

12-1-2013

Developing Ethical Competence: The Perspective of Nurse Educators from Pre-Licensure Baccalaureate Nursing Programs Accredited by the Commission on Collegiate Nursing Education

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DEVELOPING ETHICAL COMPETENCE: THE PERSPECTIVE OF NURSE
EDUCATORS FROM PRE-LICENSURE BACCALAUREATE NURSING
PROGRAMS ACCREDITED BY THE COMMISSION ON
COLLEGIATE NURSING EDUCATION

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December 2013



THE GRADUATE COLLEGE

We recommend the dissertation prepared under our supervision by

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entitled

Developing Ethical Competence: The Perspective of Nurse Educators from Pre-Licensure Baccalaureate Nursing Programs Accredited by the Commission on Collegiate Nursing Education

is approved in partial fulfillment of the requirements for the degree of

Doctor of Philosophy - Nursing

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ABSTRACT

Nurses face ethically-charged situations every day, yet ethics education is not universally integrated into pre-licensure baccalaureate nursing programs. Like other forms of competence, ethical competence requires development. Nurse educators are poised to impact on the competence of their students, both defining the ethics content and designing students' exposure. The purpose of this study is to describe the concept of ethical competence from the perspective of baccalaureate nursing faculty and describe current methods of integration and evaluation of ethics education in pre-licensure baccalaureate nursing programs. This research will be conducted using a sequential (quantitative-qualitative) mixed method approach. The first phase of this mixed method study includes an online survey designed to gather data from nurse educators regarding basic demographics and educational preparation, as well as information related to the nursing program where the participant is currently a nurse educator. Open-ended questions included on the survey are designed to collect beginning information on the concept of ethical competence. Data and content analysis will inform decisions regarding sampling for the second phase of the study, which involves semi-structured telephone interviews designed to more fully explore the concept of ethical competence. Nurse educators who will be included in the original sample teach pre-licensure baccalaureate nursing students and are employed part-time or full-time at a CCNE-accredited program that is located in one of four identified states (California, Illinois, Texas, or New York). The pragmatic worldview provided by Dewey provides a meaningful framework for this research, supporting a mixed method approach and providing insight into the concept of ethical competence.

ACKNOWLEDGEMENTS

I would like to gratefully and sincerely thank Dr. Lori Candela, my dissertation committee chair, for her guidance, understanding, and patience during my doctoral studies at the University of Nevada Las Vegas. I would also like to thank the members of my dissertation committee for whom I have the utmost respect. They provided insight and support with just the right balance of candor and encouragement: Dr. LeAnn Putney, Dr. Susan Kowalski, and Dr. Rhigel (Jay) Tan. I would also like to give a special thank you to Dr. Yu (Philip) Xu, who was there for much of my journey — his life impacted many and he will be missed.

I would like to thank the network of nurses dedicated to nursing ethics. They truly inspire and challenge me. I am forever grateful for not only their willingness to share their expertise, but also their mentorship and their friendship.

I am grateful for the support of the faculty and administration at Bon Secours Memorial College of Nursing. I have a deep respect for each person associated with that program — what an amazing team.

I am grateful for the in-house (free) editing support I received for this and countless other projects. Thank you to my husband, Christopher, and my sister, Kristin, for sharing their superb skills.

DEDICATION

This work is dedicated to my family.

For Mom, Dad, and my sister, Kristin: Thank you for the rejuvenating trips to Vegas, your words of wisdom and encouragement, and your unwavering support...I recognize how lucky I am to have each of you in my life.

For Christopher, my husband and best friend, and my children, Emily (14), Kate (12), and Tommy (10): We were on this journey together...thank you for eating leftovers three nights in a row, for listening to me endlessly process my work, for cutting me slack when I was stressed, and for believing that we could do this. I am eternally grateful and so very proud of Team Bartlett.

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CHAPTER 1

Introduction

Background and Significance

Nurses face ethically-charged situations every day. Challenges may stem from patient encounters where classic ethical dilemmas surface in decisions regarding capacity, withdrawal of care, and/or best interests (Jonsen, Siegler, Winslade, 2006; Ulrich, 2012). These traditional dilemmas require recognition and intervention, but the complexity of decisions regarding, for example, end of life or withdrawal of care are expected. What nursing students, nurse educators, and nurses may not expect are the myriad of other ethical issues that arise in clinical practice and the confounding contextual elements. For example, Siedlecki and Hixson (2011) outline the professional practice environment, which should exemplify decision-making fueled by interprofessional collaboration and respectful communication, clear delineation of roles, and the importance of the nurse-physician relationship on patient outcomes. Yet this environment does not universally exist, evidenced by the fact that interprofessional issues routinely surface as the root cause of conflict and lead to an untenable environment (Hamric, Borchers, Epstein, 2011; Ulrich, O'Donnell, Taylor, Farrar, Danis, & Grady, 2007).

Organizational issues and constraints further confound the ethical issues. Extensive work has been done on the concept of moral distress in nursing and how this “inability of a moral agent to act according to his or her core values and perceived obligations due to internal and external constraints” (Ulrich, Hamric, & Grady, 2010, p. 20) negatively impacts on nurses and on patient care. Ethics permeates all aspects of

nursing care, extending beyond the traditional patient-care issues and into personal, interpersonal, and systemic (organizational) realms. The ability to recognize and address ethical issues hinges on the nurse's ability to manage all of these facets while considering the individual circumstances and individual patient.

Nurses, as core members of the interprofessional team, must routinely integrate the principles of ethics into clinical practice. This requires nurses to demonstrate a level of competence in the realm of ethics. Nurse ethicists posit that ethical competence in nursing includes the ability to recognize and address an ethical dilemma (Wocial, 2012), but little detail has been published regarding the intricacies, development, and/or evaluation of this competence. From the medical perspective, Harvey (2003) states that "clinical ethics concerns the clinical practice, involving the identification, analysis, and resolution of moral problems affecting patients, while understanding the clinical realities of these situations in an interdisciplinary context" (p. 63). Sporrang, Arnetz, Hansson, Westerholm, and Höglund (2007) evaluated education directed at the development of ethical competence of pharmacists in Sweden and its effect on their functioning in the healthcare organization. The authors describe ethical competence as a tacit, primarily psychological skill that is developed and maintained in a social context.

The concept of ethical competence includes the ability to recognize an ethical issue, coupled with the ability to confront the issue in a measured manner that is not confounded by "moral fixations or automatic reactions...Ethical competence at work entails the ability to integrate perception, reflection and action, and to understand oneself as being responsible for one's own actions" (Sporrang et al., 2007. p. 826). Although ethicists from different professions agree on the basic definition of ethical competence,

the term surfaces only occasionally in the ethics literature. Nursing has not specifically integrated the concept of ethical competence into guiding documents (American Nurses Association, 2001; National Council of State Boards of Nursing, 2013) or accreditation standards (American Association of Colleges of Nursing, 2008). This omission in nursing faculty key references supports the exploration of the concept of ethical competence.

This raises fundamental questions regarding what exactly nurse educators think students should be taught in their undergraduate ethics education, how that content is best and/or currently delivered, and the picture of success in ethics education. Nurse educators facilitate learning to foster the development of functional, competent nurses. Educators instinctively teach how they were taught, yet appreciate the unique needs and challenges of their students and are expected to infuse traditional lecture-based education with innovation and creativity (Billings & Halstead, 2012). The National League for Nursing (2005) published a guiding document outlining core competencies for nursing faculty: facilitate learning, facilitate learner development and socialization, use assessment and evaluation strategies, participate in curriculum design and evaluation of program outcomes, function as a change agent and leader, pursue continuous quality improvement in the nurse educator role, engage in scholarship, and function within the educational environment. Attainment of these competencies qualifies nurse educators to develop and evaluate competence in their students. Determining what nurse educators think, what they teach, and how they teach provides insight into the concept of ethical competence at its very roots.

Inclusion of a specific course on bioethics or the clinical application of ethics in undergraduate or master's nursing programs does not universally exist (Burkemper, DuBois, Lavin, Meyer, & McSweeney, 2007). This lack of education negatively impacts on the active and purposeful integration of ethics into clinical practice. An assessment of ethics education in nursing program curricula has not been formally performed since Aroskar in 1977. What is known is that pre-licensure baccalaureate nursing education, burdened with content overload (Keating, 2011), routinely integrates principles of ethics into codes of practice or key job responsibilities, thus bundling ethics under legal, patient-centered, or professional standards. Some argue that nursing education requires more targeted ethics education. Park, Kjervik, Crandell, and Oermann (2012) discuss the social expectations associated with nursing ethics education and promote teaching using more comprehensive frameworks that promote the knowledge, skills, and attitude required for ethical decision-making. They posit that ethics education in nursing should promote the development of moral sensitivity and of a virtuous character that works in tandem with rational ethical knowledge and the application of professional codes, principles, and responsibilities (Park et al., 2012). Crigger and Godfrey (2011) discuss a transformational ethical approach in their development of a new ethical framework for nurse professionals (FrNP). This interesting model links the nurse as a moral agent with phronesis (practical wisdom where one has the ability to apply virtues appropriately in given situations), with the intention of attaining telos, translated as "flourishing, happiness, or living the good life" (Crigger & Godfrey, 2011, p. 62). Crigger and Godfrey (2011) eloquently merge philosophies of the past in their discussion of transformation rooted in virtue ethics. They provide a philosophical perspective and seek

to operationalize the vague concepts of ethical behavior, “civic professionalism,” (Benner, Introduction, p. ix, in Crigger & Godfrey, 2011) professionalism, and ethics.

The ubiquitous nature of ethics and ethical issues in the clinical practice setting warrants consideration. Personal, interpersonal, and organizational components impact on the context and manifestation of each ethical issue. Learning to address each unique ethical issue requires a deft hand. Like other forms of competence, ethical competence, which involves identifying and addressing these issues, requires development. Nurse educators are poised to impact on the competence of their students, both defining the ethics content and designing students’ exposure. New nurses are entering professional practice that is rife with ethical issues. It is time to consider what nurse educators perceive as essential content related to ethical competence, how they develop ethical competence in their students, and their interpretations of the state of ethics education today.

Contribution to Nursing

Ethics in nursing is not a new concept. Carper’s (1978) seminal work on the ways of knowing focused primarily on answering the questions pressing nursing regarding how nurses know what they know and what kinds of knowledge are most highly valued within the profession of nursing. Carper identified four patterns of knowing, one of which was ethical knowing, and posited that understanding and incorporating the use of these patterns is critical to the teaching and learning processes of nurses (Carper, 1978). What makes Carper’s theory (1978) accessible and relevant to both the quantitative and basic qualitative research methods planned in this study is that on a fundamental level, Carper sought to concretize abstract knowledge, skills, and attitudes required for competent

nursing practice. One of the four patterns, ethics, also referred to as “the moral component” (Carper, 1978, p. 20), embodies the philosophic, moral compass for nurses. The ethical pattern considers the concepts of morally right and wrong, professional obligations, and the development of deliberate action and associated goals (Carper, 1978; Chinn & Kramer, 2011). This pattern accounts for professional standards such as those outlined by the ANA and addresses questions related to goodness, justice, autonomy, and right versus wrong (Carper, 1978; Chinn & Kramer, 2011). This study intends to extend Carper’s work and articulate the meaning of ethical competence today as it relates to ethical knowing.

Problem Statement

Nursing faculty are charged with the creation of behavioral objectives and evaluation of the development of competence in nursing students (Keating, 2011). Yet, even at the master’s level, most nursing faculty members are not required to have completed formal training in ethics. This could be due to a lack of focused education programs, the lack of credentialing programs, and/or the belief that “competency in ethics analysis is unimportant or illusory” (Burkemper et al., 2007, p. 16). Woods (2005) laments the fact that new nurses are ill-prepared to function in the complex healthcare environment despite a general increase in formal education in ethical decision-making. Woods (2005) attributes this inability to function to external or internal barriers, including moral distress, a desire for self-preservation, and/or a lack of ethical confidence. Three general educational themes surface repeatedly in the literature: (a) the theoretical origins of ethics theory are significant and relate to everyday nursing practice; (b) ethical role models encountered in experiential learning are as significant as formal

classroom education; and (c) nursing ethics education must be practical, realistic, and reflective of current nursing practice and the healthcare environment (Woods, 2005).

There is a need to explore ethical competence as it is described by those responsible for teaching in order begin to articulate how nurse educators develop ethical competence, and establish baseline expectations regarding the ethical competence of new nurses.

Purpose Statement

The purpose of this sequential mixed methods study is to describe the concept of ethical competence from the perspective of baccalaureate nursing faculty and describe current methods of integration and evaluation of ethics in pre-licensure baccalaureate nursing programs. Results from this research may inform the development of theory related to ethical competence. Quantitative research questions will address the demographic data of nursing faculty, highlight their training and experience in ethics, and describe the inclusion of ethics in the baccalaureate nursing programs where they are currently faculty members. Open-ended questions and interviews will be used to more fully explore the concept of ethical competence from the qualitative perspective. Consideration of data collected from the quantitative aspect will enrich the description of the qualitative participants of the study, and provide information regarding national trends in ethics education based on reported demographic, education, and program data.

Research Questions

This research will answer the following research questions.

- **Quantitative Research Questions:** What is the educational preparation of nurse educators teaching ethics to pre-licensure baccalaureate nursing students at CCNE-accredited institutions? How is ethics education embedded in the pre-licensure baccalaureate nursing curriculum?
- **Qualitative Guiding Questions:** How do pre-licensure baccalaureate nursing faculty members from CCNE-accredited institutions define ethical competence? What is their experience in developing and evaluating ethical competence? How does experience relate to the development of ethical competence?

CHAPTER 2

Conceptual Review of the Literature

Although qualitative researchers often complete the literature review after the study (Streubert & Carpenter, 2011), core concepts related to ethical competence were considered prior to the implementation of this research. Completion of a conceptual review prior to the study informed the identification and verification of gaps in the literature, and provided perspective that aided in the generation of the qualitative and quantitative questions. The conceptual literature review also provides insight into my basic assumptions and potential bias. The concepts reviewed stem primarily from the actual words *ethical* and *competence*, and from the basic accepted working definition of the concept of ethical competence.

After consulting with a librarian (Kathleen Hierholzer, personal communication, May 1, 2012) a literature review was performed using the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Cochrane Library, Education Resource Information Center (ERIC), ScienceDirect, Web of Knowledge, and PubMed. Although no dissertation work was cited, ProQuest database provided information regarding (un)published dissertations. Multiple Boolean searches were performed using combinations of the following key words: *ethical competence*, *ethics*, *nursing*, *nursing ethics*, *code of ethics*, *nursing education*, *undergraduate nursing education*, and *competence*. Of note is that the term *ethical competence* did not yield significant results. For example, a PubMed search using the term ethical competence, limited to the last five years in English, yielded only 13 results, 11 of which focus on and were written by authors from countries other than the United States. Only 1 of these 13

articles referenced nursing education (Bužgová & Sikorová, 2012). A search done using Web of Knowledge using the terms ethical competence, nursing, and education yielded only three records; using the terms ethics, nursing education, and competence yielded only five records. The overlap of relevant articles identified at each of these databases was significant. During the database review, related citations identified by the database search engine were also considered and added to the literature review depending on relevance. After the initial database search, a National Center for Biotechnology Information (NCBI) profile and a ScienceDirect profile were established, so I continue to receive emails with links to new articles that contain any of the search words identified. I also registered for updates from SAGE Publications from the specific journal *Nursing Ethics*. References from cited articles were also reviewed, which led to the retrieval of several book sources and journal resources older than five years. Guiding nursing documents from various accrediting, governing, and approval agencies were reviewed as applicable.

References to ethical competence in nursing are often limited to professional behavior (Numminen, van der Arend, & Leino-Kilpi, 2009) or goodness (Smith & Godfrey, 2002; Catlett & Lovan, 2011). Articles about ethics in nursing focus on how to best teach ethics (Callister, Luthy, Thompson, & Memmott, 2009), the need for more ethics education (Benner, Sutphen, Leonard, & Day, 2010), and the moral distress and ethical issues experienced by practicing nurses (Corley, Elswick, Gorman, & Clor, 2001; Pavlish, Brown-Saltzman, Hersh, Shirk, Nudelman, 2011; Ulrich, Hamric, & Grady, 2010). This literature review focuses on the concepts foundational to the idea of ethical competence. Nurse educator and student perspectives on ethics in nursing education will

be discussed in the first section of the conceptual literature review. The second section of the conceptual literature review will focus on defining ethics in a general sense, with the third section defining the subspecialty of nursing ethics, specifically highlighting the ethics of care, international and national trends, and accreditation standards. The potential impact of ethics education will be explored in the fourth section. The fifth section of the conceptual literature review will include details regarding the concept of ethical comportment. Ethical dilemmas will be discussed in the sixth section of the conceptual literature review. The definition and application of the definition of competence will be highlighted in the seventh and final section of the conceptual literature review.

Perspectives on Ethics in Nursing Education

Brazilian researchers (Ramos, dePires, Brehmer, Gelbbcke, Schmoeller, and Lorenzetti, 2013) gathered data regarding ethics education from the perspective of 50 nurse educators from a southern region in Brazil. They facilitated a separate focus group for each of the six participating schools. Results of the research are organized into three categories: (a) experiences and motivations for teaching ethics and bioethics in nursing courses; (b) indicators and directions of changes; and (c) emerging challenges, values, and related themes in education (Ramos, et al., 2013). Although only 34% of the participants describe themselves as teachers of ethics, 38% admitted to including ethics content in their courses, especially as issues arise in both the clinical and didactic settings. Only 10 of the 50 participants reported no experience in teaching ethics or bioethics content. The educators discussed their tendency to incorporate ethics education, mentioning the significance of role-modeling, in their routine academic and

healthcare life. The educators reference the environmental barriers students face when striving for ethical behavior, specifically a lack of power, poor working relationships and conditions, and the ever-changing healthcare and academic environments. The educators also identified teaching challenges including identifying and prioritizing relevant content, incorporating active teaching modalities, and the responsibility to facilitate education while simultaneously providing moral training and instilling professional values. This research highlights the challenges nurse educators face and their perception that the practice of nursing is a moral endeavor (Ramos, et al., 2013).

A second research study considered the perspective of nurse educators in Brazil, this time focusing on their definition of a good nurse. Sartorio and Zoboli (2010) identified the importance of being a good nurse as a moral endeavor. They highlight the transition from morality, often referred to as goodness, as a purely religious concept to morality as a secular, intentional, scientific, and professional aspiration. The authors identified core themes from the data obtained from the 18 educators: (a) good nurses correctly fulfill their duties; (b) good nurses are patient advocates who are able to apply their knowledge to clinical situations; (c) good nurses are prepared and available to welcome others as persons, respecting patients' individuality and promoting autonomy; (d) good nurses are talented, competent, and carry out professional duties excellently (Sartorio & Zoboli, 2010). This competence specifically includes the intentional, reflective, and responsive application of ethical principles (Sartorio & Zoboli, 2010). The authors note that during the semi-structured and unstructured interviews, participants frequently offered conflicting opinions and contrary evidence, which made analysis of the data more challenging and also indicates the complexity of the concept of goodness.

Participants frequently focused on behaviors that were not ethical, but struggled with identifying ethical behavior outside of the fact that being good involved doing good (Sartorio & Zoboli, 2010). Sartorio and Zoboli (2010) purposefully differentiate professional behavior, specifically the legalistic view of following codes and rules, from both theoretical knowledge and the development of a moral, virtuous character. They essentially attempted to get at the unwritten curriculum, the underlying characteristics of goodness and how goodness is exhibited by nursing professionals. This article informs the work planned in my research study inasmuch as it begins to explore the subtleties of ethical behavior and the relationship of professionalism to ethical competence.

Wilk and Bowllan (2011) explored student perceptions regarding ethical conduct, specifically related to cheating in their nursing program at their college in the northeastern United States. Faculty opted for focus groups to garner input on the topics of ethics and ethical behavior from 10 junior nursing students and 10 senior nursing students. Questions were related to the students' perceptions of a code of ethics, a description of an ethical nurse, an example of an unethical behavior, barrier and challenges related to ethics, and finally their impressions regarding next steps. Of interest to my study is that the junior and senior nursing students had different foci when asked to describe ethical behavior. The junior nursing students stated what the authors deemed idealized values including being loyal, faithful, caring, and genuine. Senior nursing students focused on behavioral descriptors, describing an ethical nurse as someone who is accountable, responsible, on time, and prepared (Wilk & Bowllan, 2011). The marked change in the student descriptors demonstrates the potential for an evolving definition of ethics and a change in perception, which support the premise in my

study that ethical competence evolves and can be developed.

Ethics

“*Ethics* is a generic term covering several different ways of examining and understanding the moral life” (Beauchamp & Childress, 2009, p. 1). Ethics and morals are occasionally used interchangeably in the extant literature, but morality tends to be linked more with values, while ethics encompasses the critical processes required for thinking through those values, applying them in unique situations, and revising them as needed (American Nurses Association, 2001; Weston, 2002). Two primary approaches exist in ethics: nonnormative and normative. Nonnormative ethics, which includes descriptive ethics and metaethics, considers “what factually or conceptually *is* the case, not what ethically *ought to be* the case or what is ethically *valuable*” (Beauchamp & Childress, 2009, p. 2). Descriptive ethics surfaces in discussions of codes of ethics where expectations of conduct are outlined (Beauchamp & Childress, 2009). Normative ethics, which includes practical ethics (previously known as applied ethics) and virtue ethics, focuses on the justification of norms, what *ought* to be done and why. Practical ethics involves the interpretation and subsequent application of ethical theories and norms to a specific situation. Although originally narrowly focused on the study of the ethical and moral implications of new biological discoveries and biomedical/technological advances, the term *bioethics* now encompasses the “application of ethics to the biological sciences, medicine, nursing, and health care” (O’Tootle, 2003, p. 212), thus encompassing the practical ethical questions raised in health care. Although the terms *biomedical ethics* and *bioethics* are often used interchangeably with *clinical ethics*, a distinction can be made in that clinical ethics is a subset of bioethics (Baker & McCullough, 2009) that

focuses on the daily interactions between healthcare professionals and their patients; bioethics is more concerned with public policy and broader issues stemming from advances in technology and medicine (Jecker, Jonsen, & Pearlman, 1997). “Clinical ethics is a practical discipline that provides a structured approach for identifying, analyzing, and resolving ethical issues in clinical medicine” (Jonson, Siegler, & Winslade, 2006, p. 1).

Virtue ethics, a subset of normative ethics, and the idea of the *good* nurse who does the *right* thing were explored by Smith and Godfrey (2002) and in a replication study done by Catlett and Lovan (2011). Catlett and Lovan (2011) succinctly described the limitations of the original study (Smith & Godfrey, 2002) and clearly identified how they minimized those known limitations in their replication study. Interviews were done with 20 registered nurses, 95% of whom were white females, from three Kentucky hospitals who indicated an interest in participating in the study. Four open-ended questions drove the qualitative data collection, with questions regarding goodness approaching the central issue from both the positive (a good nurse is one who) and negative (a good nurse is one who is not) perspective. The same seven categories were identified in both studies: personal and professional characteristics, knowledge-base, patient-centeredness, advocacy, critical thinking, and patient care. However, Catlett and Lovan (2011) extended the work done in the original study and identified four distinct relationships: personal traits and attributes, technical skills and management of care, work environments and co-workers, and caring behaviors. The researchers hope that their study will fuel the development of an instrument designed to identify characteristics desirable in a nurse, which could be used to screen nursing school applicants and

potential employees. Although this research focused on virtue ethics and the concept of a good nurse, ethical decision-making behavior can be inferred (Catlett & Lovan, 2011). My research will draw upon these core ethical tenets and definitions as they relate to information provided by study participants.

Nursing Ethics

Nursing ethics is a distinct practice entity that encompasses “the values or moral principles governing relationships between the nurse and patient, the patient's family, other members of the health professions, and the general public” (Nursing ethics, 2009). Although nursing ethics shares core principles and general tenets with the more developed medical ethics, this emphasis on relationship differentiates nursing ethics from other branches of applied ethics. All of the work discussed in this section will be referenced and correlated to data collected from study participants. The standards, codes, and guidelines are likely to surface during data collection, as most nursing educators have at least a passing familiarity with these entities.

Ethics of care. Nursing embraces the concept of caring and accepts caring as integral to professional practice (Lachman, 2012). One moral theory in particular, ethics of care, demonstrates the link between caring and ethical nursing practice. The theory of ethics of care began in the early 1980s with Gilligan and Noddings who considered the work of Kolberg regarding moral development, specifically including the female perspective on moral development, specifically highlighting the impact of personal relationships on perceived responsibilities and commitments (Lachman, 2012; Sander-Staudt, 2011). Lachman (2012) describes this concept, using key examples to demonstrate how the level of commitment varies depending on the level of emotional

involvement: (a) strangers may not receive the same level of care that may be afforded a family member, and (b) caring for a neighbor's pet while the neighbor is away differs greatly from caring for a dying family member in the home. Some consider the ethic of caring a practice or a virtue (sometimes associated with virtue ethics), not a theory per se, where care involves maintaining the well-being of self and of others. Although originally designed to address personal moral development, the theory of the ethic of caring has been applied to a wide variety of ethical issues, and even used to frame political and social movements (Sander-Staudt, 2011).

International and national trends. Current trends in nursing ethics internationally reflect the importance of evidence-based practice and support the development of positive practice environments (International Council of Nurses, 2012). The international code of ethics for nursing (International Council of Nurses, 2012) serves as the standard worldwide and informs national initiatives, focusing on action based on social values. The newly revised International Council of Nurses (ICN) code of ethics for nursing specifically addresses nurses and people, nurses and practice, nurses and the profession of nursing, and nurses and co-workers. The code has been periodically revised since its inception in 1953 in an effort to maintain relevance in an ever-changing society. The 2012 revised edition continues the emphasis on respect for human rights, but also articulates the role of nurses in developing and sustaining a core of professional values and highlights the importance of creating positive practice environments. The concept of positive practice environments includes concepts such as maintaining safe and equitable social and economic working conditions, considering natural environments, and actively contributing to an ethical organizational environment

(International Council of Nurses, 2012). The international code provides nurse educators concrete examples of content and learning activities related to the core elements.

The American Nurses Association's Code of Ethics for Nurses (ANA; 2001) provides the code which guides the professional practice of nurses. The 2001 version of the code provided interpretative statements, which had been absent from previous versions of the code. The interpretative statements provide specific examples, identify essential responsibilities, and define key terms. References to competence involve the actual practice of nursing, specifically the need for nurses to maintain role-specific professional competence, engage in competence-developing activities, and delegate appropriately. In addition to identifying the obligations, goals, and values of the professional of nursing, the ANA Code of Ethics (2001) references the "ethics of the profession" (p. 10) and speaks to the ethical tradition of nursing, which is "self-reflective, enduring, and distinctive" (p. 10). Provision five specifies the nurse's responsibility to himself/herself, specifically including the concepts of integrity, safety, competence, and lifelong learning. "Wholeness of character" (American Nurses Association, 2001, p. 10) most closely embodies the intangible components of the budding concept of ethical competence. Wholeness of character requires integration of personal and professional values and includes preservation of integrity. Provision six highlights the influence of the environment on nurses' moral character, virtues, and values. Wisdom, honesty, and courage are key examples of virtues; compassion, patience, and competence are excellent "habits of character of the morally good nurse" (American Nurses Association, 2001, p. 11). These concepts from the ANA Code of Ethics (2001) emphasize the need to develop more than basic skills in nurses. Badzek, the Director of the ANA Center for Ethics and

Human Rights, is currently leading an initiative evaluating the need to revise the code and its interpretative statements with the understanding that the code must maintain relevance for all nurses in its continued effort to identify, clarify, and affirm fundamental nursing values and duties (L. Badzek, personal communication, February 5, 2113). Data obtained from the qualitative aspect of this study will be compared with details outlined in both the international and national codes of ethics for nurses.

