethical challenges among Samoan

nurses regarding those aspects related to the profession, care and workplace. This examines the use of a mixed method research and sequential exploratory design to broaden views of a few individuals into a bigger sample and explore the given phenomenon in detail and measure the complexity of ethical challenges and responses among nurses in Samoa.

Philosophical paradigms in this research

A paradigm is a set of beliefs that guide actions, and it reflects the worldview of the researcher(Guba & Lincoln, 1994). A philosophical set of beliefs consists of firstly, axiology, where values and ultimately ethics are considered. Secondly, epistemology, which considers the sources of knowledge. The third is ontology that refers to perceptions of reality, and subsequently methodology, which is concerned with the entire mode of inquiry (Mertens, 2010) Underlying philosophical assumptions that consider values, knowledge and ways of being therefore, need to be fully understood and stated, thus ensuring the researcher's position and engagement in critical self-reflection and dialogue is connected to reliable research methods, accurate representation of data, and in this instance, ultimately to improvements in practice. It is an important area of exploration that enhances the validity of findings in mixed method research as Mertens (2010) emphasised. If the practice is ethically defensible, then there is a clear need for consideration of the foundation assumption regarding the nature of worth and value and how it becomes known in any given contextual situation (Mertens, 2010). This study is underpinned by three paradigms, namely interpretivist, transformative and positivist paradigms to understand/examine the experience of nurses in Samoa about ethical challenges within their workplace. Each paradigm plays its unique role in the interpretation of the data to provide the researcher with a complete framework and multiple views to address social issues such as cultural and religious influence, social context etiquette and taboos and gender inequality. The interwoven nature of these paradigms in research studies is believed to be essential to ensure quality, as is the notion of deliverance such as validity, reliability, relevancy and oriented action (Pham, 2018).

The Interpretivist paradigm

Interpretivism views knowledge as it is constructed by humans through their interpretation of experience of and existence in the world. Interpretivism informs that all knowledge is

grounded in certain experiences and bound to the natural contexts in which we enact our lives (Hiller, 2016). Interpretive research is subjective as it accepts multiples standpoints of different individuals from different groups which makes the approach more inclusive (Thanh & Thanh, 2015). It supports research that encourages inclusion and participation, and also an approach that sometimes goes beyond inductive and deductive methods (Willis, 2007). Multiple perspectives are developed from the belief that the outside reality is flexible, which indicates that different individuals and groups have different perspectives of the world. Hence, as Klein and Meyers (1998) and Morehouse (2012) maintain, multiple perspectives provide a new and broader understanding of the given situation (Thanh & Thanh, 2015). It is a perspective that tends to gain a deeper understanding and complexity of the phenomenon in its unique context (Creswell, 2014). Willis (2007) highlighted that understanding the context that the research takes place in the interpretation of the gathered data is crucial. However, interpretivism also promotes the notion that reality is socially built or constructed and therefore seeks understanding within a particular (social) context and observable reality (Willis, 2007). Therefore, the understanding of the given context is fundamental, along with knowledge that is socially constructed and grounded in certain cultural experiences. All of these are factors that fit well with this study because of its setting in Samoa, which is a very socially orientated and culturally focused country.

The approach frequently provides rich information which is crucial for the interpretivist researcher to understand the context more completely. That is, as Thomas (2003) argues, interpretivism supports the use of qualitative methods because the interpretive paradigm interprets the reality of the world that is believed to be socially built, complex and constantly changing, aligning with what Willis (2007) suggests about reality. Furthermore, McQueen (2002) clarifies that the interpretivist researcher looks at methods that allow in-depth understanding of the relationship of participants to their environment and roles that people play in building the social fabric that they are associated with (Thanh & Thanh, 2015). There are other benefits of this paradigmatic approach, as Punch (2009) notes, arguing that the richness of in-depth data from qualitative enquiry is enabled through the researcher's deep attention to both socio-cultural realities and compassionate or concerned understanding. Therefore, the interpretivist goal of analysing subjective data fits well with qualitative methods to explore the reality of ethical challenges among nurses in Samoa.

The positivist paradigm

Positivism is a research paradigm that is well known and well established worldwide (Taylor & Medina, 2011). It is a term that was coined around 200 years ago with the view that people can be positive that real knowledge is produced by using 'scientific methods' (McGregor & Murnane, 2010). This implies knowledge that can be gained through observation and experimentation that usually select methods of science to produce reliable results (Rahi, 2017). The paradigm is sometimes known by other terms: Scientific Method, Empirical Science, and Post Positivism or, when applied to research-based enquiries, a quantitative approach (Rahi, 2017). The paradigm believes that reality consists of discrete events that human's sense or perceive and can therefore be observed, measured and predicted. Positivism therefore views reality objectively and independent characteristics of the researcher can be measured. It usually tries testing hypotheses with the purpose of improving predicted knowledge of the phenomenon (Majeed, 2020). Therefore, it must be measured and supported by evidence to understand the reality of the phenomenon (Hammersley, 2013).

The paradigm adapts the epistemology of objective data, where a natural science method is applied to determine social science studies in quantitative research (P(Pham, 2018)ham, 2018). Enhancing the understanding of entities or objects through employing empirical tests and methods such as sampling, focus group discussion and questionnaires is one method that the study employed in the second phase. Creswell in (2014) stated that positivist researchers suggested that these tests and methods provide insights that may have a high-quality standard of validity and reliability. Thus, generalising the results to a larger scale of the population is a distinct possibility, as Johnson and Onwuegbuzie (2004, cited in Pham, 2018). Therefore, results can be used for future quantitative predictions and they can also be regarded as reliable if the data were collected through objective methods (Pham, 2018). The increased validity of this study's results is a crucial advantage for the research topic for a variety of important reasons; not least being that, the generalisation of the data to a larger scale of the nurse population in Samoa carries the distinct possibility of recognition within Samoa's nursing and health services. It is, after all, the first ever study about the ethical challenges of nurses from a Samoan (or by extension) Pacific Islands' perspective and therefore carries a great deal of accountability and responsibility towards the profession, the health service, and to Samoa.

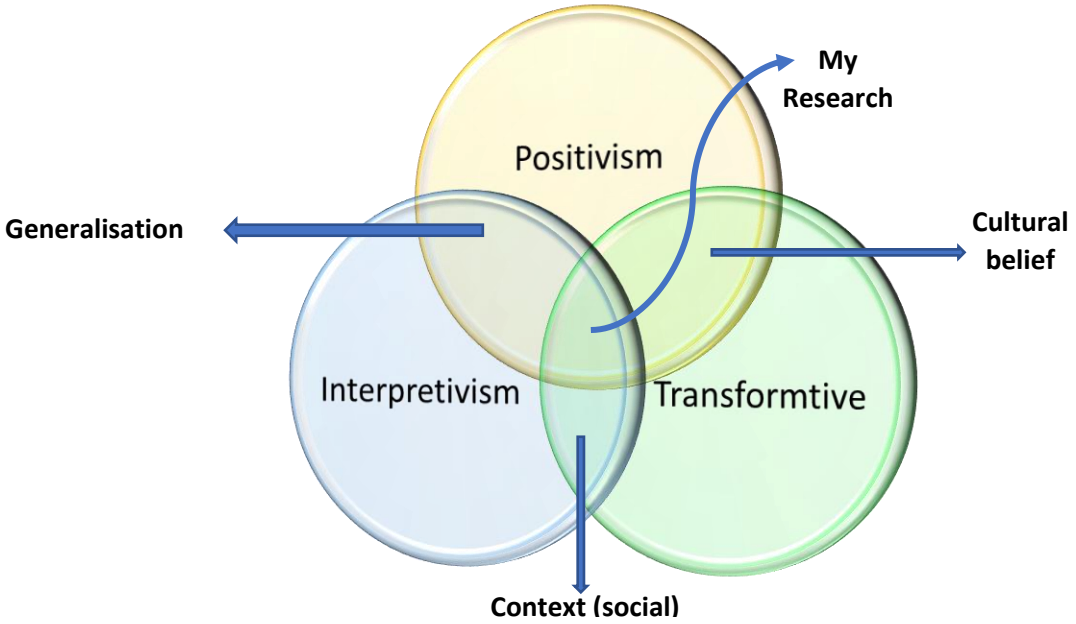
The transformative paradigm

The transformative paradigm is a critical inquiry approach based on relativism ontology (Al Riyami, 2015). This paradigm views reality as being socially constructed through the media, institution and society, but also adopts political, ethical, moral and cultural lenses when examining the (social) contexts of events or objects of the research (Hammersely, 2013). The notion here is therefore that these lenses may highlight social issues and injustices more clearly, and subsequently, as Creswell (2014) and other transformative researchers argue, there should be an action plan in research for reform that might change the participants' lives. This influences researchers to consider exploring crucial foundations and solve modern concerns in today's social context (Pham, 2018). This benefits the researcher on grounds of exploring the understanding of nurses about current ethical challenges within their workplace that are also influenced by the economy, politics and culture, which are other social factors. Subsequently, transformative researchers have been using the paradigm with the advantage that it develops connections between disciplines (such as economic, political, social and cultural ones) that may enable eventual social change.

Furthermore, one of the transformative paradigm's objectives is to recognise, challenge and help solve the imbalance of power in society to improve equality and injustice such as excluding social and economic factors (Taylor & Medina, 2011). Hence, in the context of this research, such ideas inform conscious awareness of progressive core values and beliefs of Samoan nurses and the influence on their nursing roles. Also the research shows that, although not a transformative research project, the desire within is to transform certain nursing and related practices within Samoa to make them better for nurses and by extension, for the people of Samoa. Thus, it is a belief system framework involving culturally diverse group members in the research process to consciously work within the cultural diversity context, which in turn, leads to the use of mixed methods (Mertens, 2012). Thus, this is one of the reasons that I (the researcher) chose to keep in mind the possibilities of a transformative paradigm when exploring the voices of Samoan nurses who work at the ground level delivering health care. Another reason for at least supporting transformative

paradigm for this research is the involvement of the community of nurses in the research process and partnership development especially during the recruitment process and data collection of the study.

Figure 6: ***The relationship of the three paradigms in the study***



The relationship of paradigms in the study

The relationship of human attitudes, intention and thoughts, multiple views, contextual and social factors are explored using interpretivist and transformative paradigms while the positivist paradigm generalises information to the whole population of nurses (Figure 6). Appreciation and interest in these paradigms were made known through ideas, viewpoints, comments and feedback, within the School of nursing at the university and amongst influential Samoan nurses, all of which provided an understanding of the different aspects and approaches associated with researching nursing ethics and ethical challenges that nurses encounter in Samoa. Thus, when the research was designed, the first major approach was to gather these ideas and viewpoints from those participants capable of offering significant insights and commentaries. Subsequently, in Phase One of this study, these commentaries and interpretations were gathered, analysed and pulled together to formulate the framework for a survey for the second phase of the study. This in turn enhanced the rigor and exploration

of ethical challenges among nurses in Samoa when gathering widespread survey data. The importance of social constructions of reality, the multiple views of nurses about ethical challenges, and the desire to promote good ethical practices through research within the cultural context of Samoa were all essential for the success of the study. This is why the study ultimately employed a mixed method approach, thereby fulfilling the need for the interwoven nature of all three stances of paradigms in the one study.

Conceptual Framework

A Pacific framework

A conceptual framework, which is also called a theoretical model or research model is the approach that offers a structure for all aspects of the research design and methodology (McFall-McCaffery, 2010). Pacific scholars started to develop research models in 1980, that represent the diversity of indigenous epistemologies of Pacific Islands (Gegeo, 2008). This is because pacific knowledge structures and conceptual frameworks provide perspectives of Pacific people to be represented in culturally appropriate ways. Therefore, it is important to consider an equally appropriate conceptual framework when conducting research within a Pacific nation.

There is an argument that emphasises the priority to reclaim Pacific knowledge and values for Pacific people if research is making a meaningful contribution to Pacific societies (Perese, 2009). Other authors such as Tamasese, 2005; Thaman, 2002; Gegeo, 2001; strongly supported the view with the purpose of treasuring indigenous knowledge, voices, experience, reflections and analyses of their social, physical and spiritual surroundings (Perese, 2009). Different disciplines have used and adapted Pacific research models or used them as an interdisciplinary approach to Pacific research. Models such as Vaka[5], Ta va[6], Tivaevae[7], Teu le Va and Kakala have emerged in education and the social sciences (Vatuvei, 2017). Thus,

[5] Uses the Canoe concept, significance of indigenous values, knowledge and approaches to pedagogy
[6] Ta (time), va (space) – theory of reality and knowledge where time and space are symmetrical in form, interconnected and harmonious, emphasising social relations.
[7] Cook Islands patchwork quilt, emphasis on centrality of culture, collaboration, respect, reciprocity, relationship and shared vision in research.

Fa'afaletui[8] and Fonofale[9] models have been used to research and address pacific health issues (McFall McCaffery, 2010).

The 'Kakala' framework model set and led the way for other frameworks such as 'Tivaevae' as a research discourse. These frameworks recognise the way Pacific people think and articulate theories from their perspectives in research (Vatuvei, 2017). The Kakala offers a significant path for Pacific academics to value Pacific philosophies, customs and values. Its original three stages framework of 'toli', 'tui' and 'luva' which has now become a six-stage process with added stages of 'teu', 'malie' and 'mafana' had potential use of its applicability to the study topic. Even though the Kakala model provides a research process from a Fijian cultural context, it differs from my research's context. Its application to Pacific research strengthens the philosophical view of knowledge collection and complements my research process. Therefore the researcher used one of the conceptual frameworks of Lalaga that was used by numbers of authors such as Anae, 1998; Fairbairn-Dunlop; 1998, Meleisea, 1992; Mulitalo-Lauta, 2000; and Seiuli, 2015. All the mentioned authors define the term lalaga as *to plait* or *to weave*. However, the concept was discussed differently by different authors, e.g. Fairbairn-Dunlop (1998) stressed the value of the Ietoga in Samoan society especially women i.e. women's wealth and the source of women identity, thus, weaving as a developmental task of adolescents' girls in Samoa. Alternatively, Anae uses the metaphor of the Ietoga as plaited weaves for a structuralist approach, depending on empirical data and native insights. Further expanded the use of the metaphor, as a writing style, with emphasis on the stands of a subjective and objective writing style, a model that Mulitalo-Lauta extended for use in Social worker practices. Discussing the process of producing an ietoga, plaiting and weaving to achieve that best achieved client's interest and need. Furthermore, Seiuli use the metaphor lalaga o le Ietoga as a framework for the process of collection, preparation, sorting, weaving and presentation. There is a strong emphasis on making the Ietoga from authors, but less emphasis on the lalaga concept from authors. However all the authors emphasised the significant of weaving. Hence, from these authors' perspectives of the lalaga concept, I integrated the skills and knowledge of one of the known weaver, my Grandmother, and

[8] Uses concepts or metaphor of Fale (Samoan house) tui (weaving) presenting communal knowledge creation through consensus, weaving knowledge together through grouping and regrouping

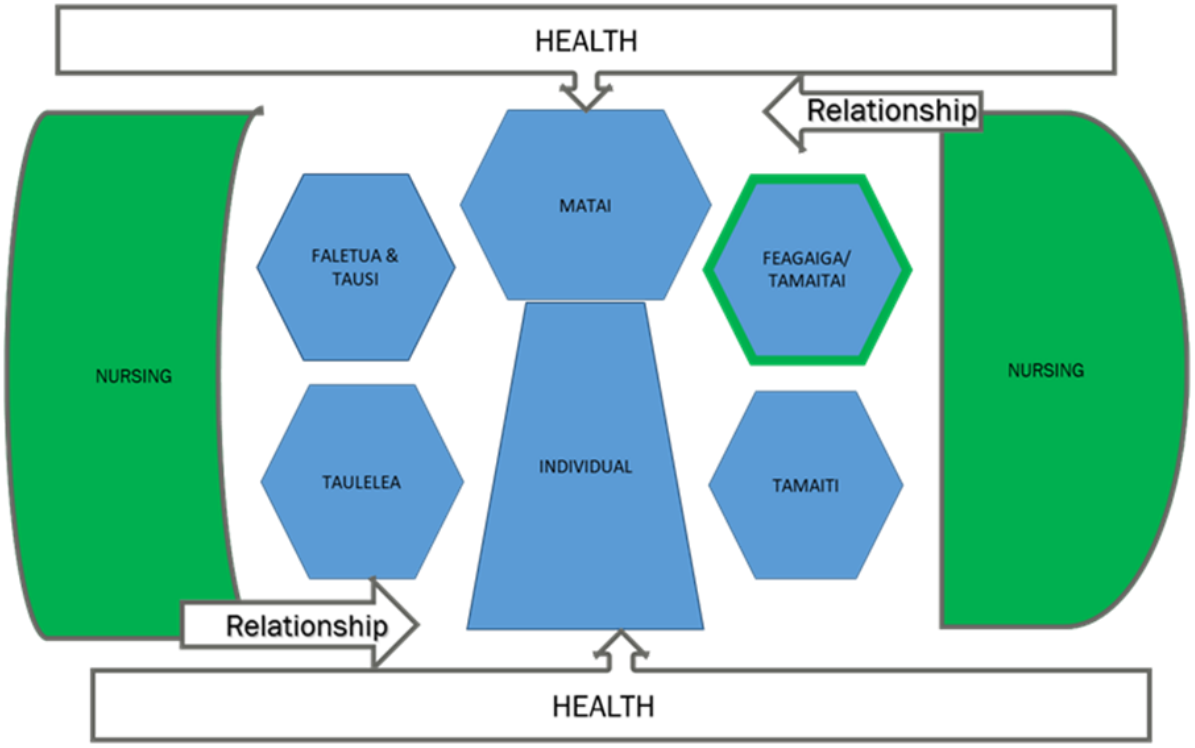
[9] Using the Samoan house (roof, foundation and pou (post)) as a metaphor to present holistic understanding of health, incorporating culture, family, the physical, spiritual, mental and other dimensions of health, as well as time, context and environment.

developed an *Ietoga* research framework or model in which the researcher may best conceptually reflect the study's context, participants, research process and also the researcher herself. However, the crucially important link between Samoan individuals and others will be discussed in greater detail later in the discussion concerning the 'Samoan Philosophy of Nursing' because it is an underlying but highly relevant conceptual framework for this research.

The Samoan philosophy of nursing framework

This research uses the Samoan Philosophy of Nursing (SPN) as the nursing framework to guide data collection and analysis. This philosophy was developed by the Samoan Nurses Association in Samoa in 1990 to deliver care within the context of Samoan culture (Enoka et al., 2014). The SPN is the conceptual cultural framework that guides the quality of care provision and culturally competent and proficient health care. The philosophy also embraces nursing law/legislation, practice, education, and research in Samoa. SPN also embraces cultural values and beliefs that underpin nursing care to reach optimum health results and make sure that the practice of health experts is culturally based within the healthcare of Samoa's context (Enoka et al., 2014). Figure 4 (chapter 2) and Figure 7 below displays the concepts of the SPN, followed by a description of the Samoan culture and family, and the importance of 'Le Va' (the relationship or space between people).

Figure 7: ***Samoa Philosophy of Nursing in a Diagram***



Source: Enoka, I S., Petrini, M A., & Turale, S. (2014). Samoan Philosophy of Nursing: A basis for culturally proficient care and policy, *International Nursing Review*, 61, 416-426.

The four components in SPN are intertwined and interrelated to each other to signify the individual, members of society/community, health and nursing. All four must work together to make a difference in the patient's health outcomes. This enables evaluation of the outcome and satisfaction of care provided by nurses. The diagram also enables viewing Samoan relationships from a holistic view rather than as an individual, a view which does not exist in Samoan society as it does in western societies (Enoka et al., 2014)

The Samoan philosophy of nursing is rather unique because it is based on Samoan culture and emphasises the importance of cultural beliefs and practice. Fundamental to the philosophy is the caring roles of the 'feagaiga' which is the "sacred covenant in the sister-brother relationship" that can also be applied to the nurse-patient relationship or researcher-participant relationship. The word feagaiga has a wide and meaningful definition that 'refers to an established relationship between different parties' that not only exist between brothers and sisters but also to their children, and between chiefs and tulafale 'orators' (Latu, 2015. p. 93). However, the use of feagaiga concept in the philosophy of nursing is simply using the roles and responsibility of the feagaiga within families as caring roles of the nurse while at the same

time maintaining that sacred relationship between individuals, families, communities and villages. For example, a Samoan nurse practitioner wears multiple hats such as taulasea (healer), the caring role of the nurse as a healer; Fai-oa (wealth maker [health is wealth]) such as a health promoter, and Ositaulaga (leader in worship, sacrifice), advocate and leadership role of a nurse as ositaulaga and pae ma auli (peacemaker), mediator role of a nurse as a pae ma auli. These roles enable nurses to communicate competently in a professional manner when greeting patients and their family to ensure health care needs are fully addressed (Enoka et al., 2014).

Despite the limited resources and budget constraints to provide nursing care in Samoa, the nurses consider the SPN principles as a pledge to deliver quality nursing care with the limited budget they work with (Enoka et al., 2014). Thus, with this understanding, and informed needs of the community, a carefully chosen research methodology or methodologies was required. This need, i.e. to serve the community, to promote culturally acceptable methods, and to produce a truly representative interpretation of the realities of the participants, is one of the reasons that Merten in 2009 strongly encouraged researchers to consider a Mixed Method design. Hence, a decision regarding the method to be used depended, in this study, on conscious awareness of factors such as context, history and the social mores of the target community, all of which are factors that drew the researcher's interest into Mixed Method Research.

Another important reason for using the SPN as a conceptual guide for this thesis was due to its cultural approach to the relationship between the participants and "I" as the researcher. As a nurse, I need to be mindful of cultural concepts to enhance trust between the research participants and myself. Therefore, in this study, I played the role of the feagaiga (sacred covenant) as a taulasea, a healer to any concerns or troubles arising from the study, faioa; wealth maker on new knowledge as the result of the study, ositaulaga; a sacrifice in the context of the study; and a pae ma auli, peacemaker to any issues that might arise during any period of the study. The researcher or the feagaiga developed a relationship with study participants as individual's with Mauli (inner being), Aitu (mental processes) and Ola (physical life) as well as part of the society and was mindful of the relationship as described in 6.2.2 during data collection. Teu le Va framework guides the researcher to connect with other

relational communities of the research. Through va tapuia that means sacred space, preliminary results of this research were disseminated to the participants to obtain their feedback about the implications of the SPN cultural framework to enhance ethical practice in Samoa. Thus, these concepts (SPN and Teu le Va) are very valuable from the beginning of the study until the last phase of the study which is the dissemination of the study results to improve nursing education, nursing policy and practice in Samoa.

Teu le Va/Samoan relational framework (values and ethics)

Teu le Va refers to Samoan relational ethics that elaborate more on axiology by strongly emphasising the family unit in relation with older adults, parents, and other people, in terms of the way you talk, walk, sit, stand and dress. Lui (2003) and Tamasese, Peteru, Waldegrave and Bush (2005) refer to the concept of the Samoan self as a "relational self". The Samoan self is the relationship that is dependent on what is called 'va' or the space between two individuals. Anae (2016) elaborates on the Samoan concept of the va as: 'va fealoai' (the space between the relational arrangement), 'va tapuaia' (sacred relational space), and 'teu le va', which is "to value, nurture, and tidy up/act social and sacred relational spaces of relationship" (p. 118). Lilomaiava-Doktor (2009) and Shore (1982) contributed to the discussion by defining 'va/teu le va' as the "fatu (essence) of the fa'asamoa" and the "tapu-ness" of the va (cited in Anae, 2016, p 120). Teu le va has relevance to an ethical understanding of Samoan peoples' relationships with each other. It defines a moral and ethical relational space for discovering knowledge about others through dialogue and sensitive interaction for positive outcomes in all our relationships with research communities (Anae, 2019). Therefore, this research employed the concept of Teu le Va to look into relational the ethical spaces between people and/or the researcher and participants to gain trust and maintain a good partnership as both the interpretivist and transformative paradigms tend to be emphasised. This concept positioned myself throughout the study in order to respect, value and nurture the spaces or relationships with participants in the context of the study.

According to Tui Atua Tamasese Efi (2009 cited in Anae 2016), "tapu (the scared) and tofa saili (the search for wisdom) are considered and situated in contemporary Samoan experience and understanding of ethics. It "provides the basis for ethical research in an indigenous Samoan context" (Anae, 2016, p. 121). Anae (2016) elaborated on Le Va as the "re-appreciation" of

spiritual, sacred, and tapu as the rightful place for ethical debates. Since the framework of western relational ethics often has a lesser acknowledgement, of the spiritual aspects of the relational space, the teu le va offers a framework that can enact sacredness within the interactions between people. This sacred essence and spiritual wakening are vital in the context of fa'asamoa due to the belief that Samoan people are connected to the gods (Anae, 2016). With this concept in mind, the sacredness and tapu of the relationship enabled the researcher to have a socially acceptable connection and partnership with the participants. In turn, this allowed for the reciprocated acceptance within the tofa saili, or the search for wisdom, regarding my desire to study the ethical challenges among nurses in Samoa. Consequently, before interviews commenced, there had to be a great deal of consultation and dialogue in terms of participants' availability, relevant spaces for interviews to take place, age and societal details of the participants. Hence, knowledge of common features of many research projects and knowing these things about the participants properly equipped or prepared me, the researcher, in the Teu le Va way, for my approach when gathering data. This included knowledge of approaches such as the way to acknowledge a female or male participant that holds a matai title; the language used if the participant is a female or a male and again a matai, flexibility in terms of the context and time for the participants. The researcher, therefore, has to be accepting, relevant and connected to culture in the acceptable Samoan way, e.g., my body language and how I dressed when engaging with the participants was important. These actions are all part of honouring the space and relationship with the participants and being able to acknowledge participants regarding their cultural background such as family and societal status. During the interview process with the participants, my focus was to build rapport to gain participants' trust and promote Teu le Va to set the scene for our conversations.

The decision to explore ethical challenges within Samoan nurses' practice as a research topic was a challenge because of socio-cultural demands that were placed on me as a Samoan researcher, for example, oral and traditional language, cultural positioning and protocols and taboos. As a result, there were delays and uncertainties due to my professional position as a nurse and a Samoan woman. This was compounded by nurses view such as that the researcher was a junior nurse and the sensitivity of the researched topic in the context of Samoa. From experience as a nurse practitioner, I realised that it is considered inappropriate for a young

health professional to ask questions about practice as you are expected to just do it and ask no question. Within the context of this research, I realised that the study participants are older than I and some have matai (titled) names and I don't, and there is a saying "e le feagai Vini ma Tapaga" meaning ''Vini and Tapaga - do not face each other". Socially and culturally, this is the researcher's feeling of unworthiness to someone with a high rank (matai title) and status, and I did not have the right to approach or face them, it didn't feel right. However, the concept of Teu le Va set a platform for me to stand on and have a conversation with participants without significant unease. Building a relationship that elevates the conversation and experience with respect throughout the study, therefore, shines a light that enables warmth, confidence and partnership with the participants; all elements that are so necessary for qualitative research in the Samoan context.

The teu le va focuses on the importance of mutual relationships to develop an ideal relationship that Efi Tupua Tamasese referred to as va tapuia (Anae, 2016). The teu le va concept highlights not only the relationship but also the understanding of the context and areas of social relationships and the impact on all the study's social groups such as participants, researchers, institutions, funders, policymakers, and Pacific societies. It is how communities are created and sustained, and what they mean that makes the community and relationships valuable. This was emphasised by Bergum and Dossetor in 2005 (cited in Anae, 2016), in which they say that healthy and ethical relationships and morality are embedded in the collective life, therefore, improving social success (Anae, 2016). In relation to the study, the relationship and the sacredness of the space is where the understanding of the context starts. A transformative paradigm emphasises a social relationship that the interpretivist paradigm so that the researcher was encouraged to consider in the process of the research. Therefore, it is a must to gain an understanding of cultural standards that are believed and imprinted within the culture and social context of the reality that participants and respondents are living or associated with in their everyday lives.

The Samoan way of interpreting teu le va in the context of Pacific research describes the moral and ethical relational space as the knowledge discovered through conversation, and delicate interactions for constructive results in all relationships with the communities being researched. It is believed that 'relationships are the essence of humanity' (Anae, 2016, p.128).

Anae (2016) claims that it is a spiritual experience, and as part of a 'relational body', affects those involved and generates strength between and across individuals, discussion, thoughts, respect, and spirit. Therefore, interviews were conducted with an awareness of respect and spirit in mind and a standby strategy such as a support person. I was also mindful of Samoan social protocols, in that any interviewee might be sensitive towards talking openly about some of the ethical challenges or might not be able to talk about the ethical challenges due to their experience. However, most shared openly, while other interviews exceeded the set time and appreciative thoughts were expressed about the relationship, sharing and also the conversation. Therefore, there was an effect of the concept of Teu le Va on both sides, not only the researcher but also the participants, and it is a warm feeling to experience. All of the measures discussed above were vital to the success of the research; however, because it was qualified nurses who were providing data, one other concept had to be considered before commencing the data gathering aspects of the research.

The Ietoga framework as a methodological approach

My role as a Tamaitai Samoa

Ietoga is considered a priceless treasure in the fa'asamoa. This is because its process is rigid, and the quality of the completed product depends on who the weaver was. The making of the ietoga can take a whole year because the processing of the raw materials to weave the ietoga is a labour-intensive job. Fortunately, I was able to observe the process of making the ietoga in my family because my grandmother was one of the master weavers of the ietoga. Watching my grandmother and how she managed the process at the weaving stage of the ietoga was so fascinating. Culturally, one of the essential roles of the Tamaitai Samoa or feagaiga is 'Faioa' (wealth maker) to make wealth such as handicrafts, making of the siapo and weaving of traditional fine mats and other mats to be used in the house for everyday use. Thus, tamaitai Samoa's capacities to do all these tasks are symbols of wealth within a Samoan family, and it's her status and the responsibility of the feagaiga or Tamaitai in the family. The significance of the tamaitai Samoa's role aligns with the SNP emphasis on the feagaiga, a sacred covenant with roles (taulasea, faioa, ositaulaga and pae ma auli) that characterises the nursing profession in Samoa.

Growing up as a Tamaitai, a Samoan lady, weaving was a significant part of my upbringing. My grandmothers' main responsibility of the day was weaving ietoga or falalilii or fala papa, (hard mat) from morning until evening or until she ran out of lauie or laupaono (pandanus leaves). Her character, skills, knowledge and talent of weaving has been passed down to my mother and aunties to carry on, characteristics such as patience, commitment and passion. Thus, the relationship that builds and yields from the weaving process is one of teamwork and support. The weaving process can be a lengthy process; it may take days, weeks, and months of weaving one 15 to 20-foot long Ietoga and can cause severe back pain from sitting long hours. However, the feeling of having a completed a piece of treasured Ietoga in the household is a valuable sense of wealth, possession or property for special occasions. As Fairbairn-Dunlop (1998) stated, ietoga is a source of cultural history and wealth.

The weaving of the Ietoga plays a big part of my upbringing, and the memory of my loved one's perseverance, commitment, hard work, passion and caring for the future are a characteristic and essence that is integrated into the weaving of this thesis. Therefore, skills and knowledge from my grandmother to my mother of weaving is utilised in this thesis. Not in a physical way of weaving a physical Ietoga but academic weaving of new knowledge in the modern reality of ethical challenges among nurses in Samoa. I am a tamaitai Samoa, a feagaiga, a fai'oa, nurse, educator and now a novice researcher, emphasising the weaving skills and knowledge from my grandmother (someone special to me). Hence, building on The Lalaga concept that has been used by many Samoan authors, has been interwoven together with my experience of western and Pacific world views of concepts and research processes in a theoretical framework of Ietoga for this study.

The Lalaga concept

The Samoan term 'Lalaga' means weaving, which is commonly discussed together with the term 'ietoga' that means fine mat. The term represents a complex and vital process of weaving a fine mat that involves many procedures before a fine mat is formed. The process is lengthy and vigilant which takes months to complete from preparation to weaving of the ietoga. Thus, a fine woven mat holds a significant value in fa'aaloaloga fa'asamoa, a traditional ceremonial exchange (Seiuli, 2015). Many Samoan authors have spoken of the term Lalaga o le, 'ietoga' as a contextual approach such as Anae, 1998; Fairbairn-Dunlop, 1994; Lee Hang; 2011;

Meleisea, 1992; to study Samoan views more precisely in research. The concept of Lalaga was later expanded by Mulitalo-Lauta (2000) as a cultural framework for social work practice with Samoan clients. Which Seiuli (2004) extended and incorporated the view into Samoan counselling and therapeutic research. Thus, from all the authors writing, the common view is the use of the approach of Lalaga which is the art of weaving as a conceptual metaphor in clinical or health work and research with the Samoan communities (Seiuli, 2015). Therefore, the concept of 'lalaga' is highly considered as a useful concept for this study due to its Samoan origin and it's a framework of weaving or integration of ways of acquiring knowledge in the research process. According to Fairbairn-Dunlop (1998) Ietoga represents qualities of respect, prestige, gratitude, recognition and obligation which greatly impacts on the researcher's role, the participants and also the research questions.

For this research, lalaga o le, 'ietoga starts from the practical side of the research setting where preparation and data collection takes place into the analysis and writing process where the weaving process occurs. The process of lalaga (weaving or plaiting) starts when the dried pandanus leaves has been stripped into strands and later, these strands are used in the weaving process. The decision on the planned length and width of the ietoga also occurs when the weaver (researcher) starts the weaving and the number of matalalaga (trails) to meet or achieve the length as set in the beginning of the weaving process. As the weaving proceeds, and the stands are getting shorter, the fegu stage occurs, the shorter strands are filled or replaced by a new strand, so that the weaving process can be continued to achieve its goal. I believe this represents the removing or adding of knowledge, perspective, interpretation, understanding and what is known (Pacific and Western world view) to what has been found from the data. Here, plaiting and integrating knowledge from different dimensions of the study and perspectives (both local and western) of the weaving process in a form of a fine mat or thesis. If the weaver is not weaving or plaiting strands closely, there is a saying that my grandmother always said to me when she saw it "le ie ga la a 'vavala' meaning 'the weaving is not finely and closely plaited' (Faasalaina, 2019). This kind of weaving shows and reflects the kind of weaver. A beginner lacking in skills can degrade the value of the ietoga. In other words, the ietoga may not be finely or closely plaited. Thus, this type will not be a priority or valuable enough to display or shown in fa'alavelave (occasions). But if it is a well, soft, finely woven and smooths type of ietoga, it holds a significant value and is reserved for chiefs' sua or gifts and

other important gift exchanges such as in weddings, funerals and hosting events. The 'ietoga can be woven into various styles and sizes depending on their intended purpose (Seiuli, 2015). This, I believe, represents articulation and critical thinking in analysis and presentation of the data. Therefore, my Ietoga or thesis matalalaga symbolised each chapter of this thesis, i.e. it supports the further assignment of essential themes which are later explained and discussed according to their specific purpose. The 'ie toga that forms from weaving intends to reflect a carefully woven cultural artefact which weaves together indigenous insights, empirical data, and western approaches (Anae, 2009; Seiuli 2013). This study as an 'ie toga is my meaalofa (gift) as a Samoan researcher, nurse and a Lecturer to my nursing profession, School/faculty/university, church, village and especially to my family. This thesis is my 'Ie tele, 'ie o le malo or 'Ietoga to the saoga or contribution to new knowledge and development of future study and research discourse of ethical challenges and nursing ethics.

The metaphor of Ietoga

Figure 8: *The Ietoga*

Source: nps.gov

The ietoga research framework is grounded in Samoan values and principles such as alofa (reciprocity), faaaloalo (respect), faasoa (sharing), galulue faatasi (collaboration) and amanaia (appreciation). These values and principles work together to protray the metaphor of ietoga. It holds each weaving stage together to strengthen the weaving of the weaver (researcher) and the relationships with the community, participants and others. The sensitivity of the topic was another reason that the researcher leant to the ietoga research framework. By using a metaphor of weaving the ietoga and lalaga concepts as a safeguard for taboos in the relationship, forgiveness for any unintended words or shortcoming of the researcher, and appreciation of the relationship, wealth – knowledge and experience, time, participation and

collaboration during the study. The ietoga research framework consists of four stages in the ietoga process. These were compiled and put together with the researchers' experience but guided by other Samoan authors interpretation of the Lalaga concept (as described in the previous section). The four stages were discussed and formulated with my late grandmother, the stages are Taaga, Kosi, Matalalaga and Faalelegapepe (Faasalaina, 2018). These are the four stages that are involved in the making of the ietoga with values such as alofa (reciprocity), faaaloalo (respect), faasoa (sharing), galulue faatasi (collaboration) and amanaia (acknowledge/appreciation).

Figure 9: ***Four stages of the Ietoga***

Faiga/Taaga stage

Faiga means 'in the making', which can also be understood as a system while Taaga means cutting and collecting. These crucial steps make the pandanus fibre soften and therefore easier to be stripped into strands for easy weaving not only that but it also forms natural prevention against fragmentation and splitting that might occur in the process (Seiuli, 2015). The application of this stage to this research, is a crucial stage to conceptualise, plan and design before the study takes place. The stage has two processes: the preparation phase and data collection phase. The preparation phase is where planning and consideration take place that looks at the goals of the study, the target population, method to use and use of the study.

Once the planning and designing are complete, the data collection phase occurs where the gathering and collection of data takes place, which involves exploring experience and perspectives of the topic and removing spikey edges of the study, considering the environment, process and diligent techniques/methods of data collection that yields raw data for the study (Faasalaina, 2018).

Kosi stage

Kosi means stripping or splitting into strands. Once the pandanus fibre transforms its colour and texture from the Faiga/Taaga stage, the raw new transformed fibre is apportioned, scraped to make it softer and lighter, and finally split into desirable numbers of strands or lengths. The scraping part is vital because, without this process, the lauie (pandanus) won't be soft and light enough to be split into strands. Thus, it is very important to the weaving process and the overall weaving of the ietoga. If the lauie fibre is scraped well enough it is as soft and light as it can possibly be. Then there needs to be an equal length of split strands so the ietoga will be soft, light and finely made (Faasalaina, 2018). Therefore, the application with regards to this research is that the scraping and stripping of raw materials, becomes the identifying technique and categorisation stages of analysis. The raw materials equates to data collection, scraping to make the strands softer and lighter and split into strands for weaving. Categorising data into themes and subthemes and placed it into bundles to be woven together with strands of literature and worldwide views, with cultural and Pacific view strands of ethical challenges.

Matalalaga stage

Matalalaga means ‘closer plait’. Close plaiting turns an ietoga into tight and well fine weaving, the weaver makes sure that during ‘fotuai le ala’ (starting the weaving) the strands need to be tightly woven, smooth and straight. There is a ‘fegu stage’ which is when a new strand of lauie replaces or fill the shorter lauie for the continuous weaving process. Towards the end of the weaving of that matalalaga, the weaver would say ‘faaiu le ala’ which means ‘last/final weave or weaving at the end’ which is another skill that the weaver needs to make sure that the pattern is the same and closely plaited in as straight a line as possible. This process symbolises the use of strands as knowledge, different views, understanding, experience and data of the Pacific and broad world views, participants, philosophers, theorists and the researcher. Therefore, the strands woven into a matalalaga equates to chapters, discussion or writing with

characteristics of fotuai, fegu process and faaiu ala to enhance the quality of the discussion and writing of the study. I believe the fegu process is also important as it symbolises the change and shift of knowledge in the weaving or it can be seen as the integration of knowledge in writing or discussion of the study. Sometimes if the weaver adds a new strand and it does not have the same length as the old one, the weaver will cut the edge of the strand to make it fit or get a more prominent strand if the old strand length is more significant. It merely emphasises the refinement of new knowledge according to the old knowledge or elaborates on evidence that fits with the study topic.

Faalelegapepe stage

This process starts with *decorating* the fine mat with colourful chicken feathers before presentation. Overlapped laui'e are removed by cutting them off for a smooth form, revealing fine patterns of weaving and adding coloured chicken feathers which are used nowadays. Layers and patterns of coloured chicken feathers depend on the weaver's decision which will be added to the Ietoga and ended with *fa'ataele phase* of applying the oil on the mat that will beautify and be presented at the Faalelegapepe. Faalelegapepe means flying butterflies which means displaying flying colours of the Ietoga (Faasalaina, 2018). The final stage of the beautiful finely made material of the ietoga is likened to a butterfly. When an i'etoga is completed and finally displayed**,** the ietoga will be hung up on long sticks, and two people will hold each end up high. Women march in line with others from one end of the village to the other, holding 'ietoga up high so that people of the village can see it and appreciate the effort and long hours of weaving. Celebratory remarks that echo approval and appreciation accompany its *presentation* (Seiuli, 2015). It is an opportunity where the value of the 'ietoga materializes, acknowledging the patient processes involved and the care taken by the weaver to produce a national treasure ('ie o le malo). This process symbolises the presentation of the thesis in this research, to other academics, to researchers and the public. Informing the community, the quality and decision making of the value of the ietoga or thesis. Thus, the feeling of appreciation and acknowledgement of hard work materialises for developing such a treasure that holds a significant value to the world of academics, researchers, educators, nurses and, in this case, especially my family.

Research Methods

The study is carried by the mixed method approach, according to Mackenzie and Knipe (2006), although the term qualitative and quantitative are usually understood to refer to research paradigms, however they are sometimes used to refer to the research methods. Therefore, this study used both qualitative and quantitative research methods within a sequential design of a mixed method research approach to explore perspectives of nurses in Samoa in regard to ethical challenges they have experienced within their workplace, practice and profession.

The use of qualitative and quantitative methods in this study

Qualitative research is a method that explores the meanings individuals or groups attribute to social or human issues; it supports inquiry of research that respects an inductive style, with a strong emphasis on personal meaning and interpretation of difficult situations (Creswell, 2014). This explores and searches answers to the 'why' and 'how' of a specific social reality in a particular context. Polkinghorne (2005) builds on this notion by adding that qualitative research assists us to understands the community that we live in and understand why things are in a socially constructed form or the way that they are (Mohajan, 2018). Subsequently, the researcher is equipped to explore interpretation and understanding, which in this study, is of nurses and their viewpoints and practices concerning ethics and ethical issues. However, because of the limited literature from the Pacific Islands, as well as little being known about ethical challenges among nurses in Samoa, the project required a greater variation of sources when data gathering. Subsequently, qualitative data was gathered from interviews with nursing experts, appropriate nursing documents (such as national nursing reports), registration and policy documents, the Nursing Act (1952, 1982, 2007) and Nursing Standards and Competencies booklets (1990, 1999, 2007, 2017). In this way, the researcher developed a more accurate understanding of the current perceptions and interpretations of nursing actions to formulate an instrument to be used by the broader population of nurses.

Quantitative research relies heavily on measurement through statistical means and is therefore identified with testing, calculating and measuring (Creswell & Plano Clark, 2018). It usually measures a hypothesis and examines cause and effect relationships and differences of variable outcomes. Thus, data is collected through the use of direct observations,

questionnaires, retrospective or prospective audit of data. The common type of observation design is a survey, which was the method that this study employed to collect data from a large sample of participant nurses in Samoa. The survey method was seen as a necessity for the success of this research as the main aim was to gather characteristic data of nurses' experiences and perspectives of ethical challenges in Samoa. Frequency and intensity of ethical challenges that these nurses encountered was measured. In this sense, the research was indeed exploratory, i.e. very little was known about ethical challenges among Samoan nurses before the study, and a survey questionnaire was found to be appropriate for the study

Finally, the Samoan philosophy of nursing (SPN) as a conceptual cultural framework alongside the concept of Teu le Va was employed to guide the researcher on ways to approach participants and in data collection. There are formal ways and formalities to be respected when you converse, and the language used to communicate is not the same in all circumstances within Samoan society. Therefore, to be an effective researcher, the researcher needed to acknowledge and maintain the sacred relationship of Teu le Va to enhance trust and cooperation with community involvement, as encouraged by the interpretivist and transformative aspects of the study.

