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NURSE EDUCATORS' DESCRIPTION OF ETHICS FROM A DISCIPLINARY PERSPECTIVE: A QUALITATIVE DESCRIPTIVE RESEARCH STUDY

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Nurse Educators' Description of Ethics from a Disciplinary Perspective:

A Qualitative Descriptive Research Study

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Abstract

Purpose/Specific Aims: A qualitative descriptive research design was employed to gain insights in how nurse educators describe nursing ethics from a disciplinary perspective and how they teach nursing ethics in a pre-licensure nursing program. The study aimed to identify how nurse educators describe ethical knowledge needed for nursing practice and how nursing ethics is viewed in relation to bio, medical and healthcare ethics.

Rationale/Significance of Study: Recent works in nursing ethics has provided some clarity about what is needed to develop nurses who are confident in using ethical decision-making in every-day practice. Nurse educators are responsible for the development of novice nurses who can effectively practice from a disciplinary perspective rooted in nursing ethics. To date, there is scant research exploring nurse educators' understanding of what constitutes disciplinary specific ethics and impact on daily nursing practice. This study is a necessary first step to identify how nurse educators understand the ethical warrants of their profession and the ways in which this is, or is not, transmitted to nursing students.

Sample and Recruitment: Nurse educators teaching in baccalaureate nurse programs in the US were purposely recruited through the Nurse Educators Group in Facebook, with subsequent snowball sampling. The final sample consisted of 16 nurse educators who met inclusion criteria and agreed to participate in the study.

Data Analysis: Data was collected using open-ended interview questions and analyzed using conventional content analysis. Data was clustered into "meaning units" from which codes and categories were derived. Codes and categories were further reexamined several times to determine if the analysis accurately portrayed the data. The codes were then developed into themes that expressed the manifestation of the content.

Findings: Four major themes were identified during data analysis. They include: *Inherent personal qualities guide nurses' sense of professional ethics, The ethical nurse is a 'good' nurse as reflected in their practice, Disciplinary nursing ethics is not discernable from other ethics,* and *Nursing ethics education is inconsistent across schools of nursing.*

Conclusions: Findings reveal there is no common viewpoint and a lack of conceptual disciplinary language of what constitutes nursing ethics among nurse educators. The research presented here suggests there is a gap in theory and practice with respect to nursing ethics in daily practice, with implications in policy, further research and nursing education.

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> "Success is not measured by what you accomplish, but by the opposition you have encountered, and the courage with which you have maintained the struggle against overwhelming odds." (Orison Swett Marden, 1848-1924)

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Introduction

Nursing exists to provide a good in terms of the unmet health needs of individuals and groups within society (American Nurses Association, 2015). However, whether most nurses possess the skills to intentionally focus on providing this good or not is disputable. Disciplinary knowledge, skills and actions aligned with nursing values are demonstrated when the nurse approaches the care of the individual or society with an awareness and aptitude to express the focus and scope of their responsibilities to the patient/society. What is described in the *Code of Ethics for Nurses* (American Nurses' Association, 2015), as "good practice" is analogous to ethical practice as described by Grace (2018).

Despite the importance and necessity of a professional code of ethics for elucidating nursing goals and how they should be met – that is, as a guide for good nursing practice and for helping nurses to overcome obstacles to good nursing practice, there remains a lack of understanding of professional nursing-specific ethics within the discipline. Some commentators have suggested there is a lack of understanding of the nature of nursing as a fundamentally ethical endeavor and nursing ethics as a distinct field of inquiry for nursing practice (Grace, 2018; Saxen, 2018). There remains a poor understanding of disciplinary specific focused ethics and this results in a lack of nursing ethics being taught; the consequences of which are that nurses in practice may lack the appropriate nursing focused ethical knowledge to guide their practice. (Bicking, 2011; Ion, 2018; Wocial, 2012).

Statement of the Problem

Within professional practice, nurses face numerous and various difficult situations that call for astute ethical awareness guided by nursing knowledge. Additionally, nurses need the

language to describe these situations and their nuances, and the skills to address them. Nurses need to understand the nursing specific ethical aspects of their actions regardless of the perceived challenges a situation may present. This is especially important in contemporary environments of health care practice, where a variety of other providers' viewpoints may serve to override nurses' unique disciplinary perspective to the detriment of patient care. Given nurses' social contract with the public they serve to provide certain services, it is imperative their voices and perspectives be heard and noted in interdisciplinary discourse about the care environment. (American Nurses Association [ANA] Social Policy Statement, 2015).

When nurses are able to practice from disciplinary and ethical standards, guided by nursing goals and perspectives to facilitate decision making, they can choose and implement appropriate interventions for patients' response to illness and facilitate meeting their healthcare needs. In doing so, nurses are practicing to the fullest capacity for that which they have been prepared. However, there is mounting evidence to suggest that nurses feel unprepared for the "real-life" clinical environments they encounter when they enter practice (Jurchak, et al, 2017; Storake, et al, 2017). Milliken (2017) found that many nurses do not recognize that nursing ethics underlies everyday activities related to nursing care. All care interactions with patients, families and communities have ethical dimensions. The nurse is either intentionally focused on meeting nursing goals of patient good or is not. For example, the nurse may be focused on completing a task expediently and skillfully without noting the patient's emotional reaction to the intervention. Other researchers have found that when nurses are prevented from implementing nursing actions which they believe to be most beneficial to the patient, they may begin to experience moral distress (Grace, et al, 2014; Sasso, et al, 2016). Jameton (1984) is often noted as the philosopher who introduced the concept of moral distress into nursing practice

(DeVeer, et al, 2013). Moral distress may be described as the uncomfortable psychological disequilibrium that results when a nurse recognizes an ethically appropriate action to take but are unable to take or complete the action (DeVeer, et al, 2013). Many nurses report moral distress resulting from the inability to act when institutional constraints, such as lack of time or resources, or lack of support from the hierarchal institutional structure prevent them from making decisions to act in ways they believe are in the best interest of their patient (DeVeer, et al, 2013; Waddill-Goad, 2019).

Contemporary health care settings are replete with obstacles to good nursing practice, such as the prevailing biomedical view focused on cure and symptom management, rather than nurses' focus on partnership, awareness, choice, caring and healing (Smith, 2019). When nurses lack disciplinary specific ethical knowledge, they may experience pervasive negative sequelae from unmet professional goals, manifested as stress and burnout. In turn, this may lead to nurses leaving the profession or distancing themselves from patients, leading to poor patient-health outcomes. Such constraints prevent nurses' ability to perform necessary actions to care in a way that is congruent with their own disciplinary perspective. Barriers to exercising moral agency, when encountered often and over time have resulted in compassion fatigue, burnout, and moral distress (DeVeer, 2011; Halm, 2019; Milliken & Grace, 2017; Waddill-Goad, 2019). Remedies proposed to mitigate these issues are often grounded in stress reduction and self-care strategies for nurses. While these strategies may be important, they fail to address the underlying problem of nurses being challenged to practice from their disciplinary perspective and the distress it causes.

Ethical nursing practice foundationally relies on an understanding of nursing's historical development, scholarly inquiry into the goals of nursing, and the knowledge and skills to meet

professional goals and responsibilities in ethical problem-solving and patient care (Grace, 2018). As those responsible for the basic and the continuing education needs of practicing nurses, nurse educators have a critically important role in fostering the development of ethically aware nurses. Additionally, they themselves must be knowledgeable about nursing ethics and possess the skills needed if they are to develop the ethical confidence from the pre-licensure level through the terminal degrees in nursing. However, nurse educators often lack this preparation themselves and therefore, nursing education and particularly ethics is often not fully grounded in nursing disciplinary knowledge (Laabs, 2015; Skela-Savic & Kiger, 2015).

The purpose of basic, pre-licensure nursing education preparation is entry into the nursing profession (American Association of Colleges of Nursing, 2020). Nurse educators are often the first professional contact a nursing student will have to influence professional development and knowledge acquisition by the novice nurse. Nursing education at the pre-licensure level, often a new student's first exposure of nursing's disciplinary perspectives, professional goals, responsibilities, knowledge, skills and judgment that is required of nurses on a daily basis. Nurse educators are the gatekeepers of the profession and provide the foundation upon which the emerging generation of nurses will practice, in turn becoming the future representation of the profession. As such, nurse educators are responsible for teaching the essential content needed to develop novice nurses who can effectively practice from the professional and disciplinary perspective; which is a practice rooted in nursing ethics. It is therefore equally important that nurse educators themselves are grounded in nursing knowledge, and able to recognize nursing ethical issues that can be articulated along with the implications of good nursing practice.

Across pre-licensure curricula there is inconsistency both in how nursing ethics is taught and by whom it is taught (Hoskins, et al, 2018). Accrediting bodies fail to provide strong criteria to guide nursing schools around the teaching essentials needed, as is evident from a review of documents, including the American Association of Colleges of Nursing (AACN) *Essentials of Baccalaureate Education for Professional Nursing Practice* (The *Essentials)* (2021). In addition, the lack of research exploring nurse educators' perspective of ethical nursing practice performed through nursing's disciplinary perspective is striking. If a nurse educator does not possess sufficient discipline-specific ethical awareness embedded in knowledge, they will be unable to integrate this concept into curricula. As a consequence, students will not receive necessary nursing ethics instruction or competency evaluation in a key component of nursing practice. It is important to understand nurse educators' knowledge of nursing ethics in nursing practice to design a more effective disciplinary informed pedagogy for nursing students. To date, there is scant research exploring nurse educators' understanding of what constitutes disciplinary specific ethics and impact on practice.

Significance

Although every interaction with a patient, every nursing decision and every nursing action has ethical implications because it should be intentionally focused on meeting nursing goals (the "good" of nursing), they are often not carried out with this 'intention' in mind. A major reason is lack of understanding of this intention as a professional responsibility (Milliken & Grace, 2017). Recent work in nursing ethics has provided some clarity about essential content needed to develop nurses with confidence in their ethical decision-making in every-day practice. There is a growing recognition of gaps in nursing ethics education in nursing curricula, thus the

translation of ethical knowledge into practice is also lacking (Gallagher & Wainwright, 2005; Hoskins, et al, 2018).

The inability to articulate their focus and perspective has left nurses feeling ineffective or prevented from using critical and creative thinking to solve problems based upon their own knowledge. As a result, nurses often begin to feel they have no professional "voice'. As nurses begin to experience moral distress, they may begin questioning the ideals of the profession or their place within it (Prompahakul & Epstein, 2020). Although nursing has been consistently named the most trustworthy profession, patients who experience poor nursing care because of the sequelae of moral distress, may begin to the lose the sense of trust that, up to now, has been a hallmark of the relationship between nurse and patient (Milton, 2018). A cogent example is the COVID-19 pandemic, which placed tremendous strain on nurses individually, and distance in their relationships with patients. Circumstances and situations occur daily in practice situations that require a strong moral compass to guide one through, and this requires a strong foundation in nursing education and preparation.

The *Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing, 2021) outlines expected outcomes of graduates from baccalaureate nursing programs. The *Essentials* provide guidance for nursing curriculum development in the U.S. and by proxy should provide guidance for the apt preparation of educators. Achievement of these outcomes will enable graduates to practice effectively in complex health care environment and assume a variety of roles. While the *Essentials* documents do refer to the importance of ethical professional practice in the framework, it is not clear that nurses are able to recognize the nursing specific ethical problems or implications once they enter practice. Additionally, if nurse educators, who rely on the *Essentials* as a driver of curriculum

design, cannot translate the expected ethical outcomes into the curriculum, then students will not have the requisite knowledge and expertise to navigate the complicated health care arena where they enter as novice nurses. Not enough is known about how nurse educators understand the ethical principles of their profession, nor the ways in which this is, or is not, transmitted to nursing students.

Purpose of the Study

The purpose of this qualitative descriptive study was to 1) explore how nurse educators describe nursing disciplinary specific ethics and 2) how nurse educators teach nursing ethics in pre-licensure education. The research questions were:

1. How do nurse educators describe nursing ethics?
2. How do they teach nursing ethics in a pre-licensure program?

The specific aims of this study were to describe how nurse educators:

1. Describe ethical knowledge needed for nursing practice.
2. View nursing ethics in relation to bio, medical and healthcare ethics.
3. Integrate nursing specific ethical knowledge into their teaching.

Assumptions

This study was based on several assumptions. The Principal Investigator (PI) of the study has been a nurse educator in pre-licensure programs for over a decade as well as a practicing acute care nurse. During that time, it was noticed that ethics classes were being taught by non-nurses in Theology and Sociology courses designed toward a wide variety of academic majors. In fact, one nursing program known to the PI presented a “Bioethics” course in an accelerated one-week course format rather than a traditional 12 to 16-week semester. Additionally, the PI has practiced in clinical settings with nursing graduates from a variety of educational institutions, including where the PI has served as faculty. During professional and collegial discussions, it became apparent that many new nurses experienced disappointment, confusion and dismay about

feelings of being inadequately prepared to face the daily challenges of contemporary nursing practice. Virtually none could verbalize the inherent ethical nature of day-to-day nursing practice. This lack of preparedness is echoed in contemporary nursing literature (Jurchak, et al, 2017). Continuing scholarly inquiry revealed that this experience was not confined to the PI's experience. The question that arises and serves as the basis for this study is what nurse educators are teaching undergraduate students in terms of nursing ethical knowledge, skills and attitudes needed for entry into professional practice. This study aims to gain insights into the question.

This research study was built on the supportable assumption that there is a distinct field of ethical inquiry, unique to the needs and goals of professional nursing practice, and which is an applied form of professional ethics. The field of nursing ethics is distinct from the bioethical framework designed within a dominant medical perspective because it is about the nature, scope and limits of nursing's responsibilities related to nursing goals as validated over time by nurse scholars informed by practice (Grace, 2001). It was further assumed that each nursing action and function performed on a daily basis in professional practice has underlying ethical implications (Milliken, 2018). The ethical nature of each nursing action occurs on a continuum, from those activities that display characteristics of overt ethical implication to activities that contain an inherent, subtle, and less obvious ethical manifestations. It was further assumed that professional nursing exists to provide a 'good' as a social contract with others (Grace & Willis, 2011). This 'good' is delineated in the *Central Unifying Focus (CUF) for the Discipline* (Willis, et al, 2008) as the basis for scholarly inquiry into nursing practice. The *CUF* offers a scope of practice framework that is the basis for nursing perspectives in scholarly research, clinical practice, and nursing education.

Several assumptions underlie the chosen study methodology. First, qualitative description is an appropriate method when little is known about a phenomenon or concept (Sandelowski, 2000, 2010). Secondly, this methodology would allow nurse educators to articulate their understanding about the concepts of "nursing ethics in practice". Additionally, respondents would honestly and openly discuss their perspectives and understandings. Lastly, analyzing interview transcripts would present the researcher with insights about how nurse educators describe their understanding of nursing ethics and reveal any gaps in how nursing ethics is (or is not) taught and evaluated in pre-licensure nursing programs.

Summary

This chapter presented a description of the need for nursing ethics knowledge and skill development to be meaningfully incorporated into nursing education in order to provide novice nurses the tools and skills they need to navigate complex health care systems they encounter daily. The concept of the nature of the 'good' of nursing is described as well as the theoretical basis upon which this concept is built. The chapter also argues for the necessity of the meaningful inclusion of nursing ethics in curriculum and to present it in a manner that offers practical daily application. The specific aims for the study were presented, along with the assumptions underlying the study. In Chapter Two, a background describing nursing ethics, barriers to nursing ethics in education and practice and the disciplinary knowledge underpinning this study will be explored.

Chapter Two: Review of the Literature

The purpose of this qualitative descriptive study was to 1) explore how nurse educators describe nursing disciplinary specific ethics and 2) how nurse educators teach nursing ethics in pre-licensure education. In this chapter, the philosophical and epistemological underpinnings of nursing ethics is discussed. Among the aspects of discussion are answers to such questions as why nursing should and does exist, what is the nature of "good" in nursing, and how society understands the nature of nursing practice. A literature review of the theory-practice gap between the theoretical and traditional pedagogy of ethics and the "reality" of ethics needed for nursing practice follows. A link is forged between the lack of understanding of the unique nature of nursing ethics and negative consequences in the form of moral distress that effects individual nurses, and the impact on the organizations for which they work, society and the nursing profession as a whole.

Philosophical and epistemological underpinnings of nursing ethics

Any discussion of nursing ethics is inextricably tied to the evolution and development of nursing's disciplinary perspective. Nursing theorists and philosophers alike grapple with questions such as why should nursing exist, and, since it does, what are the inherent and essential features that distinguish it from other professions. As Thorne (2020) aptly noted, "without clarity on what constitutes our core disciplinary knowledge we are at risk of losing our identity" (p. 1). Describing nursing as both an art and a science, Nightingale situated the domain of health within nursing knowledge, separating it from the "laws of disease (that) were under the purview of medicine" (Smith, 2019, p. 5). Central to her understanding was the whole person (body, mind and spirit) and the influence of environmental factors on health. While Nightingale established schools of nursing that were non-sectarian, accepting students independent of their religious

commitment, the schools were nonetheless based on a Christian view of nursing as a spiritual calling of service to God and to humanity (Fowler, 2015; Smith, 2019). It is perhaps for this reason that many scholars view "caring" as inherent in her writing although she did not explicitly use that word. Merriam-Webster (2022) defines caring as "feeling or showing concern for or kindness to others"; scholars, such as Watson (1979) began expanding the definition to incorporate the concept into the ontology and epistemology of nursing as an interpersonal process that promotes health in the individual or family. According to Watson, caring is "the ethical and moral ideal of nursing that has interpersonal and humanistic qualities" (Jesse, 2010, p. 111) and is a complex concept that includes a breadth of knowledge, skills, holism, empathy, communication as well as clinical proficiency (Jesse, 2010). Smith (2019) describes caring as an intentional process that involves behaviors and actions that nurture the human person. Over time, the concept of caring has become inseparable from any conceptualization of nursing identity (Ray & Turkel, 2014), carrying with it ethical implications of all nursing activities focused on the human individual and society as a whole.

