



Conflict between nursing student's personal beliefs and professional nursing values

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Abstract

Background: Studies have established that negative perceptions of people living with HIV/AIDS exist among nursing students throughout the world, perceptions which can be detrimental to the delivery of high-quality nursing care.

Objectives: The purpose of this research was to explore socio-cultural influences on the perceptions of nursing students towards caring for people living with HIV/AIDS.

Research design: The study was guided by stigma theory, a qualitative descriptive research approach was adopted. Data collected via semi-structured interviews were thematically analysed.

Participants and research context: Participants were 21 international and Australian undergraduate nursing students enrolled in a Bachelor of Nursing programme at an Australian university.

Ethical considerations: Ethical approval was granted by the Social and Behavioural Research Ethics Committee at the study university. Participation was entirely voluntary; informed consent was obtained before the study commenced; confidentiality and anonymity were assured.

Findings: Three major themes were found: blame, othering and values. Complex and interrelated factors constructed participant perceptions of people living with HIV/AIDS, perceptions underscored by the prevailing culturally construed blame and othering associated with HIV/AIDS. The study found discordance between the negative personal beliefs and perceptions some nursing students have towards people living with HIV/AIDS, and the professional values expected of them as Registered Nurses.

Discussion: There was considerable commonality between this and previous studies on how homosexuality and illicit drug use were perceived and stigmatised, correlating with the blame directed towards people living with HIV/AIDS. These perceptions indicated some nursing students potentially risked not fulfilling the ethical and professional obligations the Registered Nurse.

Conclusion: Nursing curriculum should be strengthened in relation to comprehending the meaning of being stigmatised by society. Educational institutions need to work towards enhancing strategies that assist nursing students to reconcile any incongruity between their personal beliefs and requisite professional nursing values.

Keywords

HIV/AIDS, nursing education, nursing students, nursing values, perceptions, personal beliefs

Introduction

Nurses provide care for many vulnerable individuals, including people living with HIV/AIDS. Nursing education must prepare them to provide this care without prejudice, discrimination or ignorance. This is somewhat of a challenge in the context of a world where 'stigma, discrimination, and bad laws continue to place road-blocks for people living with HIV'.¹ When addressing the United Nations General Assembly HIV/AIDS Review in 2009, Secretary-General Ban Ki-moon² emphasised that 'The fight against AIDS also requires us to attack diseases of the human spirit – prejudice, discrimination, stigma'. Similarly, Dr Peter Poit, United Nations AIDS (UNAIDS) Task Force Executive Director, informed us that 'Misinformation about the disease and stigma against people living with AIDS still hamper prevention, care and treatment efforts everywhere'.³ Nonetheless, since the first cases of HIV and AIDS were diagnosed in Australia over 30 years ago, HIV-related stigma has presented as a barrier to the provision of unprejudiced healthcare to people living with HIV/AIDS.⁴

Stigma, and how it has been conceptualised in relation to HIV/AIDS and people living with HIV/AIDS, was an important theoretical concept informing this study. Early conceptualisations of stigma evolved through the work of a variety of stigma theorists and models of stigma. The conceptualisation of stigma applied in this study has been largely based on the work of Deacon et al.⁵ which specifically focused on HIV/AIDS stigma.

Review of literature

People living with HIV/AIDS have been singled out for avoidance and stigmatised by society in general, including by some members of the healthcare professions, perceptions which continue to persist among healthcare providers around the world.^{6–10} The stigmatisation of people living with HIV/AIDS has been heavily dependent on local prejudices and stereotyping, which are influenced by socio-cultural factors that exist in society. Healthcare providers tend to share the 'stigma and discrimination present in their communities'.¹¹

