MONASH University

Developing and Evolving a Value System: A Grounded Theory

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Abstract

In the ever-changing, complex healthcare environment, nurses regularly encounter value-challenging situations that can undermine their personal and professional integrity. These situations can, potentially, have a profound personal and professional impact on nurses in relation to the delivery of quality of care and their practical agency. How nurses develop and evolve their value systems and maintain integrity is under-researched, leaving a gap in the literature. This study aimed to address this gap by providing a theoretical explanation of how nurses' value systems develop, evolve and shape their practical agency.

A constructivist grounded theory methodology was employed to collect multiple data, including focus group interviews, individual interviews, and anecdotal and reflective stories, to inform the construction of a theory that is grounded in the data. Nurses ($n = 54$) working in various clinical settings across Indonesia were recruited to participate.

The resulting theory, the Developing and Evolving a Value System (DEVS) theory, centres on the core, basic, social process of becoming a nurse and explores developing and evolving value systems of nurses prior to and during their professional nursing practice. The theory incorporates a foundational transition (Acquiring Values) and a series of three cyclic transitions (Internalising Values, Re-visioning Values, and Harmonising Values) that represent the cyclic nature of how values develop and evolve. It is informed by three emerging interrelated categories: Developing Values, Confronting Situations, and Re-adjusting Values. The first category, Developing Values, explores the basic social processes of attaining foundational values from family, professional values from nursing education, and organisational values from the healthcare organisation. These values are embraced, enacted and socialised in the workplace, and constitute the value system of nurses. The second category,

Confronting Situation, highlights how nurses, when faced with value-challenging situations, respond to manage the situations. Finally, the category Re-adjusting Values, elaborates the basic social processes by which nurses sustain their motivation and morale, which include revisiting and reconfiguring values, a key element of developing resilience. The outcomes of this category: harmonised values, inform nurses' practical agency. In addition, nurses' conceptions of values are shaped by contextual influences, including culture, workplace context, and personal circumstances, such as income security and employment status.

Different from current, mainstream understandings of the concept of value, processing values in nursing is not simply a black-or-white option or the ordering of values based on their importance. As described in the DEVS theory, it is a complex and dynamic process that continues throughout the nursing journey, demonstrating the evolving nature of values. This theory makes a significant contribution to the nursing literature.

A recommendation arising from the study is the need for the development of pedagogical strategies in early nursing education to enhance awareness of the evolvement of nurses' values. In addition, healthcare managers need to be more aware of nurses' values and how the workplace organisation impacts on the integrity of a nurse's value system, in order to create a supportive working environment for nurses.

Declaration

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

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Thesis Including Published Works Declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes one original paper published in peer reviewed journals. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, under the supervision of Associate Professor Jennifer Weller-Newton and Dr. Gulzar Malik.

In the case of Chapter 2, my contribution to the work involved the following:

Thesis Chapter	Publication Title	Status	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution*	Co-author(s), Monash student Y/N*
2	Nurses' Integrity and Coping Strategies: An Integrative Review	Published	70%. Concept and collecting data and writing first draft	Jennifer Weller-Newton, input into manuscript 20% Gulzar Malik, input into manuscript 10%	No

I have not renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Student name: Sastrawan

Student signature: Date: 16 December 2019

I hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author, I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor name: Jennifer Weller-Newton

Main Supervisor signature: Date: 17/12/2019

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Dedication

I dedicate this work to all the selfless nurses and midwives around the globe. Thank you for all the good things you have done to help others. You are humanity's heroes.

Glossary of Terms

Beliefs: Ideas, concepts, or interpretations that one accepts as true and are often based on faith.

BPJS: A social insurance agency which administers the Indonesian National Health Insurance.

Civil servant nurse (CSN): A government employee who works in public healthcare institutions, is guaranteed long-term employment and receives a monthly salary with additional remuneration and entitlements, such as incentives, service fees, pension, regular and annual leave.

Delegative task: Medical treatments that are passed to nurses to perform with full responsibility, both for the processes and their outcome.

Honorary nurse: A nurse who is recruited by the government under a work order statement. An honorary nurse usually receives less salary than a civil servant nurse and reduced renumeration and entitlements. In addition, the work order statement can be terminated by the recruiter.

Incentive: The fund awarded as an appreciation for nurses' services. 'Incentive' and 'reward' are used interchangeably by the study participants. For civil servant nurses, however, the terms 'incentive' does not include their regular salary. For the non-civil servant nurses, the term is used to describe all compensations for their service including salary.

Inner harmony: A state of being in peace and harmony, including feeling safe, joyful, and free from mental and/or emotional burden, and having acceptance of one's life.

Integrity: The term integrity is defined as the coherency of personal philosophy, values, attitudes (professional, moral, social and psychological) and actions that facilitate one to excel in life.

Mandate task: The medical treatment completed by a nurse under a doctor's supervision.

Non-permanent nurse: A nurse who is recruited by and works for the government but does not have a status of civil servant employee. Other terms used interchangeably are *PTT*, contract nurse, and honorary nurse.

Nurse density: The ratio of nurse-to-population that is calculated per 10,000 population.

Organisational values: A set of values that reflect an organisation's identity/vision or mission and are imposed by the organisation on its employees.

Personal values: A set of personal values, which includes both socio-cultural and/or religious values, that are unique to the person and used as the basis for his/her principles in navigating their personal and professional life.

Polindes: Village maternity clinic.

Poskesdes: Village health post, a combination of Pustu and Polindes.

Posyandu: An integrated service post that operates at a village level. It offers a community-based service facilitated by health professionals from a puskemas.

Practical agency: The expression of nurses' capacity to originate and direct their nursing practice based upon their free and/or informed personal-professional judgments.

Private nurse: A nurse who works for a private healthcare provider under a professional contract agreement. Depending upon their contract, they may or may not have the same entitlement as the civil servant nurse.

Professional values: A set of values that are specific to one's professional role.

PTT: A non-permanent employee, usually employed for three years and often extendable at the end of the term.

Puskemas: A primary health center (often referred to as a public health center) that provides service for the local community at a sub-district level. A number of health professionals work in *puskesmas*, including at least two medical doctors, a dentist, nurses, midwives, nutritionists, sanitarians, public health specialists, health analyst, and pharmacists.

Puskesmas perawatan: A public health center that provides in-patient services for a limited number of patients and performs simple to moderate medical/nursing tasks.

Pustu: An auxiliary *Puskesmas* that operates in a village level, providing very basic health service for the villagers. A *pustu* is usually staffed with a nurse.

Value activation: The process of surfacing values into cognitive awareness, in a formal (structured) and/or informal manner.

Values configuration: An abstract construct that describes how values are juxtaposed, perceived, weighed and measured in relation to other values.

Values socialisation: The process by which values are transferred from one person to another, in both a formal and informal manner.

Values structure: An abstract structure that accommodates all embraced values (i.e., a pool of values), making up one of the elements of a value system.

Values: Enduring beliefs or attitudes about the worth of a person, object, idea, and action, as well as philosophical standing. Values might be unspoken and, sometimes, are unconsciously held.

Abbreviations

BPJS   *Badan Pelaksana Jaminan Sosial* (Social insurance agency)

CoP   Community of Practice

CSNs   Civil Servant Nurses

DEVS   Developing and Evolving a Value System

GTM   Grounded Theory Methodology

Polindes   *Pondok Bersalin Desa* (Village Maternity Clinic)

Poskesdes   *Pos Kesehatan Desa* (Village Health Post)

Posyandu   *Pos Pelayanan Terpadu* (Integrated Service Post)

PPNI   Persatuan Perawat Nasional Indonesia (Indonesian National Nurse

                  Association)

PTT   *Pegawai Tidak Tetap* (Non-Permanent / Temporary Employee)

Puskesmas   *Pusat Kesehatan Masyarakat* (Primary Health Centre)

Pustu   *Puskemas Pembantu* (Auxiliary Public Health Centre)

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Chapter One: Setting the Stage

1.1 Introduction

This chapter provides insights into the background of the study and the genesis of interest in the topic, including the researcher's personal standpoints on how his personal-professional experiences inspired him to study the nursing world. In order to provide a context for this study, an overview of the Indonesian Health System, with a focus on the nursing workforce, is presented. A brief account of the study details, including the aim, the research questions and the study's significance, are also described. This chapter ends with a summary of the thesis structure.

1.2 "Shut the Door, Don't Let Her in!": The Impetus for the Study

The impetus for this study began with the researcher's personal encounter when he visited a friend who was hospitalised at a public hospital. He witnessed how the nurse in charge was treated disrespectfully by a young doctor, in front of the patient. The doctor was so angry that he indicated his intention to lock out the nurse while he was checking the patient in the ward. The more interesting and surprising aspect of this situation was the reaction of the patient's wife, who spontaneously sided with the nurse and opened the door for her. When, finally, the nurse stepped through the door, the researcher noticed that she was crying, yet she seemed to try to smile to the patient and his wife. In that moment, the researcher came to realise how tough a nursing workplace can be. Later, he found out that there were personal issues involved in the background. The issues appeared to involve integrity and personal values, which inspired and galvanised him into studying this topic. The heading of this section is taken

from the doctor's words during the incidence. The more detailed story is provided in Appendix 2.

The researcher comes from a health administration background with a keen interest in exploring the nursing milieu. The following section presents the genesis of his interest and his perspectives on this area.

1.3 The Genesis of Interest in Nurses' Personal Integrity

The researcher's interest in studying the nursing world began in 2006 when he conducted a qualitative study on nursing for a Master of Health Administration program at Curtin University in Western Australia. The study focused on exploring nurses' job satisfaction from nurses' and managers' perspectives and how these perspectives were shaped by the role nurses play within the system. He was aware that, without an adequate understanding of nursing issues and without an ability to see through the nurses' eyes, it is not possible for a health administrator to establish effective intervention programs. This Masters research inspired him to explore the gap and consider how to minimise the gap between management and practice. As a health administrator at the time, he was convinced that investing in improving the nursing environment was a justifiable investment, as nurses make up the major component of the workforce within the Indonesian National Health System.

After more than fifteen years of work experience in managing health policies and programs, in early 2014, he officially left his position with the local government and commenced a full-time academic/researcher career at an Institute of Health Sciences. With the new profession of nursing education, the focus of his research shifted from resource distribution and intervention in nursing care organisations and the health system to studying

how nurses strive to negotiate difficult situations within a less than ideal, unsupportive and stressful working environment, and how these conditions affect nurses' work ethos.

Figure 1 illustrates how the researcher's previous health administrator lens, combined with his existing role as an academic/researcher, influenced the way he viewed the nursing milieu and its issues, which inspired him to conduct this study.
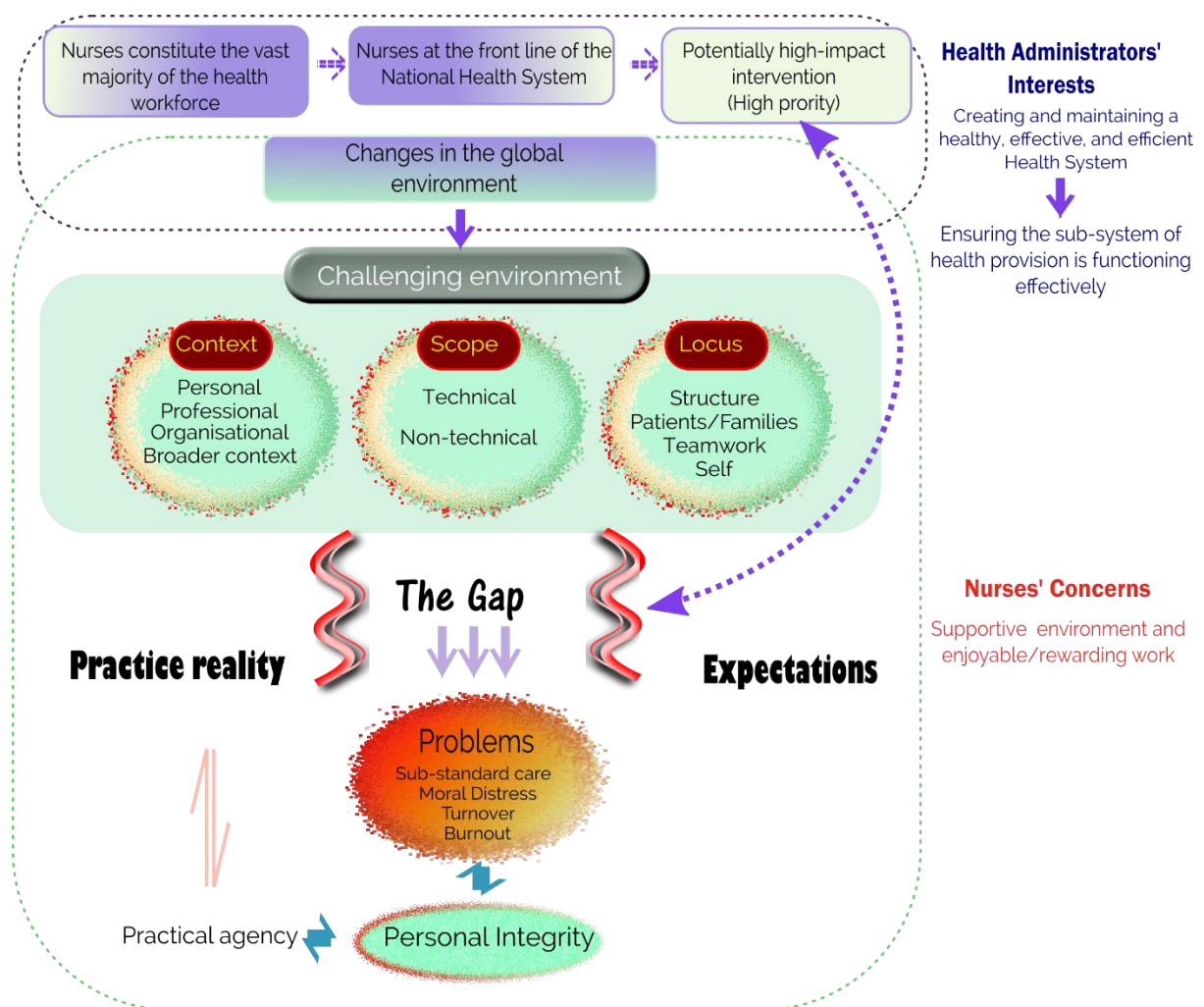
Figure 1: A perspective on the background of the study

The following sections elaborate the researcher's perspective as depicted in figure one. The structural, organisational, and personal-professional challenges along with contemporary nursing issues are presented. The needs for social skills are also highlighted and placed together within the context of the study.

1.4 Background

Nurses are the largest body of health professionals in the healthcare system in almost all countries in the world. In Indonesia, for example, 354,218 nurses and 217,726 midwives constitute almost 65 per cent of the health workforce (Pudatin Kemenkes RI, 2019). A similar figure can be found in Australia, where registered nurses outnumber other health professionals, with more than 360,000 registered nurses in 2016 nationwide (Australian Institute of Health and Welfare, 2018). Furthermore, the role that nurses and midwives play in the system is also very crucial. In Indonesia, for instance, nurses work in the community at multiple levels, from sub-villages and villages in a remote area through to institutions at the national level, such as the national referral hospital centres. The combination of large numbers and their substantive roles make nurses and midwives one of the most essential entities in the National Health System. From the perspective of a health administrator, nurses are, perhaps, the most important priority personnel to whom intervention programs are directed. The domination of nurses in the healthcare professional workforce is also a legitimate justification for placing nurses and nursing program among the top-priority intervention. Investing in nurses could be a high-impact intervention that potentially improves the overall health system performance.

Changes in the global environment, such as the changes in demographic patterns, disease patterns, technological advancement, lifestyle and many other advances, have also changed patients' expectations of nursing care. Yet, the limitations in resources often prevents nurses from satisfying their own and their patients' expectations, particularly when they find it

difficult to provide care that meets professional standards. In many situations, patients have their own expectations (Sibbern et al., 2017) which are grounded in a self-definition of what constitutes satisfactory service (Wensley, Botti, McKillop, & Merry, 2017). In this situation, the challenge is in the assessment of the quality of care, which is often evaluated through subjective parameters, such as the level of patient satisfaction (Iqbal & Li, 2017; Sun et al., 2017). Since patients' satisfaction is subjective and influenced by multiple factors, many of which are beyond nurses' control, satisfying patients' expectation becomes more arduous.

Furthermore, challenges could originate in many different loci, such as organisational structure (nursing facilities, hospital policy, management, resources), patients and families (characteristics, behaviour, expectations, values), teamwork (professional values and relationships, work culture), and even oneself (personal values and commitments). They can be technical or non-technical and situated in personal, professional and organisational areas and/or the broader context. Disharmony in either of these loci can be a significant problem for nurses.

The ubiquitous nature of the challenges in nursing makes the reality of nursing practice very dynamic and demanding (Scully, 2015; Tham & Gill, 2018) and entails various situations for nurses (Dossey, 2016), which adds to the complexity of nursing (Kitson, Muntlin Athlin, & Conroy, 2014) and, concomitantly, creates various problems for nurses.

The majority of the problems involve challenges to personal and professional boundaries, which make the situations very intricate and requires nurses to regularly re-contemplate their situations and circumstances (Erikson & Davies, 2017; Nathaniel, 2018), including dealing with moral principles (Johnstone, 2016). Nurses have been found to leave or intend to leave their profession, due to unmitigated moral situations in the workplace that are far beyond their control and acceptable limits (Ahanian, Mirzaei, & Fard, 2016). Given the

global shortage of nurses and the problem of nurses' retention and turnover (Moloney, Boxall, Parsons, & Cheung, 2018), understanding how nurses navigate their personal-professional boundaries and respond to workplace challenges, including how these challenges affect their personal integrity and practical agency, is needed.

The following sections provide more details on the contemporary challenges in nursing, including problems that are commonly encountered, and what might be needed to manage the situations. This information provides a clear justification for establishing this research. Whilst this study is conducted within the Indonesia context, the references presented in the following sections are drawn from the international nursing literature. This is due to limited research evidence on Indonesian nursing issues and challenges.

1.4.1 Structural, organisational, and personal-professional challenges in healthcare.

The structural and organisational influences are, perhaps, one of the most popular research areas in the discipline of health administration (Doran, Clarke, Hayes, & Nincic, 2014; Halcomb & Ashley, 2017). However, this literature commonly focusses on tangible elements, such as facilities, wages, workflow and scheduling, and among recommendations of the studies are the need for establishing a particular set of standard of procedures, supervision, providing better nursing facilities, and improving clinical competencies (Doran et al., 2014; Nantsupawat et al., 2017; Paliadelis, 2013). In addition, this research is often quite general in scope and framed through managerial interests. Regardless of the focus and perspective of the studies, they clearly indicate that challenges often originate at a structural and/or organisational level.

As health care services are provided by organisations that involve multiple stakeholders, the conflict of these stakeholders' interests cannot be avoided (Kitson et al., 2014; Wiechula et al., 2016). The interplay of multiple stakeholders adds to the complexity of realities

in nursing and poses even more challenges for nurses in the workplace. The interests of patients and family, the personal and professional concerns of nurses, the nursing profession's requirements, and the concerns of other team members, organisations, and the community are the factors that come into play and require thoughtful consideration in order to harmonise them (Wiechula et al., 2016). Failure to harmonise these interests could impose negative outcomes on nurses' wellbeing (Bagshaw et al., 2017).

Organisations, in many cases, are concerned with profits, hence, they tend to view nursing care from a cost-benefit perspective. As such, they are more concerned with the issue of efficiency in the workplace (Kitson et al., 2014), which can lead to moral distress resulting from involuntary depersonalisation of patients to meet institutional requirements (Cavaliere, Daly, Dowling, & Montgomery, 2010; Kitson et al., 2014; Matthews & Williamson, 2016). Often, organisations implement strict control over care cost and, at the same time, prompt nurses to increase patient throughput and lower the length of stay in hospitals (Emanuel, 2016), a policy that often does not support holistic nursing care and professional values. The domination of an organisation's policy and values often results in nurses encountering moral distress (Caram, Peter, & Brito, 2019). Indeed, evidence shows that organisational commitment can affect nursing outcomes (Timmers, Hulstaert, & Leenen, 2014).

Some other challenges in contemporary nursing are associated with the increase in workload due to staff shortages and possible team disharmony (Chitty & Black, 2011). The problem of work overload, for instance, has been reported as significant in nursing (Ceballos-Vasquez et al., 2015; Hewko, Brown, Fraser, Wong, & Cummings, 2015; Oliveira, Garcia, & Nogueira, 2016). Workload issues mainly relate to nurse-shortage leading to poor staffing, accentuated by cost-containment policy (Cavaliere et al., 2010; Tham & Gill, 2018). The increase in workload has been associated with low levels of job dissatisfaction. Evidence suggests that job dissatisfaction has been identified as a strong predictor for turnover intention

among nurses (Arslan Yurumezoglu & Kocaman, 2016). Tham and Gill (2018) reported that nurses complain about having more work than they can do in daily practice. This, coupled with poor appreciation for nurses' dedication, could influence the degree of nurses' engagement in the service, which eventually affects the quality of care (Prentice, Janvier, Gillam, & Davis, 2016) and potentially puts patient care and safety at risk (Tham & Gill, 2018).

In addition, there is a growing interest in holistic care, in which patient-centred care is emphasised. As such, nurses are required to undertake holistic, integral, and integrative nursing within health professional teams, to maximise nursing outcomes (Dossey, 2016). With patients' physical, psychological, and social integrity at the heart of nursing services, nurses are obliged to provide the best service and value-based, relationship-centred care (Helming, 2016; Van Sant & Patterson, 2013) with limited time and support. Many of these challenges can generate issues for nurses in the workplace, which are briefly explored in the next section.

1.4.2 Current issues in nursing.

In constantly dealing with difficult situations in the workplace, nurses are often negatively affected, both physically and psychologically (Nilsson, Rasmussen, & Edvardsson, 2016; Welsh, 2009). Burnout and moral distress are two intertwined conditions that are closely associated with various situations in the workplace. Factors that have been identified to cause burnout are patients' behaviour, horizontal violence in the workplace (Allen, Holland, & Reynolds, 2015; Lee, Bernstein, Lee, & Nokes, 2014; Myers et al., 2016), heavy workload and low job satisfaction (Nantsupawat et al., 2017). Nurse burnout has been known to be associated with disrupted teamwork and communication, which has the potential to pose a risk to patient safety (Karatza, Zyga, Tziaferi, & Prezerakos, 2016).

In addition, burnout has also been linked to nurses' feeling of safety in their workplace. Studies reveal that nurses experience physical and verbal attacks (Nilsson et al.,

2016; Pelissier et al., 2015; Zafar et al., 2013) and sexual harassment from their patients (Suhaila & Rampal, 2012), which can induce psychological problems in nurses (Brandford & Reed, 2016; Gao et al., 2012; Letvak, Ruhm, & McCoy, 2012; Oyeleye, Hanson, O'Connor, & Dunn, 2013). In addition, nurses working in psychiatric and geriatric care are identified to be more prone to physical attacks (Danivas et al., 2016).

Patients' negative behaviour, in association with other workplaces issues, often leads to nurses experiencing moral problems, psychological dissonance, and workforce turnover (Okwaraji & Aguwa, 2014; Valizadeh, Zamanzadeh, Dewar, Rahmani, & Ghafourifard, 2016; Wu, Singh-Carlson, Odell, Reynolds, & Su, 2016; Xiao et al., 2014; Yu, Jiang, & Shen, 2016). These moral problems can manifest in a variety of forms: moral uncertainty, moral dilemma, moral distress, moral outrage and, to some extent, moral hazard (Johnstone, 2016). A 2015 New Zealand study showed that moral distress in nursing is still a significant issue, causing 48 % of respondents to consider leaving their job (Woods, Rodgers, Towers, & La Grow, 2015). This result is consistent with a study by Cavaliere et al. (2010) and Trautmann, Epstein, Rovnyak, and Snyder (2015) who confirm the relationship between moral distress and intention to leave the nursing profession. Burnout has also been found to be associated with psychological and moral distress (Rushton, Batcheller, Schroeder, & Donohue, 2015; Wagner, 2015; Zou et al., 2016) which has been reported to affect up to 70% of nurses working in intensive care units (Van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015). Furthermore, unresolvable moral distress poses a threat to nurses' integrity (Woods et al., 2015).

Research has found that nurses describe their workplace as an environment where personal-professional integrity is harmed (Fischer Gronlund, Soderberg, Zingmark, Sandlund, & Dahlqvist, 2015; Nilsson et al., 2016), whereby they constantly experience adversity and various issues leading to moral distress (Wagner, 2015). Frustration and powerlessness, losing the capacity to care, failure to provide proper care, avoiding patient contact, becoming

emotionally aloof, cynical and sarcastic, and ignorant are among the effects of the intense pressure and moral distress that pose risks to both nurses' and patients' integrity (Cavaliere et al., 2010).

This long list of nursing issues, which stems from interaction with patients and various stakeholders in the workplace, renders nursing a 'tough' profession. Indeed, nurses are expected to be able to confront and manage all situations appropriately, not only for the sake of professionalism but also for their own wellbeing. The next section outlines some characteristics or qualities that are needed to respond to such situations.

1.5 Challenges in the Workplace

Working in a physically and emotionally exhausting environment, nurses' intelligence, emotions, values and expectations are constantly challenged (Mariano, 2016; Tham & Gill, 2018). The challenging situations in the workplace often prompt nurses to justify and balance all their internal dispositions, professional requirements, and ethical comportment with other external constraints in the workplace (Dossey, 2016; McIntosh & Sheppy, 2013). In this complex work environment, it is impossible to eliminate the sources of the problems, as many factors are beyond nurses' control and sometimes unexpected and unavoidable. Given that many situations are unavoidable, nurses are forced to confront these situations, many of which are ethically dilemmatic (Palazoğlu & Koç, 2019). Nurses are also expected to be able to handle and respond to these problematic situations effectively and to develop resilience (Yu, Raphael, Mackay, Smith, & King, 2019).

The uniqueness of each patient - in terms of their personal characteristics (values, beliefs, and their physiological and physical condition) prompts nurses to constantly adjust their own values when providing care. Furthermore, the characteristics of health care

organisations, coupled with the uniqueness of each personnel in the health care team, add complexity to the profession (Kitson et al., 2014; Wiechula et al., 2016).

Vanderheide, Moss, and Lee (2013) have described nurses' work environments as a morally uninhabitable environment or 'a shitty' environment (Richards & Borglin, 2019). This requires nurses to use their wisdom to navigate the complex and blurry personal-professional boundary in their workplace (Erikson & Davies, 2017), which raises the importance of nurses possessing the capacity to manage and engage with challenging situations in the workplace.

Challenges are present at all levels, such as at the personal-professional and organisational levels and in the broader context. At a personal-professional level, nurses need to possess a balanced set of academic and emotional intelligence traits (Basogul & Ozgur, 2016; Lewis, Neville, & Ashkanasy, 2017; Por, Barriball, Fitzpatrick, & Roberts, 2011; Waite & McKinney, 2016). At an organisational level, nurses must comply and align themselves with their organisations' policies and work culture. Although this sounds simple and straightforward, it often becomes problematic for nurses (Caram et al., 2019), particularly when the organisation's policies are not consistent with the nurses' values.

Working in dynamic interprofessional teams, nurses need to position themselves in equal-level relationships with other health professionals. Yet, the hierarchical nature of nurse-doctor relationships, in some countries, is still a long-standing challenging issue. Despite being a well-established and independent profession with a distinct underlying philosophy (McEwen, 2017), nursing is often viewed as a subordinate to the medical profession (Creviston & Polacek, 2018; McMillan & White, 2019). With the complex nature of professional relationships and the work environment, nurses need to reflect on their profession's philosophy and how this informs their engagement with interprofessional teamwork.

Indeed, these challenges and requirements make nursing an even more demanding profession (Dossey, 2016). Nursing needs more than just excellent clinical expertise, it requires a complete set of related competencies including personal, professional, managerial, social, and technological (Bostrom, 2016; Chitty & Black, 2011). Nurses require the capability of dealing with many difficult situations and the capacity to work under pressure in stressful conditions. For new nursing graduates, the challenges are even more difficult as they are often not prepared to confront the realities of practice, particularly during their professional transition (Hatzenbuhler & Klein, 2019).

1.5.1 Personal-professional balance.

The nursing profession emphasises professionalism in nurses' agency. Professionalism requires nurses to comply with a set code of conduct that has been prescribed by the experts in the profession and has been agreed upon within the community of practice (Ritchie & Gilmore, 2013). In some situations, professionalism provides a defined border between professional and non-professional conduct. In this sense, professionalism helps nurses to maintain the sense of being a professional when nurses are faced with challenging situations.

Despite a lack of consensus on a definition of professionalism (Akhtar-Danesh et al., 2013; Koch, 2019), it is often understood as separating professional world from personal concerns. This means that carrying through personal concerns/emotion in professional life could be considered an unprofessional act (Pickles, Lacey, & King, 2019). Yet, the nursing-patient relationship involves active engagement with patients, including with their intelligence, emotion, values, principles and other uniqueness in their characteristics (Luchsinger, Jones, McFarland, & Kissler, 2019). As active agents of care, nurses' and patients' emotions/feelings are equally important. Holding fast to professional standards might become a challenge for the nurses' personal interest and vice versa.

While separating the professional world from personal matters is agreed upon as an expression of professionalism, involving emotion is often a part of being a nurse (Sterchi, Brooks, Shilkaitis, & Ris, 2019). For example, nurses are expected to provide empathetic care, undertake values clarification in order to provide care that does not compromise patients' values (Day et al., 2017; Karimi-Dehkordi, Spiers, & Clark, 2019), and provide compassionate care (Monteiro, Musten, & Leth-Steensen, 2019). To provide compassionate care for patients requires nurses to have an emotional attachment to their patients (Monteiro et al., 2019). Furthermore, nurses' compassion for patients is expected to be genuine. Hence, personal and professional factors become inextricably intertwined in nursing practice.

1.5.2 Demand for social skills and self-care.

The demand for quality care requires a nurse to have both specialised clinical competencies and non-technical skills (Emanuel, 2016; Waite & McKinney, 2016), along with certain personal values that allow them to exhibit positive qualities. This includes compassion (Lee & Seomun, 2016; Papadopoulos & Ali, 2016), authenticity, honesty, sincerity, open-heartedness, emotional intelligence (Basogul & Ozgur, 2016; Lewis et al., 2017; Por et al., 2011), and many other moral qualities (Pathiratne, 2015; Stenhouse et al., 2016; Waite & McKinney, 2016; Waugh, Smith, Horsburgh, & Gray, 2014). All of these qualities are crucial to a healthy, meaningful human interaction, which is one of the key features of the nursing profession and has been a foundation for the patient-centred nursing paradigm (Dossey, 2016; Sharp, McAllister, & Broadbent, 2016) in contemporary nursing.

The introduction of these skills and qualities during nursing education is predominantly designed to support the practice of person-centred care, with patients as the central focus (Uhrenfeldt, Sørensen, Bahnsen, & Pedersen, 2018). On the other hand, the supporting skills that empower nurses to be personal and mentally strong agents of care are

often overlooked, most notably in developing countries, such as Indonesia. The nursing curriculum in Indonesia mainly focuses on professional clinical care and patients' wellbeing (Haryanti, Kamil, Ibrahim, & Hadi, 2016).

In order to promote self-wellbeing at work, nurses need abilities, such as self-assessment, self-reflection, self-care, self-responsibility, and mindfulness, as a part of holistic nursing practice (Drew et al., 2016; Helming, 2016). Nurses are expected to adopt positive work-related behaviours (Post & Roess, 2017) and lifestyles that help to maintain their physical, mental and emotional wellbeing (Lewis et al., 2017; Por et al., 2011; Rose & Glass, 2010) and spiritual wellness (Nelson, 2016; Van Sant & Patterson, 2013). Evidence shows that unhealthy, work-related behaviour imposes negative tolls on the physical and mental health of nurses (Schulz et al., 2011).

As the demand for culture-sensitive care in nursing practice is rising (Kılıç & Sevinç, 2018), nurses are required to develop their own sound level of cultural-spiritual sensitivity (Chiang, Lee, Chu, Han, & Hsiao, 2016; Goodhead, Speck, & Selman, 2016; Wholihan, 2016). In practice, nurses need to possess spiritual sensitivity in order to successfully promote, protect, and optimise the health and wellness of patients (Nelson, 2016; Pace & Mobley, 2016; Scott, 2016). Furthermore, nurses are expected to deliver compassionate care (Jones, Winch, Strube, Mitchell, & Henderson, 2016; Winch, Henderson, & Jones, 2015). Such care requires a genuine motive, which requires nurses to take into account personal, professional, moral, social, psychological, and spiritual needs. In short, nurses are expected to be all-round professionals (Dossey, 2016; Weinstein, 2016), which adds challenges to the nursing profession and highlights the importance of non-clinical skills and personal qualities in nursing practice.

1.5.3 Personal integrity: putting it all together.

Although nurses' health care organisations usually provide a set of professional guidelines and code of conduct, it is not uncommon for a nurse to experience conflicting concerns between personal, professional and social interests (Galdikien, Asikainen, Balciunas, & Suominen, 2014; Leineweber et al., 2014). Such challenges, if not adequately addressed, can harm nurses' sense of intactness and inflict negative consequences on nurses' emotions (McAndrew, Leske, & Schroeter, 2018) which affects nurses' self and professional identity (Caram et al., 2019). Nursing is not just a matter of following guidelines, it also involves nurses following their internal feelings and individual judgments. This is one of the reasons why nurses need to acquire non-technical skills that empower them to act and make critical decisions.

Many of the workplace challenges leave nurses with situations that are difficult to mitigate. These situations frequently affect nurses at a deeper level, due to the clash of personal and professional principles and the pressure of organisational requirements. Similarly, a nurse's professional conduct might be limited by personal concerns, such as family commitments or other concerns. Indeed, the gap between personal, professional, and organisational interests can overwhelm nurses when competing interests are in direct confrontation. Indeed, as there is always a personal dimension in nursing practice, maintaining professionalism might not always be straightforward, particularly when it comes to deep-level feelings. Yet, prioritising personal interests over professional responsibility or organisational concerns can undermine professionalism. In either case, the nurses' integrity is challenged. This implies that challenges and situations in nursing practice often extend beyond professionalism to the area of personal integrity. The next section presents the context for understanding the concept of personal integrity and related elements.

1.6 The Context

As the study is conducted in the Indonesian context, this section provides background information on the cultural setting. A brief overview of the Indonesian health system is presented with an explanation of Indonesian nursing. This information will assist the reader in understanding the analysis presented in Chapters Four and Five.

1.6.1 Brief overview of the Indonesian health system.

The Indonesian health system has a combination of private and public health service providers. The private healthcare providers include private hospitals, general and specialist doctors' clinics, nurses' clinics, and maternity clinics. The public healthcare institutions include many types/classes of hospitals at district, province and national levels. At the sub-district level, the government provide *puskesmas* (primary health centres, also referred to as public health centres in the Indonesian health literature) for the community.

Although *puskesmas* set out to offer primary health care for the community, they commonly are extended to function as 'small-scale hospitals', as they not only focus on promotive and preventive care but also provide medical /curative services and limited rehabilitative treatment. In addition, *Puskesmas* provides some more complex care, such as essential obstetric and neonatal care. A *puskesmas* has an emergency unit, ambulatory/mobile services, and inpatient and outpatient services (Pudatin Kemenkes RI, 2019).

For the advanced care, *puskesmas* refers patients to district hospitals, which may then refer patients onto a provincial hospital for even more advanced care. Finally, the provincial hospital refers patients who require highly specialised treatments to a specialty hospital at the national level (referral centre hospitals). In each stage of the referral system chain, nurses are

actively involved and play significant roles, such as being directly involved in the process of patient transfer.

Despite constituting the majority of the health professional workforce, the Indonesian health system is suffering from nation-wide nurse and midwife shortages (Mahendradhata et al., 2017). With a nurse density of only 20.58, Indonesia is among the five lowest-nurse-density Southeast Asian countries, just after Bangladesh, Myanmar, Bhutan, and Timor Leste (World Health Organization, 2019). Although there has been an increase in the number of nursing education institutions, the problem of nurse shortage is an ongoing issue (Pudatin Kemenkes RI, 2019). This issue is also possibly rising due to the growing trend for out-migration of nurses to the Middle East countries (Mahendradhata et al., 2017). Efendi, Chen and Kurniati (2018) suggest that the nurse shortage problems in Indonesia may also be linked to the uneven distribution of nurses and the limited capacity of the Indonesian government to employ new nursing graduates, who, in certain provinces, are quite abundant. Hence, Indonesia is currently facing multiple issues in the nursing workforce. A fuller overview of the Indonesian health system is provided in Appendix 1.

1.6.2 Indonesian Nursing.

It was not until 2014 that Indonesian nursing was nationally regulated and granted legal standing, through the government issuing of the Nursing Act ("Undang Undang Republik Indonesia Nomor 38 Tahun 2014 Tentang Keperawatan," 2014). This was an important milestone in Indonesian nursing history. The act covers various aspects of nursing, including nurses' scope of practice, nursing education, and pre-registration requirements that assert nurses to sit for a national competency test, on top of their university's exit exam.

1.6.2.1 Entry to the nursing profession and type of nurses

Entry to the profession can be accessed through a couple of nursing education options. The first pathway is a nursing diploma, which is a vocational training program of a full-time three-year education (D3 Nurse) or a four-year (D4 Nurse) education. Nursing diploma graduates are termed *vocational nurses*. The second pathway is a Bachelor program. This is an academic training program of a full-time four-year education, with the addition of an approximately one-year professional training program, thus making it a five-year program. The graduates of the latter are known as *perawat profesi* (professional nurse) and titled *Ners*. The professional program provides a nursing bachelor student with intensive clinical experiences (through an extended clinical placement) in various areas of nursing (Efendi et al., 2018). The curriculum of the professional program generally includes topics on basic professional nursing, family and community, geriatrics, mental health, medical-surgical care, emergency and critical care, pediatrics, maternity care, palliative care, and management (Haryanti et al., 2016). On satisfactory completion of this pre-licensure education, a nurse can apply for the national competency test in order to acquire a certificate of competency (for *vocational nurses*) or certificate of profession (for *professional nurses*). These certificates are the pre-requirement for professional registration in Indonesia.

Following the 2014 Nursing Act, the current nursing workforce has accommodated only vocational or professional nursing graduates. Yet, many of the existing senior nurses who were recruited earlier hold Bachelor degrees in nursing, without completing a professional program (Pudatin Kemenkes RI, 2019). For this group of nurses, this becomes another challenge, as it imposes some degree of uncertainty in their professional identity, despite their ample experiences gained from long-time nursing employment.

Many nurses who have a Bachelor of Nursing degree without the professional program undertake a Master degree program overseas (Mahendradhata et al., 2017). This becomes an issue when the nurses try to apply for a nursing job. Despite holding a Master degree, they are not acknowledged as a nurse, due to the revised definition of nurse, as stipulated in the 2014 Nursing Act; therefore, they are, potentially, denied nursing jobs.

Among the responsibilities of nurses outlined in the 2014 Nursing Act, is the responsibility to undertake delegated and/or mandated tasks. Delegated tasks are defined as the medical treatments that are passed on to nurses to perform and require nurses to take full responsibility of both task and outcomes. Unlike performing mandated tasks, which are usually performed under a doctor's supervision, delegated tasks are mostly undertaken independently by nurses. However, the Act emphasises that delegated tasks should only be delegated to nurses who have completed special training ("Undang Undang Republik Indonesia Nomor 38 Tahun 2014 Tentang Keperawatan," 2014).

The Nursing Act also assigns responsibility to nurses for handling various tasks, that are normally beyond their normal nursing responsibilities, under certain conditions, such as when there are limited health personnel in a practice. This includes performing some medical procedures (in the absence of medical personnel) and limited pharmacy services. In an emergency case, however, nurses are granted an authority to perform any medical procedures that they are capable of performing ("Undang Undang Republik Indonesia Nomor 38 Tahun 2014 Tentang Keperawatan," 2014).

1.6.2.2 Nursing employment status

There are several types of employment status for Indonesian nurses. The first is the status of civil servant nurse (CSN), who works for the government in various government's healthcare facilities throughout the country. Most nursing graduates are attracted to this kind

of employment, however, there is tough competition in the recruitment process. Those failing the recruitment process usually make an attempt to enter the nursing workforce through another avenue. The second is the status of the non-permanent nurse, which is a non-civil servant status. These nurses work under a contract-like agreement, known as '*Surat perintah kerja*' (work order). The work order can be voided anytime, unilaterally, by the employer which implies the vulnerability of this employment status. The third is the status of private employee, and this is the status of nurses who work for private health care organisations and are paid based according to a professional contract. Lastly, there is the status of *voluntary nurse*, who is neither a civil servant nor a non-permanent (PTT)/contract/honorary nurse. This type of nurse does not have any particular work agreement with the employer. As such, they can hardly be considered as 'an employee' despite, *de facto*, they are often assigned the same nursing responsibility as other nurses, particularly when there are not enough nurses available. This particular work arrangement is not acknowledged, formally, in the Indonesian health system (Mahendradhata et al., 2017). The more nuanced differences between the four classifications is presented in Table 1.

Table 1.

Types of nurse employment status

Characteristics	Civil Servant Nurses (CVNs)	Non-Civil Servant Nurses		
		Non-permanent nurses	Private nurses	Voluntary Nurse
Synonymous terms (Indonesian Language)	*PNS*	*PTT, Honorer* (Honorary nurses)*, Kontrak* (Contract)	*Perawat Swasta, Kontrak* (Contract)	*Suka rela* (Voluntary)
Employer	The Government	The Government	Private Healthcare Organisations	-

Characteristics	Civil Servant Nurses (CVNs)	Non-Civil Servant Nurses		
		Non-permanent nurses	Private nurses	Voluntary Nurse
Workplace	Public healthcare institutions: Hospitals, Primary Health Centres.	Public healthcare institutions: Hospitals, Primary Health Centres.	Private organisations.	Public healthcare institutions: Hospitals, Primary Health Centres.
Term of employment	Permanent (long-term employment), stable.	Short-medium terms, usually up to three years.	Short-medium (depending on the organisations' need).	No time-frame.
Job security level	High. Unless an employee commits a serious crime, it is less likely for the government to terminate the employment before the term ends.	Low. Employer can terminate this arrangement unilaterally any time, especially if the employers are not satisfied with the nurse's performance.	Medium. Although it is a professional contract, the employer usually is more benefitted from contract clauses.	No security.
Salary	Fixed and nationally standardised salary on a monthly basis (National standard of Civil servant salary).	Depending on the recruiting government, salary might or might not be standardised. Many honorary nurses do not receive salary but receive a limited entitlement (the central and provincial government usually set a wage standard for non-permanent nurses, but many local governments do not have such standard.	Depending on the Contract. Some organisations follow the regional minimum wage policy, but some big organizations can be generous.	No salary.
Entitlement	Various remuneration/ allowances/ incentives for the service rendered, Pension, Health insurance, professional development	Fee for the service rendered.	Depending on the contract, different employers might provide different entitlement to their employees.	A share from the service rendered (unofficial).

The readers should now have enough background information on the Indonesian nursing context, particularly in relation to the different characteristics of civil servant and honorary nurses. The next sections present information on the study, including the aim and the research questions, the alterations of the study, and the potential significance of the study.

1.7 The Aim of the Study and the Research Questions

Initially, this study aimed to provide a theoretical explanation of nurses' personal integrity and its role in shaping nurses' practical agency. It was planned to begin with exploring participants' perspectives of integrity and how they use it in their practice. In order to frame the study, three research questions were formulated, as follows:

1. How do nurses constitute personal integrity?
2. How does personal integrity impact nurses' practical agency?
3. How do nurses maintain and restore personal integrity in practice?

During the initial data collection, the researcher found that the vast majority of the Indonesian participants were not familiar with the term 'integrity', which made it impossible to explore nurses' perspectives on integrity. Nonetheless, all participants shared their experiences, which covered their personal and professional values, including how they negotiated their values when encountering stressful situations.

These emerging analysis from the data drove the study to a new direction, which necessitated the researcher to re-focus the study to explore nurses' basic social processes of developing and evolving a value system. The aim of this study was, therefore, re-phrased to providing a theoretical explanation of the value system of nurses and its role in shaping practical agency. Following the emerging analysis, the research questions were refined and refocused, as follows:

1. How do nurses develop and evolve their value systems?

2. How do nurses' values inform their practical agency?

1.8 Linking the Concept of Personal Integrity and Value System

Although the study pivoted toward a new research direction, the concept of integrity overlaps the concept of values in a meaningful way. In Western nursing culture, integrity is acknowledged as one of the core values (The National League for Nursing, 2017), suggesting that integrity is viewed as a value. However, not all scholars hold the same view. For example, integrity is regarded as many different entities, such as a thick virtue (Cox, La Caze, & Levine, 2003), a social virtue (Calhoun, 2016), a framework of values (Tyreman, 2011), and a personality trait (Trevinyo-Rodríguez, 2007).

Some characteristics that are often associated with integrity include authenticity, strength of will, dignity, autonomy, self-knowledge, respect, self-respect, courage, honour, honesty, civility, compliance, truthfulness, loyalty, consistency, coherence, and sincerity (Banks, 2010; Breakey, Cadman, & Sampford, 2015; Calhoun, 2016; Cox, La Caze, & Levine, 2017; Halfon, 1989; McFall, 1987; Prust, 1996; Tyreman, 2011). These characteristics are closely related to the concept of values. As a framework, integrity shapes the conception of values (Tyreman, 2011). This perspective clearly implies a close relationship between values and the concept of integrity. The following section presents the potential significance of the study.

1.9 Significance of the Study

Studying the concept of nurses' values, including how they are processed and influence practical agency, might reveal some elements that provide insights into nurses' commitments to their practice, which could be used to improve nursing education and practice. Nursing students need to understand and be prepared for the realities of nursing. As nursing is

not only about clinical practice but also social interaction, comprehensive knowledge about how values are enacted is important preparatory learning for the workplace.

This study has the potential to raise awareness of nurses' values, which may help with their preparedness to confront the less-then-ideal reality of practice, particularly when there are no formal guidelines available. Understanding, having knowledge of values may help in development of resilience and improve retention rate of nurses. Moreover, understanding values may assist in maintaining nurses' professional confidence thereby enabling them to become effective agents of care. Effective agents of care may also benefit patients in the way that patients are provided with a positive hospital experience that helps to achieve the healing effects and promote the patients' wellbeing more effectively.

The study findings could potentially contribute to understanding the context in which nurses work and the elements that create a positive work environment. From a managerial perspective, this study could help health administrators or non-nurse managers to better understand the nursing milieu and to inform future development of policies that are supportive of and effective in improving overall health care performance. Given that nurses and midwives constitute the vast majority of healthcare professionals, any improvements in nursing may contribute to overall betterment in the national health system.

1.10 The Thesis Outline

The thesis is arranged over eight chapters. Chapter One presents the background and the context of the study, as well as the aim and significance of the study. Chapter Two provides an extensive review of the literature, including gaps in knowledge and justification for the research. The research methodology and methods, along with the researcher's philosophical standing, are presented in Chapter Three.

Next, Chapter Four offers a comprehensive report of the emerging categories, along with their subcategories. All categories and subcategories are presented with relevant quotes, in combination with their analysis. Chapter Five highlights contextual determinants that serve as a stage/platform for the study, which helps the readers to make sense of participants' encounters and their reactions. Chapter Six presents the theoretical explanation of the studied phenomena, along with a theoretical model constructed upon the data.

Chapter Seven discusses the findings and the critical analyses of the context of the study. The constructed theory is compared and contrasted with extant theories. The contribution of the theory to the existing body of knowledge on nurses' value systems is also presented. Finally, Chapter Eight summarises the overall conclusions of the study, including the implications for nursing education, policy and practice. The directions for future research, as well as the limitations of the study, are also discussed in this final chapter.

1.11 Conclusion

This chapter has set the stage through provision of a background for the study, along with some culturally specific details of Indonesian health care organisations and nursing. The next chapter, Chapter Two: Literature Review, provides details on the relevant topics as identified in the body of literature.

Chapter Two: Literature Review

2.1 Introduction

The previous chapter presented the background and context of the study. In this chapter, in-depth insights into current knowledge around the topic are offered. According to constructivist grounded theory, conducting a literature review prior to data collection and theory development is useful to help frame the research and develop theoretical sensitivity (Charmaz, 2014). Based on this notion, an integrative literature review was conducted and published before data collection. Additional insights into some perspectives on the conception of agency are also offered.

2.2 Integrity

In order to identify a gap in the literature and provide a landscape for this study, an integrative review on integrity was published in the Journal of Clinical Nursing. The article covers a broad range of integrity themes, including the conception of personal integrity in nursing, threats to integrity, and strategies for maintaining integrity. The review also offers a framework for understanding the threats to integrity in the context of nursing (see 2.2.1 for more detailed information).

2.2.1 Nurses' integrity and coping strategies.

REVIEW

WILEY *Journal of* **Clinical Nursing**

Nurses' integrity and coping strategies: An integrative review

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Abstract

Introduction: Integrity is one of the core values in nursing that needs to be maintained by nurses in practice. However, the complexity in the nursing milieu can pose threats to integrity. An understanding of the common threats and coping strategies might assist nurses in preserving integrity in everyday practice.

Aims and objectives: To review and synthesis the concept of integrity in nursing and identify common threats and coping strategies.

Methods: Whittemore and Knafl's integrative review method was implemented. A search was performed in Scopus, Medline, Embase, PsycINFO, Cumulative Index to Nursing and Allied Health Literature, and Proquest Health and Medical electronic databases published in English between 2000–2017. Two reviewers independently assessed eligibility for inclusion. Methodological appropriateness for the included studies was assessed using the critical appraisal skills programme. The constant comparative method of grounded theory was used to analyse and synthesise data from seven peer-reviewed articles.

Results: Two major conceptions of integrity were identified. These included the sense of wholeness with regard to personal–professional concerns and ethical–moral conducts. Five entities, self, patients, teamwork and work culture, the nature of work, and organisation, were identified as interweaving elements that may induce threats to integrity. When integrity is threatened, nurses use two key strategies to survive: adjusting and compensating. An emergent framework to facilitate understanding of nurses' threats to integrity is discussed.

Conclusions: A threat to nurses' integrity takes form when there is an unmitigated gap between a nurse's expectation and reality. While the expectation comes from within the nurse, the reality materialises out of the complex interplays that occur in the healthcare workforce. Maintaining integrity demands a continual strive to balance personal expectations, professional concerns and nursing realities.

KEYWORDS
literature review, nurse, nurse–patient relationship, nurse–physician relationship, nursing practice, personal integrity, psychological and social coping, psychosocial adjustment

1 | INTRODUCTION

Integrity as a multidimensional concept has multiple interpretations (Cox, La Caze, & Levine, 2017). The Oxford dictionary provides two definitions of integrity: "the quality of being honest and having strong moral principles" and "the state of being whole and undivided" (Oxford Dictionary, 2017). In a philosophical sense, however, the term integrity is complicated as it involves several abstract concepts such as self, identity and social virtues (Calhoun, 2016; Ekeberg, 2011). For example, Calhoun (2016) views integrity as a

social virtue that manifests in three forms: integrated-self (intactness of one's desires, evaluations and commitments); the identity (fidelity to projects and principles that constitute one's core identity); and the clean-hands (conserving virtues of one's own agency in situations where common moral principles are challenged). The philosophical concept of integrity encompasses all aspects of one's life such as personal–professional values and expectations along with the entities of social and ethical conduct (Edgar & Pattison, 2011).