In the *Guide to Nursing's Social Policy Statement,* Fowler (2015) presents a detailed history of the evolution of social contract theory, beginning with the ideas of Thomas Hobbes (1588-1679), John Locke (1632-1704), and Jean-Jacques Rousseau (1712-1768). Social contract theory may be thought of as the view that a person's moral obligations to others is arrived at and dependent upon an agreement among them to form the society in which they live (Friend, 2022). More recent works by John Rawls that culminated in a *Theory of Justice* (1970/1999) are described as drawing on the ideas of Immanuel Kant (1724-1804) related to human beings as rational and capable of making their own moral rules, and rules for just societal institutions. David Gauthier (1986) attempts to modify Hobbes' theory, expanding contemporary

philosophical thought to include such ideas that individuals, and professions such as nursing, have social responsibilities. Such perspectives are evident in the bioethics literature as well as the nursing ethics literature, including Rawls' concept of justice as fairness and Kant's perspective on autonomy inasmuch as relates to patient self-determination, access to health care services, and the structure of systems of health care delivery. In describing the 1847 *Code of Medical Ethics,* Fowler (2015) notes there is an understanding of the physician's wider responsibility to the public which includes a list of societal (governmental) expectations of medicine, and medicine's expectations of government, derived from the American Medical Association's description of a profession. Nursing also relies on the idea of social contract to elucidate its relationship with society, in terms of reciprocal expectations of each (Grace & Willis, 2011). Because nursing and medicine both interact with health and illness over a wide variety of philosophical, ethical, political and professional aspects, there are similarities and differences in terms of each profession's view of its contract with society.

In response to the need for caring activities in health and illness, society authorizes and acknowledges nursing as a group to meet that need, thus creating specific expectations within a social contract. The *Guide to Nursing's Social Policy Statement* (Fowler, 2015) describes nursing's social contract as composed of 16 elements of reciprocal expectations: nine contain societal expectations of nursing, and seven are nursing's expectations of society. In terms of a social contract, expectations consist of obligations that the profession of nursing must meet in order to fulfill its role in meeting society's needs. Societal expectations of nursing include honesty, ethical standards and competence (Fowler, 2015) through caring service, honoring the primacy of the patient, responsibility, accountability, health promotion, and ethical practice activities. The social obligation which nursing further carries is to "ensure the knowledge, skill

and competence of those newly entering practice…This requires that the profession establish standards for education and practice, oversee education…and address error, incompetence, unethical, unprofessional or impaired practice" (p. 20). The American Nurses' Association (ANA) defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities and populations" (Fowler, 2015, p. 23). Through a wide- and far-reaching range of activities, nurses live out these attributes to meet society's need for nursing actions.

Historical vocation and disciplinary development

Since the time Nightingale established the focus of nursing on laws of health (Smith, 2019), nursing theorists, philosophers, and leaders have worked to refine elements of the focus of professional nursing. What constitutes the profession's particular focus has evolved over time, but the perspective remains attentive to the human response to health, wellness and illness, and interactions with environmental factors. Human relationships are also key, particularly human-to-human engagement in wholeness, complexity and consciousness (Roy & Jones, 2007). In an effort to review the nursing literature to regenerate a disciplinary perspective, Smith (2019) makes note of the variety of theoretical perspectives that delineate nursing's focus. Although the language contains variety, it is clear nursing theorists point to the human-dimension as being of primary concern. Concepts such as caring, humanization, choice, relationship, interaction, well-being and well-becoming, presence, and mutual processes are found in the nursing literature and are inherently laden with ethical implications (Litchfield & Jonsdottir, 2008; Newman, et al, 2008; Smith, 2019; Willis, et al, 2008).

Smith (2019) identified four concepts throughout the literature that described the focus of nursing inquiry: human wholeness; health, healing, well-being; human-environment-health relationship; caring. Each of these concepts contribute to the description of the human experience in all of its complexity. It could be argued that the fact that nursing's focus is on the human experience, there are deeply rooted ethical implications in the very nature of nursing and in all nursing action. For example, caring in nursing is described as "the intentions, expressions, behaviors, actions and experiences, grounded in a moral-ethical-spiritual foundation, that nurture humanization, health, healing, and well-being" (Smith, 2019, p. 10).

It follows, then, that questions about what ethical values are to be part of the nursing profession need to be considered. Debates about which approach to normative ethics is of particular interest in nursing have been noted (Grace, 2018). Virtue ethics, which emphasizes one's moral character, includes honesty, truth-telling, courage, justice and wisdom; attributes that would lead one to be admired for possessing qualities to act as one should (Hursthouse & Pettigrove, 2016). Although virtue ethics, which emphasizes the idea that the development of good character leads to consistently good actions, is often described as synonymous with nursing ethics, many scholars reject this view of defining the profession because of the foundational Platonist influence (Fowler, 2015). In contrast, an approach to normative ethics that emphasizes rules and duties (deontology) or one that considers consequences of one's actions (consequentialism) also finds elements of those principles intertwined throughout most codes of ethics. A Kantian-influenced deontological view is foundational to the Western philosophical tradition, as is consequentialism, with elements of both found in the bioethical literature (Fowler, 2015). In western healthcare, the deontological view is emphasized in respect for persons, and among other things, underlies informed consent and confidentiality whereas consequentialism

examines the outcomes of actions. Nursing ethics has historically been modeled on these principles. A central moral claim of nursing, however, is the view that the patient is a person of worth and dignity, deserving of compassion and care without regard for personal attributes or socioeconomic status (Fowler, 2015). Given the breadth of the need for ethics to guide such endeavors, ethics rooted in Western philosophical thought may not be sufficient to meet the concerns of all nurses everywhere (Prompahakul & Epstein, 2020), and there arise situations in daily practice where ethical values may conflict. This is problematic without the influence of nursing goals and perspectives as an anchor for decision-making. For example, can a nurse perform a nursing action that benefits a patient and honors patient autonomy, but at a great financial cost to the health care organization, rendering it highly difficult to afford the same action to others? This is but one example of the nature of the types of decisions nurses must make every day. Additionally, this example speaks to why traditional bioethics is not sufficient to meet the daily needs of nurses for professional practice.

Ethics in nursing: Theory – Practice Gap

Available evidence points to the problem that ethics content, regardless of curricula level, is often taught by non-nurses, focusing on principles of bioethics and medical models of decision-making related to emerging and actual dilemmas rather than the everyday issues faced by nurses (Jaeger, 2001; Kangasniemi, Pakkanen & Korhonen, 2015). Thus, it is not only bedside nurses who have difficulty articulating their ethical obligations in daily practice; nurse educators themselves are unlikely to be able to articulate the nature of nursing ethics required for daily practice. The tools of bioethics, such as traditional Western ethical principles and analysis are important for the exploration of dilemma-based problems in health care, but application in nursing practice settings necessitates nurses first understand their ethical responsibilities for

everyday nursing practice. Without this foundation, evidence supports a reluctance on the part of nurses to speak up and advocate for patients in the face of conflict (Alzghoul & Jones-Bonfiglio, 2020; Jurchak et al, 2017).

It is universally accepted that ethical inquiry, the principles derived from such inquiries, decision-making processes and reasoning judgment are important components of all healthcare practice. This is because such practice is aimed at providing a 'good' in terms of meeting the unmet health needs of a society (Grace, 2001/ 2018). However, for nursing there are various conceptualizations of what constitutes ethical practice for the profession. Generally, bioethics and its frameworks are accepted as being the universal approach to problem solving in health care. However, this perspective cannot account for the mandates of the nursing profession which examines persons and health through its distinct disciplinary lens.

Nursing education must be able meet the needs of novice nurses entering practice, and as such faculty need to broaden philosophical knowledge (Mascarenhas & Rosa, 2010), to provide effective tools that will serve nurses to use when encountering challenges in the health care environment. Theoretical wisdom must be translated into practical wisdom (Begley, 2006), promoting professional competencies as more than merely knowledge of ethical theories (Gibbons & Jeschke, 2016). How ethical competency is defined, however, is varied in the literature. Boozaripor (2018) established ethical values in nursing as consisting of personality, technical-professional, and socio-cultural competencies. Other sources rely on the *ANA Code of Ethics with Interpretative Statements* (2015) as a suitable basis for nursing education and blueprint for practice. However, nurses' knowledge and use of their Codes of Ethics in different countries is often deficient (Numminen, et al, 2010; Gibbons & Jeschke, 2016).

Professional competence, both theoretical and performance, is intrinsically linked to ethical competence (de Souza Ramos, et al, 2014; Grace, 2018). However, the nature of the contemporary health care system and environments in the US leads to conflicts with ethical values, often compromising professional principles in nursing practice (Fry, 1989; Storaker, et al, 2019). Being ethical is recognizing "the messy and expanding interdependence of decisions, interests, and persons" (Austin, 2007, p. 85). Awareness of one's professional obligation is necessary for good nursing practice, but is an insufficient component to the ethical sensitivity necessary to navigate conflicts that are encountered on a daily basis (Gastmans, 2002; Milliken & Grace, 2017). Novice nurses enter practice in a procedure-driven, cure-focused, stressed health care system that is complex, where the well-being of nurses is plagued by pressures and challenges every day. Nurses are compelled to provide excellent care that is patient-centered, while being harried by a health care system that is economically driven, valuing productivity and outcomes, often defined in monetary terms (Gibbons & Jeschke, 2016; Ray & Turkel, 2020). Realities such as resource restrictions and scarcity, combined with expectations of productive output in terms of number of tasks performed in the shortest amount of time, impact the quality time spent with patients, resulting in shortened and often rushed encounters. This is further complicated in high-technology environments where a nurse's focus is often on proper functioning of machines or computers rather than well-being of patients (Gibbons & Jeschke, 2016). A "painful busyness" (Storaker, et al, 2017) can lead to conflict in ethical values held by the nurse, compromising principles for professional nursing care (Ray & Turkel, 2020). Often, it is not so much that the nurse does not know "what" to do, but knowing what is right to do, the nurse perceives the inability to pursue the right action; "one believes one knows how to act but is thwarted by constraints; a sense of being morally responsible, but unable to change what is

happening" (Austin, 2007, p. 84). When approaches to health care ethics in nursing education focus primarily on moral reasoning, they are neither relevant nor responsive to day-to-day experiences of nurses (Austin, 2007; Grace, 2018).

Educational offerings to nursing students

Nurse educators have a clear and vital role in the professional development of novice nurses, and as such are essential to ensuring safe, quality and ethically sound patient care. Robinson and colleagues (2014) describe a curriculum for practicing nurses designed to enhance understanding of the ethical nature of nursing practice and their patient advocacy skills. End of course narratives by nurses involved in a year-long, 8-hour per month program evidence increased confidence in their moral agency ability (ability to act to provide a good) and a quantitative evaluation showed a significant decrease in the level of moral distress (Lee, et al, 2019). One of the strongest findings resulting from this project pointed to the fact that ethics education or involvement in ethics discussions has to be ongoing throughout the working life of a nurse, as nurses in this study reported they were not prepared for the harsh realities they encounter in daily practice. Yet, most ethics education content is taught by non-nurses, and often educators are unable to articulate the nature of nursing ethics in daily practice (Fowler, 2017). Further, ethics education is highly variable across nursing programs, and current pedagogy does not appear to offer nurses the tools they need to practice in complex healthcare environments (Hoskins, et al, 2018).

Literature is emerging that recognizes the contemporary healthcare environment as grounding for ethical issues in day-to-day practice, arguing that bioethics must evolve to meet the needs of contemporary nursing practice (Austin, 2007; Fowler, 2017). Nursing education must be able meet the needs of novice nurses entering practice in these environments. As such,

faculty need to broaden philosophical knowledge in response to scientific, technological and cultural progress that is rapidly evolving (Mascarenhas & Rosa, 2010), in order to provide pedagogy that results in effective tools for nurses to use when encountering daily and constant challenges in the healthcare environment. Theoretical wisdom must be translated into practical wisdom (Begley, 2006) which promotes professional competencies more than a mere rote understanding of ethical theories (Gibbons & Jeschke, 2016). However, how ethical competency is defined is varied in the literature. Boozaripor (2018) established ethical values in nursing as consisting of personality, technical-professional, and socio-cultural competencies. Other sources rely on the *ANA Code of Ethics with Interpretative Statements* (The *Code)* (2015) as a suitable basis for nursing education and blueprint for practice. However, both international and US literature suggests nurses' knowledge and use of their *Code of Ethics* is deficient (Gibbons & Jeschke, 2016; Numminen, et al, 2010).

Although nursing education contains learning objectives that align with the *Essentials for Baccalaureate Education* (2021), most ethics content relies on philosophical perspectives and theoretical knowledge that often fail to meet objectives that can relate to practice (Burkemper, et al, 2007; Vynckier, et al, 2015). Ethical sensitivity, as a necessary precursor to moral agency (Milliken & Grace, 2017), is often lacking in curricula despite its importance in developing skills to apply moral reasoning (Park, et al, 2012; Baykara, et al, 2015). In other words, nurses may fail to recognize the ethical aspects of every action and even of minor obstacles to practicing well (Milliken, et al, 2019). In current pedagogy, there is often a mismatch between what a nurse educator thinks they taught and what students experience (Hoskins, et alet , 2018; Krautscheid & Brown, 2014). Although ethical principles are theoretically defined, the lack of a comprehensive

definition of what is encompassed in nursing ethics for daily practice speaks to what is wrong with most texts used in nursing education (Simmonds, 2013).

The American Association of Colleges of Nursing (AACN) document, The *Essentials of Baccalaureate Education for Professional Nursing Practice* (2021) outlines the outcomes expected of graduates of baccalaureate nursing programs. The Essentials proffer the achievement of these outcomes will enable graduates to practice in complex health care environment and assume several roles. For example, Essential VIII concerns professionalism and values, and Essential VI addresses interprofessional communication and collaboration. While the *Essential*s do provide a framework for ethical and professional practice, it is not clear that nurses are able to recognize the ethical implications of their day-to-day actions or even recognize that an ethical problem exists. Additionally, if nurse educators, who rely on the *Essentials* for curriculum design, cannot translate the expected outcomes into meaningful application, then students will not have effective skills with which to navigate the complicated health care arena where they enter as novice nurses.

Student Formation

Nurse educators are a primary influence on student development, as person and nurse, and it is possible they may attempt to shield students from negative situations and/or experiences in the clinical setting during training. However, educators have an impact on guiding development of moral sensitivity as well as the ethical reasoning and decision-making capability that supports students and furthers the ethical integrity of the nursing profession (Hashish & Awad, 2019; Park, et al, 2012). Ethical development goes hand-in-hand with identity formation in nursing students; the professional nurse's character development is guided by meaningful ethics education and influenced by educators (Gallagher & Wainwright, 2005; Gibbons &

Jeschke, 2016). Faculty attitudes and values reflect students' subsequent values, yet values held by nurse educators, although demonstrated, are often not purposively or effectively taught (Haigh & Johnson, 2007). Gaps in theoretical training and practical application, based on an educator's conceptions and strategies for teaching, leads to ethics being "diluted" in the curriculum (de Souza Ramos, et al, 2013).

Despite the importance of ensuring novice nurses enter practice with the appropriate and necessary skills to navigate complex health care environments, the ethics education students receive is variable across programs (Hoskins, et al, 2018). While many nursing programs require a stand-alone ethics course, others attempt to weave ethical concepts throughout the curriculum (Fowler, 2017; Song, 2018). Fowler (2017) notes that as nursing education moved into college and university-level preparation, the majority of ethics education was taught by non-nurse faculty such as philosophers, theologians or humanities scholars, which moved the concept of medical ethics and Western philosophies, and more recently bioethics, into nursing curricula. This resulted in more of a focus on the difficult dilemmas inherent in the use of biotechnological advances than a focus on an applied ethics appropriate for nursing practice aligned with the profession's purpose and goals. In the US, often the *Code of Ethics with Interpretive Statements* (ANA, 2015) is used as the framework for nursing ethics education throughout the curriculum. However, there is evidence that educators' knowledge of the Code of Ethics that governs nurses within the given country is based on informal learning (Numminen, et al, 2010). No standards exist concerning the minimum preparation and qualifications of nursing educators to teach ethics (Burkemper, et al, 2007; Laabs, 2015). There is some evidence to suggest that educators report feeling insecure and lack preparation to teach ethics (de Souza Ramos, 2013). The need for nurse educators to teach ethics throughout the nursing curriculum, including didactic and clinical

components, has never been greater, yet how educators are prepared or their perception of preparedness to teach ethics is not known (Song, 2018). Further, how nurse educators understand the nature of nursing ethics in daily practice has not been studied.

In a seminal article, Carper (1979) discussed the "ethics of caring", which included the influence of nursing knowledge and science technologies on the process and act of caring on "learning to be humane", a knowledge not readily learned in solely formal courses. Yet, there persists a lack of consensus regarding content and methods by which students are socialized into the nursing profession by nurse educators (Gibbons & Jeschke, 2016; Hoskins, et al, 2018). Lipscomb and Snelling (2006) observed the tension between academic and practice-oriented values, and it was hoped that codes of ethics could provide a bridge between the two. However, schools vary in their approach to teaching the ANA *Code of Ethics* as the basis for nursing ethics. Depending on the individual nurse educator or the particular nursing course, the guidelines in the *Code* may or may not be addressed, or it may be integrated over a series of courses. Often ethics is taught as content, not as a thread throughout the curriculum. This is often left up to individual instructors who may or may not be familiar with the *Code* or how to present it as providing practical, day-to-day guidance (Davis, 2015; Hoskins, et al, 2018). For example, Davis (2015) quotes an educator explaining the primary ethical obligation of nurses is to the safety and well-being of patients, articulating that responsibility solely in terms of nurses' personal lives, using the example that nurses should be vaccinated against the measles and flu. While this type of rationale is important, it does not serve novices where "nurses come out (of school) into practice like deer in the headlights. They don't really know how to even identify an ethical issue and where to go with it to clarify their thinking" (Davis, 2015, p. 6). This phenomenon is perpetuated as nurse educators tend to have a higher, idealistic ethical

orientation, rather than being relativistic in their moral judgment and decision making (Hashish & Awad, 2019), and because they often lack preparation themselves in ethics education (Grace, 2018). The ideology of the individual educator therefore drives ethical education and expectations of their students (Hashish & Awad, 2019).