Mixed method research

Mixed method research features a diverse approach with certain philosophical assumptions and varying methods of inquiry (Creswell & Plano-Clark, 2018). In several research projects, adopting a mixed methods approach entails the combining of both quantitative and qualitative methods to produce a study that helps highlight the similarities and differences between particular aspects of the phenomenon. At the same time, others have expanded the use of mixed methods design which is mostly based on practical issues. However, attention was drawn to both approaches, it may be argued that a combined approach provides strength and perspectives to recognise existing and essential aspects of the natural world. This also acknowledges the importance of the reality and influence of human experiences(Östlund, Kidd, Wengström, & Rowa-Dewar, 2011). In 2007, Hancock implied that mixed methods that are therefore suitable not only for individual experiences but also for revealing general realities and challenges that continually reconstruct social frameworks and stratification (Cabrera, 2011). This particular aspect of a mixed methods approach is therefore seen as being

entirely appropriate when considering the experiences that nurses' encounter in Samoa (see previous discussion regarding the effects of Samoan culture on social behaviour).

As previously discussed earlier in this chapter, mixed method refers to philosophical assumptions that provide guidelines regarding the collection and analysis of data, and the combination of qualitative and quantitative approaches in many phases of the research process. As a result, at least in some circumstances, combining a quantitative and qualitative approach provides a better understanding of research problems than either approach alone; this is the fundamental principle of the mixed methods approach (Creswell, 2014). Furthermore, Creswell (2014) claims that mixed method is a practical and natural approach to research. It is practical in a sense because it provides researchers with more freedom to use all methods applicable to address a research problem. Thus, due to individual ways of solving problems using both 'numbers and words', and also by combining inductive and deductive thinking, a researcher can employ observational skills while also recording the viewpoints and/or behaviours of people. This approach is considered natural in a way that is more convincing in presenting a whole picture (Creswell, 2014). Another critical aspect of mixed method research is the choice and freedom of the research method or approach that the researcher can use. It offers ways to make research more 'meaningful, complete and purposeful' instead of using a single approach such as qualitative or quantitative and it provides researchers with more valuable research tools (Whitehead & Schneider, 2013). Therefore, it supports the intended approach of this research that offers both an adequate depth of conceptual meaning and comprehensiveness of data for analysis. Hence, a mixed methods approach may present several advantages, especially when one phase of the research may inform the next phase. Qualitative research is a legitimate form of inquiry in the social and human sciences, and quantitative researchers believe and recognise that qualitative data can play an important role when combined with quantitative research (Creswell, 2014). This is thought to be useful because merely reporting a limited number of qualitative participant views may not always provide findings of sufficient depth. However, policymakers, practitioners, and other audiences may require various forms of proof such as measures of numbers to mark, notify, and fully explain the research problems (Creswell & Plano Clark, 2018).

Furthermore, a mixed method approach is more appropriate and appealing to nurse researchers to understand multi-facet dimensions of health (Chiang-Hanisko, Newman, Dyess, Piyakong, & Liehr, 2016). Subsequently, this approach provides a more comprehensive analysis addressing ethical challenges among Samoan nurses and is therefore regarded as both highly desirable and useful in achieving the research aims. Hence, combining the analytical materials from both qualitative and quantitative data was an approach that was found to be of great benefit. The study sought the expertise (through interviews and formal documents) of selected participants and then used them to create a survey that could be efficiently delivered to hundreds of participants. Thus, the results were integrated and represented in a more comprehensive meaning and experience of ethical challenges among nurses in Samoa. The context is strongly emphasised and priorities due to, firstly, the participants in the study being Samoan, secondly, the setting of the study is in Samoa, and thirdly, the researcher is a Samoan lady. It is important for the researcher to be fully prepared and understand approaches that are relevant when addressing participants in a context that has strong cultural and religious beliefs.

To conclude, selecting mixed methods for data collection ensured that perspectives at all levels of nursing were explored in this research. A mixed method approach that employs both qualitative and quantitative approaches is highly relevant for this study. Furthermore, the chronic lack of available literature from the Pacific Islands and Samoa about nursing ethics strongly suggests that a sequential exploratory design would best serve the study.

Research Design

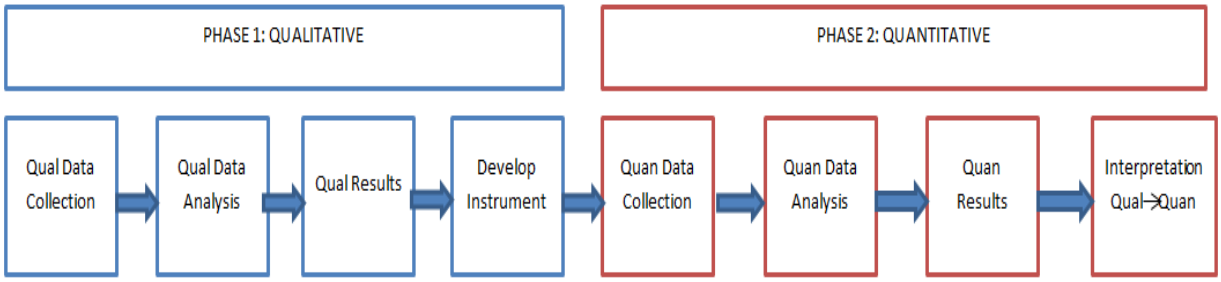
Sequential exploratory design

The mixed methods approach that was selected for this project was enhanced and refined by following a sequential exploratory design (SED) because it is a two-phase sequential design (Greene, Caracelli, & Graham, 1989) that serves the purposes of the research project very well. This is because it is characterised by an initial phase of exploring the phenomenon in the qualitative phase of data collection and analysis before constructing the quantitative phase, i.e. statistical data collection and analysis. Thus, the findings of the qualitative phase of the research are later employed to inform and explore ethical challenges among a very large

sample of Samoan nurses in the second phase of the study. Thus, the exploratory design's primary purpose is to take the broad views of a few selected individuals (and various documents) from the qualitative results of the first stage, and then carefully apply selected concepts from this first stage to apply to a more significant sample in the second phase of the study (i.e. where the qualitative material informs the development and eventual delivery of the quantitative survey material). This was of great benefit to the study, because as Creswell and Plano Clark (2018) claim, the SED approach is a useful design when a researcher wants to develop and test instruments where none are available or to find significant variables that are unknown in a larger sample. Here, it should be noted that none were indeed available that measured ethical issues among nurses in Samoa, or for that matter, the whole of Pasifika. However, it should be noted that several western surveys on this topic were found and examined but found to be of limited use and/or highly applicable to the Samoan context (see later discussion). Exploring a research topic in great detail and measuring its complexity in sufficient detail is, therefore, a major advantage of SED (Creswell & Plano Clark, 2018).

The design has value for several other reasons, such as the unavailability of a suitable instrument for the research, where variables are unknown or obscure, or there is no guiding framework or theory. As Creswell and Plano Clark in 2006 point out, the design primarily focuses on exploring a phenomenon since it starts with the qualitative method before utilising quantitative ones (Creswell, 2014). Jeanty and Hibel (2011) add that the design also better suits when explaining and interpreting relationships. This is what the study focus is about, i.e., exploring by looking at the relationship of explaining and interpreting the experience of ethical challenges among nurses in Samoa. Furthermore, it extends the understanding from the qualitative findings by drawing out conceptual elements into the larger population SED (Jones, 2016). The development of an instrument which is the survey in this study, is based on qualitative findings and the results will be tested and studied in detail in the quantitative phase (Creswell & Plano Clark, 2011; see Figure 10)

Figure 10: ***The sequential exploratory design: Instrument development mode***



Source; Creswell & Plano Clark (2011)

Finally, it should be noted that the variant of the SED approach that this study uses is the *instrument development model*. This was because of the need to develop an instrument from qualitative findings. Developing an instrument is applicable to implement in the context of Samoa because of noticeably strong cultural influences on practice and because it was thought to be highly desirable to attempt to survey as many Samoan nurses as possible. Therefore, the SED approach proved to be a very good fit in that it wove qualitative and quantitative data together for the study to enhance a comprehensive view of ethical challenges experienced by Samoan nurses.

Settings

The qualitative phase of the research (phase one) involved gathering in-depth data through semi-structured interviews at the participants' preferred setting or place to be interviewed, and at a convenient time. Considering how sensitive the topic of the study to some participants might be, the option was given to participants to allocate a time and place in which they would feel comfortable. To enable the interview to flow well, and the participants able to answer questions freely without holding back. The research setting for the survey dispersal (phase two) included both islands (Upolu and Savaii). There are six district hospitals in rural areas of both islands (Upolu and Savaii) of Samoa, one referral hospital of Malietoa Tanumafili II (MT2) in Savaii, and the Tupua Tamasese Meaole (TTM) national hospital (eight wards) in Upolu, which is situated on the main island of Samoa.

Participants Recruitment Process

The recruitment process was intentionally given to Assistant Chief Executive Officer of Nursing and Nurse Manager of main hospitals (eight wards) of Upolu, referral hospital of Malietoa in Savaii and district hospitals (both Upolu and Savaii). The meeting was allocated with the Assistant Chief Executive Officer of Nursing (ACEON), and the information was explained for the purpose of the research, ethics approval and recruitment process for participants. The ACEON then contact principal nurses of the main hospital in Upolu, a referral hospital in Savaii and the community nurse for district hospitals in Upolu and made appointments to see them to discuss the research in more detail with information sheets provided. The initial plan was to inform nurses of the research during the nurse's clinical meetings to capture potential participants who would be interested in participating. However, with a prolonged waiting period for the ethics approval that led to limited time for data collection. Therefore, I changed the strategy for recruiting participants by making posters (appendix 7 & 8) that were given out to nurse managers during meetings, to post on their notice boards with information sheets for anyone who wanted to participate. At the same time, the selection of participants was given to nursing managers to allocate participants according to the criteria as discussed during the meetings. The selection of participants was the nurse managers' responsibility, with the notion of strengthening the relationship and participation between the researcher and the target population. This is a necessary part of showing respect which is very important in the Samoan context. By acknowledging leaders and their responsibilities within the context this way, enhanced and improved cooperation and teamwork that enabled the research to proceed. The researcher later contacted participants provided by nurse managers to be interviewed and allocated time with the preferred place where she/he wants the interview to take place (as explained under 'Settings' above). Informed consent was then obtained before the interviews started. Information about the research, the procedure of the interview and consent form information was firstly explained. Thus, time was given to the participants to read the consent form document and ask any question before signing the document. It was also explained that they had the right to withdraw at any time from the research.

Procedure in which the research participants were involved

Participants in data collection utilized semi structured interviews that lasted approximately 30 to 40 minutes. One on-one interviews were performed from the end of September to the end of October 2018. Each participant was asked ten open-ended questions which were audio recorded by the researcher with the participants' permission and awareness. All interviews took place at their preferred time and place. However, for the second phase of the study, respondents completed a survey questionnaire. The survey questionnaire took 10 to 15 minutes to complete, and it was carried out throughout July to August 2019. Respondents were asked to complete a three-section survey that contained numerous questions and a Likert scale. The researcher personally distributed survey questionnaires at the respondent's workplace and collected each survey on the same day.

The two major research phases

Phase one – Qualitative Stage

Participants Criteria

Purposive sampling that provided rich information for an in-depth study was selected as an appropriate data source for the qualitative phase of this research. The required knowledge and experience base were set at an inclusion criteria of two years working experience in the district hospitals and in the main hospital as an EN and/or RN. This helped to, minimise the possibility of the researcher being biased with participant selection and enhanced the credibility and reliability of the research project (Houser, 2008). Table 1 below presents the inclusion criteria of the participants who were interviewed in this phase of the research. Inclusion and exclusion criteria helped the researcher decide on the effect of the external validity of the outcome (Patino & Ferreira, 2018). Suitable criteria for participants were well thought through, i.e. it ensured that each participant was fully able to answer the research questions of the study. Thus, consistency, reliability, uniformity and the minimisation of bias was encouraged within the study population, which are essential factors (Garg, 2016). Most importantly, the focus of this research was to interview enrolled and registered nurses who represented nursing in Samoa at all levels, i.e., from specialists and managers to nurses who were working 'on the floor'.

Table 1:*Inclusion and exclusion criteria of the study*

Inclusion Criteria	
Items	***Description***
Gender	Female and Male
Nationality	Samoa (this study is focused on Samoan perspectives)
Occupation	Registered nurse or enrolled nurse (Full time)
Working experience	Two years upwards since registration. Seniors – 5 years
Position	Work in wards (Main and Transfer Hospital) and district hospitals
Exclusion Criteria	
Management level	Nurses who were nurse managers, nurses' consultant, supervisors, principals and who were holding a position in the administration office.
Specialist	Nurses who were specialists in a specific field, i.e. midwives, unless they wanted to be interviewed not as a midwife but as a registered nurse in general.

As recommended by Creswell (2014), and as was appropriate in the Samoan context, snowballing sampling was used to identify interested participants who knew others with the same experience to enrich the data fully. It helped this research generate information from a wide variety of sources and gather information when one or two participants referred others to the researcher. Therefore, utilising social networks, and the fact that professional colleagues have shared ideas on specific issues which assists when locating participants that are hard to locate through other methods (Lopez & Whitehead, 2013). The sampling method is sometimes called 'network sampling'. However this was a challenging experience due to my background as a nurse and a Samoan woman within a strictly observed social hierarchy. However, using this approach allowed me to utilise the SPN and *Teu le Va* concepts that are so common in Samoan society to ensure my position as a researcher in exploring and understanding challenging phenomena within Samoan nursing society. To achieve these goals, i.e. to 'smooth the path' to research nurses' experience in Samoa, a close relationship was established with the Chief Executive Officer of the Ministry of Health, Assistant Chief Executive Officer of the nursing division, and nursing leaders of wards of the main, referral and district hospitals' nursing divisions. The relationship ensured cooperation and support at all levels and is in itself another reflection of a particularly Samoan way of obtaining participants within the health system.

Selected participant & recruitment

All participants were Samoan nurses, and for this qualitative phase of the research, there were twenty-one participants selected by purposive sampling, 13 registered nurses (11 seniors and two juniors), three nursing lecturers and five enrolled nurses (three seniors and two juniors). Enrolled nurses were included because they played a role in the patient care plan and decision making when a registered nurse is occupied with severe cases during a shift, and they, therefore, deliver a considerable amount of the actual nursing care in Samoa. From a nation that is plagued by limited resources and shortages of staff, every health worker around the patient is essential, and even family members when needed to play a role in delivering health care service. Hence, the final arrangement of participants were six registered nurses and three enrolled nurses who were selected from the six district hospitals of both islands (Upolu and Savaii). Seven registered nurses and two enrolled nurses were from the two main hospitals, and the three nursing lecturers were also invited to provide in-depth interviews. This research data analysis started immediately from the first to the last interview to ensure data for themes to formulate the survey that was used in the quantitative phase.

One-on-One interviews

Data for the study was gathered through one-on-one interviews using semi-structured questions such as providing examples, explaining, or stating the reason for the answer to seek clarification and elaboration on nurses' perspectives of ethical challenges within their workplaces. Also asked was, how did the perspectives that emerged during the interviews affect their decision-making about (ethically related) patient care and their profession? Both unstructured and semi-structured interview questions were mainly non-directed and open-ended questions to trigger and stimulate each participant to talk about their adaptation to and interpretation of aspects of the topic, as recommended by Lopez & Whitehead (2013).

All in all, ten questions were formulated from research questions and literature in regard to ethical challenges among nurses. The approach was open-ended and semi-structured questions to allow for unexpected responses and the emergence of issues or topics(Ryan, Coughlan, & Cronin, 2009). This flexibility of the approach not only allows the interviewer to follow less structured questions but also allows exploration of unprompted issues raised by the interviewee through clarifications. Ryan et al. (2009) stated the benefit of informality

during the interview that allows the interviewee to take control of the interview process (Ryan et al., 2009). It was an aspect that was experienced during interviews with nurses in Samoa, in regard to ethical challenges among nurses. The interviewees talked freely in regard to ethical challenges they encountered, and the interviewees led the conversation in some cases due to the interesting topics they had mentioned and the richness of their shared experience. There were times that the order of the interview questions were not followed due to the openness and flow of the experience shared by nurses during the interview. The experience directs the focus to the interviewee's story and experience, which is the main target instead of the interviewer's list of questions. The approach was aligned well to the background notion of using transformative notions that promoted the complete involvement of the participant in 'driving' the data gathering aspect of the research instead of the researcher being dominant in the process. All twenty-one interviews were recorded via audiotape with participants' consents. It was conducted in a preferred setting with a timeframe of 30 to 40 minutes, depending on the responses of the participants. However, some interviews took up to an hour and some to an hour and a half. Location and time that interviews took place are all different, but most were at their workplace. The participants' availability is essential; therefore, most of the interviews were done during their lunch break from work and some after work.

Thematic analysis

The purpose of performing interviews first-hand in this study was to use the main themes that were extracted from the interview data to formulate the new survey instrument for the second phase of the study. Therefore, to identify themes from the interview data, the six phases of thematic analysis by Braun and Clarke was employed to extract meaning and concepts from collected interview data through an examination of transcripts (Braun & Clarke, 2006). This approach uses the data to pinpoint, examine and record patterns or themes. The six phases of thematic analysis are: familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, naming and defining themes and finally producing a report. This were used as a framework to assist the analysis of the interview data. This process is not linear, but circular and repetitive, which makes it more beneficial for the study in that moving back and forth through the phases produced refined and carefully considered results. Even though the procedure states direct steps to follow, the analysis process was found to be very iterative and reflexive.

In the study, the 21 audio recordings of interviews were transcribed in the Samoan language, and it was discovered that transcribing these audio recordings was an opportunity to become very familiar indeed with the data. There was an attempt to translate the interviews into English. However, there was a gradual realisation of losing the meaning of what was actually said or implied in this approach. Therefore, a decision was made among the supervisors (one of whom is Samoan) to generate initial codes from the 'native' language (Samoan) and both (researcher and supervisor) to assist with the search for themes. Later, beginning and promising-looking themes from the Samoan language were translated as close as possible to English words. The approach added more meaning and elaboration on the classification of identified themes (which will be discussed in greater depth in the following chapter). As a result of these measures, 25 identified themes were classified into five major themes that were used in the new survey instrument layout. The process was made as reliable as possible through a continuous confirmation with the supervisors of the meanings of the developed themes.

Phase one (a) – Survey questionnaire development (the instrument)

The development of the survey questionnaire was achieved not only by looking at the themes themselves that were gleaned from the one-on-one interviews (as previously described), but there was also an exploration of other existing surveys regarding ethical challenges. Furthermore, criteria such as the overall look of the survey questionnaire, the layout, and design and instrument questions were all considered. Therefore, to an extent at least, the instrument was also informed by previous studies (Berger, Seversen, & Chvatal, 1991; Davis, 1981; Enes & de Vries, 2004; Fry & Duffy, 2001; Jonhstone, Da Costa, & Turale, 2004; Konishi & Davis, 1999). Overall, these studies supported the criteria and gave some guidance to the layout development of the survey. My primary supervisor also shared his existing survey from a previous research project (Woods, 2014) to provide an example of how such a survey might be set out and to guide the process. A university-based statistician was also consulted for advice on the design of the survey, and another two nurse academics also provided feedback on survey content and layout.

There are four parts to the Survey Questionnaire (see Appendix 12 & 13), the first part of the survey questionnaire measures demographic data. The second part considers professional issues (with the idea of looking at or identifying their understanding of ethical decision making), and the third part looks at ethical challenges and how often they occur (frequency) within their workplaces. The last part of the survey was the half page space for additional comments, for valuable insight about the topic and clarification of what might be useful to improve the instrument or the study. The purpose of the Likert Scale in the survey was to provide a degree of depth of response and generalised findings from the qualitative phase of the study to the great population of nurses in Samoa. It should also be noted here that what the interviewed nurses perceived as significant ethical challenges within Samoan nursing, were not necessarily the same as those identified by western orientated researchers. The subsequent survey questions, therefore, reflected a particularly Samoan set of perspectives on the nature of ethics and Samoan sensitivities towards ethics. The idea of frequency was also another factor that was considered for inclusion in the survey. This debate centred on a question of "do you agree or disagree" with a given item but also on measuring whether it was a significant challenge to practice. As a result of this discussion, the frequency column was added so that it allowed the measurement of the rate of occurrence related to the identified challenge.

Phase two – Quantitative Stage

Piloting survey questionnaire.

The piloting stage was an essential part of the process for the new survey questionnaire. Since it was a new questionnaire, continuous changes and refinements were made from the first to the last draft. It was a necessary and essential process that ensured the reliability and validity of the new survey questionnaire (Marshall, 2005). The identified themes from the data analysis supports the process of formulating questions included in each sections of the questionnaire while articles and advice from supervisors helped in the layout, sections format, and final presentation of the survey questionnaire that needed to be included in the pilot survey. The first pilot was trialled on two of my colleagues who are nurses and also from Pacific islands that have cultural aspects that are similar to Samoa's context to see how completing the survey was for them. Feedback was then given in regard to the clarity of instructions and

questions, the layout, and the timeframe it took them to complete the survey questionnaire. A large number of changes was made after the first pilot with supervisors, according to provided comments. I later, consulted the university statistician for clarity of the questions for measurable results before the questions were given to two nurses in Samoa, for the second pilot. I translated the English version of the questionnaire to a Samoan version with the assistance of my secondary supervisor so the two Samoan nurses could provide feedback on both versions (English and Samoan) to ensure the final draft, i.e. the one with the Samoan version of the survey instrument, was appropriate for use. There was feedback given about changing some of the words in the Samoan version. In contrast, there were some parts of the English version in the demographic section that needed changing to make quite sure that the person filling out the survey could not be recognised (which was also the same advice from the ethics committee and supervisor). After all the changes and feedback, the *eighth* draft of the new survey instrument that was specially made and formulated from the interview data was distributed for the quantitative phase of the data collection. Thus, this new survey was purposively made to cater to cultural requirements and aspects that were identified in the qualitative phase of the study. Moreover, it enables the interview data to be thematised.

Consultation for survey implementation

It was especially important for me, the researcher, to get the support through partnership of the nursing leaders for this survey to proceed, and the Teu o le Va concept was put into place to gain respect, trust and cooperation, and vice versa. Consultation was therefore made with the Assistant Chief Executive Officer of Nursing regarding the survey timetable and a request of her allocation of time for the district hospital and main hospital to be surveyed. The fieldwork was planned to be conducted in four weeks, with the main hospital (hospital wards) to be in the first week. However, there was a change to the planned timetable because Samoa was hosting the South Pacific Games (SPG) at the time and the main hospital nurses were at allocated venues for the games throughout the two weeks. So, therefore, data collection started at district hospitals of Upolu, leaving the Main Hospital for the last week. Time and day were flexible for the Manager of the wards (main and referral) and district hospital to choose from depending on their availability.

Sample- Survey questionnaire

The results from the primary data collection generated a purposely made descriptive survey that enabled an exploration of the perceptions of the greater population of nurses about their ethical challenges when working in Samoa. This was followed by extensive work in refining, testing, piloting, and eventually preparing a suitable survey document (as previously discussed). After these exhaustive processes, the survey packages were prepared. They each contained a participant information sheet, consent form, survey form and a sealed envelope in which to put the copy of the survey after completion. The consent form and information sheet in the survey package had a statement on the freedom to participate. The survey copies were collected by the researcher from a neutral source on the day or picked up on the following day to ensure and maintain complete anonymity.

The results from the qualitative phase provided a high amount of conceptual material that was used when formulating the survey instrument. This was personally delivered by me, the researcher, by using a motor vehicle to travel around Samoa to deliver the survey to all registered and enrolled nurses who were available at their workplaces at the time of my visit to Samoa, with an estimated total of 425 nurses in the workforce in Samoa. Dates and time were allocated with nurse managers of wards of the main and referral hospital, district hospitals of both islands (Upolu and Savaii) according to their usual staff meeting day. The researcher only counted respondents who were present and responded to the survey on the allocated day. There were requests from other district hospitals and wards to visit another day to survey those who were absent, but apologies were made because of the limited time to conduct the second phase of the study. The researchers' availability was flexible to respondents in the main hospital, due to their shift and busy hours, so the researcher picked up survey questionnaires from respondents on the following day or when they were available. One of the factors that the researcher needed to be aware of was to work around the availability of the respondents and not the researchers' availability.

Routine of data collection

In accordance with the previously discussed Teu le va approach, and because of several other ever-present commitments, every meeting with nurses at district and main hospitals of Upolu

and Savaii were allocated for an hour but no longer due to concerns of their time and also their responsibilities of the day (nurses are heavily committed to their extensive workloads every day in Samoa). The meetings took place before the distribution of the survey and was set up by the nurse manager and the researcher, depending on the availability of the staff (nurses). The routine of every meeting was firstly the Faatulima (greeting and introduction), then the Brief (brief presentation of the topic and the reason for the meeting request), and after answering final questions, the questionnaire was distributed to all the participants. The nurses completed the questionnaires, and the survey was collected. Finally, I offered the Faatofa, or final word of appreciation and best wishes to the nurses.

Faatulima – Greeting and Introduction

In every setting I went to, there was a brief faatalofa and faatulima (cultural welcoming) from the Nurse Manager of the ward or district hospital, and also an acknowledgement the staff's presence, from seniors to juniors and also the researcher. The nurse manager also acknowledged some who were not present. This part of the research process is very important to the overall process because this is where relationships and trust are built. I would then introduce myself and acknowledge their presence and how valuable their time was for this research. Acknowledgement is one of the main signs of respect in our culture; it is honouring the participants' status and position within the setting and putting the participant first in the relationship. It reflects how I value the relationship with the participants, which brings confidence and a welcoming feeling into the new relationship. The response from the participants was reciprocated when they saw and noticed the effort and consideration put into the relationship, which was the Teu Le Va concept and equipped the researcher before every meeting with the nurses.

Briefing and distribution of questionnaires

After the cultural/formal welcoming, the nurse manager allowed talking to the gathered nurses on the reasons for the day. I used this opportunity to discuss the survey and a little abstract of the research. The brief covered aspects such as anonymity and confidentiality, the length of the survey time (20-30 minutes), the layout of the survey and parts that each section covered were made known. During the briefing, I strongly encouraged nurses to reflect on their own experiences to answer the questionnaires. Before I gave out the survey

questionnaire I also encouraged them to ask questions at any time if they found anything that was not clear.

Questionnaires were distributed when there were no further questions. The English version of the questionnaire was also given out with the Samoan version in some settings as requested by respondents to clarify understanding on some. It is of interest to note that some participants even asked questions and made statements after filling in the survey questionnaires, often commenting that they were pleased to be able to reflect and comment on their perspective of ethical challenges among nurses in Samoa. In general, they seemed to appreciate the topic even more and the need to look at ways to safeguard the practice and also nurses from performing non-nursing procedures and also treatments. This latter aspect of the research is, therefore, an example of the transformational possibilities of such research, i.e. as a catalyst for further discussion and possible change.

Collecting the survey questionnaire

The collection time was mention at the beginning of the briefing; however, time was allowed to return the questionnaire at any time after the meeting on that day. Due to the understanding that they were busy people with commitments at work, family, villages and church, a specific time was allocated for the survey collection which in many cases only took them around half an hour to complete and the return to their busy schedules of the day. There were a few participants who requested collection of the survey from them on the following day, but six respondents did not return the survey at any time. Nevertheless, most of the survey questionnaires were collected after the allocated time and place that the meeting took place.

Faatofa- final words

After all, questionnaires had been collected, and all questions answered, a little thank you speech was said. The appreciative thoughts made known for the opportunity and privilege of allowing the survey about ethical challenges to take place in the hope that it will be useful for the future of nursing development in Samoa. Thus, ended the meeting with giving out of a koha (phone credit voucher) which was given to each of them who had returned their survey. The koha was never mentioned in advance and it wasn't until they handed me their survey

that they received a surprise gift in appreciation. They were surprised and felt appreciated with that small token. I later ended the meeting by saying my goodbyes and best wishes with all responsibilities and plans for the day and months ahead to all members and also the staff. One member responded on their behalf, expressing gratitude about the time, the opportunity to be part of the research and also the koha at the end of the relationship. They were not expecting it, some of them rejected it, but as part of the research, they accepted it with heartfelt best wishes for the research and the journey. The day ended it with the Samoan saying "tatala le fili alii" meaning "you can go now."

Descriptive analysis

Descriptive analysis was employed to analyse collected data in the quantitative phase of this study. Some texts often refer descriptive analysis as descriptive statistics (Thompson, 2009) which indicates the construction of a statistical summary that will help the researcher to manage data in a way that is easy to understand, give meaning, and simplify the understanding of the topic. It is used to calculate and define the sample and critical variables of the study (Grove & Cipher, 2019). It is a procedure that Fisher and Schneider (2016) claim are useful to turn meaning into numerical data, and it helps the researcher explain, categorise and sum up raw collected data. Also, it permits researchers to evaluate the reliability of findings so that they can predict and generalise what is known as inferential statistics. However, the main drive behind the descriptive analysis is to arrange and sum up the data, and there are two main reasons that this is very useful. Firstly, the graphical and numerical techniques which help organise and interpret the collected data into numerous figures, i.e. pie charts, histograms, tables and line graphs. These techniques allow researchers to identify trends and differences, and calculate simple statistics such as frequency counts, percentages, and scores proportions. Secondly, descriptive statistics are very useful in condensing or reducing large quantities of numerical information into a meaningful unit. Therefore, using statistical measures to condense and summarise collected data such as tendency (mode, median, and mean), variability measures (range, interquartile, and standard deviation) and other correlational techniques (Fisher & Schneider, 2016). It will determine the development of the data from the instrument once the known variable is identified through the mean, standard deviation, and the range of the scores of the collected data (Creswell, 2014).

Data coding

Appointments were made with the statistician, where data entry and SPSS software were discussed, and advice was given to send the data back to the statistician when the data entry was completed. The first attempt at data entry was challenging, but the assistance from the statistician made it more presentable and easier to understand. The three parts of the survey, which are Demographic data, Professional Variables and Ethical Challenges with frequency, were analysed using SPSS. However, questions two, three and four of the Professional Variables sections were analysed separately using Excel spreadsheet. All data analysis will be explained in considerable detail in chapter six.

Brief summary of findings

The data from open-ended questions of 21 participants were analysed using thematic analysis, yield 25 identified themes that were classified into five major themes, and later used in the new survey instrument layout. The process was made as reliable as possible through a continuous confirmation with the supervisors of the meanings of the developed themes. Participants' quotations were used to highlight issues and provide insight into ethical challenges and experience of nurses in Samoa. In depth discussion of identified themes with participants' quotations are explained in detail in *Chapter five*.

The surveys collected characteristic information from large groups of nurses (n=221) from both the main and district hospitals of both Islands (Upolu and Savaii) of Samoa. Participants' knowledge, beliefs or attitudes about a particular topic or concept are variables of interest that are commonly investigated in this way, i.e. in an exploratory and descriptive survey study design (Shields & Smyth, 2016). The survey concerning ethical issues and responses that was delivered to every nurse in Samoa yielded some interesting and useful results, as discussed in *Chapter six*.

However, the integration of both findings created a model of nurses' ethical knowledge and ethical decision making in Samoa is discussed in *Chapter seven*. The study not only provides understanding of ethical challenges among nurses but also provides a perspective of nurses' understanding of ethics and nursing ethics, ethical considerations and ethical decision making as well as ethical approaches or mechanisms, as revealed in Chapter seven.

Ethical considerations

Kapp (2006) stated that the protection and maintenance of human dignity, bodily integrity, autonomy, and privacy are the primary concerns of ethical and legal issues within research involving humans. The aim is to protect every participant who took part in the research and ensure the absence or minimisation of harm, trauma, pain, anxiety, or discomfort during the research (Woods & Schneider, 2013). As a Samoan female researcher and nurse educator with an understanding of the Samoan culture, this research allowed exploration of the reality of ethical challenges among Samoan nurses concerning their cultural values and beliefs. The information sheet and consent forms that were given out to each participant clearly stated the involvement of the participant, research procedure, role, and responsibilities of the researcher to ensure its fairness among participants (Woods & Schneider, 2013). I was also present at the time to answer and clarify any questions about the study. These were addressed before the potential participant's consent to participate in the study was sought.

As is the custom and requirement in any such research that is performed by students at a New Zealand university or other institution, this research acknowledges the Treaty of Waitangi's principles of partnership, protection, and participation. Although this research does not involve Māori people, the Tangata Whenua ('people of the land') of Aotearoa-New Zealand, these principles were also applied to Samoan people. This research was based in Samoa, and all the participants were native Samoans. Nevertheless, The Treaty's principles were useful to the researcher to be mindful of the importance of cultural and relational aspects of the research as discussed in the section of Le Va, and this was especially important and relevant to the people of Samoa. From this respect and partnership, the researcher shared results of the study with both the Victoria University of Wellington and the University of Samoa, which should subsequently benefit both countries to improve knowledge to address ethical challenges among nurses.

Informed consent

The informed consent was in simple words and acknowledged the participants' rights to present their views and choices regarding their values and beliefs. It also acknowledged the

participant's capability to decide whether to participate or not. In Appendix 5, is the consent form that was used to fully inform all participants both in writing and verbally. All information about the nature of the research and their involvement in time and contribution to knowledge was explained to participants (nurses) to ensure respect for autonomy, informed consent, and individual responsibility. It was also made known to participants that they had a right to withdraw from the research at any time without giving any reason both in the interview sessions and also before or during completion of the survey questionnaire.

Anonymity and confidentiality

The rights of privacy and data protection of all participants were respected, and contact details of participants were not collected without their consent. The researcher kept participants' details, concealed, and privacy was maintained, as well as the confidentiality of participants. Full confidentiality was assured and maintained at all times. All participants had a pseudonym or number that both the researcher and participant knew about and was used to maintain anonymity. To provide anonymity of the data, all collected data was coded, but all data that was identified as personal was stored separately from the research data. Participants' identity was suppressed as much as possible when the researcher used a direct quotation from participants in the thesis. Thus, any identifiable reference such as places, institutes, other health care personnel or any alive or dead person were omitted from the thesis.

Potential harm to participants

I, the researcher, allocated a support person as a counsellor to provide assistance and help to a participant who might have experienced mental discomfort or temporary distress during interviews. There was an understanding that the research topic might revive some unpleasant experience in the past in regard to challenges that the participants might have encountered. Therefore, a support person was contacted and given information about the research topic and plan of data collection routine were given for awareness and cooperation. However, during data collection for the research, no potential harm was noticed. The most noticeable effect was the appreciation and the use of their faith and beliefs to overcome challenges that participants have experienced and shared. Thus, with a commitment to their profession by hearing experience at a complicated situation and limited resources.

The participant's right to decline to take part

The right to withdraw was also addressed to make the participant aware that they can do so at any time until after data was gathered and analysed without giving any reason. This does not affect employment, and it was well stated in the information sheet. All participants were reminded of this right verbally and in writing. During the survey questionnaire data collection, a few respondents did not return their questionnaires when I went back for them. Therefore, it was left and made known to the respondents that it was their right if they did not return their survey questionnaires or respond to it.

Uses of information

As discussed with participants both verbally and in writing, the information obtained from this research will be disseminated; first as a dissertation for a Doctor of Philosophy degree at the Victoria University of Wellington. Secondly, and the most importantly, is to share research findings and report back to participants who are nurses of Samoa through the clinical meetings to be held at each district hospital, referral hospital and main hospital or nurses annual general meeting. However, the researcher will be open for options from nurses via nursing leaders as to what form of meeting they want the researcher to present and report the research findings. Lastly, the thesis has fulfilled the employers' requirement for the research findings to be available for conferences, teaching sessions and journal articles.

Ethical committees.

To ensure ethical standards in this research, the Victoria University of Wellington Human Ethics Committee, the National University of Samoa and the Samoa Health Research and Ethics Committee assessed the comprehensive research proposal, consent form, an information sheet, and grant approval. The final draft of the survey questionnaire instrument was submitted as well as an attachment to the first ethics application as advised by the Ethical Committee of Victoria University of Wellington and also the Samoa Ministry of Health and received approval for the second phase of the study.

Research rigour

This research underwent a variety of focused examinations of the means used to gather data, to perform any necessary analytical interpretations of the data, and of the methods used throughout to ensure the quality, rigour and trustworthiness of the study (Polit & Beck, 2014). As Amankwaa (2016), maintains the researcher should consider the worthiness of the study by establishing necessary protocols and procedures that are necessary (Connelly, 2016).

a. Credibility

The assessment of the study's credibility was achieved through explaining, analysing and identifying participants' value, accurate description and believability ideas of the study (Vaughan & Burnaford, 2016). There was a prolonged engagement with the participants (as discussed earlier) and member checking as performed by two supervisors of transcription of interviews, themes, findings and results of the study (Connelly, 2016). Selecting an appropriate sample and providing detailed descriptions and quotations from participants to verify the completion of the analysis may have achieved credibility in the study (Moon, 2013). Hence, the suggested interpretations made in the study are generally well supported with sufficient credibility as a fundamental aspect of the study.

b. Confirmability

The objectivity or the degree of consistency of findings is what confirmability looks at (Connelly, 2016). During the study, I kept detailed notes of the analysis process of identifying and the decision of themes yielded from the data. Thus, during the many supervision meetings, supervisors, as member-checkers, reviewed and compared notes and views of what I had identified from the data. Furthermore, feedback from other academic and nursing colleagues shows a similar appreciation of the emerging issues and conceptual ideas during the presentation of the research findings in research schools and workshops. These responses tended to confirm and clarify any of the uncertainties of the study, and also reminded me, the researcher, to be aware of the possible danger of being biased in regard to my own individual perspective of the study.

c. Meaning-in-context

Meaning-in-context implies an understanding the data that is produced from the lived context of those who are involved in the study (Woods, 1997), and therefore supports notions of considering the meaning and understanding of data within the contexts that they were gathered. I have previously discussed and explained the importance of the context for this study and have definitely taken into account the meaning and understanding of the lived experience within the surroundings or environment of the participants. The contextual aspect of the study plays an import role in the discussion of the experience and represents a very large part of the study.

d. Recurring patterns

Recurring patterns were identified in the first phase of the study, which enabled the development of the survey questionnaires that were used in the second phase of the study. The identified patterns were useful to formulate questions to get overall perspectives of the nursing population in Samoa. Thus, it provides certainty of ethical challenges or issues faced by nurses in general as shown by the data and it enhance confidence in the data analysis. The study, therefore, would not have been completed without the recurring pattern that was utilised in the latter stages of the study.

e. Saturation

No new emerging data from the interviews presented any new conceptual codes after all twenty participants' interview data was analysed. The participants had certainly and kindly provided data that was highly useful in this study, but it produced a massive quantity of data. It is therefore unsurprising that saturation was considered to be met after all the interview data was used, and conceptual/thematic 'maps' were the result.

f. Transferability

Transferability is the extent to which finding from the study can be transferred to another setting and context but still preserves precise meaning or interpretation (Polit & Beck, 2014). In this study, a great effort went into the design and layout of the study, considering the context, location, the target population to assist other educators and nurse researchers. The findings of the study can also be transferred to a different nursing situation, education and

clinical setting and circumstances, nursing ethics and possibly to the nursing practice and education of the Pacific islands that have a similar context as Samoa.

g. Reliability

The reliability of findings in this research was obtained through keeping comprehensive fieldwork notes of interviews and observations of the qualitative phase. An audio-recorder and verbatim accounts were used to save transcription of direct quotes of fieldwork notes. Every explanation was closely documented, so the participant's interpretation was clear and to avoid the researcher's suggestion of the event (Creswell, 2014). The qualitative data collected was audio-recorded and transcribed by the researcher and saved in a verbatim account. The reliability approach for the data contained in the study was enhanced by documenting procedures, as suggested by Yin (2003). Documenting possible steps relating to the interviews and observation was, therefore, the norm for this study (Creswell, 2014). Transcripts were checked immediately upon return to make sure that no meaning or data was lost, and the researcher took time to familiarise herself with the data (Jones, 2016). Thus transcripts were checked during transcription and checked again by supervisors, to make sure that there were no obvious mistakes in the content. Therefore, constant comparison of data with the codes and writing memos about the codes and their definitions was made. Hence, this ensured that there was no drift or shift of the meaning and definition of the codes during the coding process.

h. Validity

Validity in quantitative studies is a slightly different concept from that used in qualitative studies, although it serves the same general purpose, which is assessing the quality and interpretation of the data and the results (Creswell & Plano Clark, 2018). Quantitative validity has two levels, first, it looks at the quality of the used scores, and second, at the quality of the conclusions drawn from the results of the analysis. Subsequently, regarding the validity of the instrument of this study, supervisors and statistical experts were consulted over the final document of the survey. The final draft was piloted by some of the participants of phase one of the study (due to availability) and also another two Pacific nurses for clarity and ease of understanding before going out to 425 registered and enrolled nurses in Samoa. In doing these things, I assessed the reliability of the instrument, and the results from this testing were

addressed. This result was also compared to the overall results of the survey at the end to strengthen the validity of the quality of the results drawn from the data.

The supervisors also examined the research results to ensure validity in its final approach (Creswell, 2014). Furthermore, both primary and secondary supervisors cross-checked the data with the codes to compare the results that were derived from the data (Creswell, 2011). This ensured that the captured meaning is from the participants of the survey, and not because of a misreading or misunderstanding of the researcher (Houser, 2008). Furthermore, because participant feedback (or member checking) ensures the accuracy of the information or findings from what was observed or given through writing. It is also an excellent way to avoid bias in the interpretation of the data.

Regarding both phases one and two, triangulation of the data was another validation promoting tool used in this research, i.e., where different sources of data, such as interview transcripts and documents, were analysed and compared with each other to reduce bias and build evidence from different sources for coding and themes. Therefore, multiple sources of perspective were required for the inclusion of data triangulation to identify different perspectives among nurses and stakeholders at different workplaces in Samoa. In turn, this material was used in phase two of the research when the survey tool was being devised. Furthermore, to ensure the correctness and accuracy of interpretation of the data, the newly constructed definitions/descriptions in the new survey instrument was also piloted with a few participants from the qualitative phase so that they could give feedback, comment on, or correct the data that was drawn from their perspective in the first phase. Doing so enhanced the credibility and dependability of the descriptions/definitions used in the analytical phase (Jones, 2016).

Summary

The importance of social constructions of reality, the multiple views of nurses about ethical challenges, and the desire to promote good ethical practices through research within the cultural context of Samoa, were all essential for the success of this study. These key factors, led to the employment of sequential exploratory design of the mixed method approach, that fulfils the need for the interwoven nature of all three stances of paradigms in the one study. The sensitivity of the topic, study's context, participants, the research process and also the researcher, herself were factors that led the researcher towards the ietoga research framework using a lalaga concept. Safeguard to taboos of the relationship, forgiveness to any unintended words or shortcoming of the researcher in the context, and appreciation of the relationship, wealth – knowledge and experience, time, participation and collaboration during the study. Teu le Va and the Samoan Philosophy of Nursing provides a platform for safety and ensures the concept of respect is emphasised throughout the study. Thematic analysis of individual interviews and descriptive analysis of survey questionnaires resulted in integration of strands that formulated a model of nurses' ethical knowledge and ethical decision making in Samoa. The use of two different data sources of the study, the method and constant checking of data interpretation for accuracy throughout the study, all ensured the quality, rigour and trustworthiness of the study. However, further details is provided in the next Chapter (Chapter five) which discusses findings from one-on-one interviews with participants.

