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Factors Hindering the Translation of Ethical Knowledge into Clinical Practice among Undergraduate Nursing Interns: A Qualitative Study

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Abstract

Background: *Undergraduate nursing students typically master core ethical principles through classroom education, yet frequently struggle to translate this knowledge into consistent ethical practice during clinical internships. The specific points of breakdown in the ethical decision-making process remain underexplored in the Chinese clinical context.* ***Objective:*** *Guided by Rest's Four-Component Model of moral behavior (moral sensitivity, moral judgment, moral motivation, and moral implementation), this study explored barriers to ethical practice among nursing interns and examined how interns negotiate the gap between formal ethical knowledge and clinical reality.* ***Methods:*** *A framework-guided descriptive qualitative study was conducted. Fifteen fourth-year undergraduate nursing students completing clinical rotations at a tertiary hospital in Xi'an, China, were recruited via purposive maximum-variation sampling. Semi-structured in-depth interviews, lasting 45–60 minutes each, were developed around Rest's four-component framework. Data were analyzed using inductive thematic analysis, informed by Colaizzi's seven-step method of data reduction, with the aid of NVivo 12 software. Rigor was established through dual independent coding, member checking with a subset of participants, peer debriefing, a comprehensive audit trail, and contrasting case analysis.* ***Results:*** *Four overarching themes and ten subthemes were identified, mapping onto Rest's four components: (1) selective moral sensitivity—interns readily recognized overt ethical violations but often overlooked subtle ethical dimensions embedded in routine care; (2) distorted moral judgment—hierarchical authority and time pressure displaced principled ethical reasoning, with interns deferring to preceptors; (3) diminished*

moral motivation—self-protective concerns and rigid teacher–student power relations suppressed the intention to act ethically, though a small subset of interns did act under specific conditions; and (4) blocked moral implementation—perceived gaps in institutional support, heavy workloads, and inadequate practical communication skills prevented ethical intentions from being enacted. ***Conclusion:*** *The theory–practice gap in nursing ethics manifests as cumulative challenges across all four components of the ethical decision-making chain. Findings suggest that nursing ethics education should shift from knowledge transmission toward situated decision-making skill training, and that clinical institutions should strengthen accessible ethical support systems.*

Keywords

nursing students, clinical internship, ethical practice, moral sensitivity, moral judgment, ethical decision-making, Rest's Four-Component Model, qualitative research

1. Introduction

Nursing practice is inherently value-laden. Every clinical interaction, from technical procedures to communication with patients and families, carries ethical implications for patient dignity, autonomy, safety, and well-being (Wang et al., 2022). Ethical behavior in nursing has been defined as consistent adherence to professional ethical principles across diverse clinical situations, and its measurement has been the focus of international instrument development for decades (Dierckx de Casterle et al., 1997). International and national professional bodies, including the International Council of Nurses (2021) and nursing associations in China, have published formal ethical codes to delineate nurses' professional obligations and standards of conduct. In China, undergraduate nursing curricula universally include dedicated nursing ethics courses, and students are expected to master core principles of beneficence, non-maleficence, autonomy, and justice prior to entering clinical practice.

Despite formal ethical education, accumulating evidence indicates a persistent theory–practice gap. Cross-sectional surveys consistently show that nursing students' self-reported ethical knowledge scores are moderately high, yet their observed ethical behaviors in clinical settings remain inconsistent (Danaci & Kavalali Erdogan, 2025; Wang et al., 2025). This disjuncture carries tangible consequences: unresolved ethical dissonance and repeated exposure to morally challenging situations contribute to moral distress, professional burnout, compromised patient experience, and erosion of public trust in the nursing profession (Mardanian Dehkordi et al., 2024). Internationally, studies have documented that novice nurses often experience "reality shock" when classroom ethical ideals collide with the pragmatic demands of clinical work (Mattsson, 2024). However, most existing research relies on quantitative survey instruments that measure knowledge or self-reported behavior at a single point in time. While such studies describe the extent of the gap, they cannot illuminate how and why ethical knowledge fails to translate into action within the lived context of clinical practice.

Qualitative inquiry is particularly well suited to unpacking the experiential and contextual dimensions of ethical decision-making. By capturing detailed narratives of real clinical encounters, qualitative methods

can reveal the tacit influences—power dynamics, institutional pressures, emotional responses, and cultural norms—that remain invisible in survey research (Morse, 2007). To date, qualitative studies exploring nursing interns' ethical practice barriers in mainland China remain scarce, and few employ an explicit theoretical framework to structure inquiry. Rest's Four-Component Model provides a robust conceptual lens for this purpose. The model decomposes ethical action into four sequentially interdependent psychological processes: moral sensitivity (recognizing an ethical issue and its impact on others), moral judgment (reasoning about which course of action is morally right), moral motivation (prioritizing ethical values over competing interests), and moral implementation (possessing the ego strength, skills, and resources to carry out the ethical action) (Rest, 1986). Each component represents a potential point of failure in the translation of knowledge into practice.