Throughout the HIV/AIDS epidemic, studies have indicated that some nurses and nursing students have negative perceptions of people living with HIV/AIDS. Such perceptions can have a negative impact on the quality of nursing care being delivered.^{12–15} Due to the continuing shortage of nurses in Australia, there has been a policy of actively recruiting nurses and nursing students from overseas countries by governments, healthcare providers and universities throughout Australia. This multicultural cohort of nurses and nursing students bring with them a diversity of socio-cultural beliefs, values and practices that enrich Australian society. They also bring their culturally construed stigmas and perceptions of people living with HIV/AIDS, perceptions that may also be diverse. Societal stigma has been found to be a factor in the stigmatising perceptions of nursing students around the world towards people living with HIV/AIDS, including in China,^{16,17} Nepal,¹⁸ Thailand¹⁹ and Turkey.^{13,20}

Background to study

Nursing regulatory authorities in Australia set various codes and standards of practice,^{21–23} these are a set of professional values to which registered nurses in Australia must aspire to and adhere. Values are a set of beliefs about 'what is right, good or desirable and motivate both social and professional behaviours'.²⁴ The concepts and traits of care, compassion and duty are part of the professional values expected of nurses. There is an expectation that nurses will not only provide care to their patients, but that this will be 'humanly sensitive care'.²⁵ Values are central to the nursing profession, tenets such as respect for others, providing high-quality care without prejudice, advocating for the disadvantaged and respecting the rights and dignity of the individual.^{24,26,27} A Code of Ethics for Nurses in Australia has

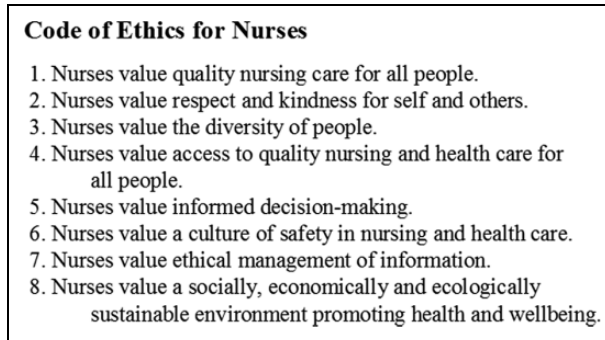


Figure 1. Code of Ethics for Nurses.²²

been developed by the Nursing and Midwifery Board of Australia (NMBA). The Code is based on fundamental principles and standards adopted by the United Nations and World Health Organization and complements the International Council of Nurses (ICN) Code of Ethics for Nurses.²² The importance of values to the nursing profession is evidenced by this Code of Ethics, which consists of eight value statements (see Figure 1).

Educational institutions providing nursing education in Australia are obliged to structure their nursing programmes towards ensuring that their students meet the requirements of the various codes and standards of practice. There is an expectation that nursing students work towards developing the requisite professional values and demonstrate their ability to practise in accordance with these values in order to become and remain registered.

This article is one of several to be published stemming from an extensive study conducted as part of a PhD candidature project. This project explored culturally construed perceptions of nursing students in relation to providing nursing care to people living with HIV/AIDS. There were a number of important and quite different aspects to this original study; hence, these aspects are published as separate papers. A previous paper²⁸ published from the study reported on how nursing students' culturally construed beliefs and perceptions influenced the stigma they associated with people living with HIV/AIDS. In contrast, the focus of this article is the apparent incongruity between the negative perceptions some nursing students have towards people living with HIV/AIDS and the professional values expected of them as Registered Nurses.

Research design

Aim and objectives of the study

The broad aim of this qualitative research study was to develop a deep understanding and appreciation of the perceptions held by nursing students from different countries towards people living with HIV/AIDS. More specifically, the study set out to achieve the following objectives:

1. Understand the cultural context of nursing students studying in Australia.
2. Develop a deep insight into the experiences and perceptions of nursing students about homosexuality, intravenous (IV) drug use and people living with HIV/AIDS, and how these views had been influenced by their socio-cultural contexts.
3. Contrast similarities and differences in perceptions within and between socio-cultural groups of students.