Integrity is considered as one of the core values of the nursing profession (Mariano, 2016). The complex and dynamic nature of nursing work require nurses to possess not only adequate clinical skills but also certain personal qualities such as social and moral consciousness (Johnstone, 2016). These qualities are regarded as attributes of personal integrity (Tyreman, 2011).

The terms "integrity," "personal integrity" and "professional integrity" need to be clarified. The concept "integrity" is implicitly personal (Tyreman, 2011). Thus, the terms "integrity" and "personal integrity" are identical and both refer to the individual's core integrity. Professional integrity on the other hand is a domain of personal integrity that applies to professional life; thus, personal–professional integrity is inseparable (Calhoun, 2016). However, personal values and professional values might clash, which adds complexity to the conception of personal–professional integrity.

Despite being highly valued in nursing, there is no consensus on the definition of integrity. Nonetheless, the concept of integrity in nursing practice tends to be understood in a reduced magnitude and isolated values such as honesty, sincerity, ethical conduct or professionalism (Breakey, Cadman, & Sampford, 2015; Tyreman, 2011). Such interpretations might be misleading and potentially diminish its value (Cox et al., 2017). Tyreman (2011) suggests integrity needs to be viewed within a social framework, which implies a more complex interplay of various entities rather than merely an independent element. Indeed, understanding integrity in a reduced construct might underestimate and consequently trivialise the true power of integrity (Cox et al., 2017).

In addition, the concept of integrity in nursing appears to be understood as the completeness of nurses' emotional state. This conception seems to be logical as the work environment often exposes nurses to many physical, psychological and moral discomforts such as exhaustion and stress. Working in a physically and mentally demanding environment, nurses often experience psychological distress (Black, 2017). Furthermore, psychological distress has been associated with burnout and high attrition rates (Mariano, 2016; Tham & Gill, 2016; Zou et al., 2016). As nurses' intelligence, emotions, values and expectations are constantly challenged, nurses might endure psychological and moral distress, which poses a threat to their integrity (Woods, 2014).

Encountering integrity-threatening situations is common in nursing care. Yet, maintaining integrity can be strenuous (Pearson, 2006) especially within complex and dynamic work environments (Black, 2017). In these settings, nurses are required to be able to justify and balance their internal dispositions, professional requirements, ethical comportments and other external

> **What does this paper contribute to the wider global clinical community?**
>
> - Maintaining integrity involves a continual effort to balance personal and professional expectations within the workplace.
> - Nurses use two core strategies to deal with the threats to integrity: adjusting and compensating.
> - A novel framework is offered to assist in understanding threats to nurses' integrity.

constraints in the workplace (Dossey, 2016; McIntosh & Sheppy, 2013). However, there are no guidelines available for dealing with integrity-threatening situations. Nurses may be coerced into subjectively judging these difficult situations and make decisions based upon their personal values and past experiences (LaSala, 2009). To manage such situations, it is important for nurses to understand the nature of threats to integrity along with strategies to deal with these situations.

2 | AIM

The aim of this review was to synthesise the concept of integrity in nursing and identify threats and coping strategies in practice. The knowledge gained from this review may assist nurses in understanding integrity in their everyday practices.

3 | METHODS

An integrative review of the literature was conducted. To guide the process, Whittemore and Knafl's (2005) proposed method was employed. Methodological rigour of the reviewed studies was assessed using the critical appraisal skills programme (CASP, 2013). The constant comparative method of grounded theory was used to analyse and synthesise data from seven peer-reviewed qualitative articles. The PRISMA checklist was chosen as a reporting guideline for this review (see Supporting Information Appendix S1).

3.1 | Search strategy

Systematic search was performed against six major databases: Scopus, Ovid Medline, Embase, PsycINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Proquest Health and Medical. To identify search terms, preliminary search was done in Scopus and Medline databases. Analysis of the words contained in the title and abstract as well as in the index terms/ subject headings (Butler, Hall, & Copnell, 2016) was performed in consultation with a librarian. Four search terms, nurse, threat,

TABLE 1 Search terms across databases

Search terms
integrity
nurs* (nurse, nurses, nursing)
midwi* (midwive, midwives, midwifery)
maintain* (maintain, maintains, maintaining)
preserv* (preserve, preserves, preserving)
protec* (protect, protects, protecting)
retain* (retain, retains, retaining),
sustain* (sustain, sustains, sustaining)
compromi* (compromise, compromises, compromising), threat* (threat, threats, threatening, threatened)

maintain and integrity, were used in the preliminary searches. However, in the main search the search terms were extended to include their synonyms as well as their corresponding and neighbouring concepts. To ensure that all possibilities would be captured, proper truncations and Boolean operators were used (Butler et al., 2016). See Table 1 for search terms.

Refinements to each database search were done by limiting searches to articles' subject area, source type, document type and other limiters unique to each database. This review included peer-reviewed empirical articles that were published in English between 2000–2017. Literature reviews and editorials were excluded. To avoid publication bias, a grey literature search was performed to find relevant unpublished theses, conference proceedings and government documents.

3.2 | Search process and outcomes

A total of 502 articles were successfully retrieved. The software Endnote was used to locate 49 identical articles, which were removed from the list, leaving a total of 453 articles for title screening. One hundred and ninety articles were deemed irrelevant upon title screening, while the remaining 263 articles were then screened by abstract. The abstract screening, which was conducted by the first author, filtered out 255 articles and left eight potential articles for eligibility assessment. A search of grey literature resulted in an addition of three relevant articles providing a total of eleven articles for full-text review. This was performed by the first and second authors with the decision on the selection of articles achieved through consensus. Upon critical appraisal, four articles were excluded for the following reasons: one article was a review, another one was nonempirical paper, and two had low CASP scores. The critical appraisal extracted seven high-quality studies: four journal articles and three doctoral theses. No quantitative studies were found. The complete search process for this review is depicted in a PRISMA flow chart in Figure 1.
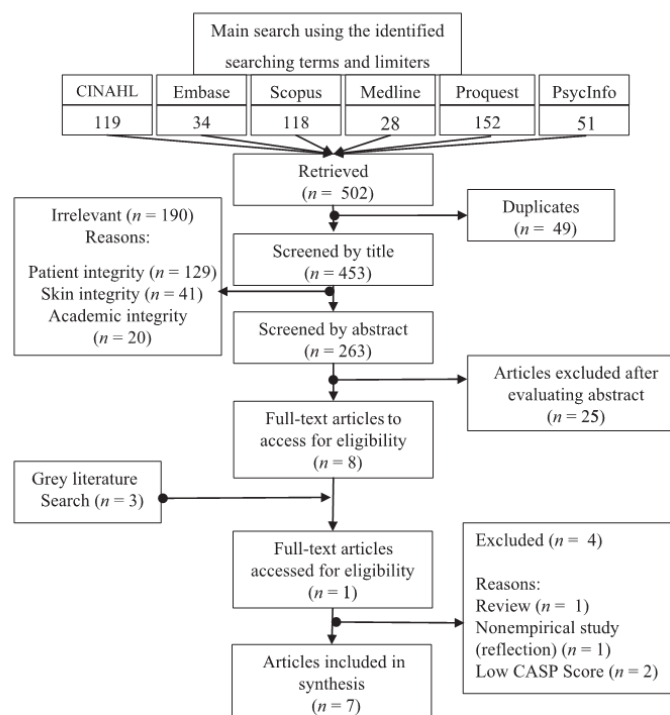
FIGURE 1 PRISMA flow chart of search strategy

3.3 | Data analysis

Following Whittemore and Knafl (2005) data analysis method for integrative reviews, the data were analysed in four steps. First, the data were reduced and extracted from each study individually and recorded in the form of a table and mind maps. Second, all extracted data were converted and combined into a primary mind map which allowed the authors to observe similarities and differences across the studies. The data were then examined from various point of views. Analysis against the extracted data on the mind map was performed by constantly comparing each theme, developing new categories and making revisions and refinements as needed.

3.4 | Summary of study characteristics

Four of the seven reviewed studies were undertaken in the USA. One study involved participants from multiple countries including the USA, the UK, Canada and Australia. One study was conducted in Sweden and one in Australia. Four studies were published in peer-reviewed journals, and three were in the form of doctoral theses. Regarding the methodologies, five studies used grounded theory, whereas the remaining employed phenomenology as the key method. The number of participants varied across studies with a minimum of 13 to a maximum of 30 nurses. In terms of study settings, five studies were conducted in acute care settings, one in a general setting and the other in both general and acute settings. Further details on each study are presented in Table 2.

4 | RESULTS

Through constant comparison data analysis method, three major themes emerged: (a) conceptions of integrity, (b) threats to integrity and (c) common coping strategies to maintain integrity. The three themes are presented below (see Table 3 for data extraction).

4.1 | Conceptions of integrity

Two major conceptions of integrity emerged from the review. First, integrity is viewed as the sense of personal, professional and social wholeness. The idea of personal wholeness incorporates three aspects: physical (Erikson & Davies, 2017; Irurita & Williams, 2001; Pike, 2001), psychological (Erikson & Davies, 2017; Irurita & Williams, 2001; Laabs, 2007; Nilsson, Rasmussen, & Edvardsson, 2016; Pike, 2001) and spiritual (Irurita & Williams, 2001; Pike, 2001). Integrity is viewed as possessing control over situations to protect oneself, maintain dignity as human beings and be recognised as individuals (Cartwright, 2006; Erikson & Davies, 2017; Irurita & Williams, 2001; Pike, 2001).

Second, integrity is viewed as social and moral conducts (Cartwright, 2006; Irurita & Williams, 2001; Pike, 2001). This concept comprises the ethical principles such as beneficence and nonmaleficence as guiding values for a good nurse (Nilsson et al., 2016). It is an endeavour to

practice in certain ways that allows nurses not to feel guilty about their work (Erikson & Davies, 2017; Irurita & Williams, 2001; Pike, 2001). In addition, integrity is viewed as a value to deal with morally difficult situations (Cartwright, 2006; Laabs, 2007; Pike, 2001). Failure to manifest what is morally right in one's practice often leads to moral distress and impacts nurses' integrity (Cartwright, 2006).

4.2 | The threats to integrity

Based upon the conceptions of integrity identified in the reviewed studies, a threat to integrity is defined as any situation that has a potential of impairing a sense of personal (physical and mental), professional, social or moral wholeness. With reference to threats to integrity, five loci of threats were identified. These included, self, patients, teamwork, the nature of work and the organisation.

4.2.1 | Self

Generally, nurses have certain expectations with reference to their work and profession. However, there might be a discrepancy between what had been imagined and the real challenges they came across in everyday practice. For example, the reviewed studies showed nurses expect to be able to consistently provide "high quality" care (Irurita & Williams, 2001; Nilsson et al., 2016). High quality care is described as providing extra care that is "over and beyond the usual expectation" (Irurita & Williams, 2001; p. 584). In addition, some nurses had strong feelings of obligations to bringing positive outcomes. However, these expectations and perceived obligations could not always be satisfied due to external factors such as limited resources or organisational policies, resulting in nurses experiencing a feeling of loss. Such a feeling sprang out of the conceived incapability of fulfilling their obligations (Irurita & Williams, 2001; Nilsson et al., 2016). When the gap between expectation and reality became overwhelming, it started to affect nurses psychologically and morally (Laabs, 2007; Nilsson et al., 2016). In the case where nurses were unable find solutions to the problems, they started feeling disappointed and distressed, which if continued may harm nurses' integrity (Laabs, 2007; Nilsson et al., 2016).

4.2.2 | Patients

Dealing with confused and aggressive patients potentially harms nurses' integrity. In Nilsson et al. (2016) study, when caring for older patients with cognitive impairment in an acute care setting, nurses were reported being at high risk of offence. The offences ranged from verbal to physical attacks that had caused nurses to feel uncomfortable and, to some extent, frightened (Nilsson et al., 2016). Repeatedly experiencing physical and psychological harassments from patients can affect nurses' integrity (Erikson & Davies, 2017; Nilsson et al., 2016).

Engaging in long-term care such as palliative care settings often creates a special bond between nurses and patients (Irurita & Williams, 2001). Nurses who are frequently involved emotionally

TABLE 2 Description of the included studies

No	Authors (year) / Title / Journal	Context	Research Summary	Methodology
1	Erikson, A., & Davies, B. (2017) Maintaining integrity: How nurses navigate boundaries in pediatric palliative care Journal of Pediatric Nursing, 35, 42–49	Country: the USA Setting: acute care unit and end-of-life facility	A grounded theory study that explored how nurses manage professional and personal boundaries, that is the process that involved in negotiating boundary, while delivering care to seriously ill children and families	18 registered nurses (10 from the end-of-life facility, 8 from the children hospital) were interviewed using semi-structured interview and were observed in their work setting. Participants were recruited by means of posting flyer and snowball sampling. Data analysis using constructivist grounded theory
2	Nilsson, A., Rasmussen, B. H., & Edvardsson, D. (2016) A threat to our integrity – Meanings of providing nursing care for older patients with cognitive impairment in acute care settings Scandinavian Journal of Caring Sciences, 30(1), 48–56	Country: Sweden Area: acute care setting (General medical, oncology and neurological clinics)	Phenomenological study that aimed at exploring the meanings of caring for older cognitively impaired people in acute care settings	13 registered nurses and assistant nurses were interviewed, and the data were analysed using hermeneutical–phenomenological analysis
3	Laabs, C. A. (2007) Primary care nurse practitioners' integrity when faced with moral conflict Nursing Ethics, 14(6), 795–809	Country: the USA Area: primary care	A grounded theory study that explored the process of managing moral problems common to primary care	23 nurse practitioners were interviewed Data were analysed using Glaserian grounded theory method
4	Cartwright, D. J. (2006) Perception of nurses regarding their moral decision-making and their ability to be resolute in their attempts to provide care that maintains moral integrity Thesis – Utah State University	Country: the USA Area: acute care, rural hospital environments	A study that aimed at describing the moral decision-making with emphasis on the process for compromising or maintaining moral integrity	16 registered nurses were interviewed. Data were analysed using the phenomenological study principles
5	Nathaniel, A. K. (2003) A grounded theory of moral reckoning in nursing. Thesis – West Virginia University, Ann Arbor	Country: the USA, the UK, Canada, and Australia in All area of care, but mostly in high stress clinical area	A grounded theory that aimed at elucidating experiences and consequences of nurse's moral distress and formulating a logical, systematic and explanatory theory of moral distress and its consequences	Data were obtained by interviewing 21 registered nurses. Data were analysed using Glaserian grounded theory approach

(Continues)

TABLE 2 (Continued)

No	Authors (year) / Title / Journal	Context	Research Summary	Methodology
6	Pike, A. W. (2001). "I don't know how ethical I am": An investigation into the practices nurses use to maintain their moral integrity. *Thesis – Boston University*	Country: the USA. Setting nurses working in acute care hospitals, ICU, nursing homes, community health centres and homecare	A grounded theory study that aimed to identify practices the nurses use to maintain their moral integrity and discover patterns in nurse's use of these practices	17 interviews with registered nurses (randomly selected). Participants were asked about times in their practices when their most cherished value was challenged/threatened by the decision of more powerful others. Data were analysed using Straussian grounded theory approach
7	Irurita, V. F., & Williams, A. M. (2001). Balancing and compromising: Nurses and patients preserving integrity of self and each other. *International Journal of Nursing Studies, 38*(5), 579–589	Country: Australia. Area: acute care hospital settings	A grounded theory study that aimed to develop a theory of balancing and compromising in response to the shared problem of threats to integrity, especially encountered when broader environmental and contextual conditions were unfavourable. Experiences of both nurses and patients on nursing care delivery were explored	Data were collected from many different sources. It made use of data from two previous studies (interview of 22 nurses and 23 patient) and other 10 new interviews (theoretical sampling) as well as data from other concurrent study. Data were analysed using constant comparative method, following Glaserian grounded theory approach

with their patients have difficulties in resolving tensions between connecting personally and maintaining professional conduct (Erikson & Davies, 2017; Irurita & Williams, 2001). A conclusive link between integrity and inability to mediate a tension between personal values and professional conduct is explored in depth by Erikson and Davies (2017). Their study revealed that failing to find the best equilibrium between the two, nurses were likely to suffer from psychological and moral repercussions that potentially threatens their integrity (Erikson & Davies, 2017).

4.2.3 | Teamwork and work culture

Problematic relationships within teamwork create a less conducive atmosphere in the workplace. Nurse–doctor relationships have been an issue in nursing practice as nurses sometimes feel being undervalued by doctors (Cartwright, 2006; Laabs, 2007; Pike, 2001). This situation springs out of an imbalanced power relationship with doctors being regarded as the most authoritative team members. In addition, there has been a stigma in the healthcare work culture where nursing is considered inferior to the medical profession (Pike, 2001). The stigma creates a feeling of powerlessness among nurses and leads to nurses' integrity being threatened (Cartwright, 2006; Nathaniel, 2003).

Personal characteristics of some doctors as well as those of peers can make the professional relationship even more troublesome (Pike, 2001). Poor communication among team members has been a common consequence of a nonharmonic relationship that can affect patients' outcomes (Cartwright, 2006; Laabs, 2007; Pike, 2001). When nurses observe less preferable outcomes that are attributable to poor communication, they experience a sense of loss that jeopardises their integrity (Cartwright, 2006).

4.2.4 | The nature of work

Nurses often endure ethically and morally difficult situations, especially when encountering end-of-life issues. Depending upon the intensity of the situation, it can bring various moral problems from moral uncertainty to moral distress, which has been linked to threaten integrity (Cartwright, 2006; Erikson & Davies, 2017; Irurita & Williams, 2001; Laabs, 2007; Nathaniel, 2003; Nilsson et al., 2016). Nurses working in departments such as intensive care and emergency settings experience more frequent and intense ethical issues that potentially lead to moral distress. This has been linked to their sense of integrity (Cartwright, 2006).

4.2.5 | Organisation

Some organisational-related factors appear to potentially threaten nurses' integrity. The factors involve limited physical resources (Irurita & Williams, 2001; Laabs, 2007; Nathaniel, 2003; Nilsson et al., 2016), policy on productivity quota (Laabs, 2007), lack of time, poor staffing and shortage of nurses (Irurita & Williams, 2001; Laabs,

TABLE 3 Data extraction and synthesis

Themes	1	2	3	4	5	6	7
Conceptions of integrity							
Sense of wholeness							
Sense of personal & professional wholeness	✓	✓	✓	✓	✓		✓
Sense of having adequate control over situation	✓				✓		✓
Ethical conducts and moral dilemmas			✓	✓		✓	✓
Threats to integrity							
Self							
Unacceptable incongruence of expectation and real practice		✓	✓				
Perceived repeated failure in providing care that patients are entitled to		✓			✓		✓
Patients							
Poorly-managed patient-nurse interaction resulting from difficulties in dealing with poorly-behaved patients or hardship in aligning personal and professional relationship	✓	✓					✓
Teamwork and work culture							
Work culture in which imbalanced-power relationships persist leading to nurses feeling disempowered and undervalued			✓	✓		✓	
Profession and the nature of work							
Nature of nursing work which requires nurses to face ethically difficult situation and moral conflict	✓	✓	✓	✓	✓	✓	✓
Organisation							
Inadequate resources leading to impeded ability of providing cares and overload		✓	✓		✓		✓
Common strategies of maintaining integrity							
Adjusting							
Expectation/value adjustment	✓	✓	✓		✓	✓	✓
Physical/instrumental adjustment			✓		✓		✓
Compensating		✓	✓			✓	✓

Notes. 1. Erikson and Davies (2017); 2. Nilsson et al. (2016); 3. Laabs (2007). 4. Cartwright (2006); 5. Nathaniel (2003); 6. Pike (2001); 7. Irurita and Williams (2001).

2007). These factors simply impede the services that nurses are able to offer and can result in disappointment and discouragement for nurses (Irurita & Williams, 2001; Nilsson et al., 2016). Consequently, nurses lose their confidence and motivation in continuing their practice (Nilsson et al., 2016).

4.3 | Common strategies for maintaining integrity

When integrity is challenged, nurses restore and maintain their integrity by adjusting to the challenging situations as well as compensating. Both strategies are presented next.

4.3.1 | Adjusting

The participants of the reviewed studies strived to adapt to integrity-threatening situations by aligning their values not only to avoid burn-out but also to preserve their sense of intactness (Erikson & Davies, 2017; Nilsson et al., 2016). Two kinds of adjustment emerged from the reviewed studies: value and instrumental.

Value adjustments

Nurses adjusted their values and expectations in response to the difficult situations by using several strategies including accepting limitations (Laabs, 2007), lowering expectations (Irurita & Williams, 2001; Nilsson et al., 2016), convincing self (Laabs, 2007; Pike, 2001), "letting off steam" (Erikson & Davies, 2017; Nilsson et al., 2016), self-preservation (Erikson & Davies, 2017; Irurita & Williams, 2001) and deadening conscience (Nilsson et al., 2016). These strategies were in place not only to ease the psychological impacts of unmitigated gaps between nurses' expectations and reality but also in helping nurses preserve and regain a sense of individual wholeness.

Physical/instrumental adjustments

Along with adjusting values, nurses used physical and or instrumental adjustments to promote their well-being (Nilsson et al., 2016). For instance, nurses participated in physical exercise activities and engaged socially (Irurita & Williams, 2001; Laabs, 2007) to restore physical, psychological and social sense of wholeness (Erikson & Davies, 2017; Irurita & Williams, 2001). In situations where nurses

felt too much pressure on their personal side, self-preservation methods were used (Irurita & Williams, 2001). However, when nurses had difficulty in coping with certain situations, they either avoided or removed themselves from the situation. Some nurses tried to avoid the source of problems by moving to a less stressful clinical environment within the same organisation (Irurita & Williams, 2001) while others had an intention to leave their job (Laabs, 2007).

4.3.2 | Compensating

In circumstances where there is a lack of time and resources or inadequate staffing, nurses are often unable to provide optimal care and service to their patients resulting in nurses feeling dissatisfied, frustrated and guilty (Irurita & Williams, 2001). To compensate their guilty feelings, nurses offered extra services for instance, using their personal time interacting with the patients and showing their attention not only to comfort the patients but also make them feel better about their care (Irurita & Williams, 2001; Laabs, 2007; Nilsson et al., 2016).

This compensation strategy was apparent where nurses worked in a specific environment or with specific characteristics of patients such as acute care settings (Nilsson et al., 2016), and older cognitively impaired patients or end-of-life facilities (Irurita & Williams, 2001; Laabs, 2007). Patients within these clinical settings tended to be more demanding. As a result, care was unequally divided between the ones who were more demanding than others less demanding. Although the less demanding patients did not enjoin the nurses to share the same amount of attentiveness, the nurses often regarded themselves as doing an injustice for not being able to do so. This raised guilty feelings that need to be counterbalanced by compensating.

5 | DISCUSSION

5.1 | Conceptions of integrity

Integrity in nursing practice appears to be conceptualised around two orientations: morale and moral. Within the morale-oriented perspective, integrity is viewed as an outcome of an action/incidence. Integrity is regarded in terms of a sense of an individual's wholeness. The intactness of nurses' physical and mental well-being appears to be one of the common conceptions of integrity among nurses. Thus, any incidence that has a potential to undermine one's sense of individual's intactness is then regarded as a threat to integrity. This concept of integrity appears to be contextualised in a broader sense than that discussed in the philosophical literature where the notion of integrity revolves around moral undertakings rather than morale outcomes of incidences (Breakey et al., 2015; Calhoun, 2016; Tyreman, 2011). For example, feeling frustrated of being physically attacked by patients as identified in Nilsson et al. (2016) study might be considered irrelevant from a philosophical perspective because of the absence of moral loads.

From a moral-oriented perspective, integrity is conceptualised around moral processes and actions. This orientation is in line with the philosophical concept of integrity. It is viewed as maintaining ethical conduct and behaviour in morally problematic situations in workplace. This conceptualisation corresponds with the notion of "a person with integrity" who maintains the consistency of his/her values and actions (Breakey et al., 2015; Hardingham, 2004). Morally difficult situations often arise from the discrepancy between personal, professional and organisational values. For this reason, nurses might encounter moral problems from conflicting values and principles. How nurses respond to morally difficult situations is affected by their configuration of integrity. Nonetheless, the pattern of nurses' mindset and projections in the reviewed studies appears to parallel Calhoun's (2016) "clean-hands" concept of integrity on the grounds that nurses strive for ethical conduct when facing morally problematic situations.

Contextualising integrity in the workplace is a complex undertaking. In some cases, nurses are confronted with difficult situations in which they might have to decide whether to stay consistent with the code of conduct, organisational policies, or hold true to their personal values. Any decision that nurses make might have both positive and negative effects on their conscience. For example, to remain consistent with organisational policies nurses may need to compromise their personal principles. Similarly, to hold true to oneself, nurses' professionalism might be compromised. While compromise is not uncommon in nursing, to what extent it threatens integrity is difficult to determine.

5.2 | Threats to integrity and dealing with them

There are several inherent conditions that if not properly governed can pose threats to nurses' integrity and make preserving integrity difficult. As identified in the review, the threats to integrity originate from the complex interplay between various components that take place in the nursing workplace. Knowledge of these components and how they are intertwined is essential. Understanding the nature of threats might assist nurses to be more mindful in their practice. The state of mindfulness in nursing plays an important role. Mindfulness helps to manage personal values and accept the unfamiliar experience without feeling negatively about it with a potential to promote self well-being and outcomes of care (Gustin, 2018).

Threats to integrity are generated just not only from nurses' interactions with patients, teamwork and other stakeholders but also from nurses' own ideal expectations. Indeed, the threats to integrity that arise from within individuals are mostly due to poor harmonisation of self-dispositions and external forces. Sometimes the gap between one's expectation and reality is too complex to harmonise. However, nurses usually have no options other than confronting the situation while trying to maintain their sense of integrity.

One of the strategies for maintaining integrity is value adjustment. This is a manifestation of self-disposition reconciliation that helps nurses survive challenging situations and keeps them remaining in the profession (Nilsson et al., 2016). Unfortunately, adjusting values usually involves lowering one's expectations and can include various undertakings ranging from accepting limitations to allowing some degrees of suppressed conscience.

In some nursing settings, nurses' morale may be challenged quite intensely impairing nurse's morale and causing some morale–fatigue-related issues such as compassion fatigue and burnout. Lack of compassion and deadened conscience have been associated with compassion fatigue and burnout (Juthberg, Eriksson, Norberg, & Sundin, 2008; Russell, 2016). Gradually becoming more indifferent to psychological and moral situations of the patients manifests nurses' suppressed conscience, which may influence the way care is provided (Raab, 2014) and potentially affects its outcomes. Yet, suppressed conscience is perhaps a natural reaction to recurring stressors rather than a planned action. It appears to be a mechanism to maintain nurses' own psychological well-being. Nonetheless, allowing suppressed conscience to continue to reach a point of deadened conscience may affect one's professional identity, particularly the image of "a good nurse" such as in the case of less compassionate care (Juthberg et al., 2008; Nilsson et al., 2016).

Another physical/instrumental adjustment strategy is removing self from the challenging situation. This strategy often includes total detachment such as leaving the profession. Nurses' intention to leave is found to be related to work environment pressure and personal factors (Hayward, Bungay, Wolff, & Macdonald, 2016). It is reported that 46% of nurses consider leaving their position due to distress (Woods, Rodgers, Towers, & La Grow, 2015). Despite being an option for some nurses, total detachment highlights the need for appropriate managerial interventions in the work environment to support the retention of nurses (Holland, Tham, & Gill, 2018) and to minimise threats to nurses' integrity. Ongoing awareness of moral encounters and associated risks needs to be introduced early in nurses' education. Continuing professional development may assist nurses in becoming more conscious and adaptive in their practice when dealing with integrity-related situations.

Having a holistic and systematic understanding of the threats to integrity is necessary to effectively deal with them as they arise. Drawing upon the thematic analysis of this review, a framework to facilitate the understanding of the nature of threats to integrity in nursing practice is proposed (see Figure 2).

5.3 | Threats to integrity: The framework

The sources and characteristics of threats are depicted in Figure 2 as multiple layers. Each layer represents one or more entities that are positioned to show their relative distance to integrity as nurses' central core. The inner layer represents the entities that nurses have immediate contact with such as patients, teamwork and the work culture. Situated in the next layer is the profession and nature of work. Finally, the outer layer represents the broader environment that includes the organisation and the wider health system.

Integrity is positioned at the core of the individual nurse as an internal personal quality of a nurse. An incidence can affect integrity after penetrating through a nurse's personal space. Among other factors that reside within the personal space is a nurse's expectation. As identified in this review, incongruence between expectations and the reality of practice appears to be a central theme of

threat to integrity. The skill required to juxtapose the reality gap is usually lacking for new nurses. Entering the profession with high levels of confidence and hopes, new nurses confront realities that are often beyond their expectations (Newton & McKenna, 2007), hence making them more vulnerable to disappointment due to the expectation–reality disparities. The expectation to provide ideal nursing care is often negated by external factors that new nurses might or might not be aware of. External factors include organisational policies, physical resources, work culture and the nature of interaction with other team members (Parker, Giles, Lantry, & McMillan, 2014). Indeed, these factors add to the dynamics of nursing care that may impact all nurses, regardless of their work experience.

Personal and professional interactions in the workplace appear to be entities that potentially penetrate nurses' personal space. Therefore, in the framework people whom nurses interact with patients, peers and physicians are accommodated in the outer ring of individual space. This suggests that personal quality is perhaps the only balancing factor that determines the flexibility of the barrier between external factors and internal space. Nurses describe the line between personal and professional as, "a blurry line" mainly because there are no universal guidelines on how to balance personal–professional concerns in everyday practice (Laabs, 2007). Indeed, developing a universal guideline would be difficult as situations are highly dynamic and unique in each encounter. Consequently, nurses are left to intuitively determine approaches in navigating the blurry, if not, nonexistent line between personal and professional space. When there is a relatively distinct line between the two, nurses are required to make decisions or take actions in such a way that preserves the best equilibrium of personal–professional gains and losses (Laabs, 2007). However, what constitutes "best" might also involve personal judgement and experience.

Navigating through professional and personal concerns is problematic as the concept of professionalism in nursing often involves personal matters. Nurses are expected to practice in a professional manner by separating personal concerns from professional work. However, high-quality nursing practice requires personalised and genuine compassionate care, which demands genuine personal values and compassion competence (Lee & Seomun, 2016) along with sound skills in managing emotion (Leonard, 2017). Nurses often engage in caring for poorly behaved patients who, for example, harass nurses verbally and sometimes physically attack them (Nilsson et al., 2016). Such experiences potentially create a sense of personal insecurity for nurses. In settings such as emergency nursing, workplace violence is reported to affect as high as 87% of nurses (Pich, Kable, & Hazelton, 2017). Within these situations, it is difficult to synchronise personal–professional concerns. In addition to nurse–patient relationships, interactions with team members might create issues that have potential to interfere with personal concerns, particularly if the interactions involve an imbalance in power relationships. In such situations, nurses may feel devalued (Apesoa-Varano, 2013). Feeling respected can be comforting, energising and confidence-boosting, and conversely, feeling the other way is discouraging, intimidating, belittling and can create many forms of negative emotions (Bournes & Milton, 2009).

The next layer is the professional nature of nursing work. Within this layer, nurses are often exposed to many ethically problematic situations
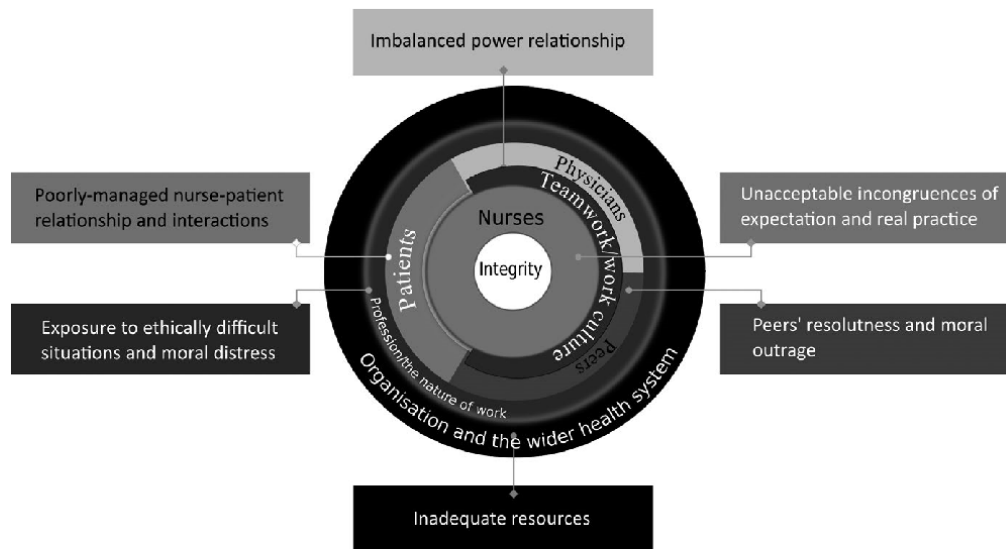
FIGURE 2 Framework of threats to integrity

(Sweeney, 2017). Repeated exposures to ethically difficult situations could induce moral problems. Some common moral problems in nursing practice involve moral uncertainty, moral outrage and moral distress (Barlem & Ramos, 2015). Moral problems have been identified as the common precursor for integrity loss (Nilsson et al., 2016). Frequent engagement with ethically problematic situations makes nurses view those encounters as inherent consequences of the profession that impel them to self-adjust. Adjustment often means compromising personal values (Laabs, 2007) and allowing a certain amount of moral residue, that is feeling unease on nurses' conscience for an extended period of time (Hardingham, 2004). The accumulation of moral residue could induce negative psychological states such as compassion fatigue (Brint, 2017; Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017) and deadened conscience (Nilsson et al., 2016), which is linked to integrity loss (Juthberg et al., 2008).

The framework's outer layer represents the organisation and the wider health system and environment. As nursing care is a subsystem within the wider health system, it is logically bound to the dynamics of the existing health system. The organisation, policies, physical facilities and human resources have a potential to impede the provision of nursing care. However, to be considered a potential threat to integrity, these aspects need to be of a significant magnitude to affect the entities that are closer to the personal layer. Problems arising in the healthcare system are usually well beyond nurses' control and require intervention by managers or policymakers. Maintaining integrity is a complex and continuous endeavour in "getting things right." "Getting things right" entails finding the best equilibrium between being a "good" nurse, a "good" person and a "good" team member. Yet, what constitutes "right" and "good" in practice is often less clear. Preserving a construct of personal integrity (e.g., maintaining

individual sense of intactness) sometimes means compromising a construct of professional integrity (e.g., compassionate care) and vice versa (Besser-Jones, 2008). Deciding on what kind of compromise and how much one is able to make is a complex intellectual process. This process requires personal qualities such as creativity, emotional intelligence (Lewis, Neville, & Ashkanasy, 2017), resilience (Delgado, Upton, Ranse, Furness, & Foster, 2017) and sound clinical knowledge.

5.4 | Further research

The processes that are involved in the formation of, and what constitutes, integrity in nursing remains nebulous. How integrity impacts and influences nursing practice is an under-studied field and warrants further research.

5.5 | Limitations

The reviewed studies were small, qualitative studies conducted in acute care settings, which constrains the resulting framework's applicability in settings such as primary health, community and nurse-led clinics might have different characteristics of threats to integrity. Furthermore, this review is limited to studies published in the English language.

6 | CONCLUSION

Integrity is a multifaceted concept that involves a complex interplay of numerous entities in nursing practice. A threat to a nurse's integrity occurs when there is an unmitigated gap between the nurse's expectation and the reality of practice. While the nurse's expectation is

internalised, the reality is enacted out in the complex interplay that occurs in the healthcare workforce. Perceived gaps between nurses' ideals and realities, combined with nurses' abilities to mitigate tensions between their values and practicalities, determine the degree to which their integrity is challenged. Maintaining integrity when challenged exacts continual adjustments and compensations to balance personal expectations, professional concerns and practice realities to retain a sense of intactness as both an individual and a professional.

7 | RELEVANCE TO CLINICAL PRACTICE

The synthesis from this review allows a more comprehensive understanding of the nature of threats to integrity and strategies to maintain it. Understanding the nature of integrity threats can raise nurses' mindfulness of their personal–professional circumstances. It may assist nurses' reflectivity of their expectations by offering insights and considerations when their integrity is challenged. Understanding and having strategies in relation to integrity may also help nurses with setting realistic goals and expectations, thereby avoiding disappointments with their professional practice.

Raising awareness of the potential problems related to nurses' integrity along with identifying the sources of the problems and viable solutions offers considerations for managers and key stakeholders when developing workplace policies. This review provides a comprehensive knowledge on nurses' integrity that could be embedded into nursing education curricula to facilitate students' preparation for the realities of everyday practice.

CONFLICT OF INTEREST

The authors have no conflict of interest.

DISCLOSURE

The authors confirm that they have undertaken the following: (1) substantial contributions to conception and design (SS, JMN), acquisition of data (SS, JMN), analysis and interpretation of data (SS, JMN, GM), (2) drafting and revising the article critically for important intellectual content (SS, JMN, GM) and (3) final approval of the version to be published (SS, JMN, GM).

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

As discussed in Chapter One, on commencement of data collection, the focus of the research shifted from integrity to values. Yet this shift did not change the research in a fundamental manner, as both constructs are inextricable: personal integrity is loaded with values (Calhoun, 2016). The conception of integrity is influenced by several individual and social factors, such as beliefs, cultures, religions, and socio-economic circumstances, which also make up one's value system (Breakey et al., 2015). Hence, the concept of integrity is likely to be driven by one's values, which implies that the research of integrity is value-laden research.

Finally, one area the published article did not explore was the concept of agency, which is important to define as it relates to the second research question: How do nurses' values influence their practical agency? This topic is presented next.

2.3 The Concept of Agency

In general, the term 'agency' has multiple meanings. It can refer to organisations, administrative divisions, offices, or businesses or it can be used to depict the capacity, condition, or state of acting or of exerting power (Merriam-Webster Dictionary, 2019), by which the latter will be further explored.

The construct of agency is discussed in many fields, including philosophy, sociology, psychology, education, ethics, law and health sciences. Although most of the literature comes from the sociology and psychology fields, agency is a multidisciplinary concept that still requires more empirical research to be fully established (Goller & Harteis, 2017). Agency, in its broadest term, is often linked to one's capacity to act (Schlosser, 2015). In this sense, a person is seen as an agent who has the power and capacity to make, and act on, his/her free choices (Ellis, 2012; Paloniemi & Goller, 2017). Hence, agency is often conceptualised as the

capacity to make free choices and act independently (Goller & Harteis, 2017), which is often examined through the reality of social and individual aspects of a person's behaviour (Eteläpelto, Vähäsantanen, Hökkä, & Paloniemi, 2013).

In sociology, agency refers to an internal quality and process that is comprised of three elements: iteration (drawing upon the pattern of thoughts and actions in the past), projectivity (making a reference to future encounters based on one's hopes, desires, and fears), and practical evaluation, which emphasises the ability of a person to evaluate and decide a particular course of action under the current circumstances and context (Emirbayer & Mische, 1998). Agency is also described as an expression of one's autonomous thoughts, for example, an individual who is in a position to make changes in his/her environment (Smith, 2017) and requires intentionality (Lumer, 2017; Sillar, 2016).

The concept of intentionality in agency relates to cognitive elements, such as his/her beliefs, knowledge, and critical thinking of a particular course of action and its outcome (Bandura, 2018), which is consciously used to pursue preferable outcomes (Bryant & Jary, 2014; Whittington, 2010). However, for an agent to exhibit agentic actions, he/she needs to possess the capability of undertaking the action, as well as the power to evoke or intervene in the actions (Paloniemi & Goller, 2017).

The concept of agency is closely associated with structural influences which have the potential to interfere with a person's agency. These include social class, gender, customs and other external attributes of the structural system. The consensus on the extent to which social systems influence a person's action, or vice versa, has been debated among scholars (Eteläpelto et al., 2013), mainly due to their different philosophical views. For example, sociologists' roots are grounded in ontological perspectives around structure versus agency and/or collectivity versus individuality. On the one hand, social existence is determined by society, which implies

that agency is shaped by social systems (Hewson, 2010; Nicotera & Mahon, 2013). In contrast, some debate that individuals have the capacity to construct their world; thus, the concept of agency is based on an individual's attributes (Giddens, 1979). A third perspective, which combines both views, structure and agency are believed to complement one another (Archer, 2015; Eteläpelto et al., 2013; Smith, 2017). In this view, both individuality and social influence are considered equally important, as structure can affect people's behaviours and people possess capacity to change their social structure (Hurrelmann, 2009).

Giddens' (1979) notion of agency highlights the agent-centredness which emphasises the agent's active power and capacity to influence social events (Bryant & Jary, 2014). Within this perspective, agency is related to one's creative inspiration, ideas, and intentional actions that are directed towards changing the environment (Eteläpelto et al., 2013; Paloniemi & Collin, 2012). Yet, other scholars believe agency does not always require an active initiator, as agency could also manifest in a passive form, such as endorsing other agents' initiatives for changes and acting accordingly (Ellis, 2012; Groff, 2012). This means that agency can also be exhibited through participation and collaboration with other people who share similar thoughts and interests (Paloniemi & Collin, 2012).

However, Gidden's (1979) view of agency is considered too limiting because it focuses only on individual rationality and reduces the complexity of social existence to merely individual actions (Archer, 2017; Bryant & Jary, 2014). Furthermore, his theory of agency has also been criticised for downplaying the context and situational elements that can influence one's decisions and actions at a particular time. This is referred to as the temporal dimension of agency (Archer, 2015) which distinguishes it from the historical pattern of an agent's life course (Emirbayer & Mische, 1998). This aligns with Eteläpelto's (2013) work that cautions against idealising and decontextualising the concept of agency but, rather, suggests regarding it as an intact personal entity within a social context, both in short and long-term timeframes.

He also argues that, although individual agency and social context can be separated analytically, both are inextricable and mutually constitutive.

The limitation of Gidden's (1976) agency theory gives rise to the realist social theory of agency, which examines agency through the relationship of humans with the world (Archer, 2003). This includes natural (human natural features, such as health and wellbeing), practical (human's competency and capability to exert changes), and social (contextual influences) perspectives. This theory allows a more inclusive perspective of agency that encompasses analysis of social influences. However, as this theory emphasises the temporal context, it has also been criticised for its inadequacy in explaining the long-term learning processes of identity development and the negotiation of identity within the social environment (Eteläpelto et al., 2013).

Another perspective on agency is offered by Hitlin and Elder (2007) who classify agency into four types: existential, pragmatic, identity, and life-course agency. Existential agency refers to the human capacity to initiate and direct actions which are innate in nature (Elder-Vass, 2010). Pragmatic agency refers to the course of actions that do not align with the agent's normal habitual pattern of social actions and are often seen as momentary actions of the agent (Hitlin & Elder, 2007). Identity agency, on the other hand, represents the normal habitual pattern of behaviour which aligns with the agent's identity (Bourdieu & Moishe, 1993). Finally, life-course agency refers to the agent's endeavour to pursue a particular quality or course of actions that have long-term implications for his/her life trajectory into the future (Crockett, 2002). Life-course agency implies the agent's capability to have a perspective on his/her future and an ability to sense long-terms outcomes based on current choices and actions (Crockett, 2002; Hitlin & Elder, 2007). This perspective encompasses almost all of the features of the existing notions of agency.

As an alternative to Hitlin and Elder's (2007) perspective, Elder-Vass (2010) proposed what he calls the emergentist framework to understand actions or agency. The framework is erected upon the understanding that humans are reflexive beings (Archer, 2017) who have reasoning capacity and capability to think critically and modify their dispositions, while drawing from experience and value (Elder-Vass, 2010). The emergentist framework provides a perspective through which various elements, such as social elements (culture, customs, social structure, organisations, and other environmental entities) and individual components (biological parts, internal dispositions and characters) are considered relevant constructs of agency that are intertwined with reality (Elder-Vass, 2010).

In more practical terms, agency is often simply examined through the agent's actions and the entity the action represented. In this sense, Hewson (2010) offers an alternative perspective on agency, which is classified into three types: individual, proxy, and collective. Individual agency refers to a feature by which an individual expresses his/her own will/values. The proxy agency, on the other hand, refers to a person's undertakings that represent other party's interests. Finally, when a person's actions represent his/her group or community, he/she is said to exhibit collective agency (Hewson, 2010).

In psychology, agency is viewed as a socio-cognitive entity in which an agent is characterised by some qualities, including self-organisation, proactivity, self-regulation, and self-reflection, that often exhibit creative thoughts and actions (Glăveanu, 2010). It emphasises the mental capacity of an agent to gain control over motivations and the actions for them (Bandura, 2014). Also, agency is often characterised by the ability and intentionality of a person as an agent to perceive and change his/her environment. "Agency operates through a triadic codetermination process of causation" (Bandura, 2018, p. 130) that includes personal, behavioural, and environmental determinants.

As can be seen in this section, the conception of agency has many different dimensions and can be examined through various perspectives and standpoints. The contextualisation of agency in the professional world needs a definitive setting. This current study seeks to contextualise the concept of agency within the nursing context. As such, we now turn to explore some perspectives on the concept of agency in nursing practice.

2.3.1 Agency in nursing practice.

The term 'agency' in nursing is used in a couple of ways. For example, the term, 'agency nurses', refers to nurses who are affiliated with a nursing agency, which is an agent that recruits casual or short-term nurses to be employed in hospitals or other health care organisations. In this example, the term nursing agency refers to an organisation. However, this study does not deal with this kind of agency. Instead, this current study uses the term agency in the sense of a personal-professional agency viewed from both theoretical and practical constructs of the nursing world.

The notion of agency in nursing appears to be grounded in Dorothea Orem's Self-care Deficit Nursing Theory (SCDNT), which includes concepts of self-care, self-care agency, therapeutic self-care demand, self-care deficit, nursing agency, and nursing system (Orem, 2001). Within this theory, nursing agency refers to the capacity of a nurse to provide nursing care for others. In addition, there is also a concept of self-care agency which refers to the capacity to carry out care for one-self (self-care agency). In this theory, nursing systems are formed on these agencies and the relationship/interactions between patients and nurses (Orem, 2001).

From this perspective, nursing agency entails mastery of clinical and non-clinical nursing skills of providing care for others (Orem, 2001) which are considered as power (Orem & Taylor, 2011) to engage in the deliberate action of nursing (Banfield, 2011). This notion

resonates with the sociological concept of agency, in which intention and deliberation are essential in explaining the concept of agency (Lumer, 2017).

It is understood that the structure of nursing agency is established upon three constructs that include: 1) the operations (social, interpersonal, and professional interactions) that are necessary for nursing care, 2) the power components (capabilities, knowledge, skill, motives and consistency), and 3) the foundational capabilities and dispositions (qualities and capacity to conduct deliberate actions) (Banfield, 2011). To appraise nursing agency, each element of these constructs can further be looked at through various perspectives, including the perspectives of development, operability, and adequacy (Banfield, 2011). From the perspective of development, nursing agency is formed upon nursing education and other skill-acquisition sources, such as the working environment (e.g., work experience) (Stein-Parbury, 2014). Operability looks at the feasibility and practicability of nursing agency which includes any internal and external factors that affect the expression of nursing agency. Finally, adequacy refers to the match between nursing demand and available care /resources/ caregivers, which is linked to nursing administration (Banfield, 2011).

In some of the nursing literature, agency is measured and evaluated on a continuum that spans from a low to high degree of agency (Cooren, 2010) and different degrees of agency can influence interprofessional teamwork (Caronia & Saglietti, 2018). However, agency cannot be zero, even when an agent takes no action, as doing nothing is also a choice (Nicotera & Mahon, 2013).

Since nursing environments often include moral situations (Elmore, Wright, & Paradis, 2018), morals have become a crucial construct in nursing agency (2013). Moral agency in nursing relates to the provision of nursing care with moral overtones and is closely connected

to a nurse's identity (Liaschenko & Peter, 2016). Milliken (2018) conceptualised moral agency as:

> "action on behalf of a patient resulting from insight into the ethical implications of a situation and the available courses of action, with a willingness to dialogue thoughts and concerns in an interdisciplinary context in order to achieve what is needed in line with patient and professional goals" (Milliken, 2018, p. 5).

A nurse's moral agency is related to moral identity which is exercised through moral agency in practice (Liaschenko & Peter, 2016). Peter, Simmonds and Liaschenko (2018) provide two examples that represent the moral identities of nurses. This includes: 1) making a difference in the lives of others (patients and community), and 2) protecting the identities of patients. As nursing agency is enacted upon nurse-patient relationships, moral agency, in this context, is very much oriented toward 'right-wrong' actions that are framed with several intertwined constructs, such as rational and self-expressive choice, autonomy, personal-professional identity, and the awareness of the asymmetric power of nurses, doctors, and patients (Rodney et al., 2013).

The terms, 'nursing agency' and 'nursing practical agency', are, indeed, interchangeable. The additional term, 'practical', is chosen to give more emphasis on nursing practicalities or the future direction and actions of nurses. To serve this current study's purposes, practical agency is defined as a nurse's set of technical and/or non-technical nursing skills and knowledge to provide nursing care.

2.4 Conclusion

This chapter has provided a literature review on the concept of integrity and agency, both in general and nursing-specific contexts. The gap in knowledge which inspired this current study has been identified, and foundational information regarding the concept of integrity and

agency has been presented. This information also helps to clarify the ambiguity in the use of the term 'integrity' and 'agency' in the nursing literature. The next chapter presents the research methods that were chosen in order to accomplish the research aim.

Chapter Three: Methodology

3.1 Introduction

In this chapter, a brief overview of grounded theory and the underpinning philosophy is presented. The chapter begins with the philosophy of symbolic interactionism. Next, the origin of grounded theory, its progress and subsequent generations of grounded theory are succinctly reviewed. A more detailed discussion on constructivist grounded theory is provided as the methodological basis for this study.

The rest of the chapter offers the rationale for utilising grounded theory to study the phenomena of interest. The researcher's philosophical stance and the more detailed account of research methods, as well as the ethical considerations for this research, are presented.

3.2 Qualitative Research: A Brief Synopsis

Qualitative research is a method of inquiry in which the researchers study social phenomena with an intention to provide various level of explanations starting from a rich explanation of an event to a conceptual abstraction of a phenomenon and theory building (Denzin & Lincoln, 2017). The hallmark of this approach is that it studies phenomena from the perspective of the people who live or experience the phenomena of interest (Charmaz, 2014). Researchers collect qualitative data through various methods, such as interviews, observations and focus group discussions, before they analyse and try to make sense of it (Denzin & Lincoln, 2017).

Qualitative approaches study social processes and, initially, there were a lot of criticisms raised by researchers of the positivist paradigm (Glaser, 1978). Despite initial criticisms, the underlying philosophy of qualitative research became more explicit and

criticisms gradually decreased (Charmaz, 2014). As a result, qualitative approaches became prominent across a number of disciplines, such as education, health, sociology, psychology and arts (Creswell & Creswell, 2017; Green & Thorogood, 2018; Murphy, 2017). The qualitative methods are developed in alignment with a range of philosophical and theoretical underpinnings. One of the theoretical perspectives that have gained popularity among contemporary qualitative researchers is symbolic interactionism.

3.3 Theoretical Perspectives on Constructivism and Symbolic Interactionism

Constructionism embraces the view that human consciousness plays an important role in interpreting an object (reality) and attaches meanings to it. It regards the object as of equal importance as the subject (human consciousness) in constructing realities (Crotty, 1998). Within the constructionism tradition, an understanding of reality is tested and confirmed through interaction with others, which results in collective understandings (Berger & Luckmann, 1991; Crotty, 1998; Schwandt, 2000; Stryker, 1980). Constructionism is defined as:

> "The view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of the interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty, 1998, p. 42).