Variation in Nursing Education

While theoretical ethical ideals often appear latent in the mindset of nurses, nursing's ideals must be activated and applied in practice to achieve the professional goals of nursing (Storaker, et al, 2017). A literature review of ethics pedagogy in nursing revealed prevailing content as including ethical principles, laws and regulations, ethical dilemmas, approaches to case analysis, professional responsibility, confidentiality and autonomy, moral philosophy and theological concepts and biomedical topics, delivered via traditional and online platforms through lectures and group discussions (Prier, 2016). Considering the variation in ethics pedagogy and faculty preparation to teach ethics, along with the challenges and consequences to nurses and students in the health care setting, it is clear that research in nursing ethics is not only greatly needed, but must include foundational studies to ascertain the state of nurse educators' understanding of nursing ethics, particularly as applied ethics, and how they describe the ethical development and professional identify formation of students.

Perceptions of Nursing Ethics in Practice

It is not clear in the nursing literature how nurses describe nursing ethics in daily practice (Grace & Milliken, 2016). Further, how nurse educators describe nursing ethics and how they address the ethical development in students has not been studied. Research studies examining ethics and faculty tend to focus on ethical issues encountered during the work of teaching. Issues

such as academic misconduct (Tee & Curtis, 2017), students' unethical behaviors in the classroom (Copeland, et al, 2016; Tang & Wocial, 2015) and the professional relationships between educator and students (Boozaripour, et al, 2018; Salminen, et al, 2013) are the focus of most studies of nurse educators. The tension between academic and professional values (Lipscomb, 2006), in terms of professional relationships between educator and student, are studied as concepts such as fairness, respect, and role inequality (Salminen, et al, 2013).

Most research studies on ethics in nursing education focus on students' perceptions of quality and effectiveness of pedagogy. Krautscheid & Brown (2014) discovered a mismatch between what the nurse educator thinks was taught, and what students experience as unapplied and forgotten ethics education, reporting instead that students trusted staff nurses' recommendations (as opposed to the nurse educator's) even if it was contraindicated by "best practice". Further, students described traditional lectures as impractical, dull, not motivating and teacher-centered. Educators, however, report case studies helpful, but present dilemma-based scenarios that tempt students to focus on how a certain person acted at one time in one place, without considering the wider context of practice (Cannaerts, et al, 2014). Cannaerts and colleagues also noted the lack of research into the perceptions of nurse educators of their contribution to ethics education. De Souza Ramos, and team (2013), found only one-third of educators in their study viewed themselves as teachers of ethics.

Other studies examined the use of the *Code of Ethics* (ANA, 2015) in US nursing education. Tinnon (2018) discussed the pragmatic use of the ANA *Code* for nurse educators, substituting the "student" for the "patient". Educators often self-report their knowledge of ethics is "adequate" for teaching the *Code* (Numminen, et al, 2013), but a mismatch between what educators' think was taught and what the students experienced as moral disequilibrium, or

conflict between what was taught in the classroom and what was modeled in the clinical setting (Krautscheid & Brown, 2014). The few studies that examined educators' knowledge of the *Code,* who described their knowledge as "generally good, found it to be based on informal self-learning, rather than formal educational preparation to teach ethical content (Salminen, et al, 2013). More often, the ethics-education literature identifies a dedicated code for educators, specific to teaching activities such as cooperation with faculty colleagues, support, teaching capacity, respectful environment, envy of colleagues, collegiality, as well as honesty, fairness and respect for students (Boozaripour, 2018; Fowler & Davis, 2017; Salminen, et al, 2013).

Inadequacy of Bioethics for Nursing Ethics Education

In practice, it is imperative nurses abide by their social contract with the public and provide "good" ethical care, but to do so nurses must be steeped in the disciplinary knowledge of their profession commencing with pre-licensure education. While many undergraduate nursing curricula require an ethics course, content is variable and inconsistent (Hoskins, et al, 2018). What ethics education content and process should look like in nursing curricula continues to be debated (Grady, et al, 2008; Hoskins, et al, 2018). However, what is evident is the majority of ethics content taught in nursing programs is rooted in the biomedical model, relying on bioethical elements that are founded in philosophy and moral theories, traditionally with a Western philosophical focus. Bioethics evolved as a study derived from the biomedical model as scientific advances in health care began to proliferate and pose new dilemmas in patient care (Fry, 1989; Jonsen, 2003).

Non-nurse philosophers such as Jameton (1984) and Jaeger (2001), charged with teaching bioethics and health care ethics courses to nursing students, have noted the inadequacy of the tools of bioethics and health care ethics courses for understanding the everyday problems nurses

face. Fowler (2017) found that a significant number of those schools that do require a separate ethics course refer students to other departments such as Philosophy or Theology. Most ethics courses are taught by philosophers and theologians; non-nurses who cannot meaningfully convey the application of ethical principles in daily nursing practice. There is an absence of evidence to support that faculty in other disciplines, who teach ethics courses in which nurses are enrolled, collaborate with nursing faculty so that the principles, cases and applications apply at the nursing practice level. Problems discussed in ethics courses tend not to rise beyond the level of dilemma-based, bioethical debate (Ulrich, 2016; Woods, 2005). It follows that many practicing nurses who received some ethics education in their studies did so from a bioethics perspective which has an ethical foundation rooted in the biomedical model and Western philosophy, and does not usually include nursing's perspectives or daily practice problems. This is troublesome when the needs of nurses are not served by education offered to them. The consequences of this include nurses experiencing moral distress.

Experiencing Moral Distress

Contemporary health care settings are replete with obstacles to good nursing practice (Jurchak, et al, 2017). Such obstacles can prevent nurses' ability to function as moral agents and perform important and necessary actions to bring about much needed change in a health care system fraught with complexity and challenges. Barriers to exercising moral agency, often over time and repeated occurrences, may give rise to moral distress. Nurses experiencing continual or pervasive moral distress have several negative consequences that affect nursing's professional goals, the individual nurse, health care organizations and, ultimately, patient care (Burston & Tuckett, 2012; Van Bogaert, et al, 2009). The ramifications of pervasive moral distress are costly; financial, emotional and physical consequences affect individuals and organizations alike

(Burston & Tuckett, 2012). Effects of moral distress include job dissatisfaction, burnout, turnover, lateral violence, disillusionment, early retirement from the profession and incidences of criminal actions and suicide (DeVeer, 2011; Halm, 2019; Mason, et al, 2014; Oyeley, 2013; Waddill-Goad, 2019). These devastating consequences affect nurses' personal and professional identity, as well as the organizations who employ them. When nurses feel ineffectual in fulfilling their professional responsibilities many begin to feel disillusioned with the profession (DeVeer, 2012; Laabs, 2015; Mason, et al, 2014). Being prevented, for a variety of reasons, to work toward overcoming barriers to good care, nurses begin to feel dissatisfied with their role. Many will leave the profession or an organization to seek better opportunities elsewhere, while others stay in their job and over time begin to experience burnout, which in turn decreases their ability to practice well (Jurchak, et al, 2017).

Systematic challenges, such as the lack of disciplinary knowledge, time and resources, combine to impact nursing autonomy in creating plans of care that meet individual patient needs. In contemporary health care settings, resources must be allocated and used prudently to contain increasing costs while improving efficiency. While this may be an appropriate goal for health care organizations, patient care suffers because nurses are prevented from locating or putting into place interventions which they believe is best for the patient (Grace & Milliken, 2016).

Inadequate staffing, care failures, discrimination by age, gender, culture, or class, racism, and witnessing poor care further contribute to the toxic environments many nurses work in (Ion, 2018; Ulrich, 2010; Ulrich & Mooney-Doyle, 2012). The harsh realities of contemporary health care environments that novice nurses will encounter when they enter practice are not addressed in traditional ethics education, which relies on dilemma and case-based theoretical principles often rooted in Western ethical frameworks (Ion, 2018). Discrepancies between what nursing

students are taught in the classroom and what they witness in clinical environments causes conflicts about the right thing to do in situations (Park, et al, 2003). For example, if nursing staff did not provide treatment or administer medication properly, were observed taking shortcuts that could potentially harm a patient, failed to give quality care, acted unprofessionally, or treated students poorly, only exacerbated students' confusion of what constitutes ethical professional practice (Cameron, et al, 2001; Park, et al, 2003). Witnessing or experiencing power inequalities with physicians or other team members, particularly with administration, exacerbates the ambiguity. Policies and procedures in place, while important to the extent they are established to support healthy work environments, can rarely address the complexity and sensitivities involved in power differentials in the system. "Protocols and routines provide the parameters of practice, not generosity of spirit" (Austin, 2007, p. 84). Contemporary health care environments require nurses to make decisions about how to engage with others, or respond to situations where some action or omission may adversely impact an aspect of another person's experience (Ion, 2018).

Consequences of Moral Distress

The mismatch between ethical theories and principles learned in the classroom and the situations encountered in practice leads to internal and external constraints to moral agency and ethical decision making (Milliken & Grace, 2017; Simmonds, 2013). Internal constraints arise from lack of experience and self-confidence, past experiences of ineffective action, and fear of retribution or job loss. External constraints involve hierarchal relationships and lack of team collaboration, inflexible institutional culture and administrative policies, limited resources, insufficient time and staffing, unclear roles and unfair distribution of responsibilities (Halm, 2019; Simmonds, 2013). "Encountering patients who are more chronically and critically ill, culturally diverse and have more complex personal circumstances, nurses struggle to manage

these varied problems and conflicts in the health care environment" (Jurchak, et al, 2017, p. 445); they struggle with ambiguity and questions of what is the right decision in any given situation. Such factors lead to moral distress when nurses feel ineffectual in fulfilling their professional responsibilities, leading to disillusionment with the profession (Burston & Tuckett, 2012; DeVeer, 2012; Mason, 2014). The ramifications of pervasive moral distress are costly; financial, emotional and physical consequences affect individual nurses, patients, and organizations alike.

Some effects of moral distress include job dissatisfaction, burnout, disillusionment, turnover, lateral violence or bullying, early retirement from the profession, younger or less experienced nurses leaving the profession, and incidences of substance abuse and suicide. Moral distress can result from less time available for the patient and lack of support from leadership (DeVeer, 2012). Emotional exhaustion, depersonalization in the health care environment and burnout result from evidence of poor care (Ion, et al, 2018). Compassion fatigue and job dissatisfaction is pervasive in contemporary environments (Kelly, et al, 2015) that demand higher work productivity and efforts in non-supportive environments (Flinkman, 2013; Laschinger, et al, 2016). Incidences of lateral violence and bullying among nursing staff and among the health care team are rising (Oyeleye, 2013; Van Bogaert, et al, 2009; Vogelpohl, et al, 2013).

Millennials currently make up 30% of the nursing workforce, and this cohort of younger nurses or those with fewer years of experience encounter ethical issues more frequently and are more likely to experience stress, bullying, burnout, high turnover and less dedication to their workplace (Kelly, et al, 2015; O'Hara & Burke, 2019; Ulrich, et al, 2010; Vogelpohl, et al, 2013). Contributing factors such as depression, smoking and substance abuse, combined with

occupational stressors, conflicts with and within the health team, lack of autonomy, excessive workload, relationships with superiors and physicians as well as personal stressors, lead to health consequences (Burston & Tuckett, 2012). Suicide risk for nurses is three times that of the general population (Alderson, et al, 2015; Epstein, 2010).

Turnover and attrition are troublesome and costly, and newly licensed nurses are at particular risk. Estimated one-year internal turnover rate is about 30% (Kovner, et al, 2016) and is expensive. Costs to organizations are estimated at $62,000 to $67,000 per nurse who leave their position, and $1.4 to $2.1 billion for new nurses who leave their first jobs within three years of starting (Kovner, et al, 2016). Ultimately, these costs are paid for by organizations and in the form of taxes used for Medicare and Medicaid (Kovner, et al, 2016). Turnover is also disruptive; when a nurse leaves, organizations are now understaffed until a replacement can be found, and when a nurse is hired to replace the one lost, the cost of orientation and integration into the organization is quite high (Kovner, et al, 2016). Most distressing to nursing, however, is the impact on professional identity, distancing from patients, compromising patient care, and unsafe practice (Grace, et al, 2014; Waddill-Goad, 2019).

Students are not immune to experiencing these realities. Seeing nurses take short cuts that may potentially harm a patient, or not giving care according to proper training, acting unprofessionally or treating students as “another pair of hands” gives rise to students conflicted about the right things to do (Park, et al, 2003; Tang & Wocial, 2015). This may continue as they enter nursing practice as novices, perpetuating the problem of moral distress in their new careers without the tools that might help prevent it.

Summary

Given the disjunction between what is taught as nursing ethics, and the uncertain preparation of nurse educators to teach and model nursing ethics in all aspects of the curriculum, an understanding of how nurse educators describe disciplinary specific ethics and how nurse educators teach nursing ethics in pre-licensure education is an important area for research. There is a failure to explore the moral identity of nursing and the development of an ethical language that fits nursing's ethical history, literature, theories and perspectives; one that does not neglect nursing's ideal to promote the richness of nursing as a distinct social good with its own disciplinary ethics (Fowler, 2017). The present study seeks to establish this line of inquiry as a first step, with the goal of ultimately promoting enhanced understanding of nursing ethics as a distinct field of inquiry; one that provides the knowledge and skills to improve quality of care, expands and supports professional development, and provides nursing students with the tools they need to navigate complex and complicated contemporary health care environments.

Chapter Three: Method

Chapter One provided an overview of the significance of the problem. Chapter Two addressed the theory-practice gap between the theoretical and traditional pedagogy of ethics and the "reality" of ethics needed for nursing practice. It also addressed the link between the lack of understanding of the unique nature of nursing ethics and negative consequences in the form of moral distress that effects nurses, the organizations for whom they work, society and the nursing profession as a whole. Relatively little is known about 1) how nurse educators in the United States describe disciplinary ethics and 2) how nurse educators teach nursing ethics in pre-licensure education. As such qualitative description is an appropriate method for obtaining data that begins to uncover the phenomenon. The purpose of this qualitative descriptive study was to 1) explore how nurse educators describe nursing disciplinary specific ethics and 2) how nurse educators teach nursing ethics in pre-licensure education. The research questions were:

1. How do nurse educators describe nursing ethics?
2. How do educators teach nursing ethics in a pre-licensure program?

The specific aims of this study were to describe how nurse educators:

1. Describe ethical knowledge needed for nursing practice.
2. View nursing ethics in relation to bio, medical and healthcare ethics.
3. Integrate nursing specific ethical knowledge into their teaching.

Study Design

As noted, a qualitative descriptive methodological approach was chosen as most appropriate to address the study questions. Reasons for this choice are discussed in more depth in this chapter along with details of the proposed study design. When issues and concepts of interest

are complex and have variables that are not easily measured, qualitative descriptive research affords the opportunity to explore the phenomenon in a thoughtful manner. Colorafi and Evans (2016), in their explanatory article of qualitative descriptive study design, note it is a method that "provides factual responses to questions about how people feel about a particular (area of interest)" (p. 17). It is a specific form of the broader array of qualitative methods.

Qualitative methods, as distinct from quantitative methods, explore the subjective meanings and perceptions of experienced phenomena. There are several different approaches to qualitative research that depend somewhat on the question(s) to be explored. Despite the differences among qualitative approaches, "many of these share the same aim – to understand (and) describe" (Holloway & Wheeler, 2010, p. 3) the phenomena of interest as perceived by individuals or groups. The qualitative descriptive method produces findings as close to the data as given by the participants. (Sandelowski, 2010). Qualitative descriptive, as an exploratory method, is particularly helpful when not much is known about a phenomenon and tends to give broader, more surface level insights than, for example, phenomenology (Willis, et al, 2016). This form of inquiry is contextually bound; that is, a theoretical framework is not always a priori chosen or defined but rather is derived from the context-bound data.

This study used a qualitative descriptive study design to delve into and probe how nurse educators describe nursing disciplinary specific ethics and how nurse educators teach nursing ethics in pre-licensure education. Since the phenomenon was studied from the participants' perspectives grounded in a form of naturalistic inquiry (Colorafi & Evans, 2016), the primary investigator (PI) maintained a reflexive stance and refrained from attempting to manipulate or extrapolate meaning during data collection. A discussion of the steps taken to maintain reflexivity will be described in further detail in Chapter Four.

Study Sample

As noted in Chapter Two's review of the literature, there is much variability in types of pre-licensure programs, educational preparation and qualifications of nurse educators, and differences in how ethics from a nursing perspective is understood. While it is important to collect an array of perspectives to meaningfully describe the phenomena, there should be enough similarity among the sample that differences in their perspectives may emerge if they exist. The technique of purposive sampling was chosen as a deliberate decision by the PI to select participants that would provide data useful for the study and address the research questions (Gray, et al, 2016). In this way, the study consisted of participants who could offer a rich description of the phenomenon of interest. The study sample included nurse educators who meet criteria outlined below.

Inclusion criteria

To be included in the study, the participant was required to meet the following:

1. English speaking.
2. Minimum educational preparation of a Master's degree in nursing, including advanced practice nurses (APRN) who are in a faculty role.
3. Teaching in either didactic or clinical courses in a 4-year baccalaureate pre-licensure program in the United States (U.S).
4. Employed in a nurse educator role full, part time, or as an adjunct.
5. Willing to be interviewed and recorded via a web-based video platform.