Accreditation standards. The American Association of Colleges of Nursing (AACN) is the professional entity that provides curriculum standards for baccalaureate and advanced degree nursing programs, governmental advocacy, education, publications, and accreditation through its autonomous arm of the Commission on Collegiate Nursing Education (CCNE; American Association of Colleges of Nursing, 2012a). AACN references concepts inherent in nursing ethics within the contexts of ethical dilemmas, a professional ethical framework that guides practice, ethical judgments and reasoning, ethical conduct in research, advocacy, and ethical codes of practice (American Association of Colleges of Nursing, 2008). The only term specifically defined in the essentials of baccalaureate education and professional nursing practice document (American Association of Colleges of Nursing, 2008) related to ethics is moral agency. Moral agency is defined as “a person’s capacity for making ethical judgments. Most philosophers suggest that only rational beings, people who can reason and form self-interested judgments, are capable of being moral agents” (American Association of Colleges of Nursing, 2008, p. 38). Although accrediting bodies like CCNE require ethics education, they are generally not prescriptive regarding the scope, implementation, or evaluation of ethics education (Bosek & Savage, 2007).

Ethics Education

A series of interrelated articles addresses the perspectives of Finnish educators and their students regarding teaching 'The Ethical Guidelines of Nursing' of the Finnish Nurses Association, a document comparable to the ANA code of ethics. Numminen, Leino-Kilpi, van der Arend, and Katajisto (2011) compared descriptions regarding teaching the code of ethics between 183 educators and their 212 nursing students in Finland using a structured questionnaire and a cross-sectional, descriptive approach. Although the teaching of the code of ethics was deemed extensive by both groups and they agreed that the nurse-patient relationship, the mission of nurses, and professional competence were most frequently discussed, the educators described their teaching as more significant than what the students perceived, indicating that perhaps students have a difficult time recognizing ethics content when it is integrated into the nursing curriculum (Numminen et al., 2011). Although various methods of instruction were used, students perceived lecture as the dominant method, while educators described greater use of discussion and seminar. The majority of students and faculty deemed the educators adequately prepared to teach ethical content related to the codes, but ethical content outside of the codes was not specifically assessed. A related article by Numminen et al. (2010) focused on the perspectives of the 183 Finnish nursing educators highlighting the analysis that educators' knowledge was based on self-driven, often informal ethics education. This research validates my intention to consider perceptions in my research.

Salminen, Metsämäki, Numminen, and Leino-Kilpi (2011) explored Finnish nurse educators' knowledge of the Finnish code of nursing ethics, specifically describing nurse educators' assessment of the implementation of the codes as they relate to human dignity,

honesty, fairness, responsibility, and freedom. The authors use the term ethical competence to specifically refer to “the nurse educator’s ethical knowledge and its implementation in her own work” (Salminen et al., 2011, p. 1). The authors link an increased knowledge of ethical principles and adherence to internalized professional ethics with an increase in feelings of ethical competence as reported by the 342 nurse educator participants. The questionnaire consisted of only one item that measured an educator's knowledge of ethical principles and eighteen items in the categories of fairness, respect, and treatment of the educator in society. Demographic data support the premise that educators have modest formal training in ethics, but that experience and age positively impact on reported ethical competence. This study provides insight into the relationship between knowledge of ethical principles and codes of ethics and the effect of that knowledge on the nurse faculty members’ interprofessional and student-teacher relationships. The authors call for increased training in ethics for nursing educators. Although the final sample was representative of the population, as with any cross-sectional survey, limitations may exist in relation to the self-reported, web-based survey and moderate national response rate. This research reinforces my intention to consider the perceptions of nurse educators’ own ethical competence as part of the qualitative research in an effort to flesh out the concept, provide a potential exemplar, and allow participants time for self-reflection.

Park et al. (2012) recently described the relationship between academic class and moral sensitivity/reasoning in 506 freshmen and 440 seniors enrolled in baccalaureate nursing programs in Korea. Reliable, valid, and culturally adapted versions of Lützèn’s Moral Sensitivity Questionnaire and Rest’s Defining Issues Test were administered to the

946 students enrolled in eight different nursing programs. Although this cross-sectional study centered on students in Korea, the authors recognize that nursing programs in South Korea have followed the trend in the United States and have increased their commitment to the inclusion of ethics education in nursing programs (Park et al., 2012). Barriers to the inclusion of ethics content identified by the authors are similar to barriers identified in the United States: varying degrees of recognized importance, lack of planned ethics content in the curriculum, time and content constraints, and the lack of qualified faculty to teach ethics (Park et al., 2012). Although preliminary analysis indicated differences in moral sensitivity and moral reasoning between the two academic classes, once student characteristics (age, gender, grade point average, number of siblings, family income, and religion) were controlled for as covariates, the differences were generally insignificant. This means that individual characteristics, not ethics education, may explain the differences between the two groups. However, the P-score, where higher numbers reflect more advanced moral judgment, was higher in seniors who had received additional hours of ethics education (Park et al., 2012). Of special note is that lecture-only ethics education positively impacted on the moral reasoning of students, indicating that, in this study, group discussion was less effective at promoting the development of moral reasoning. The authors admit that although this study did not specifically address the ability or training of the instructor, the size of the classes, or the use/disuse of critical reflection, the authors recognize that these variables may explain this finding (Park et al., 2012). Of special note is that their description of primary ethics education in nursing centered on learning the principles of bioethics with ethical dilemmas, both the educators and the students (from all levels) focused on being good practitioners as measured by the

patient-nurse relationship (Park et al., 2012, p. 576), which reflects the importance of relationships in nursing ethics.

Bužgová and Sikorová (2012) performed a cross-sectional survey with 662 part-time and full-time students of general nursing and midwifery in the Czech Republic. Based on previous similar studies, the authors expected moral judgment competence, as measured by Lind's Moral Judgment Tool's C-index scores, to be higher in nursing students in their last year of study when compared to nursing students in their earlier years of study. However, there were no significant differences in the C-index scores between years of study, and only 7% of the total sample of nursing students demonstrated high C-index scores. The authors encourage adequate education, specifically discussing the need to increase "ethical argumentation" (Bužgová & Sikorová, 2012, p. 5) in the nursing curricula.

Grady et al., (2008) investigated the relationship between ethics education or training and the use of ethics resources, confidence in moral decision, and moral action/activism in 1215 registered nurses and social workers from four states. A self-administered survey was mailed to a random sample of 3000 nurses and social workers. One in five nurses reported having no ethics education and were more likely to report not using clinical ethics consultation (CEC) services. Key predictors of moral action included gender (females more likely), master's degree, increased uses of CEC, increased perceived usefulness of CEC, and increased confidence. I am curious as to whether the quantitative data collected will support this reported lack of education.

Significant debate continues regarding a direct relationship between formal coursework or training in ethics and the intellectual and interpersonal dexterity and

sensitivity required to handle ethical dilemmas (Artino & Brown, 2009; Bužgová & Sikorová, 2012). Irrespective of field, the vast majority of the models designed to walk through the steps of resolving an ethical dilemma begin with defining the ethical dilemma (Beauchamp & Childress, 2001; Jonsen, Siegler, Winslade, 2006; Kenny, Lincoln, Balandin, 2007; Medlin, 2010; Mitchell & Yordy, 2009). The position of this researcher is that nurses must adequately and correctly define ethical dilemmas in order to fully engage in the process of resolving ethical dilemmas in the clinical setting.

Ethical Comportment

The idea of *goodness* surfaces frequently in ancient philosophies (Guttek, 2011)—the concept of ethical comportment may be the best tool to define this goodness in nursing today. Plato sought to instill an appreciation for the good life (in children), with the intention of fueling their desire to learn (Guttek, 2011). This principle reflects the lifelong learning essential for nurses today. Although Plato was specifically referencing models of a virtuous life (Guttek, 2011), nursing relies on preceptors, role modeling, and mentoring to provide positive examples of nursing in order to foster the development of *good* nurses. The analysis of right and wrong stretches back to man’s first attempts at analyzing and justifying his actions based on reason rather than instinct or superstition. Kant is credited with extending moral philosophy with his categorical imperative. Kant’s original work (as cited in Caygill, 1995, p. 100) enforces the categorical imperative with “Act only according to that maxim whereby you can at the same time will that it should become a universal law.” This imperative could only exist with the existence of an imperative, something that would drive the principle behind the action (as cited in Caygill, p. 100). Kant grounded his categorical imperative in freedom, in autonomy.

The development of character in nurses remains a central focus for educators who desire to create a generation of nurses able to advance the traditions of caring and professionalism. Knowledge of core ethical principles coupled with a strong sense of self and character, defined as the development of ethical comportment, provides students valuable tools to draw upon in the complex clinical environment.

The current focus in nursing is on the incorporation and application of nursing ethics in everyday practice (Ulrich, 2012) and on the development of the socially-embedded concept of ethical comportment. Day and Benner (2002) defined the term ethical comportment.

Ethical comportment is a prereflective, socially embedded practical knowledge that is rational, even though it is not based on rational calculation (ie. based on formal criteria). Unlike theoretical reasoning, comportment cannot be formalized. The prereflective nature of comportment means that comportment is lived and embodied in practices that are not based on formal theoretical precepts. Because it is socially embedded, ethical comportment requires engagement in a situation and a sense of membership in the relevant social group. Comportment develops in dialogue with others and is based on, or constituted by, the background understandings that make it possible for us to develop the axioms and rules involved in ethical theories (p. 77).

Ethical comportment is related to social etiquette in that etiquette, like ethical comportment, is based on a set of social rules derived from accepted norms that are applied to real-world situations in a dynamic fashion. A recent Carnegie report on transforming nursing education included ethical comportment and discussed the importance of ethical comportment and behavior development in nursing students (Benner, Sutphen, Leonard, & Day, 2010). The call for transformation in ethics specifies that nurses are faced with difficult ethical situations on a daily basis that do not involve

the grand or complex tenets of a classic ethical dilemma. Current initiatives in ethics promote the development of everyday ethics as integral to the profession of nursing (Benner, Sutphen, Leonard, & Day, 2010; Ulrich, 2012) and are likely to surface during the course of my research.

Ethical Dilemma

According to Beauchamp and Childress (2009), the four guiding principles underpinning bioethics and clinical ethics are autonomy, beneficence, nonmaleficence, and justice. The application of the principles varies depending on if they are considered (a) with a specific philosophic bias; (b) based on theology, virtue, religious principles, or feminism; (c) with a principled, case-by-case view; or (d) in light of justice, with an emphasis on resource allocation (American Society for Bioethics and Humanities, 2009). Classical ethical dilemmas arise when there is conflict among or within these four principles.

Barrett (2012) provides a synopsis of traditional models of ethical decision-making. The standards-based model relies on the rules, laws, and policies to drive action. Steps in this model include determining the primary dilemma, considering what standards apply, determining a course of action, and identifying rationale for why this standard course of action may not be appropriate (Barrett, 2012). The principles-based model, frequently used by clinical ethics consultation teams, requires deeper exploration of the issue. Steps in this model include clarifying the dilemma, evaluating the ethical principle(s) at play, deciding on a course of action, and then acting (Barrett, 2012). The virtues-based model emphasizes dispositions, values, habits, and moral character. Steps in this model include considering how a course of action will impact on the person

making the decision, specifically considering if a particular decision is consistent with the decider's values and virtues, and then acting (Barrett, 2012). The moral resonating-based model posits that lower levels of reasoning are used for less intense issues, whereas higher order reasoning is used when an issue is perceived to be complex or intense. Steps in this model include: (a) recognizing the moral issue and determining a course of action; (b) determining the level of involvement by exploring individual and situational variables as well as the contextual opportunities; (c) considering the effect of the decision on both individuals and groups including the potential of harm, proximity to the issue, social norms, the immediacy required, and the severity of the impact; and then (d) acting (Barrett, 2012).

The practice-based model addresses situations where two right choices are in competition—a frequent and challenging ethical dilemma. This model incorporates aspects of the standards-, principles-, virtues-, and moral reasoning-based models into a straight-forward model that can be tailored to any clinical dilemma. Steps in this nine-step model include: (a) recognizing the ethical issue/dilemma; (b) determining the individuals involved; (c) gathering the relevant facts; (d) testing for right versus wrong issues to differentiate ethical from moral issues; (e) testing for right versus wrong paradigms such as truth versus loyalty, individual versus community, short-term versus long-term goals, and justice versus mercy (Kidder, 1995); (f) applying the three decision-making frameworks, (g) exploring multiple (more than three) possibilities of action, termed a *trilemma* by Kidder (1995), in order to satisfy all values at stake; (h) making the decision; and then (i) revisiting and reflection on the decision (Barrett, 2012; Kidder, 1995).

Although my research does not aim to assess the knowledge of nurse educators regarding ethical decision-making frameworks, I must possess a working knowledge of these common models in order to be able to appropriately probe and explore perceptions of the nurse educators. Knowledge regarding available tools and common practice is essential to understanding the perceptions of the nurse educator. There is significant debate regarding a direct relationship between formal coursework or training in ethics and the intellectual and interpersonal dexterity and sensitivity required to handle ethical dilemmas (Artino & Brown, 2009).

Erdil and Korkmaz (2009) collected junior and senior nursing students' observations of ethical problems encountered in the clinical setting. Although this study took place in Turkey, the issues are fairly universal. The authors considered findings of previous studies that indicated students experienced dilemmas in relation to truth-telling to patients, family issues inherent in the withdrawal of care, and patient autonomy issues. Erdil and Korkmaz (2009) identified six main themes through their written survey content analysis: physical and psychological maltreatment of patients, violating patients' privacy, inadequate information-sharing with patients, active discrimination based on socioeconomic or educational status, and the (negative) impact of various relationships (nurse-patient, nurse-doctor, student nurse-nurse, etc.). They specify that the most important issue involved unprofessional behavior by the nurses and doctors, and related many of the other themes to the intraprofessional, interprofessional, and provider-patient relationships. The authors posit that ethics education alone is insufficient to prepare nurses to address these complex issues; students must have this education supported by

professional experience, personal characteristics, and organizational/institutional policies and procedures.

Competence

The National Council of State Boards of Nursing (NCSBN) originally defined and references competence as “the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health” (National Council of State Boards of Nursing, 2005, p. 1). Interpretative statements built upon this definition include the word ethically and define continuing or continued competency or competence as “the ongoing ability of a nurse to integrate knowledge, skills, judgment, and personal attributes to practice safely and ethically in a designated role and setting in accordance with the scope of nursing practice” (Washington State Nurses Association, 2010; National Board for Certification of Hospice and Palliative Nurses, 2011). According to Schroeter (2008) a distinction should be made between competence and competency where “competence refers to a potential ability and/or a capability to function in a given situation...[and] competency focuses on one’s actual performance in a situation. This means that competence is required before one can expect to achieve competency” (p. 2). For the purposes of this research and its focus on pre-licensure baccalaureate education, the term competence and its associated definition will be used.

Paganini and Egry (2011) initiated a philosophical discussion about the ethical component of professional competence from the perspective of Brazilian nurses. “From a US and WHO [World Health Organization] European Region perspective the term ‘competence’ relates to a combination of knowledge, skills, attitudes and values. A

competency is therefore a combination of attributes underlying some aspect of successful professional performance” (Paganini & Egry, 2011, p. 575). Ethics for nurses encompasses both theoretical and practical dilemmas and the associated response or decision. Professional knowledge and values drive decision-making in nurses. Paganini and Egry (2011) specify that ethical competence, a component of professional competence, “derives from human experience” (Paganini & Egry, 2011, p. 577), thus referencing both experiential and contextual learning as well as the continual development required to attain competence. The authors support the premise that formal education that is practical and socially relevant improves competence.

The Quality and Safety Education for Nurses (QSEN) initiative solidified the use of knowledge, skills, and attitudes as the primary facets of nursing education. The QSEN faculty built upon the Institute of Medicine (IOM) competencies for nursing (patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics), and proposed definitions that describe key characteristics of competent nurses (Cronenwett et al., 2007). The formal competencies document uses the word *ethical* only three times, twice in relation to patient-centered care and once in relation to evidence-based practice. Under patient-centered care the term ethical surfaces as knowledge of “ethical and legal implications of patient-centered care” (Cronenwett et al., 2007, p. 124) and an attitude where nurses “acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care” (Cronenwett et al., 2007, p. 124). Under evidenced-based practice, the term ethical is mentioned only in reference to ethical conduct in research and quality improvement projects (Cronenwett et al., 2007).

The American Association of Colleges of Nursing's (American Association of Colleges of Nursing, 2008) guiding document for baccalaureate education and professional nursing practice generally references the word competence in relation to technical skills, but also in relation to cultural competence. Achievement and maintenance of competence in all aspects of nursing practice is generally accepted as integral to ethical nursing practice (American Nurses Association, 2011; International Council of Nurses, 2012). Simply stated, a nurse who is not competent, but who continues to practice, is deemed unethical.

Summary

Bosek and Savage (2007) posit that nursing, a fundamentally morally complex activity, requires integration of ethics into clinical decision-making. Ethics, specifically nursing ethics, is multifaceted and complex, which is reflected in the myriad of perspectives explored in this conceptual review of the literature. This literature review provides insight into nurse educator and student perspectives on ethics in nursing education, ethics in a general sense, the subspecialty of nursing ethics, the potential impact of ethics education, the concept of ethical comportment, ethical dilemmas, and the application of the definition of competence. All of these concepts are foundational to the premise of ethical competence and inform decisions made regarding this research.

CHAPTER 3

Research Methodology

Theoretical Framework

Although some people debate including a theoretical framework in basic qualitative research (Creswell, 2009), I framed this research around the fundamental concepts introduced by Dewey (1929) and Kolb (1984). This decision was based on the premise that ethical competence is developed through repeated exposure to situations where ethical issues surface and must be addressed. This clearly mirrors the learning-by-doing or cyclic experiential learning posited by these theorists. Although one could argue that a competency development model could have been used to frame this work, Dewey contains the concepts of goodness and naturalism inherent in discussions of ethics. Kolb operationalizes the work of Dewey in a very concrete, yet fluid manner that provides room for qualitative exploration. The quantitative and qualitative questions intentionally embody core concepts addressed by these theorists including development, practical application, goodness, and specific knowledge, skills, and attitudes (Appendix A; Appendix B).

The experiential learning model surfaces in nursing education literature, ranging in content from articulating experiential learning theory in nursing (Fowler, 2008) to responding to the call for transformation in nursing education heralded by Benner, Sutphen, Leonard, and Day (2010; Handwerker, 2012). Lasater and Nielsen (2009) specifically expound upon the reflective stage of the experiential learning cycle highlighting the use of reflective journaling for the evaluation of clinical judgment

development in nursing students. The core tenets of experiential learning fit the practice-based nature of both nursing education and the profession of nursing (Fowler, 2008).

The beginning theoretical framework for this study drew from the perspectives provided by John Dewey. Dewey's progressive, Western educational philosophy (Oliver, 1999) provides tools to address the realities and benefits of the ever-changing workplace, the varied experiences possible in the global world, and the complex healthcare environment where problem-solving is a required skill. He opposed the traditional educational method involving memorization of facts and content, and instead believed in the educational philosophy of learning-by-doing (Guttek, 2011). Dewey provided a new perspective in education that encompassed both naturalistic and pragmatic theories. As a naturalist, Dewey called for change and rallied against the dual "traditional theories of mind and its organs of knowledge [where they were] isolate[d]...from continuity with the natural world" (Dewey, 1929, chapter 9, para 12). Dewey's naturalistic philosophy supports the integration of mind, body, theory, and practice in order to define the human experiences of living, growing, and problem-solving (Guttek, 2011). This concept specifically supported the potential for connecting units and themes from the qualitative data to identify and explore integrated patterns and themes.

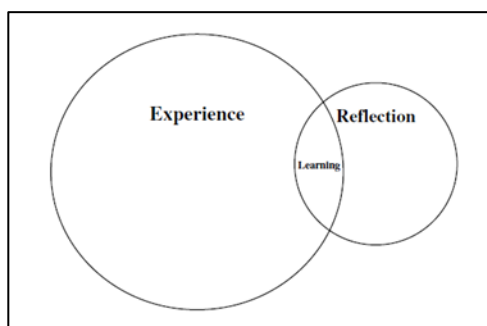
The pragmatist maxim is a "distinctive rule or method for becoming reflectively clear about the contents of concepts and hypotheses...[in order to] clarify a hypothesis by identifying its practical consequences" (Pragmatism, 2008, section 2 - the pragmatist maxim). Dewey's pragmatism specifically incorporates logic, a pattern of practical inquiry (rooted in the scientific method), and the additional identification of experience as a key element (Pragmatism, 2008). This pragmatism created an appropriate

framework for this study, which intends to identify and clarify the tangible knowledge, skills, and attitudes inherent in the budding concept of ethical competence. Dewey embraced change: “in the new experimental science, knowledge is obtained in exactly the opposite way, namely, through deliberate institution of a definite and specified course of change” (Dewey, 1929, chapter 4, para 5). For Dewey, the experience and the associated experimentation are foundational to the development of knowledge (Dewey, 1929). Nursing educators apply Dewey’s premise of the complete act of thought by facilitating students’ exposure to new experiences and supporting students as they gather information, hypothesize, take action, and reflect on the event in order to solidify the learning (Guttek, 2011). Experiential learning may be the primary way concepts foundational to ethics are solidified for students, a theory supported in the literature (Benner et al., 2010; Woods, 2005). The current emphasis in nursing ethics highlights that although theoretical principles provide guidance, it is the everyday exposure to ethical issues (Ulrich, 2012) that lends itself to experiential learning and attainment of ethical competence.

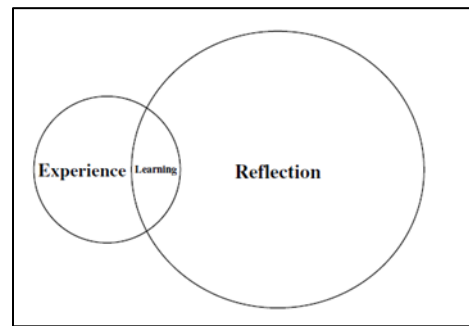
Dewey also provided insight into the development of moral character. His basic premise is that in order to maintain moral behavior in the evolving world where the concept of *good* is relative, one must develop tools that permit continued adaptation (Peterfreund, 1992). Benner et al. (2010) reflect on the development of ethical comportment and moral imagination in nursing students, and seek to inform faculty as to how to prepare nurses for the ethical challenges they will face throughout their careers. Articulation of exactly how moral comportment is developed had not been fully explored prior to the Carnegie Foundation study (Benner et al., 2010). Perhaps Dewey’s premise

that the scientific method, which is rooted in critical reflection, can frame the concepts of morality and ethics provides a foundation upon which educators can continue to build.

Kolb (1984) and Fry, based primarily on the work of Dewey, Lewin, and Piaget (p. 43), created the basis for many models of adult experiential learning. Kolb's (1984) model outlines the cyclic nature of learning and posits that concrete experience, termed *prehension*, followed by *reflective observation*, leads to the formation of abstract concepts, which are then tested in new situations through experimentation, the integration of which is termed *transformation*. The process then begins anew with the active experimentation affecting the next experience (Kolb, pp. 29-31; Smith, 2001). Fowler (2008) posits that the overlap between experience and reflection directly impacts on the amount of learning that occurs and must be considered when facilitating experiential learning. See Figure 1 for a visual representation of how the overlap between experience and reflection affects learning.



Limited reflection in experiential learning



Limited experience in experiential learning.

Figure 1. Limited reflection in experiential learning and limited experience in experiential learning. From "Experiential Learning and its Facilitation," by J. Fowler, 2008, *Nursing Education Today*, 28, p. 431. Copyright 2008 by Elsevier. Reprinted with permission.

This research sought to identify how key experiences were defined by nurse educators and subsequently provided to students. It also considered the abstract concepts inherent in ethical competence from the perspective of nurse educators and barriers to the development of ethical competence. Using this theoretical framework, I also considered whether ethical competence development required active involvement in the actual ethical situation or whether the dilemma and its contextual elements can be adequately replicated. I considered whether classroom or clinical discourse and debate could provide meaningful experiences and critical reflection sufficient to facilitate the development of ethical competence. Educators have a myriad of tools at their disposal that have been vetted by ethicists and are rooted in theory. The tools typically outline the process of identifying and analyzing an ethical dilemma (Beauchamp & Childress, 2001; Jonsen, Siegler, Winslade, 2006; Kenny, Lincoln, Balandin, 2007; Medlin, 2010; Mitchell & Yordy, 2009). Nurse educators may or may not be able to provide first-hand experiences in the realm of ethics, which leads to the fundamental question of whether ethical competence can be developed in nursing students. Thus, in addition to using this theoretical framework to inform decisions regarding design and implementation, certain aspects of this theory, particularly the balance required between experience and reflection (Fowler, 2008), were tested in relation to ethical competence development in nursing education.

Description of Research Method

According to Creswell (2009), the pragmatic worldview provided by Dewey's theoretical framework supports a mixed method approach. The pragmatic worldview considers the response to actions, situations, and consequences surrounding a research

problem. Inquiry rooted in pragmatism frequently draw from both quantitative and qualitative assumptions, where the rationale for mixing methods is rooted in the desire to look at a topic from multiple perspectives, focusing on the truth and real-world resolution of the research problem (Creswell, 2009). The greatest benefit of a mixed method study is that the quantitative and qualitative approaches can be used in tandem to strengthen a study (Creswell, 2009; Streubert & Carpenter, 2011).

Mixed method strategies are varied and determined by the intention of the researcher. For this research study, a sequential mixed method best addressed my intention and focus. The quantitative research preceded the qualitative research for several reasons. First, significant research has not focused on the development of ethical competence. Although the term has superficially been defined as the ability to recognize and address an ethical issue, this research seeks to identify the confounding issues and nuances associated with the concept from the perspective of nurse educators. The quantitative research provided demographic data on nurse educators, details regarding ethics in the curriculum, and basic insight into the knowledge, skills, and attitudes nurse educators associate with ethical competence. Not only did the survey provide national data, it provided insight as to the training, experience, and initial perspectives of the individual nurse educators. This information was used to identify the sample for the qualitative research and formalize the qualitative interview questions.

Ethical Considerations

In 1979, *The Belmont Report* outlined basic ethical principles upon which all research guidelines involving human subjects are now based (Department of Health, Education, and Welfare, 1979, Summary section, para. 1). Researchers must comply

with three fundamental principles to ensure ethical research (Streubert & Carpenter, 2011, p. 61). The first principle, respect for persons, focuses on the necessary autonomy of individuals and the protection of vulnerable populations with diminished autonomy. The second principle, beneficence, discusses the obligation to protect the well-being of the individual, specifically by doing no harm and maximizing benefits while minimizing risks. The third principle, justice, involves sharing the burdens and benefits equitably through equal distribution or distribution based on need, effort, merit, or contribution to society (Department of Health, Education, and Welfare, Part B). Appropriate Institutional Review Board (IRB) approval was secured prior to formally beginning this research from the University of Nevada Las Vegas (UNLV) IRB.