This definition holds an epistemological assumption that reality is constructed through human interaction within a specific social context, which is the basis for the theoretical perspective on symbolic interactionism. Symbolic interactionism emphasises the role of symbols, such as language or gestural communication, that are interpretive in nature. Therefore, constructionism (also known as social constructionism) highlights the way culture impacts on people's sense of reality (Crotty, 1998).

The notion of human consciousness and human interaction and the interplay between the two determines how an object is perceived and what meaning is associated with it. Following through this thought, in symbolic interactionism ontology, meanings are processed and constructed through humans' perceptions and engagement in an interaction (Blumer, 1969; Charon & Cahill, 1979; Stryker, 1980)

The interplay between human consciousness with objects in the world results in an understanding of the objects (Blumer, 1969). As a consequence of the belief that reality is constructed within the human mind, multiple realities are evident. Every person holds their reality, which will become a social reality only after it is confirmed through the social interaction within a culture (Schwandt, 2000; Stryker, 1980). Following the same logic, it is understandable that every culture holds its own reality, which varies from other cultures.

The epistemology of symbolic interaction is derived from the concept of intentionality, which emphases the interaction between object and subject. The intentionality school of thought rejects the extreme notions of both objectivism and subjectivism. Instead, it sees a subject and an object as two ends that are of equal importance in constructing the world and, therefore, they should be conceived as indissoluble parts (Crotty, 1998). Symbolic interactionism is a philosophical perspective for the constructivist grounded theorists (Bryant & Charmaz, 2007; Charmaz, 2014; Charmaz, 2016b).

Over time, the philosophical assumptions of qualitative inquiry methodologies have shifted and split. The most visible shift can be seen in the progress of grounded theory methodologies. For instance, the first generation of grounded theory, classical grounded theory, has been remodelled based upon the epistemology of symbolic interactionism (Charmaz, 2016a).

3.4 The Progress of Grounded Theory Methodology

Grounded theory first appeared with the publication of, *The discovery of grounded theory: strategies for qualitative research* (Glaser & Strauss, 1967). The publication was built upon the successful collaboration of the authors to study death and dying in hospitals in the United States of America (USA). The topic of death and dying, at the time, was not normally acknowledged by hospital staff, so knowledge around how patients and hospital staff dealt with this sensitive issue was largely undocumented. Based on their experience with interviewing and analysing data from the study, Glaser and Strauss established a systematic, methodological approach that was transferable to other topics. The major contribution of this publication included paving a path to a methodological consensus, as well as offering systematic approaches, for qualitative research (Charmaz, 2014). The systematic approach that they developed allowed researchers to construct an abstract theoretical explanation of social processes, integrated into a theory, through inductive processes (Glaser & Strauss, 1967). The earliest version of grounded theory is known as classical grounded theory or Glaserian grounded theory.

Although Anselm Strauss was the co-originator of classic grounded theory, later, he held a different view of grounded theory from that of Barney Glaser's. Together with Juliet Corbin, Anselm Strauss published another variant of classic grounded theory, which is known as Straussian grounded theory and published in the book, *Basics of Qualitative Research* (Strauss & Corbin, 1990). This publication has sparked the legendary debate over grounded theory. Responding to the publication, Glaser wrote his rebuttal in a book, *Emergence vs Forcing: Basics of Grounded theory Analysis* (Glaser, 1992). Glaser criticised Strauss for 'forcing' the researcher's ideas into the data, rather than allowing theory to emerge from the data. Glaser has been consistent with his thought that grounded theory is a method of discovery

(Glaser & Strauss, 1967) while Strauss sees it as the method of verification (Strauss & Corbin, 1990).

Straussian grounded theory emphasises the role of human agency in the social and subjective nature of meaning construction (Corbin & Strauss, 2008). This indicates that Straussian grounded theory has used some epistemological assumptions in his methodology, although Strauss did not clearly pronounce their underpinning philosophy, which inspired some of the second-generation grounded theorists to advance the methodology, both in its philosophy and approaches.

Since this time, grounded theory method has grown and been modified and extended, dependent upon the espoused philosophy of the scholars. Clarke (2005), for example, offers a perspective, known as situational analysis grounded theory, which seeks to use the social situation as the unit of analysis. Charmaz (2006) provides another perspective on grounded theory in which she emphasises and acknowledges the role of the researcher in grounded theory and that multiple realities are constructed through social interactions. Differing from Glaserian-grounded theory that suggests the researcher needs to maintain some distance from the data (Glaser, 1992; Glaser & Strauss, 1967), Charmaz advocates the researcher play an active role in constructing theory (Charmaz, 2014). Both Clarke and Charmaz criticise the former grounded theory for representing positivist epistemology, despite its original goal to challenge positivists' school of thought in social research (Bryant & Charmaz, 2007; Charmaz, 2014; Clarke, 2005; Clarke & Charmaz, 2014). Clarke's and Charmaz's work remodels grounded theory to match constructionism epistemology within a symbolic interactionist theoretical perspective.

3.5 Constructivist Grounded Theory

One of the more contemporary versions of grounded theory is the approach developed by Charmaz (2006), which she calls 'constructivist grounded theory'. Charmaz combines some of the characteristics of the Glaserian grounded theory with that of Straussian's theory and provides clear underlying epistemology for the methods (Charmaz, 2016b). Some methods of grounded theory, such as the inductive, comparative, emergent, and open-ended approaches, as well as the coding, memo-writing, and theoretical sampling in constructivist grounded theory, are directly adopted from its predecessors.

The most distinct feature of constructivist grounded theory is its distinct positioning, which shifts from objectivism to constructionism (Charmaz, 2014; Charmaz, 2016b; Mills, Bonner, & Francis, 2006). According to constructivists, research products and processes are constructed, and the construction of the realities is neither entirely subjective nor completely objective. Charmaz (2016b, p. 130) states:

> "the constructions occur under pre-existing structural conditions, arise in emergent situations, and are influenced by the researcher perspectives, privileges, positions, interactions, and geographical locations".

This implies that reality construction is also contextual. Constructivists consider that research processes as well as writing research reports are not neutral actions but, rather, interpretive renderings that involve the researcher's conscience, which is shaped and amplified by environmental factors (Bryant & Charmaz, 2007; Charmaz, 2014). This notion reflects Charmaz's philosophical stance, in which she appears to subscribe to constructivism that is informed by pragmatism epistemology (Charmaz, 2016b).

Constructivist grounded theorists try to include stated and unstated participant beliefs, assumptions and actions, as well as the surrounding circumstances in their analysis. It is believed that whatever is observable in our environment may not be as straightforward as it

seems but, as Charmaz (2014, p. 241) said, 'much remains tacit; much remains silent'. Constructivist grounded theorists seek to scrutinise the research participant's meaning and action within their social structure and taken-for-granted discourses (Bryant & Charmaz, 2007).

As the epistemological stance of constructivism views realities as constructed rather than discovered, it is essential for constructivist researchers to foster reflexivity about their actions, processes and decisions (Charmaz, 2014; Charmaz, 2017). The process in which the researchers shape the realities is made transparent through clearly articulated, reflective statements in the study. Charmaz (2014) suggests that engaging in reflexivity helps the researchers to avoid preconceiving data and making sure it is explicit in their study (Charmaz, 2016b).

3.6 Rationale for Selecting Constructivist Grounded Theory as the Methodology

Grounded theory is inductive in nature, involving iterative processes that require a researcher to simultaneously gather and analyse data, to constantly compare all instances of data by going back and forth between data and analysis. The method allows the researchers to steer and govern data collection to construct an original analysis of their data. In addition, grounded theory offers 'a set of principles, guidelines, strategies, and heuristic devices rather than formulaic prescriptions' (Charmaz, 2014, p. 3).

Grounded theory encourages researchers to embark on their study with an open mind, which allows the researchers to gain a better sense of and learn the phenomenon under study (Charmaz, 2014). The researchers should anticipate changing their mind when the emerging evidence from data suggests so. The change in mind can involve altering the existing concepts to suit the emerging analysis or the direction of the research or shifting the method of data gathering or anything else as the result of constant comparative methods (Bryant & Charmaz,

2007; Charmaz, 2014), which was evident in this study when the research question changed from integrity to exploring values.

Grounded theory methodology allows the study to move beyond description and facilitates theory construction from data (Charmaz, 2014; Clarke & Charmaz, 2014). This methodology is ideal in the situation where there is a need for understanding the basic social processes leading to theory construction and when knowledge about the topic under study is either limited or non-existent (Birks & Mills, 2015; Charmaz, 2011). This methodology, therefore, was found to suit this current study, which aimed to construct a theory of an abstract concept that is under-researched (see Chapter 2). The scarcity in literature, coupled with the intention to build theory, are among the rationales for implementing grounded theory methodology.

As personal integrity and values processing is complex and varies across persons and contextual situations, it is essential to compare not only the instance of data gathered from an individual but also data from different individuals from different settings. Given that grounded theory methods allow the researcher to represent data subjectivity and complexity, it is appropriate to apply this methodology to study how nurses evolve value systems and the surrounding concepts.

The decision to choose a constructivist grounded theory (rather than classical grounded theory) was driven by the researcher's philosophical positioning, which is presented next. The evaluation of the quality of this current study is presented in Chapter Eight, section 8.5.

3.7 The Philosophical Positioning of the Researcher

Identifying one's philosophical positioning in a study is crucial because it helps one to justifiably guarantee a locus within the methodological sphere where one feels theoretically content (Birks & Mills, 2015; Mills et al., 2006). Based on this, the researcher elucidates his personal philosophical position that governed this study.

In contemplation of ontology, the researcher believes that there are multiple truths in social life, a notion that stems from the belief that individuals construct meaning in their mind (Crotty, 1998). People can perceive one object differently which, consequently, produces plural perceptions. Even when a group of people reach a consensus on a phenomenon, other groups of people may develop different meanings. Therefore, the researcher takes the position that the reality is multiple and becomes real within people's senses through social interaction. As people and their interactions within a social structure change over time, the reality is highly likely to vary across people, time and place. All realities are a valid part of social life that deserve a study (Denzin & Lincoln, 2017).

With reference to epistemology, the researcher embraces the constructionism notion, which acknowledges that both object and subject are of equal importance when it comes to defining reality. The researcher believes that the existence of an object stimulates human awareness, which then associates meaning with it. This individually assigned meaning needs to be examined at a social level, through the process of interaction which allows social construction of the meaning (Berger & Luckmann, 1991; Charon & Cahill, 1979). Hence, the concept of social constructionism is appropriate to study social phenomena.

The researcher upholds symbolic interactionism. Interaction is central to basic social processes, through which symbols and meanings are developed and attached. He believes that

interaction between people within a specific time in a definite place determines their socially constructed reality (Clarke & Charmaz, 2014; Crotty, 1998).

3.8 Positioning the Philosophical Assumptions to Study Concepts

It is important to clearly articulate the connection of the study being undertaken with the espoused philosophy (Bryant & Charmaz, 2007; Charmaz, 2016b). Based on this, philosophical assumptions that drive this study are explained below.

3.8.1 Ontological assumptions.

Integrity and values are processed differently by different individuals. Even the same individual may see the concept of integrity and values differently at different points of time. Following the complexity of a human's construction of reality, the concept of integrity and values are also abstract and complex. Some people might value elements of integrity differently and, as such, these elements might affect people in different ways.

3.8.2 Axiological assumptions.

The study of a phenomenon that is embedded in the social life of a community, including this study, involves values. With regard to the axiological assumption, the study of personal integrity is loaded with values. Individuals' beliefs, cultures, religions, social-economic circumstances, and education are among the social contextual factors that are likely to shape individuals' perceptions of integrity (Breakey et al., 2015) and value systems. Hence, the concept of integrity is likely to be driven by one's values within a specific context and, therefore, the research of integrity is considered to be value-laden research.

3.8.3 Epistemological assumptions.

The concept of values and integrity is constructed by human beings in their mind and built upon in their conscience, which involves human senses. Factors such as intelligence, creativity, individual traits and personality (Breakey et al., 2015; Calhoun, 2016; McFall, 1987; Mitchell, 2015; Prust, 1996; Tyreman, 2011; Von Eschenbach, 2012) are brought into social interactions with other members of the community. Nurses, as agents with their clinical and non-clinical (social) capabilities, interact with other people inside and outside their workplace. A nurse develops integrity and values in their mind, which may or may not be practised; therefore, it may or may not be observable by others.

Another epistemological assumption in this research is that the process of data collection and analysis involves the intelligence and creativity of the researcher. The study participants provide data that is analysed by the researcher through a process of coding and categories development, which makes it impossible to deny the researcher's influence on the resulting theory. As a consequence of the researcher's involvement in the research, 'biases' are unavoidable. However, the 'biases' need to be justified. Researchers need to ensure that they do not introduce baseless ideas from an empty head but, rather, inaugurate thoughts that are resulted from an active cognitive process of theory sensitising and constant comparative data analysis (Bryant & Charmaz, 2007).

Instead of seeing 'biases' as unintended, in qualitative research 'biases' are expected, documented properly, and made transparent to other researchers to promote accountability of the research, which Charmaz (2014) suggests adds a richness and complexity that is beneficial (Charmaz, 2014). This section, in fact, is presented as part of this research accountability.

3.9 The Consequences of the Philosophical Assumptions

The philosophical stance that underpinned the choice of research design and affected the research process is threefold. Firstly, there was no distance maintained between the participants, data, and the researcher. Rather than playing a role as an objective-passive researcher, the researcher proactively studied the phenomena and its surrounding concepts. A study of the literature on the topic before commencing a study was not taboo; rather, it was a means of theory sensitizing that helped to shape data analysis and added rigour to the developed theory. Charmaz (2014) suggests that theory sensitizing provides a flexible framework for the researcher; it provides preliminary thoughts to pursue and issues to raise.

Secondly, the researcher sought to critically construct reality rather than trying to discover reality. The reality construction was based on participants' points of view and experiences about the phenomenon under study. The researcher constructed the theory based on the participants' ascription and the researcher's understanding of the phenomenon, which was supported by his supervisors' wisdom. He chunked and coded the complex qualitative data, contemplated emerging categories, and then integrated them in overarching abstract concepts.

Thirdly, participants constructed the meaning in and out of the symbols used in the interactions in their workplace. The researcher utilised methods that enabled him to explore the meaning and the process of assigning meaning by the participant. His understanding of the culture in which the participants live, as well as his professional experience, has helped him to advance the analysis of symbols, such as language, gesture, and posture, which were used within the defined context.

The researcher's philosophical stance (starting from the way he viewed the concept of reality, including declaring his underlying assumptions) closely resembles that of constructivist

grounded theorists. He did not, however, avoid the possibility of implementing other-than-suggested methods because, as Charmaz (2014) stressed, grounded theory is not a set of rigid prescribed methods. The researcher viewed grounded theory as a fluid, dynamic, intuitive, and heuristic way of thinking that requires intelligence and creativity.

3.10 Data Collection

In grounded theory, as Glaser (2007) stated, 'all is data', which implies that all conditions and situations in the research scene, regardless of their source and form, are the data. Building upon this definition, a grounded theory study uses multiple data collection methods, as well as collecting various forms of data from various sources (Glaser & Strauss, 1967).

Implementing multiple data collection methods is encouraged in a grounded theory approach, as it facilitates researchers to gain various insights into the phenomenon under study (Glaser, 2007) to answer the research questions. This principle bears the notion of methodological eclecticism (Charmaz, 2014), which requires researchers to not only familiarise themselves with a set of possible methodologies and their underpinning philosophy but to also possess sound knowledge on the topic being researched and its setting. The researcher took into consideration all suggestions and caveats from prominent grounded theorists, particularly that of Charmaz's constructivist grounded theory. The data collection methods are presented in the following section.

3.10.1 Methods of data collection.

In order to reveal meanings, actions, and social processes that are related to the phenomena being studied, the researcher employed multiple data collection methods including in-depth, individual interviews, focus group interviews, and anecdotal and reflective writing. To record the context of the study, he wrote memos, both in the form of methodological

journals and analytical memos, throughout the data collection and analysis process. Memos play an important role in providing context for data analysis and a record of the chronology of analytical interaction between the researcher and the data, codes and categories development (Charmaz, 2014).

Among the most common methods of data collection in grounded theory is the in-depth interview (Brinkmann, 2017). The decision to use in-depth interviews was based upon the belief that it would allow him the greatest depth of insight and reveal process and events, as well as illuminating the topic under study. In-depth interviews empowered the researcher to explore meanings, processes and actions (Fontana & Frey, 2005). In every interview, the questions were extended and probed in response to the participants' answers, to provide significant insights into the topic (Rubin & Rubin, 2012).

The characteristic of an in-depth interview is the best match for the dense data requirement of theory building in a grounded study (Charmaz & Belgrave, 2012). To capture the more comprehensive insights into both context and the data itself, interviews were conducted in two forms: group interview and individual interview.

Loosely semi-structured interviews were used to avoid a risk of forcing preconceived ideas into data, which is a typical issue when employing a detailed and systematic interview guide (Bryant & Charmaz, 2007; Glaser & Strauss, 1967). It was suggested that general, opening questions do not amount to imposing received codes (Charmaz, 2016b) and, thus, were used to lead the interview at the beginning. Statements made by the participants were probed and thoughtfully followed up, especially when the responses seemed to either form a new category or support/reinforce or negate existing ones. More details on each of the selected data collection methods are presented in the following section.

3.10.1.1 Focus Group Interviews

Kamberelis and Dimitriadis (2017) argue that focus group interviews (FGIs) allow the researcher to observe group dynamics that create and enhance memories, positions, ideologies, practices and desires among a certain group of people. A focus group facilitates people to speak in both collective and individual voices, in which the researcher can capture participants' responses in real space and time in the context of social interaction (Kamberelis & Dimitriadis, 2017). In addition, a focus group allows the researcher to strategically focus interview prompts, based on themes that are emerging during the interaction (Carey & Asbury, 2016).

The FGI was chosen because it is efficient and allows the researcher to observe multiple participants' viewpoints in a short time (Polit & Beck, 2016). It also allows the yielding of data that are seldom obtained through individual interviews (Carey & Asbury, 2016). Furthermore, focus groups helped the researcher to scrutinise the complex ways participants position themselves in regard to each other, as they process issues in a focused way (Kamberelis & Dimitriadis, 2017).

The researcher conducted FGIs during the initial data collection in order to elicit what participants meant by integrity and to bring them on the same page. Three audio-recorded focus group interviews were conducted, with six to eight nurses per group, lasting between 60 and 90 minutes. Two focus group interviews were done with participants from West Nusa Tenggara Province. The other group was attended by participants from many different provinces, including Jakarta, West Java and Sumatra, and was conducted in Jakarta. There was a total of twenty-three participants who took part in all focus group interviews. The data obtained from the FGIs was used as the bases for, and to focus, the subsequent data collection.

3.10.1.2 Individual Interviews

Brinkmann (2017) suggests interview as a method of data gathering when the main concern of the study is explorative in nature in which the researcher plays nondirective roles. This method empowers the interviewer to explore and interpret meanings, actions and processes. The researcher conducted either face-to-face interviews, which was the preferable option, or phone interviews.

Eight participants were recruited from those who had participated in focus group interviews. This allowed the researcher to obtain more insights into the studied phenomena from the individuals who had been well-situated around the topic, through the previous focus group interview. Following theoretical sampling technique, it was, however, necessary to follow the developing categories, which required new participants to be recruited from outside the focus group interviews.

The number of interviews was ascertained by the theoretical saturation (Charmaz, 2014; Glaser, 1978). The number of participants was determined by the extent to which the collected information satisfied the emergent theory and fully captured the properties of the theoretical categories (Charmaz, 2014). A total of 24 nurses were individually interviewed until data saturation was reached.

3.10.1.3 Anecdote and reflective writing

In addition to FGI and individual interviews, anecdotal and reflective writing, in the form of narrative story writing, was utilised to complement data gathering. Anecdote-reflection consists of a description of a lived experience of a particular event that is combined with a reflection on the relevant phenomena (Adams & vanManen, 2017). The participants were asked to write an anecdote and/or reflection on relevant phenomena or incidences that they

encountered, including how they felt about the incidences, how they dealt with them, what opinions and assumptions were made and how the incidences affected the participant's way of thinking and seeing the issue. They were also asked to document how the incidents related to the participants' personal and professional values, as well as moral principles, and how the participants framed and reframed the experiences to their practical agency.

3.10.1.4 Memos

Memos are chronicles of thinking, ideas, considerations, insights and impression about the research (Birks & Mills, 2015; Charmaz, 2014; Glaser & Strauss, 1967; Strauss & Corbin, 1990). The benefits of memo-writing include defining and checking the codes, helping to bring data into narrative work from the start, and identifying and analysing processes, as well as evaluating the codes that were raised to tentative categories (Charmaz, 2014; Glaser, 1978). Memos help the researcher to recall the situations, antecedents and/or subsequent events that might happen and might have relationships with the emerging categories (Glaser & Strauss, 1967). Memos are useful to explain the context, atmosphere, environment, physical appearance and body language (Birks & Mills, 2015) that may otherwise be forgotten. Furthermore, a well-written memo can assist with data abstraction, and it helps the researcher in report-writing by providing context (Charmaz, 2016b) and a record of the analytical interaction between the researcher and the data (Charmaz, 2014).

In this study, memos were written during data collection and the analysis process. It included both methodological journal entries and analytical memos that were integrated into the research process. While the methodological journal accommodated all progress and alterations during the study, the analytical memos were used to record the researcher's thoughts

on, the progress of, links between and relationships among the codes and categories (see Appendix 9).

3.10.2 Sampling methods.

For the purpose of gathering initial data, participant recruitment was conducted using a purposeful sampling method (Birks & Mills, 2015). Polit and Beck (2016) define purposeful sampling as purposefully selecting cases that most benefit the study. In other words, the participants who have experience with the key concept being studied were intentionally selected (Creswell & Creswell, 2017). In recruiting participants for initial data gathering, maximum variation sampling technique was employed in order to ensure that nurses with diverse background were represented so that various perspectives of the studied concept could be accommodated. Hence, those who were likely to represent various social-cultural backgrounds and the nature of nursing work settings were recruited. The researcher was mindful about social-cultural diversity across the nation and how diversity may characterise nurses from different parts of Indonesia. In addition, he was cognisant of the fact that nurses work in various areas of nursing services across the country, with different levels of demands, expectations and requirements. Thus, the participants initially were recruited on the bases of the distinct cultural, geographical, or sectoral properties they were situated in. Although assiduous efforts to capture any cultural/social-physical environment diversity, that account for variations, were made, it was not intended to pursue the generalisation of findings across the nation (Charmaz, 2014; Glaser & Strauss, 1967). Rather, it was a form of theoretical sensitising in which cultural factors were thought to be interfering with the studied phenomenon (Charmaz, 2014).

After tentative categories developed, data collection and analysis were continued, following the grounded theory theoretical sampling principles, and recruitment was terminated at the time the data reached theoretical saturation.

3.10.3 Theoretical sampling.

Theoretical sampling is a specific and systematic approach designed to facilitate conceptualisation and allow theory to develop out of data. Theoretical sampling is a strategy by which researchers seek and gather pertinent data to elaborate, support, and revise categories that emanate from the existing data (Charmaz, 2014). It is the process of data collection in which the emerging analysis determines the direction of the research, which includes what to pursue in the next interview and where to find the data (Charmaz, 2014; Corbin & Strauss, 2008; Glaser & Strauss, 1967). In other words, this process is driven by the emerging theory (Charmaz, 2016b) and involves a process of cyclical, concurrent data analysis that lasts until categories are fully established (Birks & Mills, 2015; Charmaz, 2014).

Theoretical sampling in grounded theory starts with a tentative category that serves as the lead to follow (Charmaz, 2014). The tentative category is derived from initial data collection in which the initial participants are recruited through purposeful sampling. The subsequent interviews attend to the nascent category that is obtained from the initial data collection and analysis (Birks & Mills, 2015; Charmaz, 2014). Some criteria for initial sampling, such as people, cases, situations, and/or settings, can be used as embarkation points (Charmaz, 2016b). Initial sampling is meant to be purposeful (Birks & Mills, 2015),

In this study, theoretical sampling was implemented as this method facilitates the emerging theory to fully develop (Bryant & Charmaz, 2007; Charmaz, 2014). Data collection began with initial purposeful sampling and was followed by the initial data analysis before implementing the theoretical sampling principles. The emergent understandings of the initial

data informed the selection of the next participants, including the questions pursued in the next interview, which were based on the tentative categories developed from previous interviews.

3.10.4 Recruitment strategies.

The research participants were recruited by means of an advertisement, which was published one month before data collection commenced. The advertisement was placed in various media, including commercial radio stations, social media, such as Indonesian nurses' Facebook groups and health-related institutional Facebook pages (hospital and education institution), nurses' WhatsApp group page and personal networks.

Nurses who responded to the advertisement received a set of detailed information in the form of an explanatory statement and consent form (see Appendices 5, 6). Prospective participants were contacted by phone or email. A 48-hour response for email communication, or 24-hour response for other modes of communication, was ensured before contacting the next participant. As a part of cultural expectation, the participants were awarded a gift worth AU$ 20, in appreciation of their contribution.

3.10.5 Inclusion criteria.

In order to be an eligible participant for this study, a nurse needed to meet the following inclusion criteria: 1) be a registered nurse, 2) have a minimum of three years of nursing experience at the time of advertising, and 3) be a non-nurse educator. The second requirement was to rule out the effect of transition that happens during the first three years of a nursing career (Chen & Boore, 2010). The last criterion was used to purposefully select only clinical nurses, due to the initial aim of the study, which was to explore personal integrity and practical agency within clinical settings.

3.11 Data Management and Analysis

Data management was done according to the university's policy on research data management and is outlined in the sections below.

3.11.1 Data storage.

The data collected from the field is stored in labArchives, a cloud-based platform that is endorsed by the university and designed to manage, organise, store, and share data while enhancing communication and collaboration. Except for the researcher and his supervisors, no access to the data is possible.

3.11.2 Recording, transcription and translation.

As it is important to document the interview (Fontana & Frey, 2005; Rubin & Rubin, 2012), both focus group interviews and individual interviews were digitally recorded following participants' consent with at least two recorder devices: the main recorder and a backup.

All focus group and individual interviews were conducted in the Indonesian language, Bahasa Indonesia, and were transcribed verbatim. The transcripts were translated into English by a professional translator. The bilingual researcher verified the translations and scanned through specific words/phrases that might be replaced with the more appropriate technical terms. To ensure the accuracy of the translation, back-translations were performed on a selection of the translated interviews by an independent person, who has a background in health services. The result of the back-translations was then compared with the original transcript (Chen & Boore, 2010).

Six participants expressed their willingness to check their interview transcript before they were translated. The researcher sent these participants their transcripts, and all agreed that the respective transcript was accurate.

3.11.3 Data analysis.

Data analysis was performed according to the constructivist grounded theory data analysis procedure. The analysis of the focus group interview codes and tentative categories helped the researcher to focus and direct the discussion in the following individual interviews. Data derived from the anecdotal and reflective writing were analysed in the same way as the FGIs and individual interviews. All data from the three methods of data collection were combined and treated as an integral entity of the research data.

The analysis was undertaken in the original language version of the transcripts (FGIs, individual interviews) and anecdotes and reflective writing. The rationale for this was that the researcher was able to do the analysis more naturally while analysing language within its context (Charmaz, 2014). This method allowed him to focus on coding and constant comparative process, that captured tacit meanings and ideas while continuously immersed in the constant comparative process (Charmaz, 2014) in his natural language. The coding was then translated into English (apart from words where there was no direct translation), so that the data could be discussed with the non-Indonesian supervisory team.

In order to efficiently manage the data, the computer software, NVIVO version 11 (Looney, 2016), was used. All research data were loaded to NVIVO and organised in a way that made the data easy to access, analyse, and retrieve for later use.

3.13.3.1 Coding and categories building

Following Charmaz's (2014a) coding practices, initial coding followed by focused coding and categorisation were performed before establishing the theory. The emerging theoretical categories and their properties were elaborated, revised, and refined by means of theoretical sampling and the constant comparative method.

Coding and category development are the core of data analysis in grounded theory (Charmaz, 2014). Coding is the process of attaching a short label, which is a word/phrase that is precise and analytic, to represent an instance in the data (Birks & Mills, 2015; Charmaz, 2014; Corbin & Strauss, 2008; Glaser & Strauss, 1967). Codes link raw data with the grounded theorist's conceptualisation of them (Charmaz, 2014). However, not all codes sit at the same level, as some are of the lower level in the sense that they are close to literal words found in the text to describe occurrences (Bryant & Charmaz, 2007; Corbin & Strauss, 2008), also known as in-vivo codes, while others are of higher-level abstraction such as the theoretical codes (Charmaz, 2014). The more abstract analytic codes result from the process of recoding the earlier codes. The researcher used diagrams to map out the ideas, codes and categories, which helped with the visual presentation of any relationship among the categories and made it an effective tool in theory construction.

Coding practice

Coding was done at both the descriptive and analytic levels. An initial coding at the descriptive level was done by carefully examining the interview transcripts. Careful practice of initial coding can help to avoid imposing preconceptions of the studied phenomenon to the participants (Bryant & Charmaz, 2007; Charmaz, 2014). Moreover, initial coding helps researchers to view the phenomenon afresh (Glaser & Strauss, 1967). Finally, a thoughtful initial coding allows categories to develop from the data, rather than applying categories to the data (Charmaz, 2014).

Charmaz (2014) advocates line-by-line coding, which is initial coding that helps the researcher to carefully scrutinise and attain any single instance in every line of the data. It encourages active engagement with the data, which finally allows the researcher to produce a novel idea about the data. Following Charmaz's (2014) suggestion, line-by-line coding was performed against the interview transcripts. Every, single line of text from the transcripts was decomposed into smaller chunks of text that allowed the researcher to observe a more detailed instance within the text. The practice of line-by-line coding facilitated the researcher to more comprehensively understand the 'big picture', which helped with the category building.

Next, a focused coding was performed, whereby the most significant codes were distilled out of the initial coding. Focus coding brought the data to the analytic level, in which the researcher scrutinised and constantly compared data within the same interview and across interviews, to find the most significant codes that had the potential to lead the analysis and the next stage of data collection (Charmaz, 2014) (See Appendix 8).

Category development

Categorisation is the process of categorising codes and patterns (Charmaz, 2014). Categorising was performed by either selecting certain codes that had predominant significance or abstracting action and/or patterns found in the existing codes into an analytic concept. Some categories that were developed in the early stage of the research were further scrutinised and compared against new data. This process changed the early categories that were only suggestive in nature to definitive ones, during the process of data analysis (Charmaz, 2014).

All emerging categories were checked against the existing ones. The researcher examined any similarity among categories and their properties. If there was an overlap, the researcher then analysed the degree of similarity represented on each entity and determined whether they should be separated, and a new entity created. This required the researcher to re-code and re-analyse the existing interview transcripts so that categories were sufficiently

represented data from all interviews. If there was a reasonable degree of congruity, an analytical category that overarched the shared characteristics and/or properties were set. Codes and categories were adjusted to the best fit with the data. All categories were created upon the data, and done very carefully to avoid preconception. This process was embedded in the theoretical sampling strategies and the constant comparative methods, which are fundamental to a grounded theory methodology (Charmaz, 2016b; Glaser & Strauss, 1967).

A thoughtful overview of the codes allowed for deeper development of categories that accurately represented the codes. The categories that resonated most with the data were elevated to high-level categories and formed theoretical concepts (Birks & Mills, 2015). Only the strong categories with significant analytic loads were raised to this level. Charmaz suggested choosing categories that can expand theoretical reach, promote theoretical centrality and incisiveness, and bear a relationship with other categories (Charmaz, 2014). The selected theoretical concepts offered the researcher an abstract understanding of relationships which formed the theory (See Appendices 10 and 11 for examples).

During the data analysis process, the researcher frequently discussed and debated codes and categories with his supervisors. The researcher presented the translated version of the transcripts, along with his codes, to the supervisors. This strategy helped to re-confirm the developed codes and resolve some issues with the codes and emerging categories.

3.13.3.2 Constant comparative analysis.

One of the crucial steps of grounded theory analysis is the constant comparative process (Bryant & Charmaz, 2007; Charmaz, 2014; Glaser, 1992). Constant comparison was made by comparing data with data, codes with codes, codes with categories, and categories with categories (Charmaz, 2014), which helped the researcher to capture the abstract pattern of the data. Emerging codes and categories were compared and contrasted with existing ones.

In the case that the newly emerging codes/categories were more inclusive and more appropriate than the existing ones, the researcher reviewed the previous ones. Constant comparative analysis facilitated the development of more abstract patterns from mundane codes and the scrutiny of the hidden constructs that were buried in the data (Charmaz, 2014). This technique was repeatedly and systematically performed against all available data, until the analysis achieved theoretical saturation.

3.12 Theory Construction

Theory integration and construction is the final step in grounded theory, which requires deep immersion in the data to actively explore possibilities, establish connections, and critically ask questions, melded with theoretical sensitivity (Charmaz, 2014). In this study, theory construction was undertaken in an iterative manner and started from the outset. The researcher strived to maintain analytical momentum by remaining open to theoretical possibilities. Following Charmaz's coding practice, coding was done in gerunds, in order to reveal both big and small actions and processes. This strategy enabled the researcher to identify sequences and make connections, as well as make progress beyond categorising types of persons and events (see Appendix 12).

3.12.1 Theoretical sensitivity.

Theoretical sensitivity refers to the capacity of the researcher to comprehend existing concepts around the topic of interest which allows the researcher to be cognisant of the emerging ones (Glaser, 1978). The process of sensitising concepts is very helpful in that it gives the researchers initial-but-tentative ideas to follow up (Charmaz, 2014). Developing theoretical sensitivity does not mean establishing preconceptions on the studied phenomenon, but rather providing researchers with essential information around it so that the researchers do

not enter the field empty-headed (Bryant & Charmaz, 2007). Theoretical sensitivity is attained from studying existing literature around the topic of interest, prior to and during data collection and analysis (Charmaz, 2016b; Corbin & Strauss, 2008; Strauss & Corbin, 1990). This is one of the peculiarities that distinguishes Straussian and constructivist grounded theory from their classical origin, in which study of the literature is discouraged until data analysis is completed. Grounded theorists continuously inspect the fit between whatever they have in hand, including their initial interests, with their emerging data (Charmaz, 2016b).

In this current study, the researcher's theoretical sensitivity enabled him to be more attentive to any possibility in the data, which helped to shape not only the research topic but also the conceptual emphasis. This interplay between the participants' and the researcher's personal-professional experiences was then fine-tuned and supported by his supervisors' research expertise.

In addition, theoretical sensitivity in this study was accomplished through the researcher's experience in the National Health System in Indonesia. Having studied public health and health administration, the researcher has valuable contextual insights into this healthcare system. In addition, he was born and brought up within the same culture as the participants in this study. These experiences and encounters have empowered the researcher to understand both stated and tacit instances and situations of the studied environment and subjects, which may not have occurred if he was not part of the research context.

3.13 Ethical Considerations

Ethics approval was obtained from the Monash University Human Ethics Committee, project approval number 1553. An additional permission letter was obtained from the

Indonesian National Nurses Association (Persatuan Perawat Nasional Indonesia - PPNI) in Jakarta.

3.13.1 Informed consent.

Informed consent (see Appendix 6) was sought from all study participants. The consent was taken before the interviews started. The points that were declared included the identity of the researcher, a brief overview of the research, and the kind of data to be sought from the participant. The participants were told that they can withdraw at any time during the interview/focus group discussion without having to give reason. The signature of each participant was collected.

3.13.2 Anonymity and confidentiality.

The researcher took all the necessary steps to ensure anonymity and confidentiality of the participants. The data were presented in such a way that made it impossible to de-identify any individual in the study. This included the use of a pseudonym in the transcripts, translations, and in verbatim quotes. The researcher invited the participants to choose a pseudonym that they liked. In addition, a single personal pronoun 'she' was used to refer to both male and female nurses, in order to rule out the possibility of being identified by gender.

3.13.3 Discomfort and harm protection.

Fundamental to ethical research that involves human subjects is the principle of beneficence and non-maleficence, by which the researchers ensure no harm in any form: physical, emotional, financial, and social. This principle also encourages the researcher to promote advantages for the participants (Johnstone, 2016).

In this study, the researcher used strategies that minimised all type of harms and discomforts at all stages of the research. In the recruitment process, for example, he emphasised the voluntary nature of participation.

In order to answer the research questions, asking questions about personal life was unavoidable, therefore, before the interview, the researcher reminded the participant that they had the right to refuse to answer a particular question(s) that they were not comfortable with. The participants were also allowed to either take a break during the interview or cease at any time, with no obligation to provide a reason. In addition, if required, the researcher would organise a counselling service. However, no participant asked to withdraw nor request counselling services.

Individual and group interviews were held in a mutually convenient location to the participant and the researcher. The selection of the place of interview met the interviewees' need, in terms of physical and psychological space to ensure a smooth interview without worrying about privacy breaches and compromises and other kinds of discomforts.

3.14 Conclusion

In this chapter, the methodological principles and the underlying philosophy have been demonstrated by the researcher, who has clearly articulated his philosophical positioning and how it informed his research methodology and methods. The methodological principles were justified and carefully applied over the course of the study. Having applied a constructivist grounded theory approach, developed categories and their properties will be presented in detail in the next chapter.

Chapter Four: The Categories

4.1 Introduction

This chapter presents the participant demographics and the categories. Through a constant comparison method of data analysis, three interrelated categories developed. These categories represent the basic social processes that participants engage in when developing and adjusting their values. The first category, *Developing Values*, reveals the process of how nurses attain, enact, and socialise their values. The second category, *Confronting Situations,* highlights the processes that nurses go through when they are faced with value-challenging situations. The final category, *Re-adjusting Values*, reflects the processes of how nurses reclaimed their personal and professional confidence through critical reflection and values reconfiguration. These categories and their associated subcategories are intertwined to reflect the whole basic social process of acquiring, internalising and harmonising values in nursing practice. This chapter offers in-depth insights into and a critical analysis of the developed categories.

4.2 Participant Demographics

The participants represented a wide geographical location (Western, Middle, and Eastern Indonesia) with a broad range of nursing experience, from 5 years to 30 years. They worked in various clinical areas within the hospital settings and in primary care centres. More than half of the participants had a qualification of professional nurse (Bachelor of Nursing plus professional program) while the rest held a Diploma of Nursing.

In regard to employment status, about an equal proportion of civil servant nurses and honorary nurses participated. Table 2 presents the participants' demographics.

Table 2.

Participant demographics

	Individual interview		Focus group interview		Anecdote & Reflective story	
Number of participants	N= 24		3 FGs (total: N= 23)		N= 7	
Geographical Locations:						
Western	8	(33%)	8	(35%)	3	43%)
Middle	11	(46%)	15	(65%)	3	(43%)
Eastern	5	(21%)	-	-	1	(14%)
Religious Affiliation:						
Islam	18	(75%)	14	(61%)	4	(57%)
Christian	4	(17%)	6	(26%)	3	(43%)
Hindu	2	(8%)	3	(13%)	-	-
Nursing experience (years)						
Minimum	5		6		5	
Maximum	30		28		14	
Median	11.5		12		9	
Employment status						
Civil Servant	11	(46%)	11	(48%)	3	(43%)
Honorary (Non-permanent)	10	(42%)	8	(35%)	3	(43%)
Private Employment	3	(12%)	4	(17%)	1	(14%)
Qualifications						
Professional Nurse	14	(58%)	13	(57%)	4	(57%)
Nursing Diploma 4 (D4)*	2	(8%)	3	(13%)	-	-
Nursing Diploma 3 (D3)**	8	(33%)	7	(30%)	3	(43%)

	Individual interview		Focus group interview		Anecdote & Reflective story	
Department/ Nursing setting:						
Emergency	3	(12%)	2	(9%)	1	(14%)
Intensive Care	2	(8%)	1	(4%)	-	-
Neonatal Intensive Care unit	3	(12%)	3	(13%)	2	(29%)
Pediatric	2	(8%)	-		-	-
Cardiac care	1	(4%)	1	(4%)	-	-
General nursing (ward)	9	(38%)	8	(35%)	2	(29%)
Primary Health Centre /	4	(17%)	8	(35%)	2	(29%)

Note:

*D4: This is a full four-year Diploma in Nursing, or an additional one-year education for D3 Program graduates. Most nurses enrol in D4 Program after completing D3 program.

    **D3 is a full three-year Diploma in Nursing

4.3 Category One: Developing Values

This category describes the processes that nurses experience in developing their initial value systems that underpin their practice. The process begins with values acquisition, in which values are derived from various sources and accumulated prior to embarking on a nursing career. These values appeared to be processed through a complex and subjective appraisal that resulted in the values being embraced, enacted and socialised into the nurses' practice. This category is further conceptualised through the sub-categories: *attaining values, enacting values* and *socialising values.*

4.3.1 Attaining values.

Most participants shared and acknowledged the role their family and their education played in the acquisition of their values. The values were attained through family upbringing and religious practices instilled through lessons taught directly by parents and/or through

observing them. For example, the value of *helping others* was passed onto nurses during childhood, as illustrated below:

> "…I remember my parents always encourage me to help everyone in need of it. It does not matter how little you can do to help; the more important thing is to have a genuine keenness to help others. This is one mentality that my parents taught me since I was a kid. Now, it has become my second nature…" (Idah, reflection)

In addition to the value of *helping others*, values, such as *being a nice person*, were also transferred through family customs, as Leka shared:

> "When I was a child, I used to see my father smiled, greeted everyone he met… He loves being around the people… he always was nice to everyone…".

The social values of *helping others* and *being a nice person* appeared to be still relevant to their current professional nursing values. Also, moral values of '*right and wrong*' were also passed on to participants from their parents, as Ella shared:

> "… I was told by my mother not to hurt people physically and mentally because it is a bad thing…it is wrong… She wanted me to be a good person, respect parents and older people…".

As Ella and Leka demonstrated in these quotes, the acquisition and transference of moral and social values of '*being a good person*' (avoiding 'bad' and 'wrong' conduct) and *respect* (respecting parents and others) were acquired through daily parental interactions, including *role modelling*.

In addition, the acquisition of values was grounded in an indoctrination process of strong religious belief systems, which is typical of Indonesian culture. Teaching social and moral values through a religious lens emerged as a customary practice amongst many of the participants' families. It is apparent from the data that, during childhood and adolescence, parents introduced the concept of God and religion, and the participants used these concepts to develop their social and moral compass. This can be seen in the following quote.

"… I found the way my parents brought me up is very much affecting how I see myself as a nurse and how I regard other people such as my patients, or the people I am working with. My mother used to tell me to behave in ways that other people would be happy with or make them feel valued, or at least not to make them feel bad about being around me. I was told that these kinds of behaviours are encouraged by our religion so that God will record them as good deeds. I remember when my father told me 'the more good deeds you have, the happier you will be because whatever you do to other people will certainly come back to you!' I have been trying my best to do so when interacting with my patients in the hospital…" (Christy – Reflection)

In this quote, it is clear that Christy's religious values, instilled through her parents, were translated into her nursing practice. The acquisition and integration of social-moral-religious values were also apparent in Ulfa's experience:

"…my mother used to teach me good manners. She told me that if we help others, we will get rewards from *Allah* [God]…I have been using this [my mother's teaching] as one of my motivations…" (Ulfa)

This quote demonstrates Ulfa's commitment to consistently upholding heavenly-rewarding conduct (the belief that God will reward good deeds) in her daily life.

The family influences on value acquisition extended into young adulthood, including the choice to embark on a nursing career. During Amalia's first year of being a nurse, Amalia shared that her parents continued to remind her of these important social values:

"My parents taught me about honesty in working…They told me always to be nice to patients, be friendly, be respectful to them [the patients] as of how we want others to respect us" (Amalia).

Similarly, Yeyen was also in the early phase of her career when her late father shared his advice on positive thinking and treating all patients with respect: "…never prejudge anyone, your patients, your boss, anyone…stay positive, and you have to do as much as you can in a good way…" (Yeyen). Yeyen's and Amalia's quotes are reflective of the power of parental influence on their values, such as *being a good and honest person*, respectful of others.

The early development of a personal value system (acquired through the family) was further shaped through the nurses' professional training and education. Nurses shared that during their nursing training, they were taught to value themselves and their nursing profession: "… I contemplated the values being taught; it seemed very noble…by then I started to get very much into it…" (Isma). Other participants admitted to enjoying the positive learning experiences offered during their training. For instance, Nana shared, "… until I learnt about nursing ethics that made me feel better…".

Isma and Nana began to start acknowledging and appreciating the values learnt through their professional nursing training, especially how these values underpin nursing practice. During their training, various personal and professional values were activated and reinforced. For example, Diah articulated, "I learnt about nursing ethics during my study… to help and respect others… our teachers taught us about it … it was in the curriculum". Similarly, Endang shared, "All of us has been taught how to care for patients with empathy when we were in the nursing training. We also learnt about working in teamwork...". As indicated in these quotes, the nurses' professional education was pivotal in enabling them to acquire professional nursing values, such as ethical and empathetic care. Clearly, professional education emerged as an important aspect of the nurses' basic social process in attaining professional values.

The values learnt and acquired through parental influence, religious beliefs and professional education were also reinforced through institutional value systems in the nurses' workplaces. Participants acknowledged the reinforcement of *organisational value systems* or *mottos* in hospitals and considered these influential to their practice. The term 'value systems' and 'mottos' were used interchangeably by the participants. Both terms refer to an agreed set of values that are prescribed and encouraged by an organisation. For example, Yeyen, who worked in an integrated public health centre, clearly described the value system in her workplace:

> "Our working motto is *CERDAS*: *Cekatan* (Skilful), *Empati* (empathy), *Ramah* (friendly), *Disipilin* (discipline), *Adil* (fair), and *Sopan* (polite)… it really reminds us of how we, as nurses, should do our job…" (Yeyen)

Similarly, Dini's hospital has a value system that served as a guide for services rendered in the hospital: "Our hospital uses a value system SMILE: *Senyum* (smile), *Mutu* (quality), *Inovasi* (innovation), *Lengkap* (thorough), *Efisien* (efficient)" (Dini). Not only did the organisational value system provide guidance for nurses, but they also influenced nurses' teamwork spirit. Uyi shared:

> "We have a motto 'responsive, friendly, professional, and religious'… the values in the motto really help in dealing with patients…the motto keeps reminding us to stay on track" (Uyi)

The motto appeared to activate other values, such as *motivation to collaborate/loyalty*, which is demonstrated in Uyi's use of the personal pronoun 'us' instead of 'me'. Upon clarification over a phone call a few months after her interview, it was clear that she meant 'all' nurses in her workplace (Memo). This supports the activation of the value of *collaborative work* in the nurses' workplace.

The organisational-instilled values apparently reinforced some of the professional values. For example, the organisational values of '*thorough*' and '*efficient*' (such as in Dini's hospital) also reflect the institution's standard of how employees should undertake their tasks within the institution. This was the case for Uyi who drew on these values to inform her daily practice as a nurse.

The values attained through parental influence, professional training, and organisation are embraced and enacted into nurses' professional practice. The justifications and subjective considerations that are taken into account by the participants during the social process of enacting values is presented next.

4.3.2 Enacting values.

Enacting values is a basic social process that includes embracing, selecting, and contextualising personal and professional values into nursing practice. While nurses acquired a variety of values from the previous process, not all the values they acquired are relevant to the nursing profession. This prompts nurses to select the most relevant and meaningful values that underpin their personal principles and shape their practical agency. In doing so, nurses indicated their use of at least three points of references: religion, humanity, and professionalism.

4.3.2.1 Looking through a religious lens

The influence of nurses' religious beliefs on their personal value systems was demonstrated through language and symbols used during the interviews. The nurses often used expressions that were closely associated with their religious affiliation. For example, participants constantly used the word '*Allah*', and expressions such as '*Insya Allah*' (on the God's will) and '*Alhamdulillah*' (All praise due to God) for Muslim participants and '*Puji Tuhan*' (praise due to God) for Christian participants. The word '*Allah*' or '*Tuhan*' refers to God, both in the Islamic and Christian traditions, in Indonesia. The use of the word '*Allah*' indicates the nurses' acknowledgment of the presence of a superior power (in a spiritual sense) that influences how they view and define their motivation, work, and themselves as human beings.

Participants seemed to view their role as nurses through a religious lens. Lia, for example, attached the religious onus to the meaning of nursing when she stated: "…nursing for me is one way of fulfilling my religious duties. Nursing makes me feel better as I am doing good in a religious sense…". Orienting their nursing role around religious values and duties emerged to be a shared process that participants engaged in when enacting values in their

nursing practice. This can also be seen in Tina's statement: "I see nursing as an act of worship, and it allows me to fulfil my religious role" (Tina). Similarly, Wiwin described "… when we nurse patients, it is a form of noble worships. Looking after the sick is indeed a form of worship..."

Clearly, Tina and Wiwin perceived their jobs as more than *just* professional work; it was a means to accomplish their religious obligations. Furthermore, religious values were used to frame and define their practical agency. Diah explained, "…from my religion; there is a lesson to 'facilitate people, do not make it hard for them, *Allah* will help you!' that is my guidance…". In addition, many of the participants shared that they felt like they were being watched by God. Ikke explained, "whatever we do, no matter how small it is, be it good or bad, *Allah* is watching, *Allah* knows … therefore we have to do our best". This belief indicates that nurses' religious beliefs play an integral role in guiding their nursing practice.

Nurses linked personal values, such as *facilitating people* (helping others) and professional values, such as *doing one's best*, with a religiously derived value of *being watched by Allah*. This feeling of being watched might act like a spiritual supervisor for nurses, which is likely to influence how nurses engage in their daily nursing practice. Religious affiliation was not the only point of reference in the process of enacting values. Another essential aspect of reference that emerged and comprised the nurses' personal value system was the concept of humanity.

4.3.2.2 Considering humanity

Nurses shared that nursing is a distinct form of humanitarian work, as Diana expressed: "Once we work as a nurse, we will always deal with humanitarian works…". The participants used the term 'humanity' to refer to the quality of *being* a human with regard to having relationships with other humans or providing humane treatment to others, including

treating patients with dignity. This value is at the core of the nurses' value system, as demonstrated in the following quote:

"…I think that the aspect of humanity is important for this job … if I treat my patients well, I will be treated well by others…" (Amalia). Similarly, Dini expressed, "…you have to treat your patients nicely, … or be nice to others…because you will reap what you sow" (Dini).

Not only do these two quotes indicate the centrality of humanity in the participants' value systems but also surface the belief about the reciprocal nature of their attitudes and care toward patients. This may be drawn upon the value of *humanity* itself.

Furthermore, the value of humanity inspires nurses to preserve their determination in undertaking their profession, as Uyi shared: "I use humanity values as one of my motivations …". This extends to justifying a nurse to step outside their professional role that is not traditionally part of a nurses' responsibility "especially in an emergency..." (Fasna – FG 1). This suggests that participants were willing to take a risk (such as the possibility of being sued if anything bad happens or being accused of performing tasks beyond their scope of practice) because of the importance of upholding their value of *humanity*. Furthermore, the quote above indicates that the value of humanity has been internalised by participants and is used as one of the essential points of reference to direct their practical agency.

Nurses also appear to have positively enacted some other values that draw from the value of *humanity*, including *going beyond their professional caring responsibility for patients*. This feeling was described as *'kasihan'*, which in the Indonesian language has several meanings. As a noun, '*kasihan*' means pity and sympathy and, as an adjective, it means sorry (Bab.la Online Dictionary, 2019). As a verb, it means feeling for someone as they are in a difficult situation (Kamus Besar Bahasa Indonesia, 2019). Dewik shared, "…Looking at the poor patient condition makes me '*kasihan',* so I would do whatever I can do to help them

wholeheartedly". In this example, the word 'poor' means lack of wealth, the state that triggers the participant's value of '*kasihan*'. This value was then expressed through the action of providing financial help and transportation for their patients. Clearly, the value nurses place on '*kasihan*' influenced the nurses' decisions and guided their practical agency.