Exclusion criteria

Participants who did not qualify for the study included:

1. Educators who teach exclusively in LPN programs, ADN/ASN 2-year programs, or direct-entry Master's programs.
2. Nurse educators who are exclusively hospital or practice-based.
3. Nurse educators who received all of their nursing education outside of the U.S.

Sampling Plan

Efforts were made to recruit nurse educators from various regions of the U.S. This sampling frame afforded a broad range of educators' experiences, as well as educational backgrounds and professional preparation for the teaching role while establishing a baseline of similarity of nursing programs taught in. A purposive convenience sample with the variation of educational background and preparation provided a broad look at the phenomenon, leading to thick description of what variability and gaps in knowledge persist.

The goal of qualitative description is to sample widely and in depth enough to capture all possible experiences in enough detail to provide a robust description of the phenomenon (Cresswell & Poth, 2018). "The intent in qualitative research is not to generalize the information…but to elucidate the particular, the specific (Creswell & Poth, 2018, p. 1580). Data collection in qualitative descriptive is an iterative process. The sample size is not determined a priori, but rather as a result of the cooccurring process of data collection and data analysis. Theoretical saturation is the ultimate goal (Holloway & Wheeler, 2010). As such, data collection continued until the ideas discussed became redundant and no new information was obtained from the interviews or analysis. This signaled data saturation was likely. In research using inductive qualitative descriptive design, the literature suggests this is generally achieved with a sample of approximately 20 participants (Cresswell & Poth, 2018). In the present study, a total of 16 nurse educators qualified and agreed to participate.

Setting

The setting and time for interviews was based on the participant's and PI's mutual agreement and convenience. A web-based video platform, Zoom™, was used as the setting for this study. This approach to data collection afforded the opportunity to adhere to COVID-19 restrictions of in-person contact in place at the time of data collection. It allowed the PI to replicate an in-person approach as closely as possible so that the person's facial expressions and gestures could be observed. Interviews conducted via this platform were video and audio recorded, allowing the PI the opportunity to re-watch and re-listen to the recordings. All interviews obtained via web-based platforms were recorded and downloaded into a password protected laptop computer solely owned and accessible by the PI. All interviews were also recorded on a password protected digital recording device to serve as a back-up to the video platform. Only the digital audio recordings of the interviews were uploaded to a HIPAA compliant transcription service and transcribed verbatim. The video and audio recordings obtained during interviews on the Zoom™ platform were maintained in a password protected laptop solely owned and accessible by the PI.

Protection of Human Subjects

Participants were advised the PI would protect confidentiality via several safety mechanisms. To protect anonymity of the data, all participants were asked to choose a pseudonym which was then assigned to a unique code number. The pseudonyms and code numbers were maintained as part of the coding manual on an encrypted, password-secured computer to which only the PI had sole access. To assure confidentiality in the reporting of the data, any and all identifying information about the participants was removed and replaced with their code number or pseudonym. Other identifying details, such as where the nurse educator

teaches or is employed, was de-identified in the transcript. In any future reporting of data, only pseudonyms or code numbers will be used. Transcripts, recordings, field notes, memos and coding manual materials will be maintained in a secured manner until all published reports are completed, at which time they will be securely destroyed.

IRB Approval

Employing principles of responsible conduct of research is paramount to maintaining ethical standards and protection of human subjects. The PI sought the approval of the Institutional Review Board (IRB) at Boston College. The application for IRB approval was submitted electronically through CyberIRB online platform. Only IRB approval from Boston College was necessary since no other study sites were utilized in this research. The study involved adult participants capable of giving informed consent, and contained minimal risk of harm to the individual. Boston College IRB Number 21.182.01E was approved with exempt status on 1/24/2021. Please refer to the informed consent located in Appendix C.

Recruitment

The recruiting strategy made use of contemporary technologies for outreach. Restrictions imposed in various areas because of COVID-19 required an approach that reached a wide variety of potential participants with minimal in-person contact. The Nurse Educators Group on Facebook (administrator: Tim Bristol, PhD, RN, owner/CEO at NurseTim, Inc.) is a public group of nurse educators throughout the U.S. and other countries consisting of over 7000 members. Verbal permission to recruit through this site was obtained from the Group administrator. Group members were be invited to voluntarily participate in the study via open posting, describing the study and listing the selection criteria. Using a purposive convenience sampling method, the

recruitment period remained open until data saturation was achieved. Additional participants were located through snowball sampling and colleague referrals.

When a participant agreed to take part in this study, the PI reviewed inclusion criteria to assure they met the requirements. A date and time for an interview was set up and all participants were asked to agree to take part in the study via informed consent sent to their designated email address (see Appendix C). The consent form included descriptors of specific practices to assure confidentiality. It explained the risk to the participant was minimal given the nature of the inquiry, however, the consent included language that the participant may decline to answer a question or stop the interview at any time.

Once the consent was sent via email, the participant was given at least 24 hours to review the consent before the appointment date and time. The participant was asked to return the consent with an electronic signature. The majority of participants did not return the electronically signed consent. At the beginning of each interview, the informed consent was again reviewed with the participant. Their verbal acknowledgment and agreement to participate was obtained and captured at the start of the recording. Each nurse educator who completed an interview was given a $25 gift card at Amazon as an honorarium. Funds for this research study and expenses were awarded to the PI as a small research study grant by Sigma Theta Tau, Epsilon Tau at-Large Chapter.

Data Collection Procedure

Demographics

After obtaining consent to join the study, participants were asked questions about demographic characteristics at the beginning of the interview. After the first few interviews, it

was decided to obtain this demographic data before the audio recording began. This was to reduce transcription time and costs, and to further protect confidentiality of the participant. Demographic data was collected to describe the sample. Demographic data obtained included gender, employment/teaching status (i.e., full-, part-time or adjunct), highest degree obtained including type of university attended (i.e., public, private, religious-based), any employment outside of academic settings, type of courses taught including whether didactic or clinical, and the regional location in the U. S. of where they were teaching at the time of the interview. See Appendix A for demographic questions.

The Interview

The interview guide was purposely developed by the PI and reviewed by the dissertation committee, all of whom are nursing educators and content experts. The interview guide consisted of semi-structured interview questions (see Appendix B). The interview guide focused on the topics to be covered and lines of inquiry to be followed. These included descriptions of the educational preparation of nurse educators, and particularly how they were taught ethics (if they were) in their nursing program. Participants who did have an ethics course were also asked to describe the types of topics that were covered and how they were presented in the class.

The interview questions explored how educators describe ethics from a nursing perspective, and how this is conceptualized and operationalized in practice and in nursing education. Participants were assured that there were no right or wrong answers, only descriptions of their knowledge and experiences. Educators were asked to describe examples of situations or experiences they have encountered that required disciplinary ethical knowledge and thinking. A particular focus on ethical implications in daily practice was included in the line of questions asked. Given the naturalistic, exploratory and conversational nature of the inquiry, the

sequencing of questions was not always the same for every participant. However, the interview guide ensured that similar types of data were collected from each participant.

Maintaining control of the flow of the interview while affording the participant opportunities to share their experiences is an important consideration in qualitative research (Munhall, 2012). Participants were redirected back to the interview questions if they strayed off topic. However, as discussions unfolded, additional probes and prompts were employed to explore more details in the present interview or aid in refining interview questions for future interviews. Using open ended questions for the majority of the interview minimized obtaining one-word answers from the participants. Through each iteration, the interview guide was adjusted based on responses and conversations, with refinement and/or expansion based on insights participants provided.

Data Analysis

Digital audio recordings of each interview were transcribed by a HIPPA-certified professional transcription service. All transcripts, field notes, reflexive diary and other researcher data analysis documents were included in the analysis. When a transcript was completed, it was read concurrently while listening to playback of the audio and video recording to ensure transcription accuracy. Comparison between transcripts, recordings and field notes was made to ensure understanding of the content. Each interview transcript and recording were reviewed in this manner at least twice to ensure the content on the transcript matched the data on the recording.

Conventional content analysis is appropriate for qualitative descriptive research (Erlingsson & Brysiewicz, 2017; Hsieh & Shannon, 2005; Saldana, 2016). After collecting data through open-ended interview questions, data are read repeatedly to obtain an overall sense of

the whole data set. Following this process, data is read word by word to extrapolate codes that identify key concepts. During this process, the PI made notes of initial thoughts and impressions of the data.

A first cycle coding technique as described by Saldana (2016) was employed by the PI when first reviewing transcripts for meaning units. As a first-pass approach to the data, structural coding was used as a helpful strategy for multiple participants in semi-structured interviews. Structural coding is question-based, and is a labeling and indexing mechanism that affords the opportunity to examine commonalities and relationships among bodies of data (Saldana, 2016). This is an important step, since certain words and their frequency in an interview may carry different meanings depending on the context in which they appear. For example, if a nurse educator describes "evaluation" of a student, it may mean a subjective appraisal of student performance, objective measurement on a written exam, or assessment of personal attributes. After this first-pass approach, conventional content analysis, as described by Erlingsson & Brysiewicz (2017) was used to examine the data in detail. Data was clustered into "meaning units", or condensed sections of data, from which categories were derived. Codes and categories were further reexamined against the data to determine if the analysis accurately portrayed the data. The codes were then developed into themes that expressed the manifestation of the content (Erlingsson & Brysiewicz, 2017).

Study Rigor – Trustworthiness

While evaluation methods for quantitative research are concerned with rigor, reliability and validity, qualitative research comparatively demands trustworthiness, dependability, transferability and credibility (Lincoln & Guba, 1991). Rigor in qualitative description research

is demonstrated through trustworthiness of the research study. Lincoln (1995) describes criteria to achieve rigor as follows:

1) Credibility: as a result of strong study design, confidence that the truth and interpretation of the data is achieved.
2) Dependability: the extent to which the data and conditions could be replicated if the study were to be repeated with similar participants in a similar context.
3) Confirmability: the congruence of two or more person's opinion (that of the participants or content experts) of the accuracy, relevance or meaning of the data.
4) Transferability; the extent to which others can envision the study findings as being applicable to other settings and groups.
5) Authenticity: the presentation of the study findings that represent the realities of the participants to the extent that readers can experience the phenomena in an imaginative way.

Ensuring trustworthiness

The PI took all necessary steps and actions to achieve trustworthiness (or methodological rigor) in alignment with the above criterion. Some steps to address trustworthiness included the PI engaging in self-reflection during the data collection and analysis phases of the study. The credibility of the study is strengthened through disclosure of the PI's background and how it may have impacted the research. In qualitative research, personal and professional experiences of the researcher, such as personally held beliefs, prior disciplinary knowledge, and professional experiences, may interfere with both analysis and reporting of the findings (Rossman & Rallis, 2016). For example, the PI has over 21 years of bedside nursing experience in acute, progressive

care settings, and has been a nurse educator for over 13 years, teaching in pre-licensure programs. Additionally, the PI completed doctoral level independent study in ethics with a prominent nurse ethicist. Thus, it is imperative that the PI lay aside any knowledge, thoughts, opinions or biases that may skew or misinterpret responses. To address this, the PI maintained close adherence to the interview guide as presented. Further, self-reflection field notes were obtained during and after each interview in an effort to strengthen an audit trail. Peer debriefing activities with members of the dissertation committee, particularly an expert in the method, took place as well. A separate self-reflective diary was kept throughout the research process as part of the audit trail. Steps the PI took to maintain reflexivity in all data collection and data analysis activities will be described in further detail in Chapter Five. Other steps to assure the rigor of this study included the following:

1) Credibility:
    - Deep self-reflection on personal and professional preconceptions, biases and preferences documented by frequent taking and reviewing of field notes.
    - Using purposive sampling to obtain thick, rich descriptions and information.
    - Maintaining audio recordings and verbatim transcriptions, use of coding methods and peer review of the data.
    - Achieving theoretical saturation through sufficient number of participant interviews.
    - Communicating and disclosing the background of the PI.
2) Dependability:

- Maintaining detailed documentation of all aspects during the conduction of the study through data analysis and results reporting.
- Adhering to the interview guide as closely as possible among different participants.

3) Confirmability:
    - Reviewing data and coding methods with the scholarly team through peer debriefing.
4) Transferability:
    - Ensuring data saturation is achieved and providing thick descriptions of content, including quotes from participants.
5) Authenticity:
    - Capturing and meaningfully presenting the data through thick descriptions by participants.
    - Assuring verbatim transcription of audio recordings.
    - Using field notes to engage in self-reflection frequently and documenting these notations throughout the study.

To demonstrate trustworthiness, it is important to note where the researcher's and participants' perspectives may differ. Theoretical triangulation, where several possible theoretical interpretations of the data and study are considered, is another strategy to establish validity in qualitative research (Lincoln & Guba, 1991/1994). In a high-quality and detailed audit trail, consisting of field notes, observations and self-searching reflexivity, the study becomes more credible when a self-critiquing approach throughout the entire process is maintained. This is evident in diary notes kept alongside other elements of the audit trail.

Summary

This chapter reviewed features of qualitative descriptive research that made it a suitable method to study how nurse educators describe perceptions of ethical nursing practice, since relatively little is known about the concept. The plan for recruitment, participant selection, and protection of human subjects was discussed. The process for seeking IRB approval was also noted. The data collection process was explained, along with steps to ensure protection of the data. The interview guide used for data collection was outlined and appears in Appendix B. The chapter concluded with a description of the conventional content analysis using first cycle coding methods that were performed as interviews were conducted. In Chapter Four, the findings from the study will be reported, including a detailed description of the major themes that arose from the data. A discussion of the findings and implications of the research study will follow in Chapter Five.

Chapter Four: Results

In Chapter One, a description of the concept of the nature of the 'good' of nursing was presented, along with the argument that nursing ethics must be meaningfully incorporated into nursing education so as to provide novice nurses the tools and skills needed to navigate complex health systems. In Chapter Two, an exploration of what is known and not known was discussed, highlighting the disjunction between what is taught as nursing ethics and the uncertain preparation of nurse educators to teach and model disciplinary specific ethics. The problem of the lack of moral identity of nursing, and the development of ethical language for nurses was identified. Chapter Three detailed the research method and the rationale for choosing it to study this problem. The study design, research questions and specific aims were outlined. The plan for recruitment, inclusion/exclusion criteria, consenting, data analysis, and scientific rigor and integrity were also described.

In this chapter, the findings from the study are presented, including how the recruitment and consenting process, data collection procedure, data analysis and the trustworthiness of the data were actualized in this study. The purpose of this study was to explore how nurse educators describe disciplinary specific ethics and how nurse educators teach nursing ethics in pre-licensure nursing education. The aims of the study were to explain how nurse educators describe the ethical knowledge needed for nursing practice, how nurse educators view nursing ethics in relation to biomedical/healthcare ethics, and how the educators integrate nursing-specific ethics knowledge into their teaching. The research questions to be addressed include:

1. How do nurse educators describe nursing ethics?
2. How do nurse educators teach nursing ethics in a pre-licensure nursing program?

To answer the research questions, a qualitative descriptive design was used to explore how nurse educators describe ethical knowledge needed for nursing practice, how they differentiate nursing ethics from other disciplinary perspectives, and how it is integrated into their teaching methods. This method was selected because of the complex nature of the concepts, and having variables not easily measured. The methodology selected afforded the opportunity to examine factual responses about how people view a particular area of interest (Colorafi & Evans, 2016). The demographics of the sample are described first, followed by a description of the themes identified that elucidate the phenomenon of interest.

Recruitment

Study participants were initially recruited through a recruitment post on the *Nurse Educators Group* on Facebook™. This group is a public group consisting of over 7000 members. The administrator, Tim Bristol, PhD, RN, CNE, ANEF, FAAN (www.nursetim.com; NurseTim™), explains "the Nurse Educator's Group was formed for registered nurses that work in staff development, clinical education or academic settings. The intent and purpose of the group is to provide a networking forum of nursing professionals that are engaged in education. It is my hope as the creator of the group that we might develop interesting and thoughtful discussions about issues relating to nursing education" (https://www.facebook.com/groups/nurseeducators/about). After securing authorization from the group administrator, a recruitment notice was posted on the Nurse Educator's Group public page. Inclusion and exclusion criteria were specifically outlined and a description of the study was included. Four nurse educators responded via Facebook *Nurse Educators Group*. Subsequently, two additional participants were recruited through snowball sampling and referrals from two of the initial respondents. Recruitment continued through a process of colleague referrals with

further snowball sampling. A total of 18 people agreed to participate in the study. However, two participants did not meet the criteria of teaching in a baccalaureate nursing program, and each of these participants did not receive their nursing education in the U. S. A total sample of 16 nurse educators were eligible and agreed to participate in the study.

Protection of Human Subjects

Several mechanisms were used to assure anonymity and protect confidentiality of the study participants. All participants were assigned a unique code number and were asked to choose a pseudonym for use during the interview. Code numbers and pseudonyms were maintained as part of the coding manual and stored on an encrypted, password-secured computer to which the PI had sole access. All identifying information about participants was removed and replaced with their code number and/or pseudonym during data analysis and reporting of findings. Any other identifying details, such as location of institutions, were deleted from transcripts. Transcripts, video and audio recordings, field notes, memos and coding manual materials were maintained in a secured manner using encrypted, password-secured computer and locked office facilities to which the PI has sole access. The PI sought approval from the Institutional Review Board (IRB) at Boston College to conduct this study. Boston College IRB Number 21.182.01E was approved with exempt status on 1/24/2021.

All respondents who expressed interest in the research were provided with a description of the study, along with a written consent form via their self-identified email address. When participants were deemed to meet inclusion criteria, they were contacted by email to arrange for an interview at a time convenient to them and the PI. Consent forms were resent if the participant did not read or acknowledge receiving the initial mailing. One participant signed and returned

the consent via email. The remaining participants were verbally consented, after confirming they received and read the written consent, on audio recording before the beginning of the interview.