The intended quantitative research considered these fundamental ethical principles by providing information at the beginning of the online survey regarding the purpose of the study, the format of the survey, anticipated risks and benefits, and the participant's right to withdraw from the survey at any time without consequence (Appendix C). Information was specifically provided to the participants regarding the fact that survey results may not be blinded in order to allow the results of the quantitative research to inform the qualitative aspect of this sequential mixed methods research. A number was assigned all participants for the coding of data. Once the survey was closed, survey data were reviewed and the content analysis of the short answer responses completed. Respondent-provided identifying information was accessed by the researcher only after the pool of potential interview participants had been identified. The Qualtrics™ data and associated results were password-protected and only accessible by the student researcher and the primary investigator (PI; researcher's dissertation chair).

Submission of the Qualtrics™ survey constituted consent.

The intended qualitative research considered these fundamental ethical principles by providing information at the beginning of the interview reminding the participant of the purpose of the study, anticipated risks and benefits, and the participant's right to withdraw from the phone interview at any time without consequence (Appendix D). Comprehension was promoted through appropriate college-level explanations and the allocation of time to address any questions. Written informed consent was obtained from all interview participants (Appendix D). Confidentiality was ensured by the researcher and PI, and a number was assigned each participant. Due to the sometimes unpredictable nature of qualitative research, unintended and unexpected effects on the participants were assessed (Streubert & Carpenter, 2011). My training in ethics provides me particular insight into and sensitivity regarding this topic, which will serve interview participants well.

Phase 1: Population and Sample

Purposeful sampling of nurse educators from institutions accredited by the Commission on Collegiate Nursing Education (CCNE; AACN, 2012b) from four states (California, Illinois, Texas, and New York) drove the quantitative survey data collection. The four states identified were each from a distinct geographic area and provided a representative national sample; the states identified also had the largest number of CCNE-accredited nursing programs in their defined geographic region (U. S. Census Bureau, 2012; Appendix E). CCNE-accredited institutions were identified as the primary population because the majority of nursing programs in the United States are CCNE-accredited (Appendix E), and CCNE's parent institution, AACN (2008), produced a

guiding document for baccalaureate education and professional nursing practice that contains clear references to ethics. CCNE-accredited schools with *entry-level BSN* (Bachelor of Science in Nursing) or *accelerated BSN* programs were included; schools that offer programming for only students who are practicing nurses (Registered Nurse or Licensed Practical Nurse) were excluded.

Faculty are appointed and promoted by the governing body of their college or university (Fink, 2012). Faculty positions are generally considered tenured, non-tenured, or instructional, which includes adjunct, distinguished, and emeritus positions. Some institutions also identify rank, which generally includes tenure, clinical, and research tracks (Fink, 2012). In an effort to target nurse educators who engage in the collective work of the faculty and college, nurse educators must teach either part-time or full-time in order to meet the inclusion criteria. Nurse educators must also teach in a pre-licensure baccalaureate nursing program, which is the primary focus of this research (Appendix A).

Each school website was reviewed individually to determine the appropriate initial contact and his/her email information. This website review provided insight into the fact that there is great variation in how schools classify faculty. For example: (a) some schools list lecturers with the full time faculty and others do not; (b) some schools differentiate their faculty by program and others do not; (c) some schools use a clinical track and others do not; (d) use of the classification of adjunct is variable; and (e) academic titles, outside of professoriate titles, are not consistent from institution to institution. Based on the variability in faculty titles from institution to institution, exclusion criteria triggers, using the program track titles as outlined by CCNE, were embedded into the quantitative survey (Appendix A). Online survey participants met all

of the inclusion criteria: (a) nurse educator in one of four identified states (California, Illinois, Texas, and New York), (b) teach in a CCNE-accredited program, (c) teach in a pre-licensure baccalaureate nursing program, and (d) part-time or full-time status.

Verification of the inclusion criteria was assessed in the first four survey questions (Appendix A). Those who were excluded based on state, CCNE-accreditation, or employment status received a message indicating they had not met the criteria for the survey and were thanked for their time; the survey then closed.

In summary, the sample was determined and identified using the following steps. First CCNE accreditation was determined to be the more common accreditation among baccalaureate nursing programs in the United States (Appendix E). Second, the CCNE website was reviewed to establish which schools offer an entry-level BSN and/or accelerated BSN program or track, indicating a pre-licensure program. Third, this list was then cross-referenced with the list of current CCNE-accredited programs (American Association of Colleges of Nursing, 2012b). Any discrepancies between the two CCNE sites were rectified using the individual school website to validate/refute current CCNE accreditation status. Finally, each individual school website was reviewed to determine: (a) the name, title, and credentials of the primary BSN program contact; (b) the email of the primary BSN program contact; and (c) an estimate of the number of faculty associated with the BSN program. The estimate was difficult to determine primarily because no school clearly identifies the courses taught or program/track affiliation for each faculty member; some schools even include staff in the directory, further confounding the effort to determine a precise number of faculty who teach in the BSN program. Based on a review of the 110 program/112 site websites determined to meet the

criteria from the four states, it was estimated that approximately 20 nurse educators teach in each BSN program, meaning that there was an initial possibility of 2240 survey respondents.

Phase I: Procedures and Data Collection

The online survey (Appendix A) was formatted in Qualtrics™ and distributed to the BSN program contact (dean, director, chair, head) of each school of nursing as identified on each school website. In an effort to minimize the responsibility of the BSN program contact and therefore increase the likelihood of the survey email being distributed, the contact was asked to forward the email with the survey link to all part-time and full-time nursing faculty (Appendix F). Qualtrics™ functionality supports the ability to exclude respondents based on their answers to questions, a function they refer to as *skip logic* (Qualtrics Labs Inc., 2012). A reminder email was scheduled in Qualtrics™ and sent to the BSN program contact half-way through the three-week window identified for survey completion. Qualtrics™ also provides an email distribution option that permits anonymous surveying, and provides an option to not record any personal information (Qualtrics Labs Inc., 2012). It should be noted that the final question of the survey asked for contact information should the participant agree to participate in the interview portion of the study (Appendix A). This information was stored in a separate file with only the respondent identification number and the information provided in this final question. This information was accessed, as needed, after completion of the analysis of the online survey. Through the use of a browser cookie, Qualtrics™ allowed for a return-and-complete later option (Qualtrics Labs Inc., 2012). Respondents were prompted to provide an answer for each open-ended question;

the survey did not progress to the next question until an answer was provided for the current question. Informed consent was imbedded into the online survey and preceded the survey questions; participation in the survey will indicate consent.

Survey questions fall into one of four categories: (a) basic demographic data, (b) information regarding the education of the participant, (c) information related to the nursing program where the participant is currently a nurse educator, and (d) open-ended questions intended to collect beginning information on the concept of ethical competence (Appendix A). A mix of closed- and open-ended questions on the quantitative survey offset the strengths and weakness of each type of question (Polit & Beck, 2008).

Although not designed to be a replication study, questions specifically designed to collect information on the education and current role of the nurse educator, curricular inclusion of a separate course in ethics, and methods of teaching and evaluating ethics drew from ideas presented in original work of Aroskar (1977) that explored ethics education from the perspective of 86 nurse educator respondents from baccalaureate nursing programs nationwide. Prior to mass distribution, the quantitative survey was piloted using nursing educators, specifically including professionals with questionnaire development expertise, content expertise, and/or copy editing experience.

Phase I: Data Analysis

An analysis of the quantitative survey data preceded the qualitative interviews. Descriptive statistics were considered and appropriate statistical procedures employed to consider the relationships/correlations between education, training, experience, course taught, and inclusion of ethics content. The researcher used the data analysis tools available in Qualtrics™ and downloaded data into the Statistical Package for the Social

Sciences (SPSS) Version 21, the most recent version of the program, to perform descriptive and correlational analyses. Content analysis of the open-ended questions provided a “systematic and objective means of describing and quantifying phenomena” (Elo & Kyngas, 2007, p. 108) through a process of categorizing the data into themes, key concepts, and/or categories. This inductive content analysis provided further insight into the foci and best interview questions for the qualitative portion of the research study.

Phase II: Sample

A sequential, quantitative then qualitative, mixed method had been identified primarily to allow for review of the survey data, specifically correlating multiple choice answers with the open-ended questions, prior to identification of the pool of potential interview participants. A review of data provided the researcher an opportunity to engage in purposeful intensity sampling in an effort to identify rich cases that provide compelling examples and descriptions (Polit & Beck, 2008) of the development of ethical competence. Purposeful intensity sampling is appropriate for qualitative research (Streubert & Carpenter, 2011). Initial thoughts about sampling included: (a) sampling from those who report teaching a specific course, such as a medical-surgical, pediatric, or nursing ethics course; (b) sampling from those who provide the richest answers to the open-ended questions, (c) sampling from those who report the most experience in teaching, (d) sampling to include nurse educators from each state, or (e) although typically reserved for grounded theory, employing theoretical sampling where, in this case, participants are chosen based on the relevance of their open-ended question answers to potential theory development (Streubert & Carpenter, 2011). The sampling procedure actually involved sampling from those who provided the richest answers to the

open-ended questions from the survey, with courses taught and inclusion of participants from multiple states also considered. Once the survey responses were analyzed and the potential pool of interview participants identified, responses to the final question of the survey were reviewed to ascertain the individual participants' stated willingness to participate in an interview. The name, phone number, and email provided in the final question of the survey were used by the researcher to contact the individual nurse educators directly.

Phase II: Procedures and Data Collection

A semi-structured interview format was used primarily because the term ethical competence is not universally used and applied. The semi-structured format allowed the researcher to ask pointed questions that target various aspects of the concept of ethical competence had the participant not begun the interview with articulation of a fully-operational definition. Several interview questions were crafted to facilitate the interview process (Appendix B); these questions were edited based on information gained from the survey. Due to the logistics of interviewing and the desire for consistency, the researcher conducted all interviews on the phone, with each interview designed to last approximately 45 minutes. The interviewer had developed interview skills that would establish a comfortable, unobtrusive environment, while shaping the interview, and facilitating engagement and discussion with the individual participants (Burns & Grove, 2009). Due to the researcher's knowledge of nursing education and ethics, the researcher capitalized on the connection with and understanding of participants, while maintaining an objective stance, bracketing as appropriate (Burns & Grove, 2009). The researcher took notes and audio recorded the interviews to ensure accuracy of transcription, while

allowing for the researcher to comment on inferences, subtext, specific examples, and common themes during the interview. Twelve interview candidates were identified and six interviews planned; data collection continued until a description of the concept emerged and data saturation reached.

Phase II: Data Analysis

After appropriate bracketing and completion of the interviews, the qualitative data were transcribed, read for a sense of the whole, coded into units, and ultimately compiled into a meaningful, intentional, reflective description of the phenomenon from the perspective of the interview participants. Although primarily used in the context of phenomenological research, Giorgi (2009) identified a method for analyzing qualitative data that applies to the basic qualitative, descriptive analysis intended in this research. Stage one of the analysis involves reading through the entire transcript to get a sense of the whole. Stage two requires coding into small descriptive meaning units, which are then considered within the context of the purpose of the study in stage three. In stage four, the themes that have been identified are linked together and redundancies are eliminated in an effort to create a cohesive descriptive statement that reflects the purpose of the study. The researcher followed a basic qualitative approach that includes the “five Cs: code, cluster, compare, contrast, and contemplate” (Dr. L. Putney, personal communication, September 19, 2112). The researcher completed the qualitative analysis using a blend of both computer and manual processes. NVivo™ was used to provide computer support for the analysis. This computer program also permitted certain quantifiable exercises such as word counts.

Triangulation was used as a key research strategy. Methodological triangulation

(Streubert & Carpenter, 2011) occurred in this study in that the initial survey provided both quantitative and qualitative data and was followed by the qualitative interviews. Combining quantitative and qualitative data provided a more full description of ethical competence. For example, the participants' perceptions and descriptions of ethical competence were considered alongside their reports of education, training, and experience. Methodological triangulation also provided the opportunity for the researcher to quantify portions of the qualitative data, thus providing an opportunity to compare the qualitative and quantitative data and validate the findings (Streubert & Carpenter, 2011). Theoretical triangulation (Streubert & Carpenter, 2011) is posited in the framework of this research, where Dewey's pragmatism and naturalism are coupled with Kolb's concrete model of experiential learning. Although a primary theoretical framework supported the design and implementation of this research, consideration of the qualitative data determined the theoretical lens through which the final work was viewed (Creswell, 2009).

Bias and Limitations

The most significant bias of this researcher stems from my level of expertise as both a nurse educator and a beginning ethicist. Work on ethics committees, formal education and training in clinical ethics consultation, and ethics curriculum-building activities have fostered the development of ethical competence in the researcher. Leading, framing, and teaching were consciously avoided during the interviews to allow for organic development of the perspectives of the participants. Giorgi (2007) eloquently discusses bracketing and adds the notion of reduction where the researcher "considers the given, even if it is real, simply as something present to one's consciousness without

affirming that it exists in the way that it presents itself. It is a reduction from existence to presence” (p. 64) and thus emerges as a phenomenon, not necessarily reality. This notion of reduction reaffirms the necessity of this researcher staying rooted in the perspective of the nurse educators as they presented it, not imposing the reality experienced or predicted by the researcher. The primary limitation of this study is the quantitative survey that required dissemination and participation, and provides self-reported data for analysis. Although emails were sent and phone calls were made as needed to facilitate the survey process, adequate return was required in order to support generalization of results (Polit & Beck, 2008).

Summary

The pragmatic worldview provided by Dewey provided a meaningful framework for this research, supporting a mixed method approach and providing insight into the concept of ethical competence. The sequential mixed method allowed for exploration of ethical competence in two distinct, but related phases. The quantitative phase, scheduled first, provided the opportunity for consideration of the education of nurse educators and the inclusion of ethics content in nursing curricula. Data obtained from the online survey and the initial content analysis informed decisions regarding sampling and interview questions in the second, qualitative phase. A mixed method approach facilitated exploration of the concept of ethical competence from multiple angles, with the intention of providing meaningful results.

CHAPTER 4

Findings of Phase One: Survey

Data Collection Processes and Results

Recruitment for the survey occurred via my student UNLV Rebelmail email account. This mail server supports Google Docs, which was used to generate a mail merge coordinating the program contact with his/her email. A second email was generated and sent to the program contact twelve days after the original email. Contacts who had responded that they had forwarded the initial email were excluded from this second email distribution list.

Despite a request for a response in the email subject line, only 18 of the 110 people contacted replied that the email had been forwarded: 3 of the 24 contacted from Illinois, 7 of the 25 contacted from Texas, 4 of the 30 contacted from New York, and 4 of the 31 contacted from California. This means that instead of the initially projected 2200 potential respondents, based on the confirmations, the estimated number of potential respondents was closer to 360 (18 programs x 20 faculty per program estimated). Of special note is that nine contacts indicated that an IRB and/or research committee review was required before my survey request could be forwarded to nursing faculty. I forwarded the requested information to all nine schools. Six of the schools approved my request within the survey window and my survey request email was forwarded to faculty—these six schools are included in the final count of 18.

Three of those sites did not notify me of approval or denial of my request; to the best of my knowledge, the survey request was not forwarded (two programs in New York and one program in Illinois). Two program contacts in New York declined to forward

my email, both citing too many requests; one school in California had very recently closed and had no faculty to access.

The total number of submitted surveys tallied by Qualtrics was 161. Four cases in which the respondents did not agree to the informed consent were eliminated. Three cases were eliminated because the respondent did not meet the inclusion criteria of part-time or full-time employment status. Sixteen cases were eliminated due to incomplete surveys, which included: (a) cases recognized as incomplete by Qualtrics, (b) cases where the respondent inserted random characters and not answers into open-ended question fields, (c) cases where the respondent did not answer more than two open-ended questions.

One of the inclusion criterion, teaching in a pre-licensure BSN program, required consideration. Cases where respondents did not check one of the two boxes indicating they taught in a pre-licensure BSN program were reviewed; cases were included or excluded based on the report of courses taught. However, cases where the respondents did not initially state they taught in a pre-licensure BSN program, but then indicated pre-licensure BSN courses they taught were included in the analysis. This resulted in the elimination of ten additional cases. The final tally was 128 valid cases for analysis.

Respondent Professional Demographics and Education

The survey targeted nurse educators from four states. Nurse educators from California and Texas each represented 34.4% of the final sample (44 respondents from each state). Nurse educators from Illinois represented 25.8% of the sample (33 respondents). Nurse educators from New York comprised only 5.5 of the final sample (7 respondents). The low response rate from New York required consideration for this analysis—data were considered primarily in aggregate form.

All of the survey respondents reported currently teaching in a pre-licensure baccalaureate program. In addition to teaching in a baccalaureate pre-licensure program, respondents reported concurrently teaching in other nursing programs: 18% teach in an RN to BSN or LPN to BSN program; 19.5% teach in a Master’s program; 10.2% teach in a Doctoral program; and 1.6% teach in another type of program. As previously discussed, academic rank policies and titles vary from program to program. Respondents with a reported academic rank of *professor* comprised 12.5% of the sample; *associate professor* 15.6%; *assistant professor* 35.9%; *lecturer* 6.3%; *instructor* 21.9%; and *other* 7.8% (other titles included *adjunct faculty*, *clinical instructor*, *assistant professorial lecturer*, *associate clinical professor*, *teaching associate*, and *professor emeritus*). Respondents were also asked to report the highest degree achieved: 0.8% reported a Bachelor’s degree; 46.9% reported a Master’s degree; and 52.3% reported a Doctoral degree. Length of time as a nurse educator and formal education in ethics during any degree work were considered in relation to one another. See Table 1 for a consideration of length of time as a nurse educator and formal education in ethics during any degree work.

How long have you been a nurse educator?	Formal Ethics Education: Associate, Bachelor’s, Master’s, Doctorate, Post-doctoral	I have never had formal ethics education	Percent who report no formal ethics education
0-5 Years	29	6	17.1%
6-10 Years	24	8	25.0%
11-15 Years	16	5	23.8%
16-20 Years	8	1	11.1%
21+ Years	21	10	32.3%
	98	30	23.4%

Table 1. Length of time as a nurse educator compared with the reporting of formal education in ethics during degree work

It is not surprising that the greatest percentage of respondents who reported no formal ethics education also reported being a nurse educator with more than 21 years of experience. A study done of accredited MSN programs in 2004 demonstrated that at least 38% of MSN programs required ethics content, which was nearly double the number of programs that required ethics content in a similar 1998 study (Burkemper et al., 2007).

The degree in which their formal ethics education was received and whether their education was provided in a stand-alone course or if the ethics education was integrated into the curriculum were also considered in relation to one another. Respondents were asked two questions related to their formal ethics education: (a) the first question asked whether they had formal ethics education in any of their degree-awarding programs, (b) the second question, which was prompted if the respondent indicated formal ethics education in the first question, asked whether this reported formal ethics education was offered in a stand-alone course or integrated into the curriculum.

Due to the question format, respondents were able to indicate that formal ethics education was offered in both a stand-alone and integrated format. More respondents identified the type of formal education provided with each degree (Appendix A–Question 11) than originally answered formal ethics education had been provided for each of the degrees specified (Appendix A–Questions 10). The numbers reflect the total number of respondents to the second, more specific question (Question 11) regarding the type of formal education they received as students. See Table 2 for a consideration of the respondents' degree(s) and ethics education delivery reported as received for each degree.

Degree	Number of respondents who reported receiving formal ethics education with this degree	Percent of ethics education provided in a stand-alone course	Percent of ethics education integrated	Percent of ethics education provided in both a stand-alone course and was integrated
ADN	6 (4.7%)	16.7%	83.3%	0.0%
BSN	64 (50.0%)	35.9%	54.7%	9.4%
MS/MSN	82 (64.1%)	32.9%	62.2%	4.9%
Doctorate	47 (36.7%)	51.1%	46.8%	2.1%

Table 2. Degree and ethics education delivery

Overall, 76.6% of the respondents reported some formal ethics education in coursework for at least one degree and 23.4% reported no previous coursework. The specific education provided was explored in the content analysis of the open-ended question related to education of the respondents.

Recent, defined as within five years, ethics training was also considered in relation to the highest degree obtained by the respondent. The basic options regarding training included: continuing education session, case presentation, webinar, clinical ethics consultation training, and other. If respondents indicated they had other ethics training, a text box permitted the respondent to describe the training. Free text answers included: reading (3), annual required corporate or university compliance training (2), dissertation (1), research ethics (1), and self-study/training (2). See Table 3 for a description of these aggregate responses.

Training in ethics in the past five years	Bachelor's	Master's	Doctorate	TOTAL
CE	0	18	19	37
CE & CP	0	7	5	12
CE & Web	0	3	3	6
CE & CP & Web	0	3	3	6
CE & Other	0	1	1	2
CE & CEC	0	2	1	3
CE & CP & CEC	0	2	1	3
CE & Web & CEC	0	0	1	1
CE & CP & Web & CEC	0	0	1	1
CE & CP & Web & O	0	1	0	1
CP	0	4	3	7
Web	0	1	2	3
CP & Web	0	1	0	1
CEC	0	0	1	1
O	0	2	2	4
O & Web	0	0	1	1
No training in ethics in the past five years	1	15	23	39 (30.5%)

Key: CE = Continuing education session(s), CP = Case presentation(s), Web = Webinar(s), CEC = Clinical ethics consultation training, O = Other

Table 3. Degree and training in ethics in the past five years

Although the quality, scope, and breadth of the training cannot be determined, it could be argued that clinical ethics consultation training, by nature of the focus and time commitment required, would provide the greatest opportunity to develop the knowledge, skills, and attitudes required for the development ethical competence—only one respondent reported completing this training. A total of 39 respondents (30.5%) reported no ethics training in the last five years. Of these 39 respondents who reported no training in ethics in the past five years, 11 of them also reported no formal ethics education during degree preparation—this means that 8.6% of the nurse educator respondents reported no ethics education or training.

Pre-licensure BSN Program Information

Respondents were asked a question regarding the inclusion of a stand-alone ethics course in the pre-licensure BSN program where they currently teach. A pre-licensure BSN nursing ethics course was reported by 18.8% of respondents. A liberal education ethics course was reported by 11.7% of respondents. Related courses were identified in the *other* section and were reported by 8.6% of the respondents (bioethics, medical ethics, research, issues and trends). Of the 58 respondents who reported a required stand-alone ethics course, 60.3% of them reported the course is required junior or senior year. Integrated ethics content was reported by 3.9% of the respondents in the *other* category. Four respondents (3.1%) reported not knowing if an ethics course is offered (free text in the *other* category). No course in ethics was reported by 53.1% of respondents.

The inclusion of ethics content into specific courses was also considered from the perspective of the nurse educators who teach those courses. Due to the fact that clinical and simulation nursing courses do not generally include exams, the 144 responses where a clinical or simulation course was indicated were not considered in the following table. The inclusion of ethics content in clinical courses was explored in the content analysis of the open-ended question that addresses any intentional inclusion of ethics content in courses taught by the respondent. Courses taught and the number of respondents who reported 76-100% of exam questions include ethics content are specifically indicated. See Table 4 for respondent reports of courses taught and the inclusion of ethics content on exam questions.

Pre-licensure BSN Course	(Number) Percent of nurse educators who report they teach this course	Percent of nurse educators who report >10% of exam questions include ethics content	
Nursing ethics	(13) 10.2%	100%	76-100% (4)
Foundational nursing	(16) 12.5%	28.6%	
Health assessment	(24) 18.8%	19.0%	
Medical-surgical nursing	(25) 19.5%	25.0%	76-100% (1)
Behavioral health nursing	(10) 7.8%	57.1%	
Pediatric nursing	(16) 12.5%	26.7%	
Women's health (L&D) nursing	(15) 11.7%	20.0%	
Geriatric nursing	(6) 4.7%	40.0%	
Capstone/Immersion course	(14) 10.9%	33.3%	76-100% (1)
Public health nursing [Includes Community]	(14) 10.9%	45.5%	
Transcultural/Global health/Vulnerable populations	(7) 5.5%	42.9%	
Management and/or Leadership	(16) 12.5%	76.9%	76-100% (2)
Professional development	(13) 10.2%	44.4%	76-100% (1)
Nursing research	(20) 15.6%	68.4%	76-100% (1)
Pharmacology	(11) 8.6%	20.0%	
Other [Terminology and writing in nursing (1), Math of drug and solutions (1), Health promotion (1), Health policy (1), Electives in addictions (1), Pathophysiology (2), Nursing informatics (2), Contemporary issues in health care (1), Seminar (1)]	(11) 8.6%	45.5%	

Table 4. Courses taught and the inclusion of ethics content on exam questions.

Although only 10 respondents reported that 76-100% of exam questions include ethics content, the courses in which this level of inclusion was reported represent the courses in which ethics content is typically embedded in pre-licensure BSN programs. The respondent numbers were too small to ascertain whether the percentage of exam questions that include ethics content is directly related to whether or not the program requires a stand-alone ethics course, or whether that percentage is related to the formal education and/or training of the nurse educator(s). These ideas were considered during the content analysis of the open-ended questions and in the qualitative interviews. Regarding the interview, one respondent did not answer this last question regarding

willingness to participate in an interview; 52 respondents (40.6%) indicated a willingness to participate in an interview. A rubric, developed after the content analysis, guided the identification of interview participants.

Survey Content Analysis

Content analysis provided insight into the perspective of the nurse educator respondents in a way that cannot be captured by multiple choice questions alone. A combination of inductive and deductive methods drove this content analysis (Elo & Kyngäs, 2007). Although the purpose of this study is not necessarily theory testing, the experiential model impacted on the development of the first four open-ended questions regarding education. The last three questions directly related to the central concept of ethical competence were developed based on the literature review. By nature of having developed seven distinct, self-contained questions, the main categories were established prior to the implementation of the survey itself. Based on this conceptualization and associated survey format, the deductive portion of this analysis began with the general and moved to the specific (Burns & Grove, 2009). However, coding within the pre-established main categories relied upon inductive content analysis—data were reviewed, coded line by line, and then sub-categories were created to group the data points (Elo & Kyngäs, 2007), thus moving from the specific to the general (Burns & Grove, 2009). Because the qualitative interviews follow this concept analysis, this content analysis focused primarily on manifest content in word counts and creating nodes, with latent content considered in relation to grouping terms and categorizing nodes for analyses and abstraction (Elo & Kyngäs, 2007).