In addition, in some situations, nurses claimed to be able to sense the lack of *'kasihan'* in their team members, as Lia recounted her displeasure when working with a partner she considered had less *'kasihan'*. She expressed "…I was irritated because I felt that my working partner lacked in *'kasihan'* to the patients; I better handle the patients alone…"

It would seem nurses like Lia valued *'kasihan'* more than *being a member of a professional team*. Indeed, she must have known that 'working alone' would expose her to a heavier workload and the related consequences. Her preference for the value of *'kasihan'* demonstrates how this value is prioritised and enacted through her practical agency to *serve better*.

The value of '*kasihan*' appears to be intertwined with the value of '*tulus ikhlas*'. '*Tulus ikhlas*' is an Indonesian language phrase that consists of two words, '*Tulus*' and '*Ikhlas*', that have an overlapping meaning, however, they have different emphases. Unfortunately, there are no equivalent words in English that can articulate the exact meaning of both words when they are used as a phrase. In English, *'tulus'* as an adjective means honest, sincere; and '*ikhlas*', as an adjective, means sincere (Oxford Dictionary, 2019). While the term sincerity resembles the meaning of the term '*tulus*', it does not fully capture the whole meaning of '*ikhlas*'. '*Tulus*' is sincerity in a social morality sense. The word '*Ikhlas*', from a cultural perspective, means sincerity in a spiritual sense (Zakaria, personal communication, Jan 29, 2019). Participants viewed 'tulus ikhlas' as a foundational or fundamental principal that guides their nursing

practice, as Amalia expressed, "… it will be difficult to work as a nurse if you do not possess the value of *'tulus ikhlas'*.

In a practical term, as expressed by Alda, '*Tulus ikhlas*' is 'sincerity and wholeheartedly in doing the tasks as a nurse'. Chika, a participant of FGI I, described *'tulus ikhlas'* as "doing the job sincerely without overthinking about incentive". However, it did not mean, the nurses would not expect rewards, as Ikke mentioned, '*tulus ikhlas'* was not meant to completely downplay the need for a financial reward from the job. It is the mindset of how to balance those needs with the role of the job and the needs of the patients. She expounded:

> "…for me *'tulus'* means giving treatments not because of the incentive. I know that all people need money. I am not a hypocrite. However, we should not compromise our tasks only because of material things, and money is not the primary motivation for helping patients, nor the way of treating them" (Ikke).

It is apparent that the value of *'tulus ikhlas'* is closely associated with the value of *altruism*. Altruism is an umbrella term that overarches a set of values, such as *compassion*, *generosity*, *perseverance*, *benevolence*, *sympathy* and other values of a similar concept. In addition to the value of *'tulus ikhlas'*, most participants emphasised the value of *honesty*, which shaped their nursing practice. Peppy, for example, valued honesty over other constructs. She expressed, "My motto is being honest and responsible. A nurse must be honest and responsible for the works they are assigned to". Wiken claimed always to be honest to her patients regarding their treatment, "I tell them [the patients] honestly and in a nice way about all treatment that has or has not been given…"

The participants talked about the value of *honesty* and *responsibility* in relation to their professional tasks. Peppy and Wiken indicated that their value of *honesty* is linked with their role of being a good advocate for their patients. In this sense, *honesty* and *responsibility* might also be considered as professional nursing values which influence their actions and help to maintain their professionalism.

4.3.2.3 Developing professionalism

Nurses view professionalism as "dedicating skill and knowledge in the way that was complying with any existing rules" (Atikah, FG 1). This view was supported by the majority of participants, including Ella, who expressed the need to "…responsibly treat patients using your nursing knowledge and skills…". This indicated that nurses valued *knowledge and skill* as well as *abiding by professional rules* (rooted in the value of *conformity*), which were infused into their professional value systems and used as another point of reference.

Besides valuing *conformity* to procedural standards, nurses also valued the quality of *being loyal* to their organisation, which comprised their professionalism. This can be seen in the following excerpt:

> "…We have to protect the hospital reputation, our [nurses] reputation as an individual, and also the reputation of the profession… if I cannot control myself [losing temperament in front of patients], I will get some complaints from the patients' family; I will get mad. The complaint will go through to the management, … then the prestige of the institution will be harmed. Patients will say 'nurses in that institution are rude', and later the professional reputation will be affected, so I need to control myself in that case…" (Ikke)

It was apparent that Ikke valued the positive image of her hospital and adjusted her practical agency in ways that maintained the image of her profession and her hospital. This attitude was likely to be grounded in her value of *loyalty* in combination with the value of *upholding the professional image*. As indicated by participants, their loyalty was enacted to maintain their professional identity as well as to sustain the image of their organisation and the nursing profession.

Loyalty to the hospital was also conceived as a willingness to undertake tasks assigned by management. This perspective came from Wiwin, who works at a private hospital. She articulated:

"…giving maximum service to hospital… that is loyal to the hospital, doing work more than normally required…, for example, they [the management] give me tasks more than my normal work, but I accepted the task and managed to complete the tasks, that is loyalty" (Wiwin)

In 'doing more than normally required', Wiwin displays an eagerness and selflessness to attend a shift outside her regular schedule when needed. This demonstrates the value of *loyalty* and *hard work*.

In some situations, it was apparent that nurses exchange values with colleagues. In addition, they learnt to balance some competing values from colleagues, directly or indirectly, in order to resolve a situation. This process is discussed in the following section.

4.3.3 Socialising values.

Socialising values describes the social process of spreading and exchanging values with other nurses, including encouraging colleagues to adopt similar values. Depending upon the situation, the shared strategy used by participants to socialise their values comprised of telling, sharing, and broadcasting.

4.3.3.1 Telling

The strategy of telling means providing verbal directions or guidance to encourage fellow nurses to consider particular values or principles. Vivit shared:

"I did not like the way she treated the patient's family. I understood that they were a little too annoying. But I thought we, as nurses, should be able to comprehend the situation. They might panic to the extent that they lost temper. I told my fellow nurses to be patient and be wise in dealing with this kind of situation" (Vivit - Reflection)

In this statement, Vivit played a role as an active agent by encouraging other nurses to respond to the situation with a more positive attitude. The underlying values were not implicitly stated; however, qualities such as *wisdom* and *patience* indicated the transference of some underpinning values. These values included *sympathy* (through understanding the

patients' condition), *self-control* (control over self and the tasks), and *professionalism* (by providing adequate care regardless of the nurses' own feelings toward the annoying patients).

The strategy of telling was also used in more formal ways, especially by nurses who were responsible for supervising 'junior' nurses. For example, Dini, who was supervising new nurses, shared that she had told several junior nurses about what she considered acceptable standards and principles. Dini felt frustrated that some junior nurses were 'money-oriented', which she considered was not a 'proper' attitude at this early stage of their nursing careers. She shared that she expected them to develop more appropriate mindsets because she believed that it would determine the kind of nurses they would become in the future. Dini explained:

> "it seems that new/junior nurses are now lacking in the sense of being a nurse. Some of them complain too much about financial reward. I told them 'you need to give your best services first, before talking about a reward. Show them you can serve patients well' I could see they lacked in skill and determination, but they talk about reward" (Dini).

It was clear that Dini tried to transfer the value *hard work* and *determination* over financial reward to her junior nurses. As a more experienced nurse and supervisor, Dini felt that it was her responsibility to help mould junior nurses to become better nurses, which included instilling the value of *perseverance*. While the strategy of *telling* was usually done through a traditional hierarchical relationship, the strategy of *sharing* was done in hierarchy-free, more democratic interactions.

4.3.3.2 Sharing/encouraging

Nurses shared what they considered 'good' and 'better' values through a communication with colleagues involving life experiences, encounters, the reasons, and values underpinning particular actions in their nursing practice. Nuri expressed, "we share the situation with our fellow nurses to find out how to handle this patient". Sharing with colleagues

also included sharing personal concerns regarding their job and their inner feelings. For example, Siti articulated, "…usually I share my feelings with my friends. I talk to them; I am a kind of an open person".

Socialising and transferring values through the act of informal sharing often felt more comfortable for nurses, as it was more relaxed than formal processes and usually done offsite and outside working hours. Ella shared:

> "Once I was also feeling very much down, which I think affected my work. I remember one of my friends [who knew my situation] took me to a restaurant after we finished working that day. She talked about quite a heavy thing such as values and principles … why I need to put aside my ego and stay focus on my work. She shared her experience with almost the same situation… I felt like I was being comforted by her… (Ella).

Nurses appeared to share values that they felt were useful and beneficial for them. Ikke, for example, shared her experience of interacting with patients and how it made her feel happy, satisfied and more confident in her job, and so she encouraged her colleagues to do the same:

> "I gave my best to my patients. As they seemed to be happy with my service and said something good to me, I was happy too; I encourage my fellow nurses to offer genuine empathy to their patients …" (Ikke).

The strategy of sharing was also done through social media. Wiwin, for instance, learnt from her *WhatsApp* group how to behave and deal with a particular doctor who was known among the nurses as being 'troublesome'. She reflected:

> "I keep maintaining communication with my friends through *WhatsApp* … some of them had the experience of working with the doctor and knew how to deal with her… this helps me to adjust my expectation when I have to work with her in a team…" (Wiwin).

Sharing values and practice was a reciprocal process. Ikke shared the value of genuine empathy through in-person communication, while Wiwin learnt strategies for dealing with difficult personalities so she knew what to expect and could proactively prepare and preserve

a sense of *inner harmony*. Inner harmony is a value that promotes the state of being at peace with oneself.

Similarly, Alda shared, "I am getting used to sharing stories with my colleagues… I felt that it helps me to feel better. I think sharing is good for us as nurses…". Sharing with colleagues appeared to benefit nurses in two ways. First, it helped them to find a better way to deal with a given situation, through sharing previous experiences and solutions. Second, sharing helped nurses to release some of their work-related burdens, which preserved their sense of *inner harmony*. A more comprehensive overview of the role social media plays in the value socialisation process is offered in Chapter 5: Contextual determinants.

4.3.4 Summary.

This section has detailed the processes that nurses engaged in when initially developing their personal value systems. The presentation of the three intertwined subcategories is not a linear or sequential order, as, most of the time, the processes of acquiring, enacting, and socialising values take place simultaneously and continuously. Furthermore, nurses' personal value systems are challenged through confronting situations in their daily practice. The next category expounds this basic social process.

4.4 Category Two: Confronting Situations

This category describes the emerging social processes that nurses experience when confronted with problematic situations. In this sense, a 'situation' is a circumstance under which the nurses' personal and professional values are challenged which has the potential to affect nurses' personal value systems and their practical agency. When confronting situations, nurses share some basic social processes, including facing and/or reacting to problematic situations.

4.4.1 Facing problematic situations.

Nurses appeared to face a number of problematic situations (and many of the problems created dillemas) in their workplace, which resulted in them experiencing negative feelings. For many of the participants, this included guilt and feeling belittled and devalued, unsupported, and physically and mentally drained, resulting in a sense of helplessness. Furthermore, these situations impacted on the quality of care the nurses wanted to provide for their patients, which compromised their established value systems.

4.4.1.1 Facing a dilemma

Conflicting personal and professional values caused a dilemma for nurses. For example, nurses shared that, on some occasions, they had to decide between obeying the instructions of a doctor or following their own professional judgements. A dilemmatic situation occurred when nurses believed that following the instructions of the doctor would result in the deterioration of patient outcomes, which can be seen in the following quote:

> "The doctor ordered me to set NGT [nasogastric tube] on a coma patient. I was a bit reluctant to obey her as I noticed an abnormal breathing problem and I was pretty sure about the possible outcomes. I disagreed with the doctor… so I was in a dilemma whether to follow the order or to go with my feelings, but I was too afraid not to follow the instruction. After a while, the patient passed away [voice softened, saddened facial expression]..." (Deby)

It was apparent that, in Deby's case, there were some values in dispute. While she was aware of the patient's condition and possible negative outcomes of the action, based on her professional judgement, she hesitantly followed the doctor's order. This indicated that, at the time of this situation, her value system was compromised. It was clear that her personal values *of self-fulfilment*, in hoping to provide 'appropriate' care based on her professional clinical reasoning and judgement, were at stake. In addition, other professional values, such as *being a patient's advocate*, might have been compromised, as she 'failed' to discuss her concerns with

the doctor and, at the same time, 'failed' to represent the patient and address the potential concerns of the patient's family, which clearly demonstrates a dilemma.

Deby shared that the incident had negatively affected her inner harmony for an extended period of time; she felt sorry because she thought her action may have caused the patient to lose their life. She believed that if she had not undertaken the doctor's order, the patient's death may have been avoided. Her feelings about this incidence, although it happened years ago, were still raw, discernible through her voice and facial expressions during the interview, demonstrating the long-term impact that such dilemmatic situations can have on nurses' personal and professional lives.

Dilemmatic situations did not just occur in hospital settings but were also intertwined with the nurses' personal life commitments. Participants shared that they were frequently in a quandary over conflicting personal-professional commitments that included choosing to care for their family or prioritise their nursing work and patients. The following excerpt articulated such a situation:

> "... a female nurse faces a dilemma when they have to play their role as a
> mother, especially when their children or husbands are sick, and at the same
> time, they have a night shift to attend. We are in a dilemma whether to put our
> family first or our patients" (Eka)

This suggests that obligation and family commitment are important considerations in a nurse's value system and have the potential to affect and direct nurses' practical agency. It was not easy for nurses to choose between family and patients, as any decision would come with consequences. For instance, choosing to prioritise professional responsibilities over personal commitments (prioritising patients over family) may result in a sense of guilt. In an effort to maintain her professionalism, Yeyen claimed to attend all her shifts regardless of her personal situation. She indicated that a consequence of this decision had affected her ability to undertake her role as a wife and a mother adequately. She expressed:

"…often, my husband gets mad because I have a lot of working shifts [leaving home too often]. Sometimes I wish I were just a housewife, so I can focus on looking after my husband and my children…I feel guilty…" (Yeyen)

This feeling of guilt was accentuated in the situation where a member of the nurse's family was unwell and in need of her attention, as Endang, in her reflection, wrote: "I felt guilty to my kid for having to leave her home while she needed my full attention…".

In the above cases, professional values, such as nurses' *professional responsibility*, are conflicting with personal values and compromising the nurses' *inner harmony*. Obviously, a value-challenging situation often results in nurses feeling uncomfortable and prompts them to re-think their circumstances and re-visit their values (re-visiting values is a separate basic social process and presented in Section 4.5.1). It emerged that not all problematic situations create a dilemma for nurses, however, all of them commonly leave nurses with a variety of negative feelings.

4.3.2.2 Experiencing negative feelings

A growing sense of unease is generated as a result of a clash in values, which requires nurses to find strategies to manage their unease on a personal and professional level. Isma articulated her feelings about being devalued, "I felt that we were not valued…". Siti also considered herself being disrespected, as she perceived she was being treated in a manner that wasn't acceptable:

"… I feel hurt, we (nurses) has been trying to treat our patients from heart …, but the patients and sometimes doctor treated us like their maids…" (Siti)

The way Siti was treated made her feel devalued and humiliated (in the context-specific sense). This was indicated by the use of the word 'maid' as a metaphor in her description (a more comprehensive analysis of the usage of such words is offered in Chapter

5.4.3). Obviously, such negative feelings (feeling devalued and humiliated) have the potential to impact nurses' inner harmony on a personal and professional level.

A couple of triggers for negative feelings include a perceived inferior relationship with doctors. Isma indicated "until now the image of the nurses is still as a doctor's assistant". Similarly, Nana elaborated her feeling about the profession as follows:

> "…the nursing job is still considered inferior to medical profession...tasks are considered low level... [that is why] nursing is not the main choice [for some people], it does not carry a decent prestige in my opinion ... no authority to decide what action should be taken in a certain condition" (Nana)

Undoubtedly, the participants were aware of the wider community's existing image of nursing as a profession, including some participants like Nana. In this situation, the values of *recognition* and *respect* are compromised and, consequently, undermine the nurses' sense of being a professional, which is likely to influence nurses' agency in their workplace.

In addition to feeling inferior, participants reported feeling helpless and unsupported by their senior nurses and their management when facing difficult situations. In particular, participants felt that their managers did not stand by them, especially when they had to deal with a 'powerful influencer'. In the Indonesian context, 'a powerful influencer' is a high-profile person who has a significant role in the community, such as those with political power (such as in a governmental position) and public figures. These feelings of helplessness increased when providing care for such people, their family, and relatives. Isma recounted an experience where she was blamed for not treating a high-profile patient the way the patient expected to be treated:

> "I have followed the protocol and all rules set by the hospital management …The patient apparently has a position in the local government…the patients complained about my services to the manager. Without any crosscheck, the manager put all the blame on me, although I had done everything based on the rules…" (Isma)

In this situation, it appeared that the values of *professionalism* were challenged and overridden by the manager in favour of the 'powerful' patient's concerns. Other participants shared that they often received *special orders* from managers that included greater attention for a specific group of patients. This is articulated in the following quote:

> "Often, we have got a message like 'please give special attention to this patient; it is the director's order!' … there is a kind of feeling 'this patient is special to the boss, so we have to pay more attention' [her body language expresses uneasiness]" (Dini)

When the director ordered the nurses to give 'special services' to a powerful influencer, the nurses' values of *equality (social justice)*, *independence* (being able to perform the assigned tasks without interference from others) and *authority* (having a clearly defined domain of works), were at stake. It would appear that the director overrode the nurses' authority and autonomy to make decisions and potentially restrained nurses from upholding their true personal-professional value system and agency.

In addition, dealing with a powerful influencer or their family and relatives often made participants feel threatened. Dewik encountered a patient who felt that they deserved special services, just because the patient had a political or family connection with powerful people. She recounted, "the patient mentioned someone's name who was in a top position in the government… sometimes they said that they were the family of the mayor" (Dewik). It was not just the explicit patient's statement that made Dewik and other nurses feel uncomfortable but also the silent postures, gestures and the subtle messages that patients delivered, which made the nurses feel intimidated. Participants construed the gesture as demanding special services from the hospital, as illustrated in the following narration:

> "Here, we usually have some (high profile) patients who think that they deserve priority…especially those who are rich and has a (political) power. They feel that they are special because they pay by cash and not using the public health insurance provided by the government. They said, 'I should get special

treatment (because) I pay, my children should get the best, other patients are using government health insurance, you can serve them later'" (Eka)

Clearly, in this situation, nurses' professional and personal values were challenged. Values such as *equal treatment*, *control over work*, and *appreciation* were contested. When patients asked for special privileges, they challenged the nurses' value of *social justice* or *equity*. At the same time, when patients mentioned the reason why they felt that they deserved greater attention and privilege (which was usually about money), the nurses felt that their humanitarian work was undervalued. The vast majority of the participants upheld the value of *humanity, helping others,* and *equity* in their practice (as presented in the preceding section), and outweighing these values with money was disappointing. When these values were downplayed by the patient, nurses felt irritated.

Another issue expressed when dealing with a powerful influencer was that the participants often felt like they were suspiciously scrutinised and under constant surveillance. Dewik shared, "I felt being watched, they looked for my mistakes…it made me feel uncomfortable... It is better to look after ordinary people". For many of the nurses, caring for 'lay' patients was easier and allowed them to maintain their personal and professional values and direct their practical agency. Amalia expressed, "I feel it is easier to deal with average patients; we can get close to share stories…". It was evident that Amalia's sense of being in the moment with 'lay' patients made up for her sense of being challenged when dealing with powerful patients and their family.

In these situations, nurses' value of *autonomy over work*, and *authority* were challenged. When nurses felt that they were being watched by the patient's family, they indicated a loss of control, authority and autonomy over their daily practice through the 'dictating' of the nurse's routine. In other words, it was the patient's family who was steering

the nurses' practical agency through acts of surveillance. In addition, this situation seemed to cause the nurses to feel disconnected from the 'privileged' patients and/or families.

Nurses shared that dealing with such challenges in their workplace left them feeling drained. In addition, heavy workloads, along with substantive responsibilities and long working hours, contributed to physical exhaustion. Nuri articulated:

"My workload is so heavy. The job is very demanding. She [the manager] want this and that, and everything has to be perfect... all make me drained!".

Similarly, Wiken indicated that the heavy workload due to a shortage of nurses could impact on the care she wanted to give:

"You can imagine, there are 16 patients with only three nurses and five patients to be observed. If anything happens to the patients at the same time, it will be really difficult for us to handle the situation" (Wiken)

Not only were workload issues associated with a limited number of health personnel, but they were also linked to additional tasks that participants had to complete. "We have to be able to handle administration work, that of the pharmacists', nutritionists', and mainly doctors'…" (Eis - FG 3). Similarly, Dini expounded:

"I have to do quite a lot of work, for example, I [have to] do administrative works, the pharmacists' tasks like preparing all medicines that should have been done by a pharmacist. I also have to check the emergency trolley at the ICU; I do all of those tasks".

It was apparent that participants were required to carry out extra tasks, which added to their workloads, including *delegated* care, such as checking a patient's vital signs, taking a blood sample, setting up an intravenous (IV) infusion, cleansing a wound or giving an injection. Nurses also shared that they are often required to perform some tasks that require highly specialised skills (that is normally accomplished through special training on top of the standard nursing competency), such as inserting a catheter, suturing a wound and prescribing

medications[1]. These tasks were claimed to affect the overall provision of the care, particularly in relation to time efficiency. Peppy shared her view and experience as follows:

> "Delegated tasks definitely add extra works to already heavy workload, and of course it takes our time, that could reduce the time that we would have used to carry out nursing tasks to our patients" (Peppy)

For some nurses, such tasks cause a dilemma between managing the increased workload and providing quality care to the patients. This, in conjunction with high pressure in the workplace, appeared to induce negative feelings, which placed a physical and mental drain on nurses, including a fear of dealing with panicked and offensive patients', families or relatives. Nony recounted her experience when nursing a police officer's baby:

> "I was setting up an intravenous on his baby head. It might be apparent to him that I was struggling to find the vein. He shouted at me "what are you doing to my baby?". I answered "please be patient, I am trying…" he got really mad, and he yelled "you want to die? If something happens to my baby, I will kill you!" he put the gun on my head. I was so scared ... Another case, there was a parent who could not accept that his baby passed away. The baby was really sick when the parents took her to the hospital [and passed away]. I was scared. The parent was really mad; he brought a really big knife and threatened us."

When telling her story, Nony spoke fluently, as if it happened yesterday. She even mimicked the gesture of the baby's father when he pointed a gun at Nony's head. While speaking, she was very animated and demonstrated how she was uncontrollably trembling. This frightening experience prevented Nony from performing her job and removed her right to practice in a safe environment, which challenged and conflicted her value of *inner peace* and *safety* potentially influencing her practical agency.

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[1] In the Indonesian Health Care System, there are two kinds of 'additional' care that are parts of nurses' professional responsibility: delegated and mandated care. Delegated care refers to a doctor's tasks/jobs of which nurses have authority to perform autonomously. Nurses bear full responsibility for the care. Mandated care is similar to delegated care except that it requires specialised training and should be performed under a doctor's supervision. The participants use both terms interchangeably. The term 'delegated care' is used throughout the thesis to maintain consistency.

Facing and confronting a number of challenges in the workplace, nurses use some strategies to react and respond to the situations. Depending upon the personal and professional values at stake, nurses shared different kinds of reactions when faced with a problematic situation, which will be elaborated in the next section.

4.4.2 Reacting and responding to situations.

This subcategory describes the processes that nurses underwent when reacting to challenging situations and how their reactions impacted on their sense of intactness and practical agency. Two ways of reacting to challenging situations emerged, including *holding firm to one's principles* and *accepting situations*. Nurses seemed to hold firm to their personal and professional values and principles, by voicing their concerns, demanding to be heard by managers, or completely ignoring any authoritarian directions/orders that went against the nurses' values and principles.

Conversely, some nurses chose to 'play safe', by just accepting the situation. In accepting situations, the nurses complied with orders or demands from more powerful individuals, such as the hospital director. This required them to make some adjustment in their value system.

4.4.2.1 Holding firm to one's values and principles

Nurses shared that when they faced a situation that was overly difficult, they used suitable occasions to voice their concerns to others, particularly the management. Bunda, who worked in one of Indonesia's national referral hospitals, shared her experience when trying to put forward her concerns at a meeting that was not designed to hear nurses' concerns. Despite this, she vocalised her issues:

"I argued (with managers) during the accreditation process that not all of the things become my responsibilities... we have been coerced into doing a lot of work outside our role as nurses…" (Bunda, FG 2).

Not all nurses were eager and able to voice their concerns, as Bunda did. This was due to the already-established assumptions of being unsupported, helpless, and inferior, which made nurses doubt the effectiveness of such an effort. However, most of the participants shared that they preferred to voice their concerns internally to their professional organisation, which was an informal process. This was usually done through social media groups with a hope to improve the situation. Leka expounded:

"I used to write on [mentioning the name of a nurses' Facebook group] to let other nurses know my issues regarding this profession. I expected the caretakers of the professional nurses' association would respond and help out…".

Apart from voicing concerns, participants also shared that sometimes they deliberately denied the orders or demands (because they were against their personal and professional values), including granting privileges and offering special attention to particular patients, including powerful influencers, along with requests for prioritising patients were often ignored. Afiya shared:

"The patient's family tried to interfere with my work; she told me that she was the hospital director's family and indicated that she wanted a special priority… I said to myself 'I am here to care for patients, not a director's family' so I treated everyone equally regardless of their background. I did not care what she (the director's family) said, I just continued doing my job." (Afiya – FG 2)

A similar reaction was also reported by Dewik who shared the same view of *social justice* (reflected through just treatment) as she expressed, "I just say 'okay' to such order, but we treated patients equally, there was no differentiation at all [smile]". By disregarding the request to grant special privilege to some patients, Afiya and Dewik indicated valuing *social justice* (personal-social value), which they carried into their professional principle (the principle of *just treatment for all patients*) while trying to be autonomous in their roles. Other

participants confessed that they sometimes gave a false impression that they accepted managers' orders; however, they continued to care for all patients equally.

Nurses also maintained their principles when teaming up with those who were considered 'less resolute'. For example, Nony, a senior nurse who claimed to always 'work with heart', preferred to take over her fellow nurse's tasks, as her perception of the work done by the colleague was less-than-adequate. The phrase 'work with heart' refers to the quality of giving a hundred percent to her work, that is, being socially and morally motivated. In this sense, Nony maintained and preserved her standard of practice and self-satisfaction as a professional nurse. She expressed that she was not content with the way one of her team mates treated patients, "I was annoyed [by the way my work partner treated the patient], so I stepped in and took over rather than watching her working without genuine motivation" (Nony). In this case, she materialised some values, such as *caring*, *determination*, and *self-fulfilment*, as well as the values of *being the patient advocate*.

Nurses shared that challenging situations generally affect their mood. As the nurses were aware that their change in the mood could be observed by patients through their facial expression, some nurses chose to cover their face with a face mask while around patients, in order to conceal their true feelings. For example, when a nurse was unhappy with a situation and was concerned that the patient and their family would observe the nurse's true feelings through her facial expression, the nurse wore an operating mask. Yeyen shared, "I wear a mask to cover my weakness, so they [patients and families] do not know, they cannot see if I am in a bad mood…". Some nurses considered it was their weakness for not being able to manipulate their facial expression in order to stay looking 'professional'. Dewik expounded,

> "…I wear a mask if I am not in a mood to smile to the [troublesome] patients
> and their family, … so they will not know whether I am smiling or not. So, I
> wear a mask to hide my feelings [laughing]".

The nurses appeared to maintain their patients' comfort by giving the impression that everything was 'normal' despite the internal conflict the nurses were going through. In this sense, the value of *caring* (*comforting patient*) was upheld and protected. In addition, this undertaking might help to avoid nurses from being labelled "…unfriendly nurse, rude nurse…" (Leka). In this way, participants tried to sustain their value of a 'good' *professional image*. However, for some nurses, using a mask to hide their facial expression raised another issue, as Ella shared "…it [wearing a mask] make me feel a bit distant with them [the patient]", meaning that she might have compromised the connection with patients. This suggests that covering the face to deliberately hide one's facial expression is not only beneficial, in some respects, but also poses a challenge to other professional values.

Common among the participants was also the principle of "creating and maintaining a peaceful athmosphere" (Uyi). This principle was likely to be informed by the personal value of *inner harmony* and the professional value of a *conducive working environment*. This principle was expressed through minimising contact with patients or their families, as a nurse shared their reaction when dealing with demanding patients, "…to cope with that kind of patients, I usually leave the room, let my fellow nurses handle them … so that the problem will not grow bigger [laughing]" (Dabrina – FG 3). Avoiding direct contact with some patients was a common strategy used to not only stay true to one's principle (creating and maintaining a peaceful atmosphere) but also to minimise negative feelings resulting from non-genuine interactions with problematic patients and their families. Wiken shared:

> "… I will do the tasks that do not require me to interact with the patients' family, for example, I can work at medication depot, I can also prepare the patients medication leaving my fellow nurses to process the medicine to the patients… better than pretending to be nice to them…"

Nurses tried to create a more conducive working atmosphere, as well as conserve their psychological state, to maintain a sense of intactness as a person and a professional. However,

at the same time, nurses compromised their professional values, such as *responsibility* (for trying to avoid the tasks they were assigned to, as well as transferring their duties to colleagues who might not want to be involved in the situation). In addition, trying to avoid undertaking clinical tasks with 'troublesome patients' might also compromise nurses' value of *connection*. Indeed, nurses chose the values they considered more meaningful to uphold at times and circumstances, which directed their agency and care toward the patient.

Yet, nurses do not defend their principles all the time. In certain situations, they simply accept some situations and respond accordingly. This is an additional strategy of responding to challenging situations and is presented next.

4.4.2.2 Accepting limitation and overriding own feelings

Some of the nurses opted to follow direction of managers in order to avoid receiving complaints from both managers and their patients. Uyi shared her experience, as follows:

> "…there was a patient who had to be moved to the intensive care unit… but because she felt uncomfortable in the Intensive care room, she came back to the ward and insisted on staying in the room where she was before… We explained to her that she could not do that, she had to move, she did not want to… and at the end, we received a call from our boss telling us to follow what the patient wanted. We had no choice; we had to follow the order to avoid problems" (Uyi)

Uyi seemed to accept the situation and 'played safe', as a reaction to this authoritarian direction. Uyi indicated, "Sometimes I just do nothing and just accept whatever happened…". For some participants, deciding to obey such direction meant overriding or compromising their own feelings. Ikke described her feelings as, '*ngempet*': the Javanese language to describe a disturbing/distressed feeling that arises from the fact that the agent has to deal with a situation that contradicts their free will or expectations. This feeling of '*ngempet*' challenged nurses' wholeheartedness in their nursing practice. Although playing safe might

help avoid some problems, this kind of response appeared to compromise the nurses' value of *self-fulfilment* with the potential to affect their practical agency.

In this research, it was apparent that nurses often have to accept some limitations and circumstances associated with challenging situations. When the magnitude of the challenging situation overpowers the nurses' capability to handle the problem, participants modified their mindsets and accepted circumstances and limitations through adjusting their internal value systems. Ella shared, "there is nothing I can do… It was too complicated. I think it would be easier for me to just get along with it…".

Wiken, who worked as a civil servant nurse at a public hospital, shared her experience of being humiliated by a patient's family who had a connection with an influential figure in the government:

> "…I was really disappointed at the beginning, but later I started to see it (being unfairly treated by patients' family) as part of my job. I feel that wherever we work, we will experience unpleasant things like this, especially if we work as a public servant, we cannot expect always to get respected all the time, although we have already done everything well" (Wiken)

In this situation, Wiken indicated that she did not have any control over the situation and, therefore, resigned herself to it through adjusting her expectations. Using this strategy, she was able to begin to view the situation as 'normal' rather than a situation that she had to retaliate against.

Another example can be seen in Dini's case where she was concerned about a heavy workload, as the doctor kept on asking her to do additional tasks on top of her usual nursing responsibilities. Dini expressed, "… but I don't want to let it take me down…, I will learn, as long as I can do it, I will do it…". It appeared that she accepted the additional workload and adjusted her attitude and her expectation, accordingly. Similarly, Nuri shared that, on some

occasions, she consciously changed her perspective about the situation. She viewed it as a motivator to become a better nurse:

> "…sometimes, I felt being underestimated by the doctor. Of course, it hurts,
> but sometimes I see it [being underestimated] as a challenge to learn more…"
> (Nuri).

This suggests that a problematic situation can also be beneficial for nurses, especially when the nurses are able to view and handle the situation with a positive attitude.

It was clear that the strategies nurses applied in reacting to the situation were situational and contextual. However, it is indicative that, depending on what is at stake, each reaction affects the nurses' value systems by either preserving particular values and/or compromising other values.

4.4.3 Summary.

This section has elaborated on the processes that occur when nurses confront problematic situations. A detailed exploration of two interrelated sub-categories offers insights into the basic social processes and some examples of values involved in confronting situations.

4.5 Category Three: Re-Adjusting Values

This category describes the processes that nurses engaged with when re-adjusting their values after encountering value-challenging situations. The three interrelated processes which inform the category *re-adjusting values* include *re-visiting values, sustaining motivation and morale*, and *re-configuring values*.

Re-visiting values encompasses the process by which nurses contemplate and contextualise their values in practice. Sustaining motivation is demonstrated when nurses regain their confidence as professionals and preserve their sense of intactness, which uplifts their morale. In re-configuring values, nurses re-evaluate the situation thoroughly, re-

considering and juxtaposing relevant and competing values in order to integrate the 'new' value compositions into their existing value systems, which are expressed through their 'adjusted' attitude towards themselves, their job, and/or others.

4.5.1 Re-visiting values.

This subcategory describes the process that nurses undertake in considering and applying values in a given situation. This basic social process includes re-visiting nurses' religious beliefs and acting on personal-professional values.

4.5.1.1 Re-visiting religious beliefs

Religious beliefs emerged as substantial elements of a participants' value systems. Participants consistently referred to their religious values as a reference point in their practice, especially when nurses needed to be grounded in positive attitudes, as reflected in Farida's statement:

> "I know I should be helping people wholeheartedly regardless of my situation. That's what my religion ordered me to do. So, I always try not to take personally whatever the patient did to me because I believe that is how *Allah* test my sincerity" (Farida).

Farida's experience of being harassed by an offensive patient, challenged her sense of being a nurse. However, she was able to maintain her focus, as well as preserve both her sense of being a nurse (*professional*) and her sense of being a believer (*personal-religious*) by responding to the offensive patient in a conscious and appropriate way.

Orienting practice around religious values, nurses often used beliefs and rituals to help them retain their sense of *wellbeing*, particularly in the onset of difficult, value-challenging situations. Amalia articulated, "in my religion, praying is to rest/calm our mind and body, so I do. It works for me". Similarly, Lia expressed:

"… it [praying and remembering God] is very important; it is a must [for me] because praying is the pillar of [my] religion. On top of all, it does help me feel relieved and calm especially when I face a hard situation both at the workplace and outside the workplace" (Lia)

Embedding religious values into their nursing practice assisted nurses to maintain rapport with patients and families, particularly when caring during difficult situations. This can be seen in the following story:

"Usually, I use religious approaches to calm down the patient's family; [such as] I told them [that] 'all living things will die, we cannot live forever, we will come back to our creator someday. I will be dead, you too, all of us will be dead. The most important for now is sending our prayer to the deceased [the patient]'. Usually, this approach works. The family become calm and can accept the situation" (Nony)

Nony demonstrates how religious values influenced her practical agency in reassuring the grieving family. The message, such as "all living creature will die… we will be back to our creator", is a common conception in the local culture that is likely to be grounded in the Islamic tradition (Al Qur'an, 2:156), which is the religious affiliation of the majority of the participants. The use of such messages indicates that nurses have internalised their religious beliefs and integrated them into their nursing practice. Hence, religious affiliation plays an important role in the nurses' personal value systems, upon which their practical agency is established.

Dealing with patients who have different characteristics under different circumstances requires nurses to possess virtues in order to maintain a positive workplace atmosphere. However, religious values were not the only element that played out in the participants' practice. Other values, such as personal-social and professional values, also have an influence on their practical agency. These values are often revisited and reinforced during hardships and are explored in the next section.

4.5.1.2 Re-visiting personal-social and professional values

Nurses applied personal values, such as *empathy*, in their nursing practice by putting themselves in their patients' situation. Ikke shared her experience when working with a fellow nurse, who she considered rude and who a patient's family complained about:

> "… I pictured myself in the situation. If I were sick, I do not want to be treated by nurses who show me their grim face and grumbling. I would think about how I feel ... so when the patients complain about with my colleague's facial expressions, I understand, and I can accept that…" (Ikke)

Similarly, Deby narrated her approach in dealing with her patients and how it affected the overall perception of her practice:

> "…when I look after a child patient, I imagine the patient is my kid. I have a responsibility to take care of the patient, and I took it little further by playing a parent role. I found the interaction and the care become much more meaningful and enjoyable". (Deby)

The above quote demonstrates how the quality of being *empathetic* could improve the overall quality of the process of care, particularly from the nurses' perspective. Clearly, empathetic practice facilitates nurses to preserve the values of *deriving enjoyment from the job* (personal satisfaction) and *the sense of being a nurse* (professional satisfaction).

As shared by participants, it is not uncommon for nurses to experience harassment (by the vulnerable patients' families) in the workplace, particularly in a high-tension department, such as in the Emergency Department and Intensive Care. However, by 'walking in the patients' families' shoes', nurses were able to understand the situation more comprehensively, which assisted them to view the harassment under particular circumstance as an 'understandable and tolerable' reaction. This is demonstrated in the following excerpt:

> "So, there was a mental breakdown [from being harassed by a patient's family], … but I realised it [the situation when the patient's family lost temper and harass nurses] could happen to me also. If I were them and if my family were very sick, and under a panic attack, I might behave the same way" (Isma)

Participants in the study felt that they were expected to handle all kinds of situations in the best manner, regardless of patients' characteristics and behaviour. To keep up with this expectation, nurses drew upon *empathy* but also the virtue of self-control, as expressed by Dabrina:

> "… we are going to be a nurse not for one or two years, we need to keep it in mind… we have to be calm, that is the most important thing. When facing any problems, we have to be calm … We [have to] learn to calm down our self, and we [have to] learn [how] to make other people calm down too" (Dabrina, FG 3)

Like Dabrina, Ikke articulated, "We have to be patient, we have to be able to control our temper, we cannot let our anger take over when we are facing very demanding patients". It was clear that the participants knew what to expect in similar situations. Also, they were aware of the virtues that would help them to stay calm so that they could preserve their wellbeing and integrity as well as maintain their agency.

4.5.1.3 Re-visiting personal-family values

Value-challenging situations often included nurses' family commitments, which required nurses to re-visit the possible impact their job has on their family. This can be seen from the following quote:

> "…I decided to attend my shift at the hospital and told my spouse to care for our sick son... a few hours later my spouse texted me 'have you ever think how much [mentioning the name of the son] wanted you to stay beside him at this time?. He kept calling you…'. I felt like crying after reading the message… I could not entirely attend my job because my mind was going back home. I decided to go home to see my son. I was feeling bad about myself …I realised I did not do it often. Had my son's condition been not that bad, I probably would have just stayed at the hospital…" (Endang – Reflection)

Endang indicated that finding a resolution for competing family commitment and her professional role is complex and emotionally exhausting. Clearly, her personal values (the value of *family*), which spurred her to be a 'good mother', are in contrast to her professional

values (of being a 'good and professional' nurse). Although she finally chose to prioritise her family over her professional expectations, this decision did not seem to be of a fixed pattern, but rather conditional on a number of contexutal circumstances.

4.5.1.4 Re-visiting moral values

An example of an instance in which nurses revisited their moral values is seen in Christi's reflection below, after experiencing a series of recent, terrifying earthquakes that hit her hospital. She was working during the night when powerful earthquakes struck and threatened everyone in the hospital.

> "I was in the nurse station on floor 3 when an earthquake struck violently. I heard everyone screaming, and the glass window broke to pieces. Some patients started rushing out of the hospital building. The quake continued striking, and I was worried the building would collapse, so I too rushed out of the building to save myself. I forgot that I had to save my patients who were still in the ward. I finally managed to get out of the building, and I just sat on the ground… trembling and frightened. A few moments later, I was taken aback by a rude voice behind me, shouting at me 'What kind of nurse you are! Why didn't you help us?'. I went blank for a moment and rushed back into the hospital to help my patients. I was about to go upstairs when the second tremor happened even more violently, so I come out running again… The following day, I started to think whether leaving my patients behind was a wrong action… I wondered if such action is a breach to my professional values… I wondered what the right one to do... Who did shout at me at the time? Was she an angel who tried to remind me of my moral… and my role as a nurse? … Finally, I managed to convince myself that my action was justifiable … I had one thing in mind…, I am a human being, I can panic and scared too … Also, just like everyone else, I have beloved families who must be worried about my condition following the earthquake. With this in mind, I can get rid of the guilt feeling". (Christi - reflection)

Christi's reflection indicated that her moral values were juxtaposed with her own values of *safety/security* and professional values such as prioritising *patients' safety* (that also overlap with ethical values, such as *benevolence*). The process of re-visiting these values was not done promptly, suggesting that value processing is not always done spontaneously and simultaneously, particularly in an emergency situation. Nurses might need some time and

practise to comprehend the problematic situation, before re-visiting and processing the affected values.

Striving to balance personal and professional commitments in practice was a common encounter for nurses. Yet, choosing between personal and professional values was a complex and dynamic internal process that require nurses to constantly revisit their previously held values. Depending upon the context/situation, each nurse might apply a different set of values to underpin their practical agency.

The process of re-visiting values is closely related to another basic social process of sustaining motivation and morale. Re-visiting values facilitates nurses to create a momentum for sustaining their motivation and morale (during challenging times) as well as restoring their professional confident, which is presented next.

4.5.2 Sustaining motivation and morale.

Problematic situations often have a detrimental impact on nurses' motivation and morale. For some nurses, problematic situations can be discouraging as they diminish a nurse's determination, which results in decreased morale. Nuri shared, "…I was so fed up with the situation [being treated badly by a doctor] … I thought I was losing interest in this job…". However, other study participants were able to find resolution, as reflected through the following excerpt:

> "I won't let myself down… There are many good things that I have been enjoying as a nurse. Instead of thinking the bad things, I would rather think the good ones so that I am motivated to get back to work…I know patients need me…" (Leka).

As indicated in this quote, nurses may sustain their motivation and restore their morale through recalling rewarding experiences and a sense of being important and special. Through

these basic social processes, nurses remember and reclaim positive aspects that are used to neutralise current negative influences on their motivation and morale.

4.5.2.1 Recalling rewarding experiences

Nurses appeared to enjoy positive and encouraging feelings when patients acknowledged their work and roles of nurses. These acknowledgements came in various forms, from tangible gratifications to the recognition of being a valuable person and a respectable community member. Some patients and ex-patients showed their gratitude by presenting the nurses with offerings, such as souvenirs, food and other common treats, which is a common practice in Indonesian culture. Several nurses shared that they had received appreciation, years after the patients had been discharged from the hospital, often at an unexpected time and place (private and public places). The following experience provides an example of this matter:

> "... I went for a vacation, and I was enjoying myself, just sitting there [at a public area on the beach], suddenly someone approached smiling, offered me a cup of coffee and a snack pack for free … she said that she was cared for by me in the hospital at class 3 room some years ago and she was thankful… [smile] They still remember me" (Nana)

Similar to Nana, Aida shared her experience of receiving gratification from her ex-patient, as follows:

> "I was playing with my kid at home when someone with a little girl came over and handed me a big bag and a birthday cake with my name on it. She said 'Mam, do you remember me?' of course I did. She was the mom of my patients a few months ago. In fact, we were very close to each other. She continued, 'I am very grateful to you. You were very kind to my daughter. We decided to make you this birthday cake because we know tomorrow is your birthday' I was very happy at that time, not because of the cake, but the way she presented in make me feel appreciated. I said to her, 'but I have never told you my birthday' she said, " no you did not, but you told her [her daughter]" (Aida – Reflection)

It would seem that receiving gratification from ex-patients is a pleasing experience that increases the morale of nurses. The gratification from patients or ex-patients were seen, in this study, as a form of appreciation and acknowledgment of the dedicated work of nurses.

Nurses also shared that they felt motivated by the positive attitudes of health professional colleagues and patients towards nurses and their care. Nurses sometimes received positive feedback, comments, and even encouragement from patients, doctors and peers, which enhanced the nurses' morale. Nony, for example, displayed a very positive body posture when sharing her story of being praised by her patients. She changed her sitting position; sat upright and leaned slightly towards the interviewer, and became animated when recounting this part of her story:

> "One of my fellow nurses told me once that she happened to overhear one of the patients said, 'if we are treated by Mrs Nony, we can recover more quickly' [laugh]…I am flattered, and it was very motivating too." (Nony).

Clearly, Nony took pleasure in receiving these positive comments from her patients; it seemed to uplift her professional confidence and morale. More importantly, the comments positively influenced Nony's determination to undertake and sustain her role as a nurse. Another positive, encouraging comment for nurses is captured in Unun's reflection:

> "A few days ago, I had an issue with my nurse manager, which made me feel a little down. The manager blamed me for something that was not my fault. But yesterday morning the doctor that I used to work with approached me in the nursing station and said, 'I know you've been doing well so far. I know you are a good nurse, so do not get cranky just because of a little misunderstanding'. Apparently, the doctor was aware of my issue with the manager. I felt like she was standing by me. Her comment was really a big relieve for me. It also made me feel like getting back on track again…" (Unun – Reflection)

Unun's story clearly demonstrates that receiving positive feedback from a doctor enabled her to preserve her morale, which was very likely carried through into her practical agency. Receiving positive feedback, coupled with having a sense of being important and special, emerged as positive influences on nurses' motivation and morale.

4.5.2.2 Recalling the sense of being important and special

Another meaningful experience that nurses enjoyed was the feeling of being useful to others. Yeyen, who worked at a public health centre that was far away from her hometown, believed that her role of being a nurse in the community was acknowledged. She shared her experience:

> "… my neighbours sometimes come to me (to seek help) late at night, so I feel that I am needed. I am not originally from here, I have no family here, but I feel welcomed and needed by my neighbours. I can feel that they consider me family … I feel I am benefited too as I am not feeling lonely after all" (Yeyen)

Enjoying the feeling of being socially recognised and acknowledged in their community was deemed as a substantial social benefit for nurses and boosted their motivation and morale.

Nurses indicated that they were proud of possessing specialised skills and capabilities to deal with the life and health of others. This sense of pride is discernible in Ulfa's statement, "I feel like I am very proud of being a nurse for I am able to do things that not many people are able to tackle...". The nurses also talked about aspects of proud moments in nursing practice, such as saving lives, as Amalia articulated, "What makes me very proud is when I succeed in saving people's lives, especially those who are in a critical condition but finally manage to go home healthy". In addition, some participants took pride in their ability to perform specific tasks. Peppy expressed:

> "Not all nurses can handle mandated tasks. Only those who have been trained to do the job are allowed to do it. ... I feel proud because the doctors trust me to do the tasks [mandated tasks]".

Peppy talked about mandated tasks, which were ones that require special skills and knowledge to perform. The doctor recognised and acknowledged her 'extra' skill set, that led to her being trusted to perform the job and provide quality care. Hence, the value of *being*

recognised and *acknowledged* was possibly an important underlying value for Peppy. Another experience that created a sense of pride in the nurses was the experience of proactively responding to a critical patient without assistance from a doctor, as illustrated below:

> "… it was around 4 am when a patient with a tracheostomy, suddenly became abnormal … the existing protocol required me to call the doctor first, so I did. But it's difficult to reach the doctor. She didn't answer my call. I had to continue handling the situation quickly. I set the oxygen … There was a clog, so I figured out what I should do. At that time, I was alone. I asked my fellow nurses to contact the doctor, but still, he/she could not be reached … in the end, I could save the patient's life, and I felt proud after all …" (Wiken)

The above story signifies that feeling proud was amplified when a nurse autonomously undertook the job to perform critical tasks to save patients' lives. On successful completion of the tasks, participants derived their self-worth from the situation. Furthermore, many nurses shared rewarding feelings when they achieved positive outcomes, of otherwise potentially fatal consequences, in emergency situations. Alda expressed, "Seeing the patient recovered well especially if they were admitted to the hospital in a really bad condition, when we manage to get good results, I feel happy". In addition, nurses expressed satisfaction when they knew that their patients were satisfied with their service. "…I felt satisfied with the way I handle the patients and their situations, especially if they are also satisfied with my service." (Fasna, FG 1).

It was visible that nurses valued their profession and took pride in being a nurse. Recollecting positive feelings (both in the sense of rewarding experience and the sense of feeling important) helped nurses to reclaim some values, such as *being appreciated and acknowledged* as a person and a professional as well as accomplish a sense of *self-fulfilment*. Drawing upon this pride, nurses are able to sustain their morale and motivation when it becomes diminished following challenging situations.

The positive sensations, resulting from the basic social process of sustaining motivation and morale, served as balancing forces for the poor experiences and negative feelings that resulted from confronting problematic situations in the workplace. Counter-balancing negative feelings with positive aspects of the profession involved a complex cognitive process in which participants needed to re-consider and juxtapose various values to avoid or minimise the detrimental effects of the situations on their morale. However, as nurses are likely to encounter difficult situations during their practice years, nurses' values will always be challenged. As a result, nurses will have to constantly evaluate situations, contemplate underlying values, and reconfigure their values in order to maintain their integrity. The social process of re-configuring values is presented in the following section.

4.5.3 Re-configuring Values.

When nurses are able to balance negative situations with positive aspects of their profession, it creates a momentum and progress towards developing resilience. During this period, nurses reconfigure their values through re-defining meaningful aspects, on a personal and professional level at a particular time under given circumstances. In the *re-configuring values* process, nurses perform deep and critical reflections, which surface some of the most fundamental aspects of their personal and professional principles, which results in a changed perspective and 'reordering' of their values. These aspects include *the concept of being a 'good' nurse* and their underlying *personal values for the professional life and motivation for the nursing profession*.

As presented in the preceding sections, overwhelming challenges in nurses' workplace can affect nurses' motivation and morale. Naturally, the challenges prompted nurses to manage the situation and take back direct control of their feelings. To achieve this, nurses reflected back on their values, such as the value of being a 'good nurse'.

4.5.3.1 Reflecting on the attribute of a 'good' nurse

Through reflection, nurses appeared to reinforce their commitment and determination to be 'a good nurse'. 'A good nurse', as defined by participants, is "a nurse who does not complain about her job and its consequences" (Wiwin) and "a nurse who has good clinical skills and acts in professional manners, determined, sincere, and from the heart" (Eka). Reflecting on the perceived attribute of being 'a good nurse' seemed to help nurses recover more quickly from a value-challenging situation, as Leka shared:

> "I used to remind myself always to make an effort to be a good nurse because it helps me feel calm… and gets me back on again when I feel a bit exhausted".

This quote implies that nurses valued the attribute of being a 'good nurse' and strived to associate themselves with the perceived image and character of an ideal professional. As indicated in the self-definition of a 'good' nurse, above, 'good' nurses possess certain characteristics, such as being passionate, compassionate, and determined. The above excerpt indicates that affiliating self with an ideal professional identity (being a 'good' nurse) could be a meaningful process that helps nurses to not only survive a problematic situation but may also assist with them developing resilience. In addition to striving to achieve and associate themselves with the attribute of a 'good' professional, nurses also appeared to strengthen their commitment to their profession through reflecting on their helping spirit.