Data Collection

Interviews took place via Zoom™ platform within 1 to 2 weeks of initial contact and receipt of consent to participate. At the time of the interview, participants were provided the option to have the camera on or off, and all participants were reminded that the interviews would be audio recorded. Demographic information was captured using information in Appendix A. The interviews followed the script outline in Appendix B. The PI developed the interview guide initially as part of an assignment in NURS 9751 *Advanced Qualitative Research* Methods (Boston College). The draft interview guide was piloted with one participant, a faculty member in an undergraduate baccalaureate nursing program at a university in the Northeast. The interview guide was refined after the pilot. The interview guide was further developed with feedback from the dissertation committee: one with expertise in nursing ethics, one with expertise in nursing education, and lastly with one who is an expert in qualitative methods. See the Interview Guide located in Appendix B for questions participants were asked during the interview.

All interviews were digitally audio recorded, and for those whose cameras were on, were video recorded via Zoom™. Only the audio recordings were uploaded to a HIPAA compliant professional transcription service and transcribed verbatim. The transcripts, audio and verbal recordings were all used in data analysis. The PI kept field notes throughout the interview process. These notes captured participants' emotions as well as the PI's thoughts and reflections about the interviews. For example, several participants were observed to blush or giggle at certain questions that were asked, with the PI inferring their possible embarrassment at not being

able to answer a question they thought they should easily be able to communicate. These notes were documented immediately after each interview, during data analysis and after peer debriefing with a member of the dissertation team who is an expert in the approach. Data used for analysis included all videos and audio recordings, transcribed interviews and the researcher's field notes.

Iterative Process

The process of data collection and analysis was an iterative one. The interview guide contained questions that facilitated discussion with participants in a sequential, conversational-flow manner. As the interviews progressed, the PI sought feedback from participants about clarity of the questions and where the interview guide could be improved. As a result, in subsequent interviews some questions in the guide were refined, and occasionally rearranged.

This refinement was also done to reflect the natural unfolding of conversation with each individual participant. Some interview questions were refined based on prior participants' answer that signaled to the PI the question needed further clarity without leading the participant's response. For example, Question 5 ("Do you think nurses encounter ethical situations in practice that require a nursing perspective?") necessitated further refinement to convey what the PI meant by ethics requiring a nursing perspective. After the few initial interviews, a clarifying question was added to Question 5: "Are there situations that nurses encounter on a daily basis that require an ethical perspective through nursing's unique disciplinary lens?". On some occasions, participants would be discussing their description of nursing ethics and it was found that their response addressed a later question in the interview guide that had not been asked yet. In those instances, the question in the interview guide was not asked a second time when it appeared in the sequence.

Data Analysis

At the completion and return of each transcript by a HIPAA compliant professional transcription service, the transcript was read concurrently while listening to playback of the record. A comparison between initial transcripts and recordings was made to ensure accuracy and understanding of content. Where necessary, corrections to the transcript were made by the PI who conducted the interview and compared them to the audio and video recordings. Each transcript was reviewed twice in this manner to ensure the content matched the data on the recordings.

Conventional content analysis as described by Erlingsson & Brysiewicz (2017) was employed to extrapolate codes that identify key concepts in the data. Transcripts were read several times to obtain an overall sense of the whole data set. During this process, the PI maintained a reflective journal of initial thoughts and impressions of the data. The field notes taken during the initial interview were compared with the notes generated during transcript review. Key words were identified as codes, with codes clustered to create meaningful categories that could be organized. Codes and categories were then reexamined against the data to ascertain if the analysis accurately portrayed the data. As the codes and categories were developed, they were further developed into themes that expressed the manifestation of the content (Erlingsson & Brysiewicz, 2017).

The same process for analyzing the transcripts was followed by a member of the dissertation committee who is expert in this approach to analysis. To assure consensus, codes, categories and themes were reviewed with an expert on qualitative methods throughout the process of data analysis. Thematic accuracy and theme refinement were discussed in light of the transcripts, the PI's field notes, and each person's impressions of the data.

Findings

A total of 18 nurse educators contacted the PI and expressed interest in participating in the study. Two educators did not meet inclusion criteria. Sixteen nurse educators who met inclusion criteria were consented and agreed to participate. A total of 16 interviews were conducted and used for data analysis.

Demographic Characteristics of Participants

Sixteen nurse educators from different geographical areas across the U.S. teaching in baccalaureate nursing programs at the time of the interviews participated in the study. Study participants were from a variety of states, including New Hampshire, New York, Florida, Colorado, Washington, Missouri, and North Carolina. Within this group, 14 identified as Caucasian, and two identified as African American. All participants identified as female. Nine participants had a master's degree, 3 had a DNP, and 4 earned a PhD. None had an EdD. Many participants reported a nursing education focus for their master's (n=7), or clinical nurse leader (CNL) designation (n=3), while one participant was a clinical nurse specialist (CNS). One participant, an APRN (Psychiatric Nurse Practitioner) was currently enrolled in a PhD program. At the time of the interviews, all participants were teaching in a 4-year baccalaureate pre-licensure nursing program. Most taught full time (n=11) while others reported adjunct status (n=5). Courses and type of pedagogy varied among the group in simulation/skills lab (n=6), clinical settings (n=5), and classroom/didactic (n=6). While the participants reported teaching several courses across the curriculum, the majority (n=10) taught in nursing fundamentals and medical/surgical nursing; other courses included maternal/child (n=3), mental health (n=1), leadership (n=1), and research (n=2).

Findings from Participant Interviews

All participants reported being very interested in the study, noting they thought nursing ethics was a poorly understood topic, but one that carried significant implications for nurses and nursing practice. Nearly all verbalized that this was a highly important area for contemporary nursing practice, and one that is not addressed or studied enough. Several asked the PI to notify them when results were published as there was great interest in the findings and implications. However, while the participants agreed that ethics was very important for nurses, they also admitted that it is not well defined from a nursing perspective. They also had significantly variant views about what nursing ethics is, how it is incorporated into daily nursing practice, how it is different from the biomedical model perspective, and what its essential elements are. Participants were quite eager to share examples from their practice that they saw as having implications of nursing ethics, yet with probing, explaining defining aspects of ethical principles from a nursing perspective in those examples revealed they were not able to verbalize those components. They seemed to recognize the "big picture", or dilemma-based, scenarios and appreciate the implications of ethical dilemmas, but expressed difficulty explaining how that is different from day-to-day nursing practice.

Several participants appeared uncomfortable with some questions in the sense that they either did not know something they thought they should, or that they could not verbalize with the meaning they wanted to convey. For example, P012 and P015 often hesitated and asked for more time to think about an example of ethics in daily practice; P016 laughed and said she was embarrassed that she could not explain the meaning of bioethics or nursing ethics; P008 blushed and giggled, saying she felt like "it is a test". All participants were reassured the interview questions were not designed to test their knowledge, but rather to gain their unique descriptions and perspectives.

Themes

Four major themes were identified during data analysis. They include: (1) *Inherent personal qualities guide nurses' sense of professional ethics,* (2) *The ethical nurse is a 'good' nurse as reflected in their practice,* (3) *Disciplinary nursing ethics is not discernable from other ethics,* (4) *Nursing ethics education is inconsistent across schools of nursing.*

Theme 1: Inherent personal qualities guide nurses' sense of professional ethics.

The participants were asked to describe the term 'nursing ethics' or how they might explain it to someone who asked them what it meant. The majority described nursing ethics as the foundation of nursing practice, a personal moral code, or as personal qualities and values an individual nurse had which guided them to act in certain ways. For example, P001 noted:

> I would describe nursing ethics as a foundation to which the nurse uses her morals, beliefs, values, and instills that on her professional piece with her patients. So, in terms of nursing ethics, I feel like there's a lot of things that are self-driven from ethics, meaning if you don't have good morals, good beliefs, good values, you're not going to possess that in your professional way in delivery to your patients.

Most participants described the inherent qualities a person already possesses as that which makes them an ethical nurse. As P006 explained*:* "Nursing ethics, I think, is something that's inside of you as a person that guides you in doing things right or wrong." Other respondents identified nursing actions the nurse might perform that demonstrates inherent qualities and ethical behaviors, and described it "making the right choices for the better of the patients" (P011), or by acting "humanely" (P002), and "fair" (P008).

Many described that a personal moral code was a part of the inherent qualities of the ethical nurse. This moral code was described as guiding nurses' ethical decision making. Nearly

all of the participants identified personally-held beliefs and values, often developed from a religious perspective and/or reinforced by working for a religious institution as the basis of the individual nurse's ethical practice. Many participants, such as P013, talked about the instinctual and intuitive nature of knowing what was right and wrong: "I've always just relied on my gut feeling too; that something didn't feel right, it probably wasn't. I kind of have to go with that gut feel, you know?"

Some participants described nursing ethics in terms of the intention underlying decisions nurses make when caring for the patient. This involved a process of considering personal beliefs, a desire to do the right thing, and assumes that the nurse knows the patient's wishes. Personal beliefs were described as both guiding nurses' ethical decision making and yet something that must be set aside as described by P009:

> Making the best decision for the whole person, taking into consideration not only your own beliefs, but your patient's beliefs and having a goal of doing what is best for your patient despite everything else that may be going on, and what their family wishes are, and what your own beliefs are. Just having the best intentions and doing what is best for your patients.

Other respondents suggested that nursing knowledge and skills applied in practice contributed to ethical nursing practice. This was described as recognizing the patient as the nurse's priority, and the nurse's ability to use "skills and knowledge to care" to exhibit "caring" for the patient (P008). Additionally, a sense of professional expectations helped guide decisions, as captured by P016 who described "doing the right thing, even when no one's looking. It's maintaining both the nursing code of ethics, but also a moral code of ethics, of doing the right thing for the right reason".

While the participants indicated their personally-held beliefs and values were the "right" ones, they were careful not to impose them on others, whether patients or students; respecting others' beliefs, even if in conflict with the nurse's, was another value of nursing ethics. As P005 stated: "Well, yeah, my belief system is what I feel like is best, but my belief system also says that everybody has a different belief system."

Only one of the participants talked about the impact or effect of ethics education on their nursing practice. The participants seemed to personalize and internalize the virtuous aspect of behaviors as congruent with their view of what constituted nursing ethics. Rather than define disciplinary ethics as principles or terminology, the participants tended to offer an applied description of virtues and behaviors that aligned with their view of the meaning of ethics for nursing. Some participants described the tension that can arise when situations are a challenge to their personal view of ethics, such as when P004 said:

> So, I would describe that (nursing ethics) as potentially being put into an ethical situation that maybe goes against your own morals and values, or the morals and values of the institution, or even the morals and values of the academic institution in which you're in as well. So, oftentimes, though, with nursing ethics, what I think about is the inconsistencies or incongruencies that can occur between what is happening and what you yourself believe. And then, how do you handle that?

In summary, in nearly every interview, participants described nursing ethics in terms of inherent personal qualities. None were able to articulate that their nursing education informed their ethical decision making. Although they were not able to describe how these inherent qualities developed, many indicated that exposure to religious upbringing or affiliation with religion-based healthcare systems helped to cultivate their thinking.

Theme 2: The ethical nurse is a 'good' nurse as reflected in their practice

Participants frequently referred to "good" (such as a 'good nurse' or 'good practice') as descriptors in terms of personal characteristics or actions which they judged against their own sense of values and beliefs. They described "good" as equal to "ethical". Several attributed their moral development to deeply held religious values. When asked to describe nursing ethics, P010 offered "How do I know what's right? There's an objective moral truth…I grew up and I'm still a Roman Catholic and so that guides everything I do." Similarly, P001 explained that her upbringing and years of Catholic school education formed the basis of her moral belief system:

> I was raised with ethical decision-making since first grade when I went to Catholic school. So, I think it's been embedded in me for my whole life about making decisions based upon looking at conflicts, beliefs, the truth behind things…So, I've never really had a problem trying to figure out where I am ethically and morally, and my values and beliefs on things.

The participants talked about qualities that constituted ethical values in a nurse which included virtues and actions. As P010 stated: "Ethical care is patient centered. It's portraying your best self." This suggests that the participants considered care that is focused on the patient as ethical, and this focus applied across patients. As P011 offered: "…good nurses value and view the whole patient and do really try to give every patient a fair shot.".

Sometimes, nursing ethics was described in terms of what nurses do not do, such as withholding your personal beliefs and opinions. P009 described nursing ethics as "taking yourself more so out of the equation, and thinking of others and their wishes, rather than being really in tune to yourself and what you think is right."

Many suggested that ethical values are qualities someone "just has" within them. They often reported it was easier to identify and describe unethical practice by noting examples when they observed behaviors they deemed unethical in other nurses, such as drug diversion activity. Influence of the behavior of others was also described, such as stated by P016:

> Sometimes we learn what the nurse we don't want to be, just as much as we learn the nurse we want to be. And the conditioning or that nurturing is what brings the next generation (of nurses) forward, more than a book that you just read, like, 'This is what ethics is." It's ethics in practice.

Nursing was termed "good" when nurses possessed certain qualities, such as openness, honesty, speaking up and advocating, being compassionate, preventing distress, use of therapeutic communication and presence, and thinking of others. The majority equated nursing ethics and "good" nursing as preserving patient autonomy and choice, particularly when discussing end-of-life issues. Nearly all participants viewed supporting patient autonomy as the highest ethical value and behavior a nurse could demonstrate. For example, P014 stated "So, nursing ethics, to me, means the balance of preserving the patient's autonomy while seeking their best outcomes…the best outcomes has (sic) to be a flexible concept, and it's really determined by the patient."

Most participants spoke about qualities and virtues such as caring, honesty, supporting patient choice and values as equating with nursing ethics. P002 described nursing ethics in terms of a "pledge" the nurse takes to do no harm. Others associated nursing ethics with professional responsibility, but few either saw that as something separate from nursing ethics or didn't know how to respond. Often, legal aspects of nursing practice were described as a facet of professional

responsibility, and while participants wanted to separate the two, they often could not. P004 offered this observation:

> There's usually a legal something that is related to that piece of it. And so, that can make you cross the line as far as that goes. And yes, there's a difference between ethics and law. And I think that the term moral reasoning might be an appropriate term, or it might be even an ethical or moral justification. But it cannot draw the line of legal. You know what I mean? You can't cross the line of legal or not legal, because if it's illegal, it doesn't matter whether something's ethical or not. It's still illegal.

Nurse educator participants had a wide-ranging view of what it means to be a "good" nurse, particularly in terms of ethical practice. They could describe what they observed to be ethical or good by a nurse's action, inaction, or personal characteristics in comparison with their own value system. When a behavior was congruent with their value system, it was deemed to be ethical. Professional responsibilities were described in the context of the legal aspect of nursing practice, and not necessarily seen as ethical nursing practice.

Theme 3: Disciplinary ethics is not discernable from other ethics

Nurse educators had wide-ranging and multi-factorial descriptors of nursing ethics. The educators tended to agree that the idea of nursing ethics in daily practice was an existent concept, yet most gave examples centered around biomedical research and a medical-model of care, such as drug-related or medical-based dilemmas, often citing end-of-life situations. The participants readily identified complex medical dilemmas as ethical issues, but only a few verbalized the ethical implications of day-to-day or routine nursing care. One educator, P012, drew upon clinical experience and gave one example:

> So, if I see somebody contaminate, say, our sterile field, or instruments or supplies or whatever, if I see it, but the person who did the contamination doesn't see it or doesn't think it's contaminated, it's contaminated…I'm not just going to kind of stand back and think 'Oh, did that happen? Did it not?' Because then it's going to weigh on me that, well, if that happened and I didn't say anything and now the patient gets injured or gets infection, that was on me. That's ethically wrong on my part…whether they're (co-worker colleague) going to get mad at me or we're going to have to delay a case or something, it doesn't matter.

Participants talked about how situations made them feel, and they generally addressed situations they viewed as having ethical implications with their internal set of ethical values. For example, P001 described a situation when caring for a patient with a substance use disorder:

> …when you encounter a situation like that, your reaction is the first thing that the patient's going to see. So, it's trying to figure out, how do you actually feel about those situations? And if you're not comfortable with them, it's going to show with the patient and it's going to be a poor outcome if the patient and you just can't connect…how (are you) going to be able to help them in the future?

When talking about learning about ethics in nursing school, many participants could not remember what they learned or how it applied to nursing. A few recalled some ethical principles by name, such as autonomy and nonmaleficence. As a typical response, P006 noted:

> I remember reading case studies and how does this make you feel? What does this spark within you? What does this make you want to do? I just remember…where we would discuss some of the ethical things that really gave us a challenge.

Other participants talked about considering the feelings and experiences of patients as part of nursing ethics. For example, P004 talked about the challenges the COVID-19 pandemic is placing on patient care as an ethical problem for nursing:

> I truly think that nursing is about the personal touch and personal services that we give, so the ability for people to talk with us or that human touch. Right now, with the problems with COVID and not being able to touch your patient or do whatever, those things can be a real ethical dilemma that occurs. And you don't see that in other healthcare professions because they're not the ones at the bedside.

One participant suggested that the nurse's workload often prevents nurses from seeing the ethical implications of practice. P007 described the "demands of the (healthcare) system" competing with a nurse's ability to "get things done" in an ethical manner:

> We have to get this done, get this done, get this done as a checklist and we might not slow down to think that even something as simple as drawing blood, or for example…when a patient comes in and we take off their clothes and put them in a gown.

Only one participant mentioned the *ANA Code of Ethics* as a guide for practice, and described *The Code* as being introduced at the beginning of the nursing program and being threaded throughout. P006 stated:

> I actually think we do a really good job of teaching ethics. We bring it in their very first course…and we teach about ethics and what it is to be ethical. We talk about the essentials of baccalaureate learning. We talk about the ANA's position statement on ethics and what that says. But, before they really even get into the program, we have a whole section in our handbook about ethics, and when students come into the program,

> the first they do is read and sign that they've read the handbook…and there's a whole, there's about a half a page on ethics and what ethics means to us and our program.