Although the first three questions regarding the nurse educators' personal educational experiences were analyzed and coded individually, comparisons between the answers given for each of the questions were explored as they relate to experiential development. Approximately 383 unique stem words were identified, 454 references coded, and 22 nodes identified for the first question, which relates to the focus of education during pre-licensure education. Approximately 395 unique stem words were identified, 366 references were coded, and 21 nodes identified for the second question, which relates to the focus of graduate education. Although approximately 551 unique stem words were identified for the practicing nurse content, only 298 references were coded and 17 nodes identified. Although the first three questions focused on the personal education of the respondents were reviewed in the order they appear on the survey, words included in word frequency tables and coding were reviewed after the completion of the analysis for each individual question. For example, *child, children, baby, infant,* and *women* appeared more frequently in the third question and were added to the concept of *patient*; this required a review of the word counts for the pre-licensure and graduate content to ensure that if these words occurred, they were coded and considered under the concept of *patient* for all three questions. Word-count queries were downloaded into MS-Excel for easier grouping and consideration of data. Linking words (examples: *and, which, that*) were frequently not included in the coding, which results in total weighted percentages that may not add up to 100%. All meaningful data points were reviewed and coded. Misspellings did not exclude a word from analysis. Words that either reflect the intention of the question or are difficult to consider without context (including: *ethics,*

nursing, course, discussion, practice, program, case, focus, recall, and study) were not considered for specific word-counts.

Open-ended question: Describe the focus of your ethics education during your pre-licensure (Diploma/ADN/BSN) nursing program. An NVivo™ word count query that included stemmed words assisted in the initial consideration of data obtained in this first open-ended question. Words that had, alone or in combination with associated terms, 11 or more occurrences and covered more than 1% of the answer content comprise this analysis. See Table 5 for NVivo™ -generated word counts related to this first open-ended question.

Pre-licensure Education General Context: <i>Specific Words</i>	NVivo™ Weighted Percentage
Ethical concepts: <i>right/rights, bio/bioethics/biomedical, good, values, wrong/wrongs, privacy, advocate, jurisprudence, autonomy, beliefs, beneficence, deontology, dignity, justice, maleficence, respect, truthfulness, utilitarianism, virtue</i>	3.22%
Dilemmas: <i>issues, situations, dilemmas, dilemma</i>	3.07%
Decision-making: <i>decision, decisions, making</i>	2.70%
Formal ethics training: <i>principle(s), definition(s)/terminology, theories/theory/theorists, philosophy, framework, fundamentals, model</i>	2.41%
Integrated: <i>integrated, integrating, integration, throughout, threaded, threading, weaved, incorporated, interwoven</i>	2.05%
Patient: <i>patient, families</i>	1.87%
Profession: <i>professional, profession, professionalism, role(s), responsibility, responsibilities</i>	1.32%
Care: <i>care, caring</i>	1.12%
Religion: <i>Catholic, faith, spiritual, theology, Christian</i>	1.03%
Clinical: <i>clinical</i>	1.02%
Code of Nursing: <i>code, ANA</i>	1.02%

Table 5. NVivo™ -generated word count: Focus during pre-licensure education.

Although the literature reflects use of the term ethics in relation to legalities, the words *legal* and *law* only covered 0.46% of this content.

Coding resulted in the identification of seven major groups of data: (a) do not recall; (b) none; (c) integrated; (d) non-nursing course; (e) not related to pre-licensure

degree; (f) reference to basic, broad, or general; (g) specific details. Due primarily passage of time, which was included in the responses by the survey respondents, 6.65% of the content reflected that the respondents do not recall the details regarding the focus of their own pre-licensure education. No focus on ethics during their pre-licensure education represented 14.05% of the content. An integrated approach covered 9.85% of the content. Non-nursing courses were referenced in 10.46% of the content and included: bioethics, medical ethics, a standard [pre-requisite] ethics course, and theology/Christian ethics. Content that does not directly address the pre-licensure degree covered 2.56% of this question’s total content. Answers referred to foci that are broad, basic, or general in 9.41% of the content. Specific details are referenced in 46.81% of the content. See Table 6 for how these references to specific details were coded into subcategories and the percentage of content each subgroup covered. Percentages greater than 1% are listed individually.

Pre-licensure Education Specific Details: Subcategories	NVivo™ Coverage Percentage
Application to nursing: role, context, environment	10.95%
Teaching modality: case studies, discussion, scenarios	7.66%
End of life	4.88%
ANA Code of Ethics, ICN Code of Ethics, Nurse Practice Act	4.79%
Patient care	4.78%
Decision-making	4.73%
Ethical theory, framework, principles	3.95%
Right and wrong, goodness	2.56%
Ethical dilemmas	1.55%
Clinical ethics consultation, similar resources	1.15%
Other: Professional, vulnerable populations, conflict resolution, academic details	1.76%

Table 6. Pre-licensure: References to specific details coded into subcategories and the percent of content covered.

Open-ended question: Describe the focus of your ethics education during your graduate education. An NVivo™ word-count query that included stemmed words assisted in the initial consideration of data obtained in this second open-ended question. Allowing for stemmed words originally resulted in the grouping of *integrity* with *integrate(d)*—a second word-count query was executed to differentiate these words. Words that had, alone or in combination with associated terms, 11 or more occurrences and covered more than 1% of the answer content comprise this analysis. See Table 7 for NVIVO-generated word counts related to this second open-ended question.

Graduate Education General Context: <i>Specific Words</i>	NVIVO Weighted Percentage
Educator: <i>educating, education, educational, educator, teacher(s), professor, instructor, mentors, teach, teaching</i>	3.39%
Dilemmas: <i>issues, situations, dilemmas, dilemma</i>	3.39%
Research: <i>research, researched</i>	2.33%
Ethical concepts: <i>integrity, rights, bioethics, honesty, truth, value, advocacy, beliefs, biomedical, confidentiality, consent, justice, organizational</i>	1.94%
Clinical: <i>clinical</i>	1.45%
Integrated: <i>integrated, integrate, woven, incorporated, throughout, weaved</i>	1.37%
Formal ethics training: <i>principle(s), theory, historical, history, theoretical</i>	1.27%
Decision-making: <i>decision, decisions, making</i>	1.26%

Table 7. NVIVO-generated word count: Focus during graduate education.

For this question regarding the focus of graduate education of the nurse educator respondents, the word *research* met the word-count frequency required for consideration, and was the only word/concept not already included in the pre-licensure word-count table. In comparison to the pre-licensure word-count table, several word references were not included in the word-count table for this question that reflects graduate education: (a) *code* or *ANA* covered only 0.39% of this content; (b) the only religious reference was to

Jesuit, which covered only 0.10% of this content; (c) *care* covered only 0.78% of this content; (d) concepts bundled under profession (*professional, professionalism, role, obligation*) covered only 0.88% of this content; (d) references to patient (*patient, pt, client, child*) covered only 0.78% of this content. *Legal and liability* covered only 0.39% of this content. Although the frequency did not meet the requirements for inclusion this table, this word count includes three relevant words not present in the pre-licensure word count—*competence, competencies, and comportment* covered 0.29% of this content.

Coding resulted in the identification of seven major groups of data: (a) do not recall; (b) none; (c) integrated; (d) non-nursing course; (e) similar to pre-licensure degree; (f) generic reference to basic, broad, or general; (g) specific details. Due primarily to the passage of time, which was included in the responses by the survey respondents, 1.56% of the content reflected that the respondents do not recall the details regarding the focus of their own pre-licensure education. No focus on ethics during their pre-licensure education represented 7.81% of the content. An integrated approach covered 6.53% of the content. Non-nursing courses were referenced in 3.31% of the content and included: medical ethics, business ethics, bioethics, and thesis work. Content where the respondent specifically referenced the pre-licensure degree covered 2.34% of this question's total content; one of the three respondents in this category also referenced an *intense focus on solving ethical dilemmas*. Answers referred to foci that are broad, basic, or general in 10.16% of the content—this included general references to teaching modality (examples: case studies, discussions). Specific details are referenced in 60.91% of the content. See Table 8 for how these references to specific details were coded into subcategories and the

percent of content each subgroup covers. Percentages greater than 1% are listed individually.

Graduate Education Specific Details: Subcategories	NVivo™ Coverage Percentage
Specialty/degree focused: pediatrics, obstetrics, education, nurse leader	28.83%
Research-focused	9.99%
Patient care	6.25%
Legal, policies	3.65%
Decision-making	3.13%
Ethical theory, framework, principles, history	2.97%
Organizational ethics	1.56%
Professional	1.28%
Clinical ethics consultation	1.26%
Other: Code of ethics, quality of life, social justice, vulnerable	1.98%

Table 8. Graduate: References to specific details coded into subcategories and the percent of content covered.

Although some similarities occurred between these subcategories and the subcategories identified in the pre-licensure education content, the obvious difference is the large percentage of respondents who referenced their advanced degree specialty when describing the focus of their graduate education. Research-focused training covered almost 10% of the content, which reflects the research focus inherent in many graduate programs.

Open-ended question: Describe what you learned about ethics once you became a practicing nurse. An NVivo™ word-count query that included stemmed words assisted in the initial consideration of data obtained in this third open-ended question. Allowing for stemmed words originally resulted in the grouping of *personal* with *persons*—a second word-count query was run to differentiate these words. Words that had, alone or in combination with associated terms, 14 or more occurrences and covered more than 1%

of the answer content comprise this analysis. See Table 9 for NVivo™ -generated word counts related to this second open-ended question.

Practicing Nurse General Context: <i>Specific Words</i>	NVivo™ Weighted Percentage
Patient: <i>patient, family, children, clients, baby, child, infants, parents, women</i>	4.24%
Dilemmas: <i>issues, situations, dilemmas, dilemma</i>	3.09%
Decision-making: <i>decision(s), make(s), making, decide, deciding</i>	2.67%
Ethical concepts: <i>respect, confidentiality, advocate, moral, integrity, unethical, vigilance, autonomy, beneficence, just, justice, organizational, privacy, truthful</i>	2.07%
Complexities: <i>complex, challenged, difficult, ambiguous, complicated</i>	1.51%
Care: <i>care, caring</i>	1.44%
Attributes: <i>beliefs, value(s), feel, feeling, feelings, felt</i>	1.22%
Committee: <i>committee(s), council</i>	1.15%
Colors: <i>grey, black, white</i>	1.08%
Health: <i>health</i>	1.01%

Table 9. NVivo™ -generated word count: Practicing nurse.

Although the word *patient* and all of its associations appeared in the pre-licensure word-count table, they did not appear in the graduate word-count table. The words included in this particular grouping of *patient* were expanded to include specific groups of people identified by age group and gender that were not present in the other two related word-count queries. Although *health* is referenced in the pre-licensure content (0.56%) and graduate content (0.58%), it did not meet the requirements for inclusion in the word-count table until considered in this question regarding practicing nurses. References to *complexities* and *committee* also appeared in the word-count chart for the first time. Several groupings previously discussed did not meet the requirements for inclusion in this table: (a) *research* does not reach the required frequency for consideration (0.22%),

(b) *legal* and *legalities* did not meet the requirements for inclusion (0.29%), (c) *clinical* did not meet the requirements for inclusion (0.36%), (d) references to *formal ethics training* (0.92%) were insufficient for consideration, and (e) the concept of *integrated* was not applicable for this content focused on practicing nurses, not formal pre-licensure or graduate education.

After a review of the content and the coding of the references, several concepts struck the researcher and prompted re-exploration of the word-count queries. Respondents used colors, specifically *grey*, *black*, and *white*, in descriptions of what they learned as practicing nurses, typically within the context of the complexities or lack of clarity—this was also not present in the pre-licensure or graduate content. For example, one respondent stated *there is much grey and very little black and white*. Although the frequency did not meet the requirements for inclusion this table, this word-count includes relevant words not highlighted in the pre-licensure or graduate word count: *personal* and *self* covered 0.72% of this practicing nurse content. Only *personal* appeared in the pre-licensure content (0.09%). Although both *personal* and *self* appeared in the graduate content, together they only covered 0.49% of that content. The other notation is that although both *values* and *beliefs* appeared in the pre-licensure and graduate content, they only covered 0.37% of the pre-licensure content and 0.20% of the graduate content; no derivation of feelings was present in either content. For this table, these words were considered separate from the general *ethical concepts*.

Coding resulted in the identification of sixteen groups of data. See Table 10 for the coding and coverage percentages.

Practicing Nurse Categories	NVivo™ Coverage Percentage
Complexities + Color references (grey, black, white)	19.00%
Ethics as integral or personal	13.96%
Clinical ethics consultation, processes, committee	10.84%
Professional conduct, responsibility	9.32%
Hands-on, experience	6.82%
Specific training outlined	6.25%
Treatment of patients	6.18%
Theoretical foundation, code of ethics	4.89%
Violations	4.56%
Resource issues	4.53%
Decision-making	3.80%
More than previously learned	3.29%
Interprofessional	2.27%
Other: documentation, none	1.56%

Table 10. Practicing nurse: References to specific details coded into categories and the percent of content covered.

References to complexities were complimented by references to the personal and integral nature of ethics. Processes to address these issues included both formal entities and professional codes and responsibility. Although there were components of categories previously referenced in the both the formal pre-licensure and graduate questions, several new categories included *experience*, *violations*, *resource issues*, and *interprofessional concepts*.

Discussion of first three open-ended survey questions: Educational foci. When considering the concept of development in this study, specifically the development of ethical competence, knowledge, skill, and attribute attainment must be assessed at various points. The continuum identified in these first three questions involved initial formal education and any advanced formal education, but then allowed for consideration that learning does not cease when school ends. In fact, in the practical field of nursing, learning is solidified with experience and a review of any Board of Nursing website will confirm that continued education is a requirement. Although the focus of this study is on

the first stage of development that occurs in pre-licensure programs, these first three open-ended questions provided insight into the experiences of the nurse educators in this study and began to outline what they recalled as important or significant.

Answers that represented a lack of focused ethics education, a lack of recall on the part of the respondent, a reference to integrated content, or non-nursing foci were not explored in any further depth. Specific themes common to all three answer sets included: (a) patient care or the treatment of patients; (b) decision-making; (c) code of ethics; (d) professionalism or professional role; and (e) resources, specifically clinical ethics consultation. Although these themes thread through each of the three stages identified, in many cases the perspective changed and demonstrated some progression, both from the individual and collective perspectives. For example, when asked about pre-licensure education, one respondent discussed the *Code of Ethics for nursing and application in the clinical and professional environment*. When asked about graduate education, this same respondent referred again to the code of ethics, but in regards to educating students, *FERPA* [Family Educational Rights and Privacy Act], *HIPAA* [Health Insurance Portability and Accountability Act], *Code of ethics in educating students*, thus relating the same content to what was likely the education focus of the respondent's master's program. Although the code of nursing was not directly referenced in this respondent's answer regarding ethics as a nurse, *importance is maintained throughout nursing. Violations can ruin career. EHR* [Electronic Health Record] *has caused an increase in vigilance by institutions*, violations typically occur in relation to some standard, such as nursing's code of ethics.

Ethical dilemmas and the associated (ethical) decision-making received mention in the pre-licensure content, frequently related to *end-of-life decision making*. In the graduate content, mentions of ethical dilemmas expanded to include *macrolevel ethical issues*, and decision-making was often coupled with references to *process* or resources such as the *Ethic[s] Committee*. When asked to consider ethics education from the perspective of the practicing nurse, the references to decision-making were greatly expanded to include references to: the *collective effort* of the interprofessional team in decision-making; *more in depth*; *various degrees of complexity every day*; that there is *much more depth related to the practice act and how I should look at decision making*; that *there are many more grey areas that require consideration and consultation before making decisions than absolute black and white decisions*; and that *decision making can be very difficult as you look at moral justice, vulnerable populations, beneficence, autonomy, and how very ill patients are as well as needs of family*.

Although not an early-identified common thread, the ideas of personal values and beliefs were articulated in the practicing nurse content, prompting further exploration of this theme in all three content areas. The pre-licensure content contained general references to the idea of personal beliefs and/or values, inclusive of *personal practice decisions*; *nursing's ethical principles and values*; and *the values that apply to nursing*; *deontology, utilitarianism, [and] ethical decision-making*. The graduate content contained some references inclusive of *personal clinical practice*; *integrated beliefs*; *values*; *ethics and service in personal and professional life*; *fostered continual personal and professional growth*; and *personal reflection*.

The depth and relative conviction expressed by respondents when discussing their personal values and beliefs as they relate to their ethics knowledge development as a practicing nurse are noteworthy. Their personal values and beliefs were mentioned in relation to complex decisions: (a) *You need to really understand yourself (and understand that your personal views may be different than others) before you can make the complex decisions that a nurse has to make, often on a daily basis;* and (b) *my personal responsibility despite what was going on, to decide what I felt was the best decision for the situation.* Personal beliefs also surfaced in relation to personal and professional ethics: (a) *many clinical situations... arose where personal or professional ethics were encountered and had to decide what personal beliefs were;* (b) *there are many instances where ethics come into play when caring for a patient, not only your personal ethics but that of the profession;* (c) *I have high ethical values. I am a patient advocate and strongly support the profession as being very ethical in practice;* (d) *Incorporating values and acting on them—for example, if I made an error, whether I would disclose and how/who would I disclose to;* and (e) *Ethical practice is essential to be believable among peers and patients. Ethics is tied to what I think and believe is right about nursing.* Respondents reported that their individual clinical practice is based on their personal beliefs and values: (a) *Nurses have a lot of latitude in providing care and that ethical practices have to do with personal conviction. The organization can mandate behavior, but the provider must search her own conviction;* (b) *I had to self-evaluate myself and my ethics. Everyone's paradigm of ethics does not fit in a neat, tidy box. I learned to be cognizant of others ethical beliefs and show them respect;* (c) *I learned how to implement my values and beliefs into my nursing practice. If an ethical issue arose, I*

had the knowledge and support from my colleagues to navigate the issue; and (d) There were many opportunities to explore my own ethical beliefs while providing direct nursing care—and in a team effort while providing direct nursing care. Others took a contrary view, highlighting that the views of the nurse are sometime irrelevant: (a) A nurse has to remove his or her own beliefs when providing information to patients and let them make their own decisions about ethical issues concerning their health; (b) patient experiences, respecting others' beliefs and health care choices according to their beliefs. Even when the recommended choices by the HCP [health care provider] might have a better health outcome; and (c) I had to make ethical self-reflection a part of my nursing practice to not impose my ethics onto others. Values judgment came into play here too: (a) Ethics is based on the individual's values. The higher in administration one is promoted, the lower the ethics one has; and (b) Ethics should hold more sway than legalities, but they do not. Many people do not live by absolutes, but tend to define ethics as a state that most benefits them.

One of the primary reasons for this survey and associated content analysis was to inform the qualitative interview portion of this research. The respondents' reflections on personal beliefs and values hinted at the intangible elements inherent in ethical competence. Since the nurse educators were compelled to articulate ideas surrounding their values and beliefs, a question specifically asking about personal beliefs and values was added to the qualitative interview questions following the question regarding goodness: How do beliefs and values, both personal and professional, impact on the development of ethical competence in students (Appendix H)?

Open-ended question: Please describe any intentional inclusion of ethics content in the pre-licensure BSN nursing course(s) you regularly teach (ex. learning objectives, teaching activities, projects, case studies). The content analysis for this question was considered separate from the other questions due to its narrow focus. The nature of the question drove formation of course-specific categories, which were created as specific courses and included the associated content referenced by respondents. Due to the focus of this question and the fact that most respondents gave answers that fit into primarily one category, a word count and the percentage of the total content covered by any one node or category provides information not central to the analysis of this question. The emphasis for this analysis is on the number of respondents who referenced each specific course and the educational examples they provided.

Eight main categories were identified after coding: (a) 65 references with details about the educational inclusion of ethics, 48 of which were also associated with a specific course; (b) 23 references to *clinical* focus; (c) 7 references to *weaving* or *integrating* content with no specific details; (d) 10 references to *no inclusion*; (e) 1 reference to *raising awareness*; (f) 41 references that included a generic listing of learning objectives, case studies, or discussion with no specific details other than what was already listed in the question itself; (g) 1 request for *more researched material*; and (h) 2 references where the respondents did not know what is included in the classroom teaching due to the fact that the respondents teach clinical only. This analysis focuses on references with a clinical mention and the references that contain detail(s) regarding the ethics education provided.

References under clinical education and simulation contained planned clinical case conferences and discussion on a myriad of topics including: *advocacy; patient rights; unequal treatment of patient; code of ethics; standards of practice; current events; diversity; hospital setting; end of life; substance abuse; ethical situations seen in the hospital setting and how the nurse might “change” that situation; and patient and family decisions*. There were also references that relate to capitalizing on events of the clinical day, highlighting observed *ethical breaches; ethical behavior; and discussing ethical situations encountered during [the students’] day*. Ethical behavior was referenced in relation to error reporting and HIPAA. Specialty-specific examples were given for mental health where students *discuss the moral complexity of this population* informally during weekly clinical briefings. A leadership clinical rotation included an activity where the student must consider an ethical dilemma *from the perspective of the nursing leader and [describe] how they would handle that situation*. A pediatric reference described an activity focused on guardianship and disclosure. A reference focused on women’s health described discussion and case studies relevant to that population including *counseling women with unplanned pregnancies, supporting families... birth defects, informed consent... assisting domestic violence victims, and assisting pregnant women.... addicted to ETOH [alcohol] and/or drugs*.

Paperwork was identified through mention of *clinical journals* and applying an *ethical decision-making model* to an ethical situation encountered by the student. The paperwork component of nursing clinicals frequently involves some sort of reflection (Nielsen, Stragnell, & Jester, 2007), either structured or unstructured. This required reflection links back to the experiential model where reflection drives the process of

development (Kolb, 1984). Students engaged in debriefing their clinical day who identify ethical issues they encountered are afforded the opportunity to reflect-on-action, which is retrospective, thus providing students the opportunity to re-assess the situation, evaluate their performance, consider the outcome, and create a plan for future action (Nielsen, Stragnell, & Jester, 2007). Although the other activities included by respondents, such as *discussions* or *what-would-you-do* scenarios, may include some form of reflection, the type of reflection triggered by those activities are reflection-in-action, which is reflection that occurs in the moment. This type of reflection is typically more focused on the actual order of events (Nielsen, Stragnell, & Jester, 2007). Depending on the experiences of the student, these pseudo-experiences may or may not provide the opportunity for reflection-on-action, which is retrospective and provides the opportunity for evaluation and change (Nielsen, Stragnell, & Jester, 2007). The value of these discussion and case studies also depends on the commitment of the students. If students are not willing to allow the case study to supplant personal clinical experience, the positive impact of this teaching modality is likely diminished.

Detailed information and specific examples not clearly associated with a course were provided for the categories of abuse/violence/addiction, academic guidelines, ANA and ICN code of ethics, end-of-life nuances, model ethical behavior, university guidelines regarding ethical expectations, and virtue ethics. The single respondent who referenced virtue ethics also mentioned the work done by Crigger and Godfrey (2011) who consider virtue ethics integral to the development of professionalism along a continuum that is reflective of the experiential learning cycle. Although this content analysis cannot focus on the input from one respondent, the work of Crigger and Godfrey certainly informed

this research and was integrated into the final analysis. See table 11 for specific courses identified and an overview of reported intentional inclusion of ethics.

Course	Intentional Inclusion of Ethics
Capstone	Letter to editor regarding ethical issue-identify dilemma, cite pro/con viewpoints, defend
Community/ Public Health	Discussion on Tuberculosis & noncompliance; utilitarianism; vulnerable populations, health disparities & ethics related to epidemiology & communicable diseases; definitions
Fundamentals	Case study on professionalism
Geriatrics	Geriatrics-focused case -emphasis on end-of-life, goals of care, & palliative/hospice
Health Assessment	Incorporated into patient interaction and interviewing techniques; informally discuss ethics — correct/ethical documentation
Health Policy	PowerPoint guided discussion
Leadership or Management	Ethical considerations faced by nurses on a daily basis; apply ethics to organizational situations; patient advocacy situations; ethical issues in nursing leadership; respect for human life, dignity, quality of life
Medical- surgical	Seeing similarities rather than differences is a good starting point; focusing on dignity; every encounter requires an ethical approach; sense of right and wrong tested on a regular basis requiring them to ask themselves if they handled the situation in an ethical manner; end of life, substance abuse, neglect and abuse; clinical ethical dilemmas
Mental Health	Legal protections for persons with mental illness; current controversies; apply ethical principles to justify intervening against the will of a person with mental illness (involuntary hospitalization, medications, restraints/seclusion; Suitcase exhibit — early asylums and new asylums (prisons); Minds on Edge is viewed and discussed; paternalism; confidentiality; past and current policy; legal issues
Nursing Ethics	Intensive case study; organizational ethics; conflicts and breakdowns; just culture, error prevention, truth-telling, integrity; advocacy; moral distress, moral courage, ANA code of ethics; community service demonstrating justice and fairness; patient rights/autonomy; basic ethical principles; ethical decision-making; ethical theory; ethical challenges; bioethical dilemmas; life and death; quality of life; right to decide; informed consent; alternative treatment issues; stem cell research; therapeutic and reproductive cloning; in vitro fertilization, donors insemination, surrogate motherhood; organ transplantation
Nursing Theory	ANA code of ethics
Pediatrics	Ethical decision-making as it relates to fetal development, congenital abnormalities, end-of-life care for children and adults, research studies, adverse/side effects of drugs; abuse; parenting; dealing with children from different religious backgrounds; differing wishes (parent, child, healthcare team); do what is right in acting as a patient advocate, in making a mistake, in taking the time to do it correctly all the time without shortcuts
Pharmacology	Addiction; related to topic
Professional Role Development	Ethical practice alongside the legal requirements and legal case review; writing of exemplars of “everyday” ethics; cultural competency; ethical principles
Research	Analyze ethical, legal, and moral issues inherent in the research process; compare Christian values/professional values with the ethical, legal, and moral issues involved in conducting research; discuss the role(s) of social justice as it relates to ethical, legal, and moral issues in research; protection of human participants; Miss Ever’s Boys — 1930s unethical behavior
Women’s Health or Labor and Delivery	Fetal demise; Catholic implications – ethics committee involvement; method of support to understand how to move through dilemmas effectively; end-of-life decisions juxtaposed with the new life association with maternal-newborn nursing; genomics – science, policy, practices; preterm infants; artificial reproductive issues, embryo ownership/storage, surrogacy (right to life and human dignity), abortion consent, edge of viability; write a paper using the four tenets of ethics (beneficence, nonmaleficence, judgment, and autonomy) applied to an OB concept; access to care and fair share of resources; distributive justice and the need for advocacy

Table 11. Specific courses identified and an overview of reported intentional inclusion of ethics.

Although the examples provided in the table demonstrate that ethics can be integrated into many courses in the pre-licensure curriculum, only 65 specific examples were given by the 128 respondents, meaning that less than 50% of the respondents described a specific example of ethics inclusion. The survey question directly asked respondents to describe, not list, intentional inclusion of ethics in their courses, but due to the online delivery of the survey, it is possible that respondents did not read and/or interpret the question as intended. However, it is also possible that respondents were unable to articulate intentional inclusion of ethics beyond general references and a reference to weaving or incorporating ethics throughout their work. Of note is the fact that although cases are presented, often in the clinical content of the course, there is little to no intentional inclusion of the tools students may need to explore all facets of the case and give students the ability to articulate themselves in the language of ethics. For example, an ethical decision-making approach, a framework, a model, or a review of principles might provide students a formalized approach to ethical situations they could employ in the future. It is also interesting that the concepts of moral distress and courage—both dominant concepts in the nursing ethics literature—received only one mention and that mention is in the nursing ethics course, which, according to the information provided by these respondents, 81.2% of these educators do not have in the program where they currently teach.