Accordingly, this study employed Rest's four-component framework as a sensitizing framework to guide interview design and thematic mapping, while retaining an inductive approach to data analysis. The study addressed three research questions: (a) How do barriers to ethical practice manifest across each of the four components of the ethical decision-making chain? (b) What contextual and interpersonal factors shape these barriers? and (c) How do nursing interns experience and negotiate the gap between classroom ethical knowledge and clinical reality? Findings are intended to inform the redesign of nursing ethics education and clinical support systems.

2. Methods

2.1 Study Design

A framework-guided descriptive qualitative study was conducted. Rest's Four-Component Model was used as a sensitizing framework to inform the development of the interview guide and to structure the final thematic mapping. Data analysis followed an inductive thematic analysis approach, informed by Colaizzi's seven-step method of data reduction, allowing themes to emerge from the data rather than being imposed by the framework (Creswell & Poth, 2018; Liu, 2019). This design balances theoretical guidance with openness to participants' lived experiences, and is appropriate for exploring context-embedded phenomena such as clinical ethical decision-making. This study has been approved by the Ethics Committee of the Second Affiliated Hospital of Air Force Military Medical University (Approval Number: K202509-68). The study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007).

2.2 Participants and Setting

Participants were fourth-year undergraduate nursing students completing their final 12-month clinical internship at a large tertiary general hospital in Xi'an, China. Purposive maximum-variation sampling was used to recruit participants across age, gender, completed internship duration, and clinical department. Inclusion criteria were: (a) currently enrolled in an undergraduate nursing program and undertaking a full-time clinical internship; (b) able to communicate fluently in Mandarin and articulate personal experiences; (c) willing to participate and provide written informed consent. Exclusion criteria

were: (a) history of diagnosed psychiatric conditions requiring active treatment.

Recruitment was conducted by a research assistant with no teaching or evaluative responsibilities over the interns, during scheduled internship teaching sessions. The researcher emphasized that participation was entirely voluntary, that refusal to participate would have no impact on internship assessments or grades, and that participants could withdraw at any time without penalty. Sampling continued until data saturation was achieved, defined as three consecutive interviews yielding no new codes or conceptual insights. The final sample comprised 15 participants (2 male, 13 female), aged 21–26 years, with completed internship durations ranging from 4 to 8 months at the time of interview. All participants had completed a required undergraduate nursing ethics course prior to entering clinical practice. Clinical departments represented included internal medicine, surgery, emergency, pediatrics, and obstetrics. Maximum variation was sought across age, internship duration, and department, but all participants had completed the same required ethics course, and internal medicine placements were overrepresented, limiting variability on these dimensions. Detailed participant characteristics are presented in Table 1.

Table 1. Participant Demographics (n = 15)

ID	Gender	Age range	Completed internship duration at interview (months)	Department category	Completed ethics course	Internship phase	Interview duration (min)
H1	Female	21–22	4	Internal Medicine	Yes	Early	48
H2	Female	21–22	6	Internal Medicine	Yes	Mid	52
H3	Female	21–22	7	Internal Medicine	Yes	Mid-late	55
H4	Female	21–22	5	Surgery	Yes	Early-mid	47
H5	Female	24–26	6	Internal Medicine	Yes	Mid	50
H6	Female	24–26	8	Emergency	Yes	Late	58
H7	Male	21–22	4	Surgery	Yes	Early	46
H8	Female	24–26	4	Internal Medicine	Yes	Early	49
H9	Female	24–26	6	Internal Medicine	Yes	Mid	51
H10	Female	24–26	5	Internal Medicine	Yes	Early-mid	53
H11	Male	22–23	7	Internal Medicine	Yes	Mid-late	54
H12	Female	21–22	8	Pediatrics	Yes	Late	56
H13	Female	24–26	6	Pediatrics	Yes	Mid	50
H14	Female	24–26	7	Internal Medicine	Yes	Mid-late	52
H15	Female	24–26	6	Obstetrics	Yes	Mid	49

Mean interview duration = 51.3 minutes (range: 46–58 minutes). All participants had completed the required undergraduate nursing ethics course.