Chapter 5: QUALITATIVE FINDINGS

Introduction

This chapter is the first of two chapters that discuss the findings of this study. As previously discussed, the first phase of the study was a qualitative one whereby a number of key participants were selected to offer their various viewpoints concerning nursing ethics in Samoa. This data was subsequently analysed, and the main themes and sub-themes extracted from that data are now presented in this chapter.

The analysis gives an account of what the participants considered to be of value during the interviews, which is increasingly seen to be part of the qualitative storytelling role, as Braun & Clarke maintain(Lainson, Braun, & Clarke, 2019). Storytelling is one of the roles of a Tamaitai[10] within Samoan families as well as in the community, which, as previously described, is of considerable interest and value to the aims of this research project. Therefore, I will be the storyteller regarding the ethical challenges experienced by nurses in Samoa that they encounter at their workplace, practice, and profession. The exploration of new knowledge gained from the Samoan nurses and the ethical challenges that they have encountered therefore allows the weaving of new concepts and strategies to guide and assist the nursing profession within Samoa, and perhaps in other countries of the Pacific and even in western countries that might learn something new or different from it. This could occur because positive attitudes or approaches to new knowledge and concepts that are easily acceptable in one cultural setting could be used to create new tools and instruments that are relevant to use in other similar socio-cultural settings. Subsequently the analysis stage of this study uses and incorporates concepts of the Teu le Va, philosophy of nursing, as well as an overall merging of qualitative and quantitative approaches, to transform understanding of the ethical challenges that have been encountered by nurses in Samoa. As mentioned previously, these have been woven into a form that represents a Ietoga (a fine mat), using the lalaga concept.

[10] The role of the researcher as *Tamaitai* Samoa was emphasised throughout the data collection and my role as a wealth maker or *faioa* was further emphasised during the analysis stage. The weaving or *lalaga* concept of the *ietoga* is one of the tasks or responsibilities of the *faioa* or wealth maker, and *ietoga* is one aspects of wealth in Samoa within families.

This chapter therefore discusses the process that was used to analyse the extensive material that was gathered from one-on-one semi-structured interviews and the implications of the conceptual framework. The discussion of findings in this chapter is divided into three parts, firstly, Samoan perspectives of ethics and nursing ethics, secondly the findings of ethical challenges among nurses in Samoa and decision makin and lastly, there is discussion regarding the methods used by nurses when addressing ethical challenges.

Conceptual Framework

This part of the study emphasises that it is data-driven analysis that stays as close as possible to what participants said and their interpretations (Boyatzis, 1998). The general approach investigates the implied meanings within the participants' interview material and relies on the researcher's ability to utilise an 'informative lens' (Smith, Flowers, & Larkin, 2009). The thematic aspect of the analysis therefore seeks to explore the underlying meaning within all the participants' interview data by producing thematical material that can then be linked to broader theoretical or conceptual issues (Braun & Clarke, 2012). Of great interest in this research is the possibility of being able to explore the socio-cultural aspect of how the social context significantly shapes understandings and interpretations of ethical challenges among nurses in Samoa and in doing so, strengthens the use of the *Ietoga* framework in this study.

Subsequently, the kosi stage, or 'stripping' of the leaves, is one of the stages in the framework of the *ietoga* which strongly emphasises and portrays the steps of thematic analysis that are recommended by Braun and Clarke, but from a Samoan perspective. The kosi stage has a major influence or impact on the weaving or lalaga concept of the *Ietoga* framework, and it is therefore highly appropriate. However, the kosi or stripping stage of the Ietoga needs to be well mastered and carefully done to ensure good equal widths and lengths of each strand for the mats. Therefore with regard to the thesis sufficient care needs to be taken to allow the main elements to emerge and be use in the thematic 'weaving' of the data.

Interviews

The pilot interviews

The questions were tested in one pilot interview in Samoa in September 2018. The purpose was to find out whether the questions elicited adequate responses that would appropriately

reflect the aim of the main research question. The pilot participant was given the study information sheet and asked to complete the consent form. The interviewee had a nursing and midwifery background, had worked in the main hospital for more than 40 years, and had extensive experience working in a tertiary healthcare institution. Once the interview was completed, the pilot participant was asked for feedback. The pilot participant feedback, responses and data then informed the refinement of the interview questions, including rewording certain questions - especially in the Samoan translation, thereby reducing repetition and improving clarity, and ensuring the focus of questions. Supervisors were later consulted and informed of the changes which confirmed a few questions for the first interview stage.

Participants' demographics

There were twenty-one participants in total, sixteen registered nurses, of which four were males, five enrolled nurses (all females), and three nurse educators (all females) (see Table 3). Twenty one-on-one interviews took place at the participants' workplaces but only one participant was interviewed at home. Among the participants who worked in a community setting (District Hospital), six participants that were registered nurses and three were enrolled nurses with years of experience. Their experiences ranged from three to 25 years. Seven registered nurses and two enrolled nurses worked in clinical settings (Tupua Tamasese Meaole Hospital (National Hospital) and Malietoa Tanumafili II (Referral Hospital) with years of experience that ranged from five to 28 years. The remaining three participants were educators who had been teaching from seven to 20 years at the Nursing School in Apia.

Table 2: ***Demographic characteristics summary of interviewed participants***

	Genders	**Years of Experience**	**Community**	**Clinical**	**Education**	**Total**
Registered Nurses	4 Males 12 Females	3 – 15 (2 Jr[11], 2 Snr[1]) 3 – 30 (3 Jr, 9 Snr)	3 3	1 6	0 3	4 12
Enrolled Nurses	5 Females 0 Male	19 – 25 (5 Snr) 0	3 0	2 0	0 0	5 0
			9	9	3	21

[11] 'Jr' means Junior, 'Snr' means Senior

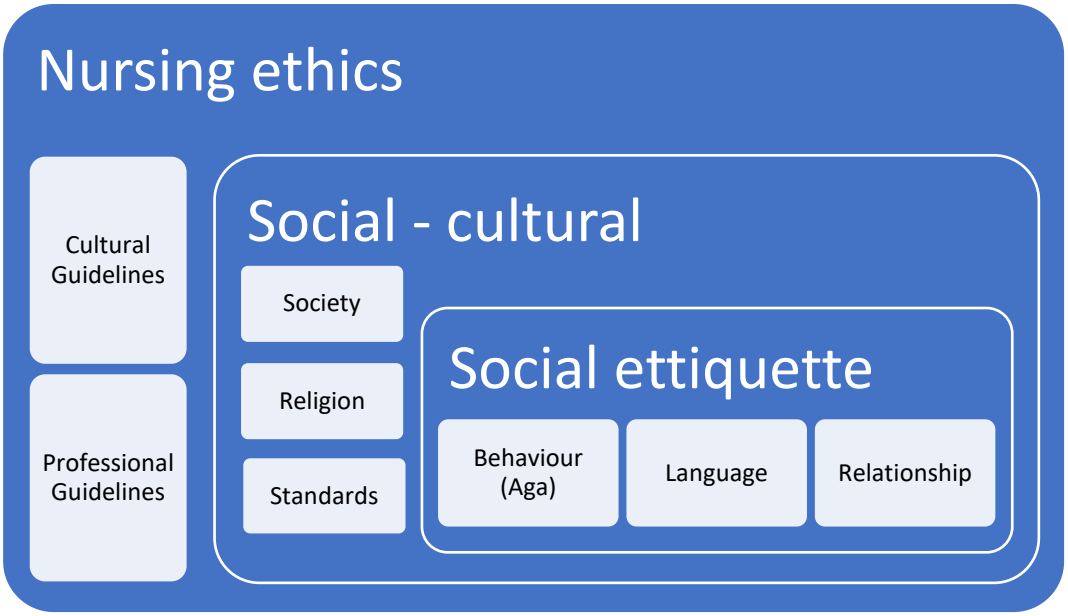
Phase 1 – Interview findings

The first phase of the research was exploring understanding and perspective of experienced nurses about ethics, nursing ethics and its relevance to practice. A major aspect of these interviews was the exploration of how they identified ethical challenges among nurses in their workplace, and how these challenges influence their decision-making during practice and working hours. During the analysis, these three sections or parts were the framework used to gather the interview data. The first section explored the Samoan perspective of nursing ethics, the second explored the ethical challenges and their decision making, and lastly how nurses address these challenges. At this stage of the chapter, the weaver or the researcher becomes a storyteller weaving together the strands of major themes and strands of subthemes.

Samoan perspectives of ethics and nursing ethics

The analysis of the understanding of Samoan nurses about ethics and nursing ethics is categorised into three themes, and each theme has sub-themes. The figure below shows brief themes with their subthemes that will be discussed in this chapter.

Figure 11: ***Samoan perspectives of ethics and nursing ethics***



Ethics as social etiquette

Most of the participants expressed their understanding of the words “ethics or nursing ethics” as the ways and attitudes of a nurse during practice, often inferring that in Samoa, ethics and

social etiquette are very strongly linked. Some used a cultural proverb to clarify what they meant, such as:

> *Ways/attitude of the nurse during practice, "e muliga ni oli i ni foli", the way you say hello, introduce yourself and establish rapport, in such way that can easily draw the attention of the patient (RNP2).*

This quote alludes to a cultural proverb that refers to the Samoan notion that appearance and character is as important and socially acceptable to others as subsequent actions may be. Hence, initially at least, attention will be drawn to appearance instead of action, as actions will come after expression and appearance such as smiling and being welcoming. Essentially, if the nurse does not adequately relate to the patient in a way that reflects social norms and requirements, then any subsequent actions will remain a cause of unease and possible distrust. Another participant used the same Samoan cultural proverb but added a different interpretation of meaning and elaborated more on expressions that would result in warmth, love, and kindness:

> *"E muliga ni oli ao ni foli" - Behaviour, the way you stand and expression in a language use that is appropriate in caring. Ways of expression that bring warmth, love, and kindness to those who are troubled (RNP3).*

Both of the above tend to suggest that Samoan nurses place great ethical importance on meeting the *social* requirements of nursing relationships with another person, e.g., the expression of behaviour that starts from the way you stand, the way you say hello, the way you start a conversation and the use of certain language. That is, the use of language that should be appropriate and respectful, as another participant maintained: "*Appropriate behaviour that we should show during caring, such as respect (ava fatafata), self-discipline (uiga pulea) and your expressed behaviour such as smiling" (RNP7)*. Here there is an emphasis on showing such socially recognised behaviour during caring practices, not only during care but also before the delivery of care, i.e., from the beginning of care to the end of care. The importance of appearance that the previous participant gave using the example of smiling, will tend to relieve pain, and make people happy. As the participant below added, one's appearance will have a significant impact on a nurse's performance:

> *It is our behaviour, ways (aga). Our ways (aga) that are appropriate for the delivery or performance of work. Ways such as behaviours, and things that are used for the purpose of work. On the other hand, of appearance, it tends to make people happy, it*

draws them in no matter how much pain they are in. Performance in nursing service also relies on our appearance (ENP2).

Another participant offers similar statements but emphasised the notion of both physical and verbal 'properness,' which in Samoan culture, is a most important aspect of human relationships. As a result, a nurse's behaviour and characteristics plays a significant role in showing respect, as the below participant emphasises:

My behaviour/character that I should do to show in front of people, is to be respectful, know how to stand, to speak, to walk, to sit and to act, to do work, to be the first to show happiness and smiles at people. This signifies how we should work every (ENP4).

There there is a strong emphasise on the nurse's appearance because in Samoan society, it is important for any child or anyone of any age to know (and is expected by a senior person) how to stand, and when to speak, to walk, to sit and to act. These are characteristics that highlight respect in Samoan culture, which some participants referred to as good manners and courtesy: *"Good manners, and courtesy, are the most important thing, and moreover, respect" (ENP5).* This participant showed a sense of integrating good manners and respect to the delivery of care, a belief that is based on nursing ethics as good relationships which the participants below referred to as 'avafatafata' (respect of one person to another). The participant goes on to maintain that it is not only that, but also 'professional guidelines' should be followed. Guidelines that guide nurses of what to do. However, there is an emphasise on the appearance of being polite and knowing how to culturally greet and talk to people:

It is a relationship (ava fatafata), guidelines (taiala) of work performance, that needs to follow and not to be over-lapped. We must follow guidelines that guides us what to do. Appearance of the nurse as a polite nurse, faatulima (cultural introductory), how to say hello (ENP1).

Hence, in general at least, several Samoan participants view nursing ethics as a form of social etiquette, and especially as related to 'appearance' e.g. being polite, smiling, being respectful and showing self-discipline. Participants also referred to nursing ethics as ways and attitudes, appropriate behaviour and manners, polite expression, and communication (both talking and language use) used to deliver care. Thus, the participants generally referred to ethics as a form of social relationships, a respect between two people and as a type of social guidelines that the nurse should follow.

Ethics as guidelines that protect and should be followed

As previously shown, the understanding of appropriate behaviours, attitudes, and social mores, such as showing respect, self-discipline, correct appropriate language, manners and courtesy, are all regarded by the Samoan nurse participants as crucial elements that a nurse should perform in order to deliver good (i.e., ethical) caring practice and services. However, there were participants who emphasised that nursing ethics was predominantly concerned with the more formal application of guidelines, laws and rules that guided a nurse's performance. However, the use of the word 'guidelines' was found to be different among participants, as some referred to guidelines as cultural rules while other mentioned them as professional principles, and yet others blurred the boundaries between the two.

Some participants actually referred to ethics as law, rules or guidelines that guide the job, roles or responsibilities, and maintained that there was a strong emphasis that following the rules or guidelines is mandatory rather than optional, but which guidelines or rules exactly?

> *[Ethics is] guidelines that guides our work, so that we will not work over the limit. Guidelines such as va fealoai, respect, ava fatafata that enable performance (RNP6).*

Here there is a strong emphasis on guidelines that guides and act as limitation for nurses' roles and responsibilities. However, the participant above refers to guidelines as respectful relationship (*Va fealoai*) respect, respect between two people (*Ava Fatafata*) which enables an appropriate performance, hence reinforcing the notion that nursing, and nursing ethics in Samoa relates to social rather than strictly ethical rules. Others connect ethical guidelines more closely to the nursing profession: "*We have guidelines to follow, guidelines for protocols to follow, our nursing standards (RNP8)".* Yet, while one participant supports guidelines and refers to them as protocols and nursing standards, another refers to guidelines as rules and code of ethics that guides nurses' work: "*Ways or rules that are used to guide work of any profession. For nurses, there is a code of ethics that guides nurses work of what should (RNP9)".* There is a consideration of standards. However nurses delivered care using culture and respect for patients' rights, "*we consider standards and these are delivered by using culture and respect for patient's rights (RNP4)".* There is an integration of professional principles and culture as this participant demonstrated by expressing her understanding of nursing ethics.

Overall, the participants' understanding of ethics and nursing ethics frequently revolves around cultural understanding of guidelines, laws and rules that guided the nurse's

performance. However, there is also considerable evidence of an incorporation of professional interpretation of participants understanding of ethics and nursing ethics by referring to nursing protocols, nursing standards and its code of ethics. Nevertheless, the data shows that Samoan nurses' understanding of ethics are mostly drawn from their cultural background and experience, even if there is a degree of defining ethical principles within cultural understanding. This reveals a type of integration of Samoan culture with western perspectives of nursing ethics, but to what extent?

Ethics as integral principles that safeguard nurses

A noted above, it was also strongly maintained by most of the nurse participants that following ethical principles was an important and relevant aspect of ethics and nursing ethics. Several participants, and nurse educators in particular, stated the relevance of ethical principles to nursing practice and how essential to professional nursing they were. Several participants often highlighted their moral concerns by references to ethical judgement and values, ethical principles and professional obligations, as below:

> *Ethics is essential to the delivery of skilled professional care. Ethics is relevant to clinical practiced-based issues and affects all areas of the professional nursing roles. It is concerned with right and wrong, agreeing what is right. Ethics as standards, ethics and dilemmas, ethics principles, importance of integrity (ESP1).*

Another participant argued that ethics is a professional obligation as much as an individualistic one, i.e., one that reflects the nature of a nurse's practice. "*Nursing ethics guides the professional obligation of the nurse and nature of their practice. Ethics is an integral part of professional nursing" (ESP2).* Yet another participant added that a nursing ethics was also a safeguard that protected nurses as much as they protected patients: "*Right of the patient, consent form - [this] safeguards nurses, standards and guidelines" (RNP2).* Yet another participant discussed their understanding of ethics by suggesting the use of a faith-based approach combined with the promotion of "patients' rights" and indications of following rules or standards to protect both patients and nurses:

> *Understanding of standards, religious belief - prayer for peace during shift; Nursing Oath - I will care, do my job with humble, respect and …., Acts and Standards - our license that protects us from trouble/practice (RNP3).*

The participant above viewed nursing ethics as a type of religiously inspired act based on standards that protect nurses from formal breaches of their practice. Another participant, noticeably an Enrolled Nurse, stated that protection from the law was the main driver for her ethical actions: "*Guidelines/standards are useful to protect us from the law (ENP3)".* This was reinforced by another Enrolled Nurse participant who also maintained that an understanding of the rules and guidelines that must be followed was a primary impetus for their ethical responsiveness: "*For legal status, it is necessary to follow the rules, and rules guides us. There are protocols and nursing standards (ENP4)".* Hence, it seems likely that those Samoan nurses who work less independently that perhaps Registered nurses tend to operate on a basic 'following the rules' level when performing nursing roles and responsibilities in delivering care.

It may be concluded from the above findings that when asked for their perceptions about ethics and nursing ethics that there is indeed a very strong connection between socio-cultural 'ways of being' within Samoa and with notions of ethics as the application of certain ethical principles or rules. Here perhaps may be seen a type of moral symbiosis where traditional social aspects of 'the right behaviour' within Samoa are often combined with learned aspects from nursing education, or perhaps as in the case of lesser trained nurses, merely the application of 'rules' that are always to be followed. In any event, it is clear enough that any nursing ethics within Samoa is strongly influenced by Samoan aspects of social and cultural norms.

Nurses ethical challenges in Samoa

Analysis of the data revealed four main themes that were strongly associated with ethical challenges and decision making. They were a) social-cultural sensitivity, pressure and cooperation, b) problems with the healthcare system and resources; c) unhelpful attitudes and relationships ("we, those and them") and lastly d) failure to follow through, as in "we talked about it, but we don't practice it." All four themes have subthemes that explain and provides specific details of each theme as shown in Table 4.

Table 3: ***Participants' Perspectives on Ethical Challenges: Themes and Subthemes***

Themes	*Subthemes*
Social-Cultural Sensitivity, Pressure and Cooperation	• Personal, family, spiritual, hierarchy and traditions. • Cultural and professional aspects: The tension between both. • Relationships: Caregivers and relatives or families.
Healthcare System and Resources: not helpful	• Overextended clinical roles. • Shortage of staff & equipment. • Attitudes/relationship: Nurses vs co-workers. • Managements and leaders – inconsistence.
"We talked about it, but we don't practice."	• Nursing education: 'the different reality'? • In service ethical training or education

Social-cultural sensitivity, pressure and cooperation

The appreciation of culture and the importance of social relationships were well covered by participants in this study. The relationship and awareness of cultural ways that help with caring, such as the proper recognition and acknowledgement of the individual and family members, and the oral, informal, and formal traditional language used to nurture and soothe the relationship of the nurse and patients/family, were all much in evidence in the interviews. Also, in evidence was the desire for appropriate behaviour and performance that nurses believed to enhance caring in the relationship with the patient, families, villages, and society.

Social cultural influences (Personal, Family, Spiritual, Hierarchy and Traditions).

There was a strong emphasis on cultural factors and their influence on ethical decision making that relate to treatments and procedures of nursing care. The majority of participants stated the importance of culture, i.e., that following cultural norms was both necessary and helpful in delivering health care, and generally maintained that nursing and culture were indivisible elements within Samoa health care settings:

> *Culture is like a transportation that drives the service while guidelines and rules monitor the job. Service goes together with culture, culture in the use of cultural language, we must consider culture to make the service easier (RNP3).*

The use of metaphor in this instance expresses the important of culture as a form of 'transportation' for the nursing service. This term carries considerable meaning because it is made clear that by strengthening the use of culturally appropriate means should inevitably lead to a smoother and more socially acceptable nursing service. In fact, in several ways, many participants offered strong support for the careful alignment of culturally appropriate practices within the nursing service, as one participant makes quite clear: "*There is no conflict between culture and nursing, in fact, nursing and culture goes together" (RNP1).* Others go so far as to claim that nursing ethics in Samoa are essentially based on culture alone: "*I don't think it has an impact because of our culture, that's where our ethics are based" (RNP9).* These, and several other comments from the participants, all therefore tended to strongly support the notion that socio-cultural factors were of paramount importance for a Samoan nurse when making ethical decisions. However, it follows that such ethics within Samoan nursing could, and sometimes did, lead to ethical dilemmas and conflict.

> *… there are times, patients bring their honour and status (to the ward) stating their titles, and all members of his family listen to him. So, there you are, saying something but he will reply back like he is... (pause with an impression of a chief) …some are like that, but some are not. So, there are times when I refer it to a senior nurse (who had a matai title) to have a chat with this old man or lady (patient). Then things or that person calms down and attention and cooperation are drawn to the nursing plan* (RNP11).

From the above participant's experience, it shows a tension between a nurse and a patient with status, however, there are ways that the nurse uses to deal with such difficulty such as getting a senior nurse who holds a matai title to act as a mediator in the situation. There is a highly respected relationship between the nurses and a patient who brings their status to the hospital or ward. However there is a fair understanding of using a cultural approach to cater to such difficulty such as the language used or a nurse who is well equipped with cultural status.

Cultural aspects and professional aspects: The tension between both

As previously maintained, there was a great deal of positivity from the participants about how important culture and cultural practices were to the nursing service. However, some of the participants expressed their views with concerns, in that attempts to follow some of the

cultural aspects of Samoan society (such as the formal and traditional language) and the *saofaiga* (cultural seating) can suppress the meaning of the message or the actions that nurses are trying to convey or perform. A good example of this problems is the uncomfortable feeling of approaching and talking to matais (titled men) who look after villages and families:

> *…there are times when you try to deliver with respect (language), but it does not really deliver the whole message that you want to deliver. Trying to be polite and respectful, doesn't feel right, I'm not comfortable with it. I can feel that I don't fit or feel appropriate to face the matais that I am talking to…. (RNP8).*

Another participant, was sharing her experience of struggling between her professional values and cultural norms, suggested that sometimes, there was a clash between considering the patients' health and (cultural) norms and nursing values and ethical principles:

> *Cultural sensitivity should not keep you away from ethical values and principles. I mean, culture should never stop you from doing your job as a nurse (ESP3).*

Here may be seen the dilemma that no doubt many Samoan nurses must face, namely the sometime difficult task of doing what is seen as being culturally appropriate, while at the same time maintaining nursing ethical values and principles. This is essentially a 'relativity' argument of considerable importance that will be revisited in later parts of this thesis.

Concerns about cultural sensitivity and the involvement of family care is therefore sometimes a problem, but at the same time, it may also be an advantage:

> *…there is a saying "au mai, au vatu", that is our culture. It's true, but I feel it's so disrespectful if I return a gift. So, most of the time, if we are given something, we make sure that every one of the staff who are on duty knows about it. It's not only me who is working, but everyone plays a part in caring and, this is a part of the family's tapuaiga (worship). It's a way of acknowledging our job. We can't stop it, it's still happening…We do both, doing my job as a nurse and ensuring the relationship* (RNP11).

Here may be seen that a gift from patient to nurse cannot be avoided in the context of Samoa, i.e., based on the importance of one of the cultural sayings in Samoa *("au maí, au vatú")* which is quite similar to the saying (you should) "give and take." The public shows their appreciation by acknowledging the care given to the patient or their relative by giving something to nurses (mostly food) and is shared among all staff who are on duty. The participant emphases the connection to families by providing gift as part of the family's tapuaiga.

Thus, the tension between the cultural and professional aspects, plays an important role in ethical decision making of the nurse in nursing care and service. Nurses acknowledge the importance of culture within nursing services however there is a tension that can lead to pressures on ethical decision making. For example, addressing the family's role in caring and understanding the importance of family is crucial, but this can sometimes be a challenge that puts pressures on nursing care and services.

Relationships of caregivers and relatives or families

As suggested above, caregivers, families and relatives offering care may be problematic for nurses in some situations. The roles and involvement of families, relatives and caregivers in caring for sick family members are well respected and acknowledged in Samoa, due to the understanding that an illness (or ill person) in Samoa is quietly worshipped ("o mai a Samoa e tapuaia", i.e. there is a spiritual connection). Therefore, the relationship of the person who is sick and his/her family is well understood by nurses. There is a spiritual connection to the patient through their prayers and thoughts:

> *…we know that "o mai a Samoa e tapuaia" and they sit and wait outside so we can't really ignore the culture. They pray/worship (tapuai) for their sick relative. Even though they are not doing anything but sitting outside shows their presence and involvement (patiently, quietly, thoughts and prayers*) (RNP11).

This show of support for a sick relative through a family presence may be highly beneficial, but sometimes it can also present problems:

> *… we hear complaints from waiting from caregivers, not just the patient. With all due respect, I just do not answer, just hold in the disappointment, and give in to whatever they are saying. Sometimes I just say, please that is enough, you are stronger than I* (ENP3).

The pressure and demanding actions of caregivers during waiting hours therefore may sometimes affect the nurse's practices, i.e., which are then made more difficult by not being able to do anything about it or to answer caregivers and patients who are complaining because of cultural norms and rules.

In this aspect, criticisms of nurses and their practices are not uncommon in Samoa, i.e. there is sometimes a negative "*attitude of people towards us, things that people say to us (RNP4)* or *"accusation from the public, labelling nurses* (RNP3)". These accusations (of poor practice) may sometimes be attached to direct criticisms of nursing practices through comparisons with observed practices in other (often western) settings:

> *Overseas people comparing overseas service and treatment to ours, creating conflict of what must be done, stating and comparing their experience between when they were overseas and here (TTM2). Comparing routine check-ups and waiting hours.* (RNP5)

Hence, the presence of family members and relatives may be a mixed blessing for nurses in Samoa; on the one hand, they may pursue good and ethically sound nursing practices within cultural norms, but on the other, their work may be criticised and challenged within the same cultural norms and rules. These situations are often not helped by problems associated with the health care context itself.

Healthcare System and Resources: not helpful

The data shows that Samoan nurses are not only challenged by social and cultural factors but by the healthcare system and resources. In general, the healthcare system and resources make things worse and are therefore frequently ethically challenging, especially for those nurses who work in the community and district hospitals. However the intensity of limited resources and pressure of the health care system more often than not falls heavy on nurses who work in the community mainly because such nurses have often to make ethical decisions within a context that at times may force them to practice in ways that they consider ethically dubious, and at times, outside their scope of practice.

Overextended clinical roles

As previously noted, (see Chapter Two, p. 52) the shortage of physicians has a significant impact on the Samoan health care service which pushes nurses to do more in terms of tasks and practices. It is also one of the obvious characteristics highlighted by the participants when stating the differences between what was taught to them in nursing schools (involving ethics and other aspects of nursing) and the reality of the practice in the community and hospital

clinics. For instance, as one participant expressed, there has always been considerable concerns among nurses about delayed treatments and care plans because there are no doctors around and patients therefore may suffer accordingly. Not only that, but they worry about the subsequent extensions to nursing roles for the benefit of patients that result in the stretching of their capabilities to do procedures beyond what they were taught and trained to carry out only in times of emergency:

> *There was a time that I was told that these procedures are only performed in times of emergency, but they (the seniors) said, doctors are always not around. Luckily nowadays there are two or three but back then, if the doctor was not available, it would delay treatment/care plans. There is an understanding that it protects us, but it's hard, it suppresses performance and delivery of care and service* (RNP6).

There was an understanding at that the time that nurses were allowed to carry out such procedures if, for instance, an emergency response was required. However Samoan nurses are pushed to carry out several procedures at other times due to the unavailability of doctors. It is not an easy position to be in, either ethically or practically for nurses, but delays for treatment affects a nurse's performance, as one participant noted: "… *it is not a complete system to deliver care"* (RNP5). This participant shared his concern of an incomplete system where sometimes there are actually too many nurses but not enough doctors.

Hence, the shortage of doctors is a well-recognised ethical problem especially in community settings, where nurses manage and monitor district hospitals. This may be made even more ethically dubious when every consultation and treatment is presented and discussed out of necessity via telephone. There were many concerns raised from this old system, as one of the participants below stated:

> *Some orders are beyond my confidence, but I end up giving it. I have no choice but to save a life. So, I [the nurse] informed seniors to reconfirm the orders and to gain confidence or reassurance (*RNP7).

This participant shared her experience of the nursing practice in a district hospital, where there is no doctor but most of the treatments and procedures are carried out by nurses. This means that sometimes there are some procedures that they perform that are outside their confidence level, and therefore morally dubious. Yet, it shows a degree of moral commitment and risk to deliver a service the best (ethical) way they can, i.e., in an effort to save a life. This

presents a great deal of psychological and moral pressure at the community or district nursing level, as shown by this participant's experience:

> *…. when Apia (refer to the doctor) called and ordered treatments which were not yet available, or the hospital do not stock such mentioned drug or it was out of stock. In other cases, when some people came for their medication but was not available here (district hospital). We referred them to Apia but in doing so felt that we were not providing an holistic service* (RN8).

This participant actually lost her patient because it was not possible to transfer him to the referral hospital. The issue is the sad result of the scarcity of human resources and equipment to deliver care.

Thus, it may be argued, there are numerous challenges within the health care system in Samoa, but it generally always falls to nurses to explain to the public and often endure the disappointment of the public. These experiences also reflect the strength of words that can impair mood and feelings of nurses during their long shifts, however there is continuous practice and maintenance of staying patient and being respectful towards the lives of others. Several participants expressed a feeling of dissatisfaction with service delivery and not providing enough or the best service for the people. These issues therefore frequently lead to situations where the ordinary role of a nurse, and therefore the extent of their decision making, including ethical decision making is significantly affected.

As previously noted, the referral system via phone and no doctors being around at district hospitals, tend to push nurses' roles and responsibilities out of their normal job descriptions. Several participants talked about having to perform certain procedures that were taught in Nursing School to only do in times of emergency because they felt that they had to help the patient by doing the best they could even though they knew it was not safe or even entirely ethical, as suggested below:

> *Insertion of IVs learnt during nursing school, but only for emergencies, but not for every day. It is a big challenge for me, and others, and I know it is not in my job description but I'm still learning from seniors. And it is hard to say, yes, it's an ethical issue but if we don't do this, that means, we are not delivering a big help to the patient. I know I'm not safe, but I try to do my best, so that I can give help to patients.* (RNP6)

This participant claimed that she knows that what she did was unsafe but was prepared to put her registration on the line for the sake of the patient, i.e., that it is morally acceptable to go beyond the normal scopes of practice if necessary for the good of the patient. This type of moral essentialism or acting in ways that are not normally permitted but for the overall good of others, tended to emerge during the interviews with a number of participants and will therefore be further explored later in the thesis. But why are Samoan nurses having to work under conditions where there are frequent occasions of shortage of staff and equipment?

Shortages of staff and other resources

All participants of this study stressed their views and concerns about this issue, and one participant stressed their experience of the impact of not having enough staff during a given shift:

> *…shortage of staff, sometimes I don't have enough patience anymore, there are times that I feel angry, when a patient is calling while I am doing something, and I end up saying what I believe is right to that person or patient* (RNP5).

Clearly, not having enough staff resources may often result in anger over the inability of a nurse to properly care for patients. Another participant noted this problem by taking an extra load to accommodate shortage of staff (which, in this instance was a shortage of nursing staff) by working alone (as an Enrolled Nurse) to carry out a home visit: "*Sometimes, if we are short of staff only an Enrolled Nurse will go and do home visits, because there are not enough staff to be in pairs in a shift"* (ENP2). For an Enrolled Nurse in Samoa to admit this, is indeed a cause for concern, both professionally and certainly ethically. Such nurses are simply not properly prepared or equipped to do such visits, which are supposed to be performed by Registered Nurses only. However, in situations where there are shortages of both nurses and doctors, Samoan nurses find themselves witnessing numerous dubious and ethically challenging practices, i.e.:

> *Another issue, at the moment is a shortage of doctors… and they [Senior doctors] send junior doctors to admit patients. When I first started, any severe patient would be admitted by a senior doctor not junior doctor. But nowadays, its junior doctors, and some people complain that they don't want to be seen by a junior doctor* (RNP12).

Such practices are not only risky for the patient and their proper care, but morally challenging too because nurses are in the forefront of complaints and raw reactions of disappointment from the public before the complaints get to doctors. Sometimes, initial reactions of the public's disappointment is verbal or their facial and physical expressions do not reach the doctors. The nurse is usually the target for complaints during the shift.

Hence, there are several nursing concerns about human resources, i.e., the disappointment of not having enough staff to deliver health care services, and concerns about the safety of patients as well as of nurses. With these concerns come questions about other resources and the quality of care:

> *There are times we ran out of medication, and I can hear them [the public], making jokes but it does not feel right, if the medication prescribed is not available, they would say "why don't you close your hospital if you don't have it" but we just stay patient* (RNP8).

The result of unavailable medication only serves to contribute to the people's attitude towards nurses which in turn leads to a type of moral unease or even distress. There is an understanding of the situation, but it influences the nurses' attitudes as well at the same time, even though it is really a systems problem. Similarly, there are some concerns with unsafe equipment such as beds and trolleys: "*Shortage of staff and instruments for example, trolleys that are not safe for patients, or beds not well operated. Resources are a problem all the time"* (RNP5). This sort of resource problem only adds to nursing unease about safely operating within a failing system. Other participants commented on similar problems:

> *There are times of shortage of instruments. Sometimes beds are not good, not safe for patients. So, when the patient is taken down to the ward, the wheels of the bed hardly move, so the person escorting the patient must help to control and push; there are no rails in some; and other beds are unsafe* (ENP5).

It would seem that the problem with resources also adds weight to nurses' tasks both physically and psychologically. The pressure of making sure of the safety and welfare of the patient takes its toll on nurses' overall strength and resilience, not only when performing nursing tasks, but also when seeking to ensure availability of those resources that patients need. Sometimes, the impact of not having enough resources also affects relationships among

staff, creating conflict, prolonging treatments, and making patients unhappy who then really question the quality of care that nurses are delivering:

> *Not enough resources create conflict among staff, sometimes patients are unhappy, it prolongs treatments who then question the quality of care. It also leads to a risk of pain and safety. Poor cooperation can push a patient to refuse treatments because of the pain. There is no safety for patients and us due to a shortage of resources* (RNP5).

These concerns of pain from insufficient resources may lead to some patients refusing treatment. Therefore, there was recognition among the participants that such problems may sometimes lead to disappointment and frustration that can be experienced between nurses and sometimes patients and families. Hence, it results in nurses' frustrations and disappointments in their inability to deliver the best care to patients and family, as well as the unsatisfactory experience from patients and family with the service provided. These were both causes of ethical concern for several participants. These concerns sometimes boiled over into relational difficulties, and especially in attitudes towards fellow workers.

Attitude/Relationship of Nurses vs Co-Workers

There was a lot of talk amongst the participants about the attitude of patients and relatives to nurses, either about their performance or 'expressions' (meaning their public persona and attitude), however one of the participants mentioned problems in this regard with not only patients but also those who came to admit patients (i.e., doctors). There is also a part of attitude that health workers playing in this situation.

> *There are a lot of problems, not only people who come in for help, but also those who see and admits patients (doctors). Some complain and dislike the appearance of the nurse* (ENP5).

This participant was specific about one of the problems that patients complain about such as the appearance of the nurse. Appearance in this respect refers to facial expressions, the way nurses or doctors move, talk, and do things, or the way the nurse presents herself or himself. This has a great influence on the relationship with the patient. Sometimes, smiling, talking well, being gentle, with an approachable face is effective, where other said "noble characters" (uiga tamalii) are a criteria of good service, while some stated that this is the initial treatment for the patients' pain.

Managements & Leaders Inconsistencies

Nursing management and leaders hold great value in Samoan nursing, being highly respected and acknowledged as 'chiefs'. Subsequently, they have a great impact on the overall performance and structure of nursing. However, some participants argued that there are nursing leaders who are producing problems for nurses by adding additional and unwanted pressures on already overworked nurses. These pressures range from minor infringements of normal etiquette, e.g., unnecessarily 'scolding' before agreeing to a request, to more publicly embarrassing incidents. In Samoa, there is a strong respect for the relationship between leaders and the led, i.e., by passively accepting a scolding. However it produces a great deal of pressure and unfairness for nurses that because of the 'social rules,' they can do little about it.

Subsequently, nurses must follow any directions from a senior nurse manager whether they agree with them or not. There were also concerns about, managers interrupting important tasks of the day with a less important request, but out of the required respect, nurses will follow through and do it. They have to show so much respect, that they obey first and complain after:

> *Leaders are not working with the staff, they are not working together, girls (nurses) are looking up at them, but they are slacking. So why do we (nurses) care, let's just do the work and then go home. Who wants to do good from below if the top (management) is not doing any good from above?* (RNP12).

This participant stated there is inconsistent management of nurses who work 'on the floor' delivering nursing service. Other participants had different backgrounds in terms of places that they work and serve as nurses. For instance, one participant worked in one of the referral hospitals as a community nurse, while another worked in the main hospital. The two contexts differed in terms of resource availability (both human and tools). Referral hospitals are more concerned with a cultural way of doing things while the main hospital is less so, and the participant from the main hospital was more experienced in terms of years of service than the participant from the referral hospital. These two different experiences therefore reflect the wide range of possible impacts of the experiences and the environments that Samoan nurses work in.

The participants' experience above also emphasises the importance of role models, a role that was strongly emphasised by nurses to guide junior and new nurses coming into the field of

nursing. The function of role modelling within Samoan society holds a high value because good learning and passing on knowledge to junior or novice nurses is regarded as a crucial skill in a nation where human resources are often stretched. It was referred to as a "burning light" by one participant, that of leading and directing novice and junior nurses to the realities of nursing within the workplace:

> *Nurses are role models, a burning light within our work, because we do everything, even though there are doctors, but they only assess and order treatments, but nurses are with the patient 24 hours* (ENP1).

However, with high valued expectation of nurses being a role model within the workplace, there is a concern when seniors are not able to deliver the expectation of being a good role model to novice participants.

The data showed both the expectations and challenges that nurses saw in management and leadership levels within nursing. Within these expectations, there are identified issues that hinder the performances of nurses and ethical decision making. This is a serious issue because the participant nurses in this study frequently emphasised how management interferes with their daily responsibilities by not working together with nurses who are delivering nursing and who lack role modelling abilities. Basically, such thoughts turned towards the notion of trying to practice within 'different realities' for many of the study's participants.

Different realities: "We talked about it, but we don't practice it."

The conversation of education and practice has been a long and common discussion point both within Samoan nursing and elsewhere for many years. In this study, the reality of nursing education and how it aligns with the practice or not was a very common talking point. The data therefore revealed lapses in nursing education, and a clear schism between desirable nursing practices and everyday reality. Also, in the data was a clear mention of the language used (both formal, informal and especially at district hospitals) when clinical practical procedures differed considerably from what was learnt within nursing schools.

Nursing education: the 'different' reality

As previously discussed in Chapter Two, nursing training and education has been established for more than 30 years in Samoa and there has been a change of approach, setting and

curriculum used to relate the types of knowledge that the nurses need. There was also a belief among nurse educators at least that not all things about the reality of nursing practice will be covered or known during the students' time at the nursing school. This shows that nursing education can only do so much and provide core skills and knowledge. That is, the School can generally cover such things as nursing procedures, ethical and legal aspects of nursing and cultural knowledge and practice to equip a nurse when entering the reality of nursing practice, but they cannot cover all contingencies. One participant shared their experience of the reality of nursing practice by reflecting back to the time of nursing training and education:

> *To be honest, things are a little different during school time and working in the district hospital, [you] have a different experience. There is a different way of doing things in reality. The level of practice is not good enough either, from school time… I should go with the understanding of doing the procedure, but most of the time it looks like everything is new, it is like getting involved in new cases* (RNP8).

The use of the word 'different,' as mentioned by participant referring to her nursing school, experience, and 'way of doing things', portrays the gap between education and practice. The way things are done shines some light of the area that differentiates between the reality of nursing education and practice in Samoa, i.e., "the way things are done" refers to method, styles, or manners of doing things which gives some ideas of the context that the participant might be referring to. This raises a number of issues, and redirects attention to the participant's comment that '*the level of practice is not good enough'* (RNP8). This concern relates to the notion that not enough hours are devoted in the nursing school to actual practice and procedures. In turn, this may alienate or at least negatively affect future nurses when they become permanent staff as registered nurses. How previous experiences as a student nurse might affect the work of future nurses in Samoa therefore it remains a very good question, but for the purposes of this study, the main focus remains on how nurses in Samoa perceive nursing ethics, make ethical decisions, and practice accordingly.

Considerations of factors that affect Nurses Ethical Decision Making in Samoa.

As previously maintained, the locations and settings that Samoan nurses work in are different; some nurses work in the main hospital where resources (humans and equipment) are more accessible than those who work in the community and district hospitals. The line of services,

the individual or community, the environment for nursing services and time/distance factors all need to be considered in every aspect of treatment and nursing services. Also, as discussed earlier, these are some of the key factors that influence a nurse's decision making in the deliverance of care in the context of nursing in Samoa. However, besides these factors, there were common elements identified from participants that they considered to enhance appropriate and relevant ethical decision making in nursing practice and sustain the partnership with the community or an individual in the caring process. From a deeper analysis of gathered data, it became apparent that such elements or factors included contextual nursing skills, professional resources, religious influences, good relationships, and communication.