One of the primary reasons for this survey and associated content analysis was to inform the qualitative interview portion of this research. The question that asked for a description of the educator's dream-world experience in teaching ethics should have adequately triggered a description of an exemplar. Although no questions were added,

deleted, or edited based on the content analysis of this question, I am eager to share what nurse educators are teaching in their individual course with other nurse educators.

Perhaps a benefit of this research will be to simply inform the practice of nurse educators as they reflect on where they identify gaps and their role in filling them.

Open-ended questions regarding the knowledge, skills, and attitudes associated with ethical competence. Although the concepts of knowledge, skills, and attitudes were originally categorized separately into three distinct questions, a review of the responses indicated that respondents did not necessarily follow this template. Some respondents provided a full answer for the first question on knowledge and then referred back to that question for the questions related to skills and attitudes; others reiterated their answers when asked about skills. The question regarding attitudes garnered some unique responses. Although the original intention was to analyze each question separately, so the pre-set questions of knowledge, skills, and attitudes would provide the categorical structure for this content analysis, based on the responses, all three questions were coded together and the categories of knowledge, skills, and attitudes were created using a more inductive approach.

An NVivo™ word-count query that included stemmed words assisted in the initial consideration of data obtained in this third open-ended question. Allowing for stemmed words originally resulted in the grouping of *personal* with *person(s)* and *communicate/communication* with *community*—a second word-count query was executed to differentiate these words. Words that had, alone or in combination with associated terms, 20 or more occurrences and covered more than 0.49% of the answer content

comprise this analysis. See Table 12 for NVivo™ -generated word counts related to these last three open-ended questions.

Knowledge, Skills, and Attitudes: <i>Specific Words</i>	NVivo™ Weighted Percentage
Dilemmas: <i>issues, situations, dilemma(s)</i>	3.09%
Patient: <i>patient, pt, family, clients</i>	2.93%
Understanding: <i>understand(s), understanding</i>	2.84%
Decision-making: <i>decision(s), decide, make(s), making, maker</i>	2.49%
Ability: <i>ability, able</i>	2.01%
Formal ethics training: <i>principle(s), theory, theories, theoretical, model(s), modeling, foundation(s), foundational, framework</i>	1.71%
Ethical concepts: <i>advocate, advocacy, autonomy, beneficence, justice, nonmaleficence, utilitarianism</i>	1.52%
Care: <i>care, caring</i>	1.38%
Open mind: <i>open, openly, openness, open-mindedness, mind(s), minded</i>	1.03%
Apply: <i>apply, applies, applied, applicable, application(s)</i>	0.96%
Clinical: <i>clinical(s)</i>	0.93%
Thinking: <i>think, thinking</i>	0.86%
Right: <i>right(s)</i>	0.71%
Communication: <i>communication</i>	0.70%
Other: <i>other(s)</i>	0.64%
Respect: <i>respect, respected, respectful, respecting</i>	0.64%
Critical: <i>critical, critically</i>	0.57%
Values: <i>value, values, valuing</i>	0.57%
Question: <i>question(s), questioning</i>	0.54%
Reflection: <i>reflect(s), reflecting, reflection, reflective</i>	0.54%
Personal: <i>personal, personally</i>	0.52%
Good: <i>good</i>	0.49%
Professional: <i>professional(s), professionally, professionalism</i>	0.49%

Table 12. NVivo™ -generated word count: Knowledge, skills, and attitudes.

An NVivo™ word-count query that included stemmed words was executed individually for the question related to attitudes. Using the same parameters and excluding the same words as done for the query above, *openness (minded), caring, respect, ability, reflection, accepting, compassion, empathy, others, personal, and situation*, each have more than 10 occurrences and each account for greater than 1% of that content.

Verification of consistent coding and analysis of these three key, related questions began with a brief comparison of the nodes and categories created during the initial coding of data. Comparing the responses for the knowledge, skills, and attitudes (Appendix G) provided the opportunity to synthesize like information and identify cross-over terms. Identified categories contained both general references and aggregated data from the associated child nodes. The concept of *common sense* was not specifically coded or included in Appendix G, but appeared in references to handling ethical dilemmas and personal awareness and development. This reference has a very practical connotation and is quite different from ethical behavior, professional standards, or goodness. Merriam-Webster (common sense, n.d.a) defines common sense as “sound and prudent judgment based on a simple perception of the situation or facts,” while another source expounds upon Merriam-Webster’s reference to simple by defining common sense as “sound practical judgment that is independent of specialized knowledge, training, or the like; normal native intelligence” (common sense, n.d.b).

Although 12 respondents gave non-answers for the question related to knowledge, only 9 gave a non-answer for the skills, and 7 gave a non-answer for the attitudes. Comments regarding a non-answer included: *I don’t teach that course so I am not sure what is required; we do not measure ethical competence, so do not know what would be required for competency; and it’s difficult to measure someone’s attitude.* The structure of the survey, which asked respondents a similar question from three specific perspectives (knowledge, skills, attitudes), may account for the increase in specific answers from respondents. A non-answer is also important since it may indicate that ethical competence is a new concept to at least some of the educators who responded to

this survey, may support the premise that ethical competence may not have an easily recalled list of inherent components, and/or may refute the premise that ethical competence can be developed by students—a statement made by five respondents.

The top categories identified for knowledge of ethical competence included: (a) foundational ethical principles, theories, and history; (b) direct references to the [ANA] code of ethics, with related references that address professional standards and standards of care; (c) decision-making, specifically critical thinking, moral reasoning, integrity, and purpose; (d) application to nursing practice; (e) personal awareness and development, with few references to reflection; (f) recognition of an ethical dilemma or issue; and (g) knowledge of resources. Some responses clearly fit into one category such as foundation content with *a framework of definitions* or in content related to knowledge of resources with *they need to know what resources are available to them and the healthcare team to help them, the patient, and the patient's family, and how to access those resources*. Other respondents articulated their thoughts and incorporated several of these categories in one succinct response: *ethical principles are a useful context for discussing patient centered care, which I believe is the foundation of ethical decision-making, and thus of ethical competence*. Of interest is that, by definition, ethical competence is the ability to recognize and address an ethical dilemma. Despite the fact that recognition of an ethical issue or dilemma provides the foundation of the definition, only 13 responses referenced this in the knowledge question. Handling the issue was only specifically mentioned in two responses to the skill question, although there was some mention of reflecting on or discussing possible solutions.

Some of the same top categories identified for knowledge were also identified as top categories in skills including recognition of an ethical dilemma, identification of resources, and personal awareness and development. In other related categories, the responses skewed differently when focused on skills. For example, unlike the knowledge responses, there were no direct references to the code of ethics under this question focused on skills, but *knowing the scope of professional nursing* and related references to professional standards, and *willing to apply evidence to practice and following sound nursing principles related to safety* and related references to standards of care define this category under skills. Clinical competence, also bundled under the code of ethics (ANA, 2001), was mentioned under skills for the first time with responses including *assurance that they are competent in their nursing knowledge and skills*. Decision-making and its related entities including critical thinking, problem-solving, judgment, and reasoning comprised a relatively large percentage of the skill content (16.79% with 41 total responses). Responses classified within decision-making provided more nuanced insight than provided in the knowledge answers, such as: (a) *debriefing using reflective discussion on the process of ethical decision-making processes and exposure to other points of view*; (b) *problem solving ability when there is no immediate correct answer based on laws, policies, or best clinical practices*; and (c) *insight into self and differentiation of self from professional decision-making*. It should also be noted that recognition of limitations, as students and nurses, not included in the knowledge answers, were included in responses related to skills associated with application in practice.

Communication references, although present in the knowledge responses, dominated the skills responses. Communication references comprised more than 20% of

the content and were addressed by 68 responses. General communication skills, assertiveness, advocacy, active listening, and asking questions cover the majority of the communication content. Although advocacy in an ethical context may have broader implications, the primary tools for advocacy are rooted in communication, which is why those 12 responses were categorized under communication: *tolerance and advocacy are demonstrated by open communication, compassionate interactions, and therapeutic touch*. Communication continued as a dominant theme through the attitudes questions, where 26 communication references accounted for 11.36% of the attitudes content. References under the attitude content integrated attitudes that promote communication including a *willingness to actively listen to all persons involved in the situation and to be accepting, not afraid to ask why, to speak up, to be diplomatic*. References within the attitude question also addressed more clearly how communication should occur: *ability to articulate the situation without prejudice, judgment and accurate in verbal and written presentation*.

The analysis of the attitudes question focused on the concepts and ideas that were emphasized by respondents within this context. Responses unique to the attitudes question included a *positive [attitude]; awe; personal responsibility and accountability; courage; and a desire for continuous learning and humility*. Although references to compassion, caring, and empathy were present in the knowledge and skills responses, the frequency increased within the context of attitude. The concept of *openness or open-mindedness* presented for the first time in responses related to attitudes. The idea of *willingness* compliments the idea of openness and was included with openness when not directly tied to another category. For example, one respondent noted *willingness to*

experience as an attitude reflective of ethical competence. Responses in this category narrowly focused on general *open-mindedness* and broaden to encompass *openness*; *cognitive* [and] *emotional flexibility*; and *open, nonjudgmental (or at least identification of own judgmental attitudes)*.

One of the most interesting aspects of this content analysis was the respondents' inclusion and sometimes contrary reports regarding the personal nature of ethics, which dominates the responses to the attitudes question. Responses to the knowledge question primarily focused on *self-awareness of one's own values and value judgments (and processes)*; *who they are and what their beliefs are*; and the need to *reflect upon their personal views. They have to recognize their own patterns of thinking to work effectively with others... especially when the rationales for decisions differ*. One response integrated the personal and professional with *there needs to be an understanding of nursing ethics and how this applies to their own ethical standards*. Respect, honesty, and integrity were also referenced as positive personal attributes in all three content areas: knowledge, skills, and attitudes. *Values and morals*, as well as *a moral compass and a modicum of common sense* were mentioned in reference to skills. Responses for the skills question also included reflection-on-action in that students need to *reflect and discuss [their] own thoughts and feelings related to ethical considerations in various situations*; and *analyze personal responses to ethical dilemmas*.

Subtle discrepancies surfaced with the responses to the attitudes question when statements such as *willingness to envision "what would I do if it were me?"* and [a student should] *be willing to view issues not only from the patient and families perspective, but, also from their own ethical values* were contrasted with statements such as *it is important*

for students to realize that once they are in the clinical environment, their needs and perceptions are secondary to those of the patient. [Students should have] a sense that they are a part of something bigger, that although their thoughts and feelings are still important, the care they give has to be focused on the needs of the patient. There is a general idea that students need to be aware of their own stereotypes and opinions. They must be willing to overcome them to do the right thing for the patient. They must be willing to be patient centered. Yet, introspection, personal values and beliefs, and a strong sense of right and wrong do not necessarily reflect patient-centered care. This is not to say that students cannot demonstrate a dual inward and outward focus. Although the collective responses presented a balanced presentation where both the internal temperature and external-patient-centered assessments play a role, with several noteworthy exceptions, the individual responses tended to discuss either an internal focus or emphasize an external focus. Although the focus of this research is not on comparing the responses from nurse educators to the professional ANA code of ethics, respondent comments were reflective of the ANA code of ethics “wholeness of character” (American Nurses Association, 2001, p. 10), which requires integration of personal and professional values and includes preservation of integrity. Provision 6 highlights the influence of the environment on nurses’ moral character, virtues, and values. Wisdom, honesty, and courage are key examples of virtues; compassion, patience, and competence are excellent “habits of character of the morally good nurse” (American Nurses Association, 2001, p. 11).

Further integration of the concepts inherent in the code of ethics followed the qualitative interviews. Based on the content analysis for these questions related to

knowledge, skills, and attitudes, the qualitative interview was used to clarify a few points: (a) how do educators transition students from identifying and embracing their own individual beliefs and values to delivering patient-centered care; (b) what is meant by models, frameworks, principles, and theories and how these tools are used by educators and students; (c) measurement or evaluation tools that are or can be used to assess understanding; (d) what actual action can/should/do nursing students take in response to ethical dilemmas, and (e) how much (if at all) does a student's personal character impact the evaluation of the development of ethical competence by nurse educators (Appendix H).

The educators who responded to the questions regarding knowledge, skills, and attitudes occasionally answered one of the three questions with an example of course/program expectations, content, or general teaching modalities they include in their course(s). Although these were coded and are represented in Appendix G, they are not the focus of this portion of the content analysis. Several respondents provided insight specific to students within the context of attitudes. One respondent stated that students must be *accepting* [of] *the emergence of a new self that can change or develop new attitudes*. Another respondent stated that ethical competence is reflected by *the ability* [of students] *to accept their own imperfection and to plan ways to change*. Five respondents countered these statements of general development with the premise that ethical competence cannot be developed by nursing students: *I do not think a nursing student can become ethically competent until they are practicing in the clinical setting*. This is quite possible, especially based on the experiential nature of learning posited in this research, and was explored during the interviews (Appendix H).

Summary

The 128 nurse educators who participated in the online survey represent nurse educators from four states, California, Illinois, New York, and Texas. As active nurse educators, it is not surprising that 127 of the 128 respondents hold an advanced degree. The formal education and training of these nurse educators varies, with 23.4% reporting no formal ethics education, 30.5% reporting no ethics training in the past 5 years, and 8.6% of these nurse educator respondents reporting no ethics education or training. The nurse educator respondents reported acquiring a wide variety of knowledge through their pre-licensure education, graduate education, and practice as a nurse, including: (a) patient care or the treatment of patients; (b) decision-making; (c) code of ethics; (d) professionalism or professional role; and (e) resources, specifically clinical ethics consultation.

The respondents reported that 81.2% of the programs where they teach do not require a specific course in nursing ethics. However, within the context of the courses regularly taught by these nurse educators, general and specific examples of ethics integration and education are reported. In fact, 65 respondents provided specific educational examples, with 48 of those specific examples rooted in specific coursework.

In order to begin to examine how ethical competence is developed, the definition of ethical competence from the perspective of the educators using the realms of knowledge, skills, and attitudes was considered. Although the educators reported teaching concepts they reported learning themselves, the breadth of concepts reported by these educators surpasses the list of ideas reported when they were asked to consider

what they themselves have learned about ethics. See Figure 2 for a visual representation of reported knowledge, skills, and attitudes attributed to ethical competence.

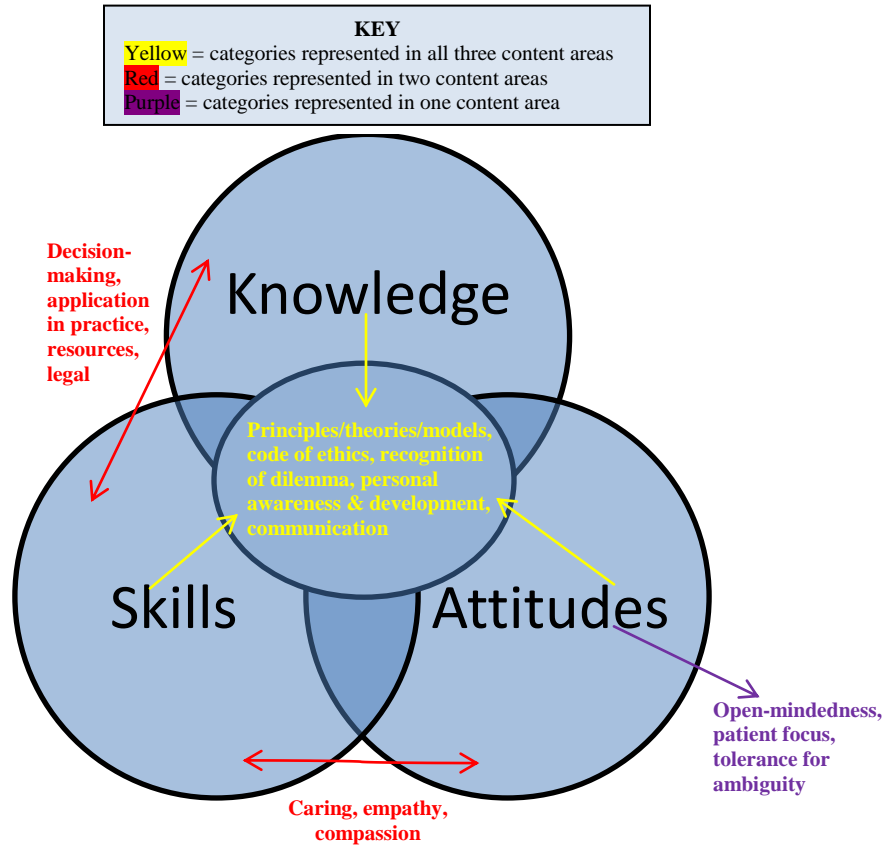


Figure 2. Reported knowledge, skills, and attitudes attributed to ethical competence.

These educators provided some hints as to how to achieve the knowledge, skills, and attitudes required for the development of ethical competence in students. Respondents specified that reflection, experience, and ethics-focused educational endeavors assist in the development of ethical competence, but no universal determination of progression or development can be extrapolated from the survey responses. Phase two of this research, the qualitative interviews, built upon the analysis of the survey responses.

CHAPTER 5

Findings of Phase Two: Interviews

Data Collection Processes

A basic rubric and defined process guided the identification of 12 potential interview participants (Appendix I). Although 12 interview candidates were identified, the goal was for 6 interviews to be completed, with data collection continuing until a description of the concept emerged and data saturation was reached. Twelve potential interview candidates were identified to ensure that changes in availability, consent, and/or nurse educator role did not impact data collection. As previously discussed, desirable interview participants were identified using the entire 128 survey participants, without limiting the review of responses to only those who indicated a willingness to participate in the interview portion of this research. Based on the survey sample size, the purpose of this study, and the content analysis, the decision was made to identify potential interview participants primarily based on their responses to the questions regarding the identification of knowledge, skills, and attitudes. Professional and other demographic data were considered when ranking potential interview participants.

The first step of the interview participant identification included a review of responses to the knowledge, skills, and attitudes questions. Responses to the three questions were considered based on the following criteria: (a) responses contained common themes and/or ideas presented by other respondents, (b) responses presented a unique perspective or idea, (c) responses were clearly articulated, and (d) responses were distinct for each of the three related questions. This review resulted in the identification of 18 potential interview participants. Using their Qualtrics-generated identification

numbers only, the identified respondents were compared to the list of survey participants who had agreed to participate in the interview; this yielded a pool of 10 interview candidates in step two. State representation was considered in step three. No respondents from New York were originally identified; all survey respondents from New York who had agreed to participate in the interview were reconsidered and two potential interview participants from New York were added to the interview participant list.

The potential participant list was reviewed to ensure broad course representation in step four. Degree representation and ethics education/training informed ranking decisions (Appendix I). Of note is that only one of the potential participants teaches in a program that has a stand-alone nursing ethics course, and one respondent teaches in a program that requires a medical ethics course. A course in ethics is not required as a stand-alone course, is integrated, and/or is included in liberal education in nine of the other programs where the interview participants teach. One potential interview participant was not sure if a course in nursing ethics was required in the program where he/she teaches.

Once the potential interview candidates had been identified, the master download file was referenced and their identification numbers were matched with their contact information. The potential interview participants were initially contacted by email (Appendix J). Two follow-up emails were sent to prospective interview participants as needed. Although most respondents did not provide their phone number, a phone call was made in two instances to facilitate participation in the interview phase.

Five respondents ultimately participated in the interviews. Although the identification of themes became possible after the first three interviews, the fourth

interview was with the Participant C who teaches a Nursing Ethics course. Participant C provided some additional insight. Themes identified in the first four interviews were confirmed and supported during the fifth interview and saturation reached. See Table 13 for a description of the basic demographics of these five educators as reported in the online survey.

Interview participant (reported information)	Participant A	Participant B	Participant C	Participant D	Participant E
State	CA	CA	IL	TX	TX
Highest degree obtained	PhD	MSN	PhD	PhD	MSN
Years of experience in nursing education	21+ years	11-15 years	21+ years	<5 years	<5 years
Employment status	Full-time	Full-time	Full-time	Part-time	Full-time
Received formal education in ethics as an undergraduate or graduate student	Yes	No	No *Post-doctoral work reported	Yes	No
Participated in training in ethics in the past 5 years	Yes	Yes	Yes	Yes	Yes
Program where they teach requires a stand-alone nursing ethics course	No	No	Yes	No	No
Courses or clinicals currently taught (per the survey) and previously taught (referenced in survey and/or in interviews)	Foundational nursing, Medical-surgical nursing, Nursing research	Behavioral health, NCLEX review course	Nursing ethics, Behavioral health (plus elective), Geriatric nursing	Health assessment, Behavioral health	Pediatrics, Women's health (L&D), Public health, Transcultural/global health/vulnerable populations

Table 13. Basic demographic information of the five interview participants.

According to the survey, the interview participants currently teach and have taught a wide variety of courses. This was confirmed and the list of courses taught expanded throughout the interviews as concrete examples were given by the participants to answer the interview questions. Of the courses listed in the survey, the only two core courses not

represented in classroom or clinical by the interview participants were Pharmacology and Management/Leadership, although the Management/Leadership course was specifically referenced by two of the interview participants. Informed consent documents were emailed to each participant who agreed to participate in an interview. Signed copies of the informed consent were returned via email to the researcher.

Each interview was performed over the phone and lasted between 40 and 45 minutes. Each participant was given the opportunity to ask any questions regarding the informed consent document and all participants were reminded that their interview would be audiotaped. Interviews were performed with my home phone on speaker-phone and recorded using a hand-held Sony® recorder, with a back-up recording made using my Apple iPhone® and the iProRecorder application. All recordings were converted to MP3s and stored with the other secure research data. The original recordings on the devices themselves were permanently deleted at the completion of the data analysis. Transcription was performed by the researcher. The audio recordings were played back using the Sony® recording device. The researcher listened to the playback and spoke into a microphone to enable transcription using Nuance Communication Inc. Dragon NaturallySpeaking Version 12™. The program is trained to only recognize the voice of the researcher, which meant that direct transcription from the audio recording by the program was not possible. The audio recordings were then reviewed again and the transcripts edited for accuracy.

Overview of Data Analysis

Employing the basic principles of the Giorgi (2009) method, the transcribed interviews were read through to get a sense of the whole. Initially, NVivo™ assisted the

researcher in reviewing and coding the transcripts, line by line, into small descriptive meaning units (nodes). The purpose of the study and the research questions were referenced to ensure the descriptive units coded were considered within the context of this study. Once the initial coding was completed in NVivo™, the nodes were considered with like nodes being combined and redundant nodes eliminated. This basic qualitative methodology also reflects the “five Cs: code, cluster, compare, contrast, and contemplate” (Dr. L. Putney, personal communication, September 19, 2112). The researcher explicated the use of compare and contrast primarily during the discussion of subthemes and in the exploration of potential links between themes. This facilitated the merging of like themes and more clearly defining the elements of each theme. Six basic themes were explored: (a) who nursing students are as people, (b) religion and spirituality, (c) the nursing role, (d) power, (e) experience, and (f) barriers. In order to directly address a key research question, interview participants’ answers to a specific question regarding their self-identified role as educators in the development of ethical competence was explored separate from the theme development. A matrix (Appendix K) provides details regarding which participant(s) provided responses that supported the identification of specific themes and subthemes.

Theme Number One: Who Nursing Students Are as People

Interview participants referenced the significance of who nursing students are or become as people as integral to the consideration of the development of ethical competence. They generally recognized that who students are as people varies and that both external and internal forces inform their development as people. Although some considered students may have an *innate grasp* (Participant D) of how to handle ethical

dilemmas, the respondents generally provided information regarding what they perceive impacts the abilities of their students to develop ethical competence and how this is manifested. Subthemes include: (a) nursing students' upbringing; (b) their self-awareness; and (c) the specific characteristics of honesty and empathy. Nurse educators perform care side-by-side with their students, which provides them time with the students in a way other professional training programs or academic environments do not. The nurse educators in this study reported that they routinely ask students to reflect on their thoughts, feelings, actions, and personal/professional development. This supports the reflection on-action and in-action discussed by Nielsen, Stragnell, and Jester (2007), and allows for unique insight into who students are as people.

Upbringing. Upbringing was noted to either positively or negatively impact the development of ethical competence in their nursing students. Participant C articulated that:

Our first teachers of ethics are certainly not in the university setting, they're at home with our parents. That's our initial exposure to ethical decision-making. In school, you know, our teachers in our early years were like, 'Hold the other kids' hands, be good to your classmates and fair and help them when they are struggling with their multiplication table –help them.' So, you know, we talk about virtue-based ethics, and that's the first ethical experience most of us have had in our lives.

The idea that ethics training begins during the formative years is not necessarily new—it would be uncommon, for example, to attend a pre-school function and not hear please and thank-you reminders, which are essentially external behaviors forced early on in order to facilitate inner consideration and contemplation. But perhaps recognizing the impact of students' formative development on who they are as adults and capitalizing on

it in heightening their specific ethical formation within the defined context of nursing is perhaps more revolutionary.

However, not all familial or formative tendencies foster ethical development through positive reinforcement. In one example provided, Participant A described a student who was raised by a *meth family* and discussed the implications of this background, specifically stating that *she will have different abilities based on the decisions she saw her family make—some of those would've been short-term pragmatic decisions rather than long term.* Ultimately this student *transcended her upbringing.* The fact that the interview respondents are both nurses and educators may have informed these opinions. Their insight into family dynamics and coping strategies provides them a frame of reference by which to incorporate this information into their impressions and educational action plans. This participant's data exemplifies what has been illustrated in experiential learning, where one learns from being embroiled in a situation, reflecting on the outcomes, and then using newly gained knowledge to inform future decisions (Dewey, 1929; Kolb, 1984). In this instance, interview Participant A highlighted the relative strength of that student in relation to her experiential education.

Consideration of parental influence on the development of students provided insight into a related issue. Participant B described parents who raise children who *have never done decision-making on their own and never encountered moral dilemmas because in the culture of many of our applicants here... that has not been part of their upbringing.* Taking into consideration the experiential model, those who have never experienced independent assessment of moral dilemmas nor independent decision-making have not developed skills in these areas through experiential learning. The initial

experience is of great importance to the experiential learning cycle—without it, there is no cycle (Kolb, 1984). This is not to say that they have not had any exposure to complex decisions or that other learning, classroom or otherwise, did not provide them any insight. It simply means that for the first time for some students, their first exposure to these real-life events occurs in the clinical setting with real people, making real decisions. The relative protection of parental oversight is removed. Participant D articulated that students' backgrounds often inform personal judgments regarding their definitions of inappropriate behavior.

The responses of the interview participants indicated that nurse educators can role model and provide opportunities for discussion, but that *maybe the amount of kindness, compassion, and caring each individual student has experienced in their real life is the determiner of...their ability to care for others* (Participant C). Participant C then followed this thought with the idea that a *caring, compassionate faculty* can positively impact on the ability of students to deliver ethically competent care. However, one of the nurse educators expressed some reticence. Participant B questioned how much impact educators can and should actually have on the personal development of students: *And it's a core issue and this is part of our development of students, but where is our obligation to assist them with this and where is it personal commitment and personal development? Where is the nurse's role in this?* In essence, the participants agreed that educators cannot discount the impact students' formative years have on the development of foundational values, beliefs, and tendencies. Participant A posited that although *a lot of times people come in and they are more or less ethically trained*, the possibility exists for student growth and development if the nurse educator is willing to actively engage.