Method

Social constructionism and the interpretive paradigm established the philosophical foundations of this research study, with stigma theory providing the theoretical basis. The philosophical perspectives provided by social constructionism and the interpretive paradigm were congruent with the intentions of the researcher and the methods employed in the study. A qualitative descriptive methodological approach was deemed the most appropriate as it provided the best fit with the purposes of the study and the context in which the study was to be conducted.^{29,30}

The stigma that continues to surround people living with HIV/AIDS informed the researcher's decision to utilise stigma theory as the theoretical foundation to this study. This is particularly pertinent in the context of this article, which focuses on the role stigma plays in the discordance between negative perceptions held by some nursing students and the requisite professional values of Registered Nurses. Hence, the significance of this article is the utilisation of stigma theory to underpin the overall study, primarily based on the work of Deacon et al.⁵ due to their focus on HIV/AIDS-related stigma. Nevertheless, the study was influenced by the work of early theorists in the field of stigma, including Goffman,^{31,32} Jones et al.,³³ as well as Link, Phelan and colleagues with their more recent conceptualisations of stigma.^{34–36}

Participants

The sample from which study participants were drawn consisted of nursing students enrolled in an undergraduate Bachelor of Nursing programme at an Australian university. At the time of the study, approximately 35% of undergraduate nursing students at the study university were international students. To be inclusive of the cultural mix of nursing students, study participants were intentionally recruited from both local the Australian student cohort and the international student cohort.

Participant inclusion criteria were as follows: undergraduate nursing students studying internally in the School of Nursing and Midwifery at the university where the study was conducted, over 18 years of age and able to give informed consent. Students known personally by the researcher were excluded. Recruitment was via posters placed on notice boards in the School of Nursing and Midwifery, emailed invitation and information sheet to all potential participants and brief personal address by the researcher to nursing students during a scheduled lecture. The result was 25 volunteers, with 21 meeting the criteria and interviewed by the researcher. Participants encompassed nine countries of citizenship; 86% were female and 14% male, reflecting the gender ratio of the nursing student population and that of practising nurses in Australia and comparable Western countries.³⁷ The majority of participants, 19 out of 21, were in the second year of the 3-year full-time course of study required to meet the requirements of becoming a Registered Nurse in Australia (see Table 1 for further participant details).

Ethical considerations

As part of the recruitment process, all potential participants were provided with an information sheet; this sheet provided details of the study and what would be required of participants. Participation in the study was entirely voluntary and participants were free to withdraw at any time. All participants gave written informed consent before the study commenced, and their confidentiality and anonymity were assured throughout. Ethical approval was granted for the study by the Social and Behavioural Research Ethics Committee at the study university.

Data collection

Data collection was through semi-structured interviews designed to explore the perceptions and beliefs study participants had in relation to HIV/AIDS and towards people living with HIV/AIDS. To assist in

Table 1. Participant details (alphabetically by country and pseudonym).

Assigned pseudonym	Country of citizenship	Gender	Age range	Study year
Anne	Australia	F	25–34	2
Fiona	Australia	F	25–34	2
Janet	Australia	F	18–24	2
Melanie	Australia	F	25–34	1
Rachel	Australia	F	35–44	2
Sandra	Australia	F	25–34	2
Susan	Australia	F	25–34	2
Deng	China	M	25–34	2
Fan	China	F	18–24	2
Jiao	China	F	25–34	2
Ying	China	F	25–34	2
Yue	China	F	18–24	2
Alice	England	F	35–44	2
Heng	Hong Kong	M	25–34	2
Lee	Hong Kong	F	18–24	2
Mark	Iran	M	18–24	1
Mieko	Japan	F	35–44	2
Pearl	Nigeria	F	18–24	2
Kim	South Korea	F	25–34	2
Sang	South Korea	F	25–34	2
Mari	Tanzania	F	35–44	3

achieving this aim, several written scenarios were presented to participants and then discussed with the interviewer (see Figure 2 for a sample scenario). The first author's (D.P.) own experiences of nursing people living with HIV/AIDS were used to develop the scenarios which included the following: an IV drug user dying from AIDS, a person living HIV with little regard to spreading the disease through their own sexual activity and someone held in immigration detention awaiting deportation being diagnosed as being HIV positive. Utilising a hypothetical scenario during interview provided a useful approach to aid in data collection to explore sensitive topics which interviewees might otherwise be hesitant to discuss.^{38,39}