4.5.3.2 Reflecting on the commitment to nursing and a helping spirit

In repeatedly facing challenging situations over an extended period of time, nurses attune themselves to the demands of the working environment by gradually reframing their perspective and beginning to view these situations as 'common experiences'. This can be seen in the following excerpt:

"…As I become a more experienced nurse, I become mentally stronger…when I was younger, I got offended easily by the way the patients' family ordered me to do my work. I used to feel irritated, especially when I thought that they [the patient's family] did not respect me as a nurse at all… sometimes, I made time to think about my job and myself; I can feel that I am a different nurse now…I change a lot… I think those experience make me more mature nurse. Now I see that kind of situation [value-challenging situations]as just bits and pieces of nursing profession…" (Idah – Reflection)

Although it was not clear whether Idah's progress towards becoming a more experienced nurse with time happened over an extended period of time or as a result of encountering a lot of challenges, in a relatively short time frame, it is obvious that Idah has gone through a process of maturation. She indicated to have engaged in the process of re-configuring her values, which resulted in a change in her attitude towards her job and circumstances. More importantly, this indicates that deep reflection is an important process that may accelerate the reconfiguration of values.

Another value that the participants commonly reflected upon is the personal value of a *helping spirit*. Helping spirit is the "intention and determination to help those in need" (Diah). Most nurses indicated that reflecting on their helping spirit maintained their motivation during challenging times. Tina expressed:

"…I chose to work as a nurse because I want to help myself, my family, and other people. I always bear in mind when I feel a little low that I have been obliging myself to do something to help. The attitude is from within me.". (Tina)

Clearly, Tina draws upon her value of *helping others* to restore her motivation and sense of intactness. In the process of re-configuring her values, Tina's statement alludes to the fact that the value of *helping others* was integrated with the value of *family* (helping family), which directed Tina to preserve and enhance her motivation to stay determined and maintain her morale.

4.5.3.3 Re-activating values

Another important aspect that could trigger the process of *re-configuring values* is *re-activating values*, which might have been overlooked as a result of pursuing another value upon encountering a problematic situation. Re-activating these values is often extemporaneously done and triggered by an emotional encounter, both within and outside the working place. Meaningful interaction with a patient can stimulate a nurse to revisit and reactivate their 'suppressed' values, that is the value that might unconsciously have been compromised or 'devalued' earlier on. For example, Eka shared a time when she felt regret being in the profession. She considered quitting but managed to regain her focus after an interaction with her patient's parents. Receiving wishes and prayers from the patients was one of the positive moments that she enjoyed:

> "I met a mother who had lost her child five times … I took care of her sixth baby who had stopped breathing twice at that time, and we did PPV (Positive-pressure Ventilation) and CPR (Cardiopulmonary Resuscitation). After one and a half month, the baby was finally discharged healthily. The mother was so grateful. She prayed for the nurses who took care of her baby. The way she prayed for us made me think 'I have a noble job, I dedicate my life to help people and they are thankful, why would I want to quit?'. After that, I have never felt regret again for being a nurse. In fact, I am now very grateful that I can be a nurse". (Eka)

Clearly, the patient's appreciation became a reason for Eka to revisit some values that she had supressed. In this situation, the values, such as *having a good job* and the spirit of *helping others*, had been diminished by the challenges she had previously faced. The above excerpt suggests that a meaningful incidence (such as receiving a genuine appreciation from the patient) can provide an important wakeup call for nurses to reconceptualise their values (in this story, the importance of self for others), which can lead to re-configuring existing values and redirecting or re-energising a nurse's practical agency.

4.5.4 Summary.

This section has detailed the basic social process that nurses undertake in re-adjusting their values. It highlighted how nurses draw upon their inherent personal and professional values, preserve their motivation and morale and, finally, reconfigure their value systems. These basic social processes allow nurses to preserve their sense of intactness, both as persons and professionals, which also facilitates them with maintaining their practical agency. The process of *re-visiting values, sustaining motivation and morale*, and *re-configuring values* might or might not happen simultaneously.

4.6 Conclusion

This chapter has presented important findings and insights into the basic social processes of nurses' personal and professional values and values processing. Nurses experiences clashes with their values in terms of compromise and restraint. This requires them to renegotiate their values in order to preserve the integrity of their value system, which is a complex, fluid entity. All basic social processes incorporated in this chapter are situated within and influenced by several contextual conditions. The next chapter presents the contextual determinants that affect the development of nurses' value systems.

Chapter Five: Contextual Determinants

5.1 Introduction

The preceding chapter detailed the social processes involved in the development and evolvement of nurses' value systems. These processes did not happen in a context-free environment. Hence, in this grounded theory, it is crucial to thoroughly scrutinise the circumstances and the context in which the social processes took place. Charmaz (2014) suggests positioning grounded theories in their social-interactional as well as their local-historical contexts is important, in order to enhance the theories. This chapter presents the contextual determinants influencing the processes outlined in Chapter 4: The Categories.

The values and attitudes that underpin nurses' practical agencies appeared to be affected by certain factors. The conditions and situations that existed along the nurses' career journey challenged the nurses' value systems and required them to continually make adjustments to their value systems. How the nurses responded to the situations and how they adjusted and harmonised their values were found to be influenced by three overarching factors: cultural determinants; job, income and employment configurations; and the workplace context. These factors are explored in the following sections.

5.2 Cultural Determinants

In anthropology, culture is defined as a complex entity of human attributes and symbols that are attained through a membership of groups, which includes knowledge, beliefs, arts, morals, law, and customs (Kottak, 2018). A number of culture-related factors were found to influence nurses' values, attitudes, perspectives and principles toward their professional responsibilities as well as their practical agency. Among the factors were a religious affiliation, the family, and social media.

5.2.1 Religious affiliation.

The majority of participants appeared to have been exposed to religious value teachings over an extended period of time during their childhood. Hence, it appears that they have internalised these values. Participants frequently made references to, and reflected upon, values that were grounded in their religious beliefs. This suggests that, in the context of Indonesian nurses, religious beliefs play a significant role in the development of an individual nurse's value system. These values are carried through into their practical agency.

Integrating religious beliefs into their value systems, participants appeared to conceive and view their professional roles and undertakings through a religious framework. Tina shared "I work here (as a nurse) not entirely for money, but I am expecting rewards from Allah...".

In the above statement, the personal value of *wealth*, that is the motivation to make money, is juxtaposed with her religious value of "expecting rewards from Allah". Even though Tina did not have any other jobs, she did not appear to maximise the economic benefits of her profession; she also expected religious bounties from God. Another example that illustrates how religious values came into play can be seen in the following quote:

> "…I am happy for I can carry out what my religion commands us to do, which is helping other people in need … I always want to be able to help people because it is a part of my religious tenets. I feel like I am a useful person… This was one of the reasons why I decided to become a nurse and always want to be a good one…" (Vivit – Reflection)

In this case, Vivit indicates that her professional values of helping patients might have been advanced upon her understanding and interpretation of her religious tenet of helping others. It is apparent that her religious values serve as a base for her personal-social values of "helping others". This value is further accommodated in her professional values set of "helping patients". In addition, her eagerness to become a 'good' nurse appears to have been influenced by her religious beliefs.

Both Tina and Vivit demonstrated how their religious values affected their attitudes towards their job. While Tina did not give a clear statement regarding how the values carried through into real actions, Vivit indicated that her religious values motivated her to practice in a 'good' way. A more vivid account of religious influences on a participant's practical agency can be found in Nony's story:

> "There was a post-operation patient who lives in a remote area. They did not have transport to go home… I knew that they would have to see a practising nurse regularly [post-operation] to have their wound checked… I offered to drive them home, and I had taught them how to treat their wound, so they did not need to see a nurse every day …I did not ask for a payment for that. …I do that often because I believe it is my *shadaqa*…" (Nony)

There are multiple values involved in the above quote. However, there is one particular value derived from the nurse's religious affiliation. 'S*hadaqa*' is a concept of charity, which is strongly encouraged in Islamic teachings (Al-Qur'an, 33:35). Not only has Nony internalised her religious teachings, particularly the importance of offering *shadaqa*, she also has incorporated this religiously derived value into her practical agency. Her kindness in offering a lift for the patient reflects agency that is beyond her professional role. Obviously, this agency was driven by her religious value of "*shadaqa*", which was juxtaposed with the value of *helping others*.

> "… there was a very poor patient, I pitied him/her because he/she could not afford the hospital fee. The patient demanded to be discharged [for the patient was concerned about the cost of the care], we helped him/her with the fee, so that the patient can be treated here (without having to worry about the cost)…We [nurses in charge] gave charity or *shadaqa*) to him from our own money…" Ulfa

Similar to Nony, Ulfa's case involves several values, with religion playing a central role. In both cases, values, such as *selflessness*, *helping others*, and *charity,* appear to have been framed in terms of the nurses' religious affiliation. These values appear to have been internalised and to have potentially comprised their value systems. Furthermore, these values,

as a complex combination entity, are translated and contextualised in the nurses' practical agency.

5.2.2 The family.

From a sociological perspective, the family has been considered as one of the most important agents of socialisation (Brinkerhoff et al., 2013). It emerged that participants' families are ones of the most fundamental sources of value acquisition for nurses. It was apparent that value systems are initiated within family settings. "They made me who I am…" (Afiya – FG 2). Afiya's simple statement was also supported by most participants. It was apparent that participants' value systems as persons and professionals are affected by their family. This illustrates the fundamental influence of family, particularly with regards to values transfer. The process of values transfer in the family is a natural process. As part of cultural socialisation, this process is influenced by culture such as the nature of the parent-child relationship.

5.2.2.1 Parental expectations

Within Indonesian culture, children are not only taught to sincerely respect their parents unconditionally but also are expected to follow their parents' directions obediently (Sudirman & Bahri, 2014). In this study, some participants appeared to embody this cultural child-parent relationship. This can be seen in Endang's reflection, which she wrote shortly after her father had passed away:

> "I remember when my parents asked me to be a nurse, they told me about positive things that I could possibly do as becoming a nurse. I said 'yes' and I enrolled in a nursing academy. I knew it cost my parents a lot of money, but they had never complained about it. They paid for my education and they worked hard for that… I think they wanted me to do well in this profession…so I will try my best not to disappoint them…" (Endang - Reflection)

Clearly Endang's attitude toward her professional responsibility is influenced by her perception of her parents' expectations of her. The strong parental expectation to succeed as a nurse is carried through into her practical agency of trying to do well in her profession. Another example of this account can be found in the following quote:

> "… my father insisted that I have to attend SPK [nursing vocational school] and be a good nurse. … I enjoy the job, and I was happy to fulfil my parents' wish" (Yeyen).

In the above statement, Yeyen gives a more explicit instance regarding parental expectation. The value that was strongly emphasised by the parents is a value and an expectation of "being a good nurse". Although in the statement Yeyen did not explicitly state how her parents' expectations materialised her practical agency, she indicated to have fulfilled their expectations. This suggests that she has carried out her professional responsibilities according to her parents' expectation. The positive feelings she felt might also emerge from her ability to follow up in her practice are the values that her parents had taught her. This parental expectation to carry through into professional life is also illustrated through Amalia's story.

> "My mother told me to find a job at the hospital [becoming a nurse], so I can help my family if they are sick. That was her will, … I respect it [her will]…I keep it in my mind, [that was] the reason I chose to stay working [as an honorary nurse] even though I did not receive any salary for a quite long time in the beginning. (Amalia)

Amalia has prioritised her parental expectation over the prospect of income (valuing the *fulfilment of parents' expectation* more than *income*). Another value that appears to come into play in the above cases is the value of *respecting parents*. The keenness of the participants to fulfil their parents' wishes is, perhaps, associated with the value of *respecting parents*. The participants appear to carry out their parents' expectations into their professional nursing lives, as a way of showing respect for their parents. Respecting parents' expectations has been part

of familial values in Indonesian culture (Sudirman & Bahri, 2014). These values have been integrated into participants' value systems and practised in their professional careers. Clearly, parental expectations shape the participants' value configuration.

5.2.2.2 Marital status

Marital status appeared to be a significant cultural determinant that created personal commitment issues in the nurses' practice. Married participants expressed and tended to place more emphasis on their personal commitment in relation to professional and family commitment conflicts. An example of personal-professional issues attributable to marital status can be seen in the following quote:

> "Family-related problems are the most frequent obstacles in my daily life. As a nurse, we are used to being two-individuals. As a nurse we have to give our dedication to our patients; as parents, we have familial responsibilities…" (Eka)

In addition, married participants appeared to be more emotional when sharing stories that involved their children and spouse (Memo). In her reflection, Aida compared her situation before and after marriage, as follows:

> "When I started getting involved in this job years ago, I was single… unmarried person. I did not have to worry about leaving home for the shifts anytime. I was so free… Now I have a family. I have a kid…I find it difficult to maintain what I have been believing as professional conduct, especially if I have a concern about my kids' safety at home …" (Aida - Reflection)

It is understandable that a married nurse, like Aida, confronts the issue of personal-professional conflict more often, and perhaps more intensely, than a single nurse. Within the Indonesian cultural context, marriage comes with serious family responsibility (Sudirman & Bahri, 2014), therefore, the problems of competing concerns and roles are likely to be more accentuated in a married nurse. Besides fulfilling their parents' interests and carrying them through into their practice, married nurses indicated that they have to consider their spouses'

and children's concerns in their personal and professional lives. This suggests that a nurse's values configuration might alter with a change in marital status.

Another example of how marriage affects nurses' values, which translates into practical agency, can be seen in the following recounted experience:

> "…because I am worried that it [a problem with my spouse at home] will influence my mood and the way I serve patients… I thought it is better for me to hold back [from caring for patients when I have serious personal problems] otherwise I might increase the number of complaints [for the health centre where I work]. We are humans, so it is normal to have family problems, for example, problems with spouse…" (Yeyen)

Yeyen is a married nurse working in a public health centre. She shared that occasionally she had experienced familial commitment problems with her spouse, which affected her morale. This suggests that a nurse's agency may fluctuate when morale is impacted as a result of experiencing familial issues. Clearly, in this example, Yeyen's practical agency was affected by the problems she was facing.

Another value that comes into play in the above case is the professional value of *loyalty*. Yeyen appeared to maintain her value of loyalty to the organisation she was working for through preserving the image of the organisation by trying to keep the number of patient complaints low. Through her belief that her care would be comprised while dealing with a personal issue which might be visible to her patients, she chose not to care to minimise the risk of patient complaints. This case provides an insight into how social process is influenced by marital status which in some cases required nurses to adjust their value systems; which serves as a base for nurses' practical agency.

Marital status has the potential of influencing nurses' considerations of their value sets in a more direct sense. This is possible due to a specific cultural expectation of marriage. In Indonesia, a husband is responsible for family income to sustain the family's living. A wife,

on the other hand, is responsible for managing family income and taking care of family members (Sudirman & Bahri, 2014).

Advancing on this cultural perspective, it is logical that a marriage necessitates that a male nurse provides wealth for his family. Male nurses are likely to take into their value system the value of "family income". The topic of income is detailed in section 5.3. A female nurse, however, is expected to carry out a significant portion of the responsibility of taking care of family members. These assignments would require nurses to reconfigure competing values that come with a change of marital status:

> "…married nurses differ in the sense that they have a lot more [family] responsibilities than a single one. Time [tighter schedule], necessities [family's needs], and the way of communicating, the way they face patients or the patients' family are more stable [controlled]…" (Elsa – FG 2)

It is apparent that, in Elsa's view, a married nurse tends to have more personal issues that might affect her attitude and practice as a professional. However, Elsa also indicated that marital status might bring about positive qualities of nursing that characterise a nurse's practical agency, such as being more controlled in interactions with patients. This quality might facilitate nurses to preserve some values and help them with the values configuration and harmonisation process. These qualities might also be associated with another contextual determinant, work experience, which forms a part of the maturation process. This will be explored more in Section 5.4.2.

The process of harmonising value systems is not only affected by nurses' religious affiliation and marital status but is also influenced by a relatively new trend in society, the emerging culture of social media, which is presented next.

5.2.3 Social media.

The advancement of internet technology has allowed social media to gain popularity among internet users in Indonesia (Dillinger, 2019). Interaction through online social media appears to have become mainstream in the Indonesian lifestyle (Wong, 2019). It seems that nurses have been well-exposed to this technology. Given that the majority of nurses in Indonesia are relatively young, the adoption of social media culture and the integration of it into nurses' practices has progressed very quickly.

As identified in Chapter 4.4.2, not all participants were able to express their concerns directly and openly to other stakeholders. Social media provides an alternative way of expressing their concerns. Through social media, nurses can voice their interests, thoughts, and feelings through both public and private channels, as Wiwin shared:

> "We had talked about it [remuneration issue] with some friends via *WhatsApp* and *Facebook*, policemen get remuneration, and teachers get certifications money, doctors also [get entitlements], how about nurses then [laughing cynically] ..." (Wiwin)

It appears that social media has helped participants promote and retain some values that would not have been possible without virtual social networking. Values, such as *freedom* (being able to voice concern), *courage* (standing up for own beliefs), and *community* (being part of a broader professional community – a borderless nurses' community), can be given an avenue of expression through social media. This appears to assist nurses to preserve some of their personal and professional values.

Social media has also provided a teaching and learning ground for some nurses, where they can attain values through the exchange of experiences on social media platforms. Learning and sharing practical and emotional encounters, particularly when experiencing a challenging

situation, provided relief for nurses in this study. For example, Leka shared her experience with a social media, as follows:

> "*Facebook* can be quite a good place to share what we feel. Sometimes, just by posting in it, I feel like releasing most of the burdens from my head…" (Leka).

Leka appears to have benefitted from posting her internal feelings on a social media platform. However, social media did not bring only positive influences for nurses. Some nurses shared negative experiences regarding the use of social media. Uyi shared, "that happened …, at the Emergency Department, patients sometimes posted something unpleasant [about nurses] on their social media account…". Uyi's experience was supported by several participants who shared a similar story about social media influence on their practice as follows:

> "…there was someone [a nurse] who made a mistake. The patient's family posted it on the [social] media, … yes, it had quite destructive influences. We felt a bit being intimidated by everyone and of course it made us become more awkward in treating patients, a kind of treating patients in a less natural way. We became too afraid of making even the smallest mistake…" (Ikke)

Through Ikke's narration, it is clear how social media affected her practical agency. Despite that she was not the direct "victim" of the posting, she learned from the situation, which directly affected her as a team member. A complex interplay of values is evident in this story. A value, such as *the feeling of being safe and free from harm*, appeared to be at stake. Ikke had become fearful of making a mistake when nursing patients. She was not able to engage in her practice applying the manners she upheld. On the other hand, as a nurse, Ikke was responsible for providing services for patients in a manner that satisfies them. Obviously, these competing values needed harmonising in order to avoid any detrimental effects. This situation has provided an example of how social media influence nurses' value configurations and demonstrates how those values can influence nurses' practical agency.

The process of harmonising value systems appears to be a complicated one. Various determinants of complexity come into play. Additional contextual determinants, such as

employment configuration and income, were found to influence the process of managing values, and are explored next.

5.3 Job, Income, and Employment Configuration

Job, income, and employment configuration are three, intertwined factors that were found to contribute to nurses' attitudes and inclinations toward their jobs. Depending upon the employment status, having a nursing job in a health provider institution does not always guarantee a decent or desired income, which may affect the ability of the nurses to fulfil their basic needs. The concerns about job and income security appear to shape the nurses' attitudes towards their job. Nuri admitted staying working as a nurse primarily to maintain her life, as she shared, "... my living needs, I have to work to fulfil it… No matter what happens in my hospital, I will stay [working in the hospital] …". Clearly, Nuri indicated she valued *income* perhaps more than other values.

The value of *economic security* (owning enough funding) emerged as one of the dominant values that drive participants' attitudes toward their nursing job. Some participants strived to retain their job despite enduring various hardships along their career journey. Although many participants complained about feeling overloaded, less respected, and less rewarded, they stayed in their jobs for years. This suggested that the value of *economic security* might override other values, such as *appreciation* and *excitement* (experiencing excitement from the job).

Another value that is likely to be associated with the value of *economic security* is the value of *job security*. Several participants who were non-civil servant nurses talked about their wishes to have a secure and stable job. This can be seen in the following quote:

> "… It has been very hard to get a good job these days. When I graduated from nursing school, I applied for an honorary nurse. I do hope that someday I will

get a more stable job as a civil servant nurse. I know that it is not going to be easy, but nothing really impossible, who knows? With this thought in mind, I treat this honorary employment as a stepping-stone to a civil servant job. The most important thing is that I need to show my ability and determination so that the human resource unit will provide me with a good reference when I need it to apply for the civil servants. It doesn't really matter whatever the situation I have to deal with as long as I get a civil servant job at the end. When it happens, I would consider all my struggles are paid off…" (Idah – Reflection)

Idah is an honorary nurse working for a public hospital. She indicates that her current job is unstable and perceives that civil servant employment is better. Although Idah did not provide a link between having a secure job and having an expected income, it would appear that a secure job, such as a civil servant job, is preferable on the grounds that this employment status guarantees long term employment and a regular, decent source of income. Idah views her current assignment as a 'transitional phase' before moving on to her final goal of becoming a civil servant nurse.

Idah indicated that she would be ready to endure any practical repercussions as a result of her struggle to become a civil servant. Indeed, to be able to survive this, she will have to reconfigure her values. At this point of time, the values of *having a secure job* and *economic stability* appear to be dominant. Regardless of the values configuration that she had when writing this reflection, Idah's story provides an example of how the concern for having a secure job affects nurses' practical agency. A similar story can be found in Isma's statement, as follows:

"There were a lot of my fellow nurses at that time decided to resign after two years of working [as honorary nurses] without any payment… But I stayed with a hope to be accepted as a civil servant nurse which is who I am now [smile] ...". (Isma)

It appears that Isma was determined to stay in their job as an honorary nurse, even without receiving an adequate incentive, in order to retain the possibility of being recruited as a civil servant nurse. Both Idah and Isma seem to assume that their assignment as an honorary

nurse will help them to get a civil servant job, and so they show their determination and dedication during the 'transitional' period (as honorary nurses). These cases demonstrate how the hope of "having a secure nursing job" influences a participant's decision to stay in their honorary employment and maintain their practical agency. The need for a secure job appears to have been part of their value system, which has shaped their attitude towards their employment status. Similarly, Ella shared:

> . "…of course, I tried to show my capability and my good intention and motivation to work. As an honorary nurse at the time, I worked very hard, and I had never complained about anything, not because it was all perfect but… you know… I was young, and I was concerned about my future… I don't want to be an honorary nurse for the rest of my life… so I thought complaining things might give a bad impression [for potential employers]… I needed to show off [my determination] and do my best…" (Ella).

Ella assumed that to be considered or granted a permanent job, honorary nurses need to demonstrate their skills, determination, and loyalty to the organisation and stakeholders. Her narration shows the 'positive' influence of her employment status on her practical agency. However, this also seems to be an indication of compromising her self-identity. Ella indicated that she suppressed her feelings toward the reality of practice in favour of 'pleasing' her managers and potential employers. She developed her value system by putting more emphasis on the value of having a secure job while, at the same time, subduing or minimising other values, such as deriving enjoyment from her current job, as was previously presented in Chapter 4, in Section 4.5.2. This kind of value system might be greatly challenged, especially when a nurse's wish to become a civil servant nurse is not accommodated.

Being a civil servant nurse, however, could make some nurses less rigorous in their practice. As Dini, who is a senior civil servant nurse, shared:

> "… some of the civil servant nurses do not work maximally. Unfortunately, there are quite plenty of nurses who have such an attitude. Maybe because they have already been a civil servant nurse, they are senior nurses…" (Dini)

Dini spoke from her experience when she was working in an inpatient ward. Dini's statement gives an impression that, for some nurses, the status of a civil servant might make them feel too confident, to the extent that it impacts negatively on their professional practice. The values underpinning the expected employment status appear to be influential in nurses' value systems. More importantly, these values are carried through into nurses' practical agency.

Job, income and employment configuration is very much personal, meaning that the values underpinning them are personal in nature. The formation of a value system, however, is also influenced by several organisational values in the context of the workplace. How the workplace context comes into play is detailed next.

5.4 The Workplace Context

The workplace context appeared to shape nurses' value systems and consequently, influence their practical agency. The workplace provides a landscape for the contextualisation of values and principles in nursing practice. Multiple, inter-related factors were found to contribute to the enactment of personal-professional values among nurses, which they carry through to their practice. Among the workplace elements are reward system and work classification, work experience, and physical resources.

5.4.1 Reward system and classification.

Depending upon the administrative level of the organisation where participants work, the reward system might vary and be set by either the local, provincial, or national governments in Indonesia. On top of these reward systems, an institution might have an additional policy regarding the reward system. However, the reward system was generally found to be problematic which was reflected in the experiences the participants shared.

In particular, participants indicated some major issues with the current reward system that centred on the criteria used as the basis for service fee distribution. Participants complained about the exclusion of workloads, performance, and work experience in the criteria for fee distribution. As has been presented in Chapter 4, Section 4.4.1, workload is one of the most prominent issues in nursing. Omitting workload and work experience in the reward policy created discontentment for the majority of participants.

The reward system has been viewed as one of the sources of 'unfairness' in the workplace. The existing reward system has created employment disparities, both horizontally and vertically. Horizontal disparity refers to 'unfair' entitlements among nurses (that depend on the type of employment and the level of education while overlooking workloads and work experience). Vertical disparity encompasses the 'unfair' entitlements of nurses in relation to that of other professions.

Generally, most of the participants indicated that the reward system had disadvantaged them, as they now receive fewer incentives than they used to. This can be seen in the following quote:

> "There is a lot of change including the policy about nurses' incentive … the differences now are just too saddening...too wide… Previously, we received an incentive based on our performance and workloads. Now, they consider only the level of education … Actually, in my opinion, those who have been working for a long time should be given more proper reward… It is unfair … Currently, there are a lot of new nurses get higher salary than that of those who work longer [more experienced] but has a lower educational background [Diploma in nursing as oppose to Bachelor in nursing]. It is disappointing…" (Lia)

Lia is a civil servant nurse. The comparison she made in her statement above is the comparison among civil servant nurses. She compared two characteristics of nurses: new nurses with higher qualifications *versus* more experienced nurses with lower qualifications. She indicated that the reward system had disadvantaged the experienced nurses who have lower tertiary qualifications such as Diploma in nursing (D3 and D4).

From the above quotes, *fairness* is likely to be the central value in Lia's value configuration. Other values, such as *income/reward*, *performance*, *workload*, *formal qualification*, and *work experience*, appear also to make up the configuration. This value configuration appears to be triggered by the current reward system in Lia's workplace.

Nana shared another point of view regarding the reward system. Nana is currently an honorary nurse working in a big public hospital in Indonesia.

> "…I think it is unfair… I believe that our workload should be made as a basis for awarding any incentive and not be based on civil servant or not civil servant status. The workload should be the main parameter. Those who usually have to face and to do risky tasks… that kind of things was not taken into account the existing regulation [policy]. We can see there is a wide gap between civil servant nurses and non-civil servant nurses [in terms of incentive], it is really unfair in my opinion, especially in my workplace" (Nana)

In this quote, the value of fairness is still the main concern. However, she viewed workload as a meaningful element that should be valued more than other competing values. Nana's stance on this matter appears to be mediated by her status as an honorary nurse. In Chapter 4.4, it was found that an honorary nurse tended to have greater workloads than their civil servant counterparts. This explains why Nana values workload more than other components when it comes to the reward system and why she perceives the reward system to be 'unfair'.

Both Nana and Lia are likely to share the same construct in their value systems. However, their values configurations appear to differ slightly when responding to the existing reward system. This demonstrates how the current reward system arrangement in Indonesia, which is workplace determinant, along with employment status, challenges the nurses' value systems.

The value of fairness characterises nurses' configuration of their values with regard to reward system issues. In Lia's quotes, the value of working experience was associated with

the value of unfairness. However, under other circumstances, a working experience can be a central value in the configuration of nurse's values and be a contextual determinant on its own. The following section explores working experience as a contextual determinant in the process of the configuration of personal and professional values.

5.4.2 Working experience.

Prolonged engagement in the nursing profession is found to be an essential factor that influences the process of 'values configuration', which underpins participants' practical agency. Both personal and professional development of participants appears to affect participants' attitudes and stance on situations. A participant shares a detailed experience, as follows:

> "… I feel that I am now becoming more relaxed, even in the most difficult situation. I feel that I am now wiser than I used to be when I was a junior nurse. In the beginning, I used to panic and sometimes I went blank in an emergency situation. But as I come across many situations almost every day, now I am very much under control. I am now accustomed to situations in my workplace. I think all those situations make me stronger psychologically…" (Unun – Reflection)

It appeared that Unun learnt from her experiences during her career. The acquired knowledge and skills enhanced her capacity, both as a professional and as a person. Being exposed to the nursing environment allowed her a real understanding of the true nature of the job and, simultaneously, inspired her to develop mechanisms to deal with issues in her workplace. In addition, through repeatedly encountering challenges in her workplace, Unun appeared to naturally develop a certain kind of quality, such as an ability to retain control over herself.

Work experience seems to be a function of time; the longer a nurse works, the more experience and development as a nurse will be acquired. As demonstrated in Chapter 4, values

are learned, embraced, enacted, maintained and harmonised over time. These processes are part of personal cognitive, social, spiritual, and/or emotional growth. The capability of managing an individual value system expands overtime, following nurses' work experience progress. Therefore, nurses' attitude and practical agency might differ according to how much work experience they have. In addition to work experience, nurses' social environments might also shape their attitudes and practical agency. This topic is explored in the following section.

5.4.3 Societal values.

Societal values represent the collective attitude toward issues, actions, and symbols used in the community (Krieken et al., 2016). Social interaction in participants' workplace used symbols that are carried through in their communication with their colleagues, other health professionals, and other stakeholders.

Under particular circumstances, communication in participants' workplace was found to be problematic, especially when the symbols (words, gesture, facial expressions, etc.) were used inappropriately. In their interaction with other health professionals, the participants occasionally confronted situations in which other parties used symbols (or used them in a manner) that were felt to be offensive by the participants. For example, the use of culturally offensive words or expressions, as well as inappropriate gestures, made the participants feel disrespected and devalued.

It was apparent that participants expected team members to project societal values and conformities in their behaviour in the workplace. Yet, some team members did not always practice up to this expectation. This can be seen in Siti's experience, as follows.

> "… she [the doctor] ordered us around, she pointed using their feet or using their left hands. I felt sad … she [the doctor] called me 'monkey!' [face turns red from anger]" (Siti).

It was not clear whether the doctor's gesture was made on purpose or spontaneously. However, in Siti's culture, pointing with the left hand or the feet in communication is unacceptable. In the West Nusa Tenggara Province, particularly in the Lombok region where Siti was brought up, particular parts of the body, such as the left hand, are considered 'dirty' because they are usually used to undertake 'dirty tasks'; therefore, using the left hand to give an order or instruction to someone is considered an insult (Sudirman & Bahri, 2014). The above case suggests that receiving culturally inappropriate gestures could create and accentuate a feeling of being disrespected among nurses.

Certain words, when used outside their context, can attract negative connotations, such as belittlement and humiliation. Several participants experienced situations in which such words were expressed towards them. In Siti's case, she was shouted at and called 'monkey'. Generally, in her society, all attributes that are associated with animals, when applied to a human, are an insult (Sudirman & Bahri, 2014). This was the reason why Siti exhibited strong negative emotions in her facial expression, indicative of a possible disruption in her value system. Her value of 'respect' appeared to be at stake, mediated by the societal values of the community to which she is bound.

Siti's case suggests that the internal process of a nurse's value system is also framed through societal values. It also demonstrates how societal values, which are always context-specific and limited to a particular culture, interfere with the individual values of nurses in the context of the workplace. In other words, there is an active interaction between nurses' individual value systems and their social environment.

In this study, several participants used similar types of expressions and vocabularies to describe their internal feelings when dealing with patients, patients' families, or doctors. Uyi shared:

"I felt like I was treated like a robot… they used to ask a nurse like me to do so many things [that were not parts of my responsibility]… sometimes I felt like a maid…". (Uyi)

Uyi has used the words that represent a societal value in her community; the word "maid" refers to household attendants who are often underpaid to do all the household chores for a hiring person. The occupation of a household attendant is among the least esteemed occupations in her culture (Sudirman & Bahri, 2014).

The use of such metaphors when describing their feelings indicates the intense nature of these feelings. Multiple values appear to be involved in Uyi's statement. Similar to the earlier case, this also concerns the value of respect. However, in this case, there is an implicit reference to the value of professional pride; that is, the nursing profession is being compared with the occupation of a household attendant. By using the term, "maid", to exaggerate the detrimental impacts of her personal-professional value, Uyi demonstrated how societal values underpin her words of choice, which represent her feelings. In addition, her perception of how others regard her profession is apparently shaped by her societal values.

Another instance that demonstrates how societal values shape the formation of attitudes towards practice can be seen in the following narration:

"I was a bit down to observe my senior treated a patient's family … Honestly, I was annoyed... Because even if the patients deserve to be scolded [for some reasons], as a nurse, we should be patient. If they really cross the boundary, then we talk to them firmly. I've once seen, my senior, [soften voice and shudder], got mad crazily [to patient's family] … the patient was dying and later passed away, and her family entered the room (to give support to the dying patient). Yes, it is true that people are not allowed to the NICU room. (I know) It is the hospital rules. She [the nurse] yelled at everyone harshly for entering NICU room... she [the nurse] could have talked nicely. Then, I talked again [to smooth out the situation] with the family and said, 'please forgive my friend, maybe she has a problem that's why she behaved like that' …" (Eka)

In Eka's Islamic community, death is considered to be one of the most significant events in which (extended) family members are expected to be present and to be near the dying

person, for religious and cultural reasons (Sudirman & Bahri, 2014). In other words, the community values the dying moment and the family's support for the dying person. This societal value appeared to be well-accommodated by Eka. Unfortunately, Eka's senior colleague apparently did not take these cultural and religious values into consideration. Observing this as 'thoughtless' action, Eka became annoyed and appeared to try to preserve the societal value by apologising to the affected family. In this instance, some values were competing against one another. Organisational values, specifically those complying to the hospital rules that ban visitors from entering the room, and the creation of a clean and comfortable workspace that fosters other patients' healing, competed with Eka's personal-societal values of the 'dying moment'. This case suggests that societal values might affect nurses' practical agency. Furthermore, this case demonstrates how nurses, despite working in a team and as a collective entity, can have a different configuration of values; Eka's configuration of values, for example, is likely to differ from her senior's.

In all the above scenarios, the situations are assessed through a cultural-societal perspective. To what extent the situation challenges the value systems and practical agency of nurses might be determined by how society assigns meanings to the symbols and actions that are involved in a given situation. Obviously, this is a complicated process, and demonstrates that a reciprocal relationship between the individual and societal values often happens subconsciously.

The organisational culture might also characterise the advancement of individual values within an organisation. How organisational culture plays out in the processing of values is presented next.

5.4.4 Organisational culture.

Organisational culture is a set of assumptions, beliefs, and values that are shared by members of an organisation, which govern behaviour and practices in the organisation (Schein, 2016). In the context of Indonesia's health system, more specifically in the context of the organisations where the participants worked, it appears that the organisational culture is hierarchical. Hierarchy, in organisational culture, is the type of environment in which entities are ranked in order of importance (Schein, 2016).

At least two conditions were found during data collection and analysis which appeared to create situations that challenged nurses' value systems. First, there existed a hierarchy, specifically between honorary nurses in relation to their civil servant counterparts. Diah shared her experience, "…we are [honorary nurses] regarded as the civil servant nurses' helping partner…" (Diah). The term 'helping partner' implies the hierarchical nature of the relationship between the two. It is apparent that the honorary nurses are not considered possessing equal status as the civil servant nurses, despite the fact that they share an equal quantity of work and responsibility in the workplace. The honorary employment status is perceived to be less esteemed compared to the civil servant, due to the characteristic of the employment status. The honorary nurses have been disadvantaged by this hierarchical organisational culture. The status of honorary employment appears to be characterised by the temporary nature of employment, lower incentive (income), and instability of employment.

Eis, an honorary nurse working in a public hospital, shared her feelings with regard to how she perceived her manager treated honorary nurses in her workplace. She indicated experiencing frustration from the impact of the situation:

> "… honorary nurses and civil servant nurses… Our boss uses to compare those
> two. Usually…, for the civil servant, in almost everything, they will always be
> considered good and right, no matter what... The ones who are blamed if
> anything happens [with patients] is us, the honorary nurses... we always wrong,

wrong, and wrong [raising tone and stressing more indicating a disappointment]. The civil servant nurses always win, so we are fed up" (Eis-FG3)

Eis' frustration appears to spring from the organisational culture that overlooks the roles and the responsibilities of honorary nurses' in the system. Not only was her statement consistent across honorary nurse interviews but it was also supported by civil servant nurses. For example, Dini, a civil servant nurse, shared:

"I pity the honorary nurses, usually the honorary nurses are asked to work, and the civil servant nurse just sit, … they [some of the senior civil servant nurses] act as they please, arbitrarily to new and honorary nurses" (Dini)

Eis' and Dini's statements above reveal the nature of the nursing organisational culture, regarding the arrangement of honorary nurses in their workplace. Obviously, such an arrangement challenges the honorary nurses' individual value systems. Among the values at stake is the value of *equality and fair treatment*. The value of *equality* emphasises equity in their status as nurses. *Fair treatment*, on the other hand, is the value that is concerned with a fair distribution of tasks and responsibility, and their entitlements in the workplace.

Clearly, organisational culture poses a substantial challenge for the honorary nurses' value systems. Their individual configuration of values is likely to be shaped by, among other determinants, their organisational culture.

The perception of the hierarchical nature of the relationship between nurses and doctors has spread among the community. This phenomenon is very common, so that many of the participants indicated an acceptance of this condition as the reality of practice. Fansa illuminated this situation through her story:

"…for most people, when they come to the hospital or public health centre, they wanted to see [and be served by] the doctors directly… this indicates that people are still underestimated the [nursing] profession. Even for a simple task that used to be handled by nurses, they (the patients) are still wanted to be handled by the doctors. I see it as a stigma on the nursing profession. There is

an impression that nurses are not equally respected with doctors …" (Fansa – FG1)

The above quotation suggests that the community tends to value the medical profession more than the nursing profession. As presented in Chapter 4: The Categories, this situation induces feelings of inferiority among nurses, despite the fact that nurses make up the vast majority of healthcare professionals. In addition, health care is understood by the participants to be a collaborative form of work, in which the role of nurses is of paramount importance. The nurse participants regard themselves as probably the most important elements of the health service, as they maintain direct contact with patients, often for an extended period of time compared with doctors who report only having a few minutes of time to interact with patients.

Within the Indonesian health service organisational culture, the role of doctors is commonly perceived as more eminent than that of nurses. The nurse's role is often seen as "a doctor's assistant", as they are expected to carry out the doctors' orders. This arrangement creates the impression that nurses are subordinate to doctors.

The configuration of the participants' value systems is likely to be influenced by the hierarchical, organisational culture. Among the values that are involved in such organisational culture are *equality, power, respect*, and *recognition*. The values of *equality* and *recognition* (the value that concerns public recognition of the profession) appear to be dominant in the nurses' configuration of values. Other values, such as *power* (the value that concerns authority) and *respect*, are also important considerations in the process of reconfiguring values within organisational culture. Obviously, the value sets that are involved in this process are contextual. A variation in the values arrangement might persist in a different context and in a different organisational culture.

In addition to organisational culture, a practical reality, the organisation of resources, was found to influence the advancement of the individual value systems of nurses, rather straightforwardly. These organisational resources are presented next.

5.4.5 Organisational resources.

Resource limitations appeared to be a common issue for nurses working for public health providers and in small private organisations. For many nurses, this limitation is more than just instrumental issues of work; it might also induce internal problems for nurses. The limitation of resources might require nurses to accommodate situations and rearrange their personal values, as illustrated below:

> "…limited working facilities is perhaps a problem that is beyond our control.
> We cannot do much about it, but of course, it affects us [nurses] and our
> patients. For example, we ask the [patient's] family to wash the patients because
> we do not have enough facility such as hot water and other... it makes me
> unsatisfied with my work…" (Chika, FG1)

Inadequate nursing facilities might be a long-standing problem in some Indonesian care settings. For a nurse like Chika, this limitation negatively affected her internal feelings. The limitations in resources at the facility made it feel as though she was holding back from giving patients the service she would, otherwise, intend to provide in her role as nurse. At the same time, this situation prevented her from deriving satisfaction from her job. Another example of a situation impacted from resource limitation is provided in the following quote:

> "…patient's family complain too much... We have limited facilities, and they
> do not want to understand our situation, and they just complain about the
> nurses. Those kinds of problems sometimes still affecting and keep lingering
> even after I am at home" (Deby)

Similar to Chika, Deby appears to be affected by the situation. However, there is a slight difference between the two examples. While, in the first case, the participant was not content with her job due to the situation, in the latter case, the participant was annoyed by the

patient's attitude towards the situation. These cases, however, show how the limitation of a facility can potentially affect nurses' internal feelings and practical agency. The values that are likely to be involved in such cases are *professionalism*, *quality*, and *work ethics* (the value that allows a nurse to feel satisfied with a job well done). A situation like this might require nurses to reconfigure these values in their value systems.

It was apparent that the shortage of nurses has been a major factor causing work overload problems. Despite the long list of tasks that should be accomplished, the number of nurses employed in each shift was felt to be inadequate by the nurses in charge, as the comment below shows:

> "The problem is that the nurse-patient ratio is very low… and I think it affects the job because of the nurse work too hard … we could lose concentration. If that happens what about the patient? I am personally worried about the risks that the patients have to face if not handled properly [due to lack of nurses] ... we might risk the patients' life…" (Alda)

While Alda was concerned about patients' safety, Wiken was worried about not being able to provide adequate services. She shared:

> "…sometimes I feel sad… why I run out of time? [because there were not enough nurses in the shift]…that's why we [nurses] could not serve people well …[looks unhappy]" (Wiken)

As the quotes illustrate, both Alda and Wiken raised the issue of understaffing in their workplace. Understaffing influenced not only the participants' feelings toward their job but also held them back from providing a quality service for patients. This resource issue impacts their practical agency. Clearly, this situation brings about several competing personal and professional values that the participants need to unravel. They will have to reconfigure their values in order to retain the sense of being an 'intact' nurse working within limited available organisational resources. This process needs a thoughtful adjustment in their value systems.

The situations resulting from limited resources are likely to vary according to the condition of each nurse's workplace. Hence, nurses' configuration of their values will differ in each given situation. In addition, it might also vary among nurses in the same situation. This suggests that the process of making adjustments to individual value system is personal and contextual. Regardless of the configuration of values, organisational resources appear to be an important contextual determinant of nurses' values advancement, which affects nurses' attitudes and practical agency.

5.5 Conclusion

This chapter has shed light on the factors that influence the advancement of nurses' individual value systems and the contextualisation of the values in their practice. The complexity of the social processes around managing value systems has been unravelled, and the contextual determinants of the landscape where the processes take place have been detailed. This chapter provides full insight into the contextual influences in nursing practice.

The following Chapter: The Theory, offers theoretical explanations and insights into the basic social processes around the development and evolution of value systems.

Chapter Six: The Theory
Becoming a Nurse – Developing and Evolving a Value System

6.1 Introduction

The emerging categories that reflect the basic social processes nurses experience along their career journey, and the contextual determinants that influence nurses' configuration of values, have been presented separately in the preceding chapters. In this chapter, the categories, subcategories and contextual determinants are interweaved to provide a theoretical explanation of how nurses develop and evolve their value systems in professional practice.

From the perspective of constructivist grounded theory, both data and analysis are created from the shared experiences and relationships with participants and other sources of data (Charmaz & Mitchel, 2006). Based on this view, not only is this theory informed by emerging categories and subcategories but it is also constructed upon analytical memos that were documented during the data collection and analysis phases. In addition, regular consultations with supervisors, who are experts in qualitative nursing research, allowed an analysis beyond a mere rich description of the studied phenomena.

The constructed theory is a substantive theory that covers a specific area within the nursing field. This theory responds to the questions of: '*How do nurses develop and evolve their value systems?*' and '*How do their values inform their practical agency?*' To provide a comprehensive insight into how this theory works and how findings emerged from the data, an overview of the theory is presented first. This is followed by a detailed explanation and then the presentation of a case example in the subsequent sections.

6.2 Overview of the Theory

The theory centres on the core, basic, social process *of becoming a nurse*, which reflects on nurses developing and evolving value systems prior to nursing and during their professional practice career. The theory incorporates a foundational transition and a series of three cyclic transitions, as well as three reference points, that represent the cyclic nature of how values develop and evolve. The reference points are major events that trigger transitional movement. The first transition is labelled *acquiring values*, which is the foundational transition (from childhood to young adulthood) wherein nurses acquire values from several sources. This foundational transition sets the scene and informs and influences the lifelong evolution of values. Set as one of the reference points in this theory is the occasion when nurses embark on their nursing career, which provides a context for nurses to integrate foundational values into their nursing practice. The basic social process that takes place during this cyclic transition is described as *internalising values*. In their daily practice, nurses encounter various situations (reference points) that challenge their personal and professional value systems. These situations prompt nurses to revisit previously held values. This basic social process is conceptualised as *re-visioning values*, in which nurses deeply reflect on their existing value systems and create and attain momentum (reference points) that drive them towards the cyclic transition of *harmonising values*.

Harmonising values is a basic social process by which nurses reconfigure their value systems in a way that maintains their personal and professional integrity. The word 'harmonising' was used because it represents nurses striving for and/or creating the 'acceptable' internal equilibrium between values compromised and 'new' values that arise from the reconfiguration process. The outcome of this process is a balanced/harmonised value system that directs or influences a nurse's practical agency. This whole cyclic transition of value processing does not stop but recycles through to *internalising values*, in which this new

value configuration is (re)internalised, enacted, and integrated into nurses' existing value systems. When this newly internalised value configuration is challenged again in practice, the processing of the value continues to evolve through a similar cyclic transition throughout the nurses' career. All basic social processes presented in this theory are influenced by several contextual determinants, including culture, workplace and job, and income and employment configurations. The variation in the contextual determinants may explain the variation of each nurse's experience of value processing.

In order to provide a clearer understanding of this theory, a conceptual model of a stethoscope is presented in Figure 2. To show how categories, subcategories and contextual determinants are related and inform the theory, all elements are presented and positioned across the stethoscope. In this model, the contextual determinants are set as a stage (in the background) for all basic social processes to perform. A performance needs a stage to be "true", as do the value system. Indeed, the same performance can be performed on a different stage in its own unique way. Hence, distinguishing the contextual determinants and the basic social processes helps to promote the *usefulness* of the theory across cultures and other unique contexts.
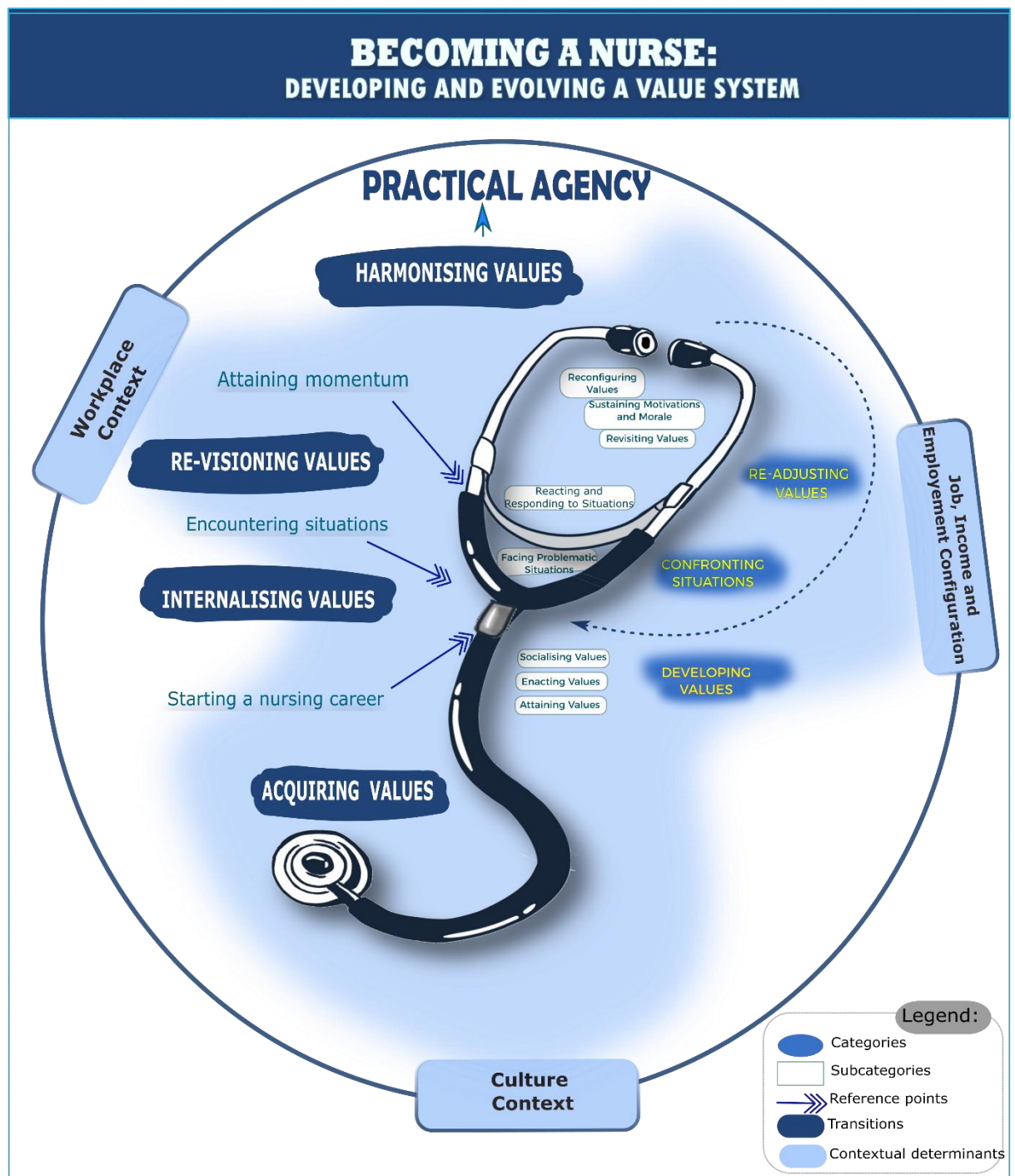
Figure 2. Conceptual model of the theory of becoming a nurse: Developing and evolving a value system

A stethoscope is a mechanical device that listens and monitors a patient's heartbeat and includes a bell/diaphragm (chest piece), tube extension, main tube, a binaural with ear plugs, and a binaural spring. Metaphorically, a stethoscope closely resembles the nurse's theoretical journey of becoming a nurse, developing and evolving a value system. One can

imagine the heartbeat as the nurse's values and the bell and its single tube as the foundational transition. For example, the bell or diaphragm of a stethoscope absorbs the heartbeat, which is similar to nurses acquiring values from their social and professional environment. In a stethoscope, the sound of the heartbeat travels through a tube extension (the single tube that connects the bell/diaphragm and the main tube). It enters the main tube through a stem representing the start of their nursing career, which is a professional platform on which the nurses enact and contextualise their values in a meaningful way.

When entering the main tube, the heartbeat sound travels in two directions. A portion of the heartbeat sound goes through to the left tube while some travels to the right tube. Which portion of the heartbeat goes to which direction is perhaps a complex acoustic process inside the tube. Yet, this process accurately represents the complex process of determining which values to apply and consider, particularly at the beginning of confronting a situation in practice. More importantly, the two-way direction represents how nurses respond to the confronting situation, e.g. with positive and/or negative responses, that stimulate the nurse to revisit and/or re-vision previously held personal and/or professional values.