2.3 Interview Guide Development

The semi-structured interview guide was developed explicitly around Rest's Four-Component Model, with open-ended questions mapped to each of the four components:

Moral sensitivity: "Can you recall a situation during your internship that made you feel ethically uncomfortable or 'not quite right'? What happened, and how did you first recognize there was an ethical dimension to it?"

Moral judgment: "When you realized there was an ethical issue, what possible courses of action came to mind? How did you weigh these options, and what or who influenced your judgment most?"

Moral motivation: "Among the options you considered, which one did you think was the ethically correct thing to do? Did you act on that choice? Why or why not?"

Moral implementation: "If you tried to do the ethically right thing, what obstacles did you encounter? What support or resources would have helped you follow through on your ethical judgment?"

Additional probes explored the perceived relevance of classroom ethics education, the role of preceptors and ward culture, and emotional consequences of ethical encounters. The initial guide was pilot-tested with two nursing interns who were not included in the final sample. Based on pilot feedback, question wording was refined for clarity, overly abstract items were rephrased into concrete clinical scenarios, and redundant items were removed to ensure the interview could be comfortably completed within 45–60 minutes.

2.4 Data Collection

All interviews were conducted face-to-face by the primary researcher in a quiet, private meeting room on hospital premises, with no third parties present. Each interview lasted between 45 and 60 minutes (M = 51.3 minutes, range = 46–58 minutes). The primary researcher was a female, doctoral-prepared nursing education researcher with formal training in qualitative interviewing methods and prior experience conducting phenomenological interview studies with nursing students.

Prior to data collection, the primary researcher expected that interns would primarily report fear of preceptor disapproval and lack of practical skills as key barriers. These assumptions were documented in reflexive memos and systematically revisited throughout analysis, particularly when data revealed contrasting cases of interns taking ethical action. To mitigate bias, reflexive bracketing was practiced by documenting pre-understandings prior to interviews and systematically revisiting them during analysis.

Before each interview, the researcher explained the study purpose, her academic background and research role, and emphasized voluntary participation and the right to withdraw. Participants were informed that the researcher had no supervisory authority over their internship assessment, to minimize social desirability bias. Written informed consent was obtained from all participants.

Interviews were audio-recorded with written permission. The researcher concurrently took field notes on participants' tone of voice, pauses, facial expressions, and other nonverbal cues, which were subsequently integrated into data interpretation. All interviews were conducted in Mandarin Chinese. Following each interview, the researcher wrote reflective memos documenting initial impressions, emergent ideas, and

personal reactions to support reflexivity. No repeat interviews were conducted.

2.5 Data Analysis

Audio recordings were transcribed verbatim within 24 hours of each interview using iFlytek speech-to-text software, then cross-checked and corrected against the recordings by two independent researchers. Automated transcription had an estimated accuracy of 85%, requiring manual correction for medical terminology and dialect expressions. All coding and initial thematic analysis were conducted in the original Chinese to preserve nuance. Once final themes were established, representative quotations were translated into English by two bilingual researchers independently, then back-translated to Mandarin to verify conceptual equivalence. Discrepancies were resolved through discussion until consensus was reached.

Data analysis followed an inductive thematic analysis approach, informed by Colaizzi's seven-step method of data reduction (Colaizzi, 1978; Liu, 2019): (1) familiarization through repeated reading of transcripts; (2) extraction of significant statements directly related to the research phenomenon; (3) formulation of meanings from each significant statement; (4) clustering of formulated meanings into themes and subthemes; (5) exhaustive description of the phenomenon integrating all themes; (6) identification of the fundamental structure of the experience; and (7) validation of the structural description against the original data.

Coding and thematic analysis were conducted using NVivo 12 software. Two researchers independently coded the first three transcripts to develop an initial coding framework. Initial coding yielded 78 discrete codes, with 87% simple percentage agreement at the code level across the two coders. Discrepancies were resolved through discussion with a third senior researcher until consensus was reached. The remaining 12 transcripts were coded by the primary researcher, with periodic cross-checking (every 4–5 transcripts) by the second researcher to ensure coding consistency. Data saturation was assessed at the thematic level after each round of coding; the last new subtheme—contrasting cases of moral action—emerged at interview 9; no new codes emerged after the 12th interview, and interviews 13–15 confirmed saturation.