Data analysis

The recorded interview data were transcribed and pseudonyms assigned to participants to protect their anonymity. A structured data analysis strategy was employed by the researchers to thematically analyse transcribed interview data. It was not the intention of the researchers to compare the two student groups during analysis. Rather, a process of content analysis was employed to all participant interview data.^{40,41}

Each of the transcripts was initially repeatedly read to increase familiarity with the participants' responses to the questions related to the scenarios. The primary researcher then coded the data, like codes were linked to bring connected ideas and concepts together into categories. This was an iterative process involving discussion and critique among the co-authors to establish the meaning behind the responses to strengthen the credibility and dependability of the process.^{42,43} The end result of these analysis and grouping processes were the explicit and implicit themes found in the data. Seven sub-themes were identified, which then constructed the three major themes arising from the analysis (see Table 2).

Kylie

You look across the ward at Kylie, sitting there serenely, quite beautiful with long black silky hair, what age do you think, maybe 25? The two guards are a bit out of place on the ward, there are whispers among the other patients and staff about why the guards are there. Kylie is not one of your patients but you listen in as other nurses quietly spread the gossip. It's hard to believe, but according to her passport Kylie is actually male, one of those lady-boys from Thailand. She overstayed her visa and was picked up by Immigration Officers who found her working in a gay brothel. She is awaiting deportation, the guards have brought her from the detention centre as she has a chest infection. Routine testing has found she is HIV positive. The nurses mutter to themselves, "there's no point in doing much for her, she'll be back where she belongs in Thailand in a few days, anyway she's got AIDS, she's going to die anyway, why bother?"

Figure 2. Sample scenario.

Table 2. Themes and sub-themes.

Major themes	Blame	Othering	Values
Sub-themes	Responsibility Fear of catching HIV Myths and misconceptions	Homosexuality and drug use Influence of authority (power)	Disparity Professional values

Results

The focus of this article, the relationship between personal beliefs, professional values and growing awareness of professional identity emerged as a thread crossing all three major themes. Hence, each of the themes are briefly discussed using verbatim extracts from interview data to illustrate the range of perspectives across the Australian and international students.

For many nursing student study participants, people living with HIV/AIDS were blamed for the spread of the disease, labelling and stigmatising them:

To be honest . . . in my culture we think this kind of person deserves to get this kind of thing [AIDS]. (Kim – South Korea)

I want to tell you China's a traditional country, if I know you have AIDS I can't have contact with you, I think you are bad people because the main way for transmission is from the sex and the drugs. (Ying – China)

Underlying the stigma of living with HIV/AIDS were culturally construed perceptions of illicit drug use and sexual activity:

In Hong Kong HIV is associated with the sexual activities, especially homosexuality – yeah, the stigma is really high. (Heng – Hong Kong)

These sentiments were shared by Sang and Kim who expressed the view that their Korean culture had very negative perceptions of anyone who had a 'very enjoyable sex life'. An enjoyable sex life involved promiscuity or people who did not take responsibility for their sexual behaviour. Both of these students

described Korean culture as being closed minded in relation to sexual activity; this subject tended to be taboo or culturally inappropriate for public discussion.

The Australian participants made little reference to sexual activity; when discussing HIV/AIDS or people living with HIV/AIDS, drug use was much more of an issue for them:

Yeah, the junky AIDS carrier, they're going to blame that person . . . (Anne – Australia)

Janet expressed similar views; she wanted to tell the person who had contracted HIV through drug use that they were 'an idiot', although she was prepared to soften this attitude if the person now regretted their actions. Another Australian participant, Susan, was also not particularly sympathetic towards people living with HIV/AIDS if they had contracted the disease through drug use.