Figure 12: ***Consideration factors in ethical decision making***

Using and adapting nursing skills within a given context

As shown earlier, the importance of education was supported by most of the participants, however there was a definite emphasis in the interviews on the reality of practice in rural areas and the application of knowledge from education. There was an understanding of normal nursing responses (to practice based requirements), however there was also mention of situations where participants would drop their formal understanding to do what they think they should do in a relationship with the moral and ethical core of nursing, their religious

beliefs, and their desire to save a life, often by preserving an overriding ethical position over a procedural or even a legal one:

> *Education is good, but when we are in rural areas, you must put into practice what you already know. I, too, understood that it is better to do what I know to save the sick than to live by the law that will not satisfy our nursing oath. We vowed to come and do the work to the best of our ability. So, whatever less ability I have at the time I'm His (referring to God), let the Lord direct what I do. I work and think of the Lord in my every action (RNP1).*

The contextual differences between the two main settings were clearly acknowledged by the participants who worked at either the main or referral hospitals on both (Upolu and Savaii) islands and district hospitals. In the former case, there is the presence of doctors but not in the latter case (i.e., there are doctors in the main or referral hospitals but not in the district hospital). The context and operation of the health system therefore places pressure on nurses in rural areas in which they must make their decision of doing what they know to save the life of a patient, whatever the regulations or procedures claim. This can therefore lead to sometimes risky but, to the nurse, acceptable ethical decisions:

> *I rather do it (saving a life) than obey the law and lose a life, especially now here in district hospital, not inside (refers to the main hospital) because those nurses can leave it to the doctors, but here (district hospital), there are two things to think about: think about your safety and think about saving the patient. It's up to you but my understanding and how I feel about it, is that it's all right to not get involved, but the ill or sick person is who needs to be saved (RNP1).*

One participant emphasised good assessment skills as being of the greatest value when making an ethical nursing decision, e.g., considering the patient's condition and everything around expenses, but also the safety of the administered treatments, "*….it all comes down to your assessment, depending on the condition of the patient. And considering whether it is safe to do it or not doing it at all. Everything is at the expense of patient care"* (RN12). It was also stressed by the following participant, that such decision making was mainly based on following nursing standards:

> *Most of the time I focus my work performance on my standards. However, my decisions will depend on my diagnosis of the patient. When I get these findings then I look at my decision -making, depending on the standards, but not relying on standards solely.*

Decisions also look at relationships and available resources. It depends, decisions are based on either my standards or guidelines under which I work, but if I feel it is appropriate for me to use one aspect of the culture to provide care, then that one will be it (RNP3).

Here, may be seen an example of the value of good assessment skills, following set standards, whilst at the same time attempting to maintain good relationships with the family, and using available resources, as previously noted earlier. This same participant went on to describe 'appropriate' care in relation to culture, which can be interpreted as creating the balance in delivery of care, by applying what is appropriate and what seems appropriate according to an assessment of the situation, both clinical and cultural.

Another participant mentioned treatment protocols, i.e., treatment guidelines that are a well-used resource in district hospitals where decisions on treatment are based on the protocol and phone call to the main hospital's doctor. In the following quote, the participant mentions the use of standards, as some previous participants did, and then relies on decision making within the contexts of culture and faith, and the ever present desire to maintain patient safety.

The first thing that comes to mind is the method; what are the treatment protocols? Also consider standards, we look after the safety of the patient; the culture, the way other people come with their Christian belief such as Jehovah's witnesses. With the culture, we deliver or do it with respect (ava fatafata) and in any case we use all three, it is not possible to use one (RNP5).

Hence, where there is an appreciation of nursing education from the participants, i.e. learned nursing skills and ethical knowledge where participants draw on guidelines and nursing standards, but also on a more pragmatic and situationally based form of reasoning. Such nurses have to find balance and ways of nursing service according to what is available in terms of resources, ability, and knowledge wise, to help an individual or the family, often with appropriate uses of cultural norms and practices, including due deference to the importance of spiritual observances.

Using Professional resources – within a socio-cultural setting

As previously maintained, the inclusion of cultural considerations is well supported by participants when discussing their roles in delivering nursing care and nursing services. Essentially, the participants believed that cultural sensitivity and nursing guidelines must work together by communicating respect and ava fatafata (respectful relation/space) for the patient while maintaining good nursing practices:

> *Guidelines and culture must go together. If we talk only of standards and guidelines to patients, it doesn't fit in with the patients' mind. But if culture and guidelines go together, it can easily fit or be accepted by the patient's mind and understanding. The method is to talk with respect and ava fatafata* (RNP6).

This key aspect of Samoa nursing cannot be underestimated because it is a common and expected consideration that the cultural aspect, e.g., the patient's religious beliefs, family values and social standing are crucial factors when a Samoan nurse is in making an ethical decision. Several participants claimed that culture and nursing guidelines and standards do and must work together, emphasising that nursing goes along with two crucial aspects of culture, which are talking with respect and the maintenance of a respectful relational space. Indeed, the role of family in Samoan society is very important (as explained in chapter 2) and this socially contextual aspect alone holds high value within nursing care and services and therefore also clearly affects (ethical) decision making. A nurse caring for an individual in Samoan society nearly always therefore includes the family as much as possible:

> *You work towards the patient's wellbeing, but you also work towards the people of the family that came with the patient, maintaining that connection/communication. Try and let people of the family be involved* (RNP1).

The use of language that strengthen communication is also a key aspect of nursing in Samoa. That is, there is a noticeable impact of oral language (informal, formal or traditional) that is used to make patients understand and be accepting of their (nurses) visit and good intentions. Language use can reassure the patient and their family but can also intimidate the patient and public.

> *...the language used, the language that we know is acceptable and well understood, just has to be fluent to be open and understandable. Be receptive in a way that it does not intimidate families but hoping that they will return for treatment and return to see a doctor and pay attention to the treatment that they need to do or take* (RNP4).

Here the participant implies that language informs good nursing practices and needs to reflect the 'language of relationships' between nurse and family, and subsequently, a considerable amount of decision making, often including ethical decision making, needs to be a shared language rather than one borne out of 'academic' ethics. That is, beneficence may well be the nurse's goal, but 'doing good' and 'doing the right thing' may well be more easily understood among both carers and the cared for when there is a shared appreciation of cultural norms through the use of appropriate language:

> *In Samoa, it is the respect between two people (ava fatafata) and the culture that takes control and helps in our work that we are doing now. So, it is both, relationships - between us and patients, and us (nurses) and doctors. Because no matter what the law and rules allow, but it needs the faasamoa and culture to help people (RNP12).*

The emphasis on *faasamoa* (culture) clearly illustrates the high value of maintaining respect and appropriate relationships, such as between the nurse and the patient and between the nurse and the doctors or other health workers and vice versa. Hence, there is an acknowledgement of the existence of treatments, protocols, laws, policies, nursing standards and governance but according to the participants, the experience of faasamoa demands that nurses follow very strict relational rules and thus maintain an effective nursing service in Samoa. However, a major part of *Samoan faasamoa* is always going to be based not just on social norms, but on religious ones. As discussed in Chapter 2 (p. 23), religion is well engrained in the faasamoa and has a great impact on the Samoan way of living which to no surprise, shown by the data of nurse experience and value of religion.

Religious influences in ethical decision making.

It has been argued in this chapter and chapter 2 that the role of religion in Samoan society is of absolute importance, and the influence of religion is heavily reflected in the nurses' experiences (as related in the interviews) of daily practice in the main hospitals as well as the district hospitals. Samoan people, nurses and their patients and families alike, tend to accept a given health related situation by frequently meeting it with hope and reliance on their faith. As previously indicated, the use of faith and the strengths that it brings tends to act as a relief mechanism and often provides Samoan nurses with a positive attitude to delivering a service to the best of their ability. This sign of hope and resilience is often therefore found in response

to a challenging situation or health care environment: "*Because I know God is helping me. Even though I do not have the strength, God will show the way to do my work if I put God in my mind"* (RNP1). In this example, the participant had previously experienced pressure to perform a procedure that was above their expertise, and there was also pressure from people as identified in this participant's experience. The weight of peoples' trusts on the nurses' shoulders trying to save a life, and the factors at play when making decisions must therefore be quite significant. However, this trust tends to be supported by the nurses' shared faith in God helping and showing the way to do the job and providing strength:

> *….and besides, give your day to the man above (God), but if you don't take your day to the man, you come in (work) and you don't feel good but if you do, you will hear the man (referring to God) putting on a smile, whispering "can you smile?" , express your smile, your appearance in front of people* (RNP2).

Hence overall in Samoa, the importance of 'starting a day with the Lord' helps nurses to focus on the moral aspects of their work. It helps to solve situations in the workplace, control and separate self and family problems from work and to guide decision making: "*So, every time I plan to do procedures or small things, I am always praying in my heart. I pray to the Lord to bring his spirit, so that I can explain well and inform the family of the whole situation"* (RNP6). These religious affiliations run very deep in Samoan society, and clearly affect most nurses' ethical decision-making situations. The depth of involvement often means that prayers are used by both nurses and family members when explaining a procedure to gain patients' confidence. As another participant noted: "*When we (RN and EN) are both working on a case, I put my faith in God. Most of the time when I see someone who is very sick, in a critical condition, I quietly sit down and say, "o God, I am a humble person, but I trust in thee, help me" (*ENP2). So, as discussed in chapter 2, religion is a huge part of Samoan culture, and it is a well-established and very common norm to address the spiritual strength that enables nurses to offer care in all contexts, and especially so in a context of scarcity of both adequate personnel and other resources. Nurses' religious beliefs also encourage and support individuals and their families religious beliefs and values, which are nearly always a strong bond that connects nurses to patients, to their nursing ability and service and a force that predominantly underpins ethical decision making that determines nursing actions.

Good relationships and clear communications

When discussing nursing ethics with the participants, maintaining good relationships with others that they come across in their practices was one of the most common topics from their stories and experiences. Relationships with patients, with families, with the community, with other nurses, with doctors and other health workers were all held to be of considerable importance. However, the level and ease of relationships is different among the various groups noted above, and some nurses obviously find these differences to be occasionally problematic. For instance, as one participant noted, there may even be differences in communication between the nurse and the patient, and the nurse's relationship with the family:

> *I do my job according of what I must do but regarding the relationship position I adjust what needs to be done. It is really hard to make them [family members] understand, so I just leave it to them, and it sometimes this lowers my self-esteem, and it sometimes affects my work* (RNP11).

Sometimes these differences affect the nurse's self-esteem and work, however with the thought of the patient as the main reason for the work, this nurse placed the relationship with the patient as being of more importance than with the family. However, according to the nature of the shared experience, the emphasis on both relationships (i.e. to the patient and to the family) is still well acknowledge for its importance, even if this contact may sometimes affect the nurse's mood, self-esteem, and performance. Thus, when making decisions, and ethical ones especially, it would seem that some nurses place the needs of the patient ahead of any other (socio-cultural) factors.

Nevertheless, it also became clearer when analysing data that a good nursing relationship begins with communicating with everyone, as one participant stated:

> *The kind of experience is to convey the word or message, by carefully explaining because of the relationship (va fealoai) with people. And at the same time, along with the message there is the thought that people may understanding and feel what the staff are facing. At the end of the day, I am happy, and the person is also satisfied and seems to understand and be happy again (RNP4).*

The clear explanation and the kind of words used to convey the message needs to be carefully chosen to reflect respect within the relationship (*va fealoai*) with people. This participant

appreciated that the use of words or language would draw the attention and cooperation for treatment and care, and felt happy about it. This reflection of the impact of language and words used to enhance relationships with the patient as well as the family was mirrored by another participant:

> *When your explanation and relationship is good and our bond with the patient is good the patient will trust me very well. That is why I try whenever I come (to work)…, I try my best to go to them and get acquainted, to talk and to try and develop this relationship, this bond, so that I can get the trust of the patient especially with family, so that the work can be done more easily* (RNP6).

The development of trust between a nurse and others such as patients and/or their families, strengthens the nurse's relationship with the patient and especially the family for future cooperation and trust, both factors thought to be essential when considering the ethical decisions and actions of the nurse. Such cooperation is essential because the role of communal support rather than just that supplied by one individual (e.g. a nurse) is placed at a high value in all stages of illness in Samoa. This has led to and confirms one cultural saying "*o mai a Samoa e tapuaia".* This cultural phase portrays a connection of family to its member who is sick, a close relationship of family to its members, a spiritual space. These relationships and responsibility are therefore a very much shared because, as previously discussed in this chapter, there is an deeply ingrained understanding within all Samoans of the role of family and community in the caring process; hence, there is also evidence in the data of the importance of this understanding when considering nursing ethics. These factors weigh in heavily in the ethical decision making of nurses and they understand the connections between the person who is sick and his/her family, and their role in appropriate and effective care. In short, this relationship treasures and acknowledges the patient's identity, family, status and dignity in nursing care, because in the Samoan context all of the stated factors are important and interconnected.

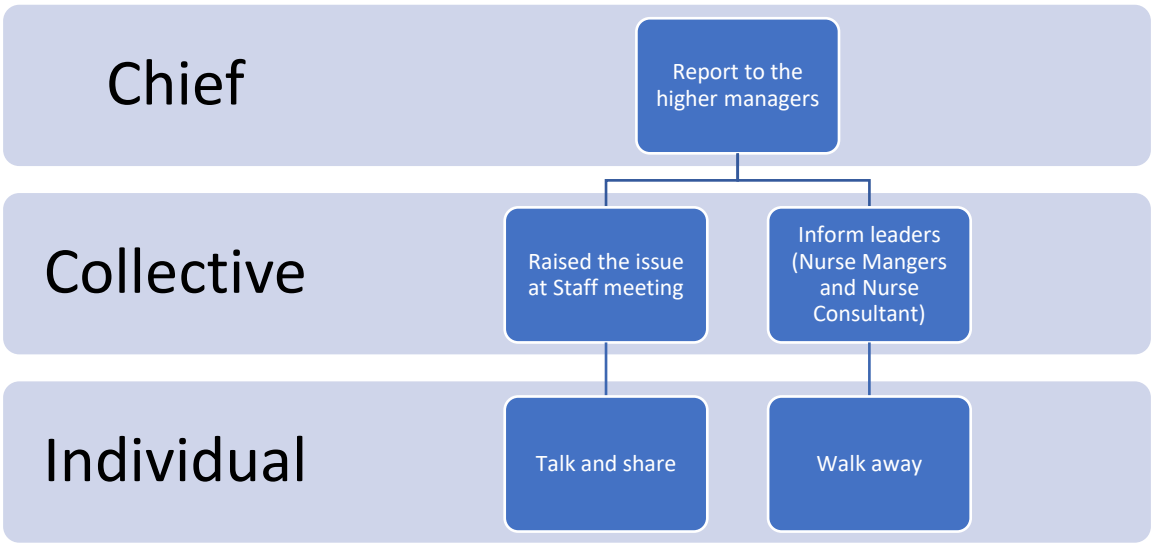
It should now be apparent that nursing ethical decision making in Samoa can be a complex affair, most notably because of the many factors that affect nursing ethical decision making within the social rules and restraints of Samoan society. As shown, there are many factors that range from numerous contextual issues such as geographical and supply problems, lack of sufficient human and other resources, and numerous factors that all relate in different ways

to the effects of expected socio-cultural norms such as religious influences, relational and communication issues at all levels, and various others.

Nurses' Methods of Addressing Ethical Challenges in Samoa

The previous section discussed a broad range of ethical elements and their adjuncts that the participant nurses considered when asked to talk about their ethical decision making. However, this group of nurses also shared their experiences of the nursing leader's role in any challenges or dilemmas (ethical and otherwise). When doing so, it was of interest to note that the approaches that nurses shared reflected similar approaches to those used between nurses and families. For instance, in village governance, it is the norm to seek or let the *matai* know of the given situation or problem, and in the nursing profession, this pattern of social behaviour is repeated when nurses refer to nurse managers. Hence, there is a shared experience, a collective approach that is found for instance in staff meetings or talks between the nurse manager or nurse consultant and other nurses. However, it became clearer during the interviews with the nurses that before taking on a collective approach, sharing with a colleague, having a laugh about it, and saying nothing and 'walking away' are also possible individual approaches when encountering ethical challenges (see *Figure 11* below). Nevertheless, as another participant noted, this more individualistic approach is less common perhaps than a more shared one, as in *Soalaupule* (sharing a problem with an authority to solve a problem by, listening and 'hearing one's voice' in decision making)

Figure 13: ***Samoan Nurses' Methods of Addressing Ethical Challenges***



What therefore now follows is a brief outline of the main themes and subthemes that emerged from the data when the participants were asked to describe how they responded to ethical problems in the workplaces. Essentially, this thematic framework moves in general from the more localised, individual responses towards collective ones before finally ending with the use of an ultimately controlling (and most powerful) authority.

Individual responses

Talk and share with someone – for confidence and help

The experiences of ethical challenges among nurses are different as well as the magnitude of these challenges. From the analysis of data, it seems that nurses have identified ways to address different types of challenge depending on their own interpretations of events and coping mechanisms. Overall, the intention of the nurse is to talk to another person i.e., friend, close colleague or a trusted senior colleague, in a direct manner to seek their help. It would seem from the analysis of data that most participants shared common concerns with their peers, but for seemingly intractable ethical problems, the norm in Samoa was to pass on concerns to a higher authority. This is an experience that often reveals the importance of position and role in the workplace, and of the usual ways that issues are often resolved through the use of the authoritative power and control of others, e.g., a sign that a senior nurse is expected to assist and give learning advice to a less senior nurse as is the case below:

> *I can talk person to person, for example, working with someone on a case, and when I know I have something I want help with, I don't say it there until it is over, what has to be done. The person has to have a good understanding of why they are going to take this and that. With little mistake people put it up on the media. I address it with staff, one to one (RNP3).*

Another interesting observation is the timing of the approach, which considerate one given the norms of social interactions in Samoa. It also reflects the skills and role of mentorship within the workplace. It would be a different approach when it comes to a junior nurse to the senior. If it is a big question there is the possibility of junior nurses sharing it with another close friend who is in a same year and not someone senior. However, there are other avenues for Samoan nurses to raise an ethical issue that goes beyond one-to-one advice or direction.

It is also evident from the data that in fact although many participants indicated a peer to peer responses to ethical issues, others employed another, less positive response.

Do nothing – "Shut up or walk away"

The result of not being able to be heard or even publicly share a concern in Samoa is often to make a quiet move to stay quiet. Here, once again, may be seen the influence of culture as well as a reflection of at least some of the participants' experiences, both of which hinders relationships between nurses and their managers. However, the participants' experiences of repeating an issue that are then ignored or receive no action or solution has led to them giving up:

> *Sometimes, culture and attitude also matter. Attitudes are a big issue in Samoa. So just shut up, without saying the same things over and over to a person who is supposed to be taking action and if nothing has been done, what else can you do? (ESP3).*

Subsequently, this problem, i.e. of not feeling able to relate an ethical issue to a higher authority, or having done so, of being ignored, tends to lead to withdrawal in Samoa. This may also occur within nursing relationships with community members or public representatives. Once more, public status, authority and sometimes the power of the community as its own socially collective force have a significant impact on a nurse's abilities to raise and resolve certain issues within healthcare-based situations. Indeed, it is not uncommon in Samoa for an individual (such as a nurse) to self-isolate from the situation to withdraw and reassess one's thoughts and collect oneself before going back to face the public again, as may be seen in the example that follows:

> *Most of the time, when I feel that my thoughts are flaring, I walk away and sit somewhere and later think to myself, this is a wrong thing to do. Most of the time, I do not want to respond when the public accuses us, but I only tell them, whatever you are saying, I pray to God to forgive what you said to us. Other times when he (the patient) says something inappropriate, I just leave. I had better walk away and then come back. But, when I went back, I told him (in a sarcastic expression) 'Is it over?', but he laughed and started to explain himself and the problem (RNP3).*

Thus, it may be seen that nurses in Samoa tend to follow social and cultural norms even when attempting to resolve ethical issues in the workplace. That is, they either raise their issues with a peer or sometimes a line manager (which seems to be a common practice throughout the

gathered data), or withdraw and 'do nothing' for a period of time until they are able to find a more suitable response and course of action. Nevertheless, it is the use of the collective and collective responses perhaps that emerged much more strongly in the data.

Collective Responses

Raise the issue at staff meetings

The discussion of matters and concerns within the workplace are expressed in staff meetings and emerged as the participants' more common ways of raising work related concerns, ethical ones included. The staff meeting (which is often 'the clinical meeting') consists of all members of the staff, from leaders (the Nurse Manager and the Nurse Consultant) to senior registered nurses, junior nurses, and enrolled nurses. It is an opportunity to talk or let other staff members know of any concerns as well as a place to share opinions:

> *We have clinical meetings; clinical meetings give you the opportunity to talk. Here are many ways that our leaders look at to see what the staff are concerned about. Well, I talk about things such as documentation errors, the quality of the documentation, the poor performance of social relationships (va fealoai) which is one thing that disappoints me* (RNP3).

Hence, the meetings are spaces where leaders will let the staff know of any concerns and vice versa; where there is a degree of discussion about 'everyday' clinical issues such as discussion around documentation errors and quality, and other issues such as disappointment around social relationships (va fealoai). This latter issue is yet another example of at least a potential problem in the relationships between nurses and members of the community that they serve. It may be argued that once more, social mores and norms tend to steer the working and decision-making activities of nurses in Samoa, including ethical decision making. It is also interesting to note that the previous participant viewed the staff meeting as a collective action where all staff members bear an obligation to attend, to talk, listen and share views on matters raised. This collective response is also a common norm within Samoan society, occurring as it generally does before, as in the following situation, any ethically related clinical issue is taken to a higher authority:

> *So, it needs to be discussed at a staff meeting before it goes as a general matter to higher management. Whatever goes wrong, I always talk and correct it on the spot,*

not leaving it to the last minute. Another is taking issues upstairs (referring to management) instead of talking and discussing it among us. Because these are things that should be discussed in staff meetings, and then later on take it upstairs as a general matter. But yet it's already been discussed with the person who is affected (RNP12).

There is emphasise on the role of a senior nurses in the experience mentioned above, just as the previous senior talked about correcting someone on the spot. However, this participant expresses disappointed of how matters are sometimes handled, as the participant feels it should be discussed first at a staff meeting before it goes to the next level of management. Here there is strong emphasise on the value of staff meetings and the act of senior members being protective of their staff, of things that they can solve within staff meetings instead of leaving the top management to handle it. It reflects respect for the skills of leadership of the nurse manager and nurse consultant as well, who are in charge of staff members of any ward or district hospital. However, it was not clearly stated of how often certain situations have been referred to top management.

Go to 'the chief' Responses

It is now probably quite obvious that in Samoa, as perhaps as in other Pacific Island communities, that the social order is of high value. For instance, high regard is paid to both village leaders and organisational leaders in, for example, health care and nursing. A sign of respect and acknowledgement of their leadership and position in society is therefore an experience that encourages a humble approach, as the participant below stated:

If anything happens, it should be shared and leaders informed. If you don't want to share, then talk to seniors, so that you can get some help. And humble yourself, eventually they (leaders) will respond to your wishes (ENP4)

However, humility does not necessarily mean that ethical issues are not addressed properly at such levels – the data revealed that there was often another level of communication that was shared when addressing any concerns among nurses and their leaders. For instance, as the following participant experienced, there is a degree at least of free will regarding who to approach, and when, which shows that Samoan nurses are not entirely socially restrained when facing the need to raise an important issue:

> *Most of the time, I talk to our leader about whatever I feel is not right. Sometimes I say it straight to staff members, but I inform our leader because that is her responsibility, whatever is not right, I will go and talk to her* (ENP2).

Subsequently, Samoan nurses seem to understand that the role and responsibility of the leader is to know affairs within staff and the workplace, and so any opportunity to talk straight to 'the chief' may be utilised. In some ways, this is regarded as another way of showing respect, i.e. valuing his or her role as a decision maker regarding any affairs that are not right within the staff or the workplace:

> *Leaders are not working with the staff, they are not working together, girls (nurses) are looking up at them but they are slacking. Why do we care, let's just do the work and then go home. Who wants to do good from below if the top (management) are not doing any good from above? (RNP12).*

Clearly, there are instances where respect for a leader may come under scrutiny, i.e. when a nurse's experience of a leader is not a positive one. Then the participant is concerned that the leader is not doing their job well, not working together with nurses who are delivering the service. The belief that leaders are not offering a good example for the nurse may then be illustrated by the common saying 'when the leader is good, staff will also follow'. Poor responsiveness from a nurse leader is therefore an experience that might result in nurses employing the 'shut up and walk away' method as noted earlier. This is unfortunate, but not necessarily a phenomenon that is exclusive to Samoan nurses and their relationships with higher managers.

Summary

In conclusion, there is a very strong connection between socio-cultural 'ways of being' within Samoa and with the idea of ethics applied to certain ethical principles or rules. The type of moral symbiosis where traditional social aspects of 'right behaviour' within Samoa are often combined with learned aspects from nursing education. It is clear enough that any nursing ethics within Samoa is strongly influenced by Samoan aspects of social and cultural norms. Nursing ethical decision making in Samoa can be a complex affair, most notably because of the many factors that affect nursing ethical decision making within the social rules and restraints of Samoan society. As shown, there are many factors that range from numerous contextual issues such as geographical and supply problems, lack of sufficient human and

other resources, and numerous factors that all relate in different ways to the effects of expected socio-cultural norms such as religious influences, with relational and communication issues at all levels. However, it may be seen that Samoan nurses, perhaps in ways not entirely dissimilar from the ways of nurses elsewhere, appear to respond to ethical issues and dilemmas in a variety of different ways ranging from what is essentially doing nothing, to raising concerns amongst themselves, to utilising the staff meeting as a collective forum, to taking issues up with managers at all levels. As in other main sections of this chapter, the information extracted from this rough outline was therefore incorporated into the nurses' questionnaire that formed the main approach to phase two of this research project. Its findings are discussed in the next Chapter.

Chapter 6: QUANTITATIVE FINDINGS

Introduction

The previous chapter discusses the findings of the one-on-one interviews, where the thematic method of analysis (which is related in this thesis to the Samoan process of *Kosi*) was firstly emphasised, i.e. pulling one lauie (pandanus leaf) to be stripped into long strands of good essences or themes to be used later in the weaving with the construction of the survey instrument, and later with findings of the quantitative phase. The survey questionnaire was therefore purposely formulated to capture the perspectives of all nurses in Samoa about ethical issues and challenges, using a broader and more inclusive 'Samoan' lens. This chapter therefore presents the results of the second phase of the study. Data was collected from the survey instrument that was formulated from the extensive material supplied by the in-depth interviews with crucial nursing participants in the qualitative phase.

This chapter commences with the way data from the survey was coded and analysed using standard statistical based descriptive analysis methods. This is followed by more detailed discussion about the five main parts of the survey results. Firstly, the sample of respondents, secondly, the demographic and professional characteristics of the respondents; the third part being concerned with the result of the responses to the professional variables questions. In contrast, the fourth part discusses the results of perceived ethical challenges and the results of the frequency of the ethical challenges. Lastly, the fifth part discusses additional comments from respondents regarding ethical challenges among Samoan nurses. In regard to the analysis and presentation of analytical material in this chapter, the Statistical Package for Social Science (SPSS) was fully utilised. This software enhances the interpretation and presentation of the results with a series of generated graphs. That is, data is presented within the survey description of items, with tables and graphs to illustrate the responses of respondents to questions that were asked in various parts of the survey.

Descriptive analysis

Descriptive analysis was employed to summarise collected data in the quantitative phase of the study. Because descriptive analysis is often related to descriptive statistics, the construction of a statistical summary helped the researcher to manage data in a way that was

easy to understand, give meaning, and simplify the understanding of the topic (Grove & Cipher, 2019). Subsequently, descriptive statistics were used in this study to calculate and define the sample and key variables of the study, with the purpose of describing the responses from a variety of variables that sought to reveal the ethical challenges and responses within the sample of nurses in Samoa. According to Fisher and Schneider (2013) this approach to quantitative data analysis is most useful as it enables a researcher to turn societal data and meaning into numerical data and helps the researcher explain, categorise, and sum up raw collected data. In addition, it permits researchers to evaluate the significance or impact of findings so that they can predict and generalise material as inferential statistics (Mishra et al., 2019). However, for appropriate presentation purposes, this study only looks at summary measures or the descriptive statistics of the data. The data is presented in words to describe basic features such as frequency in the study. Therefore, statistical description, tables and graphs are frequently used to present the data.

The vast amount of collected data from the survey was managed, organised, and summarised as described, and this reinforced the notion that it was of considerable benefit to arrange the material for descriptive analysis in such a fashion (Kaushik & Mathur, 2014). For instance, it was challenging in the beginning to sort 221 respondents into a large spreadsheet, but the chosen analytical approach arranged and summed up the data more easily. The data from the Excel spreadsheet was then transfer to the SPSS software, and the understanding gained from Excel and the software were integrated to make sense of the data. In particular, sections one and three of the survey data were analysed using the SPSS software. However, for section three, Excel was also used to analyse this section because it was much easier for the researcher to utilise in the initial period of analysis. Therefore, both outputs from the SPSS and Excel were used in the discussion of the findings of the survey data. The graphical and numerical techniques helped to organise and interpret the collected data into numerous figures such as pie charts, histograms, tables and line graphs. These techniques allowed the researcher to identify trends that were occurring within the nursing population regarding ethical challenges at their workplaces, practice, and profession. Results of the study were easily explained in the distribution of frequency, percentages and overall averages. Thus, it was entirely possible to calculate simple statistics such as frequency counts, percentages, and scores proportions (Fisher & Schneider, 2016).

It was found to be most useful to describe the nominal or categorical and ordinal levels of the data, I.e. discreet data that only categorised quantity within the category and frequency distribution (Thompson, 2009). The reason being that most of the data from the survey questionnaire is categorical, or data that can only be put into groups. Ordinal data, i.e. data that has an inherent order such as *never, sometimes, often and always* is used in the third section of the survey instrument. Frequency distribution was also helpful to identify errors during data entry (Thompson, 2009) which the researcher experienced during the data coding stage. It consists of a description of the number of subjects, selecting each possible option. Its process of translation was another advantage of the approach that is reasonably straight-forward for providing explanation (Kaushik & Mathur, 2014). Finally, it should be noted that there were a significant number of questions and ideas that were identified during the discussion of the results not only for the purposes of this study, but also for future research, which is one of the exciting advantages of the approach. That is, the results have potentially laid forward ways for future statistical analysis of nursing issues in Samoa.

Survey Data coding

Data was initially entered into Excel and then later imported into SPSS to generate the descriptive statistics. However, before descriptive statistics were obtained, the data was cleaned by correcting data entry errors such as inconsistent lower and upper-case letters, for example. A statistician confirmed the data after cleansing, and the researcher faced a new challenge of interpreting the data and assessing how many statistical tests might be applied to the data. However, the preliminary stage of the study was simple statistics that used the sample of nurses to estimate the characteristics of the population of Samoan nurses in regard to their perspectives of the ethical challenges they have encountered at their workplace. Thus, the level of measurement at the beginning stage was categorical data that had four sub-categories, although this study discussed only two of its sub-categories because of the type of data yielded from the survey questions, which are nominal and ordinal data.

The survey instrument has four sections (see Appendix 11 & 12). First was the *Demographic data,* secondly, the *Professional Variables,* thirdly, the *Frequency of Ethical Challenges,* and the last section covered *Further Comments*. The demographic section of the survey was

covered by nominal data that analyses categories such as the number of males and female participating, their age, religion, education, position, division and years of service as in the demographic data of the survey. While the second section, containing the professional variables, consists of seven questions. Question one was open-ended, asking about nurses' perceptions of nursing ethics using their own words. These were analysed using thematic analysis as used in the first phase of the study. Questions two, five, six and seven produced nominal data while question three and four were both nominal (categorical) and ordinal data (data having an exact order). Because of the different types of data yield from this section, the Professional Variable section was not performed in the same way as using SPSS as mentioned earlier. Here, Microsoft Excel was used instead to analyse each variable separately, which made the data more easily understandable. As an example, it laid out a clear understanding of the preferred method of decision making that the surveyed nurses preferred.

However, for the third section of the survey, a Likert scale was used for questions that covered twenty-five ethical challenges. This scale ranged from 1 (slightly disagree), 2 (disagree), 3 (strongly disagree), 4 (slightly agree), 5 (agree) to 6 (strongly agree). There was also a Frequency column for each ethical challenge with the Likert scale of 1 (never), 2 (rarely), 3 (sometimes), 4 (often), 5 (most of the time) and 6 (all the time). Thus, the Likert scale was used in its role as a helpful guide for the ordinal data. Written comments about the survey tool and valuable insights about nursing ethics and Faasamoa were stated in the 'Further Comments' section of the survey. Therefore, 'Further Comments' which was the last section of the survey tool, was analysed using thematic analysis together with question one (Q1) of the Professional Variable section of the survey.

Phase 2 – Survey Findings

Demographic and Professional Profile

Description of Response Rate

The sample comprised 222 respondents; however, one respondent's submission was removed from the data due to a significant number of incomplete sections, i.e. the respondent only answered one question of the whole three-section questionnaire. In the end, the Researcher was able to use the data from 221 respondents and found that 88 (39.8%) of the respondents

completed the whole survey questionnaire (i.e. from section one to the last section), 96 (43.5%) of respondents left Part B of the professional variables questions 3 and 4 incomplete (but complete the rest of the questionnaire), and the remaining 37 (16.7%) responses were missing key information (such as professional variables and some of the frequency column in the ethical challenges section). These omissions within the questionnaire might be because the layout of the survey was not clear enough for them, or they did not understand the instructions, or were in a rush to complete the questionnaire; however, this issue will be discussed in greater detail in chapter 8.

Demographic and professional characteristic of respondents

The table below shows the number of female respondents is almost three times (71.9%) higher than male respondents (27.1%). Here, it is of interest to note that the relationship between female and male nurse respondents is one of the distinctive patterns in the survey, as when compared to New Zealand statistics, i.e., in New Zealand, only 5-6% of the nurses' population are males (this noticeable difference in gender balances, will be discussed in chapter 7). The age group of 21-30 years was identified as more frequent than other groups being made up of 124 respondents (56.1%), while the age groups 31-40, 41-50 and 51-60 years were 32 (14.5%), 30 (13.6%) and 25 (11.3%) respectively, with only nine respondents being of 61 years upwards, and most of them being only part-time in their respective wards and field. This shows that most of the respondents were young adults with the addition of 39.4% (n=85) of respondents who were middle and older adults.

However, it was noticeable that this latter group tended to offer slightly more insightful responses that were considered to be in accordance with their experience and stage of nursing service. Forty-six percent (n=103) of the respondents were from Upolu's urban area which is near to the town area or the capital, and 22.6% (n=50) were from the Savaii-rural area, 14.9% (n=33) were from Upolu-rural area and 11.3% (n=25) from the Savaii-urban area (Figure 3). The number shows that majority of the respondents are from urban areas, where the cultural practice is slightly different from respondents of rural regions who are believed to be more culturally grounded in terms of commitments and relationships (to be further discussed in chapter 7).

Table 3: ***Demographic and professional characteristic of respondents***

DEMOGRAPHIC AND PROFESSIONAL CHARACTERISTIC OF RESPONDENTS		
Characteristics	**Value**	**Total N = 221 (100%)**
Sex	Female	159 (71.9)
	Male	60 (27.1)
	Missing	1
Age	21-30	124 (56.1)
	31-40	32 (14.5)
	41-50	30 (13.6)
	51-60	25 (11.3)
	61+	9 (4.1)
	Missing	1
District	U-Urban Area	103 (46.6)
	U-Rural Area	33 (14.9)
	S-Urban Area	25 (11.3)
	S-Rural Area	50 (22.6)
	Missing	10
Religion	Congregation Christian Church in Samoa	91 (41.2)
	Methodist	34 (15.4)
	Catholic	28 (12.7)
	Assembly of God	15 (6.8)
	Latter-Day Saints	21 (9.5)
	Seventh Day Adventist	11 (5.0)
	Others	21 (9.5)
Position	Enrolled Nurse	32 (14.2)
	Registered Nurse	165 (74.7)
	RN/RM	24 (10.9)
Highest Education	Certificate Nursing	23 (10.4)
	Diploma in Nursing	15 (6.8)
	Bachelor of Nursing	138 (62.4)
	Postgrad in Nursing	41 (18.6)
	Advance Diploma Nursing	2 (.9)
	Master's in nursing	2 (.9)
Years of service	<3	76 (34.4)
	4-10	74 (33.5)
	11-20	19 (8.6)
	21-30	24 (10.8)
	31-36+	28 (12.7)

The highest qualification that most respondents held was the Bachelor of Nursing, i.e. is 138 (62.4%); 41 (18.6%) respondents had Postgraduate Qualifications in areas such as Eye Care, Leadership and Management, Mental Health, Midwifery as the highest postgraduate holders,

and Primary Health Care. There were 23 (10.4%) respondents who had a basic certificate of nursing, and they were mainly employed as Enrolled Nurses (ENs). Finally, only 15 (6.8%) respondents held Diplomas in Nursing. According to the data, some respondents still hold a basic certificate of nursing from the old nursing training (hospital-based training), i.e. before nursing education moved to the university level. Altogether, 165 (74.7%) Registered Nurses, 32 (14.2%) Enrolled Nurses, and 10.9% (n=24) of Midwives who were also registered nurses responded to the survey.

Clearly, the data revealed that the highest number of respondents were Registered Nurses (85.6% n=189), which illustrates that most Samoan nurses are registered nurses and there is a considerably less number of enrolled nurses. The preliminary data also revealed that there were 34.4% (n=76) of respondents who have been working for less than three years, followed by the majority of 93% (n=42.4) of nurses who have worked for up to 15 years, while 52% (n=23.5) were nurses who had worked for more than 20 years. In the Samoan context, this latter group means that they would be known as 'seniors' in their respective areas in the workplace.

Professional variables

This section was added to the survey to seek general understanding of nurses in regard to nursing ethics. There were seven set questions that explored nurses' understanding of nursing ethics; venues that nurses learnt about nursing ethics; factors that shape their ethical knowledge; available resources for decision making; awareness of nursing standards and competencies; receiving any advice or counselling regarding ethical issues and lastly, perspectives on ethical committees. Questions were laid out differently in this section, there was one open-ended question, three questions that have provided answers that the respondent has to select from and arrange their answers from 1 to 3 (see Appendix 12). This was followed by two questions that have 'yes and no' answers with a request for clarification. It was this request, and some of the others, that led to several unanswered questions.

Understanding of nursing ethics

The first question of the Professional Variables section explored the nurses own understanding of nursing ethics. It was a free response question (i.e., not a multiple-choice

option), due to the understanding that each individual may well have different interpretations of the meaning. It was therefore an opportunity for the respondents to explain their own understanding and meaning in written words. Sixteen respondents (7.2%) did not answer this question, but the majority of the 205 (92.8%) respondents gave a detailed perspective of what nursing ethics was, in the questionnaire. Since this question was seeking their understanding and perspective of nursing ethics in a written sentence, the answers were analysed by using the thematic analysis, as used in the first phase of the study. Three major themes were identified from responses. Firstly, 'cultural perspectives' that promote social etiquette and maintain proper social relationships; secondly, as variations of 'modern' (or perhaps 'western') understandings of nursing ethics (such as through the use of ethical principles, stating the value of a code of ethics, nursing standards and competencies), and thirdly, as a legal or rule based phenomenon, i.e. nursing ethics as 'following the rules.' These identified themes will be discussed in the following chapter (chapter 7), with supporting quotations from respondents. But for now, 92.8% of the respondents stated their understanding of nursing ethics as basically one or more, or combinations of the three stated variations.

How nurses learnt about nursing ethics

Question two was focused on the area or place that nurses learnt about nursing ethics, with the follow-up instruction to select as many of the provided answers as applied to their experience. There were four possible answers to choose from, such as religious education, college, School of Nursing and continuing or postgraduate education. However, the majority of respondents chose the School of Nursing (97.7%, n=216) as the place they learnt about nursing ethics. As may be expected, some respondents chose two (12.2%, n=27)), three (6.3%, n=14) and all four (1.8%, n=4) options. But religious education (10%, n=22), continuing education (10%, n=22) and colleges (10.9%, n=24) were among the more common choices that respondents selected, together with nursing schooling. Basically, the School of Nursing was the most favourable response followed by religion and continuing education.

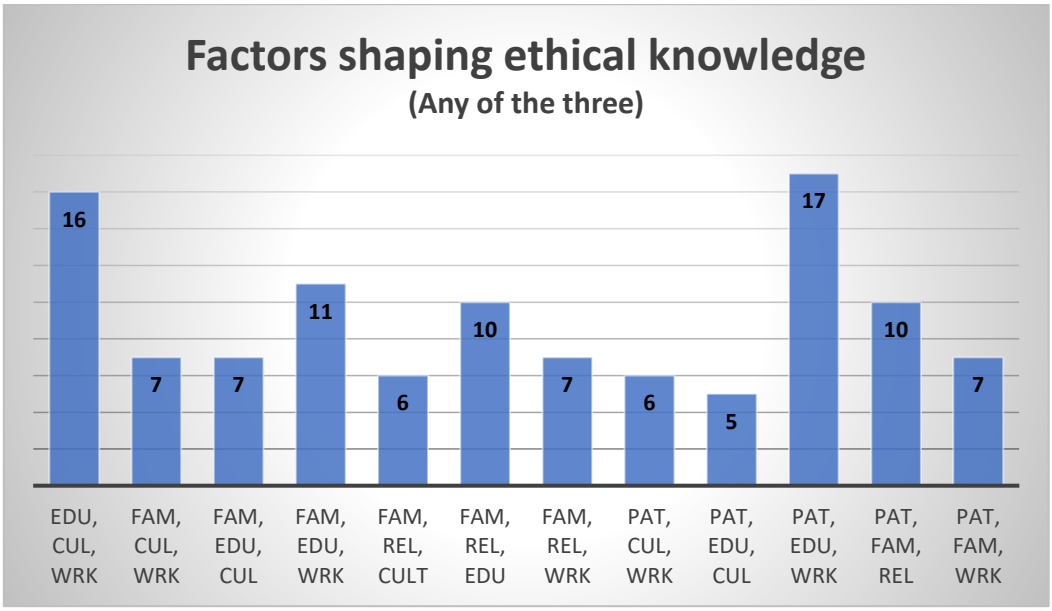
Factors that shaped ethical knowledge

The third question was focused on *factors that have shaped nurses' ethical knowledge*, with eight possible answers in the questionnaire, such as patients, family, religion, education,

culture, media, work experiences and life experiences (other than work). There were instructions *(A. Please tick any three and B. Number the three most important from 1 – 3 beside the box*) for this question, and 99% of the respondents, answered according to instruction A but only 54% of the respondent responded to instruction B of the same question. Nine percent (n=20) of the respondents who selected one response from the list, 3 % (n=6) selected two responses, and n=148 (67%) of respondents selected responses according to the instruction A (to tick any three), although 20% (n=45) actually selected more than 3 responses (n=22 provide four responses, n=5 provide five responses, n=7 provides 6 responses, n=5 provide 7 responses and n=6 selected all eight responses).

From eight provided responses, the most selected response that best explained the shaping of their ethical knowledge was work experience (64%), while the least were the media (8%) and 'life experiences' (14%). However, education (59%) and family (52%) were strongly represented, with patients (46%) a close fourth. Culture (44%) was also fairly strongly represented, which in turn was followed by a distant percentage for life experiences (14%), and media (8%). Despite a considerable number of respondents missing data of instruction B of this question, there was still clear evidence that work experience had a great impact on shaping the ethical knowledge of nurses, followed closely by education, family, patients, culture and religion. There was strong evidence that, with work experience being the highest, there was also a more limited role for education, family, patients, culture and religion in shaping ethical knowledge of nurses in Samoa. However, the selection of respondents' answers, shows a variation of differences among respondents which reflect the uniqueness of a nurse as an individual and the factors that influenced their ethical knowledge and possibly values that may have had an influence on their decision making as shown in the Figure below (Figure 14).

Figure 14: ***Factors shaping nurses' ethical knowledge***



As noted, 148 (67%) respondents selected three answers according to instruction A (*please tick any three from the list provided)*, however in the sample presented by Figure 14 above, where a glimpse of respondents (n=109) answered instruction B *(Number the three most important from 1—3 beside the box*) of the same question. As may be seen in Figure 14 (above), there are numerous variations of the three selected items among nurses' responses, and this is just a brief example of the spreadsheet (i.e., there are other variations of selection presented by the data). The selection of patient (PAT), education (EDU) and work (WRK) appears high (n=17) followed by education (EDU), culture (CUL) and work (WRK) of n=16; Family (FAM), Education (EDU) and Work (WRK) with Patient (PAT), Family (FAM) and Religion (REL) at n=10 respondents.