Interestingly, the binaural spring, the part that connects both pieces of the main tubes, is a flexible material which allows the tubes to be adjusted (outward or inward) so that the nurse can position the earplugs into his/her ear comfortably to hear the heartbeat. This represents how sometimes nurses need to adjust and reconfigure their values to accommodate the tension that arises between their evolving personal and professional values.

The heartbeat signal oscillates in these two tubes, generating momentum towards the earplugs where the nurse can clearly hear the sound of the heartbeat (their reconfigured values). This represents the process of *harmonising values*. A more detailed explanation of the theory is presented in the following sections.

6.3 Acquiring Values

This is the first transition where a nurse's individual value system is initiated. This foundational transition encompasses the pre-nursing period, which begins in childhood and continues through to the starting point of their nursing career. During this period, the participants are young, passive recipients who acquire personal and professional values from external influences. The analysis revealed that there are two eminent sources of values during this period: the family and educational institutions.

The participant's family is the first environment in which they learn and receive a range of values. Most of the participants' personal and sociocultural values were initiated and transferred through their family systems. This can be seen in Idah's story, as follows:

> "I was brought up in a happy family who taught me to be a good person. My mother used to tell me a story about good people; often she made up a story in which a good person or character won over the bad one. I guess that was the way she taught me to be a good person…" (Idah – reflection)

Through her story, Idah describes how she gained the personal and sociocultural values of *being a 'good' person* from her parents, during her upbringing, which inspires her in her current personal and professional nursing practice (Follow-up memo). This sheds light on how daily interaction and communication within the family can be a meaningful medium for the transfer of values.

The foundational period also includes the social process whereby nurses acquire the values of professional training for their future role. This process includes learning to contextualise values in ethically dilemmatic situations during the training, as illustrated in the following quote:

> "I remember when I was a student nurse, we were told to debate whether or not abortion should be supported by nurses in Indonesia. I was in the pro team … My team lost the debate because we were struggling to find good reasons [laugh] …we were having difficulties in responding to some religious

arguementations from the other team [laugh]… most of us had learnt from our parents that it is wrong to hurt anyone, let alone to 'kill' one… we do not have right over someone's life, do we?...yes, that was a tough topic, indeed, because we know we can find some reasons to do so [abortion] but it was not easy to make final decisions [smile]…" (Leka)

In her account, Leka indicated that she had learnt to compare and draw upon underlying values to address an ethical dilemma thoughtfully through a debate. She was purposely introduced to some dilemmatic situations in which her values were challenged. The debate encouraged student nurses to examine and reflect on their initial personal values (i.e., social, moral, and religious values) and their professional values learnt through their training. The cognitive process of examining values may have resulted in the nursing students beginning to structure and integrate their sociocultural foundational values with professional and ethical nursing values.

Although values are likely to have been embraced in this period, the values acquired are yet to be enacted in nurses' professional careers. Given that this is a pre-nursing employment period, nursing students do not have a platform (experience) upon which the values can truly be contextualised. By the end of this period, however, nursing students have acquired the theoretical values of nursing practice and knowledge of how these may relate to their personal, foundational values instilled during their childhood.

This foundational period is informed by the category, *developing values*, in the subcategory *attaining values,* and with the reference point of *starting a nursing career.* Beyond this reference point are the cyclic transitions of *internalising values, re-visioning values*, and *harmonising values*, which are detailed in the following sections.

6.4 Internalising Values

As nurses enter their nursing career with acquired values, they now have a platform to contextualise these values as practising nurses in a healthcare organisation. Being in the real world of nursing, nurses appeared to become more active agents in enacting their values (as opposed to the state of being a passive agent in the foundational period) as they begin to critically evaluate and apply their values to their professional nursing practice.

Within this transition, personal and professional growth occurs through being introduced to another set of organisational-related values as part of their employment. Over time nurses internalise these organisational values and integrate them into their own individual value systems. Embracing, enacting, and integrating values reflects the core social processes of internalising values of the workplace.

Most of the values prescribed by health care organisations are work values (the subset of values that are related to how a job should be operationalised). Organisationally instilled values, such as "skilfulness, friendliness, discipline, and politeness" (Yeyen) reflect the organisation's expectations regarding the standard of the personal qualities of its employees. This means that these values are enforced to ensure that nurses stay abreast with the organisation's expectations regarding the quality, performance, and standards of nursing practice. Also, the practice of these organisational values maintains a good community image of the organisation and, as such, the values are embraced and socialised regularly to employees, to form a collective, organisational identity.

The organisational values are considered essential and, by virtue of being an employee, these values are expected to be accommodated into an individual nurse's value system. For this reason, the configuration of existing individual value systems (from the foundational period) might change, particularly in a situation where the integration of these

new organisational values causes tension with existing value systems (either by complying or competing with them). Nurses combine their personal, professional and organisational values to form a new configuration that is shaped by both the nurses' and the organisation's expectations.

The process of reconfiguring values was sometimes an unconscious one. For example, Ella expressed, "I had never thought about it [contemplating underlying values] until you asked me about it" after her interview (Memo). This statement supports the idea that, for some nurses, the act of processing values can sometimes be unconscious or second nature without a specific planned action.

The process of integrating these values might or might not be straightforward. If the organisational values are compatible with a nurse's own values, the process is straightforward and requires only a little adjustment. This is reflected in Deby's statement, as follows:

> "We have to take into consideration the hospital's values that have been socialised. We need to adjust ourselves and follow the stream. For me, this is not a big deal… I mean keeping up to those values… I have a smiley face, and it's easy for me to smile to everyone, even if the hospital does not ask me to do so [smile]…" (Deby)

Deby talked about her organisational values, such as the creation of a friendly atmosphere for patients through smiling, and how she incorporated this into her own value system. She indicated that she had already embraced some of the organisational values as her own personal values, which made the integration of the prescribed organisational values straightforward. Regardless of how much value adjustment is needed, this process was very common during the first few years of participants' nursing careers.

Depending upon the individual and external contextual influences, the time needed to progress through this cyclic transition varies considerably among nurses. Peppy recounted a story of her early career as a professional nurse:

"I had been very proud of having a new job as a nurse, but three months later, I was treated very badly by a patient's family that made me feel down…" (Peppy).

Whilst Peppy had only worked for three months before she was faced with a challenging situation, Leka, on the other hand, shared that she had worked for about one year before starting to feel overwhelmed with competing values related to workloads at the hospital. The timing and variation among nurses cannot be predicted because each nurse has their own unique value system and experiences.

Some nurses, such as nurse managers, senior nurses, and/or those who have experienced challenges, transfer their professional values (embedded in their experience) to other nurses, through various media, such as formal sharing, social media groups, and informal conversations. This is the process of socialising values, by which the recipients can internalise and integrate the values into their professional values configuration. The data suggests that the process during (professional) values socialisation generally does not introduce new values but, rather, reinforces and re-emphasises the values that might have been overlooked.

The transition of *internalising values* encompasses two categories: *developing values*, subcategories *enacting values* and *socialising values*; *confronting situations*, subcategory *facing problematic situations*. As nurses confront problematic situations in their workplace, nurses are stimulated to re-think the affected values, and a cyclic transition of *revisioning values,* which is elaborated next.

6.5 Revisioning Values

One of the reference points for this cycle is *encountering situations,* which relates to an interference of the nurses' ability to undertake nursing tasks due to challenges to their personal and professional value systems. These situations might include the circumstance when

nurses' expectations do not meet the reality of their practice and/or when nurses' sense of *being a professional* is compromised. The moment when the nurse realises the discrepancy between their expectation and reality, is captured in the following statement:

> "I felt down and got bored because what I was ordered to do are tasks beyond a nurse's responsibility. It was different from what I learnt at the uni…" (Dewik)

From her statement, it appears that Dewik was concerned about the nature of the tasks in her workplace. The unfamiliar tasks she was assigned created a situation in which her current reality was deemed beyond her scope of nursing practice, which negatively affected her feelings. Although it is not very clear how much this 'moment of truth' impacted Dewik and her values, it is apparent that her values of *professionalism* in this example were challenged. Other examples that demonstrate how various situations affect nurses' value systems are presented in Chapter 4.4.1 and 4.4.2

When nurses encounter challenging situations in their workplace, it provides the impetus for finding/creating ways of reconciling the incongruent values, in a way that preserves the nurses' value systems and maintains their integrity, which influenced their practical agency. The data suggest that value reconciliation is done through rethinking, reflecting, reinforcing and/or reconfiguring values, which results in reconstructing the sense of being a nurse (See Chapter 4.5.3).

During reconciliation, some values might be unavoidably (or else voluntarily) compromised while other values might be maintained. Contextual determinants affect the process of revisiting values and reflecting, in the sense that nurses take into consideration not only their personal and professional values but also organisational, societal and cultural values, beliefs and norms (see Chapter 5: Contextual determinants).

Depending upon what values are at stake and the magnitude of the conflicting values, nurses use various strategies to deal with these problematic and challenging situations. For example, in this study, when nurses felt that they were being undervalued in their workplace, they recalled and drew on good memories and of being acknowledged as a valuable member of the health care community. By reinforcing the feeling of being needed by the community, the nurses minimised the devastating impacts that resulted from feeling undervalued in their workplace. Such processes allowed the nurses a sense of being in control over self and, concurrently, created a momentum, by which the nurses were empowered to "fight back" against the situations, to maintain their personal and professional wholeness, a key element in practical agency.

Nurses appear to process their values continually, either unconsciously or mindfully, through reflecting and by re-examining their situations and where their underlying assumptions and values came from. This process can be seen in the following example.

> "… usually I remind myself that finding a job is hard. Also, I see this job as a noble mandate from God, so I have to carry it out well. It is the key. I have to be able to control myself because if I cannot control myself, I will be complained about by the patients' family, I might get mad. The complaint will go through to the management, so who will lose? It will be me [laughing]. Then, the prestige of the hospital will be harmed. Patients will say 'nurses in that hospital are rude', and later the professional reputation will also be affected, so I need to control myself in that case…" (Ikke)

In this story, Ikke shared the logic and reasoning she used in her reflection process, including revisiting her primary, personal and professional values. Personal values, such as *having a stable job*, *religion*, *self-contro*l, as well as organisational values, such as *loyalty* and organisation *prestige*, are given a high priority during Ikke's basic social process of revisioning her values.

Revisioning values is informed by the category *Confronting situations*, and its subcategories, facing problematic situations and reacting to situations, along with the category

Re-adjusting values, and the subcategories, sustaining motivation and morale and revisiting values. The next cycle: Harmonising values occurs when nurses attain the momentum needed to bounce back and regain more control over self. The basic social process that takes place in this cyclic transition is detailed next.

6.6 Harmonising Values

Within this cycle, nurses re-evaluate, harmonise and integrate their value systems, moving toward resilience. The reference point for this transition is *attaining momentum*, which occurs when nurses have processed, re-visioned and balanced their values to take back control and direct themselves in more meaningful ways (although it does not necessarily mean that they have full control over the situation). The process of gaining better control over self appears to stimulate positive internal feelings and allows nurses to actively direct future actions, a key component of resilience, which manifests in a restored personal and professional confidence.

Nurses' physical and mental states could be impaired by confronting situations. However, in this study, most nurses were able to restore their confidence and morale, reporting internal feelings of happiness, satisfaction, respect, acknowledgment, and high morale, which is displayed in a harmonised value system. Some of the previously considered negative experiences might later be seen as neutral ones and accepted as a part of the realities of professional nursing. This can be seen from Dabrina's statement:

> "… at the beginning of the problem, I felt stress, but as time passed, I adapted to the situation… I understand that this kind of situation is not happening only now, but I am sure that this will keep happening…I am getting used to this…" (Dabrina, FG 3)

Dabrina was being shouted at by her patient's family, as the family asked for a 'perfect' service that was beyond her scope and ability to provide, due to resource limitations in her workplace. As she was aware of the nature of the situation, Dabrina appeared to make

some adjustments in her values configuration, in order to preserve her sense of being a nurse, despite unwarranted criticism. As she was able to comprehend the nature of her situation, Dabrina was mindfully moving towards resilience.

This process not only affects nurses at an individual level but also affects the collective cultural value system. For example, Lia shared a story where she indicates a shift in her collective collegial values:

> "I feel that the condition is different now compared with the one in the past. In the past, we used to help each other, for example when I was the person in charge in the inpatient unit and my fellow nurses at another unit; we kept helping each other when we had difficult situations [in practice]. But now, as there are a lot of new staffs [the condition changes]; It seems that there is a competition, there is jealousy among nurses [unhappy facial expression]…but I am now getting used to this stuff, and I see it as a common thing…" (Lia)

At the beginning of her statement, Lia did not talk about her own personal values; she talked about her view regarding cumulative values in her organisation and how they have changed. The value of '*helping fellow nurses*' might have been well integrated into their value systems before conditions in her workplace had changed. The change appears to have shifted the individual value system from a collective '*helping fellow nurses*' to '*individual achievement*'. It was not possible to analyse the shifting process per se from Lia's story; however, clearly a significant shift had happened. This forced Lia to reconfigure her values to allow her to change her attitude towards the situation (from feeling discontentment to accepting this situation– viewing this as a 'common thing' or part of practice reality). The change in values configuration, from *collectively* to *individuality*, would appear to have gone through a long cultural process that many nurses experienced. This process was catalysed by a structural change in the organisation; the change in management and policy, which is part of the contextual determinants of *workplace context* (Memo). This suggests that nurses dynamically readjust and harmonise their values following changes to their environment, in order to attune themselves to the current reality of the nursing context. More importantly, this demonstrates

the concurrent cyclic and evolving nature of the value system, at both individual and organisational levels.

The already-harmonised values are then internalised and enacted in their daily nursing practice, which underpins their practical agency (See Chapter 4.4.2 for a detailed explanation of how nurses' values influence their practical agency). At this point in time, nurses enter the cycle of *Internalising values* with an adjusted values configuration; that is, the value evolvement process starts over again. As nurses readjust their values configuration, when facing a similar situation in the future, it might not affect the nurse in the same way again, as the nurse can draw on previous experiences. However, they are also likely to come across new situations at different time points by which the re-harmonised configuration will further be tested.

After the nurses have integrated the harmonised values into their value systems, some of them proceed to socialise the relevant values, through raising awareness of their fellow nurses, a key step in evolving values towards 'better' practice. Socialising these integrated values could, potentially, help fellow nurses to develop resilience more quickly when encountering similar situations, as they can draw upon and learn from others' experiences.

The basic social processes that take place during the cyclic transition of *Harmonising values* emerged through the category *Re-adjusting values*, with subcategories, *sustaining motivation and morale*, *revisiting values* and *reconfiguring values*, as well as the category *Developing values*, with subcategories, *enacting values* and *socialising values*.

Whilst the foundational period and the cyclic transitions of the theory have been detailed separately, it is difficult to view how the theory applies to all cases in its entirety. Therefore, to facilitate a better understanding of the basic social processes underpinning this theory and how the theory encompasses and represents the process of developing and evolving

value system, an example and analysis of a case is presented next. Two additional case examples are also provided in Appendix 13.

6.7 Case Example: Elmaya's Story

Elmaya was initially an honorary nurse in a public hospital in Indonesia. At the time of data collection, she was employed as a senior civil servant nurse and still working in the same hospital. This case illustrates the foundational period and all the cyclical transitions, which represent the basic social processes of developing and evolving a value system. She shared her reflections on her early career journey when she was an honorary nurse.

> "… When I was kid… I told my mother that I wanted to be a nurse. I remember she told me that if I wanted to be a nurse, I must be a good and brave person, I have to study hard, and I have to help my parents with household works… I started to think of enrolling in a nursing diploma in [mentioning a big city in Indonesia]. My parents supported whatever my choice was, so I proceeded to enrol in the nursing academy, where I learnt many things about nursing, such as the technical and people skill. I graduated eight years ago and got a nursing job straight away in a public hospital as an honorary nurse. I was very happy with the job because some of my friends who graduated earlier than I did were still struggling to find a job. And my big family was looking proud [of her achievement] … I felt like I made them happy, and that even makes me happier…I was very determined to carry out my new job. I wanted to learn a lot of new things in my workplace. I kept working as good as I could be. I received my first salary after three months working… I felt that the salary was not enough. I told my parents about it, but they did not want me to leave the job… in fact, they were willing to support my life. I followed their suggestion. I stayed working in the hospital as an honorary nurse. As a relatively new nurse, I was very excited and determined. I always wanted to learn new things. I was happy to help my senior nurse with their tasks… But, after about eight months, I started to feel overwhelmed. It was not because of the tasks that I had to do, but because of the way, my seniors treated me. They kept asking me to help them with their work while they had never helped me with mine. I felt that I had been used by them. It might be because I was just an honorary nurse. I thought that I had to take a stand. I did not want to be used by others; I wanted to be treated fairly, just like any other nurses in the ward. I did not want to help her [the senior nurse] again. Every time she asked me to help, I tried to find excuse … the atmosphere was changing. I felt it. I felt like my workplace is no longer friendly to me because the senior nurse did not want to talk to me anymore, … she was upset because I did not want to help her anymore. In the beginning, I was affected, but I kept doing whatever I have to do. I wanted to show other people that I am a good nurse, so I tried to stick to the standard of procedure.

But to be honest, I was not feeling a hundred per cent fine with it, especially when the senior nurse and I were in the same shift. … one day I felt like she tried to approach me. It was not clear why, though. I thought that this is good timing for me to smooth out our relationship with a hope that I won't feel bad anymore about working in the same shift with her. Honestly, I thought that I was probably a little too naïve to make a confrontation with my senior. I thought that she might have done so [asked to handle her tasks] to give me an opportunity to learn to become a skilful nurse… It took us about three months to get our relationship back to normal again. After that, I thought, maybe help her a bit will not harm. I would help her again but not as intense as I did before. This was because I respected her as an older person who just happened to team up with me. I also remember when my mother taught me to respect other people, especially if they are older than we are. I decided to restore our relationship, and I thought I probably need to lessen my ego. I need to get myself to accustom to this kind of environment" (Elmaya – Reflection)

The following sections illuminate Elmaya's process of values.

Acquiring values (the foundational period): Elmaya adopted some values from her parents, including being a '*good*' person, *bravery, capacity building*, and *helping others*. She then moved from a sheltered family unit to a professional training setting upon entering a nursing education academy. She was not explicit in her story about what values she learnt from the training, however, it might be appropriate to assume that, during the training, she learnt professional nursing values, including the application of these values in ethically dilemmatic situations. This assumption is based on the findings that other participants learnt ethics because it is a part of their generic nursing training curriculum (see Chapter 4.3.1). Elmaya learnt social skills from the training, such as communications, and, possibly teamwork. This social process of absorbing values from family and professional training fits with the foundational period, acquiring values.

Internalising Values: Elmaya entered the profession as an honorary nurse. In this theory, starting a nursing career is the reference point that marks the transition from *acquiring values* to *internalising values*. Clearly, Elmaya is now progressing in this cyclic transition, as she refers to this early phase of her career and her initial values configuration of '*having a job*', *family pride*, *capacity building* (reflected through her eagerness to learn at the workplace), and

professionalism (reflected through her determination to work to her best). She also considered the values of *income*. Yet, it is not clear how significant this value is for her. After consultation with her parents, however, she indicated that she valued *income* less than her *family* values. In addition, she indicated that she valued *parental expectation*; she respected her parent's suggestion to remain in the profession, even though Elmaya thought nursing was not financially rewarding. These values, together with her other values, are likely to have been internalised during this cycle and appear to have been aligned until about eight months into her new nursing career when she experienced her first value-challenging situation in the workplace.

Re-visioning Values: The transition to this cycle is signified by Elmaya's statement "… after about eight months, I started to feel overwhelmed…". She arrived at a point where her current values could no longer tolerate her senior nurses' behaviour. Previously, she might see the process of helping her fellow nurses as part of the learning process, which she did not mind doing as a junior honorary nurse. She appears to have internalised the value of "*helping fellow nurses*" in the previous cyclic transition. However, as time went on, she reframed this process as exploitation by a senior nurse. Obviously, her value system, at this point, were disrupted as she perceived her senior nurses' behaviours as, perhaps, inappropriate and no longer acceptable to her.

The impact of the disruption in Elmaya's value system was detrimental, as she describes feeling uncomfortable in her workplace. However, she did not let herself be further 'exploited', by reacting to the situation and taking a stance. This signifies that she tried to counter-balance the threat on her existing value system by staying focused on the completion of her nursing work and adhering to the standard of procedures (reinforcing her professional values) and maintaining the image of a "good" nurse. Unfortunately, reinforcing her professional values did not resolve Elmaya's internal feelings, as she stated: "But to be honest, I was not feeling a hundred per cent fine with it, especially when the senior nurse and I were

in the same shift…". This signifies that she was still processing, evaluating and revisioning her values, as she determined how to handle or resolve the situation. This process matches the characteristics of r*e-visioning values.*

<u>Harmonising Values:</u> Elmaya attained momentum when her senior nurse approached her, which prompted her to fix their relationship. Elmaya began to recognise her contribution to the situation and she drew from other values, such as *good collegial relationship* and *deriving enjoyment in the workplace*, to help counterbalance negative past experiences. These values, therefore, become important entities in Elmaya's process of harmonising her values.

The value, such as *helping fellow nurses,* including the values of *respect*, *teamwork* and *relationship*, appears to have been restored, although slightly evolved. Her statement, "I decided to restore our relationship, and I thought I need to lessen my ego…I need to get myself accustom to this kind of environment" signifies that she was trying to harmonise values, which is a clear sign of developing resilience and restored practical agency. Furthermore, this statement indicated that she was about to re-internalise the 'new' configuration of values and integrate them into her individual value system, to restore and maintain harmony in her workplace and with her senior colleagues.

This case example provides an insight into how the application of the theory unfolds in the daily realities of nursing practice. Whilst the theory explains the basic social processes that are involved in nurses' value development and evolvement, it has some limitations, which are presented next.

6.8 Limitation of the Theory

Since a value is an abstract construct that is subjective in nature, it is not possible to ascertain an exact nurses' experiences of the configuration of values. This means that, although

this theory is able to provide comprehensive insights into the basic social processes of value development and evolvement, the theory lacks the ability to notionally explain whether the values are 'improving/expanding' or 'weakening/contracting' at each cyclic transition. However, this theory does confirm that nurses continually process their values. This process is cyclic and recurrent, which indicates constant changes in the configuration of values, e.g. that every 'new' configuration of evolved value differs from the previous one, every time a cyclic transition is completed. One particular value configuration might be suitable for one situation, however, may not satisfy another situation. Indeed, as the theory suggests, one could be confident that values are evolving following a trajectory that resembles a stethoscope, both in terms of the shape and how it works.

6.9 Conclusion

This chapter has provided a theoretical explanation and framework of how nurses develop and evolve their personal and professional value systems. The relationships between emerging categories and how the categories shape the theory have been presented. The contextual determinants (culture, workplace context, and employment configuration), as the landscape upon which the theory is constructed, have been considered during the theory's development. The next chapter will provide an insight into how all components of this theory are compared with the existing literature.

Chapter Seven: Discussion

7.1 Introduction

This study seeks to provide a theoretical explanation of the basic social processes nurses experience in developing and evolving their value systems and how this shapes their practical agency. The findings of the study, which are embedded in the emerging categories and contextual determinants and the constructed DEVS theory, have been presented in the preceding chapters. This chapter contextualises the findings and the theory in the existing literature. This chapter also highlights the contribution of the DEVS theory to the nursing body of knowledge. An important practical issue on values naming is also discussed. This chapter concludes with a discussion on the study's limitations.

7.2 The DEVS Theory

The facets of the foundational and cyclic transitions of the DEVS theory are discussed in the following sections.

7.2.1 Acquiring values.

The acquisition of values during childhood emerged as an essential process that lays the foundation for nurses' individual value systems. Sociologists believe that family is one of the most influential mediums for values transfer (Krieken, Habibis, Smith, Hutchins, & Martin, 2016). This study highlights the role that family plays in shaping nurses' personal values, particularly during the pre-nursing period. Two major mechanisms for values socialisation in the family that surfaced from this study are verbal authoritarian (*telling*) and exemplary non-verbal style (*role modelling*). This finding is consistent with socialisation theory, in which *telling* and *role modelling* are identified as the most effective and common strategies of values

transfer within social systems (Krieken et al., 2016). These strategies are used in informal familial education as an integrated part of a family's routine. The socialisation process of familial values described in this study is supported by research conducted in various disciplines, such as sociology, psychology, and anthropology (Lundén, Punamäki, & Silvén, 2019; Sümer, Pauknerová, Vancea, & Manuoğlu, 2019).

Professional nursing education plays an important role in the development of value systems. Professional values are (re)activated and reinforced during nurses' training. Participants were given an opportunity to learn to apply these values, through clinical placements, which allow nursing students to experience real practice settings (Jarvelainen, Cooper, & Jones, 2018) and simultaneously start to establish their professional identity (Arreciado Marañón & Isla Pera, 2015; Ranjbar, Joolaee, Vedadhir, Abbaszadeh, & Bernstein, 2017). Also, ethical values are explicitly and systematically socialised and integrated into the curriculum, which allows participants to adopt the values in a more conscious and purposeful manner within an educational environment. Nursing students were introduced to ethically dilemmatic situations through a simulated ethical debate during training. This simulated debate provided an exploratory learning space for students to activate, examine and practice ethical values, along with other personal values previously acquired. Simulation plays an essential role in nursing education and has been found to be a promising and innovative teaching and learning strategy (Ruyak, Wright, & Levi, 2017).

Although this study found that there were a variety of values that influence nursing practice, only content focusing on ethical values was formalised and integrated into the nursing curriculum. The values related to personal-social expectations and interactions (relationship with peers and mentors/seniors, patients' families, perseverance, self-fulfilment, and nurses' family values) appeared to be processed through the hidden curriculum. Hunter and Cook (2018) assert that the hidden curriculum is often taken for granted and overlooked, which

makes the internalisation and transference of professional values more difficult (Raso et al., 2019). Furthermore, in this study, non-technical value-laden skills, that are required in the development of cultural and emotional competencies, did not seem to be formalised in the participants' professional education, despite the essential roles that these values play in nursing practice. Yet, skills, such as emotional self-awareness, self-control, and inspirational leadership, need to be embedded into nursing education (Liebrecht & Montenery, 2016; Waite & McKinney, 2016).

On transition to practice, nurses continue to develop their values, often in an informal way, such as through sharing with colleagues, which inspires nurses to revisit and reactivate previously overlooked/downplayed values. The sharing process can be triggered by a situation in the workplace or simply by social interaction with their professional community, through online social media. Regardless of the mechanism of sharing, this process has beneficial influences on nurses, such as improving their knowledge, improving their ability to voice concerns, and making them feel like they are being heard and supported by their fellow nurses. Nurses preserve their professional confidence, thereby maintain a sense of being a member of a professional community. The process of sharing is vital, as it helps in maintaining personal values and principles (Barchard, Sixsmith, Neill, & Meurier, 2017) and is essential for nursing practice. Research has found that sharing emotions and experiences can result in positive learning outcomes among nursing students (Day et al., 2017). In addition, sharing promotes social connections with others and helps obtain social support that can help nurses to cope with workplace stressors (Kowitlawkul et al., 2019).

7.2.2 Internalising values.

The DEVS theory suggests that starting a nursing career serves as a 'gateway' through which personal and professional values enter a lifelong cyclical process of values evolvement.

This event is presented as one of three reference points that connect the foundational period (pre-nursing career) and the cyclic transition of internalising values throughout a nurse's professional career. This study found that, in the first few months of their career, nurses were enjoying their work as well as feeling highly motivated and satisfied with their achievement (i.e., of having a nursing job). The work-related problems that occurred during this transition period were commonly considered by the participants as part of learning experiences and were resolved through seeking help from more experienced nurses. This is consistent with a study by Hawkins, Jeong and Smith (2019) who found that nurses usually feel a sense of accomplishment and satisfaction during the early career period. Participants tend to adopt lessons and integrate underpinning values with their existing values without many difficulties, mainly due to being in the early process of establishing a pertinent values configuration. During this period, nurses did not experience significant issues and enjoyed a balanced mental state, which Nathaniel (2018) confirms as *a stage of ease* in which there are no clashes between their values.

In nursing, the start of a nursing career is regarded as a *transitional* period (not to be confused with the *cyclic transitions* of the DEVS theory), from a new graduate nurse to a practising nurse (Rush, Janke, Duchscher, Phillips, & Kaur, 2019; Whitmore, Kaasalainen, Ploeg, & Baxter, 2019). During this period, graduates are contextualising their personal-professional values while orientating themselves to the workplace milieu (Feltrin, Newton, & Willetts, 2019). This current study finding is consistent with a study by Rush et al. (2019), who reported that, during the professional transition, graduates develop their competencies and confidence. However, working in a complex and challenging environment, novice nurses are vulnerable, as they are exposed to many aspects of the environment that potentially affect their overall wellbeing (Labrague, McEnroe-Pettite, & Leocadio, 2019; Oneal et al., 2019).

In the DEVS theory, the basic social processes of adopting and contextualising values are integrated into the cyclic transition of *internalising values*, whereby nurses adopt (internalise) values that are relevant to their current job. Also, it sheds light on how nurses internalise organisationally prescribed values into their practice. It emerged that, during their early nursing career, participants were presented with organisational values that were expected to be internalised and integrated into their personal value system. Most of these values were similar to and aligned with nurses' previously held values that had been acquired through their professional training or family setting. Hence, the socialisation of organisational values is just a process of (re)activating and reinforcing values rather than acquiring 'fresh' values, which is consistent with the seminal text of Verplanken and Holland (2002). This makes the process of integrating these values straightforward.

The process of reactivating organisational values was triggered by the participants' engagement with their health provider organisation. The organisation purposefully exposed their employees to the endorsed values that represent the organisation's philosophy and identity. For example, the management put posters of value statements on the wall in nurses' stations, waiting rooms, corridors, and in many eye-catching spots in the hospital / public health centres, as part of the socialisation of values to all stakeholders. This was a systematic effort to bring the organisation's core values into participants' awareness, which concurs with a study by Verplanken and Holland (2002), who suggested that values can be (re)activated by making them the primary focus of attention. During the (re)activation process, values were made more visible to nurses in order for the nurses to integrate the values into practice in a more conscious and systematic manner. Values (re)activation is a necessary process so that the values can meaningfully regulate practice (Verplanken & Holland, 2002). The participants' organisational values were clearly carried through into their practice, which indicated that these values had been internalised, integrated into their value systems, and expressed through their practical

agency. This finding is consistent with many studies that show how organisational values influence nurses' practice (Hendel & Kagan, 2014; Lipchik, 2018; Purohit, Patel, & Purohit, 2014; Vveinhardt, Gulbovaitė, & Ahmed, 2017).

The processes discussed above are mainly applicable for new nurses entering the profession or nurses moving to a new organisation. The emergent analysis in this study, however, suggest that experienced nurses also encounter similar cyclic transitions, except that the issues and the entering points are different. Yet, the values that are internalised, embraced, and enacted in practice were similar and consistent across participants. The emerging values are discussed next.

7.2.2.1 Emerging domains of values

Five domains of values influencing practical agency emerged; first, *moral-ethical* values, which consists of moral-ethical-related values, such as the value of *honesty* and *equality* (social justice), that manifest in socially *just treatment* for all patients; second, *religious* values, which are the values that are derived from and are grounded in the participants' religious affiliations, such as *fulfilling religious roles*; third, the *social-altruistic* values that focus on patients' (others') wellbeing-related values, such as *helping spirit* and *empathy*; fourth, *professional* values, which are the nursing values that align with professional work, such as the value of *mastering nursing skills and knowledge* and *being a patient's advocate*. Finally, *self-focus*, which includes, among others, the values of *family*, *self-fulfilment*, and *job security*.

These domains of values are overlapping. Whilst not exhaustive, some values might match some of the criteria of other domains. For example, the values of '*tulus ikhlas*' and *humanity* can be defining values for *altruistic* as well as *moral* principles. Hence, it is arduous to analyse exclusively one specific domain of values as a single predictor for practical agency. In addition, the personal-professional principle is likely to be established upon several

underlying values that are intertwined and overlapping. The overlap in value domains is also acknowledged in the theory of Schwartz et al. (Schwartz, 1999; Schwartz et al., 2012), that suggests values should be seen on a continuum, resembling the spectrum of colour, rather than a discrete entity. However, for an analytical purpose, the value domains need to be made distinct from each other.

Furthermore, two domains (*social-altruistic* and *moral-ethical*) are inherently personal values with a social focus (social-oriented values) (Gouveia, Milfont, & Guerra, 2014; Schwartz et al., 2012). This current study indicates that, in general, regard for others, *altruism-benevolence*, is the value that is often referred to as a *traditional value* and is still a major and defining value of nursing practice. This finding is supported by a study of new nursing graduate values, which found that the traditional value of nursing remains intact despite contemporary changes in the nursing environment (Tuckett, 2015).

7.2.2.2 Emerging perspectives on values

The five domains of values that emerged from this study reflect three groups of perspective on values: expressions of personal needs and expectations, individual philosophical beliefs, and organisational/professional requirements (See Figure 3). In the first perspective, values are viewed as an expression of personal needs and expectations. The values, such as *family* (including family commitment and parental expectation), *self-fulfilment*, and *inner harmony*, are examples of personal preferences (personal expectations) concerned with the sense of being a person. The value of *self-fulfilment*, for example, is expressed through the pride gained from being trusted to perform tasks that typically require an advanced clinical skill level, such as performing certain medical procedures (delegated care). Similarly, *inner harmony* is a feeling of inner peace, gained by experiencing enjoyable work without any conflict with fellow nurses or doctors, and a fear-free workplace (i.e., free from harassment,

bullying, and any other forms of threats). Research has shown that a perceived level of threat in the workplace affects nurses' willingness to work (Ganz et al., 2019). The importance of inner harmony in nursing practice has been acknowledged in a study by Berman, Snyder, and Frandsen (2017). In addition, nurses' inner worth has been an important construct of both personal and professional dignity (Sabatino, Kangasniemi, Rocco, Alvaro, & Stievano, 2016).

The values of *professional acknowledgment* and *autonomous work* reflect nurses' personal preferences for their professional life. Values, such as *respect*, *connection*, and *appreciation*, are both personal and professional expectations. Yet, this study shows that these preferable conditions (expectations) cannot always be met in the nurses' workplace. Depending upon how significant the gap is between nurses' expectations and the reality in the workplace, this might or might not affect nurses. A huge gap between expectation and the reality of nursing practice could pose negative influences on nurses, particularly when nurses find it difficult to mitigate the gap (Sastrawan, Newton, & Malik, 2019). Most of the situations presented in Chapter 4.4 arose as a result of the failure to satisfy these needs. Maslow (1943) identified multiple hierarchical levels of human needs (basic, psychological, and self-fulfilment needs) which is echoed in participants' personal-professional values and expectations. The values discussed above are, indeed, the expression of the participants' needs at various levels.

The second perspective on values relates to the individual's beliefs and philosophy, which included the values of *tulus ikhlas*, *kasihan*, *heavenly rewards, being watched by God,* and *good deeds,* etc. Most of these values were learnt and acquired through family upbringing prior to embarking on a nursing career. They were part of participants' initial value systems that, during a nursing career, became more meaningful over time. Values from this perspective often serve as a reference point, and balance power when values from the first and the third perspectives are challenged. This is discussed in detail in Section 7.2.4
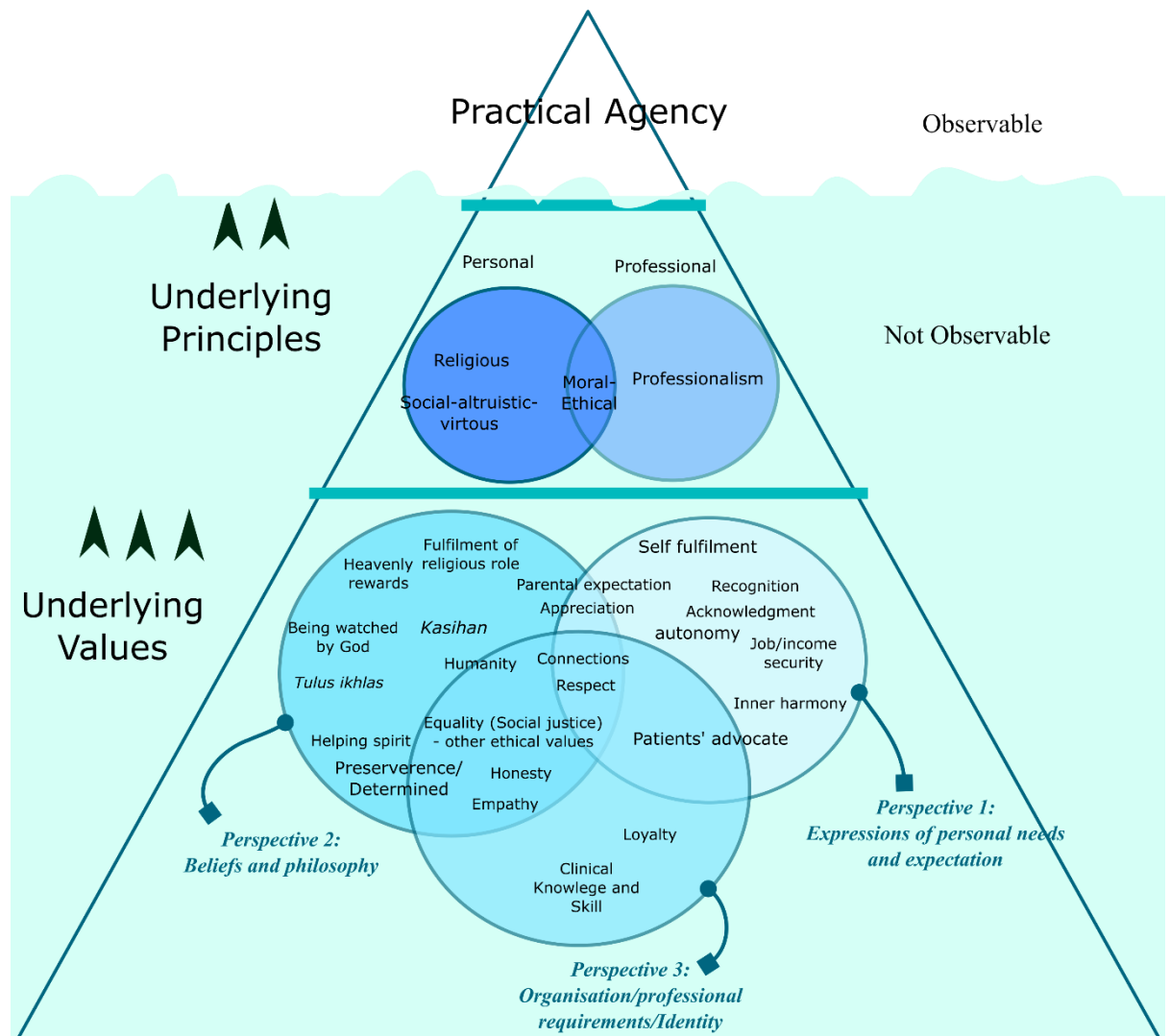
Figure 3. Visualisation of participants' values and principles

The last perspective on values deals with professionalism. Through this viewpoint, values are conceived following the requirements of both the profession and the participants' organisation. As demonstrated in this study, most of the values of this perspective were (re)activated during nursing training and during their early career. The values within this perspective are known as 'professional values', which include, among others, possessing clinical skills and knowledge, loyalty, empathy, and social justice (ethical values). Compared to the values within the first perspective, which is mostly concerned about self, these values tend to involve and be examined through the practice and relationship with others (patient,

teamwork, managers, and organisation). Hence, compromising any of these values often instigates dilemmas in nursing professional practice.

Indeed, these three perspectives are not independent of others; they also overlap and intertwine. For example, the value of *respect* has been internalised/embraced, since it was socialised through family and expressed through the practice of respecting parents. This value was then reinforced through professional training and expressed through the practice of respecting patients and peers. At the same time, participants also developed the perspective and the need for being respected as a person and professional.

All three perspectives constitute a pool of values and form a complex value system that underpins personal and professional principles. As demonstrated in this study, participants used their personal-professional values and principles to guide their practice. The combination of values of the first and the second perspectives commonly comprises nurses' personal principles of life. Similarly, the values of the third perspective, in concert with the values from the first and/or the second perspective underpin nurses' principles of professional conduct and performance. Personal-professional principles and their underpinning values are not necessarily unobservable (Schmidt & McArthur, 2018). They only become visible when they are expressed through practical agency (Stein-Parbury, 2014). This phenomenon resembles the ice-berg structure (Brown, 2019), with values and principles lying beneath the waterline and practical agency situated on top, above the surface, as depicted in Figure 3. Figure 3 implies that practical agency emanates from personal-professional principles that are informed by a unique and complex blending of multiple values, which echoes the complexity of the influence of values on practical agency.

The first and the second perspectives on values are in parallel with Gouveia's (2014) value theory, which sees values as both the guidance of action and the expression of needs, at

different levels and dimensions (Gouveia et al., 2014). However, the third perspective is not explicitly covered, although a higher-level abstraction of it can be found spread across Gouveia's matrix of values. This is because Gouveia's theory is created to help understand general human values. This study adds a professional nursing dimension to human values (which also adds complexity to the existing values theory), especially when they are brought to professional life.

7.2.3 Revisioning values.

The nursing workplace has been described as one of the most stressful environments, which implies that stress is a part of everyday nursing practice (Baughan & Smith, 2013). This condition is mirrored in this research wherein some situations posed challenges to nurses' values and subsequently created stress. Nurses encounter situations at two different levels. The toughest situation is conceptualised as a *dilemmatic situation*, in which dominant values clash and disrupt inner harmony, which can affect nurses for an extended period of time. The other situation is a *problematic situation* which is considered 'moderate', although it does affect nurses' values and can induce negative feelings. Both situations create distress for nurses, although the severity of the distress might differ between individuals and circumstances.

Many of the challenges were related to structural factors or organisational constraints, such as insufficient staffing leading to work overload, which impinges on quality nursing practice. Issues such as these can affect nurses' practical agency, for example, neglecting patients' privacy, poor interpersonal relationships and other negative influences in practice (Shafakhah, Molazem, Khademi, & Sharif, 2018). In addition, research suggests that heavy workload can create stress (Kwiatosz-Muc, Fijałkowska-Nestorowicz, Fijałkowska, Aftyka, & Kowalczyk, 2018), burnout (Yeatts et al., 2018) and increase the probability of occupational injuries among nurses (Bagheri Hosseinabadi et al., 2019).

Organisational constraints can limit the quality of care that nurses wish to provide for their patients, which undermines core professional nursing values. This finding concurs with many studies that highlight the influence of structural factors on nurses' ability to uphold their professional values in their nursing care and practice (Haahr, Norlyk, Martinsen, & Dreyer, 2019; Maben, Latter, & Clark, 2007; Schneider, Wehler, & Weigl, 2019; Stimpfel, Djukic, Brewer, & Kovner, 2019).

Other situations that often pose challenges to nurses' value systems include the work culture, such as the power imbalance among health care team members leading to issues of subordination and hierarchical relationships, which compromise the spirit of collaborative teamwork (Gleddie, Stahlke, & Paul, 2018). These hierarchical relationships often lead to participants feeling undervalued and less respected in the workplace. Furthermore, hierarchical interaction in the workplace has the potential to harm professional dignity (Sabatino et al., 2016) and cause workplace teamwork disharmony. In this study, team disharmony was indicated in a situation where participants were blamed for 'not doing the job the way the doctor wanted it', which generated negative feelings among the participants and affected their overall nursing care quality. These findings concur with Mirlashari et al. (2019) who reported that power imbalance in the workplace can negatively influence the process of nursing care. Similarly, teamwork issues are found to be associated with nurses' turnover intention (Zaheer et al., 2019). The hierarchical relationship in the current study can be seen in the doctor-nurse relationship, in which participants tended to be disadvantaged as they were positioned as subordinate to the doctor. The doctor-nurse relationship has been a longstanding issue in health care organisations, even in contemporary practice (Gleddie et al., 2018; Mirlashari et al., 2019; Omura, Stone, & Levett-Jones, 2018), which often challenges nurses' sense of autonomy and self-fulfilment. A good teamwork relationship is, indeed, preferable, as a recent study shows that a good relationship among teamwork members leads to better overall quality of care

(Egede-Nissen, Sellevold, Jakobsen, & Sørlie, 2019). In addition, having the sense of autonomous work and a sense of control over practice can affect nurses' job satisfaction and the perceived quality of care delivered (Al-Hamdan, Smadi, Ahmad, Bawadi, & Mitchell, 2019).

In this study, participants expressed issues of unfairness that is rooted in the nurse-doctor power imbalance and role ambivalence. Professional task ambiguity has been identified as one of the internal stressors for nurses in the workplace (Hertting, Nilsson, Theorell, & Larsson, 2004). In addition, role ambivalence can cause organisational conflict (Kim et al., 2017). The findings suggest that hierarchical relationships coupled with role ambiguity create a negative working atmosphere that disadvantages nurses. This is consistent with a study that found nurses often do not receive adequate status affirmation (Thomas, DiSabatino, & Rojas, 2019). Such situations can hinder nurses in achieving their full potential (All-Party Parliamentary Group on Global Health, 2016). In the participants' organisations, this situation was commonly found and considered as part of daily routine, suggesting that it is a common work culture, identified as contextual determinants in the DEVS theory.

In addition, personal concerns, such as family commitments, can conflict with participants' professional nursing roles. This conflict would require participants to make a compromise on their values, inducing dilemma/distress for nurses, which temporarily affects their practice. A similar study exploring family-work conflict regarding nurses' job performances was found in Wang and Tsai's study (2014), which highlighted the negative influence of this type of conflict on nursing practice.

Emergent from this study is that many situations in nursing practice can create internal conflicts (cognitive dissonance-conflicting values), which might lead to moral distress (Barth et al., 2019; Wilson, 2018). Indeed, a link between moral distress and burnout has been found

among nurses (Fumis, Junqueira Amarante, de Fátima Nascimento, & Vieira Junior, 2017), which is a serious issue in many countries. For example, in Indonesia, burnout prevalence among nurses working in some general hospitals in East Java is reported to be high, up to 34.8% (Setyowati, Rusca, & Putra, 2019). Burnout is found to affect nursing care negatively (Laeeque, Bilal, Hafeez, & Khan, 2019), resulting in incomplete care (leaving necessary care undone) (White, Aiken, & McHugh, 2019), and is closely linked to workforce retention issues (Moloney et al., 2018; Van Osch, Scarborough, Crowe, Wolff, & Reimer-Kirkham, 2018). Drawing from the findings of this study and existing literature, it is apparent that conflicting values, if not adequately managed, may cause more serious issues, not only for nurses but also for patients and organisations.

Challenging situations require participants to not only re-vision their affected values but other values that comprise their sense of being a professional and a person. This revisioning of values process allowed participants to view their current state more comprehensively and helped them to stay focused. This is consistent with Penz and Duggleby's study (2011), that found that nurses maintain their focus by comprehending the bigger picture of their situations in their workplace. Further, positive experiences were often used by participants to neutralise the effect of negative situations, which helped them to sustain their personal and professional motivation. The current study demonstrated that participants experienced positive feelings when their values were preserved. In contrast, they experienced adverse feelings when their values were suppressed and compromised. This suggests that values, feelings, and experiences are intertwined and the relationship between personal and professional values can negate or support each other. This finding has not been previously documented in the nursing literature; hence, this study provides a unique insight into the intertwining of personal and professional values in nursing practice. Further to re-visioning values, the process continues into the next

cyclic transition of harmonising values, in which various occurrences materialise and enhance the understanding of values processing, which is discussed next.

7.2.4 Harmonising values.

There are several situations and contextual factors that may lead nurses to compromise values. As demonstrated in this study, value-challenging situations prompt nurses to contemplate and reflect on their values. This finding parallels with another study in which nurses were found to contemplate their morals when encountering moral situations (Ko, Chin, & Hsu, 2018). Through contemplating values, participants juxtaposed the competing values as well as other relevant values, then made a contextual and situational decision of an acceptable value 'trade-off'. This value 'trade-off' can occur across personal (sociocultural-religious), professional, and organisational values, which is necessary for the process of finding the most 'appropriate' configuration of values at the time. This emerged as a deep, internal process within participants, which was achieved through critical reflection.

Participants engaged in reflection on aspects of their personal and/or professional practice. Reflection is an important life skill that is needed to navigate the mental demands inherent in daily nursing practice (Vess & Russell, 2018). Reflection and reflective practice have been known as crucial elements in nursing practice, to enable professional growth (Newton & Butler, 2019). When prompted, study participants reflected on the perceived attributes of being a 'good' nurse, drawing on past experiences and their helping spirit. The image of a 'good' nurse emerged as one of the crucial considerations in the process of reconfiguring values. The constructs of a 'good' image are operationalised through practical terms, such as *being knowledgeable and skilful, determined, sincere, genuine, wholehearted* and demonstrating *strict adherence to professional rules and norms*. This conception is similar to the professional attributes found in the literature (Aydin, Sehiralti, & Akpinar, 2017; Begley,

2010), For example, Aydin et al. (2017) identified other conceptions of professional attributes among nursing students, such as responsibility, geniality, patience, calmness, passion, loyalty, honesty, responsibility, and scientific curiosity. Furthermore, the professional attributes were abstracted into three broad themes that included intellectual/practical, dispositional, and moral attributes (Begley, 2010), which accommodate the conceptions that emerged from this study. Participants considered these professional attributes and integrated them in their values configuration.

Staying in tune with the desired professional attributes is reflected in the current study, in which participants valued and maintained their professional nursing identity. Participants' perception and reflection on the 'good' nurse image was prompted by value-challenging situations and appeared to be a common undertaking among nurses. This is supported by Begley (2011), who indicates that reflection is a regular practice in nursing, particularly when social and professional identity is at stake (Striley & Field-Springer, 2016). Furthermore, reflections can raise self-recognition of one's own significant role as well as maintain one's moral identity (Peter et al., 2018).

In addition to reflecting on the image of being a 'good' nurse, nurses also reflected on past experiences, which helped to reframe their current perspective. This study highlights how drawing on past experiences can be useful for nurses when faced with value-challenging situations. This process reflects Mezirow's (1997) Transformative Learning Theory, in which participants' previously held beliefs and values are challenged and altered. Experiencing similar situations repeatedly, resulted in participants feeling less stressed because they had learnt from their previous encounters and previously harmonised their value system (through reconfiguration). For example, in this study, participants changed their attitudes toward situations over time, as they matured professionally. In addition, they also changed their views on work challenges into a more constructive perspective by seeing them as a learning

opportunity (see Chapter 4.4.2). Metaphorically, participants changed their views from a 'glass-half-empty' to a 'glass-half-full'. As they developed wisdom, nurses became mindful that a positive perspective was more useful in terms of personal and professional development, particularly in developing resilience. This practice indicates that some participants critically reflected on their experience and underwent a perspective transformation (Mezirow, 1997). Perspective transformation is the change in beliefs, attitudes, and also emotional reactions through a process of reasoning (Mezirow, 2003). Nurses' attitudes and perspectives are therefore reflective of their values (Schmidt & McArthur, 2018). If the configuration of values changes, it is likely to be demonstrated through nurses' attitudes and this influences their future practical agency.