Self-awareness. The concept of self-awareness surfaced repeatedly in the interviews and was also referenced in the survey responses, particularly in relation to the description of what knowledge is required of nursing students to develop ethical competence. The interviews provided further insight into this idea of self-awareness and how it applies to the development of ethical competence. Participant B challenges students to consider their self-awareness, promotes *looking inward*, and questions *how can you possibly go out and take care of a client if you're not sure how you feel about things?* In the online survey Participant B presented the idea of *insight into self*. When asked, during the interview, to expound upon this survey comment, Participant B articulated that in order to achieve perspective, students need to consider *what's going on with yourself and not only how you think, and feel, and perceive things, but how you understand*. The profound addition of the word *understand* to this list fosters development past mere consideration of incoming thoughts, feeling, and perceptions by compelling the student to consider how that information is processed and internalized, what it really means, and how it informs future experiences. Although only cursory mention was made by four of the five interview participants of teaching or even reviewing decision-making models or frameworks (Participant C teaches nursing ethics and discussed the use of frameworks and models), these responses revolving around self-awareness indicate that complex processes, such as those involving ethical dilemmas or issues, begin with the individual student.

Interview participants with a background in psychiatry gave very concrete rationale for self-awareness (Participants B, C, and D). They highlighted specific issues such as mental illness, abortion, sexual offenses, anorexia, and research as examples of

situations in which self-awareness and consideration of personal values and beliefs should preface patient interaction in order to minimize: (a) projection, defined as “an unconscious defense mechanism by which an individual attributes his or her own unacceptable traits, ideas, or impulses to another” (Projection, 2009); and (b) transference, defined as “an unconscious defense mechanism whereby feelings and attitudes originally associated with important people and events in one's early life are attributed to others in current interpersonal situations, including psychotherapy” (Transference, 2009). Participant D stated: *psychiatry's always a good place to talk about that [projection and transference]—you really want to avoid that to the extent they possibly can.* Participant B stated: *I'm driven by the fact that there's so much stigma and discrimination in mental health.*

Perspectives regarding self-awareness provided insight into this core element of ethical competence. Interview participants identified self-awareness as something that needs to be considered in the preliminary stages of patient interactions. The interview participants and survey respondents indicated that self-awareness alone is not sufficient to facilitate the development of ethical competence. Therefore, the concept of self-awareness is discussed further in relation to the components of ethical competence and the role of the teacher.

Specific characteristics. Although all of the interview participants referenced specific characteristics and/or answered questions regarding specific characteristics, some discrepancy appeared among the interview participants as to the efficacy of considering character or personal characteristics in nursing students. Participant B described personal experience with completing letters of recommendations for students where the person

writing the recommendation was asked to rate the character of a student. No definition of character or a list of what comprises character was provided, yet often the *allusion to character* occurred in things like letters of recommendation or counseling referrals. Yet, Participant B also gave examples of questionable character that involve academic honesty and incivility. Despite the reservations expressed by this particular interview participant, character and specific characteristics were identified as a relevant subtheme.

One of the interview questions specifically asked participants to consider the idea of goodness in nursing students as related to the development of ethical competence. Although some of them replied that goodness was indeed related to the development of ethical competence, only Participant E directly accepted the concept of goodness and expounded upon the concept:

But, in a situation where we try to keep our conscience healthy, and we identify virtues, and we try to behave in a virtuous manner, I see that as not being in conflict. Because good is good. The dilemmas come into play when individuals see something that I would interpret as good, someone else sees as evil or vice versa.

It should be mentioned that this loose definition of an ethical dilemma does not mirror the classic definition used in this research where two or more of the foundational ethical principles are in conflict (Beauchamp and Childress, 2009), thus resulting in essentially two potential right answers. Participant E later presented examples of an ethical dilemma in Oncology that reflected the more classic conflict between principles including autonomy and nonmaleficence. Although I am compelled to point out this slight discrepancy as part of my work regarding considering what nurse educators are teaching, it is important to recognize that in the context of this particular thread, Participant E

seemed to differentiate good from evil in an attempt to accept the concept of goodness into the emergent paradigm for the development of ethical competence.

Participant D directly rejected the idea of goodness stating: *In my opinion, I don't really like the term good, goodness. I think it's so subjective and it's just my opinion – period. Because when we start to think about good, the opposite of that is bad.* Rather than goodness as a characteristic or quality, the interview participants generally focused on good behavior or the perspective of a patient in determining good or bad, which is reflective of the goodness referenced by Sartorio and Zoboli (2010) in their work on defining a good nurse.

Honesty was referenced in several iterations including general references to honest behavior and specific references to academic honesty. Clinical references provided examples of honest behavior such as accurate charting and error reporting. Academic honesty, including plagiarism, cheating, and deception, was referenced by three of the interview participants (Participants A, B, and D) as an example of unethical or dishonest behavior. Of note is that the interview participants referenced a general disregard for ethical practice in the academic setting. Participant A explained that:

Students usually draw a very sharp line—almost like a black marker—between ethics of the workplace and academic ethics. Not too many of them would do this, but a few, if they could see another student's test when they were taking an exam, might use that information, but they wouldn't think it was unethical. They think of academics as being kind of the game...

This highlights the complex nature of nursing school where students perform and are evaluated in both the academic and clinical environments.

Empathy is the final characteristic or ability expressed by the interview participants that relates to who their nursing students are as people. This supports the findings of the survey in that empathy surfaced in the survey analysis, frequently in conjunction with compassion and caring. In addition to being a characteristic of students, based on the survey and interviews, empathy is also a core component of ethical competence. The interview participants used the term empathy, which is generically defined as “the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner; also the capacity for this” (Empathy, n.d.), as a characteristic held by students that may positively correlate with ethical behavior. This ability to take on the perspective of another surfaced as foundational to the development of ethical competence. Yet, empathy is another ambiguous term that is not routinely measured, assessed, evaluated, or really even mentioned in nursing curricula. Participant D succinctly captured the essence of the discussions regarding empathy:

So I would think that if someone is highly empathetic, and there are certainly some objective instruments that you could use to maybe measure that—personality scales definitely will show some of that—but I think probably, yeah, it would make sense that if you’re really high in empathy, it might correlate with ethical behavior.

Several of the interview participants spent a few minutes discussing extreme cases of lack-of-empathy, such as those involving mirror neurons or life experiences that led to desensitization, in order to provide some perspective on the range of empathy that could be experienced (or not experienced) by humans. Participant D articulated the connection between compassion, empathy, and ethics:

When I think about it with you, I might be confusing compassion with ethics. And compassion is what I really look for—are they able to... and probably empathy—that's a big thing too, and that's totally separate from ethics, but it seems like it would be some component. But that's what I usually look for. So I'm looking for signs of empathy that seems genuine and that just means, for example in psychiatry because I'm seeing them with patients—it's that ability to show concern for what's going on with that patient, and also to show some understanding of story when they're sharing story with the patient.

Regardless of their unique perspective, the interview participants kept coming back to empathy and reiterating the analogy of *putting on another person's shoes* (Participant E).

Theme Number Two: Religion and Spirituality

Survey respondents used the words *Catholic, faith, spiritual, theology,* and *Christian* in response to the survey question regarding their pre-licensure education. These and other related words did not otherwise surface in any meaningful way elsewhere in the survey, so no specific alterations were made to the interview questions to include the concepts of religion or spirituality. Despite the fact that the student interviewer did not intend to directly prompt the interview participants to address religion or spirituality, four of the five interview participants (Participant B did not) incorporated these concepts into their descriptions and answers.

Religion. The interview transcripts revealed two specific references to the *Golden Rule* (Participants A and E); if the Golden Rule is defined as “a rule of ethical conduct, usually phrased ‘Do unto others as you would have others do unto you,’ found in various wordings in most major religions” (Golden rule, 2010), several iterations of this definition were present in both the survey and interview transcripts. It is important to

note that during the interviews, the religious discussion extended far beyond mere definition. Participant A articulated:

You have to remember that nurses are secularized now, but originally, the people who took care of the mentally ill, the people who took care of the ill - period - were religious-based, and a lot of the orders of nuns were the nursing sisters. And there was a religious feeling of doing good. And there was a religious context, at least in the Western world of moral context, and of doing the good thing, so I think that's definitely part of it and it's in keeping with some of the philosophers. They say do good, do not do harm—it's very much in there.

This insight directly reflects the findings of Sartorio and Zoboli (2010) who considered the perspective of nurse educators in Brazil, focusing on their definition of a good nurse. Sartorio and Zoboli identified the importance of being a good nurse as a moral endeavor. They highlight the transition from morality, often referred to as goodness, as a purely religious concept to morality as a secular, intentional, scientific, and professional aspiration.

The religious link to goodness or morality is complicated and nuanced. For example, Participant E, who teaches at a Christian university, provided a well-rounded picture of how her religion both informs and limits her:

Religion is not one of my fondest words because...we have the option to believe that god is either approachable or he is very angry and judgmental. Different religions portray god in different ways. If religion causes me shame, then I'm not going to approach god for help...what I believe, if you want to call it religion, is that my god truly loves me and desires to help me. And I believe that he is for me and not against me, then I will approach him. And so that's my own explanation about why I don't really like the word religion. I believe fully that my perception of righteousness, actually what is right, has a profound effect on the way that I interact with others in any situation. And I believe the majority of my students do as well. Now, if I was

teaching in a different university environment, that was more secularly-minded, then I am sure that the perceptions of what is right and what is wrong would be much greyer. I will tell you that as I grow in my own personal experiences, I'm finding more and more that I am able to take on the perspective of others and interact with them where they are, whether that be, regardless of what the diversity is, whether that be in sexual orientation, or it be something that's completely cultural. In my willingness to receive them as they are, I find myself being much more effective in interaction with them, in particular with regards to their health. If they sense that I am not judging them and shaming them, then they approach me much more readily, just like I approach god much more willingly whenever I perceive him as not shaming or judging me. And I have really, this summer, had lots of opportunity to practice that in particular with homosexual individuals of both genders. And religion would lead me to go "uh-uh, that is wrong," but relationship makes me look at it differently.

Although nursing ethics shares core principles and general tenets with the more developed medical ethics, this emphasis on relationship differentiates nursing ethics from other branches of applied ethics. Nursing ethics is a distinct practice entity that encompasses "the values or moral principles governing relationships between the nurse and patient, the patient's family, other members of the health professions, and the general public" (Nursing ethics, 2009).

Participant E provided insight into the way religion informs who the participant is as a nurse, and also verbalized awareness of the potential impact of a religious background and/or religious environment on ethical decision-making and the delivery of nursing care. One example of this is the Ethical and Religious Directives (ERDs) for Catholic Health Care Services (United States Conference of Catholic Bishops, 2009) provided to Catholic institutions by the Catholic Church that outlines the Church's position on key ethical issues with special attention paid to issues related to beginning-of-

life and end-of-life decisions. Issues such as abortion are directly addressed with clearly outlined guidelines that stipulate the decisions that may be made. The ERDs came to mind because the Participant E articulated that the participant's perceptions in a more secular environment would be much greyer, because religious doctrine does not necessarily dictate certain ethical decisions. This begs the question of how much religion informs decisions made by nurses and the impact of their personal, particularly religious, beliefs on their impression(s) and attempted resolution(s) to ethical dilemmas in the clinical setting.

Participant D referenced religion in a different context, cautioning in the online survey response that students need to develop a *definition of ethical behavior that is broadly applicable and not just a personal code of ethics they may have based on their religion, personal experience, etc.* Participant D expanded on this idea when the survey response was reviewed by telling a story of when the participant was gifted a cross by a well-intentioned nurse manager. As an atheist, Participant D graciously refused the gift, offering instead to give it to another nurse. Participant D reflected on the fact that *the nursing profession is...one of those professions where we have...it largely seems to be pretty Christian or at least religious in some respects.* But the fact that a cross was given was not really the core of the story, the response of the nurse manager affected

Participant D:

And then it was funny because she said to me, 'Oh my god, you seem like such a good person!' ...There might be this view that if you're not religious, you certainly can't be ethical. And she was very surprised; she and I have this good relationship, and she said, 'You're so nice and you seem so nice,' but without that religious—you know, for me to say 'I don't believe'—put me automatically into that other category. You know, so I always say,

I always tell my students during orientation about that we have a respect for all cultural values, we have a respect for spiritual values, and we have a respect for people who have no religious preference whatsoever. You know, and so I kind of feel that out a little bit. That would be interesting to look at in terms of that because I think that might be more prevalent than we think.

Through this example, this interview participant provided insight into the importance of teaching students to incorporate all aspects of a person into an assessment and to not make assumptions or project beliefs onto another person.

Spirituality. Although spirituality and religion are often used synonymously, the words were used deliberately and individually by the interview participants, which provided the impetus for seeking a universally applicable and acceptable definition of spirituality.

Puchalski et al. (2009) provide a definition of spirituality in their work on a National Consensus Project focused on improving the quality of spiritual care as a dimension of palliative care.

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred (p. 887).

Spirituality was addressed in several instances by the interview participants and was typically used in the context of recognizing and differentiating spiritual (and other) issues from ethical issues. There was an expressed concern that spiritual issues are largely unidentified. Participant E directly addressed spirituality. The perspective presented ties back into organized religion, integrates ideas presented in the survey responses, and references the definition provided within the context of the church-supported university

setting where Participant E teaches: *We definitely talk about things in terms of spirituality and virtues... We're not narrow in limiting things to quote Christianity, but in my studies of humanity and sociology, and the world religions, you know, even the ancients, virtues are virtues.* To these interview participants, spirituality seemed to have a broader connotation than religion.

Theme Number Three: Nursing Role

Although, based on the survey results, a theme involving the role of the nurse could delve into many aspects including technical competence or interpersonal communication skills, the interview participants provided insight that illuminated the role of the nurse as a professional member of a community and as a public servant. The three subthemes discussed present nursing in a different manner that required consideration. The interview participants did not merely list the attributes of a nurse they are trying to foster in their students, they presented nursing as a unique entity and defined three specific aspects of nursing as they relate to ethical competence: (a) moral community of nursing, (b) service, and (c) hidden relationship.

Moral community of nursing. The phrase *moral community of nursing* was used by Participant C who also referenced an *old article* that is still used in class to speak to the:

...moral community of nursing—that we are so fortunate in our professional experience to have a real moral community to help us. And I talk about our technical being part of our community, the documents with nursing, the nurses we work with being part of our community, the other professionals with whom we work being part of our community.

The article by Aroskar (1995), who did seminal work presented in the literature review on ethics education in 1977 and whose work informed this research, provides insight into

the concept of nursing as a moral community. In her exploration of the moral community of nursing, Aroskar applies the core tenets of the ANA Code of Ethics, which at that time focused on addressing the ethical nurse-patient relationship, to nurses as they function in an interconnected, interdependent group of moral agents. Participant C tied in spirituality, although in a larger sense than previously discussed, and reflected these ideas in reference to Florence Nightingale, specifically Nightingale's beliefs:

...and her social embeddedness and so much her spiritual embeddedness—her belief that nursing really is a calling, as it was for her...we talk about the search for meaning that nurses are immersed in...such extremes of life, and illness, and suffering...and moral choice and end-of-life issues and about nursing's commitment to social justice.

This moral community of nurses informs nursing practice and directly impacts on the active role nurses take in establishing ethical practice. The concept of a moral community encompasses much of what current literature would deem professionalism. The interview participants also mention of incivility among nursing students. Participant B attributed this incivility to the fact that *the culture has changed over the last five years*. Participant B also articulated that even though character is largely undefined and people are quick to attribute actions to character, a certain amount of character is required of members of the nursing program and of the profession.

Based on the input from the interview participants, this moral community of nursing begins with the individual nurse and extends to the clinical environment where nurses are placed in challenging situations that may test their abilities. Participant A noted:

Honesty, and an honest day's work to do what we should be doing with the patient and to really extend one's self -I think that's very important. To report

things accurately, to report one's own errors, to fulfill our responsibility, and to fulfill our responsibilities not only to our individual patients but to our unit, where we're part of a group and if somebody's floundering with a bad assignment, you know we can extend. And that's hard for students to get. We tell them now because they'll need it later when they get out. For now they're so 'tunnelly' ... all they can see is theirs, at least in the beginning of the semester.

These repeated references by the interview participants to the daily challenges indicate that every situation, no matter how small, provides an opportunity for teaching.

Service. The interview participants expressed uncertainty when attempting to define terms like ethical competence or when ruminating on caring or empathy, citing ambiguity and a lack of clear definitions as the root cause of their uncertainty. Despite their uncertainty about these core concepts, the interview participants directly and indirectly referenced nursing as a service profession in their examples of advocacy, identifying the patient's perspective, and supporting patients and their families when facing ethical dilemmas. The interview participants repeatedly reinforced that the role of the nurse is to advocate or facilitate decision-making, but that in many cases, the final decision is not theirs to make—it is the patient and/or the family who bears responsibility for the decision. Nurses support, empathize, provide resources, and facilitate conversation in order to best serve the needs of their patients and their families, but discerning how to handle a difficult situation while not internalizing or injecting oneself into the situation is not an easy skill for nursing students to learn. Participant A shared a story about an exemplary student who had a natural ability to serve her patients. When questioned by the faculty member, the student denied clinical experience:

And I said, 'What have you done that informed you for this role?' And she said, 'Well...waitressing for seven years.'

And I said, 'Ahhh.' And she was very efficient too and she was very cordial...and I said, 'What did that teach you?' And she kind of cocked her head to the side and said, 'The client doesn't particularly care if you have a headache.'

This simple story provides a concrete example of how nurses maintain their personal-professional boundary within the bounds of service.

Hidden Relationship. An interesting subtheme identified was that of the hidden or private relationship between the nurse and his or her patient. Two of the interview participants specifically addressed the unmonitored nurse-patient relationship.

Participant C referenced *how naked and how private—how private nursing ethics is because it's even very hidden. What the physician writes on the chart is very public; but what the nurse does, person-to-person, in that person's room is very hidden...* The interview participants foster development of ethical competence by highlighting the responsibility inherent in the nurse-patient relationship, especially one that is so private. In particular, there was concern expressed by Participant D regarding not sufficiently developing ethical competence in students:

...and my worry about that is that our profession is one where nurses spend a lot of time with patients alone. So you don't have that team atmosphere where your actions might be tempered, even if you were prone to maybe being a bit unethical, because there's a group you're going to be less likely to do so, but nurses operate alone a lot, especially in the inpatient setting. And so patients are very vulnerable. And so my fear in that is that if we put people who would behave in that particular way—who might not have good basic solid sense of ethics there— that patients are in danger.

Nurses may be privy to details and may be faced with challenging situations within the confines of the private nurse-patient relationship. They must advocate not only for the patient, but, in a very real sense, for their fellow nurses and consider how to seek help

when facing an ethical dilemma. In order to uphold the sanctity of the nurse-patient relationship, nurses need to act ethically within the confines of that relationship, but also recognize an issue and take appropriate action outside the bounds of that nurse-patient relationship to provide ethically competent care.

Theme Number Four: Power

Power, or lack thereof, was not a theme that was identified in the survey results. In fact, the word *power* was not always used by the interview participants either, but their examples, stories, and references referred directly to power issues, leading to the identification of power as a theme. Nurses can exercise power to promote human flourishing; power, although neither inherently good nor bad, can also be exerted to oppress others, specifically patients in the clinical setting. Presented in the context of the feminist ethical perspective, Liashenko and Peter (2006) explain that “When teaching nursing ethics it is essential for nurses, both students and instructors, to understand and reflect on their own use of power and to avoid the tendency of viewing themselves as powerless” (p. 183). The relative power of the nurse in interprofessional collaboration is well-documented, with much discussion regarding the perceptions of powerlessness that often lead to a diminished capacity for moral agency and the resulting moral distress (Corley, Elswick, Gorman, & Clor, 2001; Liaschenko & Peter, 2006; Pavlish, Brown-Saltzman, Hersh, Shirk, Nudelman, 2011; Ulrich, Hamric, & Grady, 2010). The fact that power was an emergent theme in relation to the development of ethical competence in nursing students is meaningful and important. This theme specifically includes two different aspects of power: powerlessness and potential power.

Powerlessness. By nature of the student role, the decision-making power of the student is

not significant. Even if students are involved in ethical dilemmas, their participation is typically that of an observer—*they witness these things unfolding, but they usually don't have to do something* (Participant A). Interview participants presented different levels of powerlessness. Sometimes the powerlessness reflected the nature of their role as student. Participant E stated that students are on *very thin ice*. Participant C described that students may find themselves in a situation where they identify a clinical ethical issue with the nurse with whom they are working, and could be conflicted as to whether to advocate for the patient or side with the nurse with whom they are working. In these instances, the expectation is that students rely on their instructor to help them sort out the issues and come to a resolution.

They don't feel empowered to confront the registered professional nurse that they are working with clinically. So what they usually do is come to their clinical instructor and kind of lay out the issue with their instructor who then either helps them to confront the situation or really works with them to engage with the nurse to kind of explain the issue with the treating nurses, and also to help get some clarity, and support the nurse as well, you know, the clinical nurse caring for the patient (Participant C).

The interview participants also appreciated that students exhibit a certain level of fear in the clinical setting—students are afraid of doing harm, they are intimidated by new experiences, and they are afraid of failure. The participants articulated that students do not always have the capacity to address uncomfortable situations and rely on their instructors to make the decisions and intervene as appropriate.

A student relinquishing or not embracing his or her power is not the only tendency discussed that resulted in this perceived or actual powerlessness. The interview participants discussed their tendencies to protect or alleviate the burden of an ethical

dilemma from their students. Participant D articulated:

I think that we certainly talk to them and we say if there's something that bothers you, if you see something that's not, you know, that is not ethical behavior, compassionate behavior, then let's talk about it. You know, let's discuss it. But that's probably the extent when I think about it. Actually just letting them know it's okay to talk about it, but I also think sometimes we're trying to protect them—or I know I am—you're trying to get them acclimated to the profession, and you're trying to put them at ease because they're anxious, and so...I do have this tendency to want to protect them.

The interview participants talked a great deal about debriefing, discussing, and assessing feelings, but there was very little action discussed outside of notifying the clinical instructor. The participants acknowledged that they attempt to capitalize on ethical situations that may arise—taking the opportunity of an actual, clinical example to drive discussion—but the student bears little to no responsibility for action. This inclination to protect students from the real world activities of nursing bears consideration and will be discussed further in Chapter Six.

This perceived powerlessness does not only affect the students. The interview participants discussed their collective desire to integrate ethics content, yet they highlighted a lack of control over the clinical environment, which practicing nurse educators agree challenges educators to identify, locate, or create meaningful educational experiences. Perhaps more concerning is that the participants lamented a lack of control over the content in other courses in their nursing curriculum. Many of the interview participants referred to another course where they believe specific content is provided, but they were rarely sure of that content, its delivery method, or the consistency with which it is taught: *You know, I'm pretty compartmentalized, like many faculty, and doing my specialty* (Participant B). They made general references to core principles related to

the Code of Nursing being taught in foundational courses or ethics being bundled with content in the legal course, but very little concrete information regarding how ethics is actually currently integrated into their specific nursing programs.

Potential power. The interview participants provided examples of potential power and articulated both the need to empower students and the responsibility that comes with empowerment. Participant C clearly articulated that we may be doing our students a disservice by keeping them in the periphery:

The only way they'll learn to be an advocate for their patients is to be an advocate as a student. You know...sometimes they're just so surprised at how well they do advocate for their patients in the clinical area, even though they're very new and are...sometimes they're very frightened—they're very frightened by the setting, the situation, and by the nurses as well.

Sometimes, as Participant E described, empowerment involves simply teaching students how to identify and use their resources, which based on feedback from the interview participants includes resources ranging from their clinical instructor, to library databases, through a clinical ethics consultation. The next theme addresses the relationship of experience to the development of ethical competence and explores this concept further.

Power is also addressed on a larger stage through discussion of the nurse as a change agent. Participant A stated that knowledge required for the development of ethical competence includes recognition of the *nurse's power in society to act as a change agent by example. I think that's important. That's my moral line.* Participant A recognized the implications of the daily work of nurses:

...because people look up to nurses so much and we are the trendsetters...I said to my students, 'You are so powerful.' I said that for a lot of things: instead of writing on the patient's chart 'Hirschsprung's comma MR' for mentally retarded...

use the lead and write out “mentally retarded”...let’s not use abbreviations because they are pejorative to an extent. So think about who you are and the power that you have in the world.

This call to power reminded me of Carol Taylor who recently presented “The Power (and Limits) of One” for the National Nursing Ethics Conference (NNEC; 2013, March); she also summarized some of her thoughts in an interview (Loria, 2013). Taylor stated both in the interview (Loria, 2013) and in her presentation that nurses have the choice to be who they want to be as nurses. She posited that nurses have the power to change things when they are not working, despite the institutional and organizational issues. Taylor supports The National Nursing Ethics Conference, which brings together bedside nurses to provide time for discussion, reflection, and education on ethical issues nurses face in the workplace. Practicing nurses and student nurses alike seem to need reminding of their potential and actual power at the bedside and in the world.

Theme Number Five: Experience

Life experience was generally referenced by all of the interview participants. Although none of the participants directly referenced the experiential learning cycle, components of experiential education shone through. In this first example, Participant E discussed the cycle indirectly:

It’s like I’m learning that the mental and spiritual things that we get good at are something that we exercise or practice—just like physical prowess comes through repetition and practice. And with playing the piano, you get better at it with practice. And I find the same thing with putting on someone else’s perspective—it’s easier with practice.

The interview participants discussed the need for experience, the element of reflection

present in discussion and debriefing in particular, and the fact that their knowledge, skills, and attitudes developed over the course of time, with each new experience drawing upon what they had previously learned.

They also referenced the negative impact the lack of experience has on development: *Sometimes they can't even imagine some of the things that happen, that ethically occur* (Participant D). Experience does more than drive education, it informs decisions and opinions. For example, there were references to evolving opinions:

So if you think everyone should be resuscitated, I personally believe that unless that is your moral imperative, I believe that over the period of your work as a nurse and your professional life that that's going to change. And that's based on practice, and on self-examination, and more exposure to ambiguity. And you have to do something about it as a registered nurse, as a professional registered nurse (Participant B).

The reference to moral imperative ties back into who students are as people—the extent to which they can and will change varies from individual student to individual student and *depends greatly upon that individual's willingness to think in a different way* (Participant E). Subthemes addressed in this section include clinical experience and age.

Clinical experience. Interview participants were asked to define and/or describe when they knew they had ethical competence. All of them referenced something clinical, but their stories varied. Participant C focused on heightened internal awareness of ethical behavior as a student, while the remaining four interview participants focused on either a transition or focus in clinical practice that informed their development. Working in areas rife with ethical dilemmas and challenging patient populations drove the development of ethical competence in the interview participants. They described their experiences with advocating for a pediatric patient when it was difficult (Participant A), repetitive practice

with the mentally ill population (Participant D), death and dying in the oncology population (Participant E), and working in an environment *where all of my beliefs about how people should be cared for were challenged* (Participant B). Participant D expounded upon the impact of dealing with a consistent psychiatric population:

It helped to see those conditions over and over and to see that no matter, that people that totally didn't know each other and aren't related in any way, have the same types of behavioral issues and sometimes the same conditions. I was able to see—wow, things are not really...people aren't' good or bad, and things are not good or bad, and things are not always under their control. So it's a little disconcerting—it really changes your world-view and maybe makes it seem a little less safe. So I could see where for some people remaining very black-and-white feels very safe to them, but we do have to consider the grey.