It was interesting to see how different nurses selected their responses and how many of them seemed to revolve around family, patient, education, culture, religion and work experience. It was obvious too that not all nurses shared the same developmental opinions concerning the origins and influences on their ethical values and thoughts, each having their own ways of learnings, and experiences of what they perceive to have influenced their ethical knowledge. It is also of interest to note that even though life experiences (14%) and media (8%) produced low percentage replies, it is clear enough that some nurses at least place a greater emphasis on the shaping of their ethical knowledge by media and life experiences.

Figure 15: ***Order of important factors shaping nurses ethical knowledge***

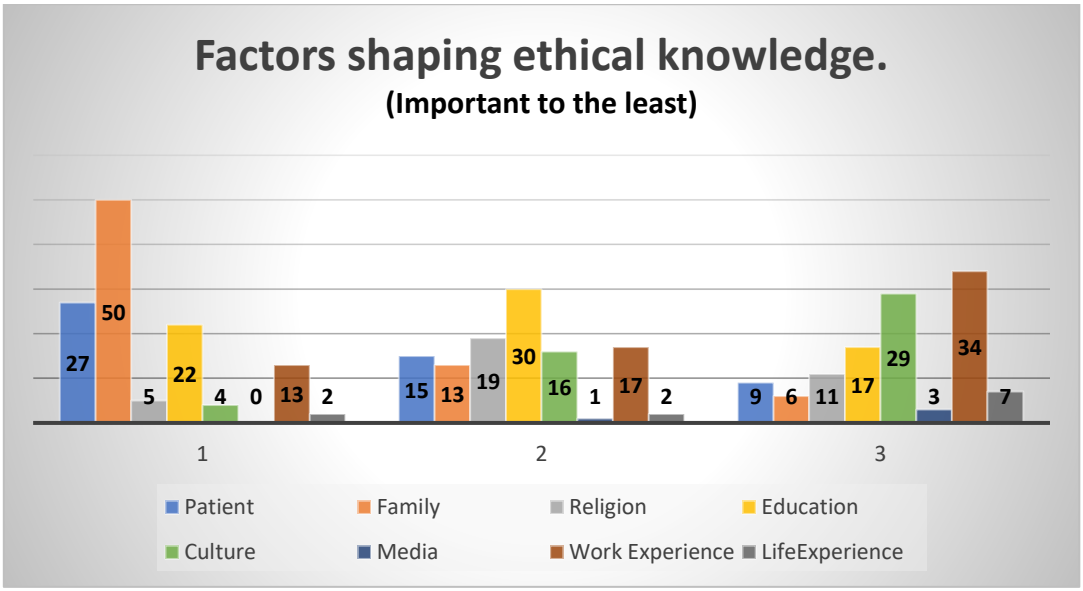


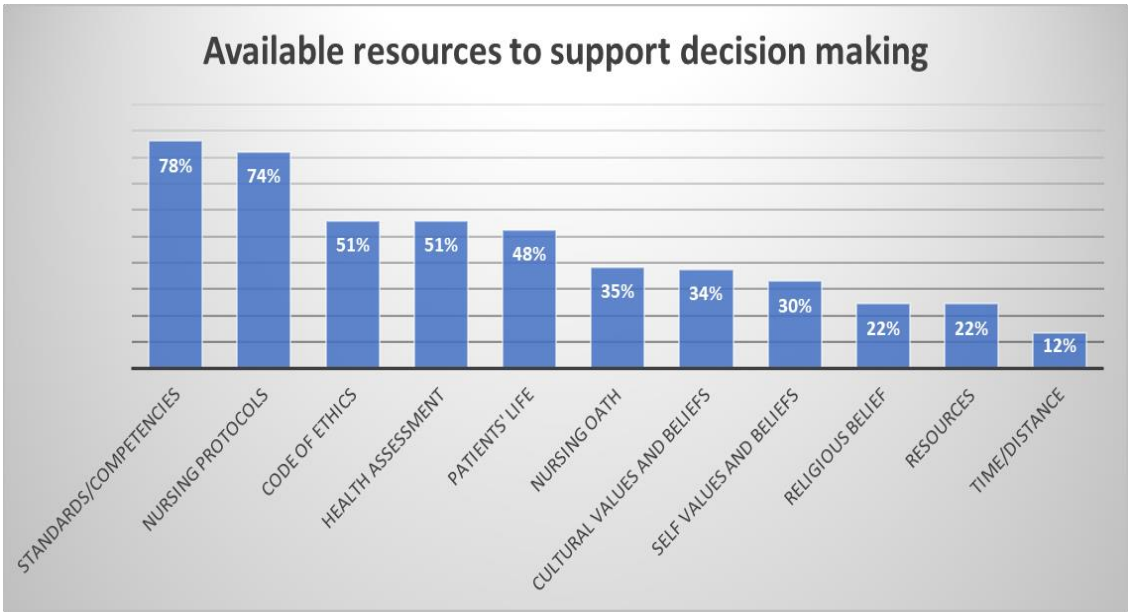
Figure 15 shows that work experience (64%) was the most selected answer of the possible factors that shaped their ethical knowledge. However as may be seen in Figure 15 above, the most selected answer by respondents as being a major influence when it involved ethical knowledge, was family (n=50, 40.7%), second was education (n=30, 26.5%) and the third was work experience (n=34, 29.3%). Hence, there is clearly work experience is a consideration which shapes ethical knowledge, but there is also greater emphasis placed on the influence of family and family values. This seems to reflect a more personal aspect within this question, i.e. the importance of family which can reflect values, relationships, roles and responsibilities and also perhaps a collective sense of obligation. This may be because the Samoan family is not just made up of one person but three or more individuals within relationships where, values, etiquette, attitudes and customs, social status, obligations and roles and responsibilities are of crucial importance. Then again, 'education' and 'work experience' are the second and third most selected answers indicating the strong influence of ethical values within the nursing profession and connection to daily experiences or reality in formulating ethical decision making and subsequent actions.

Available resources for ethical decision making

The Professional Variables section of the survey (Question Four) considered the resources that are available for Samoan nurses to support their ethical decision making in their workplace. These main resources are all extracted from the thematic material supplied by the nurse

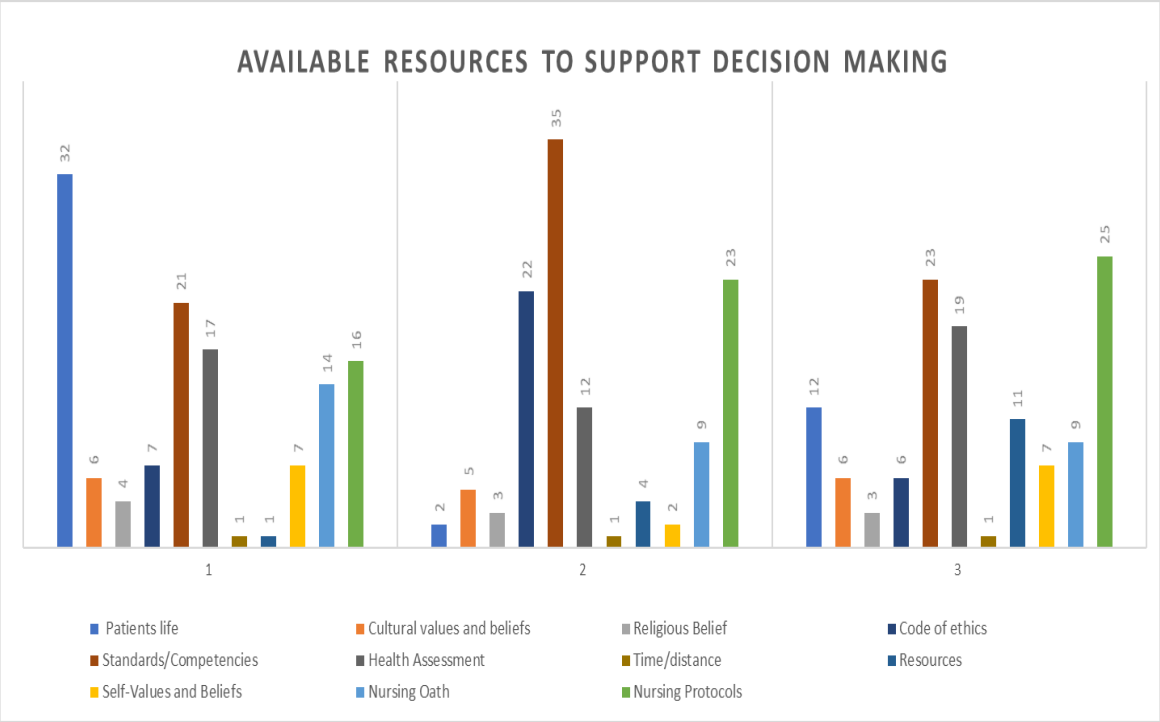
participants in the interview phase of the study. The available resources varied from the professional resources, cultural, personal and availability (health personnel and resources). The majority of the respondents (99%), answered this question. In their replies, as, in figure 14, most respondents selected standards and competencies (78%, n=172), while far less considered time and distance (12%, n=27). Essentially, many respondents considered standards and competencies and nursing protocols to be the most available resources that supported their ethical decision making, followed by the Nursing Code of Ethics, health assessments and patients (valuing patients' lives and condition of illness).

Figure 16: ***Available resources to support nurses' decision making***



Instruction B of question four asked the respondents to place their selected answer from the most important resource to the least by labelling the box with numbers from one to three. It was a challenging question to analyse due to missing data, as mentioned before. This was because although 99% of respondents completed part A of this question, only 54% of respondents were able to continue to answer instruction B. Figure 17, as shown below, provides more detail of how the respondents categorised their selected answers from the most important resource to the least.

Figure 17: ***Order of preferred resources to support nurses decision making***



Regarding part A of question four, the highest percentage of the selected answers wass 'standards and competencies' (n=172, 78%). However, the instruction B (Label response from the most important to the least using numbers) of the same question, shows that 25.4% (n=32) respondents chose 'saving the patient's life' as the most important aspect on which to base their decision, followed by 'standards and competencies' (29.7%; n=35), and then by 'nursing protocols' (20.5%; n=25). This data tends to illustrate that in ethical decision making, nurses firstly consider 'saving the patient's life', followed by a desire to follow standards and competencies, and then nursing protocols. This finding is of considerable interest and will be revisited later in Chapter 8.

Nursing Standards and Competencies Awareness

Nurses' awareness of the nursing standards and competencies for the profession were explored in question five. It was a well-answered question (*Are you aware of the nursing standards and competencies for the nursing profession?*) with the majority of the respondents (98%, n=216) responding 'yes' but only 2% (n=4) selecting 'no'. There is a high percentage of nurses' awareness of nursing shown by the data. The previous questions strongly support and shows strongly emphasis nurses' usage of nursing standards and competencies in ethical

decision making. This question shows the well-established awareness of nurses about the existence of nursing standards and nursing competencies in the nursing profession, which supported the understanding of nurses as shown in the previous question with other resources of its usage in workplace.

Being advised and/or receiving counselling regarding an ethical issue

Question six sought the respondents' responses about their experiences of receiving any advice and/or counselling regarding an ethical issue. Thus, it was followed up with the question of: 'if yes, what was the nature of the issue?' From the total of 221 respondents, 3% (n=7) did not provide any answer, 29% (n=64) selected 'yes' and 68% (n=150) of the respondents selected 'no'. The number shows a high percentage of respondents who stated no, which therefore raises the question about how nurses deal with ethical challenges without necessarily seeking advice or counselling. Here it may be speculated that some may ignore an ethical issue, or perhaps deal with it in a different way, e.g. either culturally or by normalising it as a simple matter, or even "sweeping it under a carpet" as one participants stated in phase 1 of the study. These interesting possibilities will be further explored in the next chapter.

Perspective on the use of an Ethics Committee

The last question for the Professional Variables section of the survey, sought the perspective of respondents in regard to their possible use of an ethical committee if one was made available to them (as in "should there be an ethical committee in nursing to go to for advice?") As in other cases, this question was followed-up for clarification ('if yes, why?'). It was a well responded question, 72% (n=160) of respondents answering 'yes' and 25% (n=55) of respondents answering 'no' (with 3% (n=6) of respondents not providing an answer). There were a lot of respondents who support the idea of having an ethics committee to look at areas to improve ethical decision making within a practice. This result clearly strengthens the recommendation for an ethics committee to advise nursing practice and education.

Ethical challenges and frequency

Section two of the survey consisted of 25 statements of common ethical situations that nurses have faced in Samoa that were identified from the phase 1 interview data of the study. These are shown in Table 5 below. This section was developed from the common themes identified in the interview phase of the study. There were 25 statements of ethical situations identified in this way, and they were subsequently arranged under five major areas, such as *culture, health system, ethical problems, ethical decision making* and *approaches*. A Likert scale of one to six was used to measure this section divided into two columns headed 'ethical challenges' and 'frequency'. The frequency column was added to explore the weight or intensity of the ethical challenges among nurses in Samoa.

As shown in the table below (Table 6), 17 of the 25 statements have a high degree of validity for the respondents taking the survey, whilst three statements (5, 20 and 21) were much less so, i.e. being considerably less common. There are four statements (9: *Provide better care for those who can afford it than those who cannot*; 11: *Avoid taking action when I learn that a nurse colleague has made a medication error;* 12: *Working with nurses who are not doing or not considering the need to do treatments at an exact time*; and 14: *Unable to maintain patient confidentiality due to patient allocation*). These had a high number of respondents agreeing that the statement is valid, but also that the given situation never happens. Conversely, statement 6 (*Carry out the doctor's order via phone (District Hospital Referral System via phone) that I am not confident to give*) in particular, had a high disagree percentage but there was also a high percentage of occurrence within the workplace. This result, and the previous one, will be discussed in conjunction with the eight statements in detail in the next section of the chapter.

Table 4: *Summary of ethical challenges responses (%)*

Ethical Situations	*1*	*2*	*3*	*4*	*5*	*6*	
	Strongly disagree	*Disagree*	*Slightly Disagree*	*Slightly Agree*	*Agree*	*Strongly Agree*	*No Response*
1. Cultural values and practice are important in nursing care and service.	*1%*	*0%*	*0%*	*16%*	*31%*	*51%*	*2%*
2. There is a dilemma between cultural practice (language and setting) and nursing care/practice.	*5%*	*5%*	*5%*	*23%*	*29%*	*29%*	*4%*
3. Encountering cultural pressure (faia, status, honour) while performing nursing care and service.	*7%*	*4%*	*4%*	*24%*	*29%*	*28%*	*6%*
4. Following family members request to seek traditional healers rather than hospital treatments	*22%*	*11%*	*9%*	*19%*	*17%*	*23%*	*7%*
5. Observe without taking action when a nurse colleague allows family members perform nursing actions e.g. medications.	*35%*	*12%*	*14%*	*11%*	*10%*	*12%*	*5%*
6. Carry out the doctor's order via phone (District Hospital Referral System via phone) that I am not confident to give.	*18%*	*9%*	*11%*	*20%*	*18%*	*19%*	*5%*
7. Having NO doctor at District Hospitals (24/7). So, nurses perform patient consultation and treatments.	*12%*	*3%*	*3%*	*15%*	*21%*	*41%*	*5%*
8. Carrying out treatment with limited resources that compromise nursing care and quality service	*6%*	*4%*	*4%*	*19%*	*23%*	*40%*	*4%*
9. Provide better care for those who can afford than those who cannot.	*28%*	*8%*	*11%*	*10%*	*15%*	*22%*	*6%*
10. What is taught in classroom is not the same as what is practiced in hospital setting.	*14%*	*5%*	*6%*	*23%*	*21%*	*27%*	*5%*
11. Avoiding taking actions when I learn that a nurse colleague has made a medication error.	*21%*	*11%*	*10%*	*12%*	*16%*	*25%*	*4%*
12. Working with nurses who are not doing, not considering the need to do treatments at exact time.	*22%*	*8%*	*9%*	*13%*	*19%*	*24%*	*5%*
13. Performing ordered procedures beyond scope of practice or Job Description.	*19%*	*5%*	*7%*	*13%*	*22%*	*31%*	*4%*
14. Unable to maintain patient confidentiality due to patient's allocation.	*20%*	*12%*	*8%*	*14%*	*22%*	*21%*	*4%*
15. Attitude towards nursing care and work affects the standard of care and conduct.	*8%*	*1%*	*4%*	*21%*	*27%*	*35%*	*5%*
16. Decision making is affected by culture sensitivity.	*7%*	*5%*	*4%*	*19%*	*32%*	*29%*	*5%*
17. Saving the patient's life is more important than caring about myself as a nurse.	*13%*	*8%*	*4%*	*15%*	*19%*	*37%*	*4%*
18. I feel safe to use nursing protocols	*0%*	*0%*	*1%*	*7%*	*19%*	*70%*	*3%*
19. Feeling tired, feeling oppressed and burned out impacted on performance and decision making.	*10%*	*5%*	*5%*	*19%*	*28%*	*25%*	*8%*
20. I care more about personal values than nursing ethics.	*29%*	*12%*	*9%*	*20%*	*14%*	*8%*	*8%*

Table 5: ***Summary of ethical challenges frequency responses (%)***

Frequency		1 Never	2 Rarely	3 Sometimes	4 Often	5 Most times	6 All times	No Response
1.	Cultural values and practice are important in nursing care and service.	4%	2%	10%	20%	20%	29%	15%
2.	There is a dilemma between cultural practice (language and setting) and nursing care/practice.	5%	7%	15%	21%	23%	16%	13%
3.	Encountering cultural pressure (faia, status, honour) while performing nursing care and service.	6%	9%	12%	19%	24%	17%	14%
4.	Following family members request to seek traditional healers rather than hospital treatments	8%	10%	16%	14%	21%	19%	11%
5.	Observe without taking action when a nurse colleague allows family members perform nursing actions e.g. medications.	24%	17%	14%	14%	10%	10%	13%
6.	Carry out the doctor's order via phone (District Hospital Referral System via phone) that I am not confident to give.	14%	12%	17%	17%	14%	14%	13%
7.	Having NO doctor at District Hospitals (24/7). So, nurses perform patient consultation and treatments.	5%	5%	9%	8%	21%	36%	17%
8.	Carrying out treatment with limited resources that compromise nursing care and quality service	4%	5%	14%	14%	20%	28%	16%
9.	Provide better care for those who can afford than those who cannot.	28%	8%	11%	10%	14%	10%	19%
10.	What is taught in classroom is not the same as what is practiced in hospital setting.	5%	9%	18%	21%	18%	13%	17%
11.	Avoiding taking actions when I learn that a nurse colleague has made a medication error.	22%	17%	20%	12%	8%	8%	14%
12.	Working with nurses who are not doing, not considering the need to do treatments at exact time.	19%	12%	19%	14%	14%	10%	13%
13.	Performing ordered procedures beyond scope of practice or Job Description.	13%	9%	16%	15%	16%	18%	14%
14.	Unable to maintain patient confidentiality due to patient's allocation.	16%	14%	18%	15%	12%	11%	14%
15.	Attitude towards nursing care and work affects the standard of care and conduct.	6%	8%	17%	21%	19%	14%	14%
16.	Decision making is affected by culture sensitivity.	5%	8%	19%	20%	18%	15%	15%
17.	Saving the patient's life is more important than caring about myself as a nurse.	4%	11%	14%	14%	15%	26%	16%
18.	I feel safe to use nursing protocols.	2%	1%	3%	10%	19%	48%	17%
19.	Feeling tired, feeling oppressed and burned out impacted on performance and decision making.	7%	12%	19%	17%	20%	14%	11%
20.	I care more about personal values than nursing ethics.	17%	14%	23%	14%	10%	6%	16%

Cultural Context

'Cultural values and practice are important in nursing care and services' was the first general statement that was used to generally seek perspectives from the nursing population. It sought responses on the value of cultural practice in nursing care and service. According to the data, there were 51% of the respondents who strongly agreed with the statement from 98% of the total responses. Furthermore, out of 85% of respondents who responded to the frequency column, 29% stated that it happened all the time. The statement itself sought responses of whether or not the respondent nurse believed that cultural values and practices were important when attempting to offer ethical practice. The data shows that nurses strongly agree that it is important, and it happens all the time. However, if the analysis asked the question of whether the importance of cultural values and practice is an ethical challenge, according to the numbers, the data shows that it can be interpreted as an ethical challenge and it happens all the time. There is a possibility of the numbers showing that cultural values and practice is very important, and nurses use it all the time in nursing care and service however there is also an ethical challenge in its integration to nursing service and practice. Such challenges will be clarified in later statements as follows.

'There is dilemma between cultural practice (language and settings) and nursing care/practice'. The question sought responses that related to cultural practice, i.e., the use of language especially the spoken language such as when the nurse sits with matais and leaders of the village or community. This situation relates well to the well-stated nature of the dilemma mentioned by participants in phase one of the study (see chapter 5, pages 112-117). Ninety-six percent of the respondents responded to the statement, and 29% of their responses strongly agreed. Equally, 86% of the respondents ranged from slightly agreeing to strongly agreeing. This result is therefore of great interest because it suggests that nursing ethics in Samoa is heavily dependent on socio-cultural observances as much as any other factors. This observation is supported by the 81% of respondents in the statement Frequency Column. The data also shows that 23% of the responses reveal that there is a dilemma between cultural practice and nursing practice that happens most of the time, which is two percentages higher than often (21%) and all the time at 16%. Hence, there is a clear indication of the statement being an ethical challenge and it is happening most of the time or often. The small difference regarding the existence of the ethical challenge might be a reflection of years

of experience and status, i.e., they may often see it as challenge, but are able to manage it or have ways to cope with such a challenge or dilemma.

The nurse experience question of '*encountering cultural pressure such as faia (relation), status and honour while performing nursing care and service'* sought responses of the existence of cultural pressures at nurses' workplaces. There was a 94% response to the statement, and 29% agreed that it was a challenge. Of the 87% of respondents who responded in the Frequency column, 24% stated that it happens most of the time. However, overall, 81% out of 93% of respondents agreed with the statement, i.e., that it was an ethical challenge, and 72% of the responses maintained that they encountered cultural pressures while performing nursing care and services. The data therefore confirms that there are a number of culture pressures during nursing care and service at the nurses' workplaces and that these pressures are apparent most of the time.

'Following family members request to seek traditional healers rather than hospital treatments' was the fourth statement that sought response of nurses' experience because according to the thematic analysis, this statement is one of the commonly recognised challenges within the workplace. There was a 94% response and 23% strongly agreed with the statement while 21% stated that it happens most of the time. There is one percent difference between strongly disagree (22%) and strongly agree (23%), which shows that there are nurses who either value traditional healers or the patients' right to decide on treatment. But the 23% of nurses who strongly agree shows that traditional healers are a concern and that there are ethically challenging treatments at their workplace. Twenty-one percent of respondents stated that this mostly happens. The closeness of the strongly agree and strongly disagree percentage queries the interpretation of the statement as to whether the respondent strongly disagrees because of following a family request to seek out a traditional healer or is it because they strongly disagree that it is an ethical challenge.

Statement Five sought nurses' perspective on, '*observing without taking action when a nurse colleague allows family members to perform nursing actions e.g. oral medications.'* This statement was identified from the thematic analysis, as a concern around honesty and telling the truth about administering oral medications to family members. The majority of 35%

strongly disagree with the statement, in other words, family members performing nursing actions e.g., giving medication, is not an ethical challenge. Twenty four percent responded that it '*never*' happens. Hence, many respondents did not regard family interventions in nursing care to be an issue of any major relevance. The data reflects the understanding of nurses that although nursing care is not a family responsibility, overall, it is not happening in situations where nurses are in attendance. Here, it seems likely that the interpretation of the statement's contextual meaning is vague and not specific enough. For example, the word 'medication' is not well specified, or it may be perceived differently by different nurses, i.e., it could refer to oral medication or injection. However, the data clearly reveals the understanding of a nurses' role and what ought not to be the family's responsibility in caring.

Within the health care context

'Carry out the doctor's order via phone (District Hospital Referral System via phone) that I am not confident to give' was the sixth statement. Fifty seven percent generally agreed with this statement (i.e. via the addition of slightly agree (20%), agree (18%) and strongly agree (19%) shows that the statement is an ethical challenge in the workplace. Additionally, in support of this claim another 17% of the respondents stated that it happens at least sometimes. With the addition of 45% (often (17%), most of the time (14%), and 14% of all the time), it is clear that it is a common issue. Therefore, the data from this statement shows an interesting outcome whereby 57% of respondents agree that when order treatments via telephone, it is an ethical challenge but there is a close difference between each answer and an equal split of 'never' and 'often', so this too tells a story that nurses are unsure about this issue, or that maybe it depends on the treatment that has been ordered or the number of times it has occurred. Whether they sometimes feel confident to carry out a telephoned doctor's order or not, may well depend on the experience of the nurse. However, it remains reasonably obvious by the occurrence of the statement that divides number of respondents in half, that there is an understanding that this might be influenced by respondents' experience and workplace situations. This interesting phenomenon will be explored further in this thesis (see chapter 8).

Statement Seven sought responses to one of the challenges in the district hospital that strongly emerged from the qualitative phase of the study, i.e., '*Having no doctor at District Hospitals (24/7). So, nurses tend to perform patient consultations and treatments*.' Of the

ninety-five percent responses, with 41% of them strongly agreed with the statement. The number responding with 'most time' (21%) and (36%) of 'all time' reveals a great deal about the nature of nursing work without sufficient medical support within the Samoan health care context and it is quite clear that there are many nurses who support such concerns as originally explained and shared by participants in phase one of the study.

'Carrying out treatment with limited resources that compromise nursing care and quality service' was the eighth statement. Forty percent of respondents strongly agreed with the statement that this is an ethical challenge. Twenty-eight percent of respondents indicated in the Frequency column that this happens all the time. Thus, with the addition of others in general support of this claim (i.e., 19% slightly agree, 23% agree and 40% strongly agree), it would seem that it is a common cause of ethical concern for Samoan nurses. In addition, 82% of respondents stated that this is happening very frequently within the workplace, which shows a high percentage of this type of challenge that nurses encounter every day within their respective workplaces. The percentage shows as well that it is not just a one territory or district concern but a national challenge.

Statement Nine sought nurses' perspectives on the provision of care; whether to '*provide better care for those who can afford it over those who cannot afford it*'. The statement derives from phase one analysis of nurses experiences of the provision of care. Twenty eight percent of respondents strongly disagreed with the statement, and 28% responded that it never happens. The data shows considerable disagreement from the respondents regarding this statement; it shows the understanding of what ought to be done and not, 'right and wrong', regarding accessibility and affordability, and therefore equal provision of care.

Statement Ten sought responses to the reality between nursing education (what is taught) and the hospital setting (what is practised), i.e., '*What is taught in the classroom is not the same as what is practised in a hospital setting*'. Twenty-seven percent strongly agreed and from 84% of respondents in the Frequency column, 21% responded that this often happens. It is interesting to consider as well, the addition of 71% of respondents who agreed either slightly or more so with the statement that it is an ethical challenge, especially when considering the 61% response rate that it often occurs (21%), takes place most of the time

(18%) and happens all the time (13%). This reveals an interesting issue in relation to the reality of nursing education, e.g., there are no specific areas identified but it provides useful percentages for evaluation and further research on the 'theory-practice gap' as it is sometimes referred to.

Ethical challenges

'Avoiding taking action when they learn that a nurse colleague has made a medication error' was the eleventh statement that sought responses of nurses' experiences during a typical shift at work. Twenty-five percent of respondents strongly agreed with the statement that it is an ethical challenge, although 22% of respondents in the Frequency column, responded that it never happens. Nevertheless, 53% agreed either 'sometimes' or above that it was a fairly common ethical issue, while an additional 59% responded either it never happens (22%), rarely (17%) or sometimes (20%). Hence, the data shows that respondents agree that the statement is an ethical challenge however addition of 59% respondents that responded that it never happens. There appears to be an understanding that the statement, is not a right thing to do during provision of care. Regardless, the occurrence tells a different story. Accordingly, the data raises a question of integrity and maybe nurses are telling the truth from their experience that it never happens within their workplace. The occurrence results also shows the relationships and respect that nurses have for one another within the workplace, not to tell, or is just another matter to be swept under a carpet as one participant stated in phase one of the study. However, the result is of interest and worthy of further consideration.

The twelfth statement sought responses to the experience of working with another colleague who does not give medication or treatments on time. '*Working with nurses who are not doing, not considering the need to do treatments at the exact time*.' This is one of the statements formulated from phase one analysis of nurses' honesty around administering treatment. Twenty-four percent of the respondents strongly agreed and an additional 33% of respondents either slightly agreed (13%) or agreed (19%) that this is an ethical challenge. Furthermore, 19% claimed that it happens 'sometimes', although another 19% of the respondents responded that it never happens. Hence, although several respondents recognised the issue as an ethical challenge, the majority of respondents (57%) maintained that situation does exist. However, looking at the data individually, there is an occurrence of

the challenge within their respective workplaces. The result shows variation among nurses of how to deals with situation, they realise and understand that it happens quite a lot but are uneasy about saying so in the survey.

'*Performing ordered procedures beyond nurses' scope of practice or job description' was the* thirteenth statement. Thirty-one percent responded as 'strongly agree' with the addition of 66% who recognised that the statement as an ethical challenge. Furthermore, 18% responded in the frequency column that it happens all the time. There are a close gaps between categories in the frequency column as identified: never (13%), rarely (9%), sometimes (16%), often (15%), most times (16%) and (18%) all the time. This exists in the workplace as shown by the high percentage of respondents who agreed with the statement overall. The data shows that the nurses' responses, from 'never' to 'all the time' were considerably more scattered than other results, which can reflect that experienced nurses may recognise it but don't see it as a problem and juniors don't recognise it or maybe accept it and see it as a norm due to scarcity of human resources. There is also a question of which workplace because respondents are nurses from both community and clinical areas, so possibly of those who responded 'never' are those who are working in the main hospital alongside with doctors. This is unlike those situations where nurses who are in district hospital operate the facility without an available doctor at all times.

Statement Fourteen seeks responses on the confidentiality of the patient in terms of allocation, as in, '*unable to maintain patient confidentiality due to the patient's allocation'*. Twenty-two percent of respondents agreed with this statement, and 18% responded in the frequency column that it happens sometimes. The distribution of responses in frequency column was reasonably close however there is an existence of the situation shown by addition of 38% from often to all times (15%, 12% and 14%). Yet, 56% (slightly agree, 14%, agree, 22%, and strongly agree, 21%) which tends to suggest the contrary, i.e., that it is an ethical challenge. This result shows that nurses understand and experience such challenge, but the scatter of responses tends to suggest that it only occurs sometimes suggested the situation context. Looking at the data broadly, there is an existence of the challenge among nurses, however the range of those who consider it more commonly an issue than others can vary considerably, most likely according to different backgrounds and workplaces.

The fifteenth statement concerned '*attitudes towards nursing care affects the standard of care and conduct'*. Thirty-five percent of those who responded, strongly agreed with the addition of 96% of respondents who agreed that the statement was an ethical challenge in their workplace. Furthermore, 21% respondents from the frequency column responded that this issue often occurs. The findings reflect the reality of Samoan nurses' understanding and experience, i.e., that nurses also play a role in the healthcare situation, but regard nursing attitudes towards care requirements as being of ethical relevance to Samoan nursing practices. Samoa treasures respectful relationships and attitudes (good or positive, mostly respectful) this is one characteristic of enhancing or maintaining that relationship. Attitude has a great impact on standards and performance of nursing care and one of the criteria of professional conduct. This is useful data to help initiate ways to help and support nurses within the nursing profession. As one old cultural saying goes "e fofo e le alamea le alamea" meaning the sea creature called alamea will solve/heal its own doings/attacks. The phrase refers to solutions to challenges, in that the solution lies or is found within profession or within the environment that cause or raises the challenge.

Ethical decision making

Statement Sixteenth, '*decision making is affected by cultural sensitivity*'. The high percentage of respondents to the statement showed agreement, i.e., with 32% agreeing that it is an ethical challenge of some importance. Twenty percent of the respondents indicated that it often happens. In addition, 96% respondents slightly agreed (19%), agreed (32%) or strongly agreed (29%) that their ethical decision making was affected by cultural sensitivity. In total, 63% responded: that it occurs often (20%); it happens most of the time (18%); and 15% said it occurred, all the time. The data shows that there is a high percentages of those who agree that culture influences nurses' decision making, and therefore, that there is a high degree of consideration and awareness of culture in the decision making of Samoan nurses. Indeed, in Samoa, this is a very culturally sensitive approach especially in community nursing where there is emphasis on the inclusion of culture and awareness of families, villages and churches. The influence of culture is also considered in clinical nursing, but the results are not as intense as in community nursing.

'Saving the patient's life is more important than caring about myself as a nurse' was the seventeenth statement. Thirty-seven percent responded to 'strongly agree' that it is an ethical challenge, and 26% stated that it happens all the time. The result shows that what many Samoan nurses' claim to value in their profession tends to go beyond self-interest, i.e., instead of themselves when it comes to ethical decision making and service. It appears to illustrate tendencies towards values, commitment and sacrifice to save a life with scarce resources and possibly at one's own expense. In many ways, the data suggests an ability to deliver nursing care with the handicap of limited resources, i.e., making use of whatever resources are available to deliver care. However, there were 25% in total who disagree with the statement which shows that they prefer to value guidelines and rules for nursing. This result shows a different type of commitment and priority among nurses in Samoa.

The eighteenth statement, *'I feel safe to use nursing protocols'* seeks responses whether they (the nurses) feel safe in using nursing protocols at their workplace. This statement from the phase one analysis refers to nursing ethics as nursing protocols and feeling confident and safe when using them to guide their decision making on treatment. Seventy percent responded by strongly agreeing with the statement, which is perhaps unsurprising. In comparison, 48% of respondents noted that it happens all the time. The percentage shows that this is one of the resources that nurses rely on for daily decision making (especially including ethical decisions), practice and service. The results show support for the use of nursing protocols particularly in community nursing as it is one of the resources that is considered safe to use for decision making, as also shown in the Professional Variables part of the study. It is probably regarded by many Samoan nurses as 'safe to use' because it is a formal tool that is supported by nursing and health care authorities. However, following protocols may not be entirely suitable for ethical decision making in all situations (see later discussion in Chapter 7).

Statement Nineteen ('Feeling tired, feeling oppressed and burned out impacts on performance and decision making') sought responses about what nurses feel about the workload and challenges within the profession, especially when under duress (as indicated in phase one of the research). Twenty-eight percent of respondents agreed that this was an ethical challenge, and 20% responded that it happens most of the time. These percentages reveal that several nurses in Samoa tend to exhibit signs of burnout and are concerned that

this situation will affect their abilities when *performing nursing care and decision making*. Nevertheless, although this phenomenon clearly exists, its specific areas need to be further explored (see chapter 8).

Finally, the statement '*I care more about personal values than nursing ethics*' sought the respondents reactions to what they considered or prioritised when they encountered ethical challenges. Perhaps unsurprisingly, 29% responded by strongly disagreeing with the statement, although 23% of the respondents' claimed that it is sometimes occurred. Basically, the data shows that nurses disagree with the statement, arguing that it is not an ethical challenge. There is a strong emphasis of the use of nursing ethics as shown in the Professional Variables results and the occurrence results show high on 'sometimes', 'often' and 'most of the time'. It shows a possibility of using personal values in decision making in some cases but not as often as how nurses use nursing ethics in decision making.

Responses to ethical challenges

The twenty-first statement sought responses to one of the possible methods that nurses may use in response to ethical challenges, which in this case was: "Do nothing at all". "There is no point of saying the same things over, and over." This may seem like an odd statement in such a survey, but its use was based on the observation that such statements were not uncommon from at least one or two participants in phase one of the research. As a result, it was included as an option in the survey, albeit an unlikely one. Yet perhaps surprisingly, only 29% of respondents' strongly disagreed with the statement, and even more surprisingly, 26% of the respondents' noted that they (or others that they had perceived) had used this option often. Certainly, the result vary from slightly disagree to strongly agree, and undoubtedly the majority disagree with the statement. Yet, the frequency data shows that it sometimes happens in workplaces even though nurses say they don't agree with it. In fact, 34% state that it *is* happening within their workplace. Therefore, there is possibility that 'doing nothing' is an option when faced with the hopelessness of raising an issue at appropriate levels, but it may come down to an individual's adaptation/resolution skills and personal values or personality. Nevertheless, as one participant in phase one of the study mentioned, walking away was a mechanism that individuals (and maybe others) used, and so at least for some, this action is obviously a possibility at least.

Statement 22 looks for responses to the method of addressing challenges such as '*talk/share a dilemma/challenge with a colleague'*. Fifty percent of the responses strongly agreed with the statement, and 36% of the respondents stated that the statement often happens or occurs. Thus, the data confirmed considerable evidence that the common method that nurses use to address matters or challenges within the workplace was to share their concerns with another nurse. This strongly supports phase one views of sharing challenges with other members of the staff or a colleague. Indeed, the majority seem to prefer this method to address ethical challenges, which more than likely reflects the common Samoan cultural approach of 'faasoa' (share), i.e., letting another person know of a concern or matter, and this reflects the generally widespread personal values common to many Samoans.

Statement 23 sought responses to one of the other commonly noted methods from phase one of the study, namely to "discuss challenges during a staff meeting". Sixty-four percent strongly agreed with this approach, an even higher result that previously, with an equally impressive percentage of 44% stating that it happens all the time. In fact, according to the data, 100% (slightly agreed, agree or strongly agreed) that ethical challenges are discussed in staff meetings all the time. This then is a highly significant result. It may be argued that it reflects family principles that a head of the family and members will come together to discuss if there is an issue within the family. This is also village practice as well. If there is an issue, village members and leaders will come together and discuss the issue and find a resolution. It is therefore pretty clear that the same principle applies to nursing staff meetings. This approach is therefore, the most likely one with regard to being the most common nursing action when faced with an ethical dilemma or challenge.

Statement 24 dealt with a continuation of the ways in which nurses address ethical challenges but the question focused whether they reported directly to the nurse manager or nurse consultant ('the Chief') of their workplace. Fifty-six percent responded by strongly agreeing with this, with 48% claiming that it happens all the time. Most of the respondents agreed that the statement is an ethical challenge. The data shows significant support for the notion that nurses report directly to the nurse manager of their respective workplaces. It also shows what would appear to be an appreciation of a nurse manager, the position that Samoan nurses clearly consider when seeking help with an ethical issue. In the health and hospital settings of

Samoa, the nurse manager's position holds great value and is usually regarded as a safe option by his or her staff.

The last statement, i.e. number 25, sought responses to whether nurses "report to the Director of Nursing or authorised people", as this is another approach that nurses took to address challenges according to the phase 1 of the study, albeit a less likely one. Thirty-two percent strongly agreed with this statement, and 27% stated that it happens all the time. According to the data, it shows that this statement supports the idea that some ethical challenges need to be reported to the Director of Nursing. In the frequency data, there is a close count of respondents for 'never to happen at all', even though the majority stated that it happens all the time. The data shows that there are some who don't report it to the Director of Nursing, which shows the possibility that only senior nurses report to the Director of Nursing and junior nurses do not have the confidence to do such a thing or maybe rely on nurse managers' decisions instead.

Summary

This chapter provides comprehensive coverage of the results of phase two of this study. A brief background and professional characteristics of nurses were identified from the demographic and professional characteristic sections of the survey, and these results were discussed in light of the topic of the thesis. Various understandings of nursing ethics were well stated in the Professional Variables section, along with the well-defined methods and resources used for ethical decision making. Hence, new strands (themes and perspectives) are woven in with the phase one results to strengthen the weaving process of the *ietoga* framework. This strengthening and refined weaving has subsequently yielded some very useful results that will now, in the next chapter, be used to discuss the aim of this study that is '*to explore and develop an understanding of the concept of ethical challenges and decision-making among Samoan nurses when delivering patient care in their nursing profession'* with the objectives of firstly, gaining an understanding of the perspectives of Samoan nurses about nursing ethics and its relevance to nursing practice. Secondly, to identify and understand ethical challenges and decision-making in nursing practice that impacts on patient care in Samoa. Thus, lastly to understand the methods that Samoan nurses use to resolve and address ethical challenges within their workplaces or health system.

Chapter 7: NURSES MORAL KNOWLEDGE AND ETHICAL DECISION MAKING IN SAMOA

Introduction

The plaiting of strands of lauie tightly together makes it look neat and fine for its value. The previous chapter discussed the analysis of the raw data from the survey tool that was specifically developed from the material gathered by the collection of qualitative data. This data revealed the results of the wider population of nurses' perspectives on ethical challenges and ethical decision making in Samoa. As this analysis expanded upon the findings from the qualitative interview data, it is now possible to combine the analytical material from the thematic analysis with the descriptive material from the survey to produce a reliable account based on the main aims of the research, i.e., to explore and seek understanding of nursing perspectives/interpretations of ethical challenges within Samoan workplaces, and the impact on nurses' ethical decision making and their nursing practices.

This discussion chapter is divided into five sections, the first section is 'Faasamoa' and it serves as foundation and collective perspective of nursing ethics in Samoa, complete with sub sections of Aiga (family) and Faasamoa (culture). The second section extends the discussion on perspectives of cultural knowledge to nursing ethics and education; adapting the role of the Tamaitai Samoa to the nursing profession; the impact of social hierarchy and the influence of Faasamoa on ethical knowledge and nursing education. Thirdly, there is discussion concerning nursing integration of western perspectives of nursing ethics, with ethical theories and knowledge in nursing education, and the professional and legal implications of the application of nursing ethics. Fourthly, the nurses' experiences of ethical challenges within their nursing practices, which draws the discussion towards the implication of ethical knowledge on nursing practices and ethical challenges that nurses experience within cultural, practical and education contexts. Lastly, the discussion relates to nursing ethical decision making and, in particular, the main experiences of nurses in relation to those cultural aspects that impact so heavily on nurses in Samoa, e.g., appearance, performance, language, relationships, and faith. This section also discusses the approaches Samoan nurses use to deal with ethical challenges within the nurse's workplace. It will show that these approaches are

often applied differently to ethical challenges depending on the context and severity of the encountered situations.