Processing values was found to be undertaken either subconsciously or mindfully. This is supported by Bardi and Schwartz (2003), who suggests that the process of contemplating values is done quickly (often simultaneously) and sometimes sub-consciously. While the sub-conscious processing of values cannot be learnt or taught, the processing of mindful values can be improved and achieved through mindfulness and self-awareness training, which can assist nurses with becoming aware of their values and practice. Several studies have highlighted mindfulness in nursing practice and its positive outcomes (Duarte & Pinto-Gouveia, 2016; Harker, Pidgeon, Klaassen, & King, 2016; Slatyer et al., 2018). Participants' purposeful reflection is an example of a mindful value processing exercise. The process of reflection, itself, requires an active, cognitive undertaking in which a nurse mindfully draws upon values (Bagheri, Taleghani, Abazari, & Yousefy, 2019; Sumner, 2010), revisits affected values and, interestingly, creates momentum to bounce back from difficult situations (developing resilience). As nurses become accustomed to problematic situations and become more experienced, the process of revisiting values through reflection becomes second nature.

7.2.4.1 Values (re)configuration

As explicated in the DEVS theory, revisiting and reconfiguring values signifies a thorough and integrative process of re-adjusting the value system. This theory suggests that in nursing practice, values are processed in a complex and comprehensive manner and framed within a situational context. This finding contrasts with existing literature in which values are depicted as abstract concepts that are ordered based on their importance (Monroe, 2019). Nurses do not just simply 'order' and 'choose' the value from an already-established pool of values, they must determine which values they can draw on to counterbalance the compromises of other values. In many situations, participants in this study found that the competing values are of 'equal' significance, which makes the process of re-visioning and harmonising values even more challenging. In this situation, nurses redefine and reshape their perceptions of the involved values by taking into consideration the contextual circumstances at the time. Clearly, this indicates that the conception of values is both situational and contextual. As a result, when faced with a similar situation at different points of time or context, nurses might react and respond differently. For example, a participant decided to prioritise her family (the value of family) when her child was severely sick but also prioritised her patients (professionalism) at another time when her child's condition was not as serious (see Chapters 4.4 and 4.5 on how nurses revisit and reconfigure values when encountering challenging situations). In addition, nurses often felt undervalued and not respected in their workplace, which is suggestive that nurses' value of *respect* was compromised. While *being respected and valued* are participants' *personal-professional needs*, these needs sometimes cannot be fulfilled in practice. Yet, this limitation was counterbalanced by the positive experience of *social needs* fulfilment, such as receiving acknowledgment for being a valuable member (as a nurse) of their community.

The nature of the situation and its circumstance are found to be crucial aspects that influence the overall social process of *re-visioning* and *harmonising values,* the result of which

can inform nurses' practical agency. Furthermore, this current study demonstrates that although all nurses experience the same cyclic transitions of values processing, each nurse differs in their previous experiences with value-challenging situations, how they react and respond to the situations, what values are being (re)considered, and how they perceive these values under current circumstances. These variations account for the uniqueness of the process of configuration of values among nurses across situations over time. This finding is in contrast with the existing understanding that values are relatively stable over time across situations (Bardi & Schwartz, 2003; Schwartz & Bardi, 2001). Clearly, this current study demonstrates the changing nature of values in nursing practice over time.

Having to compromise some values was found to affect participants' morale. This finding is supported by many studies that found nurses' morale is linked to difficult and stressful situations in the workplace (Ahmed, 2019; Gleddie et al., 2018; Wang et al., 2018). Furthermore, this current study also found that participants' morale was boosted following the process of reconfiguring values (building resilience), which has not been documented in the literature. Hence, this study provides fresh insight into values configuration processing in the nursing world.

In addition, participants used altruistic values to sustain their morale when it was challenged. This is supported by Wang et al. (2018), who suggest that altruism is an essential quality that assists nurses in maintaining and restoring morale. Nurses' morale appeared to fluctuate as a result of situational and contextual circumstances. It was found that some aspects affecting morale include depression, stress, and helplessness (negative influences) as well as happiness and interest (positive influences) (Chen, 2010). Additionally, while Chen (2010) suggested that feeling interested or being passionate could have a positive impact on nurses' morale, this current study indicated that low morale caused a couple of participants to lose interest in their profession. Hence, there might be a reciprocal relationship between nurses'

morale and experiencing negative encounters in their workplace. Regardless of the nature of the relationship, it was also found that when nurses reconfigure and harmonise their values, their morale generally is restored, and resilience is developed.

The DEVS theory adds layers and complexity to how values are processed, which is missing from Schwartz' motivational values structure[2], particularly when values are situated within a professional and cultural context. For instance, religious values in Schwartz's (2012) theory is grouped under the value of *tradition* and placed in a diagonal position with *self-direction* in both thought and action, which indicates that, in order to be able to uphold the value of *self-direction*, one might have to compromise one's *tradition/religious* values. However, this was not the case in the DEVS theory. In this study, the participants' religious values serve as central reference points, which were often used to reframe and/or strengthen other values within their value system. For instance, it was clear that the participants' value of *self-direction* was shaped by their *religious* value (as in the case where nurses felt being watched by God). Instead of viewing this 'surveillance' as limiting their freedom to think and act (in nursing practice), nurses used their *religious* lens to direct their 'freedom' into a more positive direction, such as assisting them to stay focused, be genuine and empathetic, and pursue the sense of *self-fulfilment* through fulfilling their religious roles. In this sense, this study provides an alternative perspective to Schwartz's (2012) motivational relationship of values.

Another alternative perspective to Schwarz's circumflex theory is evident and is illuminated through this current study's findings, wherein participants perceived themselves as being *underestimated* and *devalued* (which have their root in the value of *power* in Schwartz's

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[2] Schwartz (2012) used statistical methods to map human values on a two-dimensional spectrum and showed their motivational relationship through a circular continuum arrangement of the values. This circular continuum is known as 'the circumflex'. Schwartz suggested that the values in the diagonal position are competing with each other. The pursue of one value would require a compromise on the other values. Likewise, the adjacent values support each other, meaning that the pursuit of one value would lead to maintaining the adjacent ones.

circumflex theory). Responding to this situation, participants enhanced their sense of being needed and accepted as a member of society (which is rooted in the value of *social security*). This implies that the value of *social security* was used to balance their compromise on the value of *power*.

This finding suggests that the relationship among nurses' value structures might be more complicated than previously thought. Indeed, nurses' value structures may differ from the general two-dimensional, continuum, circular value structure that is suggested by Schwartz (Schwartz, 1999; Schwartz et al., 2012). Indeed, this current study introduces the concept that values, and their relationship are two inextricable entities which comprise nurses' value system. In addition, values clearly are evolving due to the dynamic nursing environment and shaped by contextual determinants.

7.2.5 The role of contextual determinants.

Contextual determinants affect not only the perception of values but also how they are processed and expressed through nursing practice. Given the importance of the context in processing and expressing values, the DEVS theory considers at least three inter-related factors, such as cultural context (social environment, including religiosity), workplace context, and individual characteristics and circumstances (job, income, and employment configurations). The participants' religious culture permeates their perspective towards their profession and practical agency and is discussed in the next section.

7.2.5.1 Religion and practical agency

Religiosity emerged as a dominant cultural determinant that gave meaning to nurses' demanding professional life. Religious values were found to be a construct of participants' personal-professional principle. The underlying religious values, in the context of this study,

were informed by the beliefs of *being watched by God*, *fulfilling religious roles*, *being granted heavenly rewards*, and *doing good deeds*. For example, participants viewed nursing as a way of fulfilling a religious role. This is supported by a study in Indonesia that found nurses regarded their work as a means of fulfilling their religious obligations and doing good deeds (Liem, 2019). In this current study, religious values were used as a central reference point with which other values were framed through. A more detailed account of religious values is presented in Chapters 4.3 and 4.5.1.

The culture-religion background of the Muslim participants had a strong affiliation with Islamic traditions. Many aspects of the participants' practices were framed through Islamic beliefs. A similar pattern also emerged from a couple of participants with different religious affiliations, who also viewed their profession and practice through Christian and Hindu perspectives. This implies that the use of religious values in the nursing profession prevailed within this study context and was consistent across all participants. These religious beliefs play a vital role in the processing of nurses' values and shape their practical agency. Although this contradicts the findings of a Spanish study, which found that religious values are among the least important values among some groups of nurses (Jiménez-López, Roales-Nieto, Seco, & Preciado, 2016), this current study's finding is supported by several studies that show the influence of religious values on practice. For instance, Czarnecki et al. (2019) found that religious beliefs influence nurses' conscience and practice. Further, religious orientation has been found to help nurses adjust to their work environment (Samadifard & Narimani, 2018) and has mediated nurses' ethical behaviour (Hassanian & Shayan, 2019). Additionally, a recent study in Iran by Shafakhah et al. (2018) found that religious beliefs stimulate and facilitate the development and practice of professional values. Another study by Pembroke (2016) argued that religious principles (Christian and Buddhists) are consistent with the nursing profession

and the implementation of them in practice can be beneficial for nurses, as they help to control oneself and simultaneously promote wellbeing.

The variation in the results regarding religious values in nursing practice is likely due to contextual elements, such as culture. The role of religious values in nursing is commonly acknowledged in some countries with strong religious traditions, such as Indonesia (Herlianita, Yen, Chen, Fetzer, & Lin, 2018; Supriyanto, Hamid, Rosyada, Mansyur, & Efendi, 2019), Middle-Eastern Countries, such as Iran (Hassanian & Shayan, 2019; Samadifard & Narimani, 2018; Shafakhah et al., 2018) and Saudi Arabia (Alshehry, Almazan, & Alquwez, 2019; Cruz, Alquwez, Albaqawi, Alharbi, & Moreno-Lacalle, 2018). A similar theme is also found in a study conducted in Ireland (Timmins et al., 2018), in which religious values are found to be carried through into nursing practice. Furthermore, it is suggested that, in engaging with patients and families, nurses need to possess religious competency (Timmins et al., 2018).

Religion was not the only factor that influenced how nurses perceived their professional job. There were some other factors that intervened in the process of developing and evolving values. Personal needs and characteristics, such as nurses' job security and employment status, were among those factors which had an influence, and are presented below.

7.2.5.2 Job security

Within the context of the Indonesian nursing workforce, how nurses process their values and direct their practical agency was also influenced by their personal situation, including income and employment configuration. This is expounded in the DEVS theory, where income and employment status are situated within the contextual determinants. These determinants, job security and employment status, apply only to a group of Indonesian nurses, such as honorary nurses who experience a lower level of job security compared to civil servant nurses. Many of the honorary nurses were concerned about unreliable income from their

nursing job, which affects their ability to support their survival. While feeling worried about the sustainability of their job due to their vulnerable employment status and struggling to fulfil their financial needs, participants strived to maintain professionalism. This finding can be explained using Maslow's (1943, 1987) hierarchy of needs, which suggests that people have lower and higher-order needs that must be addressed. Physiological needs of safety and security are lower ordered (most basic) human needs that need to be taken care of first (Maslow, 1943), although they do not have to be fully satisfied before one can start addressing other higher-level needs (Maslow, 1987).

While income and job security influence honorary nurses' perceptions of themselves, it did not appear to affect honorary nurses' performance. This was indicated through the civil servant nurses' acknowledgment and endorsement of honorary nurses working as a team. This suggests that, contrary to some studies (Halter et al., 2017; LaVigne & Cosme, 2018; Lee, 2019), economic factors may not always be the primary consideration for remaining in the nursing profession.

Interestingly, honorary nurses did not view their performance as an output of their current employment status. They perceived it as an investment in their future employment[3], in the hope of being promoted and recruited as future civil servant nurses. This is an example of a value configuration in which time is a factor. In this case, nurses valued future job security more than current economic gain. It can be argued that the honorary nurses conceived their professional job as a means to achieve more meaningful worth, such as 'helping others/family'

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[3] At the time of writing this thesis, the Indonesian government announced a new scheme of nurse recruitment that took effect in February 2019 (Permen PAN&RB No 2 Tahun 2019). The new scheme, *Pegawai Pemerintah dengan Perjanjian Kerja (PPPK)* [Government's employees with a work arrangement] replaced the old honorary scheme of recruitment. Through the new scheme, the existing honorary nurses are given a priority for fresh recruitment and receive relatively comparable rewards with civil servant nurses. The experiences of the honorary nurses presented in this study offer useful perspectives in the context of values.

and 'carrying through' parental expectations to 'become nurses'. This finding resonates well with the study of Seitovirta, Lehtimäki, Vehviläinen-Julkunen, Mitronen and Kvist (2018) who found that nurses assigned higher values to non-financial rewards. It implies that a value can be overridden by other values, depending on the context and the timing. Also, some values can be more meaningful at specific point of time compared to other values and a value can also become the opposite value at a different time, which is reflected through the process of evolving a value system.

Contextual factors, such as individual characteristics, situation, timing, and other external (environmental) factors, can either positively or negatively affect nurses' processing of values. For example, delegated tasks can negatively affect nurses' practical agency due to increased workloads. Yet, such tasks also stimulate other nurses to create a space for self-development in the workplace. This implies that, depending upon how nurses configure the values that are involved in a situation, their attitudes towards the situation will vary.

The DEVS theory views contextual elements as a landscape in which the process of value development operates rather than as a direct causal factor that affects the expression of professional values, as indicated in Shafakhah et al.'s (2018) study. Dependent upon how an individual perceives this landscape, it might enhance or limit the development and the expression of their values.

7.2.6 Values, value expressions, and practical agency in nursing.

Numerous discussions on the role values play in practice can be found in the nursing literature (Garcia & Jenkins, 2018; Pickles et al., 2019; Schmidt & McArthur, 2018), including how values relate to a particular attitude and behaviour (Jones, 2015; Schmidt & McArthur, 2018). In nursing, values are expressed through both competent care and relationships with patients and practical agency (Mash, Govender, Isaacs, De Sa, & Schlemmer, 2013). However,

as this study revealed, sometimes nurses' practical agency was not always a true expression of the nurses' values. Consider the participants' cases who regretfully followed the manager/director's 'orders' to give special privileges/services to particular patients. The practical agency that the nurses exhibited at the time was not their true professional agency and is an example of what is known as 'proxy agency'. This is the type of agency that represents other's values, in this case, the values of the manager/director/organisation, that might be different from one's own. This finding provides an alternative insight into the nature of practical agency in nursing along with its underlying values.

Environmental factors, such as patients, teamwork/work culture, organisation and the wider health system, can be sources of threats to nurses' value systems and sense of integrity (Sastrawan et al., 2019). Consistent with existing studies (Callwood, Groothuizen, & Allan, 2019; Ganz et al., 2019; Sheingold, Hofmeyer, & Woolcock, 2012), this study provides evidence of how the environment affects nurses' values and sense of intactness, both on a personal and professional level. Further, the DEVS theory demonstrates how workplace challenges can trigger nurses' processes of revisiting their values in order to adjust to the challenging situation and stay harmonised. The DEVS theory illustrates the intertwining between situations (challenges), values, and responses to the situation (practical agency). How the DEVS theory differs from existing value-related theories, and how the DEVS theory adds to the body of nursing knowledge, are discussed next.

7.3 The Contribution of the DEVS Theory to Nursing

Although the concept of values is not new in nursing, the comprehensive theory of how values are developed, processed and evolved to drive practical agency is not found in existing nursing literature. However, there are a couple of theories that have synergies with the DEVS theory. These theories include the theory of maintaining integrity (Erikson & Davies,

2017; Laabs, 2007) and the theory of moral reckoning (Nathaniel, 2018). Given that these theorists used grounded theory methodology, their resulting theories revolve around the basic social processes in which values are central and, thus, are closely related to the DEVS theory. Hence, the comparison of the DEVS theory with these theories is essential in order to provide more comprehensive insights on the topic of nursing values. In addition, there are some studies that explore concepts of values (or similar concepts) in the nursing profession that provide useful analyses and/or frameworks (Fagermoen, 1997; Kaya & Boz, 2019; Ranjbar et al., 2017; Sastrawan et al., 2019; Shafakhah et al., 2018), which help in articulating the contribution of the DEVS theory to the body of knowledge in nursing.

Most of the extant literature on value-related studies in nursing offers insights into specific themes, such as resilience (Tabakakis, McAllister, Bradshaw, & To, 2019; Young, Godbold, & Wood, 2019), moral distress (Chen, Lee, Huang, Wang, & Huang, 2018; Lee, Robinson, Grace, Zollfrank, & Jurchak, 2019), empathy (Duarte, Pinto-Gouveia, & Cruz, 2016`; McKinnon, 2018), ethical values (Monroe, 2019; Skela-Savič & Kiger, 2015), and work values (Parks & Guay, 2009; Wang, Chou, & Lai, 2019). Other studies focus on identifying professional nursing values (Curtis, Horton, & Smith, 2012; Fagermoen, 1997; Kaya & Boz, 2019) and a few studies examine the professionalisation in which values are involved (Arreciado Marañón & Isla Pera, 2015; Ranjbar et al., 2017) and socialised into the profession (Bäckryd, 2019; Lee & Yang, 2019).

While these studies contribute meaningfully to the advancement of nursing knowledge and practice, the actual process of values development, and how these values are manifested in practice, remains obscure. The concept of values in these studies is embedded in the phenomena being studied only at a specific time or around a specific event. By contrast, the DEVS theory covers a broader span of time and is more inclusive, through the inclusion of the development and evolvement of values from pre-nursing education, professional training, and

the nursing career, hence, filling a gap in the body of nursing knowledge. Furthermore, the DEVS theory is the first to address how values are carried through into the nursing workplace, thus, providing a perspective on how an abstract concept (values) translates into everyday nursing practice. Indeed, this knowledge will help to make sense of nurses' practical agency in the workplace.

7.3.1 Theories of maintaining integrity in nursing.

In the DEVS theory, the basic social process upon encountering a situation aligns with the studies around the social processes upon encountering conflicting values, such as in the *theory of maintaining integrity* (Erikson & Davies, 2017). Erikson and Davies's (2017) theory illuminated the social processes of how nurses navigate personal and professional boundaries in practice, particularly when nurses encounter an integrity-threatening situation. Their theory focuses on the process of maintaining integrity, which they described as 'connecting personally/behaving professionally' (Erikson & Davies, 2017, p. 45). The DEVS theory, on the other hand, elaborates an overarching concept that includes the processing of values, which covers not only the construct of integrity but also any value-based construct. Regardless of the debate on whether integrity is a value or set of values (Breakey et al., 2015; Calhoun, 2016) or a framework of values (Tyreman, 2011), the concept of integrity overlaps significantly with the concept of values. Therefore, the threat to integrity is essentially a threat to a nurse's value system. Based on this notion, the basic social processes described in the DEVS theory enhances Erikson and Davies' (2017) theory of maintaining integrity and offer synergetic explanatory power for both theories to effectively unravel the phenomena under study. This is possible, since the DEVS theory provides the whole component of value acquisition and processing in professional practice while Erikson and Davies (2017) provide a focused insight into moral, value-related, social processes.

The DEVS theory elaborates on three critical elements of values development and evolvement. These elements, which include *values*, *situations*, and *context*, determine how values are perceived, processed, and (re)configured, and their influence on practical agency. The DEVS theory suggests that values, values processing, and practical agency are dynamic, fluid, and situational and are meaningfully shaped by contextual determinants. Also, there is a reciprocal relationship between values and the nursing environment. This finding is consistent with a Spanish study which suggested that the work setting could influence the professional values that are perceived by nurses (Fernández-Feito, Palmeiro-Longo, Hoyuelos, & García-Díaz, 2019).

Ranjbar et al. (2017) proposed a model of moral and professional identity development in nursing students, the process of which includes values reconstruction that progresses along the timeline of nursing training. Whilst Ranjbar et al.'s (2017) model is created only for nursing students, it aligns with the DEVS theory in a couple of important ways. First, this model supports the process of the acquisition and reinforcement of professional values, including ethical values, during training, which serves as a moral compass in practice. Secondly, as the model shows a change in nursing students' values over time, it supports the idea of the evolving nature of values and their configuration described in the DEVS theory.

7.3.2 Moral theories in nursing.

In the discourse on nursing, moral integrity is one concept that is often discussed. A moral is an abstract concept that primarily echoes the beliefs and perceptions of what defines 'right/good' or 'wrong/bad' conducts (Johnstone, 2016). Undertaking nursing tasks is not only about utilising sound clinical skills in nursing but often involves an examination of moral values in practice. A couple of grounded theory studies that specifically explore moral integrity in nursing practice can be found in the literature (Laabs, 2007; Nathaniel, 2018). These studies

proposed various stages/phases that reflect various events around moral challenges, which are congruent with the cyclic transitions illustrated in the DEVS theory. For example, the first stage of Laab's (2007) theory, *encountering conflict*, which encompasses the situation where nurses' values and desires clash with those of others', aligns with the reference point of *encountering situation*. Next, *drawing a line* and *finding a way without crossing the line*, the phases in which nurses consider and determine a course of action and the way to proceed without compromising moral integrity, corresponds with *reacting and responding to the situation* within the cyclic transition of *re-visioning values* in the DEVS theory. Finally, *evaluating action,* the phase that covers the process by which nurses evaluate the degree to which their actions conform their moral ideal, parallels with *revisiting and reconfiguring values*.

Similarly, the stages identified in Nathaniel's theory overlap two cyclic transitions in the DEVS theory. The *stage of ease,* the first stage of the theory of moral reckoning, describes the circumstances in which nurses enjoy a sense of comfort and confidence due to the seamless integration of their core beliefs and professional and institutional norms (Nathaniel, 2018). Similar processes emerged in the cyclic transition of *internalising* values, described in the DEVS theory. Likewise, the social processes, such as finding a resolution to the problem and deciding actions as well as contemplating past events, that take place in the *stage of resolution* and *stage of reflection* of Nathaniel's (2018) theory correspond with the cyclic transition of *re-visioning values*.

However, as Laab and Nathaniel focus on moral experiences during the nursing career, the process of value development with respect to non-moral values remains unknown. The DEVS theory fills this gap by providing broader contextual insight into values processing in a variety of situations over time and contributes in a novel way to advancing understanding of the phenomena.

7.4 Issues with Values Naming

It is not easy to examine a value as a single, discrete entity, and its subsequent effects on nurses' practical agency. As Schwartz (2012) asserts, a value structure is a circular construct, on a continuum, rather than a set of discrete variables. Consequently, every researcher may come up with several values and use different terms to refer to the values. Hence, the naming and categorisation of values can be confusing. In this study, the naming of values does not follow any particular stream. Instead, the terms used in this study came from the participants' own words and the researcher's analysis of the participants' phrases, body language, and the context of the participants' experiences. As a result, the naming of the values might require further abstraction, especially when they need to be compared with existing frameworks that use different terms and categorisation of values. Further abstraction would undoubtedly result in a different 'label' of the value. For example, when a participant indicated valuing *equal care for all patients* regardless of the patients' social-economic background, the underlying value was labelled '*equal/fair treatment*' at the operational level. However, it could also be conceived as '*social justice*' at a higher level of analysis.

An issue might arise when one wants to locate the values in an available framework that does not use the same level of abstraction. For example, in Schwartz's (2012) theory of value, *social justice* is not explicitly listed, but parallel values, such as 'benevolence/caring', the closest concept within this circumflex of values structure, might be used as abstraction of 'fair' treatment of others, depending on the person performing the analysis. However, if the person sees 'equal/fair treatment' as a manifestation of professionalism, these underlying values might be abstracted as 'professional' or 'ethical' values. Similarly, if the nurses' intention to provide equal/fair treatment is seen (by the person doing the analysis) as 'following the policy or procedure set by the organisation', it might be abstracted and labelled 'conformity to organisational policy'. Since the 'true' reasoning of nurses is very subjective and often built

upon the combination of several aspects of experience, the process of abstraction might also introduce 'bias'.

This cannot be avoided because value is a truly abstract concept that can only be observable through its expression as practical agency. The nurses' practical agency, however, is likely to be informed by multiple components, such as nurses' values and personalities (Parks & Guay, 2009). In this regard, the researcher analysed some of the most representative underlying values through the attitude and actions of nurses, as shared by the respondents (spoken or written), including their body languages (recorded in the memos) during the interview. However, most of the value clarification was done by phone after the interviews, during the theory construction. During this timeframe, participants might have completed another cycle of value evolvement, as per the DEVS theory, that may have changed their perspective on the underlying values through a reconfiguring of these values.

7.7 Study Limitations

As with all studies, there are some limitations of this study which need to be acknowledged. Although the participants of this study came from various nursing settings, they were from a relatively similar cultural background (Indonesian culture) and worked under the same healthcare system. This circumstance possibly limits the applicability of the study findings to nurses from different cultural backgrounds and working within different healthcare systems. In the constructed theory, however, culture influences are separated from the main theory and conceived as a contextual determinant, which means that the core basic social process expounded in the theory might still be relevant across cultures.

Whilst the study captured the perspectives of participants, some meaningful perspectives may have been missed from other nurses who did not consent to participate. This

limitation, however, has been minimised through theoretical sampling and a rigorous grounded theory approach to data collection and analysis. In addition, the participants of this study were from a broad geographical location, which makes the process of data collection very challenging, particularly gaining physical access to the locations and the associated time constraints. There is an extensive geographical coverage in Indonesia that requires extra resources and travel time. As a result, not all participants were interviewed face-to-face, whereby facial expressions and gestures can be recorded and used to enhance the interview analysis. However, this limitation has been minimised through conducting phone interviews as well as (re)contacting the participants by phone after the interviews, when it was needed to ensure that the participants' critical points are accurately captured and represented. There were four phone interviews conducted and eight follow-up phone calls made during the data analysis. In addition, three phone communications were undertaken with local experts, to confirm the accuracy of some of the culture-related constructs that emerged from the data.

7.9 Conclusion

This chapter provided an insight into how the theory, Becoming a Nurse: Developing and Evolving a Value System (the DEVS theory), compares and contrasts to extant theories; and how the DEVS theory contributes to advancing our theoretical understandings of the processing of values in nursing practice. Further, the selected properties of the theory have been detailed to provide clarity and coherence of the theory with nursing practice. The next chapter presents the overall conclusions of this study.

Chapter Eight: Conclusions and Recommendations

8.1 Introduction

In this final chapter, a summary of the study and the constructed DEVS theory, is provided. The chapter begins with a brief description regarding the shift of the study's focus. Some recommendations for education, policy and/or practice, including directions for future research are offered. Finally, the approach to evaluate the quality of this study, which was assessed using Charmaz' (2014) four criteria for grounded theory, is presented. This chapter ends with final remarks concluding the whole PhD thesis.

8.2 Refining the Focus

Originally, this study set out to provide a theoretical explanation of nurses' personal integrity and practical agency. However, as the study evolved and tentative categories developed creating a new direction, which is common in qualitative research. This necessitated the researcher to re-focus the aim of the study from studying how nurses conceptualise personal integrity to exploring the basic social process of developing and evolving a value system. The tentative categories that developed at the early stage of the study, during the initial data collection, presented the researcher with new research questions to follow in the subsequent data collection and analysis phase. These revised research questions were: 1) How do nurses develop and evolve their value system? and 2) How do nurses' values inform their practical agency?

A constructivist grounded theory methodology (Charmaz, 2014) was employed to help to achieve the aims of this study. This methodology has facilitated the construction of the theory, *Becoming a Nurse: Developing and Evolving a Value System*, that offers a

comprehensive theoretical explanation of basic value-related social processes in nursing. These processes are summarised in the following section.

8.3 Developing and Evolving a Value System

The process of developing and evolving a value system is highly dynamic, inherently contextual, and very situational in nature. Although each nurse had unique experiences and circumstances, they engaged in similar basic social process in their practices. As this study highlighted, nurses developed and evolved their values through several processes as follows:

a. Nurses acquired foundational values from multiple domains through familial education in family upbringing settings. The foundational values that are relevant to the nursing profession were (re)activated and systematically reinforced during their nursing education.

b. Transitioning to professional practice, nurses were externally exposed to organisational values, that were endorsed and imposed by the organisation in which they worked. During this period, nurses internalised personal, professional, and organisational values and integrated them into their own personal value system.

c. When faced with challenging situations, nurses revisited their values, reflected on past experiences, and readjusted the affected and/or relevant values. This enabled them to retain their sense of intactness as a person and professional nurse. Nurses harmonised their values by reconfiguring the values within their value system which underpinned their practical agency.

d. Harmonised values can be challenged by another situation, which prompts nurses to reiterate values through similar cyclic transitions, time and again; thus, implying a dynamic and cyclical nature of values processing as well as the evolving nature of values.

8.4 Recommendations

This study raises some crucial aspects for consideration that spread across the domains of nursing education and clinical practice. As the data were collected from Indonesian nurses, some context-specific recommendations are also offered to improve the nursing provision in Indonesia. The recommendations are presented in the following subsections.

8.4.1 Recommendations for education.

Facing problematic situations is a common encounter in nursing practice. Hence, it is necessary to introduce nursing students to an early mindset regarding values compromise and reconfiguration, particularly when dealing with tensions in the workplace, to avoid or minimise repercussions (Hunter & Cook, 2018). Despite values being fundamental to nursing, not all nursing education providers systematically incorporate and acknowledge personal-professional values in relation to shaping nurses' practical agency into their education and training. If new nurses have not been explicitly made aware of the need to reflect on personal, professional, and socio-cultural values, then they may be unprepared to respond to the complexity and reality of practice (Hatzenbuhler & Klein, 2019). This can impact on nurses, particularly during their professional transition (Pryjmachuk, McWilliams, Hannity, Ellis, & Griffiths, 2019) which has been found to be a stressful process (Hazelwood, Murray, Baker, & Stanley, 2019). Therefore, it is recommended that all entry to practice nursing curricula create space for specific pedagogy that prompts student exploration of personal-professional and socio-cultural values, along with ethical values, in a structured manner. Teaching strategies, including simulation, virtual reality, small group reflection, and case-based learning, directed to stimulate nursing students' awareness of the interplay of their personal and professional values in their profession is recommended.

In some countries, such as Australia, New Zealand and the UK, such pedagogical programs have been integrated into the curriculum. Nursing education institutions, particularly in Indonesia, could draw on the experience of implementing such a program from these countries. The work of David Seedhouse, who developed a web-based program (also available on apps for iPhone and android platform) that allows people to engage in values exchange activities in an entirely safe environment (Seedhouse, 2011), is one such program. This program assists many health profession students, including nurses and doctors, to critically reflect and examine their values through real-life scenarios. Alternatively, education institutions could develop similar programs, with some local contextual modifications adjusted to suit their needs. Such programs might help nurses to confirm their previously taken-for-granted values and better understand fellow nurses and other professionals, thus avoiding misunderstanding as well as facilitating conflict resolution when it occurs in the workplace. In addition, nursing education and nurse educators should foster a values-based curriculum, drawing upon McAllister's (2015) work on transformative learning and values-based curriculum, as well as evaluation of learning innovation (Day et al., 2017).

In addition to value exchange activities, it is also vital to develop nursing students' capacity to be reflective. An alternative pedagogical strategy to develop students' critical reflective skills is found in Newton and Butler's (2019) work, which highlights the potential use of audio-visual (video) technology to learn and enhance students' reflection. Educators or students may record real workplace scenarios, or create simulated ones suited to the learning objectives, so that students can critically analyse the case, draw from it, and establish and practice reflection skills. This pedagogical strategy could be readily adapted, as nursing students are increasingly techno-savvy (Newton & Butler, 2019) and they usually own a smartphone (with video recording capability) that can be used for this purpose.

As demonstrated in this study, most situations are rooted in the interaction/contact with others (patients, families, teamwork, managers). This requires nurses to possess a set of social skills that help with their interactions in the workplace and respond to challenging situations (Fukuta & Iitsuka, 2018). Skills, such as assertive communication, self-control and mindfulness, and religious and cultural competency are among the skills that are required by nurses (Day, Levett-Jones, & Kenny, 2012; Richardson, Yarwood, & Richardson, 2017). In Australia, these skills have been incorporated into the registered nurse's standards for practice (Nursing and Midwifery Board of Australia, 2016) and integrated into the nursing curriculum. The need for such skills for nursing students is supported by some research studies (Laari & Dube, 2017; Liebrecht & Montenery, 2016; Waite & McKinney, 2016). Yet, in other countries, for example Indonesia, social skills beyond therapeutic communications are less formalised in the curriculum (Haryanti et al., 2016), which predominantly focuses on clinical skills (Faculty of Nursing Universitas Indonesia, 2018; Haryanti et al., 2016). Hence, for nursing education contexts with similar characteristics to Indonesia, incorporating social skills in the curriculum is recommended. Innovative pedagogical approaches to develop such skills may include psychological role-play (Liebrecht & Montenery, 2016), a learner-centred educational camp (Lau & Wang, 2014) and simulated board-games (Henderson, Kofinas, & Webb, 2017), which could be employed in future curricula.

The pedagogy of personal-professional values and supporting skills in professional education should not be considered as a prescribing/unifying practical solution for students but as an avenue for raising students' awareness of their own values and strengths. This may help them with transitioning into the nursing profession (Rush et al., 2019), directing their practical agency towards more positive directions as they embark on a nursing career, and achieving longevity in the profession.

8.4.2 Recommendations for clinical practice.

Within the context of Indonesia, a short course on nursing philosophy and underlying values designed for managers/health administrators would be useful. As managers/health administrators are in leadership positions and are pivotal in establishing policies that allow nurses to achieve their potential in the workplace, raising their understanding of value systems is recommended as an avenue for moving forward. New and established managers might benefit from a purpose-designed program aimed to enhance managers' awareness of value systems. Such a program may augment managers' understanding of how they influence the nursing workforce and inform future policy. Development of this program could be done through collaboration with Indonesian nursing education institutions.

A 2016 report on global health suggests that facilitating nurses to achieve their potential will have "the wider triple impact of improving health, promoting gender equality and supporting economic growth" (All-Party Parliamentary Group on Global Health, 2016, p. 3). This implies that providing a supportive environment which allows nurses to uphold their personal-professional values that influence their professional practices may have positive domino effects on a global level.

Regarding organisational values transfer, a special program that focuses on the socialisation of values needs to be designed and implemented in a structured manner. This dedicated program should be aimed at introducing organisational values and showing how they align with nurses' personal and professional values, in order to smooth the integration of organisational values into the new nurses' value systems. Such a program could also help with the initial professional transition process. Zarshenas et al. (2014) highlight the need for new nurses to form a sense of belonging and develop/strengthen a professional identity during this socialisation process. However, existing socialisation programs only focus on bridging the gap

between theory and practice (Goodare, 2015) and tend to overlook the influences that organisational values can have on nurses' agency. Moreover, a sense of belonging that is nurtured during this significant transition sets up a sense of belonging in the nursing profession (Zarshenas et al., 2014). As observed in the current study, organisational values can shape nurses' practical agency. Creating a learning program that allows active participation of nurses in evaluating and internalising organisational values could enhance the existing professional transition programs and promote long-term involvement and retention in the workforce.

For organisations that have not considered communities of practice (CoP), it is recommended that such communities are established and facilitated by the healthcare organisations or the professional organisation at a local level. Through a CoP, nurses would be able to voice their dilemmas or problematic situations, learn from each other's experiences, and foster the exchange of values in a safe environment. Establishing a CoP is beneficial for all health professionals, as it provides peer support which can facilitate better performance in practice and create better care outcomes (Walker, Batinelli, Rocca-Ihenacho, & McCourt, 2018). In addition, in a recent trend, an online CoP (Swift, 2014) could be established that draws on the work of Alshammari and Jung (2017), who demonstrate a detailed process for designing an online CoP system for nurses. They incorporate human values in developing real-life scenarios, which helps to identify problems and find solutions. Also, they highlight potential benefits of an online CoP for various stakeholders, including direct and indirect stakeholders as well as non-targeted users (Alshammari & Jung, 2017). Targeting multiple stakeholders is one of the advantages of online CoP over a conventional program.

Specific to the Indonesian context, it is strongly recommended that the policy regarding nurses' entitlement and remuneration is reviewed. The job distribution and nurses' workload policy needs to be aligned and matched with remuneration policy, in order to promote a sense of 'fairness' among employees (mainly nurses) in the workplace. A recent study in

Indonesia shows that sixty per cent of nurses expected an improvement in the reward system (Asmirajanti, Hamid, & Hariyati, 2019). This issue needs to be urgently addressed, in order to avoid repercussion on the long-term retention of nurses. It is indicative in this study that overcoming these issues would meaningfully improve nurses' internal feelings and their sense of being valued equally as healthcare professionals. In addition, local healthcare organisations might also need to evaluate nurses' workload distributions and available support for nurses, as these elements, along with other structural elements, can help to avoid Indonesian nurses' burnout (Nursalam et al., 2018).

As demonstrated in this study, many of value-challenging situations in the Indonesian context were found to be associated with the value of respect within health professional teamwork. This raises the issue of interprofessional collaboration. There are some differences in attitude among health professionals toward collaboration in the Indonesian context (Suryanto, Plummer, & Copnell, 2016), which implies that collaborative practice needs to be bolstered. In order to contextualise it into practice, those in health leadership positions can use a framework provided by WHO (2010). The framework for Action on Interprofessional Education and Collaborative Practice provides some insights and considerations, including elements and mechanisms that influence the process and outcomes of interprofessional collaboration with an emphasis on creating positive outcomes and improving the entire health system. The framework also emphasises the importance of interprofessional education in preparing health professionals, including nurses, to undertake collaborative practice (WHO, 2010). Regarding interprofessional communication, Claramita et al. (2019) provide a guideline that can be used to support interprofessional collaboration. This piece of work is suited for work cultures within hierarchical socio-cultural contexts, such as Indonesia (Claramita et al., 2019). In addition, Grace et al.'s (2017) model identifies values across professions, which

provides an avenue to find common ground for values that can be used to enhance collaborative practice.

The recommendations offered have arisen from the findings of this study. The timely completion of this study and the resulted theory need to be further explored in the context of the changing workforce. Hence, some future research directions are offered, as follows.

8.4.3 Future research direction.

This current study provides a detailed account of value development and evolvement in nursing. Due to the practical limitations as presented in Chapter 7.7, this study still leaves room for exploration and extension of relevant constructs in future research that includes:

a. More research is needed to explore the extent to which each contextual determinant affects the basic social process. Understanding the contextual determinants may help with creating interventions that facilitate a supportive working environment for nurses.

b. More culturally diverse participants or more specific nursing settings need to be considered in future studies. This could enhance the usability of the study's findings and test the resulting theory. This may provide deeper insights into the dynamics of nursing value system and the transferability of the DEVS theory.

c. Similar research is warranted on other health professional disciplines who are part of the healthcare team but have been educated under different philosophies, for example, the bio-medical model of medicine. Such studies may extend the applicability of the DEVS theory.

d. The relationship between values and practical agency needs to be unravelled considering the complexity of an individual's characteristics. This could be done by

including some possible mediating factors such as personality types and/or previous knowledge or work experience in the area.

e. Future research needs to explore the role of personal-traditional values and their influence in development and evolvement of professional values in nursing.

f. Investigating how the development and evolvement of nurses' personal-professional values can be supported and formalised in the curriculum and evaluation of the impact of the education on nurses' practical agency over time are further areas of future research.

The next section explicates the evaluation of the quality of the study. This piece of information is crucial, as it helps the readers to determine the trustworthiness of the findings, the constructed theory, and the recommendations of this current study.

8.5 Evaluating the Quality of the Study

Charmaz (2014) suggests four criteria that can be used to evaluate the quality of a grounded theory study: *credibility, originality, resonance and usefulness.*

8.5.1 Credibility.

Credibility in this study was achieved through several avenues. First, the researcher's familiarity with the topic and its setting was one of the strengths of this study. The researcher shared the same cultural background as the participants, which deepened the data analysis. The researcher's natural immersion in the culture has effectively facilitated the interpretation of participants' tacit meanings, particularly in relation to the culture, such as gestures, word choices, gimmicks, and social structure influences. In addition, the researcher consulted local

cultural experts in order to enhance the analysis of the culture-related constructs that appeared in this study.

The researcher's familiarity with the topic and the setting was also achieved through his engagement in the local health system as a health administrator for more than fifteen years before changing career to become an academic at a tertiary institution. These experiences, combined with his educational background in Health Administration, allowed a comprehensive understanding of the study context, including all structural issues within healthcare services.

The credibility of this study was also established through peer debriefing, which included regular consultations with the supervisory team who had expertise in grounded theory and the field of research. The supervisory team composition helped to address the areas in which the researcher lacked expertise, such as clinical nursing and qualitative research/grounded theory experience. All emerging categories in the DEVS theory were critically examined and openly discussed with the team, which improved the quality of the analysis and enhanced its credibility. Charmaz's constructivist grounded theory methods were followed strictly at all stages throughout the study. The supervision also helped with the study's methodological adherence, which is an essential element to achieve the credibility. In addition, the progress and the results of the study were also presented at least three times to a panel of experts (grounded theorists and nursing researchers) within the university during the researcher's PhD candidature. The researcher received additional valued feedback from this expert panel, which has been integrated into this thesis.

Other endeavours to enhance credibility were done by providing audit trails and using triangulation. To allow an audit trail, all processes, incidences, thoughts, feelings, contexts, analysis, and decisions were documented in real time and stored in the university approved

LabArchives to enable easy review. Triangulation of data was achieved through multiple methods of data collection and from various nursing settings.

8.5.2 Originality.

Charmaz (2014) explains the original contribution as the one that "offers a fresh or deeper understanding of the studied phenomena" (Charmaz, 2014 p.288). A study's originality is examined through parameters such as whether it offers new insights and new conceptual rendering of the data. Originality also emphasises the social and theoretical significance of the study. Finally, it assesses the position of newly constructed theory within the existing ones (Charmaz, 2014). There is a plethora of literature on values in nursing practice. Yet, most of these studies focus on professional values and often omit reference to personal values. In addition, most of the studies found in the literature exclusively cover or revolve around one event or point in time, and many represent only Western nursing culture. This resulted in a limited ability to comprehend the whole picture of value processing. More importantly, the absence of literature on value processing within an Eastern culture, such as Indonesia, has left the topic of personal-professional values unclear.

This current study claims its originality, as it sheds light on the basic social process of value development and evolvement in nursing, which is not currently found in the body of nursing literature. As such, the resulting theory offers fresh perspectives on nurses' values and their internal processing in practice. For example, it brings forward the evolving, complex, dynamic, situational, and contextual nature of values as opposed to the notion that values are stable over time, as discussed in Chapter 7. Also, it challenges the existing understanding that values are ordered according to their importance. In many ways, this theory advances current knowledge on the topic as well as challenges some current understandings of values. For example, it advances the view that a value is often understood as an independent factor that

affects practice. This study shows that values conception can also be changed by a situation in practice, which reflects the reciprocal nature of the value-practice relationships. These examples demonstrate the original contribution of this current study to the body of nursing knowledge.

8.5.3 Resonance.

The criterion of resonance is concerned with the degree to which the theory represents participants' perspectives, ideas, experiences, and tacit meanings (Charmaz, 2014). To facilitate resonance in this study, the researcher checked regularly with the study participants during data analysis, thesis writing, and after the final theory was completed.

The researcher used theoretical sampling method to pursue and advance the emerging categories. Concurrent data collection and analysis, as well as the constant comparative method, facilitated the researcher to construct the DEVS theory as well as elaborate on all properties of the theory. Data saturation was reached in the 21st interview. However, to ensure that the data were fully saturated, the researcher interviewed three more participants, in which neither fresh theoretical insights nor new theory properties developed. This means that the researcher had fully captured participants' experiences, thereby demonstrating resonance.

In order to reveal tacit or taken-for-granted meanings, as well as to ensure a proper representation of participants' ideas and experiences, the researcher recontacted the participants to confirm or ask for a clarification of some of their statements. The researcher sent the interview transcripts to the participants, to check the accuracy of the interview transcripts. Also, during data analysis, the researcher made some follow-up calls to the participants, when he was unsure of the content and the meanings that the participants conveyed. This strategy helped the researcher to not only better understand the interviews but

also to avoid imposing preconceptions on the data, leaving participants' experiences to emerge and inform the categories in a more organic way.

Finally, the researcher presented participants with the constructed theory. This strategy has assisted the researcher in evaluating whether the resulted theory resonates with the participants' ideas and experiences and is an accurate account of their experiences. The feedback the researcher received is reflected below:

> "…I can tell [that] your theory reproduces my value journey with great fidelity. I did not realise that I had gone through such processes during my practice until you sent me the visualisation of them, which was easy-to-understand. I learnt from it about my values and how they can come through in my daily practice. Thank you for involving me in the study…" (Wiken)

> "I was surprised that you are able to [literally] draw my experiences with so many details… I found your research correctly portrayed my encounters in the hospital…" (Amalia)

These comments indicate that the study has encapsulated participants' experiences and integrated these into the DEVS theory. The theory makes sense to the participants as well as offering new insights about their values in professional practice. The comments are indicative that the criterion of resonance has been achieved.

8.5.4 Usefulness.

The criterion of usefulness emphasises the implication and applicability of the study and its contribution to the existing body of knowledge (Charmaz, 2014). This current study not only illuminates many aspects that previously were unclear and under explored but it also offers insights into some new areas of personal-professional values in nursing practice. Hence, it makes a fundamental and useful contribution to nursing.

The DEVS theory provides a framework for understanding the complexity of internal values processing and untangles this complexity through a visual presentation which, according

to the participant's quotes presented in the previous sections, is easy to comprehend. The theory brings to light previously taken for granted aspects of values development in nursing and raises awareness of how it affects nursing practice. Furthermore, nurses can use DEVS to reflect on personal and professional encounters along their career journey, which will help to increase personal-professional confidence in upholding and maintaining their integrity, which is key to directing their agency. Given that this study provides a framework for studying nurses' values, along with some potential contributions, the criterion of usefulness is demonstrated in this study.

8.6 Concluding Remarks

This study raises awareness of personal and professional issues that nurses face in their workplace by providing valuable insights and deeper understandings of nurses' internal values process. The understanding of this internal process will help nurses' preparedness for and transition into their workplace, in a more positive manner. Eventually, this may assist nurses with preserving their sense of being as a nurse and maintaining their active agency for directing their professional lives in more meaningful ways. The information provided in this study can also be used to enhance nursing education and practice, as well as assist managers to improve the overall working environment, nursing processes, and outcomes.

This study has identified a core process conceptualised as '*Becoming a nurse: Developing and evolving a value system*'. The basic social processes have been unravelled and presented as an integrated entity that constitutes the DEVS theory. The DEVS theory unpacks many aspects of values development and evolvement in nursing and contributes significantly to the body of nursing knowledge.

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Appendices

Appendix 1. Overview of the Indonesian Health System.

Indonesia has thirty-four provinces and more than seventeen thousand islands that make up a total area of 1.904.569 square kilometers. It is the fourth most populous county in the world after China, India, and the United State of America (United States Census Bureau, 2019). The national census in 2010 recorded the population size of more than 261 million and it was estimated to be more than 265 million in 2018 (Badan Pusat Statistik, 2011), comprised of more than 300 ethnic groups speaking more than 700 traditional dialects (Simons, 2019). The official national language is Bahasa Indonesia. Indonesia is also known as the most populous Muslim-majority country in the world with around eighty-seven per cent of its population affiliated with the religion of Islam. The second biggest religion is Christianity, which comprises ten per cent of the population. The remaining three per cent embraces Buddhism, Hindus, Confucianism, and minority spiritual teachings (Na'im & Syaputra, 2011).

The Indonesian Health System is comprised of seven subsystems that include: health endeavours; health research and development; health financing; health human resources; pharmaceutical, medical devices and food; health management, information, and regulation; and community empowerment ("Peraturan Presiden Ri Nomor 72 Tahun 2012 Tentang Sistem Kesehatan Nasional," 2012). Within this health system, nurses are engaged in multiple sub-systems, most importantly in the subsystem of health endeavor, in which nurses are one of the central players.

One of the important milestones in the Indonesian Health System was the launching of the *Badan Penyelenggara Jaminan Sosial (BPJS)* program, which is universal public health insurance that took effect on 1 January 2014 (Humas BPJS, 2018). Since the launching of *BPJS*, there have been some changes in health funding and payment arrangements. As the

health payment mechanism has changed from out-of-pocket payments to an insurance-based system, the funding schemes for public healthcare institutions has changed accordingly. However, it should be noted that some people still prefer an out-of-pocket payment method as they believe that they would receive better care and attention from doctors and nurses when paying in cash (Djohani, 2015).

This milestone has had a significant effect on the provision of health care, which also influence nurses and nursing care provision. Data show that there was a significant increase in the utilisation of healthcare service shortly after the BPJS program was launched. This trend affects nurses in the way that their workload increased following the program, and that the number of available nurses was limited at time (Pudatin Kemenkes RI, 2019)

BPJS collaborates with all public-funded healthcare institutions and many private healthcare organisations as the health providers for the BPJS beneficiaries. BPJS allocates participating healthcare institutions a certain amount of funding (known as *the capitation*) based upon the number of service beneficiaries. The participating institution makes a claim for reimbursement on a monthly basis. Sixty per cent of the claimed capitation is allocated to a service fee that distributed among healthcare workers (including nurses) in the institution (*PP Menteri Kesehatan no 19 tahun 2014*). This service fee is often referred to as 'incentive' or 'reward' by the participants of this study.

The Central Government provides a general guideline on the distribution of this service fee that is reimbursed through BPJS. It uses two broad categories: type of employment and/or position and presentation at the workplace. The type of employment is defined by variables such as the type of profession (medical and non-medical), level and type of education (professional and vocational), managerial tasks (head of wards, other administrative positions). The presentation is determined by employers' attendance (presenteeism) at the ward (*PP*

Menteri Kesehatan no 19 tahun 2014). Each variable is scored and calculated using a particular formula. For civil servant nurses, a service fee is awarded on top of their regular salary. However, non-civil servant nurses who work in some local governments (districts/municipality level) often entirely dependent upon this monthly service fee for their primary income. This means that the income for the non-civil servant nurses fluctuates following the fluctuation of the service demands, which denotes irregularity in the flow of their income.

With regard to the healthcare provision, the Indonesian Health System has a combination of private and public health service providers. The private healthcare providers include private hospitals, general and specialty doctors' clinics, nurse's clinic, and maternity clinic. Private healthcare providers mostly operate in the city/town. The public healthcare institutions, on the other hand, operate at all level of government administration. This includes many types/classes of hospitals at district, province and national levels. The Indonesian Ministry of Health reported that there are 2,813 hospitals and 8,841 clinics spread over the nation (Pudatin Kemenkes RI, 2019). At the lower level, *puskesmas* (primary health centres, also referred to as public health centres in the Indonesian health literature) operate at the sub-district level.

Although *puskesmas* sets out to offer primary health care for the community, it commonly extended to function as a 'small-scaled hospital' as it does not only focus on promotive and preventive care but also provides medical /curative services and limited rehabilitative treatment. It has an emergency unit, ambulatory/mobile services, and inpatient and outpatient services. Also, *puskesmas* provides some more complex care such as essential obstetric and neonatal care. There are 9,993 *puskesmas* in 2018; all have beds. Yet, only thirty-six per cent (3623 puskesmas) are publicly pronounced as *puskemas perawatan,* which is a *puskesmas* that offers inpatient care for patients with simple-moderate medical/nursing complexity (Pudatin Kemenkes RI, 2019). This type of *puskesmas* is reported as having an

average of eleven beds (Directorate of Health Service, 2014d). For more advanced care, *puskesmas* can refer patients to District hospitals, that can also refer the patients to the provincial hospital for even more advanced care. Finally, the provincial hospital would refer patients who required highly specialised treatments to a specialty hospital at the national level (referral centre hospitals). In each of the referral system chain, nurses are actively involved and play a significant role, such is directly involved in the process of patient transfer.