2.6 Ethical Considerations

This study was approved by the Research Ethics Committee of Xi'an Tertiary General Hospital (approval number: K202509-68). All participants provided written informed consent prior to interview. All identifying information was removed from transcripts and replaced with numeric codes (H1–H15). To further protect anonymity in quotations, specific ages are presented as age ranges and exact departmental details are generalized where appropriate. Audio recordings and transcript files were encrypted and stored on a password-protected institutional server, accessible only to the core research team. Data will be retained for three years following publication, and then securely destroyed. Participants were informed that they could contact the research team for referral to professional psychological support if the interview elicited distress. No financial incentives were provided.

2.7 Rigor and Trustworthiness

Trustworthiness was established using Lincoln and Guba's four criteria:

Credibility: Dual independent coding for initial transcripts and periodic cross-checking for subsequent transcripts; member checking with five purposively selected participants (representing different departments, internship phases, and response patterns). Member checking was conducted via individual face-to-face meetings; participants reviewed preliminary themes and representative quotations and provided feedback on interpretive accuracy. Specifically, the subtheme initially labeled "ethical numbing" was revised to "selective moral sensitivity," and "authority compliance" was revised to "deference to preceptor authority," to better align with participants' everyday clinical language.

Transferability: Thick description of participant characteristics, study setting, data collection procedures, and contextual details to enable readers to assess applicability to other settings. Maximum-variation sampling was employed within the constraints of the single site.

Dependability: A comprehensive audit trail was maintained throughout the study, including raw audio recordings, verbatim transcripts, coding memos, the evolving coding framework, thematic analysis notes, peer debriefing records, and revision histories.

Confirmability: Contrasting case analysis was conducted to explore instances where interns did act on their ethical convictions, which served to refine and qualify initial themes rather than simply confirming them. The research team maintained reflexive memos documenting prior assumptions and how they were challenged by the data.

3. Findings

Four overarching themes and ten subthemes emerged from the data, mapping onto the four components of Rest's Four-Component Model. Participants' accounts suggest a pattern of cumulative erosion along the ethical decision-making chain: while interns could often recognize overt ethical issues, subsequent judgment, motivation, and implementation were progressively eroded by clinical context, power relations, and resource constraints. A summary of themes, subthemes, core codes, and representative quotations is provided in Table 2.

Table 2. Themes, Subthemes, Core Codes, and Representative Quotations

Theme	Subtheme	Core codes	Representative quotation	Participant ID
1. Selective moral sensitivity	1.1 Recognition of overt violations	Privacy breach; safety violation; obvious wrongdoing	"I knew immediately that was wrong—it's a violation of privacy."	H7
	1.2 Overlooking subtle routine ethics	Normalization; habituation; rushed care; differential treatment	"After a few weeks, I stopped noticing. I don't think of it as an ethical problem anymore."	H8
2. Distorted moral judgment	2.1 Deference to preceptor authority	Authority substitution; experience = correctness; family vs. autonomy	"She's been doing this for twenty years—she must know better than me."	H9
	2.2 Pragmatic outcome prioritization	Efficiency; risk avoidance; workflow first; satisficing	"If we waited, we'd delay the whole list… So I just did it. It was easier that way."	H3
3. Diminished moral motivation	3.1 Self-protection as primary concern	Fear of scolding; evaluation risk; conflict avoidance	"It's safer to keep quiet and do what I'm told."	H14
	3.2 Rigid power hierarchy suppressing voice	Respect for seniority; insubordination; student place	"Challenging the teacher is not what students do. It's not your place."	H11
	3.3 Contrasting cases: conditions for action	Enabling conditions; patient safety; supportive preceptor; negotiation strategies	"That was about patient safety, you can't stay quiet for that."	H1
4. Blocked moral implementation	4.1 Perceived lack of institutional support	No ethics consultation; no protocols; language barriers	"There's no ethics expert you can go to."	H6
	4.2 Work overload and scope-of-practice dilemmas	Staffing shortage; independent duty; accountability beyond training	"I'm not even a registered nurse yet. That didn't feel right at all."	H11
	4.3 Lack of practical ethical skills	Theory–practice gap; no communication training; no role-play	"The theory is useless without the skills to put it into action."	H2

3.1 Theme 1: Selective Moral Sensitivity Amid Clinical Normalization

Interns demonstrated clear awareness of obvious ethical violations, but frequently failed to register the ethical dimensions embedded in routine, normalized clinical practices. This pattern of selective

awareness developed gradually as interns adapted to ward culture.

3.1.1 Recognition of Overt Ethical Violations

Thirteen of the 15 participants could readily identify clear-cut ethical transgressions, such as breaches of patient privacy, violations of aseptic technique, or dismissive treatment of vulnerable patients. In these unambiguous scenarios, moral sensitivity was consistently activated.