A few participants talked about social justice and social issues as being in the realm of nursing ethics. For example, P002 described the focus of the university where she currently teaches as having a global health focus, stating that she thought social justice issues had an ethical focus particular to nursing. P003 echoed this, noting that nursing ethics, for her, had a Christian focus that included social teaching and global vision versus bioethics which had a "more local focus". P009 described the social determinants of health as a focus of nursing ethics in practice.

A few educators described feeling empowered to "speak up" about a situation that they felt was wrong, with assertiveness and advocacy for patients as well as colleagues considered an ethical nursing value. P012 stated "If something is wrong or something's bothersome to us, we're not afraid to stand up and speak up against it within the best interest, and not just the patients and family, but for fellow co-workers as well."

Several participants described the nursing role (action) as nursing ethics, including therapeutic communication, presence and touch. P006 offered an example of witnessing a nurse working with a pregnant teen:

> A teenage girl was pregnant and trying to tell her parents how to say that, what to do. And the physician didn't really…he was kind of like 'well, you need to decide'. So, it was an ethical thinking (sic) when (he said) 'well, figure out what you want to do, and if you want me to tell your mom, I will.' But when he left, it's when the nurse kind of took over and said 'that's a really big thing. How can I help you? Let's talk about this, let's

> problem solve. If you want me to be in here…' and so that to me was a big ethical thing where the nurse was much more involved than the physician was.

One participant viewed nursing ethics as involving the open sharing of information through communication about the patient with members of the healthcare team so that care could be better coordinated. For P015, openly and honestly sharing information about a patient, such as a drug-addicted birth mother and deciding what to do about the baby, was an ethical issue for nurses. Disclosure, in the form of all information regarding a patient situation, was considered by some participants as an ethical standard to enhance discussions about what should be done.

A few nurse educators referred to protocols and standards of practice as ethical concerns of nurses because these keep patients safe. For example, one educator talked about missing one of the "5 Rights of Medication Administration" as an ethical problem, rather than as a nursing practice error. Others offered protocols, particularly Advanced Cardiac Life Support (ACLS) protocols and hospital standards regarding resuscitative efforts, as being the guide for ethical decision making in those emergency situations. For example, P010 was asked to give an example of a situation that required a nursing perspective that involved a nursing ethics dilemma. The participant stated:

> My first thoughts are dealing with a code in the emergency department. The ACLS guidelines are when you decide to withdraw…and when you've been resuscitating somebody, the goal is for the team to agree to end resuscitative efforts. And, if one member of the team does not feel that they want to end it, then the team usually agrees to continue until everyone is on board.

The participant went on to describe the nursing implications as involving her comfort level with continuing resuscitation efforts when weighing the patient's potential quality of life if

they are successfully resuscitated; but it was interesting to note when asked about nursing ethics, she discussed a team collaboration scenario using established medical guidelines. P016 also discussed protocols to drive nurses' decision making, further offering "I think we heavily go on protocol because it keeps us (nurses) in a safe place."

All participants were asked if there was such a concept as nursing ethics. Virtually all participants affirmed there was. They were then asked if there is a difference between nursing ethics, as they described to the PI, and bioethics. Some participants observed the differences lie in nursing's holistic approach to the persons, others felt they shared common characteristics, and others opined there were no differences. A few participants asked the PI what was meant by "bioethics" and they were redirected to give their best explanation of what bioethics meant to them. Several hesitated, some laughed nervously, and a couple quipped they felt like they were taking a test but were reassured they were only asked to share their understanding and description of the concept. For example, P012 described nursing ethics as "a code by which nurses are upheld", and "that if something is wrong…we're not afraid to speak up against it." As a probe, the participant was asked to describe how bioethics was different, she stated "I guess I would have to go back and kind of really get the definition of bioethics."

It was evident that the participants held varied descriptions of what constituted bioethics and how that was different from the concept of nursing ethics. Some participants saw the two as the same, as described here by P006:

> I think that they're probably pretty much the same because, to me, bioethics is ethics of something living, bio. And I think ethics is something that lives within us. And it's a human quality. So, I would say they're both similar.

Participant P010 noted nursing ethics was “always doing what’s right, even when you have to make difficult decisions”, and when asked if she thought nursing ethics and bioethics are different, she simply said “no”. Some participants described ethical principles, as highlighted by P002:

> Bioethics, I’m thinking of things like, is this the same as nonmaleficence and beneficence and those principles? I believe they’re the same. I think they follow the same principles…I think about bioethical principles as do not harm, the patient’s right to choose, those kinds of things, a sense of autonomy. So, yes, I believe in practice it’s the same thing.

Participant P006 tried to articulate how bio and nursing ethics were different by stating “I think that maybe the difference is the way people view them.” She then provided an example around the issue of abortion:

> …maybe somebody views bioethics totally different than ethics…I’m thinking of abortion…some people see a real ethical decision for people and I think some may think of it as bio, as a living thing again, and a fetus. And so, they may see that as an ethical dilemma within themselves. But it’s also biological (ethics) because it involves something biological.

Some participants saw a divide between technology and science, with caring for the human person as what defined the separation of bioethics from nursing ethics. Participant P004 described the divide as bioethics being scientific and nursing being “the personal touch that goes along with (bioethics)”. Other participants initially described nursing ethics and bioethics as blended but then went on to describe aspects relevant to nursing ethics such as advocacy and preserving dignity, such as explained by P014:

> Well, bioethics, to me, is the preservation of life as much as possible, so that's a difficult balance. So, yet, it can be different than preservation of life, if you call that the definition of bioethics. Sometimes the goal of preserving our patient's autonomy, coming out with the best outcomes for them as defined by the patient, is not the preservation of life. It's more the preservation of dignity, so we're looking at each person as being in and of themselves worthy of dignity and respect and being able to choose their own outcomes as long as legally and ethically possible…so yes, nursing ethics can definitely be different from bioethics.

Participant P013 described nursing ethics as "those truths that all nurses hold", and explained this differs from bioethics because of legal implications: "I mean, you have to take the judiciary system and the legal system into consideration when you think about bioethics because a lot of those issues land in court."

Despite the variety of descriptions of bioethics, nearly all participants attempted to articulate nursing's holistic perspective of patient care and preserving patient autonomy as a key feature of how bioethics is differentiated from nursing ethics. Nearly all struggled to define bioethics, but in several instances identified a technology and/or biological basis, in contrast to the biopsychosocial focus of nursing toward human care needs. Most were able to identify dilemma-based complex care problems, including high-profile cases in the media, as belonging in the bioethics realm versus nursing ethics that focused on the human response to that dilemma. However, when asked for examples of daily ethical problems specific to nursing, most continued to identify those dilemma-based complex care problems as a representative case.

The wide-ranging and variant responses of nurse educators demonstrated the elusive nature of capturing a cohesive or definitive description of nursing ethics. It appeared the

educators attempted to synthesize their own meaning of nursing ethics from a variety of sources, including personal background, experience, education, religious affiliation, outside training, personal and professional experiences, protocols, policies and legal standards, as well as their view of the nurse's role and function.

Theme 4: Nursing ethics education is inconsistent across schools of nursing

The data demonstrated strongly that ethics varied widely and inconsistently across nursing curriculum. Despite the fact that all participants agreed that ethics was an important concept, and that nursing ethics was the basis of all nursing practice, the education of nursing students in ethical content was often weakly introduced or inconsistently applied. Nearly half of the participants had no formal ethics training in their own pre-licensure program, while some had an ethics course taught in another department (i.e., philosophy, theology), and most of those were not taught by nurses.

In the current sample, only a few participants reported their current university requires a stand-alone ethics course for nursing students. One did have a nurse educator who taught an ethics course at their university, but the remainder were taught in a department other than nursing. One school offered medical ethics as an elective course for nursing students. One participant did not know if her current university had an ethics course for students, admitting "I'm embarrassed to say (I don't know)" (P008).

Nearly all the participants reported ethics "interwoven" throughout their curriculum. Most could not describe how that was operationalized, although several spoke about using case studies and discussion as a teaching method in their courses. One participant admitted she had not thought about ethics as being a part of the simulation course she teaches, but then later contradicted herself, saying "I bring a lot of ethics and I do it intentionally" (P005). Participant

P007 noted that in her course "I bring the terms in a lot. So, I know that they've (students) learned a lot of those terms early in the program, of autonomy, beneficence, veracity, all those things." Self-reflection by students was highlighted by nearly all the participants. For example, how to evaluate ethics as a part of personally-held beliefs, P008 offered:

> …that they (students) recognize what their own values and beliefs are, so that they don't impose those on our patients. And that they're respectful of our patient's own values and beliefs…(they) do a self-assessment. If you don't know yourself, you can't get to know your patient. So, you identify what you like and what you don't like, so that you won't impose those feelings onto your patient.

When describing weaving ethics throughout the curriculum, the participants often cited dilemma-based type ethical problems; end-of-life care was a frequently offered example. P016 reported using the Terri Schiavo case in her course to explore with students how they would feel as a nurse on her case. P015 has students explore ethical issues in a written reflective paper, citing an example of predetermining the sex of a baby. Some discussed how they incorporated ethical principles, such as autonomy or beneficence, into their pedagogy, but this was not a strong feature in their responses. As noted by P009:

> …but I don't really label it as ethics. I talk a lot about…I play devil's advocate a lot in our discussion, so when I pose questions to my students, I try to stay neutral and have a position on both sides, so when a student responds, I ask them to think about it another way. I try and set things up so that they can see it more than just their initial reaction…so I think the biggest way, though, that I bring ethics in is just getting people to think about things from outside their perspectives.

Almost none of the participants could describe how their colleagues, teaching in other courses within the nursing curriculum, include nursing ethics in their content. Most participants could not explain if or how students were assessed for ethical behaviors, with the exception of a few participants lumping ethics under the category of 'professionalism' in clinical evaluation tools. P010 evaluated students' behaviors and determined if they were "patient-centered" which was equated with ethical care and professional behaviors. P010 also reported evaluating if students portrayed "their best self". Otherwise, students' thinking was assessed through reflective or analytical papers, or through classroom discussion.

While many reported they were comfortable teaching ethical content to students, others recognized the challenge of teaching this content. For some, the challenge was not wishing to engage in controversial conversations with students, as was captured by P006:

> I wouldn't say that I'm comfortable with it (teaching ethics). I think because I'd rather have something that has concrete content. I like lab values because they're black and white, pretty much. And ethics to me is grey, and sometimes it's harder to teach something grey. And I think one of my biggest fears, when I'm talking about ethical things, is that I'm going to hit a nerve with a student that maybe has gone through that and they're going to affected by it.

A few participants noted discomfort in teaching ethics, possibly reflective in the lack of their own understanding of nursing ethics, such as offered by P006, who noted "I'm also worried that they're going to ask me a question I won't know how to deal with."

Teaching ethical content to students of different generations were challenging to some nurse educators because of students' lack of life experiences. Some, such as P001, saw younger students as a challenge, as captured here:

> …in the courses I teach, these students are very young and don't have a lot of life experience, don't have a lot of background with ethics. So, I think it's harder for them to pull that together at their age of 18 to 20, versus teaching at an older adult level where they have had more life experience, more challenges that they faced and help to have had to deal with independently to make better decisions.

Whereas others viewed nontraditional, older students as more difficult:

> As an educator, just remembering what it was like to be a student and they asked a lot of questions, and it's okay for them to ask a lot of questions, and to meet them where they're at…I've taught accelerated BSN students and usually…they're a little more worldly, I would say. And therefore, they're a lot more verbal and vocal about their opinion, and I'm kind of burned out on that kind of teaching because they think they know better than me or the nurses around them…whereas I prefer to teach the traditional BSN program because they're still young and it's easier to mold them into being a competent nurse who learns it's okay to ask questions, but comes with no expectations, whereas the accelerated students come with expectations.

Despite the reported importance by all participants for nursing ethics and ethical reasoning skills for practicing nurses, it was evident that a common definition of nursing ethics, as well as how pedagogy was operationalized, implemented and evaluated is lacking across nursing programs and nursing curriculum.

Themes Summary

The overall description of nursing ethics by nurse educators demonstrated the highly eclectic nature of their understandings of a complex concept. The nature of nursing ethics, particularly as required for daily practice, depicted multifaceted and often conflicting descriptors

by nurse educators as they attempted to elucidate the concept. In this study, nurse educators were asked to describe nursing ethics as a separate concept from bioethics, the nature of nursing ethics and how it is recognized in day-to-day nursing practice, and how ethics is taught and evaluated in nursing students.

While responses sometimes shared similarities, nurse educators often struggled with articulating the meaning they were trying to convey. Further, the nurse educators readily recognized the ethical implications of complex dilemmas encountered in health care, but few described the ethical decisions made by nurses on a day-to-day basis during routine care. Descriptions of what makes a 'good' nurse, or what values are most important for nurses were also varied. The participants struggled to differentiate nursing ethics from bioethics, while many could not articulate a meaningful descriptor of either. The participants also described nursing ethics in terms of personal values or personal qualities of the individual nurse, often gauging those qualities by their own personally held values and beliefs. Several included legal aspects of nursing practice and quality improvement as components of ethical practice for nursing.

Responses to questions such as whether bioethics and nursing ethics were different, and if so, how are they different, were quite varied and most struggled to articulate any differences. Most participants described nursing ethics through the lens of nursing's holistic approach to patient care. When asked to explain what nursing ethics meant, answers ranged from describing personal characteristics of individual nurses, to behaviors of a 'bad' nurse, to explanations of what is 'right and wrong' in terms of patient care. Descriptions were most often subjective in nature from the participant's point of view. Each educator had a distinct perspective that a 'good' nurse equates to an ethical nurse, but when asked to provide an example, they often spoke about deeply complex ethical dilemmas that may only occasionally arise.

The majority of nurse educators sampled reported having had no ethics course, or scant ethics education in their pre-licensure nursing education, For the few who did report taking an ethics course, some mentioned ethical principles by name, such as beneficence and nonmaleficence, but did not elaborate on what the terms meant. Of those who did take an ethics course, most admitted they did not remember anything from those classes. While some did report exposure to ethical content in graduate school, it was mostly described in relation to ethics of research activities.

Trustworthiness

An important standard to qualitative research is reflexivity. That is, a researcher must be cognizant of how they potentially influence the process of the research study. In order to achieve reflexivity, the PI engaged in self-reflection during the data collection process by keeping a diary recording thoughts, observation notes made during the interview, and when reviewing the audio recordings after completion. Further, debriefing about the data with the dissertation chairperson, the qualitative expert on the team, helped the PI to process the findings in a neutral way.

In qualitative descriptive research, scientific rigor is demonstrated through trustworthiness of the study (Lincoln & Guba, 1991). Trustworthiness involves credibility, transferability, dependability, and confirmability. Credibility, or demonstrating confidence in the 'truth' of the findings, can be accomplished through several techniques, for example triangulation and peer debriefing, and member checking. Credibility was maintained through self-reflection, purposive sampling to obtain thick, rich descriptions from participants, and peer review of the data. The PI relied on triangulation with the dissertation chair and method expert to prevent selective or narrowed perception, and to reveal any potential blind spots. Peer debriefing with the method expert aided in neutralizing assumptions of the PI. Transferability, showing

where the research findings may be applicable in other contexts, is achieved by thick description: describing a phenomenon in sufficient detail that the conclusions drawn from the data may be transferable to other settings, time, situations or participants. In this study, purposive sampling was used to obtain thick, rich descriptions from participants. Detailed accounts of the experiences of the participants were elucidated so that expressive descriptions of the topic could be obtained during interview. Dependability, where the findings are consistent and could be repeated, was achieved by ensuring an audit trail was maintained throughout data collection and analysis. Adhering to the interview guide as closely as possible, and maintaining documentation of data collection and data analysis helped to ensure dependability. All field notes, PI notes, and coding schemes were maintained and used consistently throughout the process. Confirmability is the extent to which the findings are shaped by the participants, and not PI motivation or bias. Reviewing data and coding methods with the dissertation team methodology contributed to confirmability. Confirmability was further established by maintaining the audit trail, triangulation and reflexivity as described above. The PI held preconceived notions and personal background in abeyance during data collection and analysis. The PI engaged in self-reflection and peer debriefing throughout the data collection and analysis process. The evaluative criteria as described by Lincoln & Guba was the series of techniques chosen to ensure study trustworthiness as described above (Cohen & Crabtree, 2006).

All participants agreed to be recontacted for member checking during data analysis. However, this was not done in the context of this study because of the variation in descriptions by the participants. As a hypothetical example, one participant might offer a contradictory view of another participant's response if it went against her personal value system, as was evident in the data. The PI reserved the option to recontact the participants if it appeared to lend further

trustworthiness to the study. Where applicable, data was reported using quotes from participants to offer a thick description of content. Review of data with the feedback from the dissertation team methodology expert ensured data saturation had been achieved. Assuring verbatim transcription of each audio recording, using field notes to assist with coding, and meaningfully presenting captured data using thick descriptions by the participants lends to the authenticity of the study. An audit trail consisting of field notes, observations, self-searching reflexivity further contribute to the trustworthiness of the study.