But one single experience does not always lead to development of competence.

Participant B differentiated the development that can occur in students while in school from the development possible when facing real-world dilemmas.

And that they were recognizing that something has changed about the way I see people in the way I can communicate—and that's just a really small piece. And then they, you know, they've got three more semesters after this, where hopefully, and I believe that they take the skills with them, they are practicing as becoming part of the professional that their becoming. But I think it's a 50-50 thing. Frankly, I would think that the formality of it...seeing the ethical dilemmas that come up with removing life support, seeing the ethical dilemmas with, you know, a split family that has two different opinions on what should happen and what the medical community has to do to facilitate whatever needs to be done, to recognizing that your peer at work is coming to work high—what you do about that? Some of those things can't come until you work.

Age. Age was identified as a subtheme due to the frequency with which age was referenced and the context in which age was considered. The participants posited that

age positively impacts on personal growth: *I was a much better nurse at age 35 than I would have been at age 22 simply because of my life experience. Somewhere in that personal growth, I gained the ability to realize that people's lives are very different* (Participant E). In addition to the articulation of improved ability with age, they also noted that youthful students or nurses are not always taken as seriously as someone who looks older. Participant A stated that an important assessment that had been expressed by multiple nurses was finally heard and acted upon perhaps due in part to the fact that although the interview participant did not have a large amount of experience, the participant was ten years older than the other nurses, so the responding physician thought the participant had experience and trusted the input. Participant C recalled a situation where the participant perceived being too young, too inexperienced, and too nice to speak up as a student—an experience Participant C reported is still reflected upon almost 50 years after the event occurred. Participant D summarized professional development in relation to age and the experiences of a nurse:

And I think, I just think about myself, and I started out as a 19-year-old nurse and...I think I saw things very black-and-white. I didn't have the extent of exposure that I got as I became a nurse to such as economic circumstances and to varying lifestyles, just the issues in life that happen. And I think nursing itself sort of brings that to you.

Based on their stories and examples, the interview participants highlighted that age impacts on development primarily due to the fact that age is associated with experience. But the interview participants cautioned that age alone does not lead to the development of ethical competence: *And I believe a great deal of that has to do with maturity. But I also know people who are in their 50s who are still very self-centered* (Participant E).

Interview participants also made mention of age in relation to the benefit of a

fresh perspective. They noted an appreciation for the perspective of the novice nurse or nursing student who may find something ethically distressing that does not necessarily distress a seasoned nurse. Erdil and Korkmaz (2009) gathered information from 153 undergraduate nursing students in Turkey regarding their perceptions of ethical dilemmas in the clinical setting. Over 93% of the student-identified issues included either references to physical and psychological maltreatment, ignoring patient privacy, or inappropriate informed consent and information sharing. Of interest is that in this beginning work, the students identified that 92% of the time the key factor involved in these issues was either the unprofessional behavior of the nurse, physician, or other members of the healthcare team. The fresh, student perspective may do more than point out faults among our interprofessional teams—there is a certain sense of desensitization that occurs over time in some nurses. The literature refers to this as the crescendo effect where the moral residue rises with each instance of moral distress and may minimize any positive impact experience may have on one’s ability to resolve situations that cause moral distress (Epstein & Hamric, 2009). Participant E discussed how students may be able to provide valuable insight into the current practice environment that may otherwise have gone unnoticed: *But we should hear the voices of our young ones – I believe that.*

Theme Number Six: Barriers

Interview participants were specifically asked to discuss barriers they face in respect to developing ethical competence in their students (Appendix H). Although their answers to this specific question are included in this theme, they referenced barriers throughout the interview, thus warranting consideration of barriers as a stand-alone theme. Barriers discussed include: (a) knowledge deficit, (b) curriculum content

overload, and (c) nurse practice issues.

Knowledge deficit. The interview participants were very honest and forthcoming in admitting their lack of consideration of the topic of ethical competence, their lack of knowledge regarding the topic, and/or their relative inability to easily articulate their thoughts on the topic of ethical competence. *Well, frankly until your survey, I never gave it a thought about whether they were ethically competent* (Participant B). Participant E admitted that the participant's own applied perspective on ethical-decision-making only recently evolved to include models or templates such as those based on virtue ethics or feminism. *On a personal level, I had made ethical decisions historically based on what I would want others...how I would want others to consider my situation.* Only Participant C, who teaches the course in nursing ethics, referenced these frameworks or models in any meaningful way, outlining the use of an ethical decision-making model found in their nursing ethics book.

But this lack of consideration is not limited to the interview participants. They identified holes in their individual programs, citing a lack of program and/or course outcomes related to ethics, and recognizing that more buy-in from nursing faculty may be needed to impact any change on this front. Participant B admitted that during a recent curriculum redesign, ethics content was not even mentioned. Participant B also offered insight regarding the implementation of new content as a thread. Faculty must design progression goals for each course and/or each level of the program to ensure adequate coverage. Participant B supported the education of faculty and implementing a stair-step model similar to a business plan to facilitate the integration of ethics content in nursing curricula.

The first interview question (Appendix H) asked for their definition of ethical competence. Participant A described layers of competency, with the lowest layer:

...prescribed by law or statute, then up from that would be specific behaviors directed towards the client...and then if you work it up a notch, it's the personal comportment both in the workplace and then in a larger way in the world...to be of the world and to address things with some degree of ethical maturity.

Interview participants made general references to *underlying principles* (Participants B and C), placed an emphasis on *ethical behavior(s)* (Participants A, C and D), and even referenced *human decency standards* (Participant D). Only Participant C, who teaches nursing ethics, articulated the definition presented in the literature, which simply involves recognizing and addressing the ethical dilemma. Based on the survey results where 23.4% of the educators surveyed did not have formal education in ethics, this is not surprising. Although the definition provided by Participant C extended far beyond the basic definition, incorporating the need to differentiate ethical, legal, cultural, psychological, and spiritual issues from one another and the need to recognize conflicting viewpoints, highlighting the need to support families, the core of the working definition used in this research was present.

The interview participants outlined that opportunities to expose students to classic ethical dilemmas, for example involving end-of-life or surrogacy decision-making, are not common. Participant A summarized this:

They're not that many examples of things that are really out there—I have to go for the glimmers. And so if I have a discussion that's an issue about a student then I think they might be going in that direction. But in a sense, they're also saying, 'Do you really care about all this stuff? I mean is it something you want, you know, you want to hear from us?' So I do tend to

draw them off so that they know I do care. So it's kind of touchy sometimes.

Students too have a knowledge deficit of sorts in that they are unaware that the code of ethics and the profession of nursing expects ethical behavior in the glimmers and in the larger, more obvious, situations.

Curriculum content overload. The interview participants overwhelmingly cited a lack of time as the primary barrier to the intentional inclusion of ethical content that could support the development of ethical competence. Their insight supports the premise that nursing education, burdened with content overload (Keating, 2011), routinely integrates principles of ethics into codes of practice or key job responsibilities, thus bundling ethics under legal, patient-centered, or professional standards. Not quite half of the participants who completed the survey teach at a school where nursing ethics is a stand-alone course, which means that ethics content is expected to be integrated much of the time. Yet, the clinical experiences may or may not present, and the faculty may or may not be versed in ethics content. Participant C began by stating that in *every single nursing course in the curriculum, ethical issues are identified and spoken to*. But after providing an example, the Participant C clarified with the following:

We do integrate discussion of ethical issues into every course... maybe not in a huge way, not any huge way...maybe three hours of content surrounding common ethical issues in pediatrics, common ethical issues in obstetrics, as well as Med-Surg and other courses.

But even this level of integration is not shared by the other participants. For example, Participant B stated that ethics, specifically the Code of Ethics, is introduced in orientation and is then referenced in the handbook. *There are bits and pieces of that, while I'm sure they're not formal—when I got the questionnaire, it made me realize that it*

is not formal in every course that we have in our program (Participant B).

The issues spill over in the clinical setting, where time constraints also negatively impact on the incorporation of ethical content and the intentional development of ethical competence.

I think that's because there are so many other pulls in terms of their time. You know, they're teaching skills, they're teaching assessment, they're certainly teaching therapeutic intervention and they're dealing with all the crises that have been on the unit, and they're trying to reinforce, kind of that concrete, clinical learning—whatever that is—in their own specialty. And I think they do address ethical issues as best as they are able to in like their one-hour of post-conference, and I don't know if they feel like that's their biggest call...to address the ethical issues. I mean...if it's blatant and dramatic, of course they will, of course they will, but if it isn't, if it's more subtle, I'm not sure that it's always addressed (Participant C).

Nurse practice issues. One of the key barriers identified by the interview participants involves practicing nurses who model less-than-perfect ethical behavior for students and/or who supplant the expertise of the nurse educator. Participant A identified issues ranging from documentation of medication administration not reflective of the time actually administered, consulting the nurse in place of the instructor, and handling specific clinical situations in a way that if the instructor were involved would be packaged differently. Consideration also was given nurses who:

...don't...what's the way I should say this...they don't have a deep regard for the patient—it's a job. They wouldn't do things unsafely, they would always do things as well as they could, but it's not for any reason other than it's their job. And they don't bring any particular level of subjective caring—it's a formal caring, but it's not the subjective caring... You have to be able to extend yourself to seeing the world through their eyes, to seeing what they are experiencing (Participant A).

Role of the Nurse Educator in the Development of Ethical Competence

In order to explore how educators develop ethical competence in their nursing students, the interview participants were simply asked how they would like to develop ethical competence in their students, provided they resided in an academic dream world with no barriers or limits (Appendix H). Although they provided insight throughout the interview, their answers to this question were collectively concise, clear, and cogent. In order to not dilute their responses and to provide a full picture of their current practices and recommendations, the key ideas are presented in the same straight-forward manner used by the interview participants.

Teach students: It's not about you. Although they certainly made references to the Golden Rule or to self-awareness, including considering your opinion in an ethical dilemma, when faced with clinical ethical dilemmas, the interview participants resoundingly focused on the perspective of the patient and/or family. Of note is that the patient and family were routinely mentioned throughout the interviews in relation to the decision-making process when the interview participants discussed an ethical dilemma in the clinical setting. They exhibited an understanding that nurse educators must facilitate self-awareness and assess the foundation of their students, but ultimately the goal is to move past this focus and foster an external focus on other(s) that includes empathy. Empathy also surfaced as a key element of ethical competence in the survey.

Provide intentional and explicated integration of ethics. The interview participants made a repeated call for earlier, more explicit introduction of expectations and guidelines regarding ethical behaviors and practice. Interview participants gave some consideration that specific prerequisite work could possibly inform nursing students. This coursework

includes a foundational philosophy course that many students have taken somewhere in their undergraduate work or coursework in critical thinking, which was presented by Participant B as a possibility, but does not yet exist in the programs of these interview participants. Participant A described how one school outlined academic expectations with ceremony:

Our institution has a ... ceremony at the beginning of the first semester of nursing. They come to us as usually low sophomores or high sophomores, but then they get their prereqs out of the way...and so their first nursing class...about three weeks in, they have a ... ceremony and they're white-coated and they take a pledge to be...to work within, I would say, professional standards...parameters...and they have put something about academic dishonesty in there and academic honesty...and they all sign a form that they agree to it. I don't know if this does any good for pragmatics, but it does let them know where the faculty stand...so, it's helpful.

The basic sentiment expressed by the interview participants was best summarized by Participant B: *I'd like to have them know earlier on in their first semester what behaviors are of an ethical person. It's just like state practice, kind of...if you're going...to have a thread, you'd better be starting it before the fourth semester.* But established curriculum threads with verbiage attuned to ethical competence do not universally exist in nursing programs, so their integration is generally not measured and is therefore variable.

The interview participants divulged that although they note discussion of ethical topics throughout their individual programs, the faculty members are primarily responsible for introducing and driving the discussion with students. They also provided consideration that ethics could be meaningfully integrated into *what I'm teaching technically. For example, if I'm teaching health assessment, then I will incorporate it even into health assessment. So when we're going over subjective history, we'll talk*

about some of those ethical things that can arise (Participant D). There was a general acknowledgment that nurses are informed by the type of nursing they practice. For example, a nurse with a psychiatry background is influenced by that background, even when teaching other subjects.

But I also kind of like to feel them out during group discussion, even if it's something like health history...How they're going to deal with someone who lives a life they're not familiar with or maybe even they don't personally agree with? How are you going to deal with that question? How will you compassionately and ethically deal with that? (Participant D)

This expertise informs case studies and other exercises intentionally integrated into subjects with which they have extensive clinical experience. This is one of the concrete ways nurse educators infuse ethics content into their daily teaching.

Explicating the content is something that surfaced very frequently in the interviews. Take for example this situation where although the basic premise is reviewed, the rationale is not always made explicit: *We can't make the decision for somebody...so the ethics of not treading on someone's decision... we don't talk about the reasons behind that—we don't talk about the general principles I don't think as much given the situation* (Participant A). The irony is that students are constantly asked to cite rationale for their actions and interventions.

Introduce ethical terms early. Providing students a vocabulary gives them the tools they need to engage in interprofessional dialogue. Although all of the interview participants referenced use of the term *ethical dilemma* for larger ethical issues, they only reported occasional use of the term *moral distress*—more frequently in the intensive care setting and in the community setting outside of nursing—and only referenced a few of the ethical principles, with autonomy surfacing most frequently. The interview participants

highlighted that even if students are not exposed to the terms, they certainly are able to express the feelings surrounding an experience. *So they might say, 'I don't think this is right – what do you think?' or 'I saw this today and I felt really uncomfortable.'* *You don't always have a label or descriptor attached to it that is in the vocabulary...*(Participant B). But there was general agreement among the interview participants that: *They need to label them so that they can discuss them in an interdisciplinary environment in which we all practice now* (Participant C). They also recognized that words are powerful tools that students must learn to wield. Students also need to be taught *to behave in an ethically competent way as far as verbiage, as far as what we do to people who are not as fortunate as ourselves—I think those are important to communicate someplace at the beginning* (Participant A).

Foster insight beyond belief systems. Participant B discussed hearing success stories from students after they have graduated: *they learned something about valuing another person, not having a negative expectation... their thinking probably changed from the time that they were in the class...and that they were advocating because they knew what was right.* And yet a belief in what is right is not really the goal. They placed emphasis on the ability of students to *do some problem-solving about their decision-making* (Participant B) and considered how they would maneuver a situation where, for example, their personal beliefs and professional career collide. Participant B also reported pushing students in their final semester to consider this situation some of them may face as a new graduate: *you're looking for a job, you're going to go to an operating hospital that is one-stop-shopping and you believe that doing elective abortions is morally and ethically wrong, and that's the only place you can get a job.* The interview participants discussed

driving the discussions beyond personal belief systems and into consideration of how to function in the complex healthcare environment where right and wrong are not always clear and where doing the right thing is not always easy.

Capitalize on situations. The clinical setting provides a myriad of situations rife with ethical issues that can be used as exemplars, and/or drive discussion. All of the interview participants have a clinical component to their work and they recognize the value of having the clinical setting at their disposal. The interview participants admitted that they do not see many examples of classic ethical dilemmas, such as end-of-life or beginning-of-life issues. Although the interview participants indicated that they really focus on the day-to-day things in clinical practice to exemplify ethical practice, they present both levels of cases.

According to the interview participants, flashier examples present in research ethics, published in books like *The Good Nurse: A True Story of Medicine, Madness, and Murder* (Graeber, 2013), or captured in the media could be used to capture students' attention and provide meaty examples (Participant D). Highlighting the daily interactions with patients and the interprofessional team provides concrete examples to which the students can frequently relate. For example, examples can include things like *conflict in family, conflict between physicians and nurse, nurse and nurses, nurses' aides and patients—just a lot of disrespectful communication, a lot of really horizontal violence, abuse of students, abuse of doctors towards nurses, disrespecting patient wishes* (Participant C). Participant C continued to tell the story of a 96-year old woman trying to deny consent for a colonoscopy, and the pressure by the staff that was not alleviated until the daughter arrived and agreed with her mother. The interview participants indicated

that perhaps providing both levels of examples would provide nursing students a foundation upon which they can continue to build.

The clinical rotations with a defined specialty provide the opportunity to present unique examples for students:

Students have not had introduction to harm reduction prior to coming to my course. And they often have a lot of questions related to the ethics of that practice. So when we talk about asking someone if they'd be willing to cut down on their drinking, if they'd be willing to only drink between certain hours so they could hold a job...the evolution of the thinking of the student and the maturity, not only of the person but in their role as a nurse, and their other ways of thinking—is it wrong to encourage people to do this? Should there be a brochure in the bathroom that tells you how to find the correct vein if you are going to use an IV drug? So most of time, in my setting, that's where these questions arise. And then the consideration for them: they say, 'Is it ethically okay for us to do that?' (Participant B)

Capitalizing on these specific clinical situations provides a unique perspective that assists students in developing a semblance of ethical competence.

Role-model. Nurse educators rely on role modeling for teaching technical skills, interpersonal skills, and management skills. One of the interview participants stated that clear articulation of the rationale behind actions does not always occur. In the case of role modeling: *We don't explicate enough and we don't say it earlier on...we do more modeling than actual explication, and I think we ought to do both* (Participant A). There was a recognized need by the interview participants to find the balance between doing/modeling and allowing the student to dwell in the ethical situation and consider a plan of action independent of the clinical instructor. The challenge remains that the clinical environment is full of real people whose lives are impacted both positively and negatively by the student-teacher interactions.

Identify the fakers and praise the performers. The interview participants universally appreciated that currently no tool is designed to evaluate ethical competence or even ethical behavior objectively. In the absence of this tool, clinical evaluation provides valuable information regarding specific ethical concepts such as *advocacy* (Participants A, C, and E); *respect* (Participants B, C, and D); *professionalism* (Participant C); and *interprofessional values* (Participant C). Papers, discussions, exam questions, and reflections also received mention in the coursework arena. But the interview participants emphasized the need for evaluation that extends beyond the checkbox or the students' self-reports, and extends into the observation of the instructor, everything from watching their facial expressions to witnessing a patient interaction. The following response by Participant A summarized the thoughts shared by several of the interview participants:

How do I know...I don't think I ever know for sure because there's the behavior and then there's faking the behavior. I don't know for sure, but as far as I can read it, I can usually get the feeling that at least they're expected to have ethical competence when they begin a discussion or they preface something like, 'You know I really didn't know what to do, but this seemed more like the right thing to me. Can I check it out with you?' So that tells me that they're dealing with some sort of a dilemma... And so they want to know and they want to be affirmed. So that tells me that that student's moving in the direction of working on that and is trying to become competent within the frame of the discipline. So at least... the talking, the talking is not the walking... but at least they're exploring the ideas, and I like to have the dialogue about that. Anything they wrote in a response paper—they might've done it, they might've not done it, they might have just wished they did, but I'm not sure. When I see them actually do something, then I can make more of a decision.

Positive feedback is also of the utmost import. *I think we just need to praise their socks off whenever they do anything that seems to be right* (Participant A). The interview participants generally expressed that students are very unsure of themselves in the clinical

setting. Adding layers of ethical complexity to the already challenging healthcare environment creates fear and uneasiness in students. The role of the educator must include providing positive feedback in order to foster development, especially in the clinical setting.

Summary

The second phase of this research, the interviews provided insight into some of the responses given on the survey, supported responses given on the survey, and illuminated certain aspects of this research including the role of the nurse educator in the development of ethical competence and the barriers to this development. Although a clear definition of ethical competence was not presented by the interview participants, perhaps this is more meaningful than had a definition been clearly identified. The fact that ethical competence remains elusive, intangible, and perhaps even unattainable by nursing students warrants reflection. This section focused on exploration of six basic themes: who nursing students are as people, religion and spirituality, the role of the nurse, power, experience, and barriers, with an additional focus on the specific self-identified role of the nurse educator in the development of ethical competence. Figure 3 provides a visual representation of the core themes and subthemes explored.

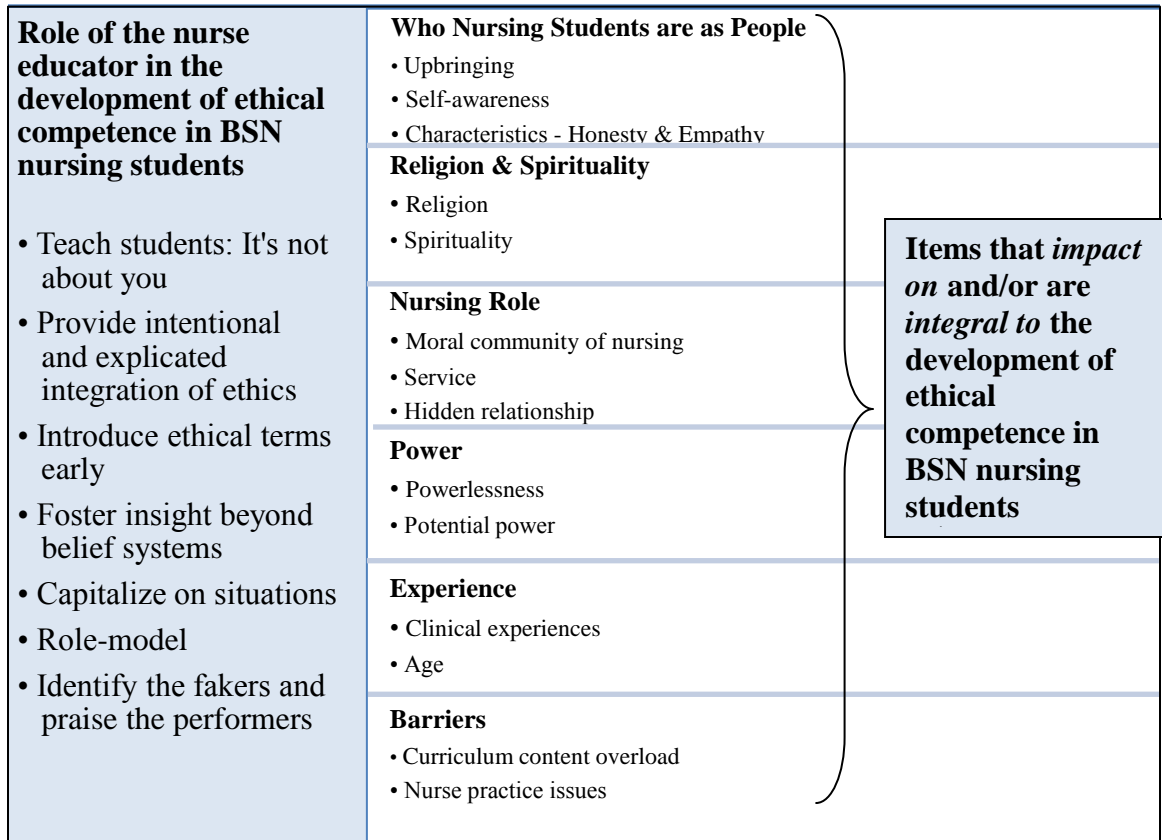


Figure 3. Visual representation of interview themes and subthemes.

The nurse educators who participated in the interviews offered direct advice regarding the role of the nurse educator in the development of ethical competence in their students.

Each of the five educators was quoted 9-12 times in the discussion of the primary themes and subthemes (Appendix K), meaning that their measurable contributions to the research were relatively equal. The distinguishing factors that bear mention regarding the clinical expertise of the educators themselves revolve primarily around the educator who reported teaching nursing ethics, Participant C: (a) only Participant C reported intentional inclusion of definitions, frameworks, and decision-making models to drive analysis of ethical situations with students; (b) Participant C clearly articulated unique ideas

including the idea of a *moral community* and the hidden relationship between the nurse and patient; (c) only Participant C presented the definition of ethical competence reflected in the current literature; (d) only Participant C referenced a story about personal development of ethical competence that occurred as a student, not as a nurse; and (e) only Participant C confidently stated that ethics is integrated throughout the program where Participant C teaches.

It is also interesting to note that the three nurses with a background in behavioral health (Participants B, C, and D) did not as frequently include religion in their discussion of ethical competence as their non-behavioral health counterparts (Appendix K). In fact, the primary reference to religion included by Participant D was negative and highlighted assumptions and judgments made in the name of religion. The fact that Participant B did not reference religion or spirituality at all may explain why Participant B was quoted the fewest number of times. The impact of the educator on the development of ethical competence in students provides the impetus for much of the discussion that follows in Chapter Six.

CHAPTER SIX

Summary, Discussion, Conclusions, and Recommendations

Summary

The basic premise of this study was to explore the perceptions of nurse educators—what are they actually doing, what are their actual experiences, and what definitions are they using. Completing the analysis for phase one of the research prior to the onset of phase two allowed for the information provided by the first phase to inform decisions made in the second phase of this research. Although the survey and interviews were considered separately, their data are intertwined and provide a more robust picture of key elements of this research. The research questions were addressed by both the survey and interviews—this summary of the research findings combines findings from both sources.

The survey provided information regarding the quantitative research questions. Consideration was given the educational preparation of nurse educators teaching ethics to pre-licensure baccalaureate nursing students at CCNE-accredited institutions and was found to be comprised primarily of doctoral-prepared (52.3%) and master's-prepared (46.9%) educators. Their educational preparation generally included the following emphases in their undergraduate education: application of ethics to nursing, exploration of teaching modalities used, end-of-life issues, an introduction to The ANA Code of Ethics, an emphasis on patient care, and a focus on decision-making. Their graduate education, although varied, generally included the tenets present in their undergraduate education and expanded to include research-focused and specialty-focused topics and a longer view of ethics that included the healthcare environment, organizational ethics, and legalities. What they each learned as a nurse also varied, but there was a large emphasis

on realizations regarding the complexity and ambiguity present in the clinical environment, a renewed emphasis on ethics as integral or personal to the delivery of nursing care, and an articulation of professional conduct and responsibility. In this section regarding knowledge gained as a practicing nurse, there were also increased reports of the impact of experience and exposure to issues related to ethical violations, resource allocation, and interprofessional concepts. This research question was sufficiently addressed in the survey responses and was not directly considered in the interview. However, one could argue that the relative lack of expressed consideration for the topic of ethical competence by the interview participants prior to the survey and interview calls into question the educational preparedness of nurse educators in general to foster the development of ethical competence. This may be due in part to the fact that 30.5% of the survey respondents reported no training in ethics in the past five years, and 8.6% of the survey respondents reported no formal education or training at all.