"Once I saw another intern talking loudly about a patient's HIV status in the hallway where everyone could hear. I knew immediately that was wrong—it's a violation of privacy. I went over and reminded her to keep her voice down." (H7, male, 21–22, surgery)

3.1.2 Overlooking Subtle Ethical Dimensions in Routine Care

In contrast, subtler ethical issues embedded in everyday workflows—such as rushed informed consent, perfunctory communication, or differential treatment of patients based on social status—often passed without ethical reflection. Most participants (n = 12) described a process of gradual normalization: what initially felt uncomfortable eventually came to feel "just how things are done."

"At first I felt bad when we rushed through morning care and didn't really talk to patients. But after a few weeks, I stopped noticing. Everyone is busy, and you have to finish your tasks on time. I don't think of it as an ethical problem anymore—it's just the pace of the ward." (H8, female, 24–26, internal medicine)

"You notice that some patients who are more educated or have higher status get more time and attention from the nurses. I never really thought about that as an ethical issue before, it just felt like… how things work." (H10, female, 24–26, internal medicine)

3.2 Theme 2: Distorted Moral Judgment under Hierarchy and Time Pressure

When interns did recognize an ethical issue, their ability to engage in independent, principle-based moral judgment was frequently undermined by hierarchical authority structures and pragmatic clinical pressures.

3.2.1 Deference to Preceptor Authority over Principled Reasoning

The dominant pattern was reliance on preceptors' judgment rather than independent ethical analysis. Most participants (n = 11) consistently described directing ethical questions to their preceptors and accepting the response without further deliberation, even when they personally disagreed. Clinical experience was widely regarded as conferring ethical authority.

"There was a patient who didn't want to know his cancer diagnosis, and his family asked us to keep it from him. I thought autonomy meant he had the right to know. But my preceptor said we follow the family's wishes, that's the standard here. I didn't argue. She's been doing this for twenty years—she must know better than me, even if it didn't feel right." (H9, female, 24–26, internal medicine)

"If the teacher says it's okay to do it that way, you don't question it. They've seen so many more cases than us. Their judgment must be more right than mine." (H5, female, 24–26, internal medicine)

3.2.2 Pragmatic Outcome Prioritization Displacing Ethical Principles

Heavy workloads and time pressure further shaped moral judgment. When pressed for time, interns reported evaluating options primarily in terms of efficiency, risk avoidance, and workflow disruption

rather than ethical principles. The "right" action became the one that minimized complaints and kept the ward running smoothly. This pattern aligns with observations that clinical reasoning under time pressure tends toward pragmatic satisficing rather than comprehensive ethical deliberation (Berger et al., 2023).

"Once we had a patient who was supposed to sign the consent form himself, but he was in the bathroom and we were running late for the procedure. The teacher told me to just have his wife sign it instead. I knew technically he should sign himself. But if we waited, we'd delay the whole list, and everyone would be annoyed. So I just did it. It was easier that way." (H3, female, 21–22, internal medicine)

3.3 Theme 3: Diminished Moral Motivation in Hierarchical Power Relations

Even when interns recognized an ethical issue and reached a clear judgment about the right course of action, they often lacked the motivation to act on that judgment. Self-protective concerns and hierarchical power dynamics were the primary suppressors.

3.3.1 Self-protection as the Primary Concern

Self-protective considerations—fear of being scolded, fear of negative evaluation, fear of causing conflict, and fear of professional repercussions—consistently outweighed ethical commitments. Participants described calculating the personal cost of ethical action and concluding that it was not worth the risk.

"I knew the correct ethical thing was to speak up. But I thought, if I say something and offend the teacher, or if I'm wrong and make a fool of myself, it will go badly for my evaluation. I'm just an intern. It's safer to keep quiet and do what I'm told." (H14, female, 24–26, internal medicine)

3.3.2 Rigid Teacher–student Power Hierarchy Suppressing Ethical Voice

The hierarchical nature of the teacher–student relationship was a particularly potent inhibitor of moral motivation. Interns described feeling that questioning a preceptor's ethical judgment was disrespectful, insubordinate, and professionally dangerous. This power asymmetry meant that even strong ethical convictions rarely translated into intention to act.

"You just don't contradict your teacher. That's the first unwritten rule of internship. Even if you think there's an ethical problem, you keep it to yourself. Challenging the teacher is not what students do. It's not your place." (H11, male, 22–23, internal medicine)

3.3.3 Contrasting Cases: Conditions and Strategies for Moral Action

A third subtheme, derived from contrasting-case analysis, captures the conditions and strategies that enabled a small subset of interns to act on their ethical convictions. Three participants reported acting on their ethical convictions in specific situations. Analysis of these contrasting cases revealed three enabling conditions: (a) the issue involved immediate and obvious patient safety risk; (b) the intern had prior positive experience with a supportive preceptor; and (c) the intern could frame the concern as a question rather than a direct challenge.