At the village level, there are some simpler health facilities available. *Pustu* (auxiliary health centres) and/or *poskesdes* (village health post), *polindes* (village maternity clinic), and *posyandu* (integrated health post) offer basic health service to the locals. Both *pustu* and *poskesdes* are headed by a nurse. *Polindes*, on the other hand, is attended by midwives. Nurses and midwives who are assigned to attend these facilities are required to stay in the facilities, which often located at a very remote area and should be ready to offer a 24/7 service when needed by the locals. Being a single staff in these facilities, nurses work autonomously. They are supervised by *puskesmas*, though. The significance of this arrangement for nurses lays on the additional challenges from the burden of working individually in a remote area (with all consequences that entails) and unscheduled working hours. In some remote places, security is often another issue that adds difficulties for nurses in charge (Maria Beka, personal communication 5 February 2019) which also adds challenge to nursing work.

Despite constituting the majority of the health professional workforce, statistic shows that the Indonesian Health System is suffering from nurses and midwives' shortages, national-wide (Mahendradhata et al., 2017). With a nurse density of only 20.58, Indonesia is among the fifth lowest-nurse density Southeast Asian Countries, just after Bangladesh, Myanmar, Bhutan, and Timor Leste (World Health Organisation, 2019). Although there has been an increase in the number of nursing education institutions, the problem of the nurse shortage is continuing (Pudatin Kemenkes RI, 2019). This issue is possibly deteriorating with a growing trend for

outmigration of nurses to Middle Eastern countries (Mahendradhata et al., 2017). Efendi et al. (2018) suggests that nurse shortage problems in Indonesia are also linked to uneven distribution of nurses and the limited capacity of the Indonesian government to employ new nursing graduates, which in certain provinces are quite abundant. It would seem that Indonesia is facing multiple issues in the nursing workforce.

Appendix 2. "Shut the Door, Don't Let Her in!": The Impetus For This Study – A Complete Story.

The impetus for this study began with a touching personal encounter when I visited a friend who was hospitalised a public hospital. While he was in the ward, a young doctor came in for a routine visit, without being accompanied by a nurse. The doctor's facial expression and gimmick certainly showed that he was quite unsettled, though I did not know what had happened and why. He was grumbling to one of his team, who was apparently a nutritionist, and a nurse finally came over and knocked on the half-open door. The doctor told the nutritionist "Shut the door, don't let her in!". At that moment, I was shocked by the incidence. As one who has learnt about doctor-nurse relationships and was actually witnessing this reality, I was very much amazed by how intense it could be in practice. The more interesting thing was the spontaneous reaction of the wife of the patient to the doctor's order. She yelled at the doctor with an even-higher tone and said "How could you do that to her? [the nurse in charge], she has been nursing my husband nicely for days and she has just left this room less than five minutes ago, and you just came five seconds ago! That's rude! Let her in...". The wife then opened the door for the nurse and asked her to come in and join the team. The nurse came in with tears but tried to smile to the wife and the patient. Obviously, she had something to say but did not say anything. There was a very awkward situation in the ward; no further communication in the room occurred until the doctor left the ward.

Out of curiosity, I asked about the details of the incidence and offered assistance for the nurse (as an ex-health manager, I understood what could be done in such an incidence). Yet, the nurse objected the offer politely and asked me and the wife not to speak out about it. The nurse was willing to take the blame. From a short conversation, I had the impression that the doctor was upset, for he did not find the nurse in the station when she was supposed to be there and teamed up with the doctor for the patient visit that day. Yet, the nurse explained to

me why she was not at her station at the time. She was taking a phone call on the balcony just outside the station. It was her husband's call, letting her know that their only daughter (seven years old) was sick and in need of medical assistance. Also, the nurse let me know that she actually had been in confrontation with the doctor a few days prior to the incidence. The nurse was quite eager to share her situation with me as I revealed my identity as an academic who is concerned about nursing issues. This incidence reflected nurses' deep-level hardships involving personal integrity, which inspired and galvanised me into studying this topic.

Appendix 3. Ethical Approval from MUHREC.

MONASH University

Monash University Human Research Ethics Committee

Approval Certificate

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number: 1553
Project Title: Indonesian Nurses' personal integrity and practical agency: a grounded theory
Chief Investigator: Assoc Professor Jennifer Newton
Expiry Date: 17/07/2022

Terms of approval - failure to comply with the terms below is in breach of your approval and the *Australian Code for the Responsible Conduct of Research*.

1. The Chief Investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash letterhead and the Monash University complaints clause must include your project number.
6. Amendments to approved projects including changes to personnel must not commence without written approval from MHUREC.
7. Annual Report - continued approval of this project is dependent on the submission of an Annual Report.
8. Final Report - should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected completion date.
9. Monitoring - project may be subject to an audit or any other form of monitoring by MUHREC at any time.
10. Retention and storage of data - The Chief Investigator is responsible for the storage and retention of the original data pertaining to the project for a minimum period of five years.
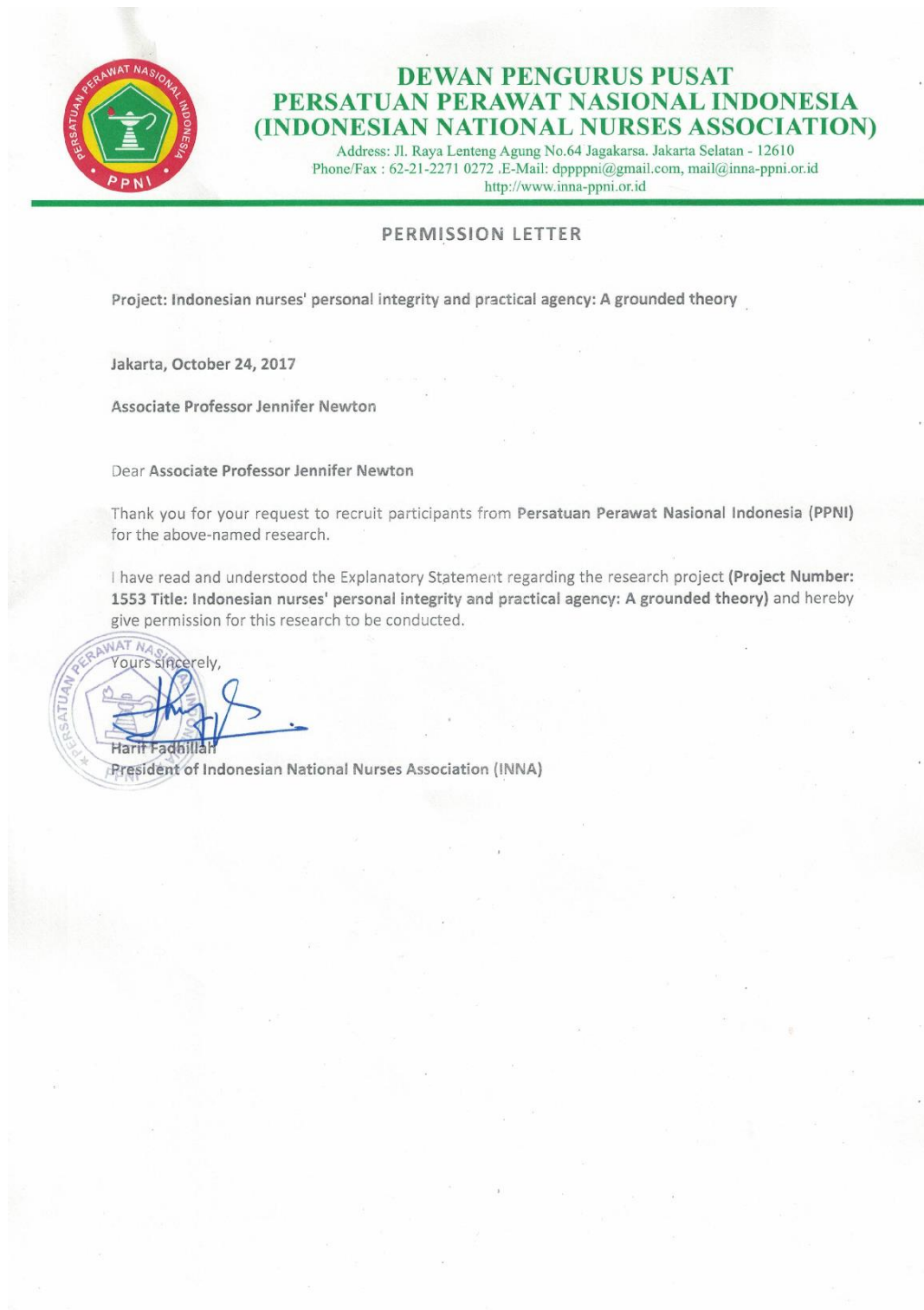
Thank you for your assistance.

Professor Nip Thomson

Chair, MUHREC

CC: Dr Gulzar Malik, Mr Sastrawan

List of approved documents:

Document Type	File Name	Date	Version
Supporting Documentation	Advertising flyer	10/05/2017	1
Supporting Documentation	Interview topic and opening questions	10/05/2017	1
Consent Form	consent-form-sastra	11/06/2017	1
Explanatory Statement	explanatory-statement_Final	10/07/2017	2

Page 1 of 1

Appendix 4. Permission Letter from the Indonesian National Nurses Association.

DEWAN PENGURUS PUSAT
PERSATUAN PERAWAT NASIONAL INDONESIA
(INDONESIAN NATIONAL NURSES ASSOCIATION)
Address: Jl. Raya Lenteng Agung No.64 Jagakarsa. Jakarta Selatan - 12610
Phone/Fax : 62-21-2271 0272 .E-Mail: dppppni@gmail.com, mail@inna-ppni.or.id
http://www.inna-ppni.or.id

PERMISSION LETTER

Project: Indonesian nurses' personal integrity and practical agency: A grounded theory

Jakarta, October 24, 2017

Associate Professor Jennifer Newton

Dear **Associate Professor Jennifer Newton**

Thank you for your request to recruit participants from **Persatuan Perawat Nasional Indonesia (PPNI)** for the above-named research.

I have read and understood the Explanatory Statement regarding the research project **(Project Number: 1553 Title: Indonesian nurses' personal integrity and practical agency: A grounded theory)** and hereby give permission for this research to be conducted.

Yours sincerely,

Harif Fadhillah
President of Indonesian National Nurses Association (INNA)

Appendix 5. Example of Explanatory Statement.

EXPLANATORY STATEMENT

(Nurses – Individual Interview)

Project: Nurses' Personal Integrity and Practical Agency: A Grounded Theory

Assoc. Professor Jennifer Newton	Sastrawan
School of Nursing & Midwifery	Phone : +61 3 9902 0367 (Office)
Phone: **+61 3 9902 4570**	Mobile : +61 455898738 (Australia)
email: **jenny.newton@monash.edu**	+62 87865000879 (Indonesia)
	Email : sastrawan@monash.edu

My name is Sastrawan and I am conducting a research project as part of my PhD studies in the School of Nursing and Midwifery at Monash University under the supervision of Associate Professor Jennifer Newton and Dr Gulzar Malik. The aim of this study is to develop a theory on nurses' personal integrity in the Indonesian context. We believe that understanding the concept of integrity will help raise awareness and simultaneously promoting mindfulness in nursing practices as well as empowering nurses to be more effective and positive in their practice.

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed above.

What does the research involve?

Participation will involve undertaking in an in-depth individual interview to explore your personal and professional experiences as a nurse. This information will add to understanding the nature of nurses and nursing. We aim to develop a theoretical framework of the concept of personal integrity and how this is influenced by Indonesian culture.

It is anticipated that the interview will take around one hour and will be held in a mutually convenient location to the participant and conducted by the student researcher.

Why were you chosen for this research?

We consider you as a potential participant for this research based on the information on the nature of your job/workplace that you have given to us. These qualities are viewed to be unique with the potential of introducing valuable insights into the emerging theory.

Source of funding

This study is part of the Doctor of Philosophy program at Monash University in which the student researcher is enrolled on a scholarship through the Australia Award Scheme.

Consenting to participate in the project and withdrawing from the research

You will be provided a consent form with which you are required to sign and return prior to the interview. You will only will be interviewed if you agree with all circumstances described in the consent form and if you sign the form. During the interview, you have the right to refuse answering any question(s) that you are not comfortable with. Should you feel discomfort, you can either take break during the interview, or quit any time with no consequences and no obligation to provide reasons. If you decide to withdraw from the study, you may request discarding all or part of data that we will have obtained from you, otherwise, we will keep and include the data in our analysis.

Possible benefits and risks to participants

The benefits that can be gained from this study may enhance your practice as a nurse. Through raising an awareness of integrity it may promote mindfulness with regards to your motivations, reasons, actions and consequences of your nursing practices. This may lead to an improved performance in your practice and subsequently, the patient care that you provide.

Understanding nurses' personal integrity may assist nurse managers with their decision making with regard to allocation of resources, to minimise nursing problems and address these effectively.

Education institutions may benefit from this study by providing understandings about personal integrity that can be used to inform curriculum when needed. Thereby preparing future nurses, to comprehend the concept of integrity so that they are more prepared for practising as a qualified nurse.

The potential discomfort for you as an interviewee is that you might share unpleasant nursing events that you have gone through. The interviewer may or may not ask you some personal experiences/ feelings toward the less desirable/ sad occurrences in the past. For this reason, you may or may feel discomfort in recounting such events. However, discomfort is likely to be at the minimum and you will be given time to recover, then to continue interview or to end the interview.
We will do our best to keep the interview, your details, and the venue of the interview confidential and leave no way for others, except for the research team members, to de-identify you as a participant.

Services on offer if adversely affected

In the case where the interview induces significant psychological impact on you, and if you agree to, we will refer you to a qualified counselling service for support.

Payment

You will be awarded a small gift worth AU$ 20 in appreciation of your contribution. If you withdraw from the study after the interview is commenced, you will still be awarded a gift worth AU$ 10. However, if you decide to withdraw before the interview begins you will receive no gift.

Confidentiality

We will take all necessary steps to ensure anonymity and confidentiality of you. We will:

1. Use pseudonym in the transcripts, translations, and in quotes. You will be able to choose any name that you would like as your pseudonym. However, in the real interview, we will address you with your real name to maintain a close connection between you and the student researcher.

2. Use a single personal pronoun, that is 'she' to refer to both male and female nurses in order to rule out the possibility of being identified by gender, especially when there may be only a few number of participants with particular gender.

3. Ensure that there will be no access to data except for the research team members.

4. Present data / quotes in such a way that provide no way of de-identifying any individual in the study

Storage of data

All data will be stored in LabArchives. This is a cloud-based collaboration and data storage service endorsed by Monash University.

Use of data for other purposes

Data from this study may be used as examples in a methodological book in the future time. We will, however, maintain confidentiality of those who are involved in this study.

Results

The results of this study will be published in a journal article form and in a thesis. Both forms of publication will be made available to public through databases. You will be given a hard copy of the article should you ask for it.

Complaints

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics (MUHREC):

Executive Officer
Monash University Human Research Ethics Committee (MUHREC)
Room 111, Chancellery Building E,
24 Sports Walk, Clayton Campus
Research Office
Monash University VIC 3800

Tel: +61 3 9905 2052   Email: muhrec@monash.edu   Fax: +61 3 9905 3831

Thank you,

Sastrawan
Student researcher

Associate Professor Jennifer Newton
Principal researcher

Dr. Gulzar Malik
Associate researcher

Appendix 6. Consent Form.

MONASH University

CONSENT FORM

(Nurses –Individual Interview)

Project: Nurses' Personal Integrity and Practical Agency: A Grounded Theory

Chief Investigator: **Associate Professor Jennifer Newton**

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

I consent to the following:	Yes	No
An individual interview with the student researcher	☐	☐
Audio recording during the interview	☐	☐
Contact from the student researcher to clarify the data the I have provided from the interview;	☐	☐
Participate in checking and acknowledging the transcripts from the interview.	☐	☐

Name of Participant _____

Participant Signature _____ Date _____

Appendix 7. Interview Guide.

Appendix Interview guide

1. Introduction
   a. Introduce researcher
   b. Brief explanation of the study
   c. Ensure the participant explanatory sheet is provided to the participant and consent form has been signed
2. Body of interview
   I am interested to understand how you view your profession, your practice and yourself as a professional nurse
3. Examples of general/opening questions
   - Describe your workplace and the nature of work you are doing
   - Describe the work culture in your organisation / workplace
   - Please tell me why you chose nursing career.
   - What do you love / hate the most about your work? Explain!
   - What guides your underline practice as a nurse?
4. Examples of probing questions
   - Please tell me about any circumstance that makes you think/act differently as a person and a professional?
   - Please tell me your memorable encounter(s) as a nurse that affect your feeling, your way of think, or your practices.
     o Why are the encounter(s) memorable
     o how do they affect your feelings?
   - How the encounter(s) challenge your values/principles?
     o What kind of values/principles were challenged/affected? In what way (positive / negative)?
     o What values/principle that you think you have compromised / preserved? why.
   - How the encounter(s) affect your practice?
     o what practices have been affected and?
     o How did they affect your practices?
     o If there were changes in your practices, why did you change?
   - How did you survive the situations?
     o What did you do to survive the situations?
     o How do you recover from the situations?
5. Closing
   a. What do you think can be done to promote integrity in workplace?
   b. do you have advices for other nurses including those entering the profession and those think of taking nursing career?
   c. Do you have any questions for me?
   d. May I have your permission to contact you again should I require further clarification?
   e. Would you like a summary of the study when it is completed?
   f. Thank you

Appendix 8. Coding Example.

Transcript	Initial Coding	Focus Coding
I found the way my parents brought me up is very much affecting how I see myself as a nurse and how I regard other people such as my patients, or the people I am working with. My mother used to tell me to behave in ways that other people would be happy with or make them feel valued, or at least not to make them feel bad about being around me. I was told that these kinds of behaviours are encouraged by our religion so that God will record them as good deeds. I remember when my father told me 'the more good deeds you have, the happier you will be because whatever you do to other people will certainly come back to you!' I have been trying my best to do so when interacting with my patients in the hospital…"	Acknowledging family bring up influences Carrying through parents' influence in practice Being told to well-behave Being told to make others feeling valued Receiving religion's tenets Learning the reflective nature of good deed in the religion Carrying through lessons from parents in practice	Attaining personal values from parents Practising values

Transcript	Initial Coding	Focus Coding
The doctor ordered me to set NGT [nasogastric tube] on a coma patient. I was a bit reluctant to obey her as I noticed an abnormal breathing problem and I was pretty sure about the possible outcomes. I disagreed with the doctor, but you know it is not easy to argue with the doctor so I just kept silent. That night the doctor [who told me to set NGT] was the grumpy one. To be honest, she is very difficult to work with [smiling]. So I was in a dilemma whether to follow the order or to go with my feelings, but I was too afraid not to follow the instruction. After a while, the patient passed away [voice softened, saddened facial expression]. For a quite long time, I kept wondering whether it was my faults. If I did not set it [NGT] the outcome might have different. I should've reminded the doctor about the possible outcomes of it [setting NGT]. I felt sorry for the patient and her family. I felt guilty for quite a long time	Being ordered to set NGT Feeling reluctant to obey Noticing abnormal breathing problem Using professional judgment Disagreeing silently Working with a grumpy doctor Being in dilemma Following a doctor's order Feeling afraid to refuse doctors' instruction Observing patient passing away Indicating sad and regret feeling Blaming self for failing to remind the doctor Feeling sorry Feeling guilty for a long time	Undertaking delegated task Facing dilemmatic situation Compromising professional values Being influenced by practice reality Working with a less-than-ideal team

Appendix 9. Memo Examples.

Focus Groups Memo.

<281117> I am very excited today to start my data collection (this FGI). I have eight participants who confirmed their attendance and two more participants who promised to come if they could make it due to last minutes change in their timetable. (Update: these two participants texted me during the FGI session letting me know that they were unable to attend). This FGI is conducted at a meeting room in a hotel in Mataram, Lombok.

<281117– Memo was written right after the FGI is completed> At the beginning of FGI, I think I spent too much time on the introductory statement. I should not do the same thing in the next FGI. During the FGI, I was feeling nervous for I realised that I did it the way I did FGD (a little too passive) and tried to fix it by taking more active roles. Here came an issue. I tried to get my participants talked about personal integrity, as this FGI was designed to get ideas from the participants and to get everyone and myself on the same page. As I started to direct the interview to this topic, I sensed a little gap between what I knew from the literature about the concept of integrity and the actual conception of integrity. When I tried to be more straightforward, I asked a question "what does integrity mean to you?". I saw my participants look each other, smiling, and it was quite a long pause before a participant spoke up 'I think, integrity is….' And another participant answer 'let me try…' these answers were shocking as they started with 'I think' and 'let me try'. For me, it was a clear indication that the participants had difficulties in explaining integrity. When finally, someone gave 'a better answer', I realised that she used the words that I used to explain my research during the introduction and explanatory statement session. At this point in time, I assumed these were due to lack of experience of facilitating an FGI. I was motivated to re-read some literature on conducting FGI,

which I did after this first FGI. I also learnt to be more careful during the introduction and explanatory statement not to explain too much about personal integrity. It was not possible to not talk about it at all as it was part of the introduction of the research.

Methodological Memo.

<191217 – This memo is written after the third interview during the initial data collection> So far, I have conducted two focus groups interview and interviewed three participants. I am feeling a bit at lost now how to continue this initial data collection. When I commenced this study, I was always wanted to explore the concept of personal integrity in nursing. I spent more a lot of time researching literature on this and more than a year to frame my research on this topic. But I am now faced with a reality that this topic might not be the 'thing'. I started to feel that something was not quite right during the first group interview. Yet at that time, I thought it was only a technical problem (due to lack of experience of facilitating an FGI). Now, after observing the same thing, I started to feel very 'annoyed' and feeling guilty. In the last two interviews, I tried to suppress this feeling and continued the interview by repeatedly directing back the talk to 'integrity' and hope the participant use the word 'integrity' more often during the interview. I did not happen. At this point, I realised that it might be methodologically wrong.

I believe that continuing doing the research this way would potentially lead to pre-conceiving / imposing ideas, which can nullify the research. I am having a dilemma whether to continue the research with a possible compromise on the quality of the research and my research integrity or to stop it now and possibly start over which mean I might need much longer time to complete this PhD and more resources. I feel that this is about idealism versus practicality.

<201217> I had just made an important decision last night. I decided to stop this data collection and go back to Melbourne to consult my supervisors. The reason was that 'there is no point of researching nurses' integrity while I compromise my (research) integrity myself'. I might be spending more time completing my course, but I think it worth it. But I also hope that I do not have to start over with brand new research topic. [*<Update 040218> I guess I was too paniced that I totally forgot that this is a grounded theory study that requires researchers to follow the emerging direction. I also forgot that this is just initial data collection and I was too focused on my proposed topic of integrity that I forgot to think of another alternative at the time – a typical newbies' situation*]. However, because tomorrow's interview has been scheduled, I will interview this respondent before going back to Melbourne.

[**<Update 150218>**: after careful analysis of the transcripts, and after discussion with, and receiving feedback from, my supervisors, I came to realise that my respondents predominantly talked about values. So I did a quick literature search on value and its relationship with integrity. I found a couple of philosophical articles that talk about these construct and that they are overlapping. This was a very encouraging as I immediately came to know that 1) I do not have to search for a new research topic 2) none of the data I collected previously during initial data collection is wasted. 3) all of my previous work (during the research proposal preparation) are highly relevant 4) I can continue my study plan and determined to complete this course on time yeah!!- Feeling fully motivated now]

Interview Memo: Interview with Yeyen.

<250318> Initially, Yeyen agreed to be interviewed in the afternoon in her office. One day before the interview, she asked for a reschedule (via phone). She wanted to do it the following day at her house. I am a little concerned that interviewing her at home, with the

presence of her spouse, might change how she would express her opinion during the interview session. I thought I need to know the reason why she changed her mind, was it due to confidentiality, sense of freedom to speak, or simply convenience. But I remember that all participants have the right to not giving any reasons for any decision on their participation. So, I did not ask her anything. I just asked whether her spouse was fine with this interview. She assured me that her spouse and kids were fine. This answer gave me a clue that she is a married nurse. She greeted me with an Islamic expression and used some other Islamic phrases during the phone call, which also gave a clue regarding her religious affiliation.

I came about ten minutes late to Yeyen's house. She and her little family welcomed me nicely, and it did not take long for me to get along nicely with her family, who were very friendly. I spent around fifteen minutes on building rapport with her and the family. Some information that I got from this short introductory conversation was the fact that Yeyen came to this town a long time ago as a single nurse, lived a 'lonely live' – as she described- in a rented room, but a few years later married to the homeowner's child.

As a cultural requirement, I politely asked for permission from her spouse to interview. When I did the explanatory statement, her spouse was still with us, but fortunately, a few minutes later, the spouse leaves us, and gave a body language to continue the interview.

The interview was done in the living room. When I saw some decorations inside the room, I was convinced and very confident that she was a Muslim, and I believed that I do not need to ask any question regarding her religious affiliation.

When talking about family during interview, I saw a painting, of a couple of old persons, hung on the wall and asked Yeyen whether the ones on the painting were family member (because I believe they are the participants' parents – and I was about to explore the family influence on her as a person and a professional). She confirmed they are her parents. I

made a mistake by asking her where they are now (it was just a spontaneous question- assuming they were living together in this house, which is a normal practice in this culture), just to make her a little emotional because it turned out both parents passed away only a few months ago. Drawing from this experience, I need to be more thoughtful in dealing with family-matters in the next interviews.

Despite this stupid mistake, I found it was actually quite helpful in terms of bringing back the participant's memory about her parents' life and got her to talk about it quite easily. I had the impression that Yeyen was brought up in a good family who taught her many kindness and personal values. She was told to respect people regardless of who and what they are. She also talked about thinking positively about everything. She also was taught (by her parents) to be a responsible person and became a family-oriented person. This was probably the reason why she had a dilemma when this mindset was brought to practice. I could see she has a problem to balance her personal and professional responsibility which appeared to affect her mood. Yet she tried to sustain her motivation and morale. I felt that this piece of information could be the naming for a focused code (because this theme seemed to be consistent in the last four interviews so far). I thought that I need to dig deeper on this in the next interview.

At the end of the interview, she refused the voucher that I handed and said she was happy to participate and talk to me. But I insisted that she had helped me with the interview and the voucher was just a little appreciation for this participation.

Analytical Memos: 'Looking through a religious lens'.

<020418> It looks to me, almost all actions are related to participants' religious values. I think this theme should be labelled 'acting on religious beliefs'.

<070418>The label 'acting on religious beliefs' does not fit all participants' experiences with regard to religious values. I think the more inclusive label would be 'Drawing and Reflecting on religious values'. So far, there is an indication that this theme possibly can be raised as one of the categories in this study, as this theme is very consistent among participants. But I need to wait until some more evidence emerges from the next interviews and wait until you can see how this relates to other categories.

<100418>The theme 'Drawing and Reflecting on religious values' does not seem to be strong enough to be a category. Also, its properties do not go further than what I have seen from the previous interviews. But I think it still has the potential to be a subcategory. Again, I cannot decide it now as I have to wait and see other emerging themes and how they are conceptually intertwined.

<250718> The theme 'Drawing and Reflecting on religious values' should be relabelled (again) to 'Looking through a religious lens'. This new label is now incorporating all related constructs very nicely. Participants do not only talk about their activities but also principles and attitude and also actions in the workplace. There were many participants talked about their religious principles which seemed to shape their attitude toward their job and their actions. As other themes also emerged simultaneously, I believe this theme might become a subcategory of the possible category 'Enacting values'

<121018> As themes became more visible, 'Enacting values' (which was thought to be a category), does not strong enough to be a category, but it now becomes a subcategory of the category Developing Values. As such, the theme 'Looking through a religious lens' can be accommodated as a subheading under the subcategory Enacting Values.

<040219> The theme 'Looking through a religious lens' does not seem to be the core part of the theory as I believe this theme is quite specific to Indonesian Culture. (It was also

discussed with my supervisors). As such, it should be considered contextual influences rather than the core basic social processes that are the focus of this study. Move this theme to contextual determinant!

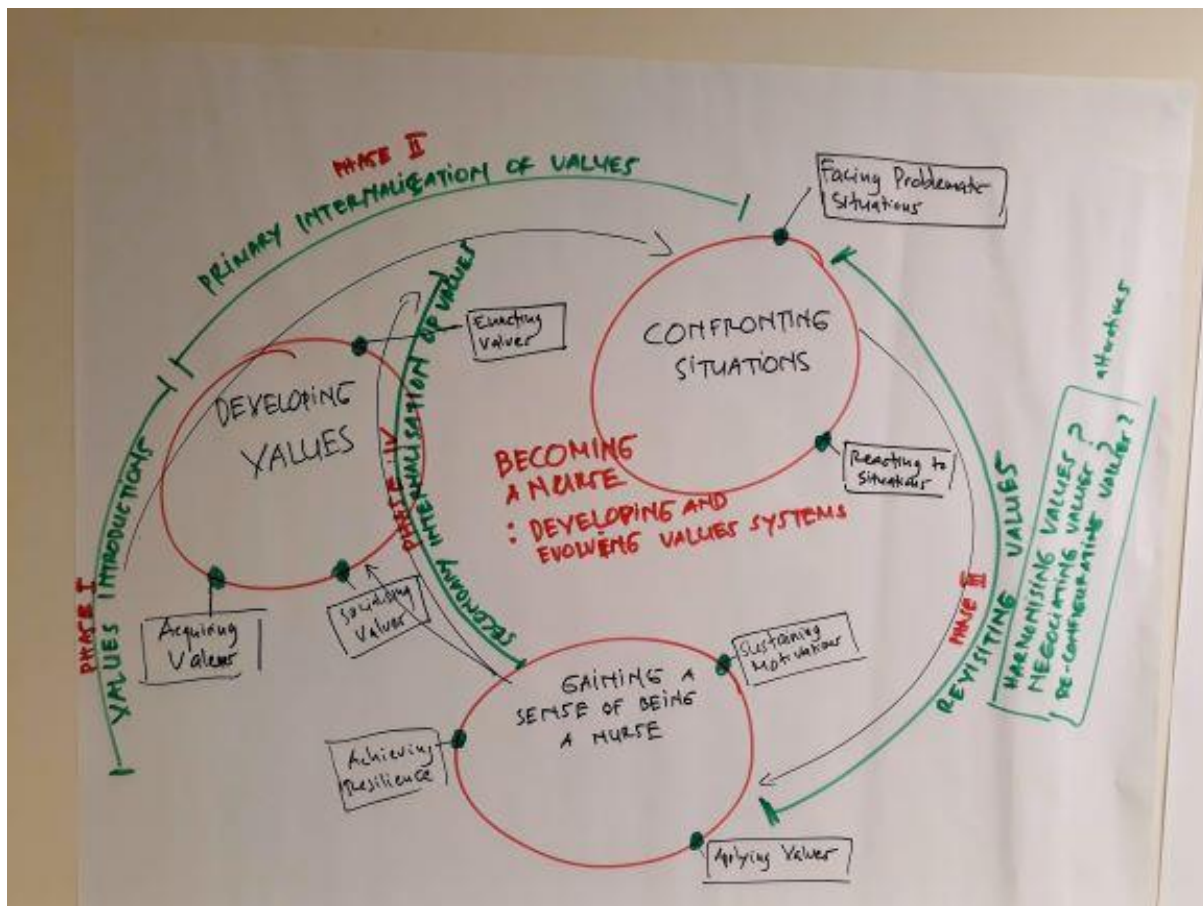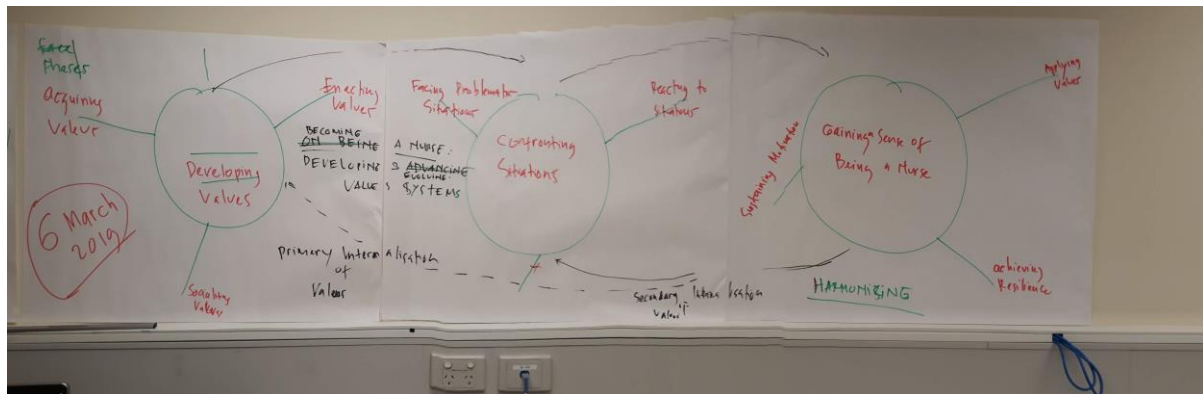# Appendix 10. Example: Process of Category Development.

Example of early progress of the Category Developing Values (5 June, 2018)
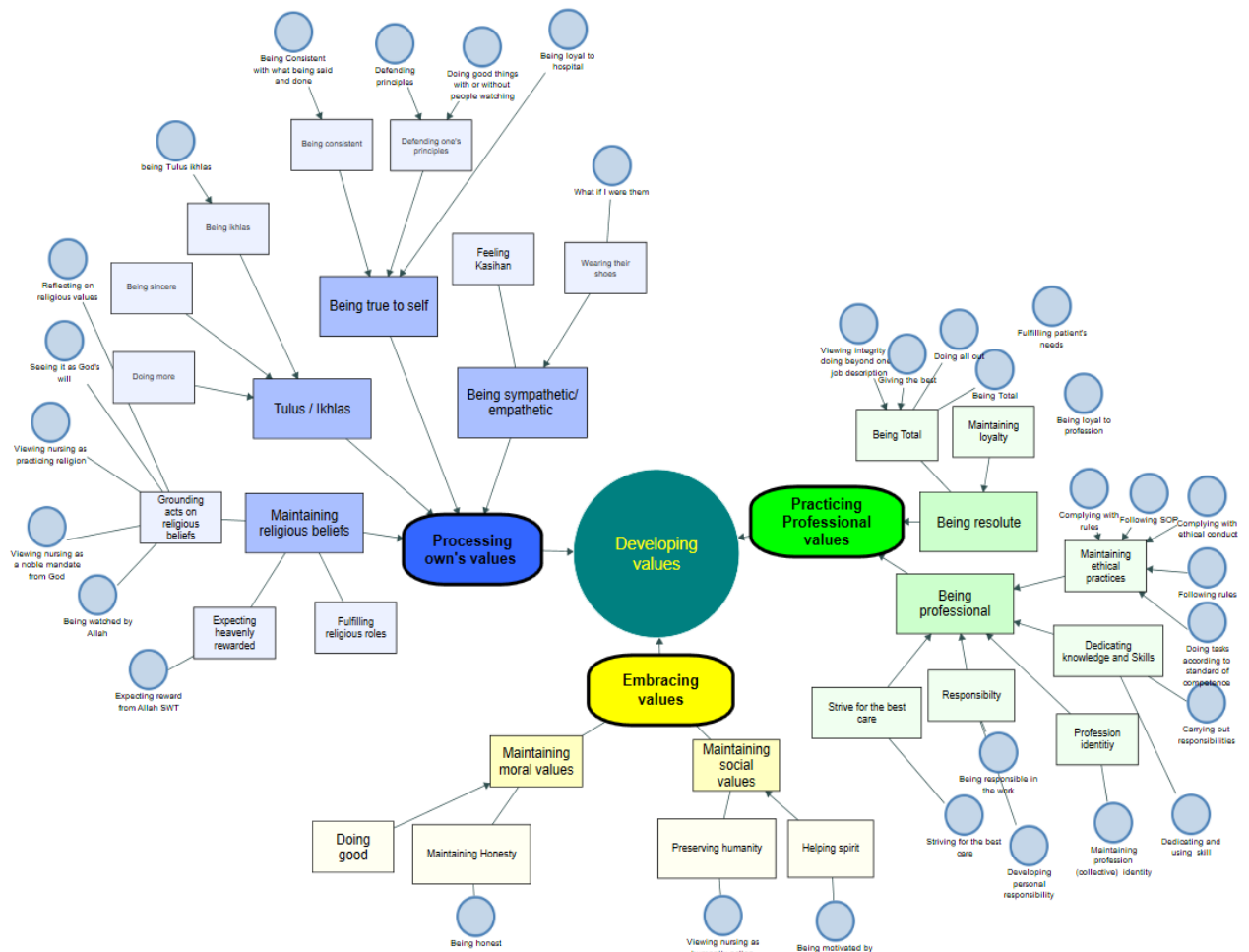
Appendix 11. Concept Development.
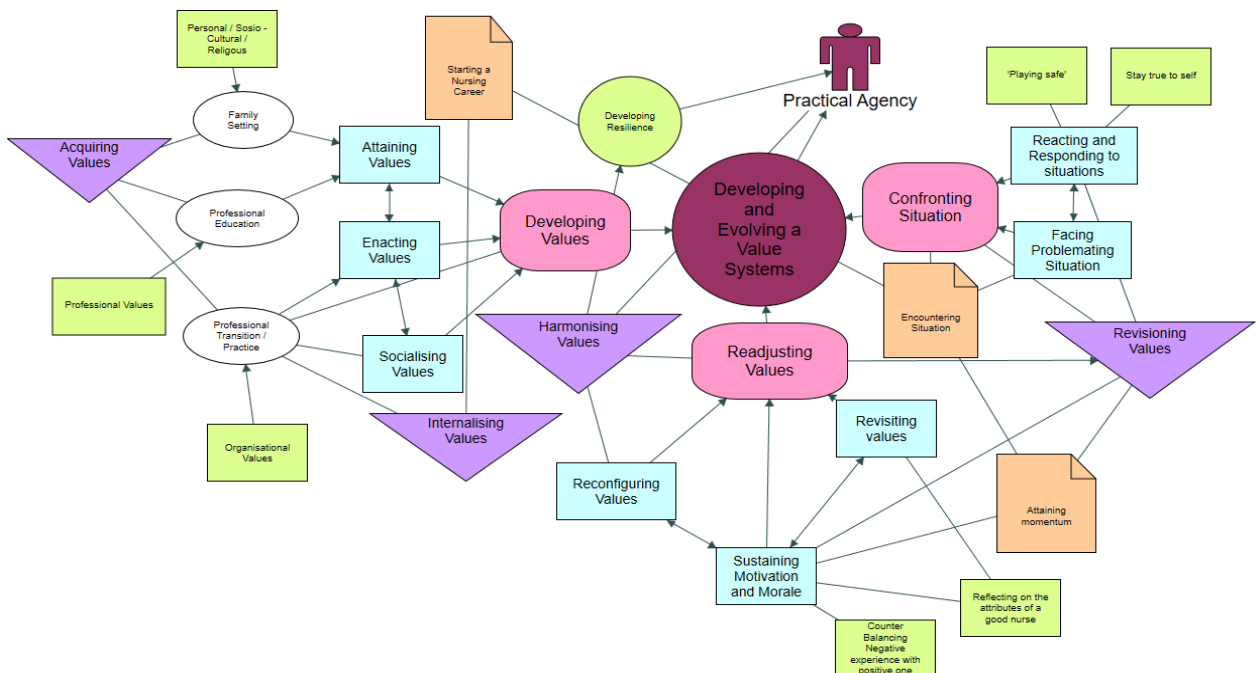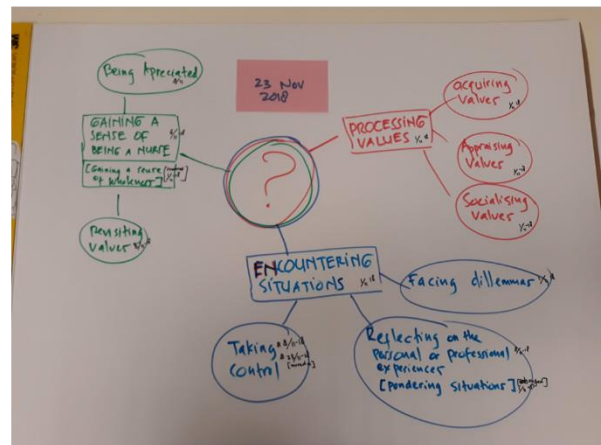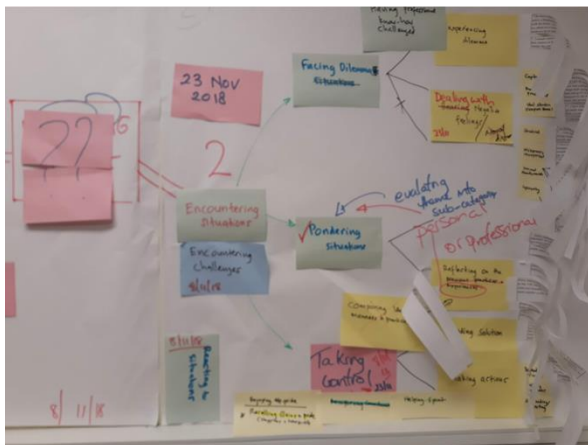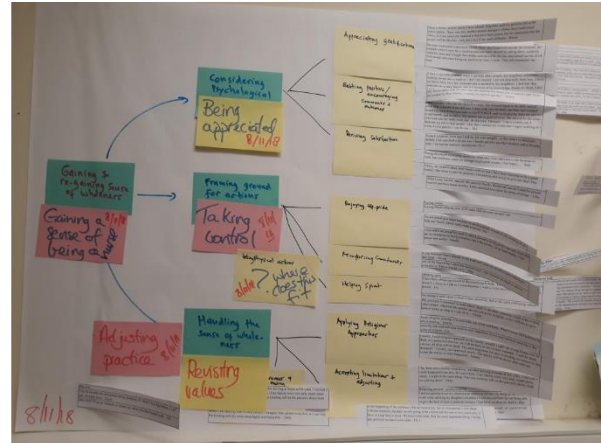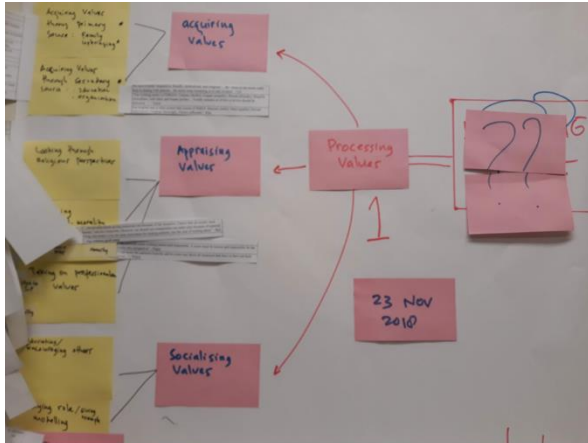
Appendix 12. Theory Development.

Appendix 13. Case Examples.

Case 1: Eka.

Eka is a civil servant nurse who works in a major hospital. She has worked in several units such as the emergency department, intensive care, and neonatal intensive care. Different from the first case, this case is about personal issues that affected Eka's practice. She shared her story:

> I was a new nurse, and I was very excited about this job…I learned a lot of things to be a professional nurse… when my mother passed away, I became unstable emotionally. So, my mood at home was carried through to work. I carried my problem to work, so I could not concentrate, and the head of the room reprimanded me "why did you perform your duty carelessly?"… I felt a little silly. I thought that I should not get down for a long time; I have to face it …I became more mature by then, and I think I would be able to separate the private problems from the hospital's... (Eka)

Based on this story, some relevant processes and values can be extracted from Eka's story, as follows.

Foundational Transition 1: There is no information for Phase 1 from the above story. However, Eka's statement about her family's roles in passing on lessons is presented in Chapter Categories, for the subcategory, 'attaining values'. That statement is a clear indication, therefore, that Eka has likely gone through Phase 1.

Cyclic transition 2: Eka's first sentence in the above story serves as a signpost of Cyclic Transition 2. Eka had a very positive attitude toward her profession in the early stages of her career. As a new nurse, she appeared to be eager to learn. She acquired new knowledge and skills that she wished to use to help her to grow as a professional nurse. This indicates that she possessed a value system which included capacity-building and professionalism. Eka's transition to phase 3 was brought on by a personal issue.

Cyclic Transition 3: Different from the first case, Eka encountered her first value-challenging situation when she was overwhelmed with heartfelt grief. Unable to confine her feelings, she carried them into her workplace, and her grief interfered with her professional life. Her personal values obviously clashed with her professional ones. Coming across a difficult situation is a signpost of cyclic transition. Therefore, it is certain that Eka is now in Cyclic Transition 3. Upon receiving criticism from her immediate supervisor, Eka gained momentum to bounce back. Her statement "…I felt a little silly. I thought that I should not get down for a long time…" indicates that she is ready to rebound. This also is an indication that she is transitioning to Cyclic Transition Four

Cyclic transition 4: As Eka gains momentum, she is now in Cyclic Transition 4. Eka's progress in this phase can be seen from her statement, "I became more mature by then…", and her elevated confidence in handling similar problems in the future. In this sense, Eka appears to have achieved resilience and has managed to adjust her value system. In this phase, Eka has successfully made an adjustment in her value configuration which preserves the integrity of her evolving value system.

Case 2: Wiwin.

Wiwin is a contract nurse working in a prominent private hospital in Indonesia. Initially, she worked in a small private hospital then moved to another small private hospital in the same city. Later, this hospital was taken over by prominent private hospital management. Now Wiwin is working under this new management. She shared her story as follows:

> "I started to feel down with my routine in this hospital (as a nurse) and considered moving to another hospital again. It happened 6 months after this hospital was handed over to [mentioning an international class private hospital name] management... (previously). We (nurses working in previous hospitals) used to work unsystematically…sometimes we came to see the patients only during the doctors' visit (as a team)…the hand-over was not done at the nurse

station without visiting the patents (so we do not know the most current condition of the patient) as it should be done… the wrong dose of medication sometimes mistakenly being given to patients, I have reported to management, but no follow up…Sometimes blood pressure was not measured…in the new place (new management), the standard of procedures was very clear … it requires nurses to do patient observation often …The hospital has its own early warning score that is determined by hemodynamic, general condition… from all aspects. When the score of a patient reaches a certain point, there is a clear algorithm for nurses…Now, as I am getting used to this hospital procedures, I am feeling sorry for who I was, how I had worked…Now, as I have been exposed to this system in which all procedures are clear… I am changed, I am different now...(from the nurse who I was)…I am feeling better.

Different from the first and the second case, this case starts from the middle of Phase 2. Obviously, Wiwin has already built her value system around the institutional values from her previous hospital. Given that she had been working for quite a while in her previous hospitals, Wiwin might have traversed the circle of the theory many times. In this story, she appears to be at the beginning of Transition 3.

Foundational Transition 1: No information available. However, it is justifiable to assume that Wiwin went through this phase during her family upbringing and professional training. This missing piece might be fulfilled by drawing upon other participants experience at this particular period of time.

Cyclic Transition 2: Wiwin enters the values development cycle from around the middle of this cyclic transition. Wiwin had attempted to internalise the institutional values of her new management. It took six months with her new employment before she felt that her inability to uphold her new organisation's expectation became problematic. With regard to her previously stable value system, Wiwin indicated that she had not prioritised professionalism as she honestly recounted many sub-standard nursing practices that were being done by her and her colleagues, collectively, in her previous employment. By contrast, under the new management, she was expected to provide a high quality of care which required her to work harder than ever. These two different management standards appear to have quite the opposite

values configuration, which made Wiwin struggle to stay abreast with the new management's value system.

Cyclic Transition 3: After six months of attempting to incorporate the new management's values, Wiwin reached a low point, to the extent that she considered leaving the hospital. This signifies that she just entered Phase 3. As the available chunks of information did not provide enough data on how she managed to resolve her internal issues, it is not possible to present further analysis for this transition. However, based on Wiwin's claim that she has been able to adjust to the situation, it is justifiable to assume that she has moved through Transition 3. She must have reflected and reconsidered the values to adjust to the new situation.

Cyclic Transition 4: A signpost for this phase can be seen prioritised from Wiwin's statement, "…I am changed, I am different now... (from the nurse who I was)… I am feeling better". This signifies that she has achieved a new configuration of values, informed by her institutional values. This means that she has successfully integrated her value systems with that of her organisation's.

In all three cases, as well as other cases that are not presented in this example, influences of contextual determinants are persisting in the background; thus, suggesting that underlying assumptions and values have been shaped and framed through contextual conditions.

Appendix 14. Theoretical Sampling in Practice.

I was exploring properties of one of my categories: confronting situations, through an interview with a respondent who was a civil servant nurse working in a government-funded hospital. During the interview, I was interested in her story about her being a 'vocal' person in her workplace. She was able to voice out her concerns in the workplace, almost in any situations. I was able to obtain much information around this particular experience that formed subcategory 'holding firm to one's values and principles'. I double-checked the background, the settings, and the context within which the participant experienced the social process under study, and tried to find the links between the context, their encounters/situations, and their reactions. For this particular participant, I was convinced that she was benefitted from her past experience as a nurse manager for five years, and her current status as the most senior/experienced nurse in the ward. At the time of data collection, she worked as a ward nurse (clinical nurse). While analysing these, I felt that there was something missing and that thing could not be obtained and generated from this participant. This interview, however, gave me ideas of what I should pursue and explore more in the next data collection to complete the category.

My emerging analysis of this interview was that the respondent reacted and responded to the situations she was facing in positive ways. This inspired me to explore 'the other side' (i.e negative responses) within a different setting. I looked back to my list of potential participants and found two potential participants who represented the opposite characteristics of the previous participant. These two participants worked for private hospitals, relatively new nurses with four to six years of nursing experience and relatively young. I was lucky that both participants agreed to participate in this study. I interviewed the first one, and I focused on exploring the alternative social process of reacting to, and dealing with, situations. The

information I obtained from this interview gave rise to two tentative subcategories, initially labelled 'experiencing powerlessness' and 'overriding gut-feelings'. These subcategories were further explored in the following interview with the second participant.

Upon the completion of these two interviews, I was still not content with the resulting category and subcategory as I felt that the data I obtained might just apply to young nurses working at private hospitals. If this were the case, the analysis of the data would be part of the contextual determinant chapter, rather than a theoretical category. My knowledge of organisational behaviour and local work culture (hierarchical working culture) told me that the feeling of powerlessness possibly linked to 'being a junior and less experienced employ' and that this feeling might change with the personal and professional development and maturation process. Also, the information I collected from these participants was possibly representing the participant's work culture and the peculiarity of their organisation, rather than a commonly shared basic social process. Clearly, there were some fundamental questions that needed answering. There was a gap that needed mitigating. To fill this gap, I felt that I need to recruit older/senior nurses working at a private hospital and young/junior nurses working at a public hospital. Interviewing participants with such characteristics would help to form more robust analysis as they provide additional meaningful insights from various perspectives and would make the resulting category and subcategories more robust and grounded in data.

Based on this notion, I, again, consult my list of potential respondents. I found a respondent who is a relatively young new nurse and working in a public hospital. Unfortunately, I did not find a senior nurse working in a private hospital on the list. I tried to find one through my private networking. With help from one of the previous respondents, I finally found the respondent who I believed could help with the category development. The subsequent interviews with these respondents were able to advance the tentative analysis; as

such, it helped in strengthening the developing category. From these interviews, I was able to

develop subcategory reacting and responding to situations, with a particular focus on the social

process of 'accepting limitation and overriding own feeling'. The interviews also confirmed

the social process of 'experiencing negative feelings', which is part of subcategory facing

problematic situations. Besides, these interviews inform the development of contextual

determinants.

The process of recruiting participants using theoretical sampling was continued until

all categories were fully developed, and all properties of the categories were properly analised.