SULU MODEL

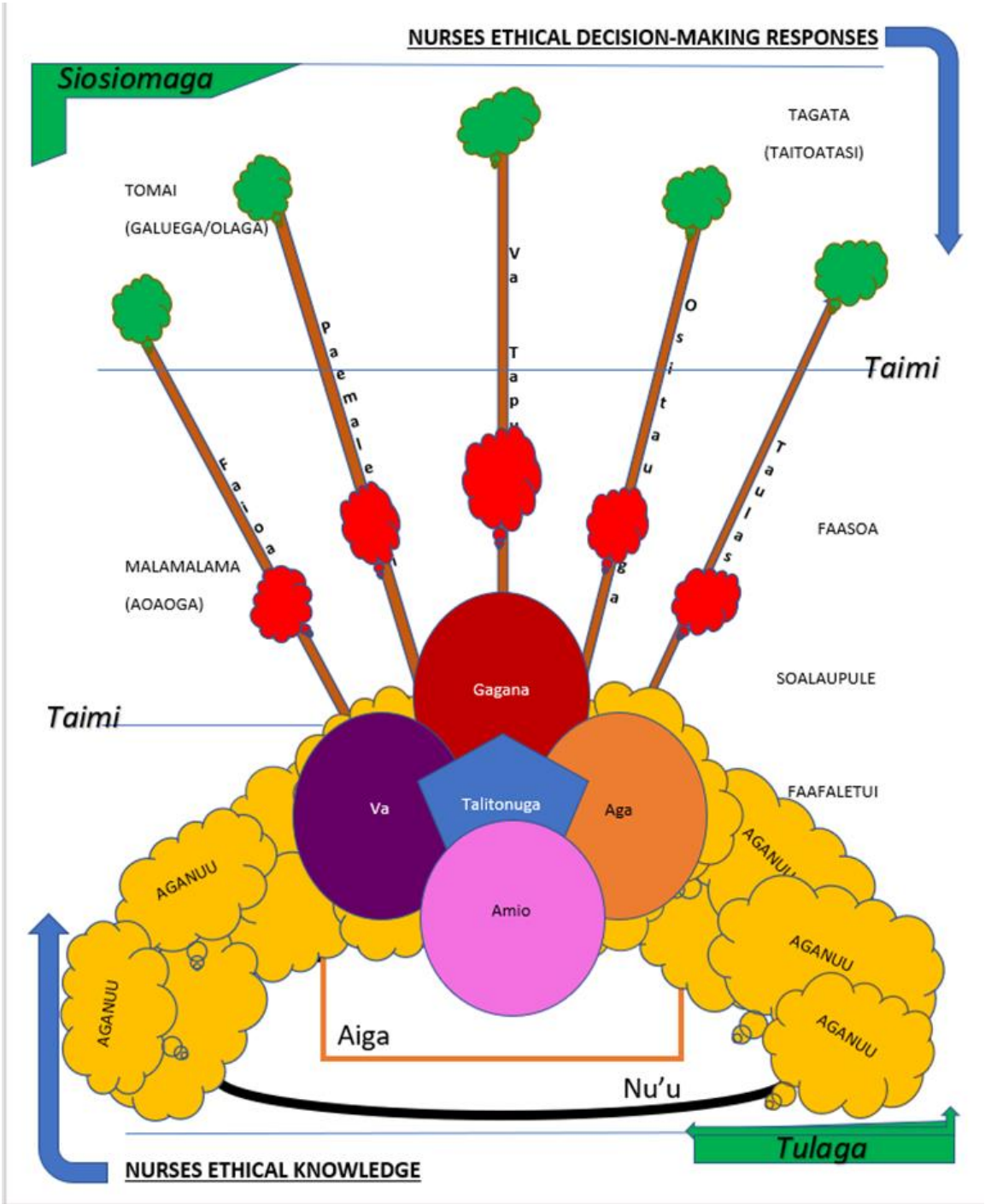
The discussion starts with a model that was developed and formulated from interviews and survey results of the study. The findings from analysis of this material enhanced my thinking by transforming it to a theoretical model (conceptual framework) that underpins views and experience of nurses' ethical knowledge, ethical challenges and ethical decision making in Samoa. This is possible because findings and results from the participants' and respondents' perspectives explain aspects which encompass a holistic picture of the Samoan culture in a powerful way, and its highly significant influences within the context of this study. That is to say, the transformation of the results to a conceptual framework therefore place a strong emphasis on the existing concept of Samoan culture (*faasamoa*) that is foundational and complex. This has been developed into a conceptual model (see Figure 16) that provides assistance and a mechanism to further explicate the concept of Samoan nurses responses to ethical challenges and make them more accessible to the reader.

The theoretical framework that represents nursing perspectives of ethical decision making is presented as a cultural headdress traditionally called a Tuiga. The rationale of why I use the Tuiga as a metaphor to represent this framework was based on the concept that the tuiga holds a significant value in Samoan society. It binds social structure, status, relationships, and culture. Decision making starts from the head, and the tuiga expresses mana that comes from the head where decisions and solutions are formulated. Tuiga is one of the measina (treasures) in Samoa, its form is expressed as a divine mana of ancestral links (Siilata, 2018). It is used as a personal adornment of paramount chiefs that is instilled with inherent cultural values. The tuiga has reserved status as only chiefs can wear it, however this is extended to taupou (females) and manaia (males) (Siilata, 2018). Therefore, it can be interpreted as being able to be 'worn' by both males and females in the Samoan nursing context.

There are five main aspects of this model: first, it starts from the base of the Tuiga, secondly the five long rods, thirdly; there is a second line of red feathers, the fourth aspect is the line of green feathers and lastly are the five mirrors at the front of the Tuiga. Theoretically, the

bottom of the headdress represents the most important part of foundation and communal strength, the five rods show extending cultural roles, stability and height, and the red and green line of feathers decorates and gives a unique colour and art to the headdress. The five mirrors on the headdress indicate significant and different values and most importantly reflection.

Figure 18: ***THE SULU MODEL: Nurses moral knowledge and ethical decision making in Samoa***



Faasamoa as a foundational and collective perspective of ethics (Base of the model)

The base of the model as shown above (Figure 18) places a strong emphasis on aiga (family), nuu (village/society) and faasamoa (culture). These are aspects that provide a firm foundation for Samoan nurses' individual and collective perspectives of ethics within families and societies/communities (as discussed in Chapter 2). The faasamoa or culture as illustrated by arch of hairs (yellow colours on the model) governs family and village life, valuing the groups' dignity and collective achievements rather than those of individual members. It signifies values, division of power, status, labour, and expectations but most importantly the main motivation of protecting the family status and social welfare. The expectation that is strongly laid out by the faamatai, is a conceptual division that set and directs an individual to their 'place' and is based on the rights and duties of each person within a collective, rather than within an individualistic society. The concept is also applied to family, and this is also exercised in the institution of the village or fono (meeting). The faamatai is of the greatest significance to the faasamoa due to its system of established authority. Therefore, the concept of aiga (family), nu'u (village/society) and faasamoa (culture) with faamatai are inter-related and one concept supports and strengthens the others. Hence, the Samoan society's social and cultural institutions are strong and more intact with their focal point being a network of social relationships that provides honour and prestige to its members. In this thesis, it is my contention that it is these are crucially important concepts that underpin all ethically related perspectives of ethics and ethical decision making in Samoa.

Aiga (family): where it starts

The family unit is where an individual starts to learn values and beliefs that affect the rest of their lives. It is a unit that firstly exposes an individual to a communal lifestyle and operates within a collective society. It is without doubt a central element and the primary social unit in all Samoan life. Subsequently, aiga directs individuals to roles and responsibilities that each member of the family should fulfil and are expected to fulfil in society. Examples include women being responsible for 'indoor activities' such as weaving ietoga and making handicrafts while males are responsible for 'outdoor activities' such as farming and planting crops. The head of the family is the matai (title man) and mothers act as the support and advisor for the

family. The younger members of the family respect and serve those who are older than them. Counsel is therefore never offered in reverse, it only come from above in an age-graded ladder of responsibilities to others. However, one ultimate guide for conduct that dictates all ages, even older members of the family or community, is 'Tu i lou tulaga'. Tulaga here, refers to both a position and to a role (Mageo, 1998). 'Tu i lou tulaga' or 'Stand at your post' (as discussed in Chapter 2) emphasises both the position and the role of an individual within family. It is a spatial metaphor that refers to performing roles in a group that aligns with one's status and rank, which for Samoans is synonymous with behaving respectfully on all occasions.

In Samoa therefore, these vital social relationships and the maintenance of such relationships, are undoubtedly heavily influential on both the growing child and the child's possible future role as a nurse within society. As other participants and respondents in this study stated in numerous ways, family is simply the beginning of ethics in Samoa. However, because the family is the starting place of those roles and relationships, the social rules tend to be expanded in the wider society of the village. The cycle of social and cultural development that every individual is exposed to in village life therefore has a highly significant effect on social relationships and behaviour within the family and village society. However, in relation to the ethical actions of nurses in Samoa, it is also evident from an analysis of the data that there are changes to responsibilities and roles that are due to modern changes and advanced education, although the foundation of societies within villages is still the same. This aspect of social relationships may therefore present challenges, including ethical ones, for any nurse working with various members of a given village.

In this regard, sometimes it is not the patients that cause ethical and social challenges but family members, as the data revealed. For instance, family members sometimes demand resources that they do not have, and often more nursing time and attention for a family member. These social challenges, the expectation of the public of things that they think they or their family member should have from nursing services, may sometimes constrain nursing responses. In part at least, this implies their experiences from overseas, and especially those health-related institutions and services that they encountered when receiving medical and nursing care service. According to the data, this is commonly experienced at the district

hospitals, and Samoan nurses' frequently voice their frustrations about unrealistic public expectations.

As previously described in Chapter Two and also noted in Chapter Five, there is a strong emphasis on cultural values, traditional morality and social etiquette when nurses are asked to describe ethics or nursing ethics in Samoa. Cultural norms are therefore included in most traditional definitions or perspectives of morality, and clearly these are strong reflections of the Samoan context of family and social relationships i.e. social etiquette is not only expressed as good manners and social protocols, but also within the strongly emphasised need for proper relationships and conduct. This includes personal relationships, inter-personal relationships, and wider socio-cultural relationships.

Samoan social etiquette/nurses' cultural expression' of ethics in practice

The Samoan phrase, "E iloa oe I lau savali, tu, nofo, tautala ma lau gaioi" meaning "a person is recognise by the way you walk, stand, sit, speak, and move" is a well-used and well known phrase that is commonly used in Samoa and it has an extremely broad meaning. The phrase indicates that Samoans 'recognise' a person by the way they walk, stand, sit, speaks, and move. It is an observational phrase that tells a lot about character and expectations of a Samoan person, e.g., the way they should act and behave within family, society, and community of Samoa. It is a phrase that was well used by the nurses who participated in the interview phase of this research (as in Chapter 5) and some of the responses to the survey (as in Chapter 6) when asked about their interpretations of the word 'ethics'. In both cases, this summarises what Samoan nurses believe ethics to be, i.e., attitudes and behaviours that refer to the way the person interacts or presents themselves, such as the way you talk, speak, walk, your facial expressions and performance. As one participant indicated when asked to define ethics, the importance of "*attitude, behaviour, the way you present yourself…reflects who you are",* i.e., what your ethics are all about. There is therefore, a strong expectation of 'appropriate' social behaviour within the context of Samoan ethics. 'Appropriate' has been frequently used by Samoan nurses to help describe the kind of manners and attitude that the nurse should have or show with examples such as avafatafata (respectful relationships), alofa (love) and faaaloalo (respect). The use of the Samoan phrase shows value of the culture and its influence on the interpretation of nursing ethics.

In general, several nurse participants in both phases of this study clarified ethics as being more about attitude, as in for instance, being well-respected and cheerful, graceful and highly responsive to the patients' requests. Many respondents noted this aspect of what they perceived to be proper ethical behaviour, and many also define nursing ethics as a form of respect or avafatafata (respectful relationship with one another), and alofa (love/kindness). These are the common cultural concepts that Samoans nurses believe to be at the heart of ethics and essential elements that steer nursing ethical actions.

The cultural proverb: "E muliga a ni oli ao ni foli" has a similar meaning with the phrase used earlier and was mentioned by participants from time to time during both phases of the research project. This proverb refers to impression and performance, how expressions, manners and attitudes matter before actions or performance. As one participant from the interview phase stated *"E muliga ni oli ao ni foli - behaviour, the way you stand and expression in a language use that is appropriate in Caring".* The type of language used is therefore considered to be highly important in all relationships, i.e., it has to be appropriate. It is one of the main factors that enhance a relationship or a relational space (va fealoai). The development of relational space at the initial stages of the relationship with the patient or anyone else involved at the time is perceived in Samoa as a crucial aspect of an (ethical) relationship. As another participant noted: *"...our job starts with the culture - with Faatulima (cultural greetings), sit down, ava fatafata, and end with culture"* (EN17). Subsequently, the Faatulima plays a crucial role in the relationships of nurses and the patient, the family, and especially the community. This cultural introductory phase shows acknowledgement, respect, reciprocity and cooperation between the nurse and the patient or the community. The initial stages develop the necessary trust and cooperation involved in any relationship as expected from both the nurse and patient or community. Thus, these important Samoan proverbs have a highly significant place in social relationships, and are related to performance, expression, movements, verbal responses, the use of language, actions, attitude, or behaviour before and during a procedure or a major task. These characteristics leads to an emphasis on the 'importance of the space' because these are characteristics that initiate that respectful space and relationships which are essential aspects of any ethically related actions in the context of Samoan society, and in nursing practices especially.

Relationships: Relational and respectful space

In this research project, the 'Va' concept was well used by nurses to convey their interpretation and understanding of nursing ethics. For instance, when elaborating more on nursing ethics as va ma tagata (relational space between people), va fealoai (respectful space) one respondent stated: *"Nursing ethics is the relational space between people, respectful space and rules of the job that have been leaned" (RN170).* Other respondents offered similar thoughts, maintaining overall that there is a strong emphasis on valuing relationships in nursing care and services. However, as seen in earlier chapters, these relationships are always extended to all others concerned with the patient's welfare, and subsequently Samoan nurses are constantly aware that they must maintain good (ethical) relationships between themselves and not just the patient alone, but also the people around the patient such as caregivers and family. The same requirement extends of course to health care personal surrounding the nurse, such as doctors and staff members (and vice versa). Maintaining this respectful relationship is therefore of tremendous importance for any Samoan nurses.

Such is the importance of maintain proper relationships between individuals in Samoa that there is an integration of culture within nursing standards and guidelines. As one participant from the interview phase stated: *"Culture, [the way] you stand, the way you walk, are all in the standards and va fealoaloa'i (respectful relationship) respectful space" (EN18). Again, in this relational space the importance of appearance and the use of correct greetings and responses*, *Faatulima* (the given titles of individuals in each village) enhances social comfort by setting aside any uneasiness in the situation and helps to promote mutual confidence and respect.

Furthermore, it may be seen once again (i.e. as noted previously in this chapter), that there is a strong emphasis on the importance and uses of the Teu le Va concept. Va means space between or the betweenness, not an empty space but a space that relates, that holds separate entities and things together, the space that in context, gives meaning to things. The meanings change as the relationships/the context changes. Teu le Va is a well-known Samoan expression that means cherish/nurse/care for the Va, the relationships. The value and the importance of relational space is therefore not only important to the researcher but also participants, and in

the relationship of the researcher to participants within the strict boundaries of Samoan cultural norms.

Hence, to practice in what would be regarded by all as an ethical manner within Samoan society, a nurse must show adequate respect for va. In a village context (see Chapter 2), people know their faasinomaga (identity) (see Chapter 4) and learn about the va relationships (Tuagalu, 2008). Subsequently, this study is as much framed by the participants views about the importance of va tapuia and va fealoai *(respectful relationship)* with patients, family, and community as it is by its chosen methods. There is a very strong influence of Va within the nursing profession of Samoa, both from long established socio-cultural practices and because of its integration in the Samoa Philosophy of Nursing (see Chapter 4) and its common applications by Samoan nurses. In both cases, the connections between relationships, respect and ethics was a most powerful one throughout the research process.

Extending perspectives of cultural knowledge to nursing ethics and education; (the rods of the model)

On the model, there are five long rods that are labelled fai'oa (wealth maker), pae ma le auli (peace maker), va tapuia (sacred space), ositaulaga (a leader in worship, a sacrifice) and taulasea (a healer). The rods represent the Samoan view of social stability and the extension of social-cultural knowledge to nursing education and ethical practices. These 'rods' are essentially a representation of what one participant described as: "…*those guidelines [that] include pae ma le auli, o le taulasea and all gafa (roles) of the feagaiga (sacred covenant)* (RN2). As previously maintained, this vital aspect of culture is deeply embedded within the nursing profession in Samoa, and it strongly emphasises the role and responsibilities of a Samoan nurse in their part in being fai'oa (wealth maker), pae ma le auli (peace maker), in maintaining va tapuia (sacred space), and being an ositaulaga (a leader in worship, a sacrifice) and a taulasea (a healer). This results in the integration of the role of the tamaitai Samoa (Samoan lady) in families and societies and connects to the nursing professions through education and practice. Extending the role of the tamaitai to the nursing profession in Samoa is very well embedded in Samoan culture (as discussed in Chapters 2 and 3). Nevertheless, because Samoan nurses clearly practice according to both deeply embedded social mores and

norms but at the same time are influenced by mainly western ethical norms through nursing education, the rods show the connection to western views of nursing ethics. Hence the rods symbolise a Samoan nurse's knowledge of nursing ethics that is embedded in culture, drawing especially on the long-established roles of the tamaitai and the sacred relationships within families that are represented by notions of 'brother' and 'sister'. This integration is well stated in the development of the Samoan Philosophy of Nursing (1990) and the development of the Samoan Nursing Curriculum (as noted in Chapter 2). The rods also represent the length of experience especially at the top of the rod (where the second line of feathers is located).

The role of the *Tamaitai Samoa* (Samoan lady): Images, Gender and Selves

As previously stated, the nursing profession in Samoa adopts the cultural roles of the tamaitai (ladies) in families (as stated in the Samoan Philosophy of Nursing) as a characteristic of the nursing profession in Samoa. The tamaitai roles such as the taulasea (a healer), fai'oa (wealth maker), ositaulaga (leader in worship, a sacrifice) and pae ma le auli (peace maker) therefore strengthen cultural considerations, applications, and the integration of vital cultural aspects in nursing practice. This means that considerable value is placed on the status of the tamaitai Samoa in the circle of family, villages, and society in their relationships with members of the nursing profession. As a result, it portrays attributes that a nurse should uphold when delivering nursing care and provides a public image of the importance of a nurse, i.e., the cultural perspectives honour the nurse's role in society and provide a status that reflects and values a Samoan female's obligations to families, villages, churches, and society. This experience of obligation and roles of the tamaitai Samoa on nurses, was well identified by participants and respondents when discussing the role that family and others have on a nurse's ethical decision making and practice.

It is also important to note that the hierarchy status and honour that is afforded to nurses within the society affects their ethical decision making and practices, as the data also clearly shows. For instance, it is stated in one-on-one interviews that status within villages and honour is sometimes one of the challenges that, although usually not problematic, may at times also cause disagreements over the expectation of treatment and status accorded to given patients and/or their family. This further emphasises those cultural aspects that must be considered by nurses when offering treatment and especially when exhibiting social

behaviours, such as the way to present oneself and address other people. Once again, these requirements highlight the need to be mindful of status of a known person in the crowd of those who came to seek medical and nursing care. It is one of the pressures that is commonly voiced by nurses that can affect activity if the day and performance that they know should be used to deliver service. It is without doubt, a major consideration when a Samoan nurse is involved in many situations involving ethical decision making and subsequent actions. However, as noted earlier, the maintenance of cultural norms is not the only source of ethically related knowledge, decision making and practice for Samoan nurses. The understanding of ethics and nursing ethics frequently revolves around cultural understanding of guidelines, laws and rules that guide a nurse's performance. However, there is also considerable evidence of an integration of professional interpretation of participants understanding of ethics and nursing ethics by referring to nursing protocols, nursing standards and the Nursing Code of Ethics.

The influence of Fa'asamoa on ethical knowledge and nursing practice

Great value and extensive emphasise was placed on fa'asamoa by several participants in this study towards its huge value to nursing practice and by extension, to nursing ethics as practiced in Samoa. Participants frequently suggested that fa'asamoa or culture was the 'transportation' that drive the work of nursing. Other participants stated that nursing should always be connected to culture, while others stated that nursing ethics is literally based on Samoan culture. Hence, related to the model as shown, but not necessarily represented in it, is the strong and great value of the fa'asamoa within nursing practice. Furthermore, this powerful emphasis on cultural values and practices in nursing care was very highly supported in the survey in phase two of this study (e.g., by 97% of the respondents, which is itself convincing evidence of the importance of cultural values and practices within Samoan nursing services. As one participant maintained *"culture is the foundation of nursing ethics"* RN9.

The integration of western perspective of nursing ethics in nursing education (red feathers)

The first line of red feathers on five rods from the bottom of the headdress model, represents the application of western knowledge of nursing and nursing ethics. However, it should now be apparent that these are 'feathers of western knowledge' that are attached to the rods of the already deeply ingrained *existing knowledge* of ethics through observances of socio-cultural mores that nurses employ on a daily basis in Samoa. Subsequently, it is argued here that the often used empirical, aesthetic, personal and ethical ways of knowing in nursing (Carper, 1978) are still extensively used in nursing education in Samoa (see Chapter 2) but also used to underpin practice. Furthermore, specific ethical knowledge such as the Code of Ethics, ethical principles and guidelines are also a part of the Samoan nursing curriculum, and all of these sources were well emphasised by the participants and respondents in this study. Indeed 79% of respondents identified their School of Nursing as the venue where they learned about nursing ethics; however, there were other venues that some of the nurses identified along with the School of Nursing, such as religion, continuing education and colleges. Nevertheless, the School of Nursing remains the most influential venue where Samoan nursing students are taught nursing ethics, even if they still associate learning ethics with being taught about appropriate 'guidelines and rule' as one participant noted: "*During our time, ethical guidelines and rules of performed procedures and practice were included in every subject"* (RN1). However, it is also apparent from data used in this thesis that Samoan nurses clearly seem to understand that there are significant differences between what they learn about nursing ethics in the School of Nursing (i.e. frequently 'western ethics' that are based on objectivity and western principles and rules) and the daily need to observe strict cultural rules within what are frequently subjectively focussed ethical practices when offering nursing care.

Still, according to at least some literature on nursing ethics nurses often have insufficient knowledge about ethics, codes of ethics and ethical decision making, and furthermore that the use of ethical knowledge by nurses in lower and middle income countries tends to be less than adequate, i.e., that nurses in these countries have a poor understanding of the basic concepts of ethics (Numminen et al., 2009; Osingada et al., 2015). However, in this study, 60% of the respondents at least stated their views of nursing ethics as the application of what is

right and what is wrong, what one ought to do, and offered a number of ways in which nurses might achieve these aims. Furthermore, as well as various mentions of principles of ethics, the code of ethics, values and beliefs, ethical behaviours, nursing: standards, acts, protocols, competencies, obligations, principles, guidelines, regulations and rules, several participants noted patients' rights, dignity, values, and other moral reflections. Hence, it seems that although Samoan nursing education is delivering ethical knowledge and ethical theories during nursing training, according to the data the ethical challenges for Samoan nurses lies in the reality that nurses face on a daily level in clinical settings and workplaces in terms of the difficulties that are involved in dealing with the powerful influence of socio-cultural factors alongside their application of ethical knowledge which is largely based on western ethics perspectives and gleaned from educational sources in Samoa.

Influencing factors and nurses' experiences of ethical challenges in nursing practice (green feathers)

The second line of feathers on the top of the headdress model, represents the work and life experiences of the nurse at practice. It represents the different elements that the nurse may experience during practice. This may take place at the workplace (primary, secondary, or tertiary), a cultural matter (faasamoa and faamatai), an individual (nurse), relationship with clients (individual, family, community, and villages) and the health system. The height of the rod from the blue line (on the model) represents the length of experience. Note: the higher the experience the less likely it may be for a nurse to encounter ethical challenges that cannot be overcome. The rod also represents the extensive application of ethical knowledge gained from their nursing education, and nurses combine all these knowledge sources with experiences gained from what has already been described as the socio-cultural milieu that is Samoan society. This all represents the multiple elements through the combination of knowledge, experience and cultural sensitivity in the Samoan nursing service as revealed by the data.

According to the data obtained for the purposes of this research, nurses mostly experience ethical challenges at their workplaces and in clinical settings, and some of these challenges are major ones. As previously described in earlier chapters, these challenges include factors such as limited resources overextended clinical roles, management inconsistences, socio-

cultural factors and educational development. Indeed, as the quantitative data also revealed, there are clear signs of the impact of education on ethical knowledge (i.e. 59%), however 64% of respondents also showed that work experiences highly influence and tend to 'shape' their ethical knowledge. Other moral influences were also provided by family (52%), patients (46%), culture (44%) and religion (36%). Overall, the variety of factors that influence ethical knowledge reflect the values and priorities that individuals draw on during ethical decision making.

Nevertheless, the study identified the importance of cultural values within the shared collective that is Samoan society, and 50% of respondents strongly agreed that these played a major role in their practices. As already suggested, the importance of cultural values on nursing practice can also be seen as ethically challenging by nurses, because values such as the proper use of appropriate language and actions can have huge consequences. Samoan society operates essentially as a collective, and this concept has been previously discussed in relation to nurses' responses when addressing moral challenges. Subsequently, ethical challenges often occur, not because of conceptual uncertainties, but because of the constant need to maintain good relationships between nurse and patient, nurse and family, nurse and village, and so on. In this collective, it is therefore often not really a matter of an individual nurse making an ethical decision. Most of the time, family members turn up to look after one patient, especially if the patient is a chief matai of the family, some family's sleep outside of the room where the patients are admitted and nurses must practice in accordance with the Samoan phrase "o gasegase a Samoa e tapuaia" which means the illness of a family member is sacredly being prayed for. Hence, while the nurse may well appreciate cultural values they often find that they must adhere to social rules to avoid any indication of a social transgression (which also can be read as an ethical transgression). They also need to practice according to nursing orientated best practice values and norms. Subsequently, there can be care based problems of, for instance, if a family chooses to camp outside of the patient's admission room. As a result, senior nurses (i.e., the ones higher up the rods of the model) tend to be the experts when talking to families who are sometimes difficult to manage. In this scenario it may also be seen that a position of seniority within the workplace is well recognised by the public because of the social norm that they are seniors in the job with more experience and should not be challenged. This aspect of nursing in Samoa therefore tends to reinforce relationships

based on mutual trust and respect. In the study, there is clear evidence of the influence of socially recognised relationships that enhance confidence and trust between members of the public and senior nurses. In Samoa, this is therefore another way that junior or young nurses learn how to behave ethically in Samoa.

The impact of language and oral traditions

Language (see centre of the model) or more precisely, the correct use of language, is an essential part of the Sulu model. It was clearly identified by several participants as contributing both positively and negatively to nursing care and practice in Samoa. For instance, the sometimes traditional Samoan concepts misalign with nursing as learned in nursing education. This, coupled with a preference for oral forms of communication, has introduced a number of challenges, some of them ethical ones, for the nursing profession in Samoa. The Samoan language ('Gagana Samoa') is characterised as having a single dialect however it is overshadowed by the obstacles associated with differences in vocabulary and levels of oratory (formal, informal and oratory). However, effective oral communication in Samoa needs to appreciate the different contexts of language including informal, formal and oratory. The data shows that nursing participants tend to lapse the use of oral traditional language needed to maintain va fealoai (meeting protocols) and va fealoaloa'i (a respectful space).

Consequently, there needs to be a strong emphasis on oral traditional communication in Samoan nursing ethics according to both the participants and the model. Faasinomaga (identity) starts within the family and is based on understanding and knowing your language. It not only ensures relationships with patients, family and community, but also ensures confidence in self in nursing delivery and in an advocacy role. As one participant stated: *"Cultural language is easily acceptable and well understood by people"* (RN4). The vital role of using an appropriate and correct type language therefore useful in the delivery of nursing service that enhances acceptance, understanding and cooperation of people, a sometimes-wider ethical goal perhaps, but an important one none-the-less.

Work/life experiences

Resources – Shortage of staff and other resources

The health care context presents large challenges for nurses in Samoa because resources such as personnel, various medications, tools and equipment for treatments and nursing care are either limited, insufficient, unsafe, or out of stock. The data shows the intense impact of staff shortages on nurses' ability to deliver quality nursing care, leading to frustration and anger over the inability to provide proper care and the overload to accommodate such scarcity of staff. The data shows challenges (as in Chapter 5) that both concerns the profession and by extension, the ethical dimension of nursing in Samoa. Nursing practice is not only at risk in these situations because the proper care of patients is affected and therefore becomes of ethical concern to the nurse. This is also morally challenging because nurses are forefront of the often-raw reactions of disappointment and complaints from the public before the situation is realised and responded to by health professionals. Such consequences therefore damage the elements of trust and respect that are essential between nurses and patients, further undermining the moral disquietudes of a given situation. Insufficient resources may therefore lead to disappointment and frustration that are experienced between the nurses and sometimes patients and families. Nurses are frustrated and disappointed in their inability to deliver the best care and the unsatisfactory care experienced by patients and their families. These ethical concerns sometimes create relational difficulties and especially in attitudes towards fellow workers.

Overextended clinical roles

The Samoan health care service is greatly affected by a shortage of physicians which pushes nurses to carry out more tasks and practices. The participants clearly identified the different realities between practice in community and hospital clinics and what was taught in nursing schools. As one participant noted: "*it is not in my scope of practice or Job Description but if we don't do this, that means, we are not delivering a big help to the patient"* (RN6). The data in phase two of this study showed clearly the existence of the ethical challenges faced by nurse's in their workplace that challenges the confidence levels of nurses and gave them not much of an option but to carry it out an order to deliver care and help patients regardless of the ethical concerns that the nurse may have held. Overall, and although many respondents stated some

of the benefits such as an expanded knowledge and skill of procedures such as IV cannulation, Foley catheterisation for men, suturing and many other procedures normally associated with the work of doctors, there was always the fear of error with the procedures. As a result, many Samoans nurses rely on faith for guidance and strength to provide the service and performance, which although spiritually comforting, is not particularly ethically sound.

Nursing Education

As it discussed in Chapter two, and now as indicated in the Sulu model, nursing education is an integral part of Samoan nurses' moral knowledge and preparation for practice. The nursing programme in Samoa is four years for a bachelor's degree, (one year to complete foundation papers, and three years to complete bachelor's degree papers). In the National University of Samoa nursing program, all courses of the programme have 'integration of nursing ethics in them' and one course is specifically designed to deliver the ethical and legal elements of nursing practice.

The reality is a different story as various participants and respondents stated, i.e., what is taught is quite different from what is encountered at the workplace. It is a well stated concern by nurses, especially the younger, newer ones, that there is a significant gulf between the reality of practice and what is taught during nursing education. As one participant stated: "*what is taught in the classroom is not the same as what is practiced in a hospital setting*", and this is an ethical situation that remains unresolved. It is an ethical problem because there was a clear understanding amongst the participants/respondents of this study that ethics, autonomy, accountability, rights, dignity, clear understanding of standards, protocols, values, beliefs, attitudes, behaviours, appropriate manners, traditional ways and theories/framework all matter a great deal. Thus, when the newly qualified Samoan nurses enter practice settings and find that many things are significantly done differently to their expectations, they face a series of ongoing ethical quandaries, none of which are of their own making. When this occurs, it seems likely that it is only a matter of time before some ethical decisions are made that are highly dubious.

Ethical decision making and approaches to ethical challenges (the mirrors)

The five mirrors (circular shapes in red, purple, orange, pink and blue colours) in front of the headdress model, represents five (5) aspects that are mostly considered by nurses when encountering ethical challenges at their workplace, and in particular, social and cultural influences on nurses ethical decision making. It also represents aspects or areas that nurses mostly valued and reflected on to improve their overall ethically related performance in the workplace. The importance of self-expression (physical, intellectual and emotional), the way you talk, act or carryout nursing service, having faith but with minimum resources and ability, all working together to build a relationship with the patient, family and community or villages, was expressed. Here, is where the moral concept of nursing is emphasised, and nurses in Samoa not only reflect on nursing skills and knowledge but also on the maintenance of ethical relationships and performance allied to cultural awareness, of the patient, the family and to the community in an ethically aware and acceptable way.

Ethical awareness and consideration

The study reveals that nurses in Samoa believe Aga (Behaviour), Va Fealoai/Va Tapuia (Performance), Tapuaiga (Relationships), Gagana Tautala (Oral, Formal and Informal Language) and Faith/Spirituality (represented by the five round shaped mirrors in front of the model) to be important and vital to enhance ethical, safe and quality led nursing practice. In numerous parts of the data gathered in both phases one and two, there was a strong emphasis on cultural values, religious beliefs and relationships that nurses learn over time, beginning with their families and villages, all through their nursing education, and then when in professional practice. All these factors hopefully equip them for their everyday work as a nurse in hospitals and community settings. Furthermore, the data revealed that there was adequate evidence of the existence of ethical knowledge and theories, traditional ethics, code of ethics, ethical decision-making skills, and philosophies underpinning the principles of ethics in Samoan nursing education, but that nurses in Samoa felt that they could not always apply that knowledge in certain settings. However, findings also reveal nurses' understanding and awareness of cultural aspects that aids challenging ethical experiences such as Aga (Behaviour), Va Fealoai/Va Tapuia (Performance), Tapuaiga (Relationships), Gagana Tautala (Oral, Formal and Informal Language) and Faith/Spirituality. These were considered concepts

or aspects that nurses use in their daily experience of ethical tension and challenges. Thus, they support Levine's (1977) observation regarding ethical behaviour that "Ethical behaviour is not the display of one's moral rectitude in times of crises. It is the day-by-day expression of one's commitment to other persons and the ways in which human beings relate to one another in their daily interactions (p. 846).

Ethical mechanisms and approaches

The far-right side of the model lies the line (from the top: individual, shared, collective and chiefly) of approaches that nurses in Samoa use to discuss ethical challenges. Following the values that nurses consider in their decision making as represented by the middle mirrors of the model as previously discussed. There are four levels of approaches as identified and each approach is used differently according to the severity of the ethical challenges encountered by nurses. These may arise at an individual level, a shared level, a collective level to that of a chiefly level that involves higher members of management such as nurse managers, nurse consultant and the director of Nursing depending on the severity of the ethical challenge. Therefore, not all ethical challenges are treated the same due to their context or environment in terms of resources and also people who are involved in relation to relationships and culture. Most of the experiences involving ethical challenges were identified as having taken place in practice at nurses' workplaces. Therefore, there is a sign of independence of the nurse in their decision making, however there is a strong emphasis on communal ways of making ethical decision together with other members of the staff. Further discussion concerning ethical mechanisms and approaches will be provided in the next chapter.

Summary

The Sulu model summarises and combines all findings from the study in regard to nurses' ethical knowledge, ethical considerations and ethical decision making. In Samoa nurses' understanding of ethics is obviously very much embedded in their culture and social relationships. The influence of cultural 'etiquette' that Samoan society expects an individual to follow when behaving, acting and performing nursing duties in the community is a huge one. Awareness of social institutions in the community and relational and sacred spaces enhance good relationships between nurses and members of the Samoan community. All of

these moral values, beliefs and knowledge were integrated with the western perspective of ethics and nursing in nursing education. The curriculum shows great emphasis on both western and the cultural dimension of nursing ethics. However, the nurses' experiences of ethical challenges occur mostly in a clinical or community setting, where nurses deliver nursing care and services. Nurses experience ethical challenges differently due to the environment in which they work as well as the resources that are available in their workplace. Even though with a challenging environment and in context, nurses consider relationships, behaviour and appearance, performance and language in their decision making as well as their faith. Their approaches vary from either personal, collective or chiefly depending on the type of ethical challenges encountered by the nurse.

Chapter 8: DISCUSSION AND CONCLUSION.

Introduction

Nurses in Samoa are faced with ethical challenges at their workplace like nurses in other countries. This study builds on and generally supports other existing knowledge of the ethical challenges, and responses to these challenges, that are faced by nurses within the Samoan context. However, this study is different in a variety of ways from other such studies, mainly due to its discourse concerning the highly influential socio-cultural influences that affect Samoan to nurses' approaches to ethical challenges at their workplace. It is also believed that this study is the first of its kind from the Pacific region, especially Samoa. However, this thesis not only adds to the existing knowledge about the experiences and perspectives of ethical challenges among Samoan nurses in particular but also incorporates a methodological approach to the research that is also heavily influenced by perspectives from a Samoan or Pasifika socio-cultural context. This combination of highly relevant socio-cultural aspects in both ethically related material and methodology hopefully enhances the overall research approach.

The study uses a sequential exploratory design with a mixed method approach to explore perspectives and experiences of nurses in Samoa about encountered ethical challenges at their workplace. It contains a national exploration of nurses' experiences that include nurses from the main hospital and district hospitals of both islands in Samoa (as fully explored in Chapters two and four). The aim of the study was to explore and develop an understanding of the ethical challenges and decision-making among Samoan nurses when delivering patient care within their nursing profession. The previous Chapters (Chapters five, six and seven) provide a detailed interpretation of what the study discovered concerning Samoan nurses' ethical knowledge, ethical challenges and moral decision-making methods that were eventually presented using the Sulu model.

This Chapter presents discussion of the main findings of the study and also offers a number of observations in regard to nurses ethical knowledge, ethical challenges and ethical decision making in Samoa. Firstly, it provides the overview of the findings of the research and discussion concerning how the findings achieved the aim and objectives of the study (as

outlined in Chapter one). There is then a more detailed discussion of how the study findings contribute to nursing literature and in particular, how the study reflects contemporary discourses of relational ethics and social ethics in nursing. Thirdly, there is discussion about how this thesis, offers new methodological tools, i.e. with respect to the role of the *Teu le Va* concept, that address the socio-cultural aspect of performing a research project in a specific Pacific nation; and this material subsequently pays particular attention to the Samoan philosophy of nursing that complements the newly developed methodology. Fourthly, the chapter notes some of the many limitations that the researcher encountered during an extensive period of time that was marked by significant challenges, the outbreak of Covid 19 in New Zealand being an obvious factor. Lastly, there is discussion about suggested ways to strengthen nursing ethics in Samoa, and offer recommendations for nursing practice and education, as well as suggestions for future research or study.

Overview of the main findings

This study aimed to understand the ethical challenges and decision-making processes among nurses in Samoa when delivering patient care, and within the nursing profession. The study had three objectives. These were: to gain an understanding of the perspectives of Samoan nurses about nursing ethics and its relevancy to nursing practice; identify ethical challenges and decision making in nursing practice that impacts on patient care in Samoa, and thirdly to understand methods or ways that Samoan nurses use to resolve and address ethical challenges within their workplaces or the health system.

The findings of the study revealed five broad categories that assisted in fulfilling the aim and objective of the study. The first category clearly showed that cultural aspects were a fundamental perspective of ethics within the Samoan society and nursing practices. It also highlighted several factors that directly influenced and generally supported the ethically related viewpoints and decisions of Samoan nurses. These factors included many social-cultural factors such as family (collective), culture (relationships), language (oral traditional language) and religion (faith), which are reflected as subcategories within this category. These influences were heavily influential upon Samoan nurses' perceptions of their roles and responsibilities but also on their approaches to nursing care that at the same time supported what they regarded as mainly acceptable ethical decision-making. The second category

discusses the extending application of the social and relational space (relationship) to the ethically related aspects of nursing education and services. Here, the Samoan role of the *tamaitai* is adapted and modified to complement the Samoan nurses' roles and responsibilities. Attention is also paid to the vitally, important role of maintaining the va tapuia (respectful space) between oneself and the patient, family and other co-workers within specific and wider social environments. The third category discusses nurse's awareness of what are mainly western perspectives of nursing ethics and issues relating to attempts to integrate their use within Samoan social-cultural concepts involving the social system, relationships and responsibilities in a communal practice within that society. The fourth category deals with the workplace environment, nurses experiences (and length of service) and identifies ethical challenges that Samoan nurses frequently encounter in their everyday practices within the health system. This category features three subcategories that examine ethical challenges from the perspectives of cultural experiences, workplace experiences and nursing education experiences. In the fifth and last category, there is evidence that revisits the typical Samoan nurse's uses of, and responses to cultural and social relationships, language, performance, appearance and faith in ethical decision making. Consideration is also given to Samoan nurses' methods of responding to ethical challenges which are then discussed in four subcategories such as the chiefly level, collective approaches, and shared and individual ways of responding.

Culture is a fundamental perspective of ethics and nursing ethics in Samoa

This study discovered that nurses' knowledge of ethics start at home, i.e., through their upbringing and family influences where their cultural responsibilities are deeply imprinted. There is some evidence in the limited amount of Samoan or Pasifika literature to support this assertion, i.e.: "Young people feel connected to their culture and identity through relationships with family, their peers, and communities. Importance was placed on cultural values, collective wellbeing" (Malatest International, 2021). This implies that Samoan nurses enter nursing education and practice with a fair idea of what is right and wrong according to *fa'asamoa* (Samoan ways) and religious beliefs, as discussed in Chapter two. The importance of culture to an individual and the role of the culture in positioning individuals into their social system and its responsibilities within society cannot be underestimated in Samoan society,

and by extension, in Samoan nursing practices. Hence, although such positioning starts from the aiga (family), the practicing of communal cultural mores, values and norms eventually extends from being part of the *aiga* into all aspects of communal life. The study clearly shows that most of the nurses' understanding of the ethics starts from inside the family and then extends into society via mainly cultural means. This includes a deeply developed understanding of respect for older (or wiser) people, which in turn extends into respect for nurse managers and other administrators at all levels. The teu o le Va or taking care of the space between relationships, which once more is the cultural norm in all Samoan nurses' interactions with their patients and others, and the maintenance of va tapuia (relational and respectful space) undoubtedly comes into its own when Samoan nurses are attempting to resolve an ethical issue or challenge. This powerful mixture of socio-cultural influences on the ethical decision making and subsequent actions of Samoan nurses has some wider general support in literature. Gallagher's (2020) argument that although a variety of ethical approaches and theories are generated differently among different cultures and traditions, they still inform moral life and offer rules and guidance as it defines what it means to do the right thing and to live a 'good' life. Other nursing authors have on various occasions, suggested that social and cultural norms and rules tend to underpin a great deal of ethical decision making and actions amongst nurses in different countries (Atkinson, 2015; Hunter & Cook, 2020; Ludwick & Silva, 2000; Woods, 2010).

Fa'asamoa or 'the Samoan way' (as discussed in Chapter two), is a way of life, a valued heritage and a set of structured principles for social life in Samoa (Stewart-Withers, 2011) . It refers to a Samoan way of life that governs family and village life. It is a social and organisational system that is ruled by chiefs, and one that is based on the rights and obligations of all members of the family, with shared rights to family resources. This communally orientated *fa'asamoa* places a great emphasis on the group's dignity and collective achievements rather than on those of individual members. Its village governance system is well-organised and coherent, which is the focal point of a network of social relationships that provide honour and prestige to its members. The faamatai as a system of authority, is of greatest significance to the fa'asamoa where it is difficult to challenge and would be even more difficult to change. Hence, all nurses practicing in Samoa are strongly influenced by this well established and largely rigid system. Any viewpoint regarding ethical decisions and actions are therefore first and foremost

framed by constant considerations of fa'asamoa. Other authors, although very few, have noted the rigidity of such a tradition, as for instance may be seen in the view of Fowler (2017) who suggests that established traditions are the vehicle that carries the concerns from the past to the present for nurses. The Samoa way of life and its communal lifestyle with its nurturing relationships with each other mirrored the narrative of what Fowler calls 'social ethics'. Here then, once more, is another claim that nursing ethics is a type of social ethics, and in this instance, an ethic that should take into account those deeply embedded social structures that affect the well-being and thriving of individuals and community. However, sometimes there is the possibility that social ethics may suggest some a type of social manners or etiquette – and so this possibility was also explored in this study.