A number of the international participants were also quick to link HIV/AIDS with drug use and their culturally construed perceptions of drug users leading them to characterise people living with HIV/AIDS as 'bad people':

Well . . . people get infected because they do drugs, they use the same needles and this is their route for getting HIV . . . these are bad people. (Yue – China)

Ying certainly regarded people living with HIV/AIDS as bad people because they must have contracted HIV through drug use or sexually, and she wanted to have nothing to do with such people. In fact, there exists some fear of people living with HIV/AIDS and a strong desire to set them apart from the rest of society:

In my country, if you heard some people have AIDS . . . you have to tell the government, like the police. Why don't you do that here [Australia] – why don't you tell the police or have special hospitals to monitor them? (Ying – China)

Even though participant Kim had never met anyone living with HIV/AIDS, she previously described growing up in culture where drug users were perceived to be deserving of AIDS; this helped to shape her perceptions and construct the quite detailed image in her mind of someone living with HIV/AIDS:

They are very sick and they are very lonely and quite isolated from friends and family . . . people usually pretend to not discriminate but actually they do . . . I'm sure the people with HIV or AIDS are living a horrible life. (Kim – South Korea)

However, there was disquiet among some study participants about the blame they witnessed being directed at people living with HIV/AIDS:

Oh there was a lot of talk among the nurses [about a patient with HIV] . . . blaming and not being sympathetic . . . I felt like he was being judged all the time because he was gay . . . as nurses we should take care of people, not judge them. (Pearl – Nigeria)

Pearl had witnessed first-hand the indiscriminate devastation AIDS had brought to many African nations, and she showed empathy rather than blame for people living with HIV/AIDS. Mari, from Tanzania, shared Pearl's sentiments; she described attitudes blaming people living with HIV/AIDS as being terrible and they shocked her.

Mieko's perceptions of people living with HIV/AIDS were shaped as a high school student in Japan:

When I was a student at high school they portray HIV in a sexual way – the image, my image, it is a gays disease. (Mieko – Japan)

Some participants, such as Mieko, indicated a willingness to change their perceptions as they widened their knowledge and experience:

Japan is very conservative, but my perspective has changed since living in Australia . . . the gay is not some weird thing anymore . . . if I'm in Australia I have a different feeling, but if I go back to Japan – my perception goes back to my Japanese way. (Mieko – Japan)

However, other participants indicated that they had no desire to change their perspectives; their culturally construed perceptions were too ingrained:

The culture is already in my mind, I still have the same idea and discrimination as in China – if I know somebody has HIV I think I should deliberately just keep away from them. No I will not change, because he or she must have some behaviour badly – that's the problem, cause of HIV. (Ying – China)

I feel sorry for them if they got AIDS, but taking drugs is wrong . . . my culture says they are bad people, so it's their fault. (Kim – Korea)

In contrast, and at times, conflicting with these negative personal beliefs and perceptions, the participants showed that they also held many very positive values. The perceptions of many participants towards the people portrayed in the scenarios they were presented with showed compassion and understanding. This showed in their emerging professional identity.

A great deal of idealism and enthusiasm for the nursing profession was evident among the study participants. Sang showed some of her moral values and compassion when she described the ideal she was striving for as a nurse:

As a nurse, for me I have an image of Angel, like Nightingale or something like that, so I want to be like that sort of nurse – rather than one who is just working like a machine. (Sang – Korea)

Similarly, Ying showed a strong sense of professional duty towards her patients:

I'm her nurse, this is my shift . . . I have responsibility to take care of her . . . I take care of her because I am professional. (Ying – China)

However, this needs to be contrasted with her previously quoted description of people living with HIV/AIDS as 'bad people' and being adamant that her culturally construed views towards them would not be changed.

Jiao talked about the role of the nurse in providing psychological support to their patients, including to people living with HIV/AIDS, trying to make them feel better and know there are people to help them. Her compatriot, Fan, advocated for fairness and equality in healthcare for everyone:

. . . it doesn't matter, he's got his own right to get a proper treatment, no matter if he's HIV – you can't treat some with any discrimination. (Fan – China)

Lee and Ying both emphasised their sense of professional duty as nurses, to take care of their patients regardless of who they were or the illness with which they were afflicted. This was part of their developing professional nursing identity. A sense of duty and responsibility to their patients was strong among most of the Chinese participants. However, in contrast to the views of her Chinese peers, Yue's perceptions were a little different. When talking about showing care and compassion to people living with HIV/AIDS, Yue observed that duty only went so far. She indicated that nurses should be able to choose to put

their personal beliefs ahead of their professional values when it came to providing nursing care to people living with HIV/AIDS:

I think the nurse – the job of the nurse to just care for people, and it's sort of part of the job – but if the nurse don't want to do it – I think they don't need to do it. (Yue – China)

Australian nursing students echoed the compassionate and professional views of Fan and Ying, thereby illustrating their developing professional nursing identity. Fiona commented

In my opinion, it doesn't really matter – HIV as well – you want to provide the best care that you can in any situation. (Fiona – Australia)

In a similar fashion, Rachel had no hesitation to show compassion and provide comfort when presented with the scenario of a woman living with AIDS who is about to die. Alice also indicated enormous sympathy for the dying woman, she felt

Obviously compassion, yeah, she's had a horrible life, she's dying of AIDS – just have complete compassion for her, it's very, very sad. (Alice – England)

In summary, the nursing culture of compassion and social responsibility was shared across most of the students from the nations and cultures represented. In tandem with the compassion shown by almost all the participants, a sense of duty was particularly evident among the Asian nursing students.

Discussion

A 1987 report described AIDS as being 'a fatal disease that strikes at homosexuals . . . with a catastrophic vengeance . . . society has tended to blame the victim . . . made to feel that they have deserved it'.⁴⁴ In Australia, 30 years after this report, the perception of HIV/AIDS as being a self-inflicted disease contracted predominantly by homosexual men has remained prevalent, including among participants in the study reported here. Previous studies have explored the personal and professional values of nurses, finding that the main factors influencing values to be culture, professional education and personal experience.^{24,26,27,45,46} However, the role stigma has played in relation to values has not been well explored in the context of nursing students previously.

There was considerable commonality on how homosexuality was perceived and stigmatised by students of similar nations represented in this study. In general, participants demonstrated limited acceptance of homosexuality. Homosexuality was seen as deviant and their perceptions suggested stigmatisation of anyone who was homosexual. Similarly, illicit drug users who became infected with HIV/AIDS were afforded blame for their infection by many of the participants; they were characterised as being 'bad people'. The labelling of people living with HIV/AIDS as being deviant has been highlighted in previous studies.^{47–49}

According to Deacon *et al.*,⁵ stigma can be perceived as an ideology revolving around perceptions of fear and blame, relying on prejudice and social stereotypes. Homosexual activity and drug use were perceived as threats and created fear among many of the study participants. The responses of participants to the scenarios presented during interview indicated an inextricable association between HIV/AIDS, homosexuality and drug use. This correlated with the stigma and blame that continue to be directed towards people living with HIV/AIDS throughout much of the world.^{50–53}

All the study participants were in a state of transition as they were moving from the role of nursing student to that of qualified Registered Nurse. For many students, this transition challenged their

culturally construed personal values. As they were transitioning, they sought to incorporate the professional nursing values expected of them in the context of Australian society with, for some, its unfamiliar cultural norms and taboos. The interview data demonstrated that some of the student participants were aware and establishing a professional nursing identity for themselves. This required some degree of reconciliation of their personal beliefs and perceptions, with the professional nursing values expected of the Registered Nurse.^{21,22}

The interview data showed little evidence of awareness by some participants of discrepancies between their personal values and the professional values for which they were striving. HIV/AIDS was characterised by a number of the study participants as a disease associated with homosexuality and drug use, labelled as 'bad people'. These perceptions, heard throughout this study, were at odds with the expectation that nursing care be delivered without prejudicial attitudes and meet the requirements of the Code of Ethics for Nurses in Australia.²² Studies have shown that depending on the patient's illness, negative perceptions and prejudicial attitudes can be found among some nurses throughout the world.^{6,54-56} This study has supported these findings among nursing students in Australia, more specifically in relation to negative perceptions of HIV/AIDS and of people living with HIV/AIDS, thereby indicating that some nursing students may be at risk of not fulfilling their obligations under the Code of Ethics for Nurses in Australia.²²

Implications

In a similar fashion to nurses in most nations around the world, nurses in Australia practise under the auspices of a regulatory body (the Australian Health Practitioner Regulation Agency). Furthermore, nurses remain bound by a set of Standards of Practice, Code of Ethics and Code of Conduct²¹⁻²³ within that practice. Nursing students must adhere to the Codes and work towards meeting the Standards of Practice prior to becoming a Registered Nurse.