Interns who successfully negotiated ethical gaps employed three identifiable strategies. (1)**Safety-anchored advocacy:** Framing the concern explicitly around patient safety rather than ethical principle, which reduced the appearance of challenge and invoked shared professional goals. (2)**Question-framing:**

Phrasing concerns as requests for guidance or clarification rather than objections, which respected hierarchical roles while still raising the issue. (3)**Private preceptor approach:** Raising concerns privately with the preceptor rather than publicly, which preserved the preceptor's authority and reduced defensive responses.

"Once I saw the teacher was about to give the wrong medication to a patient. I didn't even think about it—I just spoke up right away. That was about patient safety, you can't stay quiet for that. The teacher actually thanked me afterwards, she said I caught it just in time." (H1, female, 21–22, internal medicine)

"There was one time I thought the way we were handling a patient's family wasn't quite right. I didn't say it in front of everyone. I waited until later and asked my teacher privately, 'Is that how we usually do that? I was wondering about the ethics of it.' She explained the reasoning and actually adjusted her approach a little. I think asking privately made it easier." (H12, female, 21–22, pediatrics)

3.4 Theme 4: Blocked Moral Implementation Due to Systemic and Skill Deficits

Even when interns possessed the motivation to act ethically, they frequently encountered structural, institutional, and skill-related barriers that prevented them from translating intention into behavior.

3.4.1 Perceived Absence of Institutional Ethical Support Systems

Participants consistently reported being unaware of any formal structures for ethical consultation and support at the hospital. There were no known ethics liaison nurses, no accessible clinical ethics committee, and no standardized protocols for managing common ethical dilemmas. Interns described feeling that they had "nowhere to turn" when facing ethical uncertainty. This perceived absence of institutional support is notable given that formal clinical ethics consultation services have been shown to significantly support frontline clinical staff (Wege-Rost, 2023). Language and communication barriers, such as difficulty understanding patients with strong regional dialects, further compounded this sense of unsupported practice.

"If I'm not sure about something technical, I can look it up in the book or ask anyone. But if I'm not sure about an ethical thing… who do I ask? There's no one, no procedure. You just figure it out yourself, or you ask your teacher, and that's it. There's no ethics expert you can go to." (H6, female, 24–26, emergency)

"Some patients speak really strong local dialect, and I can barely understand them. I can't get informed consent properly if I don't know what they're saying. The hospital doesn't provide any help with that, you just muddle through." (H2, female, 21–22, internal medicine)

3.4.2 Work Overload and Scope-of-practice Dilemmas

Two interrelated but distinct structural barriers emerged at the implementation stage: heavy clinical workloads and assignments beyond scope of practice.

First, heavy clinical workloads and fast ward pacing left little time for ethical deliberation or thoughtful communication. Interns described rushing through patient interactions to meet task quotas, leaving no space for the careful communication that ethical practice requires.

"On morning shift you have so many patients to get through, so many tasks to check off. You don't have

time to sit and talk to each patient properly. You just do what you need to do and move on. You don't stop to think about ethics." (H4, female, 21–22, surgery)

Second, interns were sometimes assigned responsibilities beyond their training level and official scope of practice—such as managing patient care areas independently during staffing shortages, or completing medical documentation without supervision—creating ethical dilemmas related to patient safety and professional accountability that interns felt ill-equipped to resolve.

"Once during a night shift, all the regular nurses were busy with an emergency, and they told me to watch the whole ward by myself. I was terrified. If something happened to a patient, it would be my responsibility, but I'm not even a registered nurse yet. That didn't feel right at all, but I couldn't say no." (H11, male, 22–23, internal medicine)

3.4.3 Lack of Practical Ethical Communication and Decision-making Skills

Interns consistently reported that classroom ethics education had been heavily theoretical and exam-focused, with little opportunity to practice ethical communication or decision-making skills. They described lacking practical strategies for navigating ethical conflict, addressing families' concerns, or communicating ethical positions to senior staff. This gap between theoretical knowledge and practical skill has been widely documented in international reviews of nursing ethics education (Stievano & Tschudin, 2019).