The data largely indicated that although the understanding of cultural etiquette is acceptable to the nurse participants and is also perceived by them as of considerable importance to the patients and others during the delivery of nursing care and services, there are certain distinctions and similarities that need to be considered. Culturally focussed social etiquette not only draws cooperation and trust of the people, but it enhances partnership and participation to nursing care, service and initiatives. As such, it is a part of cultural awareness and sensitivity, but not necessarily a major driving force when a Samoan nurse is making an ethical decision. It has already been maintained that cultural practices and cultural ways of doing things such as appropriate manner/behaviour and language used (oral, formal, or informal), the approach of acknowledging families and communities, knowing salutations of families, the inclusion of families in caring is very significant in establishing a good relationship with the patient, families and communities. Here then, the boundaries between cultural responsiveness and cultural etiquette become quite blurred, and the nurse's adaptation of the Feagaiga (sacred covenant) role such as taulasea (a healer), fai'oa (wealth maker), pae ma le auli (peace maker) and ositaulaga (leader in worship, or a sacrifice) as part of his or her nursing professional roles are combined with those of an ordinary Samoan individual who is at the same time mindful that the observance of cultural norms always must include examples of good social etiquette. Nursing ethics in Samoa may not necessarily be driven by social etiquette, but it is an essential part of the maintenance of trust and respect that are the necessary forerunners of eventual ethical decisions and actions. One other important element in relation to the maintenance of trust and respect in Samoa is of course associated not just

with actions, but with speech. That is, in Samoa there are cultural ways of doing things such as Soalaupule, i.e. by making use of oral language or seniors to talk and acknowledge whoever (titled or untitled) who is disappointed or disagreeing with the nursing service.

As frequently indicated within the analyses of the gathered research data, a more crucial aspect of the a Samoan communal culture is the perceived value of the group, e.g. communal unity more than individualism, where perceptions of an individual person/creature/thing is always in terms of that individual's relationship to the group, in terms of va, or 'relationships' (Pollard, 2015; Wendt, 1996). As an example, the findings of the study show that the participants and respondents all value the Teu o le Va, but they also frequently mention the important of va tapuia and va fealoai (respectful relationship) with patients, family, and community. Once again, many nursing actions, and ethics related ones in particular, would not be possible in Samoa without the strong influence and recognition of va within the nursing profession of Samoa. This connection is so strong that it forms a major part of the Samoa Philosophy of Nursing (as discussed in Chapter four) and is a very clear example of what has become known as a 'relational ethic' par excellence (Bergum, 2004). This aspect of Samoan culture is therefore of considerable importance to nursing ethics in Samoa.

The influence of socio-cultural knowledge in nursing ethics and education

The result of the study showed a well-defined understanding amongst Samoan nurses about ethics and the relation of nursing ethics to nursing practice. The nurses' understandings of ethics (as for instance showed by the data in Chapter Five) is obviously very heavily embedded in social relationships and cultural ways of life. Social positions such as age, cultural status (titles), experiences (culture and work related), environment and contextual situations within the community and nursing care and service determine the relationship with self, others, and tend to direct relationships within the working environment. As also discussed previously (e.g. in this chapter and in Chapters two and seven), the importance and influence of culture on ethical knowledge and perception of Samoan nurses, clearly shows evidence of the integration of socio-cultural concepts to selected aspects from the nursing curriculum and education as well as nursing practice as reflected in the Samoan Philosophy of Nursing Conceptual framework.

This all further suggests that there is a distinct and strong connection between socio-cultural knowledge and the ethical viewpoints of actions of Samoan nurses that are not only clearly connected to upbringing and communal living, but to other factors that are more closely related to nursing education. The combinations of these two major forces that 'mould' the Samoan nurses have been noted earlier in this thesis, but it is now maintained that these two powerful connections tend to operate in a two-way combination rather than separately. That is, Samoan cultural practices affect Samoan nursing education, and Samoan nursing education affects the ethical practices of nurses within the socio-cultural settings that make up all Samoan life. This interesting phenomenon has been recognised by other nursing ethics commentators, e.g. Boozaripour, Abbaszadeh, Shahriari and Borhani (2018), who in their literature review of ethical values in nursing education, maintain that nursing ethics is underpinned by a combination of learned competencies that are based on a mixture of technical-professional, personal and socio-cultural ethical values. Such it seems, is the case for nurses in Samoa, where they are obviously influenced by socio-cultural values and norms, but at the same time are also fully educated and prepared professional nurses. As a result, the associated problems of combining more localised and heavily culturally orientated viewpoints on ethics with the more universal and less culturally affiliated main approaches to ethics that are so often seen in 'western' interpretations of ethics is a well-known issue for nurses and nurse educators in many countries. These concerns, and certainly this combination of factors (i.e. cultural and professional crossovers) certainly seems to be the case from previous examinations of the data in Chapters five and six. Essentially, the differences in interpretations and pluralities involved in ethical meaning and the possible clash of ethical values that may result are sometimes referred to as the products of 'ethical diversity '(Genuis & Lipp, 2013), and the exact relevance of ethnic and cultural beliefs and values in ethical decision-making and in clinical practice often remains a point of contention (Wells, 2005).

The integration of western perspectives of nursing ethics in nursing education

As previously noted, this study maintains that there is an integration of western perspectives of nursing ethics in nursing education and nursing practice in Samoa, although not without certain difficulties. The underpinning skills and knowledge that present-day Samoan nursing students require, such as ethical theories, code of ethics, critical thinking and ethical decision-making skills, and the philosophy of nursing ethics, are well established in the curriculum. The

data shows reasonably widespread understanding from the nurses participants about patients' rights, what one ought to do in a complicated situation (often by reference to previously learned ethical principles), and frequent mention of the need to use of the Code of Ethics, Code of Conduct, competencies and standards, and nursing protocols, a phenomenon that has been noted among other nurses in a number of other nations (Dierckx de Casterlé, Izumi, Godfrey, & Denhaerynck, 2008). Subsequently, this study reveals that Samoan nurses are far from lacking insufficient knowledge about ethics, codes of ethics and their uses and much more. Yet, in developing countries, there may still be seen a raft of arguments that claim that nurses in lower and middle-income countries tend to have a poor understanding of basic concepts of ethics (as discussed in Chapter 2).

Such claims are basically dubious. According to this data, there is high percentage of ethical knowledge and awareness amongst Samoan nurses, and in many ways their acute awareness of the huge importance of cultural and social values and norms within a type of social ethic that is modified in part by selected notions gleaned from western ethics are entirely appropriate for use in Samoa, and most likely, several other nations in the Pacific and beyond. However, the data also shows that the application of this ethical knowledge and awareness in practice is often a problem for the nurses. In part, this may be a reflection of how nursing ethics are taught in classrooms (Woods, 1997), i.e. the sometimes inappropriate use of theories and concepts that whilst of some value in perhaps moral philosophy or even bioethics, are found to be of little real value in the concrete or 'real world' as some nurses are wont to say. There is a different reality for nurses between education and practice as often mentioned by participants, and it sheds some light on practical contexts and social environments that heavily influence the application of ethical knowledge by nurses. Nevertheless, the influence of socio-cultural factors to their application of nurses' knowledge of nursing ethics in Samoa was not only easily identified, but also found to be of considerable value to them when attempting to balance ethical concerns and values. It may be a double-edged sword in many ways, but it is at least a highly mindful way of framing ethical issues within a given cultural context such as Samoan society.

Contextual ethical challenges in Samoan nursing practices

The influence of contextual factors on the nurse practice environment is a well-recognised phenomenon in contemporary debates about the adequacy of ethical responsiveness of nurses within what is now often referred to as the 'ethical climate' (Johansen & O'Brien, 2015; Numminen, Leino-Kilpi, Isoaho, & Meretoja, 2015). That is to say, it is one thing to prepare nurses educationally to make ethical decisions and act accordingly in an ideal, conceptual way, but often something entirely different in a health care arena where other factors predominate (Koskenvuori et al., 2019) . This study shows that ethical challenges encountered by Samoan nurses frequently came from issues relating to socio-cultural factors, the healthcare system and resource shortages, and the different reality between nursing education and clinical experience. These contexts predominated throughout the analysis of all data that was gathered for this research project. For instance, there was overwhelmingly strong emphasis on the observance and maintenance of cultural factors and their powerful influence on ethical decision making. This was undoubtedly a major finding. There is little doubt that in Samoa, and most likely in several other Pacific nations who share similar socio-cultural backgrounds and ways of being, that any nurse would struggle to deliver ethically mindful care to others without due deference to the maintenance of cultural traditions and responsiveness. There is therefore a highly respected relationship between the nurses and patients who bring their given status to the hospital or ward and there is strong evidence that the proper use of cultural norms such as the careful use of appearance, appropriate language, and respectful actions are as much a part of a nurse's ethical responsiveness in Samoa as any theoretical or learned ethical approaches in the educational setting. The challenge then, is for every Samoan nurse to balance social and cultural observances with the perceived norms and standards of his or her profession within a health care system that is often unable to fully respond whether from lack of resources or adequate staffing levels to provide sufficient levels of ethically appropriate nursing care.

In Samoa, difficulties associated with the healthcare system and lack of resources often make things worse and are therefore frequently ethically challenging, especially for those nurses who work in the community and district hospitals. However the intensity of limited resources and pressures on the Samoan health care system more often than not fall heavy on nurses who work in the community, mainly because such nurses have often to make ethical decisions

within a context that at times may force them to practice in ways that they consider ethically dubious, and at times, outside their scope of practice. It is perhaps at times like these that nurses in Samoa turn to their nursing leaders and managers for assistance. As previously maintained, nursing management and leaders hold great value in Samoan nursing, being highly respected and acknowledged as 'chiefs'. Subsequently, they have a great impact on the overall performance and structures of nursing. However, some participants argued that there are nursing leaders who produce problems for nurses by adding additional and unwanted pressures on already overworked nurses, a phenomenon that has been well recognised in other nursing settings (Humphries & Woods, 2016). In Samoa, these pressures range from minor infringements of normal etiquette, e.g., unnecessarily 'scolding' before agreeing to a request, to more publicly embarrassing incidents.

As previously indicated, the reality of nursing education and how it aligns with the practice or not was a very common talking point among the participants used in this study. The data revealed lapses in nursing education, and a clear schism between desirable nursing practices and everyday reality. There was also a frequent mention of the type of language to use (both formal and informal, and especially at district hospitals) when clinical practical procedures differed considerably from what was learnt within nursing schools.

Overall the existence of ethical challenges for nurses may be said to vary among countries, according to several contextually related factors, e.g., Rainer et al. (2018) argue that ethical challenges experienced by nurses in New Zealand, Australia or America are not the same as ethical challenges in other international nursing communities (especially perhaps by Samoan nurses). However the above mentioned countries are grouped, it is the impact of the various contexts as outlined above, both in the broader and more specific senses that appear to determine many of the ethical decisions and actions of Samoan nurses. Thus, the ethical situations and challenges that are encountered by Samoan nurses every day are often dealt with by nurses in ways that are born out of compromise and necessity rather than by adequately argued and desirable means.

Decision making considerations and approaches to ethical challenges

This study argues that Samoan nurses' experience of ethical challenges are often handled differently depending on the nature and magnitude of these challenges, i.e., Samoan nurses address different types of ethical challenges depending on their own interpretations of events, coping mechanisms and availability of support. In general, the study reveals that there are three main levels of approaches that Samoan nurses appear to adopt, firstly is an individual response, secondly a collective response and lastly the 'chiefly response'.

An Individual response occurs when a nurse will talk or share an ethical issue with someone else on an individual level, mainly for confidence and help. As maintained within this study, the usually culturally appropriate way in Samoa under such circumstances is to pass on concerns to a colleague of equal standing, or as is also often the case, to someone in higher authority. This is an experience that often reveals the importance of position and role in the workplace, and the usual way that issues are resolved through the use of the authoritative power and control of others. As a rule, nurses in Samoa tend to follow these social and cultural norms even when attempting to resolve significant ethical issues in the workplace. That is, they either raise their issues with either a peer or a line manager (which seemed to be a common practice throughout the gathered data), or, which is just as likely, to withdraw and 'do nothing' for a period of time until they are able to find a more suitable response and course of action. These forms of nursing responsiveness to ethical challenges has been recognised in nursing literature and research for several years (Ewuoso, Hall, & Dierickx, 2021; Goethals et al., 2010; Woods, 1999)

Nevertheless, Samoan nurses employ other forms of responsiveness to ethical issues belonging as they do, to a professionally orientated tradition of raising such issues through collective responses shown by raising issues at staff meetings. Data showed that there was a strong emphasis of Samoan nurses valuing staff meetings and often being protective of seniors within their staff members. They showed a preference for handling smaller issues at staff meeting rather than elevating them to higher management (although this too may occur under highly difficult circumstances). This reflects respect for the skills of leadership of nurse managers and nurse consultants, who are in charge of staff members in any ward or district hospital. This is a sign of respect and acknowledgement of their leadership and position in

society and therefore encourages a 'humble' approach, which is a reflection of the culturally associated 'chief' approach. Samoan nurses therefore understand that the role and responsibility of the leader is to know affairs concerning the staff and workplace, and so any opportunity to talk straight to 'the chief' may be utilised. In some ways, this is regarded as another way of showing respect, i.e. valuing his or her role as a decision maker of any affairs that are not right within the staff or the workplace. Once again, the Samoan ways of nurses when responding to ethical challenges is not entirely different from nurses elsewhere, although the reasons for their actions may not be exactly the same.

Overall, the findings of this study reflect a reasonably significant number of the theoretical or conceptual themes related to nursing ethics that were previously discussed in the literature review in Chapter Three. These themes include the influence of a collective or 'relational' approaches to autonomy in response to ethical challenges (Gómez-Vírseda, de Maeseneer & Gastmans, 2019; Woods, 2010) and consideration of the importance of socio-cultural aspects in nursing ethics (Abbas, Zakar & Fischer, 2020; Almoallem et al., 2020; Woods, 2010, 2012), the role of context and 'ethical climate' in ethical decision making (Humphries & Woods, 2016; Koskenvuori, Numminen, Suhonen 2019; Olsen, 2007), and the role that nursing education might play in preparing (Samoan) nurses for adequate responsiveness to ethical challenges.

In particular, this study clearly adds a considerable amount of evidence and value to the growing discussion in nursing ethics on the value of relational ethics towards good nursing practice. Clearly, the relational aspects of nursing care in Samoa are of immense importance from all perspectives be they individualised, community focussed or inter-professional. This study also heavily indicates the enormous influence of and cultural aspects and 'social ethics' in nursing ethics. Such an approach clearly supports valuing the social context and social relationships, of the nurse and the patient, family, community and the environment in regard to a nursing ethics that are suitable for a given society which, in this instance, is Samoan society.

This overall approach therefore also suggests that an 'ethic of care' may well be an entirely satisfactory explanation for the general approaches of Samoan nurses to ethical challenges. As noted in Chapter 7, an ethic of care in nursing is a phenomenon that is frequently perceived

as a driving force in the decisions and actions of nurses in several different settings and nations (Gallagher, 2020; Gastmans, 2006; Lachman, 2012; Woods, 2011). The strong focus of an ethic of care on personal and social relationships, caring values, and caring within particular contexts (Barnes, 2012) therefore has a considerable amount of resonance with the ethical responses and practices of nurses in Samoa.

Finally, and perhaps of equal importance to this study is the influence of the surrounding environment in which nurses work. It is important when it comes to ethical decision-making during situations of patient care, and more widely to the nursing profession. In regard, some of the findings of the study confirmed what has been discussed and reported from other countries, namely that any problems within the immediate or wider social or physical environments, be they limitations such as resource problems, or social and/or cultural misunderstandings or mistakes, may all have a distinct effect on a nurse's ability to respond in an ethical fashion. Basically, when culturally interpersonal observances, within what are longstanding social ways of living are insufficient, then the results of any ethical deliberations will not be as complete as they might be, nor will they be always fully acceptable to those involved. The Samoan context is therefore a particularly absorbing one when discussing ethically related issues and concepts.

Final conclusions of the study

The perspectives of Samoan nurses about nursing ethics and its relevance to nursing practice are obviously very much rooted in culture and social relationships. The influence of cultural 'etiquette' that Samoan society expects an individual to follow when behaving, acting and performing nursing duties in the community is a huge one. Awareness of social institutions in the community and relational and sacred spaces enhances good relationships between nurses and members of the Samoan community. All of these moral values, beliefs and knowledge have been integrated with western perspective of ethics and nursing in nursing education. Where the curriculum shows great emphasis is on both western and cultural dimension of nursing ethics. Nursing ethics decision making in Samoa can be a complex affair, most notably because of the many factors that affect nursing ethical decision making within the social rules and restraints of Samoan society.

The understanding of ethical challenges and decision-making in nursing practice that impacts on patient care in Samoa depends on many factors. These factors range from numerous contextual issues; i.e., geographical and supply problems, lack of sufficient human and other resources; and numerous factors that all relate in different ways to the effects of expected socio-cultural norms such as religious influences, relational and communication issues at all levels, and others. The health care system includes the way things are processed and lines of communication within the different sectors of the system. The nursing division is within the system and has different policies and regulations and the health care system itself has a great impact on decision making for nurses. For example, the referral system – using the telephone to refer and discuss treatments and patients. The idea here, was to make the system effective for quality service, offer a training or a course for nurses to undertake advance practice for district hospitals as a nurse practitioner to enhance the autonomy of the nursing profession, and maybe contribute to relieving patient flow and treatment errors and enhance confidence and knowledge as well as skills to nurses.

Samoan nurses use a cultural approach to resolve and address ethical challenges within their workplaces or the health system. The study reveals aspects that nurses in Samoa values such as Aga (Behaviour), Va Fealoai/Va Tapuia (Performance), Tapuaiga (Relationships), Gagana Tautala (Oral, Formal and Informal Language) and Faith/Spirituality which are important and vital to enhance ethical, safe and quality led nursing practices. Nurses considered these values in their decision making not only in relation to practice but also as an approach to address ethical challenges. There are three levels of approaches identified, and each approach is used differently according to the severity of the ethical challenges encountered by nurses. These range from an individual level, a collective level to chiefly level that involves higher members of management such as nurse managers, nurse consultants and the Director of Nursing and depend on the severity of the ethical challenge. Therefore, not all ethical challenges are treated the same due to its context situation, the environment in terms of resources and also people who are involved in the relationship and culture. Most of ethical challenges identified took place in nurses' workplaces. Therefore, this is a sign of nurses' independence in their decision making, however there is a strong emphasis on communal ways of making ethical decisions alongside other members of staff.

Limitations of the study

This study is no exception when it comes to limitations, and although all studies have some, this one has been fraught with many. The study has been a fascinating one, where several important and interesting elements of nursing ethics have been explored. These include Samoan nurses' perceptions of ethics in general and nursing ethics, perspectives and experiences of ethical challenges, matters relating to the context of the nurses' workplaces, and nurses' ethical decision-making approaches. All of these aspects of nursing ethics in Samoa made the research topic a highly interesting one in its own right. However, there were a number of often unavoidable limitations during this study.

Firstly, and without any doubt at all, this study was significantly affected by the outbreak of Covid 19 in the world, and particularly in New Zealand in March 2020. Since that time there have been several intermittent periods of various forms of 'lockdown' where different levels of restrictions have been applied, thus limiting both the overall performance of the study and the abilities of researcher and supervisors to pursue regular face to face meetings. No amount of Zoom meetings or phone calls quite matches the ability to exchange ideas on a more interpersonal level.

Other delays were also experienced during this study that were not associated with the Covid outbreak. For instance, there were lengthy limitations during the qualitative phase that affected data collection and data analysis. The delay in conducting interviews and analysis of the interview data was due to a long wait for the support letter from the National Health Service in Samoa for permission to conduct the required interviews. This also delayed the analysis phase and later the survey development for phase two of the study. Being an insider as a Samoan researcher, a nurse was beneficial to the study however this can be another limitation even though I have highlighted and addressed these issues (Chapter four). However there is still a possibility of bias and subjectivity in the study.

Secondly, the timeframe and the amount of data collected from the first 21 participant and second phase of the data collection with 221 respondents, the analysis, survey development of the study might lead to over-represented and misrepresentation of the data during analysis and presentation of the qualitative and quantitative data sets. Nevertheless, the integration

of data (Chapter 7) hopefully brings a close or equal representation of both data set in the discussion of nursing ethics in Samoa.

Thirdly, the quantitative phase of the research had a minor limitation in that the layout of a small part of the survey questionnaire may have had an effect on the ease of filling out the survey. This is referred to in section two of the survey questionnaire where the Likert scale section of the Frequency column was originally positioned in a fashion that may have caused some confusion for some respondents. Nevertheless, developing the survey was a good learning experience, especially when related to those areas of survey design that will help other researchers. Another, more disturbing experience was my inadequate knowledge of the statistical analysis which led to more delays of the project; however, I was most ably assisted in this regard by a university statistician and supervisors who assisted in analysis and the production of the findings of the study.

Finally, a significant limitation was definitely a socio-cultural one involving my own difficulties in being separated from family and friends in Samoa for such a lengthy period of time. This brought with it a number of difficulties, especially during the time of my aunt's funeral, Covid 19, and the recent passing of my dearest grandmother. It has not been an easy time for this journey in many ways, but it has been a training that develops resilience and determination. There were cultural differences in terms of living and education however, the opportunity and purpose of being here as a representative for the wider population of nurses in Samoa, is an honour and a true sacrifice for the development of nursing.

Recommendations

The findings of this study highlighted important issues that should be of considerable interest to nurses, nursing education and practice, as well as future research, especially in Samoa. Hence, the following recommendations are made in an effort to assist in the improvement of the education and practice of nursing ethics primarily *within Samoa,* but possibly also in other Pacific nations. This will be achieved by considering the ethical challenges that Samoan nurses encounter and respond to in their everyday practices with a view towards strengthening certain approaches and responses within nursing education and practice.

Nursing education

It should be noted that most of the participants praised the level that new nurses recruited have of theoretical knowledge of nursing procedures. However, some of the participants provided some suggestion for areas that need attention in order to strengthen and enhance future nurses' ethical knowledge and awareness. For example, the nurse's relationships and cultural approaches with members of the community. This is because in this study, the data exhibited a strong belief from nurses working in community settings that relationships and cultural understanding (language and actions) and subsequent nursing approaches are key factors to community nursing alongside those of theory and practical knowledge (skills). These factors should assist in ethical knowledge and decision making in the community or clinical setting in Samoa.

However, whilst the data from the study revealed a high degree of appreciation for the changes that nursing education has developed in previous years regarding training new nurses for the practice, there remains is still room for further improvements in nursing education in Samoa. Subsequently, the Samoan nursing education institution (National University of Samoa) is advised to re-evaluate teaching and training strategies that best support a learning style that will enable nursing students to implement specific ethical knowledge for use in future practice. Clearly, all elements that relate to the teaching of nursing ethics should begin first and foremost with a careful overview of Samoan cultural mores and practices to 'set the scene' as it were, in a contextually appropriate way. Only then should learning strategies such as observation, clinical case review, discussion and reflection be attempted that will enable ethical knowledge to ensure quality and safe practice. Here, an emphasis on reflective skills within a framework of critical thinking may be developed. This framework could still incorporate ethical principles, theories and codes, but should be very mindful of the main elements within 'social ethics' and 'relational ethics' that reflect Samoan (rather than western) cultural norms and values. The value of the Samoan Philosophy of Nursing (as previously discussed) should be maintained throughout any teaching sessions on nursing ethics. Obviously, there would still be a requirement to offer teaching related to self-evaluation, complex reasoning skills and good levels of interpersonal communication and relationship skills. Furthermore, there is a strong need for the integration of nursing ethics in terms of ethical knowledge to be applied to all courses of the nursing degree programme. This would

underscore the value of student nurses being able to practice meaningful reflective skills, share knowledge and experiences with peers and colleagues to develop future skills as well as strategies for implementation.

Nursing practice

The study identified several suggestions for the continuous or ongoing education of nursing ethics to be used by nurses in a clinical setting in Samoa, to strengthen and remind nurses of the importance of ethical knowledge and available resources in decision making, both in general and ethically speaking, to promote good nursing practice. Therefore, educators need to provide a nursing ethics forum or programmes that target practicing nurses/participants and deliver a learning style and the linguistic requirements for greater ethical knowledge and awareness to enable them to be more able to meet any future ethical challenges or problems. The forum/programme should be flexible and be offered in multiple modalities to include nurses in both community and district hospital nursing. However, the forum/programme should also evaluate changes in knowledge and practices over the last five years, providing opportunities for the way, nurses could best incorporate ethical knowledge into their practice and the discussion of complex clinical ethical challenges in Samoa. Nurse managers, consultants and educators at different workplaces should encourage and support nurses by ensuring setting aside a designated time to allow nurses to reflect, share knowledge, experience and thoughts on an ethical problem or challenge, and assess implementation strategies.

The findings clearly identified the channels that are used when nurses are addressing ethical challenges in different settings of nursing in Samoa. Some of these channels are more successful than others, i.e. there is much to be gained from identifying a significant ethical concern and bringing it to a staff forum or meeting, but little to be gained from silence or "walking away." Hence, this study suggests the use of more formal channels for clinical ethics discussion to support nurses in clinical and community practice in terms of safety, function and goals. Such approaches would provide nurses with advice and recommendations regarding the best course of action and could also be a non-challenging training venue for less experienced nurses.

The study also suggested that an ethics committee might be employed to carry out clinical ethics consultation to help patients and personnel to clarify daily ethical problems in health care practice, and to improve collaborative decision making. The ethic committee could be formulated by nurses who should have certain skills and competencies in ethics, in order to support nurses in dealing with their ethical challenges. This committee might also be an extension of a hospital ethics committee that would be a permanent body that included a team of individuals from healthcare personnel such as physicians, nurses, clergy and social workers. The goal of the ethics committee would be to improve the quality of care for the patient and families by finding best solutions to certain aspects of ethical challenges that occur between the nurse or healthcare personnel, patient and families. An extension of this service could include providing educational activities to enhance ethical awareness in clinical practice, help formulate strategies to deal with ethical conflict and moral distress and strengthen cultural sensitivity and integration to ethical approaches. The committee might also have a role in assessing the nature of ethical challenges in the context of Samoa and draw upon relevant knowledge and processes about ethics not only to formulate an ethics consultation service, but also to perform ethical analyses, provide a formal mechanism for major ethical issues, develop a local code of ethics and make changes on policy to protect patients, nurses and families.

Future Research

This study provides a foundational ground of perspectives and experiences of ethical knowledge and ethical decision making among nurses in the Pacific islands region, especially Samoa. Nursing ethics research is still in the early stages in the Pacific when compared with western countries, but this study provides a little ray of light that at least could encourage other neighbouring islands to undertake research with similar or preferred methods to address ethical challenges in their own arena of nursing practice. Samoa is a very small island to undertake such research, but it is also a very unique country that has traditions and values that speaks volumes of its' cultural relationships, participation and partnerships that are incorporated in nursing practice.

This research pursued nursing ethics starting from nursing practice and nursing education and analysed these to formulate a model. Relational ethics, social ethics and situational ethics has been mooted in this study that interestingly developed and emerged through analysis. However, further research needs to explore how nursing ethics is taught in nursing education settings both in Samoa and elsewhere. Further research is clearly needed in Samoa and beyond, that investigates those ethical challenges that are specific to Samoa and other Pacific nations, and even perhaps other low-middle income nations who share some similarities with Samoa.

CONCLUSION

This study demonstrates that nurses' understanding of nursing ethics are very much embedded in culture and social relationship. There is a very strong connection between socio-cultural 'ways of being' within Samoa and with notions of ethics as applied to certain ethical principles or rules. The type of moral symbiosis where traditional social aspects of the 'right behaviour' within Samoa are often combined with learned aspects from nursing education. It is clear enough that any nursing ethics within Samoa is strongly influenced by Samoan aspects of social and cultural norms. Nursing ethics decision making in Samoa can be a complex affair, most notably because of the many factors that affect nursing ethical decision making within the social rules and restraints of Samoan society. Where many factors range from many contextual issues; i.e., geographical and supply problems, lack of sufficient human and other resources, and numerous factors that all relate in different ways to the effects of expected socio-cultural norms such as religious influences, relational and communication issues at all levels, and others. However, nurses considered cultural values in their decision making, not only in relation to practice, but also the approach to addressing ethical challenges. Thus, nurses revert to cultural approaches to address ethical challenges from an individual level, a collective level to a chiefly level depending on the severity of the ethical challenges' encountered.

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APPENDICES

Appendix 1: University Ethics Committee Approval

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Phone 0-4-463 6028
Email judith.loveridge@vuw.ac.nz

MEMORANDUM

TO	Alovale Sau
FROM	Dr Judith Loveridge, Convenor, Human Ethics Committee
DATE	26 June 2018
PAGES	1
SUBJECT	**Ethics Approval** **Number:** 0000026006 **Title:** Ethical Challenges: Workplace, Patient Care and Decision-Making Among Samoan Nurses

Thank you for your application for ethical approval, which has now been considered by the Human Ethics Committee.

Your application has been approved from the above date and this approval is valid for three years. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards,

[redacted]

Judith Loveridge

Convenor, Victoria University of Wellington Human Ethics Committee

Appendix 2: Samoa Health Research Ethics Approval

Please address all correspondence to the Chief Executive Officer

Government of Samoa
Ministry of Health

Office of the Chief Executive Officer
Private Mail Bag, Motootua
Tel: (685) 23330
or 68100 ext 102
Facsimile: (685) 26553

Alovale Sa'u
Principal Researcher
Victoria University of Wellington
NEW ZEALAND

8th August, 2018

Subject: "Ethical Challenges: Workplace, Patient Care and Decision-Making among Samoan Nurses" Research

Dear Alovale,

Thank you for your request for ethics approval to conduct your research, ***"Ethical Challenges: Workplace, Patient Care and Decision-Making among Samoan Nurses"***. Thank you also for your interest in researching to understand the ethical challenges faced by the Samoan Nursing profession and how they affect the Nurses' ethical decision making and their Nursing practice experiences.

The Health Research Committee (HRC) at its meeting on Tuesday 7th August, 2018 assessed and evaluated your research proposal. The HRC is pleased to inform you that your ethics application has been approved in principal pending on the submission of the following:

- Ethics Clearance from the Nursing Faculty of the National University of Samoa
- Support letter from the General Manager of the National Health Services.

We will proceed with the signing of the Memorandum of Understanding once we receive these documents.

Should you require further information/clarification, please do not hesitate to contact Quandolita Reid-Enari or Merina Ieremia on telephone 68106 or email: QuandolitaE@health.gov.ws or Merina1@health.gov.ws at the Strategic Policy, Planning and Research Division.

Sincerely

[redacted]
Quandolita Reid-Enari
ACTING CHAIRPERSON – HEALTH RESEARCH COMMITTEE

Appendix 3: National University of Samoa Ethics Approval

"IA AO SAMOA"

LĒ IUNIVESITĒ AOAO O SĀMOA (Fa'avaeina 1984
THE NATIONAL UNIVERSITY OF SAMOA

University Research & Ethics Committee

National University of Samoa
Le Iunivesite Aoao o Samoa

Chancellery Office
Administration Bldg
Top Floor, Building A

T: +685 21428
F: +685 25489
E: d.leehang@nus.edu.ws
W: www.nus.edu.ws

PO Box 1622
Lepapaigalagala Campus
Toomatagi
SAMOA

21 August 2018

Alovale Saú
PhD Candidate,
Victoria University Wellington

Dear Alovale,

Re: Ethics Approval for Alovale Saú's PhD Research on Ethical Challenges: Workplace, Patient Care and Decision-making Among Samoan Nurses

We have considered your proposed study and we are satisfied that it meets the NUS minimum ethical clearance requirements for approved research.

Your proposed research focuses on an important aspect of the Nursing profession, especially given the recent MMR cases in Samoa. I wish you well with your research.

Should you have any further queries, please contact Mr Eric Groves (UREC Secretariat, NUS).

Ma le fa'aaloalo tele,

NATIONAL UNIVERSITY OF SAMOA (NUS)

[redacted]

Peseta Dr Desmond Lee Hang
Deputy Vice Chancellor – Academic & Research
Chairman, University Research & Ethics Committee

cc: Dr Iutisone Salevao – Manager, Research
Sala Maatasesa Samuelu Matthes – Dean, FoHS & HoS SoN
Eric Groves – UREC Secretariat

Appendix 3: Information sheet for participants

Ethical challenges: Workplace, Patient Care and Decision-Making among Samoan Nurses

INFORMATION SHEET FOR PARTICIPANTS

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

Who am I?

My name is *Alovale Sa'u* and I am a Doctoral student in *Graduate School of Nursing, Midwifery and Health* at Victoria University of Wellington. This research project is work towards my doctoral thesis.

What is the aim of the project?

This project *develops an understanding of the concept of ethical challenges and decision-making among nurses of patient care and nursing profession.* This research has been approved by the Victoria University of Wellington Human Ethics Committee *[#0000026006].*

How can you help?

You have been invited to participate because ***this research focus at nurses who works at the main hospital of Tupua Tamasese Meaole (TTM), transfer hospital of Malietoa Tanumafili 2 (MT2) and district hospital of Upolu and Savaii.*** If you agree to take part I will interview you *at your workplace or any prefer location*. I will ask you questions about *ethical challenges among nurses at their workplace, during patient care and the impact of these challenges to decision making to patient care and nursing profession*. The interview will take *30 – 40minutes*. I will audio record the interview with your permission and write it up later. You can choose to not answer any question or stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any time before *28th of September.* If you withdraw, the information you provided will be destroyed or returned to you.

What will happen to the information you give?

This research is confidential*. This means that the researcher named below will be aware of your identity but the research data will be combined and your identity will not be revealed in

* Confidentiality will be preserved except where you disclose something that causes me to be concerned about a risk of harm to yourself and/or others.

any reports, presentations, or public documentation. Only my supervisors and I will read the notes or transcript of the interview. The interview transcripts, summaries and any recordings will be kept securely and destroyed on *31/12/2022*.

What will the project produce?

The information from my research will be used in PhD dissertation and a brief report submission to the nursing council of Samoa, Ministry of Health, National Health Service and School of Nursing to inform nursing policy, nursing education, quality assurance and also improves quality patient care and organisational culture.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to answer any question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study before *28th September, 2018*;
- ask any questions about the study at any time;
- receive a copy of your interview transcript*;*
- read over and comment on a written summary of your interview*;*
- be able to read any reports of this research by emailing the researcher to request a copy.

If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact me:

Student:

Name: Alovale Sa'u

University email address: [redacted]

Supervisor:

Name: Dr Martin Woods
Role: Primary Supervisor
School: Graduate School of Nursing, Midwifery and Health.
Phone: [redacted]
martin.woods@vuw.ac.nz

Name: Dr Ausaga Faasalele Tanuvasa
Role: Secondary Supervisor
School: Faculty of Health.
Phone: [redacted]
ausaga.faasaleletanuvasa@vuw.ac.nz

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convenor: Dr Judith Loveridge. Email [redacted] or telephone [redacted]

Appendix 4: Information sheet in Samoa

Luitau o Aga Tausili: Falefaigaluega, Tausiga o tagata lautele ma Faaiuga-fai I Tausi-Soifua o Samoa.

ITULAU O FAAMATALAGA MO SUI AUAI O LENEI SAILIILIGA

E valaau/faatalauula atu ma le faaaloalo tele, mo se avanoa e auai ai I lenei sailiiliga. Ma le ava tele, faamolemole, faitau ma le manino lenei itulau ae lei faia lau faaiuga e te auai ai pe leai foi I lenei sailiiliga. A faapea o lau faaiuga e te fia auai, e momoli atu le Faafetai faalelava, ae a faapea o le a e le taliaina lenei faatalauula atu, e momoli atu foi le Faafetai tele lava I lou manatu I lenei sailiiliga.

O ai lenei auauna?

O lou igoa o Alovale Sa'u, o loo aotauina au I le faailoga o le faafomai I le tofamanino, I le aoga o Tausi-soifua, Faatosaga ma le soifua maloloina I le Univesite o Vitolia I Ueligitone, Niusila. O lenei sailiiliga o le galuega tele lea mo le faailoga/mataupu o le Faafomai I le tofamanino.

O le a le autu o lenei sailiiliga?

O lenei sailiiliga o le auiliilina o le tamaoaiga o manatu i luitau o aga tausili ma faaiuga-fai I fale faigaluega, faatinoina o le tausiga e tausi soifua I Samoa o tagata lautele aemaise ai le galuega faatausi soifua. O lenei sailiiga ua faatagaina mai e le Human Ethics Committee (#0000026006) i Univesite o Vitolia I Ueligitone, Niusila.

E faafefea ona e fesoasoani?

E valaau atu ma le faaaloalo tele mo se avanoa e auai ai I lenei sailiiliga ona o loo taulai le faamoemoe I Tausi soifua o loo galulue I maota o gasegase o Tupua Tamasese Meaole, maota o gasegase o Malietoa Tanumafili le 2 ma maota o gasegase faaitumalo o Upolu ma Savaii. O le a faatinoina le faatalatalanoaga pe a e malie e te auai I lenei sailiiliiga, e tusa ma le 30 I le 40 minute lona umi. O le a pueina foi le faatalatalanoaga I le masini pueleo pe a finagalo I ai ma aoteleina i faamaumauga tusitusia I se taimi oi luma. O loo I a oe foi le filifiliga I le taliina o fesili pe taofiina foi o lenei faatalatalanoaga e aunoa ma se mafuaga faalia. O loo I te oe foi le faitalia e te tuua ai lenei sailiiliga e ala I le faafesootai mai i soo se taimi ae lei oo atu I le 28 o Setema. O le a aveesea uma faamatalaga ma faamaumauga tusitusia pe a faapea o lou finagalo lea, o le tuua o lenei sailiiliga.

O le a le tulaga o le a tupu I faamatalaga ua tuuina mai?

O faamatalaga uma o lenei sailiiliga o le a faalilolilo. O le uiga o lea faamatalaga, o suafa uma o e na auai I lenei sailiiliga o le a le faailoaina, ua na o tuufatasiga o faamatalaga tusitusia mai faatalatalanoaga o le a faalia I lipoti, aoaoga ma faamaumauga aloaia mo tagata lautele. Ua na o le faufautua ma le auauna nei o le a faitauina faamaumauga tusitusia o faatalatalanoaga ma

aotelega o faamaumauga. O nei faamaumauga tusitusia o le a faamausaliina lona teuina ma ua fuafuaina e faatamaiaina I le aso 31 o Tesema, 2022.

O le a le faamoemoe e maua mai I lenei sailiiliga?

O faamatalaga mai lenei sailiiliga o le a faaaogaing mo le faamoemoe o le faailoga o le Faafomai o le Tofamanino ae le gata I lea, o le a tuufaatasia ai se lipoti puupuu mo le faalapotopotoga o tausi soifua I samoa aua le faaleleia o auaunaga ma aoaoga faaletausisoifua aua se agai I luma o tausiga ma agaifanua o faalapotopotoga.

A e taliaina lenei valaau, o a aia tatau o le sui auai o lenei sailiiliga?

E le faamalosia lou auai pe a e le fingalo i ai. Ae a faapea e te malie e te auai I lenei sailiiliga, o lou aia tatau nei:

- Filifiliga e le taliina ai so se fesili;
- Faailoa ai le tapeina o le masini pueleo I soo se taimi ao faatinoina le faatalatalanoaga;
- Faaui i tua ma le sailiiliga ae lei aulia le 28 o Setema, 2018;
- Faaleo ai so o se fesili e faatatau i le sailiiliga I so o se taimi;
- Tauaaoina ai le faamaumauga tusitusia o le faatalatalanoaga;
- Faitauina ai ma faailoa mai ai manatu I le aotelega o faamatalaga tusitusia o le faatalatalanoaga;
- Maua le avanoa e talosaga aim o le aotelega o tuufaatasiga o faaiuga o le sailiiliga.

A I ai ni fesili, o ai e faafesootai?

A I ain i fesili, I le taimi nei po o le lumanai foi, faamolemole faafesootai le auauna nei:

Tamaititi Aoga

Suafa: Alovale Sa'u
Imeli o le Univesite: [redacted]

Faufautua

Suafa: Dr Martin Woods
Matafaioi: Faufautua Autu
Aoga: Graduate School of Nursing, Midwifery and Health.
[redacted]
martin.woods@vuw.ac.nz

Suafa: Dr Ausaga Faasalele Tanuvasa
Aoga: Faculty of Health.
Telefoni: [redacted]
ausaga.faasaleletanuvasa@vuw.ac.nz

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convenor: Dr Judith Loveridge. Email [redacted] or telephone [redacted]

Appendix 5: Consents form for participants

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Ethical Challenges: Workplace, Patient Care and Decision-Making among Samoan Nurses

CONSENT TO INTERVIEW

This consent form will be held for *5* years.

Researcher: *Alovale Sa'u, Graduate School of Nursing, Midwifery and Health,* Victoria University of Wellington.

I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.

I agree to take part in an audio recorded interview.

understand that:

I may withdraw from this study at any point before *28th September, 2018*, and any information that I have provided will be returned to me or destroyed.

The identifiable information I have provided will be destroyed on *31/12/2022*.

Any information I provide will be kept confidential to the researcher and the supervisor.

I understand that the results will be used for a PhD dissertation.

My name will not be used in reports, nor will any information that would identify me.	Yes ☐	No ☐
I would like a copy of the transcript of my interview:	Yes ☐	No ☐
I would like a summary of my interview:	Yes ☐	No ☐
I would like to receive a copy of the final report and have added my email address below.	Yes ☐	No ☐

Signature of participant: _____
Name of participant: _____
Date: _____
Contact details: _____

Appendix 6: Consent form in Samoan

Luitau o Aga Tausili: Falefaigaluega, Tausiga o tagata lautele ma Faaiuga-fai I Tausi-Soifua o Samoa.

MALIEGA O LE TALATALANOAGA

O lenei maliega o le a taofia mo le 5 tausaga.

Researcher: *Alovale Sa'u, Graduate School of Nursing, Midwifery and Health,* Victoria University of Wellington.

Ua ou faitauina lenei itulau o faamatalaga ma ua uma foi ona faamatalaina. Ua faamalieina foi fesili uma I tali sa tuuina mai. O loo I ai foi le malamalamaga I le mafai e faaleoina ai fesili I so o se taimi.

Ua ou malie e auai I le talatalanoaga e pueina I le masini pueleo,

loo I ai le malamalamaga e:

Mafai ona faaui I tua mai lenei sailiiliga I so se taimi lava ae lei aulia atu le 28 o Setema, 2018, ma o le a toe faafoi ina mai pe faaleaogaina faamatalaga tuuina atu I le faatalatalanoaga.

O faamatalaga e pei ona tuuina atu ma tusitusia o le a faatamaia I le aso 31 o Tesema, 2022.

So se faamatalaga ua tuuina atu o le a teu malu e le o loo faatinoa le sailiiliga m a le faufautua.

Malamalama I le faaaogaina o le iuga o lenei sailiiliga mo le faailoga o le faafomai o le tofamanino.

O lou igoa o le a le faaaogaina I aotelega o tusitusiga po o nisi lava faamatalaga e ona faailoaina ai lou nei tagata	Ioe ☐ Leai
Ou te manao I se itulau o le faamatalaga tusitusia o lenei faatalatalanoaga:	Ioe ☐ Leai
Ou te manao I le aotelega tusitusia o lenei faatalatalanoaga:	Ioe ☐ Leai
Ou te manao e maua se aotelega tusitusia o lenei sailiiliga ma o le tuatusi o lau imeli o loo tusiina atu I lalo.	oe ☐ Leai

Saini o le sui auai_____
Suafa o le sui auai _____
Aso _____
Faamatalaga o fesootaiga _____

Appendix 7: Research Flyer for Recruitment

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Ethical challenges: Workplace, Patient Care and Decision-Making among Samoan Nurses

The application of good practice can be problematic in the reality of nursing in Samoa due to limited resources, cultural and religious values and shortages of nursing staff. In particular, western ethical standards, nursing theories and a code of ethics that are taught in nursing education and training in Samoa can be challenging when the application is not align with cultural values and practice of Samoa. This means that even though nurses have the understanding of what to do, there are constraints that hold nurses back from doing the right thing, and most of the constraints are more than likely associated with factors outside of the nurse's control.