A degree of incongruity could be seen between expectations of professional practice and the personal beliefs and perceptions articulated by the nursing students in this study. For example, Value Statement 4 of the Code of Ethics for Nurses in Australia states, in part, that nurses 'seek to eliminate prejudicial attitudes concerning personal characteristics such as race, ethnicity, culture, gender, sexuality, religion, spirituality, disability, age and economic, social or health status'.²² Some incongruity was therefore noted between this aim and the blaming of people living with HIV/AIDS demonstrated by study participants.

Among the participants, the international nursing students experienced conflict between their developing professional nursing values as nursing students in Australia and their personal values in the context of their native country. This conflict in values, found to be very much a part of the construction of the students' perceptions of HIV/AIDS and of people living with HIV/AIDS, has implications that need to be addressed by the nursing profession. Some of the international nursing students indicated that their perceptions of people living with HIV/AIDS had changed after graduating with a Bachelor of Nursing degree and becoming more familiar with Australian society. However, it should also be noted that some nursing students may consciously decide to maintain their adherence to cultural norms and beliefs of their youth. For example, after living in Australia for years, Ying was adamant that her views would not change because, as she put it, the 'culture is already in my mind'. This was not only just about maintaining cultural heritage but it was also about choice and personal views on society.

The sense of culture and personal values students embodied could be in conflict with meeting the professional standards and values expected of the Registered Nurse in Australia. The nursing profession, including educational institutions and regulatory authorities, needs to recognise this potential conflict. It is also important for them to understand that providing knowledge and fostering acceptance of difference may not necessarily lead to desired perceptual change in the individual or desired outcomes in nursing practice.⁵⁷⁻⁵⁹

Strengths and limitations

The systems of university nursing education and nursing practice regulation in Australia differ considerably to that of many nations. Hence, the findings of this study should be considered in the context of the study setting and sample. The participants were selected from one Australian university cohort of nursing students. The views of this cohort may not be typical of other Australian university nursing students. However, paradoxically, the study university had a large cohort of international students that helped to strengthen the study. The international participants who volunteered came from countries well represented in the student cohort numbers.

To aid in data collection during participant interviews, a number of scenarios were presented to participants. While these were utilised to stimulate discussion, they were potentially confronting to participants and could have influenced their perceptions of people living with HIV/AIDS. However, the scenarios were based on the researcher's own experiences and were extensively evaluated for realism by an experienced HIV/AIDS nurse clinician.

There was also a risk that the scenarios could evoke stigma other than HIV/AIDS or homosexuality stigma, such as stigma towards immigrants or transgendered people. The researchers recognised this risk and minimised it during participant interviews by keeping the focus on the HIV/AIDS-related issues presented in each scenario during the interviews. Overall, steps were taken during each interview to minimise risks associated with using confronting scenarios. The risks were deemed to be outweighed by the benefit of presenting such realistic scenarios to the participants.

Conclusion

Nursing regulatory authorities in Australia set standards and codes which practising nurses in Australia are mandated to adhere. Educational institutions that provide nursing education in Australia structure their nursing programmes towards ensuring that their students understand their obligations and meet the requirements of the various codes and standards. However, evidence from this study indicated that nursing students, particularly international students, were struggling to meet some of these statutory obligations. This strongly suggests that educational institutions need to work towards enhancing strategies that assist nursing students to address these issues and ensure that all requirements under the Registered Nurse Standards of Practice are met before graduation. Assumptions and labelling can hinder the individualisation of healthcare to best meet the needs of each and every client, something all nurses, and nursing students, should be striving to achieve. Personal beliefs and perceptions do intersect with professional nursing values; the challenge is to make this a positive coming together, rather than a discordant collision.

Conflict of interest

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