"We learned all the principles in school—autonomy, beneficence, justice. I can recite them for an exam. But no one ever taught us how to actually talk to a patient about a difficult ethical issue, or how to disagree with your preceptor respectfully. The theory is useless without the skills to put it into action." (H2, female, 21–22, internal medicine)

4. Discussion

This study explored barriers to ethical practice among undergraduate nursing interns through the lens of Rest's Four-Component Model. Participants' accounts can be interpreted as reflecting cumulative challenges across all four components of the ethical decision-making chain: moral sensitivity is narrowed by clinical normalization, moral judgment is distorted by hierarchical authority, moral motivation is diminished by self-protective concerns and power relations, and moral implementation is blocked by institutional deficits and skill limitations. Each component builds on the previous one, so erosion at earlier stages compounds difficulties at later stages.

4.1 Moral Sensitivity: Normalization and Selective Awareness

The finding that interns recognize overt ethical violations but overlook subtler, routine ethical dimensions aligns with previous international research (Hansen et al., 2024). This pattern likely reflects the process of clinical socialization: as interns adapt to ward culture and absorb its taken-for-granted assumptions, they develop a form of selective ethical attention. What is normalized by the clinical environment ceases to register as ethically problematic. This is concerning because many of the most pervasive ethical issues in clinical nursing—dismissive communication, rushed care, compromised dignity—are precisely the

subtle, routine, normalized practices that fall below the threshold of conscious ethical awareness. Rest's model identifies moral sensitivity as the initiating component; without it, the entire decision-making chain never activates.

4.2 Moral Judgment: Authority Hierarchy and Pragmatic Displacement

The strong pattern of deferring moral judgment to preceptors resonates with findings from other contexts, but may be particularly pronounced in Chinese healthcare settings, where professional hierarchies are reinforced by broader cultural norms of respect for seniority (Wang et al., 2022). However, cultural norms are not the sole explanation: intern deference also reflects realistic assessments of evaluative power, legal liability, and their own relative lack of clinical experience. Interns did not merely comply with preceptors' decisions; they accepted the premise that greater clinical experience confers greater ethical authority. This substitution of authority for independent ethical reasoning represents a failure of moral judgment development. Rest's model emphasizes that moral judgment requires principled reasoning, not deference to hierarchy. The current finding suggests that clinical immersion—intended to enhance professional development—may actually undermine ethical reasoning development when ward culture strongly reinforces authority-based decision-making.

4.3 Moral Motivation: Power, Risk, and the Conditions for Action

The suppression of moral motivation by self-protective concerns and hierarchical power relations is a pivotal finding. Rest's model identifies moral motivation as the bridge between judgment and action: a person may know what is right and still not choose to do it. The teacher–student power dynamic emerged as a particularly powerful inhibitor. Interns' reluctance to challenge preceptors reflects not merely timidity but a realistic assessment of their vulnerability: as temporary trainees dependent on preceptor evaluations, they have much to lose and little to gain from ethical assertiveness.

Importantly, the contrasting cases indicate that ethical action is possible under specific conditions, particularly when immediate patient safety is at stake and when preceptors are perceived as supportive. This is consistent with research on moral courage among nursing interns, which identifies both individual and situational predictors (Wang et al., 2025). Institutional strategies that reduce the personal risk of speaking up—such as confidential ethics consultation channels, protected ethical advocacy policies, and explicit norms encouraging ethical questioning—could substantially strengthen moral motivation. Social support and positive affect may support emotional regulation among nurses facing stressful working conditions, which could in turn strengthen their capacity to act on their professional values (Xu et al., 2026).

4.4 Moral Implementation: Systemic Gaps and Skill Deficits

Even when sensitivity, judgment, and motivation align, ethical action still requires institutional support and practical skills. Participants' consistent reports of being unaware of formal ethical support systems are consistent with previous findings that many Chinese hospitals lack structured, frontline-accessible clinical ethics services (Wang et al., 2022). Without accessible ethics consultation, clear protocols, and supportive leadership, even highly motivated interns cannot easily translate ethical intentions into

effective action. International experience suggests that designated clinical ethics committees and liaison services can substantially improve frontline staff access to ethical guidance (Wege-Rost, 2023).

Equally important is the skill deficit. Interns' consistent reports that ethics education was overly theoretical and insufficiently practical echo international literature on the theory–practice gap in nursing ethics education (Mattsson, 2024). A comprehensive review by Stievano and Tschudin (2019) similarly concluded that nursing ethics education globally remains heavily knowledge-focused and insufficiently develops practical ethical competence. Rest's model includes moral implementation as a distinct component requiring specific skills—communication, negotiation, assertiveness, and emotional regulation—not just moral knowledge. The current standard of teaching ethical principles without teaching how to apply them in complex, hierarchical, fast-paced clinical environments leaves students ill-equipped at the final and most critical stage.