Summary

This chapter presented the findings from the study. The process of participant recruitment and consent was reviewed. Protection of human subjects was ensured using established processes. Procedures for data collection and data analysis were described. Four themes were identified from the data. These are: *(1) Inherent personal qualities guide nurses' sense of professional ethics, (2) The ethical nurse is a good nurse as reflected in their practice, (3) Disciplinary nursing ethics is not discernable from other ethics, (4) Nursing ethics is inconsistent across schools of nursing.*

Participants' descriptions of nursing ethics lacked a disciplinary focus. How nursing ethics was operationalized in daily nursing practice was highly varied or not evident. A description of nursing ethics in practice, in nursing education, and as differentiated from the bioethical-medical model emerged but was often convoluted. Participants overwhelmingly reported that nurses simply possess internal qualities that are ethical and appropriate for nursing practice. Several attributed these qualities to religious upbringing or religious influence of the academic or healthcare institution with which they were affiliated, with the idea that these qualities were intrinsically and inherently present in the nurse. The participants had difficulty

describing differences between a bioethical or bio-medical model approach to ethics and disciplinary specific nursing ethics. In instances where the nurse educator noted there was a difference between the two, the examples most cited were complex dilemma-based healthcare decisions that are not frequently encountered. The data also highlighted the variability of ethics pedagogy in nursing curriculum, both in terms of how, and whether, it was taught, and how it was evaluated. In Chapter Five, findings are discussed in further detail, in relation to what is known and not known as reviewed in Chapter Two, along with implications for nursing practice, education and further research.

Chapter Five: Discussion and Implications

In Chapter One, the lack of knowledge surrounding nurse educators' description of nursing ethics from a disciplinary perspective was introduced as the problem and research questions were identified. In Chapter Two, the foundation for undertaking this study, which centers in the idea that nurse scholars have responsibilities to further the goals of the discipline and to improve nursing practice and nursing education, was discussed. A review of what is known and not known about how nurse educators describe ethics from a disciplinary perspective was presented along with a critique of current literature and evidence. In Chapter Three, a description of the method was provided with the rationale for why it was chosen to study this problem. In Chapter Four, findings from this study involving sixteen nurse educators from different areas of the U. S. were presented. The findings are a result of a descriptive analysis of recorded interviews and subsequent verbatim transcripts.

This chapter provides a discussion of the findings in relation to what is known and not known about how nurse educators describe nursing ethics from a disciplinary perspective. Insights from the study are highlighted and related to the literature reviewed in Chapter Two, along with the PI's prior understanding of the concepts. The discussion, as presented, is organized around the four themes that were identified in the data: (1) *Inherent personal qualities guide nurses' sense of professional ethics*, (2) *The ethical nurse is a 'good' nurse as reflected in their practice*, (3) *Disciplinary nursing ethics is not discernable from other ethics*, (4) *Nursing ethics education is inconsistent across schools of nursing. S*ome concepts inevitably overlapped with each other, yet despite similarities, the data did demonstrate a highly variant and wide-reaching understanding of nursing ethics from a disciplinary perspective and how it is recognized in daily practice. The chapter discusses implications of the findings for nursing practice and

nursing education. Implications for policy and further research as also described. The chapter concludes with limitations of the study.

Discussion of Themes

Four major themes were identified during data analysis. They include: (1) *Inherent personal qualities guide nurses' sense of professional ethics*, (2) *The ethical nurse is a 'good' nurse as reflected in their practice*, (3) *Disciplinary nursing ethics is not discernable from other ethics*, (4) *Nursing ethics education is inconsistent across schools of nursing.* Each theme will be discussed in further detail.

Theme 1: Inherent personal qualities guide nurses' sense of professional ethics.

The personal qualities of the individual nurse arose as a major theme from the data. The nurse educators in the study often described an ethical nurse as one who possessed certain qualities that were, to them, inherently 'good'. Many of the participants described those admirable qualities that a nurse possessed which made them ethical, suggesting that the nurse simply "was" ethical. The literature has explored the idea of virtue ethics (Hursthouse & Pettigrove, 2016) as one's moral character, including honesty, truth-telling, courage, justice, and other attributes that would lead one to be admired for possessing such qualities. As has been seen, however, many scholars reject this view of defining the nursing profession in this way (Fowler, 2015). It would appear, however, that the participants of this study subscribe to the idea of virtue ethics as a basis for identifying nursing ethics in practice.

Rather than explain what nursing ethics means, the nurse educators instead chose to identify how it would be characterized. They often spoke in terms of how an ethical nurse would act, and occasionally, how an unethical nurse could be identified through what they deem to be bad behaviors. While most of the descriptions of an ethical nurse were similar, the qualities

identified were seen through the individual educator's perspective. In other words, the educators themselves seemed to decide what, or who, was ethical in their view. This was assessed using their own set of values and beliefs as the ethical standard by which others would be deemed ethical.

In describing the inherent qualities ethical nurses possess, the nurse educators often used a mixture of virtue ethics, deontology, and consequentialism as the way they viewed nursing ethics. In some cases, the participants emphasized rules and duties, or the deontological approach, to the meaning of ethics, yet then added virtues or qualities the nurse might possess, and finally conclude with a consequentialist approach where they discussed consequences for actions deemed to be unethical. What was clear, however, is that the nurse educators clearly saw their version of ethics, in whatever manner they explained it, through the perspective of nursing; that is, that the patient is a person of worth and dignity, deserving of compassion and care without regard for personal attributes or socioeconomic status (Fowler, 2015). Not surprisingly, since the educators interviewed were based in the U.S., all held a Western philosophical view of persons and their individual importance that seemed to guide their thinking.

Very few of the participants could identify the inherent ethical implications for the day-to-day, routine actions of the nurse. Rather, the nurse educators tended to view ethics through the lens of the personal qualities the nurse should have. Given this view, what was particularly troublesome was that few could articulate how they would recognize or evaluate this quality in students. A few did point out some behaviors they deemed were unethical, or unprofessional, but overall, they did not think that ethics, as a nursing skill in practice, could be evaluated or assessed. Since nurses are asked to work in complex and complicated environments, where they will face numerous and various difficult situations, it is important that nurses have sufficient

tools at their disposal to address these challenges, more than merely possessing some inherent quality deemed 'good'. This highlights the need to further refine a definition of nursing ethics that is a useful and meaningful guide for practice, and one that empowers nurses to make important decisions in their day-to-day work.

Theme 2: The ethical nurse is a 'good' nurse as reflected in their practice.

In theme 1, inherent personal qualities were often described as necessary for a nurse to practice ethically. In theme 2, the actions of what this ethical nurse would do were revealed. Participants described actions they thought demonstrated that a nurse was good, or what signaled good practice. For many, this meant operationalizing a faith-based, or religious approach, to nursing care. The participants talked about commitment to their faith and not participating in actions that would go against that faith. For example, one nurse educator who admitted to having a Christianity-based background and another who did not, brought up an example from practice involving a woman in the early stages of pregnancy who begins bleeding. While they both said that giving a particular medication would be physiologically important, one nurse educator said it was still wrong to give it, while the other said it was wrong to not give it. This type of thinking becomes problematic when trying to decide what are the ethical and "right" actions of a good nurse.

Others talked about when a nurse was open, honest, or not afraid to speak up against what (s)he thought was wrong. Most agreed that not imposing their beliefs on others made them an ethical nurse. Some nurse educators offered examples of behaviors that they deemed unethical. For many, it was perhaps easier to identify examples of unethical behavior rather than be able to describe nursing ethics as a concept. Several used the example of drug diversion activities as an example of an unethical nurse. Others talked about the influence of other nurses in modeling

ethical or unethical behavior. Interestingly, while some did note that there are both good and bad role models, most of the educators said that for ethical questions, they would direct a nurse to consult with other nurses who might be more experienced for guidance, and did not qualify that the nurse should seek out an experienced nurse whose behaviors they admired.

Most, however, viewed end-of-life issues and patient autonomy as of the highest ethical value. Nearly all nurse educators interviewed talked about preserving patient autonomy in some manner. Supporting and promoting patient autonomy emerged as the highest ethical ideal a nurse could have. Qualities such as caring, honesty and supporting patient choice were all actions the ethical nurse would demonstrate. Often, legal aspects of healthcare, and of nursing practice, were described as an ethical value for nurses, yet few could draw a distinction between legalities of nursing practice and nursing ethics.

Overall, when a nurse's behavior appeared congruent with the participant's own value system, it was deemed to be ethical and the nurse was "good". That is, the participants evaluated a nurse as "good" through their own perspective and values, rather than as a measure against an established definition of "good"; a nurse is ethical if that nurse's behaviors align with the participant's beliefs of what is ethical. Without a clear definition for nursing ethics, or how it is operationalized in practice, nurses begin to surmise what constitutes a good nurse using their own value system as the measure.

Theme 3: Disciplinary nursing ethics is not discernable from other ethics.

The nurse educators had wide-ranging descriptors of nursing ethics, however most had difficulty parsing out the difference between that concept and that of bioethics or medical ethics. The majority saw bioethics and medical ethics as synonymous with nursing ethics. Although they agreed there was a need for ethics through a nursing perspective, when asked to give

examples, the majority of participants cited examples of ethical dilemmas or high-profile end-of-life decision making cases. One participant did offer an example of nursing ethics involved in the insertion of a peripheral intravenous access catheter, but that was a rare description of the recognition of ethics in routine, daily nursing activities among participants.

Many participants stated there was a difference between bioethics/medical ethics and nursing ethics, but admitted they could not verbalize the difference between them. Two participants felt there was no difference, describing nursing ethics as the same as bioethics. Others were asked to describe the difference between bioethics and nursing ethics, and few were able to define bioethics. Many described medical ethics, particularly when considering ethical medical dilemmas, as the basis for nursing ethics. Some participants saw a divide between technology and science, with caring for the human person as what defined the separation of bioethics from nursing ethics. A few asked the PI for a definition of bioethics as they were not able to define it themselves.

Protocols, standards of practice, and laws were also described as the ethical standards that nurses follow. To many, this was the ethical basis of nursing practice. Participants often talked about the use of protocols that guide decision making, particularly in life-sustaining emergency situations, and these protocols were described as ethical standards for action. The participants who used these examples, however, did not talk about how these protocols are generally created through the medical-model perspective. In other words, even though nurses use protocols in practice, they are not derived from a nursing perspective and are not truly ‘nursing ethics’ although they may be used as part of a nurse’s ethical decision making. A few saw the legal aspects of healthcare as the deciding factor over the “right” thing to do.

The majority of participants talked about preserving a patient's autonomy as the primary driver of a nurse's ethical activity. To many, this was the concept that separated nursing ethics from a medical model or bioethical perspective. A few used the terms "beneficence" and "nonmaleficence" but without context and as a passing comment, indicating they were familiar with those terms, but did not specifically connect them to nursing ethics. The vast majority of participants said nurses had a unique ethical perspective in patient care, and then when asked to give examples reached for preserving patient autonomy in decision-making, or described dilemma-based problems from the medical perspective. There was a disconnect between what educators' thought nursing ethics should be and how they saw it in practice. Most participants described nursing's perspective of the holistic care of the person as what constituted the basis for nursing ethics.

Theme 4: Nursing ethics education is inconsistent across schools of nursing.

It was evident, both in terms of how the nurse educators were themselves educated, and in the current curriculum of universities where they presently teach, that ethics education across schools of nursing was highly variant, if at all present. These findings are consistent with that of Hoskins, Grady & Ulrich (2018) who reported inconsistency across pre-licensure curricula both in how nursing ethics is taught and by whom. In the present study, this inconsistency often translated to a source of discomfort and lack of preparation to teach ethics in the curriculum. Of those who reported feeling comfortable teaching nursing ethics, the majority related it to their internal feelings of confidence in their own beliefs and values. In other words, those who were most assured of their personal internal beliefs and values as being "right" also reported feeling most comfortable with teaching ethics. There were different pedagogical approaches to learning and teaching ethics within pre-licensure curricula. Among these educators, the use of case

studies, personal stories and examples, and encouraging students to engage in self-reflection were the most often used methods to address ethical issues for nursing practice. Of those nurse educators who did not feel comfortable teaching ethics, the reasons usually centered around the aversion toward engaging in perceived potential confrontation with students when discussing sensitive topics.

The Essentials: Core Competencies for Professional Nursing Education (2021) outlines the outcomes expected of graduates of nursing programs across a trajectory of education, from pre-licensure to advanced practice nursing. The *Essentials* (2021) outcomes proffer graduates will be enabled to demonstrate competency to practice in complex healthcare environments and assume several roles. While *The Essentials* (2021) delineates ten Domains for Nursing that outline the core competencies for nurses, it also includes concepts associated with professional nursing practice that are separately defined, but integrated throughout the Domains. Concepts for professional nursing practice include clinical judgement, compassionate care, evidence-based practice, health policy, social determinants of health and ethics. In this document, ethics is defined as:

> Core to professional nursing practice, ethics refers to principles that guide a person's behavior. Ethics is closely tied to moral philosophy involving the study of or examination of morality through a variety of different approaches (Tubbs, 2009). There are commonly accepted principles in bioethics that include autonomy, beneficence, non-maleficence, and justice (ANA 2015; ACNM, 2015; AANA, 2018; ICN, 2012). The study of ethics as it relates to nursing practice has led to the exploration of other relevant concepts, including moral distress, moral hazard, moral community, and moral or critical resilience. (AACN, 2021).

The data from the present study demonstrates the wide variability in how nurse educators recognize nursing specific ethical problems or implications for practice. Nurse educators rely on the *Essentials* (2021) for curriculum design; however, it appears from this data that meaningful application of the expected outcomes is not occurring in nursing curriculum on a consistent basis. Interestingly, those educators who said ethics was taught throughout their nursing curriculum could not state for certainty where it was taught or how. Most said it was "interwoven" throughout the curriculum but could not point to where ethics was definitively taught.

Even more surprising was that many schools of nursing are not requiring an ethics course as part of pre-licensure nursing education. Of those that do, the courses are often elective courses, or if required, are taught by a department outside the school of nursing, and often not by nurses. When students receive ethics education from a medical or bioethical model it is questionable whether they will be able to use the broad concepts and principles of ethics in a meaningful way in daily nursing practice (Ion, et al, 2018). Without knowledgeable nurse educators who can guide students to translate ethical principles into meaningful tools to assist them on a daily basis, the curriculum contains unworkable and unusable ethical content.

Discussion

The purpose of this qualitative descriptive study was to explore how nurse educators describe nursing disciplinary specific ethics and how nursing ethics is taught in pre-licensure education. Specific aims of the study included how nurse educators describe the ethical knowledge needed for nursing practice, how that ethical knowledge is differentiated from other disciplines, and how nursing disciplinary knowledge is integrated into their teaching. Underpinning the study are the assumptions that each nursing action on the part of the nurse

occurs on a continuum of ethical implications, with the majority of daily practice consisting of activities that contain inherent, subtle and less obvious ethical implications. Because every interaction with a patient has ethical dimensions and implications when the nurse is intentionally focused on meeting patient goals informed by nursing knowledge and nursing's goals (Milliken & Grace, 2017), the significance of the perspective of nurse educators, who are responsible for conveying disciplinary knowledge to students, is important to understand.

In contemporary healthcare environments, nurses are exposed to a variety of other disciplinary viewpoints that may cloud or override nurses' unique disciplinary perspective (Austin, 2007; Milliken & Grace, 2017; Ulrich, et al, 2010). This study provided evidence to support this is an ongoing problem, both in nursing practice and in nursing education. Instead of the nurse practicing to the fullest capacity for which they have been prepared, they are being placed into healthcare environments where the nursing perspective is often "drowned out" and nurses are given decision-making tools that are derived from bioethical and medical ethics models. Often as a result, nurses report experiencing moral distress when they have inability to act when institutional constraints or lack of knowledge prevent them from acting in the best interest of their patients (Waddill-Goad, 2019).

The findings of the present study highlight the lack of a clearly defined, widely accepted definition of the concept of ethics through a nursing-specific disciplinary lens. Scholars have written on the concept elsewhere (Grace, 2018; Smith, 2019) but the results of this study point out that this has not been assimilated into the pre-licensure nursing curriculum in a meaningful way. The findings from this study suggest nurse educators themselves have not been educated with this type of disciplinary perspective of ethics, thus it is not incorporated into their pedagogy. The educators who did include ethics in their pedagogy most often did so from the bioethical and

medical ethics models, or relied on their own sense of a personal values-based ethics. As has been shown in the literature, these models do not provide sufficient tools to nurses in practice when they encounter daily ethical dilemmas that are often too subtle to be recognized or acknowledged (Kangasniemi, Pakkanen & Korhonen, 2015).

Implications

This study has several implications to inform further nursing education, practice, research, and policy. Each will be discussed here separately.

Education

This study highlights the need for design of nursing curriculum that clearly communicates a nursing perspective in ethical patient care as suggested by the *Essentials* (2021) document. It is evident that a meaningful description of the concept of nursing ethics for the baccalaureate level nurse, separate and unique from bioethics and medical model ethics, needs to be developed and incorporated into disciplinary knowledge. This is germane since nurses' issues in practice are not biomedical in nature, but rather are actually quite different and grounded in the disciplinary perspective as described by Willis, et al (2008), and Smith (2019). A language of what nursing ethics is in relation to the daily problems nurses encounter is needed to ground practice in a way that supports nurses' ability to make ethical decisions. With that conceptual language, tools could be further developed for nurses to support them in expanding ethical awareness and decision making, possibly reducing moral distress (Jurchak, et al, 2017).

The study revealed that a nurse educator's background and belief system, from whatever its source, influenced the way they view ethics. Each educator defined "best" or "good" from their own experience and viewpoint. This is problematic when nurses view situations from a

personal religious perspective, or value-laden decisions of right/wrong or moral/not moral as it promotes judgement of another rather than open discussion about personal preferences with another. When nurses practice from a sense of their own beliefs, not only is the variation in opinion potentially vast, but it also may not be reflective of a disciplinary perspective. If nurses arrive at a disciplinary perspective of what ethics is, educators can ensure student nurses know what that definition is and help them to understand how a nursing perspective may guide their practice. Nurse educators should have a firm understanding of the ethics for daily nursing practice that arises from their educational preparation to enter the teaching role.