WHAT IS THIS STUDY ABOUT:
This research explores and seeks to understand nursing perspectives/interpretations of ethical challenges within Samoan workplaces, and how they affect the nurses' ethical decision making and their nursing practice experiences. This will be pursued with the aim of developing an understanding of the ethical challenges and decision making issues among Samoan nurses when delivering patient care.

WHO CAN PARTICIPATE?
You have been invited to participate because this research focus on nurses who work fulltime in wards (senior-5+ yrs.' experience, junior– 2yrs). This research is focusing on discussing general aspects of professional ethical practice and how nurses' address it in workplaces'. Please be reminded that this research is not seeking details of particular cases. If you agree to take part, I will interview you at your workplace or any preferred location.

WHAT IS INVOLVED?
I will ask you questions about ethical challenges among nurses in their workplace, during patient care and the impact of these challenges on decision making for patient care and nursing profession. The interview will take 30 – 40minutes. I will audio record the interview with your permission and write it up later. You can choose not to answer any question or stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any time before 28th of October.

WHAT ARE THE BENEFITS OF PARTICIPATING?
You will be contributing to help understand how to address and make ethical decisions in patient care, inform nursing policy, nursing education, quality assurance and also improve quality of patient care and organizational culture.

If you decide to participate, please let the Principal Investigator know (refer to contact information provided). Thank you as well for considering this request if you decide not to participate.

Have a pleasant day and God bless.

CONTACT INFORMATION—to ask questions, please contact;

Principal Researcher
Name: Alovale Sa'u
PhD Candidate - Victoria University of Wellington
University email address: alovale.sa'u@vuw.ac.nz
[redacted]

Supervisor:
Name: Dr Martin Woods
Role: Primary Supervisor
School: Graduate School of Nursing, Midwifery and Health.
[redacted]

Name: Dr Ausaga Faasalele Tanuvasa
Role: Secondary Supervisor
School: Graduate School of Nursing, Midwifery and Health.
[redacted]

GRADUATE SCHOOL OF NURSING, MIDWIFERY & HEALTH | TE KURA TAPUHI HAUORA
FACULTY OF HEALTH | TE WĀHANGA TĀTAI HAUORA
VICTORIA UNIVERSITY OF WELLINGTON, PO Box 7625, Newtown, Wellington 6242, New Zealand
Phone + [redacted]
Website www.victoria.ac.nz/health

Appendix 8: Research Flyer in Samoan

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

FAAMATALAGA O FESOOTAIGA - a i ai ni fesili faamolemole faafesootai mai;

Igoa: **Alovale Sa'u**
Univesite - Victoria University of Wellington, NZ
Aoga: Graduate School of Nursing, Midwifery and Health.
[redacted]

Faufautua ole Sailiiliga:
Suafa: **Dr Martin Woods**
Matafaioi: Primary Supervisor
Aoga: Graduate School of Nursing, Midwifery and Health.
[redacted]

Suafa: **Dr Ausaga Faasalele Tanuvasa**
Matafaioi: Secondary Supervisor
Aoga: Graduate School of Nursing, Midwifery and Health.
[redacted]

GRADUATE SCHOOL OF NURSING, MIDWIFERY & HEALTH | TE KURA TAPUHI HAUORA
FACULTY OF HEALTH | TE WĀHANGA TĀTAI HAUORA
VICTORIA UNIVERSITY OF WELLINGTON, PO Box 7625, Newtown, Wellington 6242, New Zealand
Phone [redacted]
Website www.victoria.ac.nz/health

Lu'itau o Aga Tausili ma Talafeagai i Falefaigaluega, Tausiga ma Fa'ai'uga Fai a Tausi Soifua o Samoa

O le fa'atinoga o 'au'aunaga talafeagai e ono avea ma fa'afitāuli i le 'au'aunaga fa'a-tausi-soifua i Samoa ona o le lē a'ua'u o mea faigaluega e fa'atino ai le galuega, malosi o le aganu'u ma talitonuga fa'akerisiano ae maise o le 'uti'uti o le 'aufaigaluega (tausi-soifua).
Ae fa'apito se manatu i ta'iala ma alāfua fa'atu'atitia, konesepi fa'atausi-soifua ma alāfua o amioga talafeagai mai atunu'u i fafo o lo'o a'oa'oina i a'oa'oga fa'a-tausi-soifua e ono avea ma lu'itau i lona fa'aaogaina i le 'au'aunaga ona o le lē o gatasi ma tu ma aga fa'a-Samoa. O lona uiga, po'o le a lava le tomai ma le silafia e le tausi soifua o ta'iala o amio ma aga talafeagai (pulea) e tatau ona fa'atino, ae e i ai lava lu'itau e tuomia ma tāofiofi ai le tausi-soifua mai le fa'atinoina o le amiotonu ma le fa'amaoni o le 'au'aunaga. Ae peita'i, o le tele o lu'itau e o gatasi lava ma nisi o tulaga e lē gafatia ai e le tausi-soifua ona atoatoa le fa'afoeina o lana 'au'aunaga.

O LE A LE AUTU O LENEI SAILIILIGA;

O le 'auga o lenei sa'ili'iliga ina ia su'esu'eina le silafia, talitonuga ma finagalo o tausi-soifua i le latou fa'auigaina o lu'itau o amioga ma aga talafegai i totonu o Samoa; i nofoaga o lo'o galulue ai, o le tausiga o le soifua maloloina o tagata, ae maise o le a'afiaga o nei lu'itau i le fa'atinoga o le 'au'aunaga fa'a-tausisoifua. O le sini ma le fa'amoemoe o lenei su'esu'ega, o le faufauina ma le tu'ufa'atasia o finagalo ma silafia o le saofa'iga fa'a-tausi-soifua i lu'itau o amioga pulea ma talafeagai ma fa'afitauli o fa'ai'uga fai i le fa'atinoga o le galuega.

O AI E AUAI?

Ona o le amana'ia tele o lou sao taūa i le atina'eina ma le si'itia o le tulaga o lenei 'au'aunaga taua, ua talosagaina ai le lagolago a nisi o sui o tausi-soifua o lo'o galulue i totonu o falema'i o Tupua Tamasese Mea'ole (TTM), Malietoa Tanumafili II (MTII) fa'apea ma Falema'i Fa'a-Itumalo i Upolu ma Savai'i. E mana'omia tausi-soifua sinia ua lima tausaga ma luga atu tausaga o le 'au'aunaga, ma tausi-soifua ua lua tausaga o le 'au'aunaga. E fa'ailoa atu ma le fa'aaloalo tele, o le a lē fa'apito le su'esu'ega i se vaega o le 'aua'unaga, 'ae o le a fa'amoemoe i lou finagalo malie e te 'auai ai i lenei taumafaiga. E talosaga atu fo'i, fa'amolemole, i lou finagalo malie o le a mafai ai ona e fa'ailoa mai lou taimi avanoa ma le nofoaga e te finagalo e fa'atino ai le fa'atalatalanoaga ma lau susuga.

E FAAFEFEA ONA E FESOASOANI?

E i ai fesili o le a fesiligia ai sou taofi e fa'atatau i le matāupu ua uma ona fa'ailoa atu. O le fa'atalatalanoaga o le a lē noatia se finagalo e fa'atatau lava i a'afiaga po'o lu'itau o amioga ma aga talafeagai o lo'o feagai ai ma le 'au'aunaga fa'a-tausi-soifua i totonu o falema'i. E talosaga atu fo'i ma le agaga maulalo i sou finagalo malie ona e mana'omia le pu'eina o fa'atalatalanoaga mo le 30 minute i le itula. E ia te 'oe fo'i le faitalia e fa'aauau ai pe taofia fo'i le ta talanoaga ae maise fo'i o le toe tu'u'eseina o ni manatu ma lagona fa'aalia mai le talanoaga. Ou te talosaga atu fa'amolemole ia fa'ailoa mai lou finagalo fia 'auai a'o le'i aulia le aso Faraile, 26 Oketopa, 2018.

O LOU SAO PE A E AUAI?

O lou 'auai i lenei su'esu'ega o le a fesoasoani i le fausia o ni auala e fo'ia ai fa'afitauli i amioga ma aga talafeagai i le fa'atinoga o le tausiga, iloiloina o faiga fa'avae fa'a-tausi-soifua ma le tapenaina ai o ni 'auala e fa'aleleia ai le 'au'aunaga fa'a-tausi-soifua, fa'apea fo'i tu ma aga i le lotoifale fa'a-tausi-soifua.

E talia ma le loto fa'afetai lou taliaina o le fa'atala'u'ula atu, ae ta'atia atu pea i lau aia tatau e te filifili ai sa'oloto lou finagalo pe e te fia auai pe leai i lenei taumafaiga.

Fa'amanuia le Atua i lā outou 'au'aunaga taūa mo si o tatou atunu'u pele o Samoa.

Appendix 9: Semi-structured interview guide (English and Samoan)

Ethical Challenges: Workplace, Patient Care and Decision-Making among Samoan Nurses

INTERVIEW GUIDING QUESTIONS

Na o le fia faamanatu atu ae lei amata le ta faatalatalanoaga, e sefulu fesili o lenei faatalatalanoaga ae e ono fai atu fesili ese mai I fesili ua atofaina mo lenei faatalatalanoaga e faalauteleina ai se faamatalaga ua aumai ina ia maua tonu le uiga o faamatalaga ua tuuina mai.

1. Can you tell me about your understanding of nursing ethics and its relevance to nursing practice?

   O le a sou talitonuga ma sou finagalo I le faauigaina o ethics (aga talafeagai) ma lona faatauaina I le auaunaga faatausi Soifua. (ethics – taiala mo amio pulea)

2. Can you tell me about your experience in the use of nursing ethics in your everyday nursing practice?

   E mafai ona e faamatalaina lou faaaogaina o taiala o amioga taupulea I le faatinoga o lau auaunaga faatausi Soifua I aso uma?

3. What sorts of things do you understand to be ethical challenges?

   O le a sou silafia, o a ni luitau (challenges) e afua mai I le faaaogaina o ou tomai ma agavaa e faavae I luga o nei taiala e faatonutonu ai amio pulea (ethics)

4. Can you tell me about some of the common ethical challenges that arise in your workplaces?

   O a ni luitau o aga taualoa ma aga tausili e faavae I luga o taiala e faatonutonu ai amio pulea (ethics) sa aliae mai ao faatino lau galuega faatausi-soifua?

5. What sorts of impact do these challenges have on your decision making around;

   a. Nursing practice?

   b. Patient care?

   c. Nursing as your profession?

(What would you do) (How would you feel)

O a ni aafiaga o nei luitau I sau silasila ma sou finagalo I le

a. Aoaoga (Faataitaiga o le tausiga) faatausi Soifua? Itu o aoaoga (Education)

b. Tausiga? Tausiga o Soifua (Practice)

c. Galuega Faatausi Soifua? Galuega Faapolofesa (Profession)

6. How do you as a nurse resolve and address ethical challenges within their workplaces – for example what works well and what is less successful?

   E faapefea ona e foia ma faailoa ia luitau I totonu o lou fale faigaluega? E mafai ona tuuina mai se faataitaiga, ae na faamalieina lea gaioiga/auala pe leai?

7. Are there any particular aspects that you commonly consider in your decision making? As an individual, what factors would you consider in making your ethical decision making? Think of yourself as in a total/whole environment.

   Pe a aafia oe I ni luitau faapenei, o a ni vaega e muamua taulai ai lou mafaufau pe a fai ou faaiuga fai I ni tulaga faapenei?

8. Is there anything about nursing in the fa'a Samoa way that creates particular ethical challenges?

   E I ai ni aafiaga o le aganuu faasamoa I le tausiga faatausi Soifua e aliae ai ni feteenaiga ma avea ai ma luitau I aga taualoa o le tausi Soifua?

9. Do you think there should be a mechanism in place to help (address) or support nurses who are affected with these kinds of challenges?

   What will it be?

   Do you think there should be ethical committee in place?

   Why is it important and what should be the roles-expectation?

   O a ni tulaga e tatau ona fuafua ma faataatia e lima taitaiina ai le soalaupuleina ma le foia o mataupu e aafia ai tausi Soifua I taiala o amio pulea (ethics)

10. Please add any other comments about ethical challenges in the workplace.

    E I ai ni faamataga faaopoopo I I tulaga o le luitau I aga taualoa I totonu o falefaigaluega

Appendix 10: Survey information and consent sheet

Ethical challenges: Workplace, Patient Care and Decision-Making among Samoan Nurses

SURVEY INFORMATION FOR RESPONDENTS

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

Who am I?

My name is *Alovale Sa'u* and I am a Doctoral student in *Graduate School of Nursing, Midwifery and Health* at Victoria University of Wellington. This research project is work towards my doctoral thesis.

What is the aim of the project?

This project *develops an understanding of the concept of ethical challenges and decision-making among nurses of patient care and nursing profession.* This research has been approved by the Victoria University of Wellington Human Ethics Committee *[#0000026006]* and Samoa Health Research and Ethics Committee.

How can you help?

You have been invited to participate because *this research focus at nurses who works at the main hospital of Tupua Tamasese Meaole (TTM), transfer hospital of Malietoa Tanumafili 2 (MT2) and district hospital of Upolu and Savaii*. If you agree to take part, you will complete a survey. The survey will ask you questions about *ethical challenges among nurses at their workplace, during patient care and the impact of these challenges to decision making to patient care and nursing profession*. The survey will take you *10 – 15 minutes* to complete.

What will happen to the information you give?

This research is anonymous. This means that nobody, including the researchers will be aware of your identity. By answering it, you are giving consent for us to use your responses in this research. Your answers will remain completely anonymous and unidentifiable. Once you submit the survey, it will be impossible to retract your answer. Please do not include any personal identifiable information in your responses.

What will the project produce?

The information from my research will be used in PhD dissertation and a brief report submission to the nursing council of Samoa, Ministry of Health, National Health Service and School of Nursing to inform nursing policy, nursing education, quality assurance and also improves quality patient care and organisational culture.

If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact either:

Student:

Name: Alovale Sa'u
(PhD Candidate)

University email address:
[redacted]

Telephone –
[redacted]

Supervisor:

Name: Dr Martin Woods
Role: Primary Supervisor
School: Graduate School of Nursing, Midwifery and Health
Phone: +[redacted]
[redacted]

Name: Dr Ausaga Faasalele Tanuvasa
Role: Secondary Supervisor
School: Graduate School of Nursing, Midwifery and Health.
Phone: [redacted]

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convenor: Dr Judith Loveridge. Email hec@vuw.ac.nz or telephone +64-4-463 6028.

Human Ethics Committee information in Samoa

If you have any concerns about the ethical conduct of the research you may contact the Chair of Health Ethics Committee in Samoa on ([redacted]

Appendix 11: Survey information and consent sheet in Samoa

Luitau o Aga Tausili: I falefaigaluega, faatinoina o le tausiga I so o se tafa ma faaiuga-fai I Saofaiga a Tausi-Soifua i Samoa.

ITULAU O FAAMATALAGA MO SUI AUAI O LE SUESUEGA.

E amana'ia tele lou sao ma lou silafia i lenei su'eus'ega. E moomia lou faitauina ia e malamalama i le auga o le sailiga a'o le'i faia sau faaiuga i le auai ma lou le auai. E tali sapaia ma faafetaia lou taliaina ae e malamalama fo'i se manatu pe a le auai sou finagalo i lenei galuega.

O ai lenei auauna?

O lou igoa o Alovale Sa'u, o loo ou aoga i le Univesete o Vitolia i Ueligitone i Niu Sila. O loo 'ou taumafai mo le faailoga o le FAAFOMA'I I LE TOFA MANINO I le aoga FAAUUINA O TAUSI SOIFUA, FAATOSAGA faapea le SOIFUA MALOLOINA, I LE Univesete o Vitolia I Ueligitone I Niu Sila. O lenei sailiiliga poo lenei su'esu'ega, o se vaega tele lea o lenei faailoga FAAFOMA'I I LE TOFA MANINO.

O le 'autu o le su'esu'ega/sailiiliga [poloketi]?

O le faufauina ma ati'ae le tamaoaiga o manatu ma silafia mai le Saofaiga Faa-tausiSoifua, ia auiliili ma su'esu'e ni faai'uga tatau, talafeagai ma tail gofie mai lu'itau ma faigata e alia'e mai talitonuga ma agatausili i Falefaigaluega, o faatinoga o le galuega faatausi-soifua aemaise le soifua maloloina o soo se tagata. Ua mafai ona faataunuu lenei galuega ona o le lagolago ma le faatagaga a le Komiti o Agafesoota'i a le Iunivesete o Vitolia, Ueligitone i Niu Sila #0000026006 faapea le Komiti of Agafesootai a le Matagaluega o le Soifua Maloloina.

E faafefea ona e fesoasoani?

Ona o le amanaia tele o lou sao ma le faaleleia o lenei auaunaga, o le faamoemoe ma auga o le sailiiliga, olea faatinoina i Tausi-Soifua oloo galulue i falema'i nei:

1 Tupua Tamasese Meaole; 2 Malietoa Tanumaili II; 3 Maota Gasegase Faa-Itumalo i Upolu ma Savaii

O lou maliega I lou auai I lenei sailiiliga, e ala I le faatumuina o lenei pepa fesili. O lenei pepa fesili e na o le 10 – 15-minute (pe sili atu foi) e te faatumuina ai. O le faatumuina o lenei pepa fesili, o le a le noatia se finagalo e faatatau lava i aafiaga poo luitau oloo feagai pea ma le tausiga poo galuega faa-tausi-soifua i totonu o falema'i a le tatou atunuu. E ia te oe fo'i le avanoa e te faailoa mai ai le faaaauauina o ni fesili poo le taofia pe tuuina ese fo'i o ni manatu mai lenei sailiiliga. Ae fia faailoa atu fo'i, afai ua e le fia auai i le sailiiliga, faamolemole ia faailoa mai.

O le malu puipuia o faamaumauga e tuuina mai.

O lenei sailiiliga e malu puipuia uma faamaumauga. O faamatalaga uma o lenei sailiiliga o le a le fa'aigoina. O le uiga o lea faamatalaga, e leai se tasi, e oo foi I le tagata o loo faatinoa le sailiiliga ona iloa lou faasinomaga. O lou taliina o fesili o lenei suesuega, o lou tuuina mai foi lea o le faatanaga e faaaogaina ai faamatalaga ua e tuuing mai. Ae o au tali o le a le fa'aigoaina pe faailoa foi. O le taimi lava e tuuina mai ai lenei suesuega o le a le toe maua se avanoa e toe sui ai au tali. Faamolemole, aua nei tuua ni faamatalaga e faatatau I te oe I tali o le a e tuuina mai.

O le a le faamoemoe e maua mai I lenei sailiiliga?

O faamatalaga mai lenei sailiiliga o le a faaaogaina mo le faamoemoe o le faailoga o le Faafomai o le Tofamanino ae le gata I lea, o le a tuufaatasia ai se lipoti puupuu mo le faalapotopotoga o tausisoifua I Samoa. E iai fo'i se lagona e fia faaaoga le lipoti aua le faaleleia o auaunaga ma Fuafuaga aemaise ia siitia tulaga tau aoaoga faaletausi soifua, O le isi fo'i itu taua, ia taualoa ma amanaia le auaunaga faatausi-soifua i ana faalapotopotoga ma soo se vaega aemaise atunuu i fafo. A'o le itu maualuga, ia nanea ma maualuga se tausiga o le soifua maloloina o tagata uma o Samoa, aua se agai I luma o tausiga ma agaifanua o faalapotopotoga.

A I ai ni fesili, o ai e faafesootai?

A I ai ni fesili, I le taimi nei po o le lumanai foi, faamolemole faafesootai le auauna nei:

Tamaititi Aoga

Igoa: AlovaleSa'u

Imeli o le Univesite: alovale.sa'u@vuw.ac.nz

[redacted]

Faufautua o le sailiiliga

Suafa: Dr Martin Woods
Tulaga: Faufautua Autu
Aoga: Graduate School of Nursing, Midwifery and Health.
Telefoni: [redacted]
martin.woods@vuw.ac.nz

Suafa: Dr Ausaga Faasalele Tanuvasa
Aoga: Faculty of Health.
Telefoni: [redacted]

Faamatalaga mo Human Ethics Committee

Niusila - A I ai ni popolega i ni aga o le o tautaia le sailiiliga, faafesootai le Kovana o le HEC o le Univesite o Vitolia; Dr Judith Loveridge, Email hec@vuw.ac.nz po o le telefoni +[redacted]

Samoa - A I ai ni popolega i ni aga o le o tautaia le sailiiliga, faafesootai le Kovana o le HEC o le Matagaluega a le Soifua Maloloina ([redacted]

Appendix 12: Survey Questionnaire Instrument

GRADUATE SCHOOL OF NURSING, MIDWIFERY & HEALTH | TE KURA TAPUHI HAUORA
FACULTY OF HEALTH | TE WĀHANGA TĀTAI HAUORA
VICTORIA UNIVERSITY OF WELLINGTON, PO Box 7625, Newtown, Wellington 6242, New Zealand
Phone +
Website www.victoria.ac.nz/health

ETHICAL CHALLENGES SURVEY AMONG SAMOAN REGISTERED AND ENROLLED NURSES

[What are Samoan nurse's perspectives of ethical challenges within their workplaces and how do these perspectives affect their decision-making about patient care and their profession?]

The application of good practice can be problematic in the reality of nursing in Samoa due to limited resources, cultural and religious values and shortages of nursing staff. Western ethical standards, nursing theories and a code of ethics that are taught in nursing education and training in Samoa can be challenging when the application is not align with cultural values and practice of Samoa. This means that even though nurses understand what to do, there are constraints that hold nurses back from doing the right thing, and most of the constraints are more than likely associated with factors outside of the nurse's control.

Results from the primary data collection (interviews) generates this survey, that enable an exploration of the perceptions of the greater population of nurses about ethical challenges in Samoa. This survey has been approved by the Victoria Human Ethics Committee and it is completely anonymous. It should only take 10 – 15minutes of your time to complete and please do not include any personal identifiable information in your responses.

Please, there are 3 Parts of this survey to complete. In Part 1, it requires you to tick an answer from Demographic information, Part 2 are Professional Variable questions to complete according to instructions provided and Part 3 of the survey needs you to indicate on the scale of 1 – 6 your experience of ethical Challenges in practice and how often it occurs as in Frequency column. Humbly encourage you to please read instructions well at each parts of the survey.

ETHICAL CHALLENGES SURVEY AMONG SAMOAN REGISTERED AND ENROLLED NURSES

DEMOGRAPHIC DATA

(Part 1 - Please tick one only)

GENDER – ☐ Female ☐ Male

AGE - ☐ 20 or under __ ☐ 21 – 30___
☐ 31 – 40___ ☐ 41 – 50___
☐ 51 – 60___ ☐ 61+ ____

DISTRICT - ☐ U-Urban Area ☐ U-Rural Area
☐ S- Rural Area ☐ S-Urban Area

RELIGION – ☐Congregation Christian Church of Samoa ☐Methodist
☐ Catholic. ☐Anglican Church.
☐Assembly of God ☐Latter Day Saints
☐Seventh Day Adventist ☐OTHERS _____

EDUCATION - ☐Certificate in Nursing ☐Diploma in Nursing
☐ Bachelor in Nursing ☐Postgrad in Nursing (Specialty)_____
☐Master's in Nursing ☐Doctorate in Nursing

POSITION - ☐Enrol Nurse ☐Registered Nurse

DIVISION - ☐Maternity ☐Paediatric
☐Medical ☐Surgical
☐Emergency ☐Mental Health
☐Eye Unit ☐Private
☐Outpatient (PHC) ☐Education
☐Community _____
☐OTHERS _____

YEARS OF SERVICE AS A NURSE - ☐< 3 ☐3 – 5 ☐ 6 – 10
☐ 11 – 15 ☐16 – 20 ☐ 21 – 25
☐ 26 – 30 ☐31 – 35 ☐36 +

Part 2 – *Please read the instructions for each question.* ***Please note that question 3 and 4 of Professional Variables has two instructions (labelled as A and B).***

PROFESSIONAL VARIABLES

1.What is your understanding of Nursing ethics? ***(Please write a one-line answer)***

_____
___

_____
___

2. Where did you learn about Ethics or Nursing ethics? ***(Please tick as many as apply)***

☐ Religious Education ☐ College ☐School of Nursing
☐ Continuing or postgraduate education

3. What factors have shaped your ethical knowledge? ***(A. Please tick any three. B. Number the three most important from 1 – 3 beside the box)***

☐Patient ☐Family ☐Religion ☐Education ☐Culture
☐Media ☐Work experience ☐Life Experience (other than work)

4. What resources that is available to support/help you with your decision making in your profession? ***(A. Please tick as many as apply. B. Number the three most important resources you consider from 1 – 3 beside the box)***

☐Patients' life	☐ Cultural values and beliefs	☐ Religious Belief
☐Self-Values and Belief	☐Nursing Oath	☐ Nursing Protocols
☐ Code of Ethics	☐ Nursing Standards/Competencies	☐Health Assessment
☐Time/distance		☐Resources

(Please tick one answer only)

5. Are you aware of the Nursing standards and Competencies for the nursing profession?
☐ Yes ☐No

6. Have you received any advice and/or counselling regarding an Ethical issue?
☐Yes ☐No **If yes, what is the nature of the issue?**

_____
_____
_____
_____

7. Should there be an Ethical Committee in nursing you can go to for advice?
☐Yes ☐ No **If yes, Why?**

Part 3 *– Consider your experience as a nurse in your workplace. Please read situation statements well and place a tick on the scale of 1 to 6 under "**ETHICAL CHALLENGES**" to indicate the extent you agree or disagree that this is an ethical challenge and "**FREQUENCY**" (how often it occurs) in practice.*

	SITUATIONS	ETHICAL CHALLENGES						FREQUENCY					
		Disagree			Agree			Never			Often		
		1	2	3	4	5	6	1	2	3	4	5	6
	Note – 1 - Slightly disagree, 2 – Disagree, 3 – Strongly Disagree, 4 – Slightly Agree, 5 – Agree, 6 – Strongly Agree,							1 – Never, 2 – Rarely, 3 –Sometimes, 4 – Often, 5 – Most of the time, 6 – All the time					
1	Cultural values and practice are important in nursing care and service												
2	There is a dilemma between cultural practice (language and setting) and nursing care/practice.												
3	Encountering cultural pressure (faia, status, honour) while performing nursing care and service.												
4	Following family members request to seek traditional healers rather than hospital treatments												
5	Observe without taking action when a nurse colleague allows family members perform nursing actions e.g. medications.												
6	Carry out the doctor's order via phone (District Hospital Referral System via phone) that I am not confident to give.												
7	Having **NO** doctor at District Hospitals (24/7). So, nurses perform patient consultation and treatments.												
8	Carrying out treatment with limited resources that compromise nursing care and quality service												
9	Provide better care for those who can afford than those who cannot.												
10	What is taught in classroom is not the same as what is practiced in hospital setting.												
11	Avoiding taking actions when I learn that a nurse colleague has made a medication error.												
12	Working with nurses who are not doing, not considering the need to do treatments at exact time.												
13	Performing ordered procedures beyond scope of practice or Job Description.												
14	Unable to maintain patient confidentiality due to patient's allocation.												

	SITUATIONS	ETHICAL CHALLENGES						FREQUENCY					
		Disagree			Agree			Never			Often		
		1	2	3	4	5	6	1	2	3	4	5	6
	Note – 1 - Slightly disagree, 2 – Disagree, 3 – Strongly Disagree, 4 – Slightly Agree, 5 – Agree, 6 – Strongly Agree,							1 – Never, 2 – Rarely, 3 – Sometimes, 4 – Often, 5 – Most of the time, 6 – All the time					
15	Attitude towards nursing care and work affects the standard of care and conduct.												
16	Decision making is affected by culture sensitivity.												
17	Saving patient's life is more important than caring about myself as a nurse.												
18	I feel safe to use nursing protocols.												
19	Feeling tired, feeling oppressed and burned out impacted on performance and decision making.												
20	I care more about personal values than nursing ethics.												
21	Do nothing at all. There is no point of saying the same things over and over.												
22	Talk/share dilemma/challenge to a colleague												
23	Discuss challenges during staff meeting.												
24	Report directly to the Nurse Manager or Nurse Consultant of your workplace												
25	Report to Director of Nursing or authorised people.												

FURTHER COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

THANK YOU, *FOR COMPLETING THIS SURVEY. WE APPRECIATE YOUR FEEDBACK. PLEASE PLACE THE COMPLETED COPY IN THE ALLOCATED COLLECTION BOX ON THE DESK IN THE CLINICAL CONFERENCE ROOM. HAVE A LOVELY DAY.* ***GOD BLESS.***

Appendix 13: Survey Questionnaire in Samoa

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Website www.victoria.ac.nz/health

SAILIILIGA O AGA TALAFEAGAI/TAUSILI O TAUSI SOIFUA RESITALAINA MA TAUSI SOIFUA FAAMAUINA I SAMOA

[O a ni silafia, talitonuga ma finagalo o Tausi-soifua o Samoa I luitau o amioga ma aga talafeagi I totonu o Samoa, I nofoaga o lo'o galulue ai, o le tausiga o le soifua maloloina o tagata aemaise le aafiaga o nei luitau I faaiuga fai I le faatinoga o le auaunaga fa'a-tausi-soifua?]

O le fa'atinoga o 'au'aunaga talafeagai e ono avea ma fa'afitāuli i le 'au'aunaga fa'a-tausi-soifua i Samoa ona o le lē a'ua'u o mea faigaluega e fa'atino ai le galuega, malosi o le aganu'u ma talitonuga fa'akerisiano ae maise o le 'uti'uti o le 'aufaigaluega (tausi-soifua). Ae fa'apito se manatu i ta'iala ma alāfua fa'ata'atitia, konesepi fa'atausisoifua ma alāfua o amioga talafeagai mai atunu'u i fafo o lo'o a'oa'oina i a'oa'oga fa'a-tausi-soifua e ono avea ma lu'itau i lona fa'aaogaina i le 'au'aunaga ona o le lē o gatasi ma tu ma aga fa'a-Samoa. O lona uiga, po'o le a lava le tomai ma le silafia e le tausi soifua o ta'iala o amio ma aga talafeagai (pulea) e tatau ona fa'atino, ae e i ai lava lu'itau e taomia ma tāofiofi ai le tausi-soifua mai le fa'atinoina o le amiotonu ma le fa'amaoni o le 'au'aunaga. Ae peita'i, o le tele o lu'itau e o gatasi lava ma nisi o tulaga e lē gafatia ai e le tausi-soifua ona atoatoa le fa'afoeina o lana 'au'aunaga.

O aotelega o le tuufatasiaina o faatalatalanoaga I le vaega muamua o lenei galuega o loo fausia mai ai lenei itulau o sailiiliga mo le vaega lua o lenei poloketi. O le sini ma le faamoemoe o lenei itulau o sailiiliga o le aoina mai lea o finagalo ma silafia o le saofa'iga fa'a-tausi-soifua o Samoa atoa i lu'itau o amioga pulea ma talafeagai ma fa'afitauli o fa'ai'uga fai i le fa'atinoga o le galuega. O lenei itulau o sailiiliga e malu puipuia uma faamaumauga, ma ua faatagaina mai e le Komiti o Agafesoota'i a le Iunivesete o Vitolia, Ueligitone i Niu Sila (#0000026006) faapea le Komiti o Agafesoota'I a le Matagaluega o le Soifua Maloloina I Samoa. E I ai le manatu na o le 10 – 15 minute e te faatumuina ai lenei sailiiliga ma e fautuaina ma le aga faaaloalo, faamolemole e aua nei faaaogaina ni vaega po faamatalaga foi e ona faailoaina ai se tagata I lau tali po o lou manatu foi.

Faamolemole, e tolu vaega o lenei itulau o sailiiliga e manaomia ona e faatumuina. Vaega 1, e manaomia ai lou tuuina ai o le faailoga sao (√) I le pusa e tasi I le vaega o faamatalaga faafuainumera o tagata lautele. O Aga faapolofesa, o loo I le Vaega 2, faamolemoe faatumu agai I faatonuga o loo tuuina atu ai I fesili taitasi o lea vaega. Ma le vaega 3, o loo faatalauula atu ai, e faailoa mai I le fua mai le 1 I le 6 lou iloa ma le tomai foi I luitau o feagai ai (Ethical Challenges) I fale faigaluega ae faafia foi ona tupu (Frequency Column) ao feagai ai oe ma auaunaga. Tatalo atu ma le agaga maualolo, faamolemole, faitau lelei ifo faatonuga I vaega taitasi o lenei itulau o sailiiliga.

SAILIILIGA O AGA TALAFEAGAI/TAUSILI O TAUSI SOIFUA FAAMAUINA MA TAUSI SOIFUA FAAMAUINA I SAMOA

FAAMATALAGA FAAFUAINUMERA O TAGATA LAUTELE

(VAEGA 1 – Faamolemole tuu le faailoga sa'o (√) I le pusa e tasi).

ITUPA – ☐TAMAITAI ☐ ALII

TAUSAGA - ☐ <20__ ☐ 21 – 30___
☐ 31 – 40___ ☐ 41 – 50___
☐ 51 – 60___ ☐ 61+ ____

ITUMALO - ☐ U-Nuu tulata I le taulaga ☐ S- Nuu tulata I le taulaga
☐ U- Nuu I tua ma le taulaga ☐ S- Nuu I tua ma le taulaga

EKALESIA – ☐Ekalesia Faalapotopotoga Kerisiano, Samoa ☐Ekalesia Metotisi
☐ Ekalesia Katoliko ☐Anglican Church.
☐Assembly of God ☐Ekalesia o Aso e Gata ai (Mamona
☐Ekalesia Aso Fitu ☐Ma isi _____

TULAGA O AOAOGA - ☐Tusipasi muamua o le faatausi soifua
☐Tusipasu Faatipiloma o le Faatausi Sifua
☐ Tusipasi Faatikeri o le faatausi Soifua
☐Postgrad in Nursing (Specialty)_____
☐Master's in Nursing
☐Doctorate in Nursing (PHD)

TULAGA I LE GALUEGA - ☐Tausi Soifua Faamauina (EN) ☐Tausi Soifua Resitalaina (RN

VAEGA O LOO E FAIGALUEGA AI - ☐Itu o Mai Taga ☐ Itu o Tamaiti
☐Itu o gasegase Pipisi ☐ Itu o gasegase taooto
☐Itu o Faalavelave Faafuasei ☐Itu o Gasegase o le mafaufa
☐Itu o Fofoga ☐ Vaega Tutoatasi
☐Itu o gasegase Tausavali (PHC) ☐Itu o Aoaoga Faatausi Soifu
☐Itu o le soifua maloloina o alalafaga _____
☐Ma isi _____

TAUSAGA O LE AUAUNAGA FAATAUSI SOIFUA - ☐< 3 ☐3 – 5 ☐ 6 – 10
☐ 11 – 15 ☐16 – 20 ☐ 21 – 25
☐ 26 – 30 ☐31 – 35 ☐36 +

Vaega 2 *– Faamolemole faitau lelei faatonuga mo fesili taitasi.* ***Faamolemole, o le fesili 3 ma le 4 o lenei vaega (Professional Variables), e lua ona faatonuga (faailogaina o le A ma E).***

O AGA FAAPOLOFESA (PROFESSIONAL VARIABLES)

1. O le a lou malamalamaga I le faauigaing o Aga Talafeagai faatausi Soifua (Nursing Ethics)? *(Faamolemole tusi lau tali I le fuaiupu e tasi)*

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2. O fea na e mauaina mai ai aoaoga tau Aga Tausili/Talafeagai? (Ethics or Nursing ethics) *(Faamolemole, tuu le faailoga sao (√) uma I tali e talafeagi).*

☐ Aoaoga Faalelotu ☐ Aoaoga I Kolisi Maualuluga ☐Aoga Faatausi Soifua
☐ Aoaoga Faaauau or postgraduate education

3. O a ni tulaga/vaega o loo fausia ai lou tomai/iloa I Aga Tausili/Talafeagai? What factors have shaped your ethical knowledge? ***(A). faamolemole tuu le faailoga sao (√) I ni tali se tolu. (E). Faanumera mai le taua o lau filifiliga/tali mai le 1 I le 3 I autafa o le upu po o le pusa foi)***

☐Gasegase ☐Aiga ☐Ekalesia/Talitonuga ☐Aoaoga ☐Aganuu
☐Ala o Faasalalauga ☐Tomai mai I Galuega (Work experience)
☐Tomai mai le Olaga (ese mai le galuega) Life experience (other than work)

4. O a punaoa(resources) o loo I ai, e fesoasoani/lagolago I a te oe I au faaiuga fai I lau galuega? ***(A) Faamolemole tuu le faailoga sao (√) I ni tali se tolu. (E). Faanumera mai le taua o lau filifiliga/tali mai le 1 I le 3 I autafa o le upu po o le pusa foi***

☐Soifua o le gasegase ☐ Tu ma Aga Faaleaganuu ☐ Talitonuga Falelotu
☐Talitonuga ma le faataua faaletagata ☐Tautoga o le Tausi Soifua ☐ Taiala Faaletausi Soifua
☐ Code of Ethics ☐ Nursing Standards/Competencies ☐Health Assessment
☐Taimi/Mamao ☐Meafaigaluega

(Faamolemole tuu le faailoga sa'o (√) I le tali e tasi)

5. O e silafia le taiala e faatonutonuina galuega ma tomai (Nursing standards and Competencies) mo le galuega Faatausi Soifua?

☐ Ioe ☐Leai

6. Na e mauaina se fautuaga ma/po o se counselling e faatatau i feeteenaiga o aga Talafeagai? (ethical issues?) Have you received any advice and/or counselling regarding an Ethical issue?

☐Ioe ☐Leai **Afai o le Ioe lau tali, o le a le natura o le faafitauli?**

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7. E tatau ea ona I ai se komiti o Amioga Talafeagai (Ethical Committee) I le totonu o le faatausi Soifua e mafai ona e alu I ai mo se fesoasoani/fautuaga?

Vaega 3 *– Mafaufau i le taimi ao faatino lau galuega faatausi soifua I lou fale faigaluega. Faamolemole, faitau lelei tulaga o faamatalaga ma tuu le faailoga sao* ***(√)*** *i le fua mai le 1 I le 6 I lalo o le* ***"LUITAU O AGA TAUSILI/TALAFEAGAI"*** *e faailoa mai ai le tulaga e te ioeina ai pe e te le ioeina ai o lenei o se luitau ma* ***"FAAFIA FOI ON TUPU"*** *(o le tele o taimi e tupu ai) I le galuega.*

	FAAMATALAGA	LUITAU O AGA TALAFEAGAI/TAUSILI						O LE TELE O TAIMI E TUPU AI					
		Le lagolagoina			Lagolagoina			E lei Tupu			Masani ona Tupu		
		1	2	3	4	5	6	1	2	3	4	5	6
1	Faatauaina o Aga ma Tu faaleaganuu, e taua I le tausiga ma le auaunaga faaletausi soifua.												
2	O loo I ai le faafitauli ile va o le aganuu (Gagana ma le Saofaiga) ma tausiga/galuega faatausi soifua.												
3	Fetaiai ma aafiaga (pressure) faaleaganuu (faia, tulaga, mamalu) a o faatinoina tausiga ma auaunaga faatausi soifua.												
4	Faataunuuina o talosaga a le aiga, e o I tua e saili fofo Samoa (taulasea) nai lo o togafitiga I le falemai.												
5	Matau e aunoa ma se galuega e faia pe a faatagaina e se tausi soifua se tagata o le aiga e faatinoina le galuega a le tausi soifua. Faataitaina o le tapeina o le I.V drip, tauaaoina o fualaau ma isi.												
6	O le faatinoina o se oka (order) a le fomai e ala I le telefoni (Referral System) ae ta te le o toa e tuuina atu.												
7	O le leai o se fomai I le 24 itula I le vaiaso (24/7). O lea la, o tausisoifua e faatinoina le vaaiga o mai ma togafitiga.												
8	Faataunuuina o togafitiga I le utiuti o mea faigaluega e faaaoga, aafia ai (compromise) faatinoina o le tausiga ma le lelei atoatoa o le auaunaga.												
9	Faatino pe ave ma le atoatoa le auaunaga I e gafatia le auaunaga nai lo I latou e le mafai.												
10	E le o, o gatusa mea o lo o aoaoina I potuaoga ma faatinoga/galuega o loo faatinoing I falemai (wards).												
11	Aloese mai le faatinoina o se galuega pe a o iloaina se tausi soifua ua ave seseina se vailaau pe faatino seseina se galuega.												
12	Galulue ma se tausi soifua e le faia, amanaia le taua o le faatinoina o togafitiga (treatments) I le taimi tonu.												
13	Faatinoina o galuega (ordered procedures) I tua atu o tulaga o galuega po o matafaioi po o faamatalaga o galuega.												
14	Le mafai lea ona tausisi I agatapuia (pts confidentiality) o gasegase pe a faatulaga gasegase.												

	FAAMATALAGA	LUITAU O AGA TALAFEAGAI/TAUSILI						O LE TELE O TAIMI E TUPU AI					
		Le lagolagoina			Lagolagoina			E lei Tupu			Masani ona Tupu		
		1	2	3	4	5	6	1	2	3	4	5	6
15	Uiga faaalia agai I le galuega ma auaunaga a le tausi soifua e aafia ai le tulaga o le tausiga ma amio.												
16	E aafia faaiuga fai o le tausi soifua I le maaleale o le aganuu.												
17	Laveaina o le ola o le gasegase e sili atu le taua nai lo o le laveaina o au le tausi soifua.												
18	Ou te lagonaina le saogalemu pe a faaaogaina (protocols) a tausi soifua.												
19	Lagona o le lelava, lagona sauaina ma le fiafaamaamulu e aafia tele ai le faatinoga ma faaiuga fai.												
20	E tele atu lou popole I uiga taua faaletagata lava ia nai lo aga talafeagai/amioga lelei o le faatausi soifua												
21	Leai se mea e faia. E leai se uiga o le fai atu pea I le mea e tasi ae leai se tali mai.												
22	Talatalanoa/faasoa atu faafitauli/luitau I se uo a faigaluega (tausi soifua)												
23	Talanoaina luitau I le taimi o fonotaga o le aufaigaluega.												
24	Lipoti sao I le taitai o tausi soifua (NM/CNC) o le itu (ward) lea e faigaluega ai												
25	Lipoti atu I le faatonu o le faatausi soifua po o se tagata ei luga atu (authorised) o le matagaluega.												

O ISI FAAMATALAGA TAUA.

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FAAFETAI TELE, *MO LE FAAMAEAINA O LENEI SAILIILIGA. MATOU TE TALISAPAIA OU MANATU FAAALIA. FAAMOLEMOLE TUU LE KOPI UA MAEA I LE PUSA O LO O I LUGA O LE KESI I LE POTU O FONOTAGA. MANUIA TELE LE ASO.* ***FAAFAMUTA LE ATUA.***