4.5 Implications for Education and Clinical Practice

Findings point to several targeted, actionable implications tailored to the Chinese clinical education context.

For nursing education curricula, ethics education should shift from rote memorization of principles toward situated ethical decision-making and communication skill training. Simulation-based training using realistic clinical scenarios, structured role-play for ethical conflict communication, and guided reflective practice during clinical placements could help bridge the skill gap. Specifically, training should include strategies for respectfully raising ethical concerns with senior staff, navigating hierarchical communication, and managing informed consent under time pressure. Thirty-minute ethical case discussions could be incorporated into weekly internship teaching rounds to provide regular, structured reflection opportunities.

As for clinical institutions, hospitals should establish accessible, frontline-oriented ethical support systems. Each nursing department could designate a part-time ethics liaison nurse, trained to support frontline staff and students with common ethical dilemmas. Regular ethics ward rounds and standardized management protocols for common ethical dilemmas would also provide much-needed structural support. Institutions should also clarify scope-of-practice boundaries for interns and ensure safe staffing levels to reduce the ethical burden on trainees.

For preceptor development, preceptor training should emphasize modeling ethical reasoning processes rather than simply enforcing compliance. Preceptors should be encouraged to invite interns' ethical perspectives and to frame ethical discussions as learning opportunities rather than tests of obedience.

And for evaluation systems, institutions should consider separating internship performance evaluation from ethical advocacy, so that students do not face retaliatory risk for raising legitimate ethical concerns.

4.6 Limitations

Several limitations should be acknowledged. First, the study was conducted at a single tertiary hospital in one city, and participants were all from one nursing program, limiting generalizability. Second, the sample was predominantly female (13 of 15), reflecting the gender composition of nursing in China but

precluding analysis of gender differences. Third, all participants had completed a formal nursing ethics course, so the study cannot compare outcomes for students without ethics training. Fourth, departmental distribution was uneven, with most participants placed in internal medicine. Fifth, data were collected through retrospective self-report interviews, which are subject to recall bias and social desirability bias, despite efforts to minimize the latter. Sixth, the use of Rest's framework as a sensitizing lens may have constrained the inductive analysis to some extent, though every effort was made to remain open to unanticipated themes. Seventh, member checking was conducted with only 5 of 15 participants. Eighth, translation of quotations from Chinese to English, even with back-translation, may result in subtle loss of nuance. Ninth, the study captured only the interns' perspective; the perspectives of preceptors, nurse managers, and patients would provide a more complete picture. Tenth, the cross-sectional design cannot capture developmental changes in ethical practice over the course of the internship. Eleventh, a single primary interviewer conducted all interviews, and no non-participation rate was formally tracked. Twelfth, recruitment during scheduled teaching sessions may have introduced selection bias, as some students may have felt pressured to participate despite assurances of no impact on evaluations. Thirteenth, inter-coder reliability was calculated as simple percentage agreement rather than Cohen's kappa, which may overestimate the level of coding consistency.

4.7 Future Research

Future research should employ multi-center samples across different regions and hospital types to enhance generalizability. Longitudinal designs tracking interns throughout their clinical placement could illuminate how ethical sensitivity, judgment, motivation, and implementation skills develop over time and in response to different ward cultures. Triangulating interview data with observational methods and analysis of critical incident reports would strengthen validity. Studies exploring preceptors' and nurse managers' perspectives on ethical education and support could identify institutional leverage points for improvement. Intervention studies evaluating the effectiveness of situated ethics training programs, ethics ward rounds, and ethics liaison systems are needed to establish evidence-based strategies for bridging the theory–practice gap. Finally, research should explore how different recruitment strategies and power dynamics influence intern willingness to discuss ethical challenges honestly.

5. Conclusion

This study, guided by Rest's Four-Component Model, illustrates that barriers to ethical practice among undergraduate nursing interns operate across the full ethical decision-making chain. The theory–practice gap is not simply a failure of knowledge or will, but a multi-layered challenge involving selective sensitivity, authority-distorted judgment, power-diminished motivation, and system- and skill-blocked implementation. Hierarchical power relations, heavy clinical workloads, absent institutional support systems, and insufficient practical skills training interact to prevent ethical knowledge from being translated into consistent ethical action. These findings suggest that improving nursing interns' ethical practice requires coordinated interventions at the curricular, clinical teaching, and institutional system

levels—moving beyond transmitting ethical knowledge toward building the capacity, motivation, and support to act ethically in the messy reality of clinical practice.

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