It was clear that educational preparation of the nurse educators themselves was lacking. The majority of participants admitted they had not taken an ethics course prior to assuming their educator role. However, they also said they felt comfortable teaching ethics, and this was usually from their own values and perspectives of what was “good” or “right”. Nurse educators who are not themselves educated in nursing ethics and perspectives may not be effectively incorporating this necessary knowledge in their pedagogy. It was not evident that the participants could definitively explain how ethics was incorporated into their pedagogy. Nurse educator programs at the baccalaureate level should include a stand-alone nursing ethics course that is foundational to the curriculum and pedagogy of the program.

Practice

Additional study results revealed that often the nursing role was seen as synonymous with nursing ethics. Although professional identity does carry implications for ethical actions in practice (Grace, 2018), nursing role and professional identity are two different elements. In this study most participants did not view them as such. Nursing ethics was often described as what the nurse did or did not do, pointing to the nurse’s role. The educators tended to explain nursing

ethics through nursing's metaparadigm as their description of the basis of disciplinary ethics (i.e., holistic view of persons) but tried to apply bioethical and medical ethics models to problems in practice. The importance of conceptual language from a disciplinary perspective is needed to further the understanding of nursing ethics and to incorporate it into nursing curriculum (Hoskins, et al, 2018). As a consequence, students may fail to see the ethical implications of their professional identity as different than merely identifying whether a task was done properly or not and if the patient was harmed or not harmed by their action.

As has been previously discussed in Chapter Two, moral distress may arise when nurses encounter barriers that prevent them from acting as moral agents in their daily practice. Nurses struggling in the transition from school into the realities of contemporary practice can lead to experiences of moral distress in novice nurses (Hoskins, et al, 2018; Jurchak, et al, 2017; Ulrich, et al, 2010). The consequences of moral distress are costly to the individual nurse, healthcare organizations, and society (Burston & Tuckett, 2012). When nurses feel ineffective in fulfilling their professional responsibilities, they may begin to feel disillusioned with the profession and choose to leave (Jurchak, et al, 2017; Mason, et al, 2014). Other consequences of moral distress include burnout, turnover, lateral violence, emotional exhaustion and depersonalization of the healthcare environment (Ion, et al, 2018; Kelly, et al, 2015; Oyeleye, 2013), all of which negatively impacts patient care.

A few study participants said that when an ethical dilemma arose in practice, they would refer the matter to the ethics board. Only one participant could say that a nurse was on the ethics board of their clinical facility, and yet said the nurse was present to report the "facts" of the case. The implications here are that few nurses are active members on ethics boards, and that for those who are, they may not bring a nursing disciplinary perspective to the table since there is a

variable conceptual understanding of that perspective. Instead, the bioethical and medical-model ethics seem to be the prevailing framework for ethical dilemmas reviewed by ethics boards. Nurses effectively prepared with a disciplinary perspective of nursing ethics must bring that knowledge to ethics boards as members who can contribute to the discussion of ethical dilemmas with additional viewpoints of ethical decision making that enhances the frameworks often used by ethics boards.

Research

Opportunities to advance knowledge development of nursing ethics through research include examining to what extent nurses feel prepared for the environments they encounter in practice. Additional research might include presenting case studies that center on identifying the daily ethical situations encountered by nurses in practice, and if they are able to verbalize their nurse perspective in considering those situations. Research of whether nurses feel as though they have an equal voice on the team is important since creating opportunities for dialogue is essential to working through ethical questions that arise from practice. A next-step from this current study might include identifying nursing activities or healthcare situations recognized by nurse educators as having ethical implications for nurses in day-to-day practice. Further research into pedagogies that effectively and meaningfully teach nursing ethics should be conducted. Additionally, research into how to assess ethical competency in nursing students is needed. Lastly, exploring the impact of nursing ethical knowledge and its impact on easing nursing students' transition into practice may be important to improving retention and reducing moral distress (Kovner, et al, 2016).

Policy

Schools of nursing have the option to be accredited by two different bodies, or not at all. For example, some schools are accredited by the Accreditation Commission for Education in Nursing (ACEN) through the National League for Nursing (NLN). ACEN outlines Standards and Criteria (ACEN Accreditation Manual, 2020) for nursing programs that include faculty qualifications, program plan of study, resources used in the program, and evaluation plan (self-study). Standards and criteria vary slightly depending on the type of program (associate, baccalaureate, graduate). The goal of ACEN accreditation is to ensure nursing education is supported by schools of nursing and that programs are operationalized in a safe, effective and consistent manner (Gaines, 2022).

Another accrediting body, the Commission on Collegiate Nursing Education (CCNE), through the American Association of Colleges of Nursing (AACN), incorporates the *Essentials* (2021) into its standards of program evaluation. The focus of CCNE accreditation is on academic nursing to contribute to the overall safety of the public's health (Gaines, 2022). Since CCNE utilizes the *Essentials* (2021) as a guide to its accreditation criteria, there is some inclusion of ethics within conceptual language of the standards. The implications are the schools of nursing accredited by ACEN may not be focusing on ethical concepts or standards in their curriculum since they do not rely on the *Essentials* to meet accreditation benchmarks in their program. Because ACEN is focused on reviewing the nursing program itself, rather than specific curriculum content or nursing competencies, important elements for nursing practice, such as those outlined in the *Essentials* (2021) are lacking specificity, and as such, schools of nursing with ACEN accreditation would not focus on this aspect in curriculum. As a matter of policy, the NLN should consider review of their standards to establish core competencies or minimum educational benchmarks for nursing students, including ethics education.

Limitations

This study has several limitations. First, it should be noted the PI has studied ethics from a variety of perspectives and subscribes to the idea that there is a disciplinary-specific nursing ethics in daily practice. The majority of participants in this study have not been educated in this manner; thus, the PI was required to attempt to hold in abeyance any preconceived notions or judgments when speaking with participations.

Recruiting was limited to one interest group on one social media platform, and many participants were recruited through colleague referral and snowball sampling. Educators who have an interest in the concept of ethics were most likely motivated to participate, which may have influenced the results. Nurse educators who were not told ahead of time that the study was about ethics in practice may have offered different perspectives. The sample size, purposive sampling procedure and inclusion criteria decrease the generalizability of the findings. Additionally, since the sample was limited to nurse educators from the U. S. the data gathered and analyzed represents a Western perspective, and other perspectives might have contributed to different results.

The self-report method of data collection through interviews may have produced findings that were different from what participants actually do in practice or educational situations. Participants may have been motivated to tell the PI what they thought the Investigator was looking for. Many participants hold terminal degrees and have participated in conducting research, and may have offered answers that they viewed as supporting the PI's aims. Further, because data was gathered over the Zoom™ platform, the environment may have caused discomfort at being video and audio recorded, and may have cause the participants to act in abnormal ways or produced artificial results.

Conclusion

The research presented here suggests there is a gap in theory and practice with respect to ethics in nursing practice. The lack of disciplinary focus on what constitutes ethics for the day-to-day activities of nurses, or whether there is understanding of such a concept, may be a contributing factor to the growing moral distress that is being experienced by nurses in contemporary healthcare settings. The consequences of moral distress among practicing nurses are costly, both psychosocially and economically, and has implications for patient care outcomes (Grace, et al, 2014). This research began with the assumption that nurses in practice learn from the nurse educators who are responsible to guide them through curriculum and prepare them for entry into practice. It is evident that there is no common viewpoint and a lack of conceptual disciplinary language of what constitutes nursing ethics among nurse educators. Conceptual clarity of nursing ethics is imperative in order to incorporate it meaningfully in pre-licensure curriculum, and to ultimately affect nurses, nursing practice and patient outcomes.

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Appendix A

Demographic Data Questions

After obtaining consent to join the study, participants will be asked questions about demographic characteristics at the beginning of the interview. These questions will be used to describe the study sample.

1. Age of participant
2. Gender
3. Employment/teaching status
4. Highest degree obtained
5. Type of university attended
6. Employment outside of academic settings
7. Types/names of courses taught
8. U.S. region where currently teaching

Appendix B

Interview guide

Opening:

Thank you for agreeing to participate in this interview. The purpose of this study is to describe how educators understand nursing ethics in nursing practice and nursing education. I will be asking a series of questions to explore how you describe nursing ethics. You are asked to answer the questions to the best of your knowledge and ability. To reiterate, there are no right or wrong answers. If you would like to skip a question, or if there is a question that makes you feel uncomfortable that you prefer not to answer, please feel free to decline to answer. If you wish to stop the interview at any time, please let me know; all answers you have given up to that point will be used for analysis in the study. I would like to confirm that you had an opportunity to review the consent form I previously emailed you. Do you have any questions about the content in the consent? Do you now give assent to participate in this interview?

Interview questions:

Q. 1. In your own nursing education background, were you required by your program to take an ethics course? If so, describe the types of ethics courses you took. (If no, will skip to Q. 2)

Probe 1. Which department or school taught the ethics course? Who taught the course?

Probe 2. Describe what topics you recall being covered in the course.

Probe 3. How was the course taught (lecture, discussion, independent learning, etc.)?

Probe 4. Did you take additional ethics courses prior to when you started teaching? If so, what were the courses?

Q. 2. (If no ethics course required) Were there any elements of nursing ethics or bioethics within other areas of the curriculum at the school you attended?

Q. 3. Describe how ethics is incorporated in the pre-licensure nursing curriculum at the university where you presently teach. (If participant has taught at different universities, will ask to describe the different curriculums for each for comparative reasons).

Probe 1. If answer is similar to "a bioethics course" (i.e. stand-alone course), ask whether this course is taught by the school of nursing or another school/department.

Probe 2. Does your university have a graduate nursing program? If so, is there a difference in the ethics education for graduate students, for example, an additional ethics/philosophy/theology course, and ask where in the curriculum this course is taught (as above)? (If the university has graduate programs).

Q. 4. When I use the term "nursing ethics", what does that mean to you? How would you describe it to someone?

Probe 1. Do you think nursing ethics and bioethics are different? In what ways do you think they are different? Are there similarities? (If there are differences described, go to Probe 2).

Probe 2. How would you recognize the difference between nursing and bioethics in clinical practice?

Q. 5. Do you think nurses encounter ethical situations in practice that require a nursing perspective? Would you provide an example? As a teacher, how do you incorporate this nursing ethical perspective into your teaching? How would you explain the concept of "nursing ethics in daily practice"? Do you think there is such a concept?

Probe 1. Based on your explanation, describe three ethical situations or behaviors a nurse might encounter in day to day practice that require nursing ethical reasoning and decision making?

Probe 2. How do you explain to students the types of nursing ethical situations they will encounter in practice? What types of nursing ethical problems will they face when they enter practice?

Q. 6. When reflecting back to your active clinical nursing practice, can you think of an example when you encountered a situation that required knowledge of nursing ethics? Describe the situation for me. (If the answer is no or cannot readily recall an example, skip to probe 2).

Probe 1. In this situation, what guided your thinking to help you to make the decision you did? What was your ethical reasoning process? What role did your prior ethics education play in this decision-making process? How did this situation make you feel?

Probe 2. In your experiences and interactions with teaching nursing students, have you (or they) encountered situations that required ethical reasoning guided by a nursing perspective? What was the thought process that led to the decision? Did your prior ethics education factor into this decision? How did you explain your reasoning to the student? (Or, conversely, how did the student explain their reasoning to you).

Q. 7. Reflecting on your own teaching practice and experiences, how have you incorporated ethical nursing practice in your curriculum? What topics do you think should be taught in the nursing curriculum? How are students taught about a practice that is guided by nursing ethics?

Probe 1. Describe your preparation or comfort level with teaching nursing ethics.

Probe 2. What course have you taken as preparatory for teaching nursing ethics?

Probe 3. Do you belong to professional organizations that address? What has that been like for you?

Q. 8. What does “ethical competency skill(s)” mean to you? What behaviors by a student would demonstrate to you that they are competent in nursing ethical reasoning and nurse driven ethical decision making? How would you evaluate students’ nursing ethical competence? How are these skills incorporated into their nursing care and practice?

Q. 9. Describe by what standards or methods students are assessed by your school for nursing ethical competence. 991/

Probe 1. What are the standards or methods you use to assess ethical competence in students?

Q. 10. Please feel free to add anything that you think is important or interesting to know about this topic that was not explicitly asked.

Conclusion of Interview:

Thank you for your participation in this interview. I am grateful for your time and for sharing your insights. If you have any final questions, please feel free to ask them now. I want to affirm that all your answers will be kept confidential and your anonymity will be maintained during data analysis and any reporting of data. If you are willing to share what you thought about this interview experience, or if you have any feedback or suggestions for interview guide revisions or refinement in the future, I would welcome your comments at this time. Again, thank you for your participation in this research study.

Appendix C

Informed Consent

Boston College: Connell School of Nursing

Informed Consent to participate in study: Nurse Educators' Description of Ethics from a Disciplinary Perspective

Researcher: Catherine Cuchetti, MSN-Ed, RN,

CNE Type of consent: Adult Consent Form

Invitation to be Part of a Research Study

You are invited to participate in a research study. You are being invited because you are a nurse educator who teaches didactic and/or clinical courses in a 4-year baccalaureate pre-licensure registered nurse program and have met the inclusion criteria for the study. Taking part in this study is voluntary. This research is being conducted as part of a doctoral dissertation through Boston College William F. Connell School of Nursing.

Important Information about the Research Study

If you agree to participate, you will be asked to consent to an interview that may be approximately 30 minutes. The interview will take place via web-based platform (such as Zoom) at a date and time that is mutually convenient to you and the Principal Investigator (PI). The interview will consist of questions about how you describe ethics and how it is taught in your program.

Please take time to read this entire form and ask questions before deciding whether to participate in this research project.

What is the study and why are we doing it?

The purpose of this study is to explore how nurse educators describe nursing disciplinary- specific ethics and how educators teach nursing ethics in pre-licensure nursing education.

What will happen if you take part in this study?

When you agree to participate in this study, you will be asked to consent to having the interview recorded on a web-based platform, such as Zoom. The interview will be recorded in both video and audio, unless you stipulate you consent to audio recording only.

If you agree to take part in this study, you will be asked to respond to a series of open-ended questions during an interview and you will be asked demographic information, including:

- Your professional background (we will **not** ask for your name but you will be asked

to choose a pseudonym, nor will we ask the identity of your organization).
- Your description of the ethical knowledge needed for nursing practice and how it is integrated into your teaching activities.

How could you benefit from this study?

Although you will not directly benefit from being in this study, you might feel pleased that your participation contributes to the work being conducted on ethics in practice from a nursing- specific perspective. The information gained from this study may help future nursing novices entering practice and future research in this area.

When you complete an interview, you will be given a $25 gift card to Amazon as a honorarium for your time and contribution to the research.

What risks might result from being in this study?

The risk to you is minimal, however it is possible you may be asked questions that might make you feel uncomfortable. You may decline to answer a question if it makes you feel uncomfortable, or you may stop the interview at any time. If the interview conducted over a web- based platform causes discomfort, alternative arrangements may be made without video display or via telephone. The principal investigator (PI), Catherine Cuchetti, is available to speak with you at any time. The faculty overseeing this dissertation study, Dr. Jane Flanagan, is also available to speak with you at any time.

How will we protect your information?

When you agree to participate in an interview, you will be asked to choose a pseudonym and will be assigned a unique code number. All data gathered will be maintained in an encrypted, password-secured computer of which the PI has sole access. Identifying information will be removed from any data and replaced with the pseudonym and your code number. Other identifying details, such as where you teach or are employed, will be de-identified in the transcript of the interview. The audio recording of your interview will be sent to a HIPAA-certified professional transcription service. We will not share the video recording with the transcription service. Audio recordings will be sent with a reference to your pseudonym and unique code number only. Your name will not appear on the audio files sent to the service.

The demographic questions will ask about your educational and professional background, including your age, gender, employment/teaching status, highest degree obtained, and the regional location in the U.S. where you currently teach. You will not be asked to provide the name of the school in which you teach. Any data that might reveal your identity will be kept on a password-protected computer. If the findings of the study are published, we will not include any information that will make it possible to identify you.

At the end of the interview, you will be offered a $25 gift card in thanks for your time. Your email address will be used to send the gift card to you, but will not be linked to your interview data.

The Institutional Review Board at Boston College and internal Boston College auditors

may review the research records. State or federal laws or court orders may also require that information from your research study records be released. Otherwise, the researchers will not release to others any information that identifies you unless you give express permission, or unless we are legally required to do so.

What will happen to the information we collect about you after the study is over?

Because research is ongoing, we cannot give you an exact time when your research data will be destroyed. We will not share your information or research data with other investigators not identified in the project.

How will we compensate you for being part of the study?

Your contribution to this study is voluntary, and you will not be compensated for your participation in the research. As a thank you for participating, however, you will be given a $25 gift care to Amazon when the interview is concluded. You will be asked to provide your name and email address to deliver this honorarium to you. This information will be collected after you complete the interview and will not be connected to your interview responses and data.

What are the costs to you to be part of the study?

There is no cost to you to be in this research study.

Your participation in this study is voluntary

It is entirely your decision to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You may skip any questions that you do not want to answer. If you do stop the interview, any information collected up to that time may be used in data analysis.

If you choose not to be in this study, it will not affect your relations with Boston College, or any other professional nursing and educator organizations.

Contact information for the study team and questions about the research

If you have questions about this research, you may contact the PI, Catherine Cuchetti, by email cuchetti@bc.edu or by phone at (603) 703-7194. You may also contact the Boston College Faculty Supervisor, Dr. Jane Flanagan at flanagjg@bc.edu .

Contact information for questions about your rights as a research participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Boston College

Office for Research

Protections Phone: (617)

552-477834

Email: irb@bc.edu

Your consent

At the beginning of the interview, you will be asked if you have read this consent form and if you have been given 24 hours to consider your response. You will then be asked if you agree to participate in the study and your consent will be verbally obtained and recorded. You will also be given the opportunity to ask any questions before the start of the interview.