The second quantitative research question considered how ethics education is embedded in the pre-licensure baccalaureate nursing curriculum. Survey findings indicate that only 18.8% of survey respondents report a required course in nursing ethics, with 11.7% reporting a liberal education ethics course, 8.6% identifying another ethics course such as a course in medical ethics or bioethics, and 3.9% of respondents indicating ethics content is integrated. Respondents indicate that 53.1% of the nursing programs where they currently teach do not require a course of any kind in ethics. Although this data represents only 128 survey respondents from 4 states, this is reflective of cursory internet program searches done by the researcher when identifying this particular research topic. When examination question content was considered, the respondents

identify only four courses where more than 50% of the examination content reflects the inclusion of ethics content: Nursing Ethics (100% of the exam content related to ethics), Management and/or Leadership (76.9% of the exam content related to ethics), Nursing Research (68.4% of the exam content related to ethics), and Behavioral Health (57.1% of the exam content related to ethics). These four courses were referenced by the interview participants as courses where ethics content is believed to be addressed, although it is important to note that the interview participants did not summarily link ethics with professionalism or legalities alone. Although this research question was primarily considered within the quantitative research tradition, the anecdotal comments from the interview respondents indicate that although the majority of the programs do not require a course in ethics, and even fewer require a course in nursing ethics, there is incidental inclusion of ethics content across the curriculum, at least according to these interview participants.

Content analysis was performed on the open-ended survey questions geared towards defining ethical competence. Interview participants were asked outright to define the term. Figure 4 takes the base model developed given the survey responses regarding knowledge, skills, and attitudes, and adds components specifically articulated and/or expounded upon by the interview participants. In particular, the interview participants discussed the importance of cultural competence, the importance of listening, and the importance of providing patients and their families with support devoid of judgment.

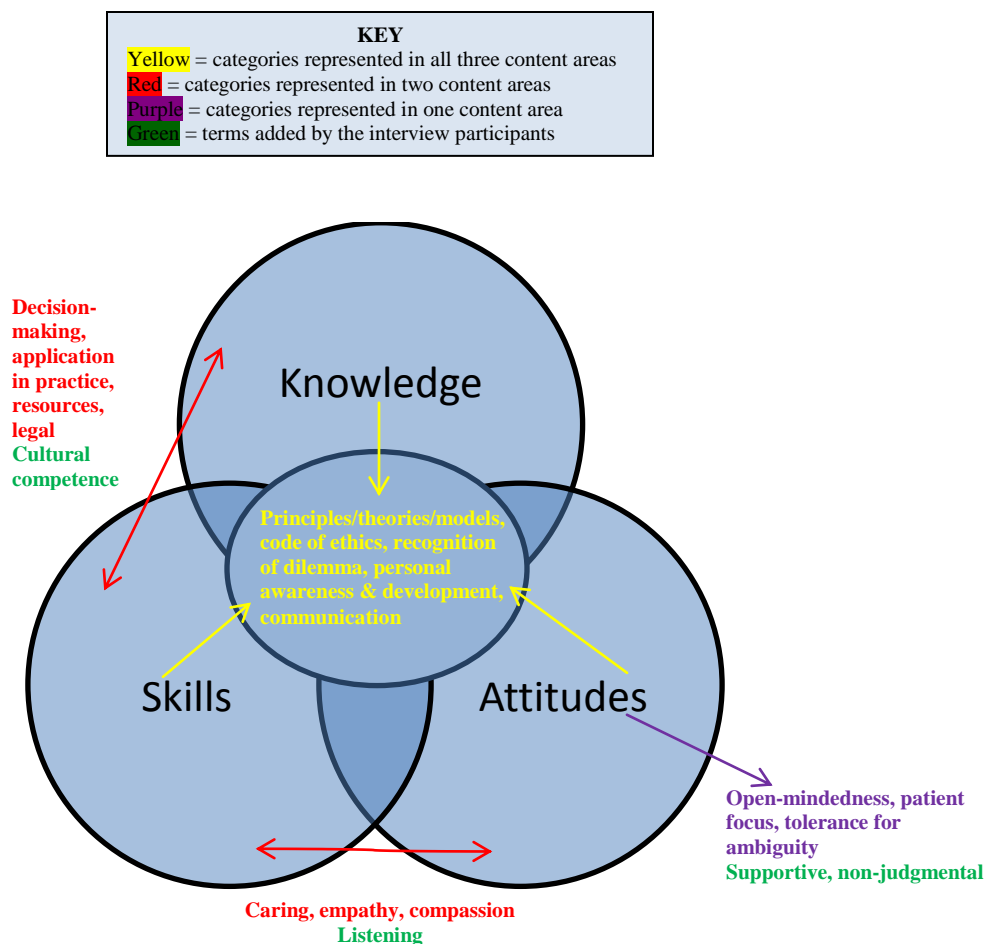


Figure 4. Knowledge, skills, and attitudes attributed to ethical competence: Survey + interviews.

Despite the relative completeness of this model, which accounts for the educationally-accepted perspectives of knowledge, skills, and attitudes (Cronenwett et al., 2007), the definition of ethical competence contains nuances that were more fully addressed in the interviews. The themes identified from the interviews, including who nursing students are as people, religion and spirituality, the role of nurses, power, experience, and barriers, with an additional focus on the specific self-identified role of the nurse educator in the development of ethical competence address the final two research questions. The broader

foci of the themes encompass the concepts of development and evaluation of ethical competence and the relationship of experience to the development of ethical competence and therefore bulk of the conclusions posited.

Discussion and Conclusions

Clarity regarding ethical competence. Classic ethical dilemmas, where two or more foundational ethical principles are in direct conflict and there is no necessarily right answer, do not occur on a daily basis for the nurse educators involved in this research. The idea that ethical competence encompasses only these types of dilemmas is not reality for the educators in this study. Their definition of ethical competence extends into the concepts of ethical comportment and ethical behavior, thus encompassing the everyday practice of the nurse. Ethical competence is a term nursing must carefully define for itself as a profession. Casual references to ethics surface in mass media and in relation to business acumen. For example, nurses have regularly topped the list of professionals when respondents were asked, “Please tell me how you would rate the honesty and ethical standards of people...” (Gallop, 2012, para. 1). The link between honesty and ethical standards is reinforced in the phrasing of this question. It is interesting that honesty clearly surfaced as a subtheme for both the nurse educators who participated in the survey and the interview participants. This ranking supports the positive interactions the general public has had with nurses and may reflect the emphasis placed on patient autonomy, patient’s rights, truth-telling, a collaborative relationship with patients, and the articulated values of the profession from nursing’s professional Code of Ethics (Gallop, 2012). Yet, the nurses in this study did not universally define ethical competence as it is defined in the literature. The knowledge, skills, and attitudes identified are reflective of

the ANA code of ethics insomuch as they refer to professional and personal values, integrity/honesty, compassion, and competence; but the focus of the interview participants remained on the day-to-day nurse-patient interactions and the everyday ethical situations that require ethical comportment and ethical decision-making.

Although the concept of *good* or *goodness* garnered both positive and negative feedback from the interview participants, the idea that good or right behaviors should be monitored and expected of students reflects the Code of Ethics' "habits of character of the morally good nurse" (American Nurses Association, 2001, p. 11). Nurse educators facilitate the sharpening of a nurse's ethical instincts by fostering the development of a moral compass, an internal moral guide of right and wrong that exemplifies goodness or character. They also provide concrete tools that can be applied to ethically-charged situations, including models of ethical decision-making, professional exemplars, and professional guidance documents. Nurse educators acknowledge that each situation is a unique blend of contextual, organizational, and interpersonal facets. Because of this, nurse educators recognize the importance of fostering the development of ethical competence in their students.

Perhaps beginning with concrete knowledge, skills, and attitudes could provide some initial structure for the nurse educator. Based on the survey and interviews, I am not convinced that nurse educators are universally prepared or willing to develop students as moral or ethical beings. For example, the references to religion or spirituality indicate that although this may inform who some nurses are as people, religion no longer embodies or defines nursing as a whole. Although nurse educators are privy to private details and the inner-workings of their students, their focus is on ensuring appropriate

behaviors and processes, not necessarily developing virtuous beings. They ask students to define and embrace their individual, personal beliefs and values, and appreciate the impact they may have on their interactions, but not impose them on others. Crigger and Godfrey, (2011) hinge their seminal work on virtue ethics, stair-stepping the ethical development of members of the profession of nursing. Yet, based on the survey results and interview details, I am not convinced that nurse educators are ready to embark on the transformational work Crigger and Godfrey (2011) propose. Virtue ethics requires the development and evaluation of habits (Barrett, 2012), which encompasses the idea of developing character with the core assertion, rooted in the work of Aristotle and Plato, that “character and values precede conduct and relationships” (Crigger & Godfrey, 2011, p. 50). Although I certainly appreciate the benefit of developing nursing from within as a profession, based on the stories told in the interviews, it may be more reasonable to enforce the external behaviors first, and promote internal development of virtues or character secondarily through the expectation and enforcement of external displays of ethical behavior. In reality, we may no longer expect to work with nurses who are called to nursing or who necessarily relish the service aspect of our profession. Perhaps nurse educators want students called to serve, but we may need to recognize that a calling is not what brings all nurses to nursing. We need nurses to be able to survive in this hierarchical business model called healthcare. We are asking students to function in what educators deem a highly complex, ambiguous environment that is externally controlled by policy, procedure, standards, and regulations. Perhaps providing specific guidelines, through accrediting bodies or elsewhere, would better-define the knowledge, skills, and attitudes expected of new graduates.

For example, the current National Council of State Boards of Nursing's revised NCLEX-RN detailed test plan (Item Writer/Item Reviewer/Nurse Educator Version, 2013) includes testable content regarding applying principles of ethics, ethical practice, client rights, advocacy, confidentiality, advance directives, informed consent, legal rights and responsibilities, and abuse/neglect (National Council of State Boards of Nursing, 2013). Client rights, advance directives, informed consent, legal rights and responsibilities, and abuse/neglect are heavily driven by policy and procedure and the semantics of those are well-documented. Ethical practice is further defined as: (a) "recognize ethical dilemmas and take appropriate action, (b) inform client/staff members of ethical issues affecting client care, (c) practice in a manner consistent with a code of ethics for registered nurses, [and] (d) evaluate outcomes of interventions to promote ethical practice" (National Council of State Boards of Nursing, 2013, p. 13). Of interest is that the working definition for ethical competence is included in the blueprint, but is not labeled ethical competence, which may explain why the term was not universally defined by the interview participants in a similar fashion. The principles of ethics, ethical issues, ethical practice, and ethical dilemmas are also not clearly defined. Although the term *clinical decision-making/critical thinking* is used in the blueprint, it is used in reference to an emergency response plan, a security plan, calculating dosages, and when addressing expected effects/outcomes of medications—not in relation to ethical practice. My research is validated by the fact that universal definitions, components, perceptions, and applications were not universally reported despite the fact that all nurse educators have access to and are expected to utilize this document to guide curriculum development, implementation, and evaluation. If ethics is deemed important to the

development of beginning nursing students, which I believe it is, there must be better definition and integration of the concepts. The idea of *competence* is central in much of nursing education. Ethical competence is important enough to better-defined and included in guiding documents.

We may also need to consider transitioning beyond doing what is right into doing what is right for the person, as they may not always be the same thing. There is a huge emphasis on patient-centered care in the results of this research; there are references to promoting autonomy, facilitating decision-making, and supporting rights. There is also quite a bit of reference to empathy, being other-centered, in this research. The concept of empathy was never at the forefront of my work regarding ethics and empathy was not specifically addressed in the literature review. Krznaric (2012), who contributes to the University of California, Berkley site dedicated to the Greater Good Science Center, offers six habits of highly empathetic people: (a) cultivate curiosity about strangers, (b) challenge prejudices and discover commonalities, (c) try another person's life, (d) listen hard—and open up, (e) inspire mass action and social change, and (f) develop an ambitious imagination.

Considering empathy beyond considering the perspective of another, especially in this light, does permit the concept of empathy to encompass much of what the interview respondents consider to be ethical competence. It begins with individual relationships and extends into social change, thus encompassing the social tenets referenced in experiential educational theory (Gutek, 2011), considering the implications of individual action on the moral community of nursing, and allowing for personal growth and development. I argue that empathy alone may not be enough to promote ethical

competence. The ability to consider the perspective of another inform objective decisions may not provide rationale for problem-solving, or give sufficient legal or moral justification of choices. There is literature to suggest that empathy is the primary building block for the development of ethical behavior (Dickens, 2011, Krznaric, 2012; Ward, Cody, Schaal, & Hojat, 2012). Yet, we must tread cautiously. Ward, Cody, Schaal, and Hojat (2012) discuss a study of 214 undergraduate nursing students who completed the Jefferson Scale of Empathy at the beginning and at the end of the 2006-2007 academic year. Results indicate a statistically significant decline in the empathy of nursing students who were exposed to more patient encounters, which is consistent with reference studies performed with medical students.

Positioning empathy as the cornerstone of the development of ethical competence would require a shoring up of empathetic practices and consideration of the impact empathy may have on the individual student nurse. This veritable jading of students references the idea of the crescendo effect where the moral residue rises with each instance of moral distress and may minimize any positive impact experience may have on one's ability to resolve situations that cause moral distress (Epstein & Hamric, 2009). The crescendo effect has been identified in experienced nurses, particularly those who function in areas with frequent ethical dilemmas (Epstein & Hamric, 2009). This reinforces the need for educators to explicate rationale and support students in the challenging clinical environment. Interestingly enough, based on this work, the protective nature exhibited by the interview participants may not be unwarranted, although protection that stifles growth must be reconsidered.

Experiential learning. As the survey results were reviewed and the interview transcripts coded, references to cultural competence triggered thoughts about the parallels between cultural competence and ethical competence. Using Campinha-Bacote's (2002) traditional model based on the work of Leininger, the development of cultural competence occurs over time through process and experience—it is not simply an event. This process requires a desire that fuels the development of cultural awareness, which is supported by cultural knowledge, and developed through repeated cultural encounters that ultimately foster the attainment of cultural skill (Campinha-Bacote, 2002) and reflect empathy modeling. Cultural competence training insists that generalizations and stereotypes be minimized and that each encounter allow for the patient's individual expression of culture, whatever that means to that individual. The parallels between the knowledge, skills, and attitudes are obvious. The desire to develop cultural competence could be likened to the self-awareness and perhaps empathy required for the development of ethical competence. Both processes require experience to provide a context for application and solidify the learning. There is also the idea that one does not ever stop developing cultural competence, the learning is not finite. This ongoing development also applies to ethical competence.

Another very recent publication also highlights the experiential component. Ramos, Brehmer, Vargas, Schneider, and Drago (2013) discuss Brazilian professors' conceptions about the ethical dimension of nurse training, highlighting relationships associated with the professional role and identifying the spaces and strategies for teaching ethics in this process. The researchers performed a qualitative research study where 50 professors were interviewed in six school-based groups; they labeled the research a case

study in order to ground it in the Foucault tradition of social research. Basic conceptions expressed by the professors include: (a) ethics is constructed around relationships, with oneself and with others, which require responsibility and professional action; (b) ethical competency is intrinsically linked to professional competency; and (c) ethical training has an experiential component. As for the consideration of teaching, results indicate that ethics occupies different spaces in the formative process, with discussion serving as the primary methodology used to cover theoretical and practice principles. The authors describe a “theoretical-practical fragmentation” (Ramos, Brehmer, Vargas, Schneider, & Drago, 2013, p. 119) where the theoretical application only “timidly” (p. 119) addresses practice. Educators are challenged to adopt methodologies that mirror or simulate ethical dilemmas that surface in practice and provide a variety of experiences. This supports my findings that students are not afforded the whole ethical experience due to a myriad of factors including insufficient opportunities, insufficient clinical time, and the calculated risk in involving students in ambiguous, challenging situations that may be at the edge of their understanding. We must recognize that new nurses are still developing ethical competence and require ongoing support.

Experience is inextricably related to the development of ethical competence. Discussion and case presentation remain the primary methodologies for instruction of ethics content, especially the more classic ethical cases. Although case studies allow for the consideration of the process of ethical decision-making, the interpersonal factors, the aforementioned empathy, and the interprofessional and organizational issues may or may not surface. Plus, there is the fear factor, which cannot be underestimated. The interview participants reference the fact that students are fearful, especially in the clinical setting.

This fear may not be adequately addressed in the confines of a classroom, where students can opt in or out of engaging in a situation. Perhaps it is better to permit the nursing students to face the ethical issues in the clinical setting as student when they have the guidance of the clinical instructor, the assistance of the nurse, and the support of their peers. Of great interest is the fact that although the interview participants certainly reference case studies or discussion, their examples of how they develop or measure ethical competence were rooted in the clinical setting where students were beginning their practice of nursing. The feelings engendered, the reflection in-action and on-action (Lasater & Nielsen, 2009), and the moments of clarity and breakthrough were all generated through clinical experience. In most cases, the interview participants referred to debriefing after the situation, which adequately fulfills the reflection component required in the experiential cycle. It must be reiterated that the core tenets of experiential learning fit the practice-based nature of both nursing education and the profession of nursing (Fowler, 2008). Fowler (2008) also cautions against an imbalance between reflection and experience (Figure 1). Nurse educators must recognize the role they play in experiential learning and provide adequate experience, while requiring appropriate reflection to promote the development of ethical competence. Nurse educators must identify the ethical situation, articulate the issues, engage the students in action, and then provide time for critical reflection (Mezirow, 1998) to set the stage for transformation. Although the research suggests that the nurse educators in this study, both from the survey and interview phases, are incorporating what they perceive and report to be ethical content, it is not routinely or systematically being done in a way that guarantees that the development of ethical competence is promoted. There is disagreement about whether

nurse educators could afford students ample opportunity to fully develop ethical competence. I appreciate that stance and agree that experience informs nursing practice, but posit that we must at least try to prepare students for the challenges we know they are going to face. We owe it to the students, we owe it to our patients, and we owe it to our profession.

Moral community. In their role as nurse educators, particularly in the clinical setting, these interview participants are routinely provided the opportunity to reflect on the functioning of the clinical unit and on the relationships between and among the nursing community members. Their expressions of dissatisfaction with some of what they are seeing links back to Aroskar's (1995) version of a moral community where she cautions that "Communities can shape and misshape us. These possibilities should be of significant concern for the nursing profession, practically and ethically" (p. 135).

Aroskar asks nurses to consider how their everyday working relationships impact on patient care and how their daily actions reflect respectful treatment of each other. One interview participant references incivility as an issue among nursing students; others discuss the ethics of charting, confidentiality, and legally binding mandates such as HIPAA. According to Aroskar (1995), all of these actions reflect decisions made "every day that affect the practice of our nurse colleagues and other nursing personnel and the welfare of our patients" (p. 135). Based on this research and the student contingent of the nursing community, we must begin to consider if we are indoctrinating and welcoming our new nurses into a community that prides itself on ethical practice and has the infrastructure to support and foster the development of ethical competence. Perhaps this is proof of the fact that educators and academia have not successfully prepared the

current nursing workforce and that more explicit educational initiatives are necessary to impact change.

Educational theory has long discussed the impact of the formative years informing who people are as adults (Mezirow, 1991/1998). Dewey (1929), referenced throughout this research, articulates the link between the academic environment and social reform. The power issues identified throughout the course of this research depict nursing students as perceiving they possess very little power, but the stories demonstrate the actual impact nursing students have on the clinical environment and their potential impact on a much larger social scale. Drawing upon insight gained from the survey and interviews, nurse educators need to focus on: (a) identifying the limits of students' power in the clinical setting, which may be imposed by the patient situation, the nurse, other members of the interprofessional team, the instructor, or the student himself/herself; (b) considering the limits themselves: are the limits actual or perceived, yielding or unbending, related to patient safety or patient comfort, and/or simply in place to alleviate staff, educator, or student discomfort; (c) choosing to collaborate with the student to devise a course of action; and then (d) participating in the evaluation and reflection process with the student. The steps to address ethical issues in the clinical setting can be applied to everything from a decision made by a nurse, a patient's need for advocacy, a conflict among the interprofessional team, or a classic ethical dilemma. The issue is that this takes an astute educator with some ethical acumen, who both appreciates the value of integrating ethical content into daily practice and is willing to take the time to address what may be classified as daily issues. As presented by an interview participant, allowing a student to question why a nurse opted to lie to a patient about the patient's

psychiatric agents and tell the patient they were vitamins is not easy and presents a unique set of challenges, but the student will remember and learn from that situation. That student can then be given the power to act on a small scale and directly impact patient care. That student can make a difference. The next time an issue arises, if the theory of experiential learning holds true, the student will have the experience from that situation to draw upon, thus empowering the student to further develop the ability to identify and address a clinical ethical situation.

We must empower students through experiential learning to address the difficult situations. However, not all difficult decisions are true ethical dilemmas, though many of them contain ethical tenets or elements. I would also agree with Repenshek (2009) that moral subjectivity is inherently uncomfortable, but this discomfort does not necessarily reflect the inability to act or lead directly to moral distress. Although not strictly ethical dilemmas, related issues involving ethical comportment and professionalism—both components included in the descriptions of ethical competence by these nurse educators—require more than a modicum of accountability. The perspective of the interview participants on the hidden or private relationship between the nurse and the patient has great impact on the significance of this research. This simple idea, stated so eloquently and directly by the interview participants, highlights the responsibility of our future nurses. There must be a process whereby ethical competence is developed and ethical behaviors are instilled in order to protect the sanctity of the nurse-patient relationship upon which our entire profession is based. Whether that process begins by demanding behaviors that develop the attitudes, or instilling virtuous tendencies that dictate behavior,

I am not sure. Regardless of the means, the end result must be that nurses practice in an ethically competent manner with the resolve and fortitude required of such responsibility.

This ethical competence would hopefully spill over into the environment, promoting a climate that supports interprofessional collaboration and responsibility—a moral community. Dickens (2011) posits that empathy does indeed provide the impetus to ethical behavior and ultimately competence if considered a practice, not merely a feeling. She recommends that the practice of empathy guide action in the workplace to establish an environment of connectedness.

Unified goal. Based on my findings, one of the biggest identified and modifiable barriers to integrating ethics content that fosters the development of ethical competence is the commitment required by a unified faculty and administration. Content overload and time constraints exist (Keating, 2011), but they do not excuse the lack of integration of information deemed necessary. Perhaps the emphasis needs to shift from what we are teaching to how we are teaching, but this is not a reference to concept-based curriculum. The interview participants and survey respondents clearly identified instances when they typically integrate ethical content into their course content, specifying how they weave the ethical content into their primary topic. Perhaps teaching ethics does not actually take more time, it simply takes focus and intentionality. The integration of ethical content must be consistent and thorough to ensure competency, primarily because this competence is based on experiential learning. Receiving information without the ability to operationalize it in a meaningful manner can impact on the retention and future use of that information. The clinical setting provides a plethora of opportunities for exposure and discussion. However, there also needs to be some way of ensuring that ethical

models, theoretical principles, definitions, and decision-making frameworks are introduced to provide student the tools and language they need. Collective identification and creation of innovative strategies can compensate for the lack of experience expressed by some nurse educators and alleviate some of the stress inherent in integrating strategies that foster the development of ethical competence. This unified integration must also include the academic environment where unethical practices identified in the interviews ranged from cheating, to HIPAA/confidentiality violations, to incivility.

Recommendations

Hamric (2001) rather profoundly stated that “At times it seems that the term ‘integrated’ is nursing code for ‘vanished.’ In the case of ethics, seriously integrating ethics content throughout any curriculum, whether at the associate, baccalaureate, or graduate level, is a challenging undertaking” (p. 115). This research supports this statement. We must recognize the important role educators have in the development of ethical competence, which is so much more than simply fostering in students the ability to recognize and address an ethical dilemma. We must use the classroom setting, whether in a nursing ethics course or another defined course, to explicitly provide students a vocabulary of ethical terms, outline guiding principles, discuss common ethical issues, and develop this skill set by using ethical decision-making models. Nurse educators must also appreciate that the work they do in ethics in their individual course matters to the development of students as a whole irrespective of whether their program requires a course in nursing ethics or not. If the development of ethical competence is deemed a process, there must be incremental progress made in each course to foster continued development.

Perhaps more importantly, nurse educators must be vigilant, articulate, and explicit in their clinical role modeling and exploration of ethical issues in the clinical setting. Nurse educators must begin to intentionally create experiences where students are required to respond to and engage in the management of an actual or perceived ethical issue or dilemma. Keep in mind that with the advent of simulation, nurse educators now have a means by which to create scenarios that engender discomfort, fear, and/or unease while providing a safe environment for students. Nurse educators have the resources to walk students step-by-step through the process of personal belief and value identification, basic interpersonal skills and interprofessional collaboration, the identification and assessment of an ethical dilemma, the phases of an ethical decision-making model, and reflection on both the resolution of the dilemma (or lack thereof) and on how this experience will impact the future practice of the student. Students must begin to develop good habits of ethical decision-making. The more students are permitted to practice ethical decision-making and demonstrate ethical practice in the clinical setting, which includes the simulated clinical setting, the easier it is for nurse educators to foster and evaluate the development of ethical competence.

I recommend we take a moment to critically reflect and consider the nurses currently in practice, the healthcare environment, and the future of nursing. What we are currently doing regarding ethics education is not adequately preparing nurses to function in today's clinical environment. Although it may be desirable to develop a caring body of moral beings who are called to the profession of nursing, that may not be realistic. I recommend we utilize the findings in this study and continue to consider concrete ways to objectify actions and behaviors and set measureable goals and standards. Based on

the laments and requests of the interview participants, it may also be reasonable to begin to consider developing a more objective tool for the evaluation of ethical competence.

The development of such a tool would require further research that involves experts and authorities on nursing ethics and nursing education. The development of tools related to caring, empathy, self-esteem, ethical decision-making, and defining ethical issues could inform this work, but the integration of an expert panel would be required to develop a robust tool that measures the full extent of ethical competence as defined by qualified nurse educators.

Nurse educators need increased education, training, and access to resources. The mere fact that the interview participants did not universally or readily admit that they themselves thought they were ethically competent demonstrates this need. Books are readily available to provide guidance and insight for educators. As one example, Davis, Tschudin, and de Raeve (2006) edited a book that provides insight into teaching the teachers. National ethics institutes provide websites with detailed access to current publications and research (occasionally from their own peer-reviewed journals), relevant editorials, premiere books, and educational opportunities—one example of a website is the Kennedy Institute of Ethics from Georgetown University (2013). Tools have been developed that assist educators in opening the door to self-awareness and values assessment in students as they relate to ethical decision-making. For example, a relatively new tool, the Ethics Lens Inventory, provides insight for students regarding their value preferences, how those values impact their handling of ethical decisions, and how consideration of the values of the stakeholders involved in an ethical decision can decrease conflict (EthicsGame, 2011). The National League for Nursing (NLN; 2012)

issued a statement regarding the ethical issues prevalent in nursing education programs. By issuing this statement, the NLN “seeks to broaden ethical guidelines for nurse educators, to address the development of a culture and environment that is based on cooperation, support, and mutual enrichment needed to fulfill the educational goals of a program of learning” (National League for Nursing, 2012, Background section, para. 2). Caring, integrity, diversity, and excellence are highlighted as values core to the establishment of ethical practice in the learning environment, which was identified as an issue by the interview participants. There are a myriad of resources available, but they require a desire on the part of nurse educators to continue to develop and to learn how to best integrate nursing ethics into their curriculum. We must recognize that there is a learning gap that exists in large part due to the gap in the education the educators received themselves. Recognizing the issue is the first step towards resolving this gap in education that is potentiated by nurse educators who lack expertise in articulating and teaching ethics, specifically nursing ethics.

There is a reason all of the activities identified by the nurse educators were included in this dissertation (Table 11). Creation of a streamlined curricular approach to integrating ethics content and fostering the development of ethical competence in students is possible, but it requires a commitment from nurse educators to implement a concrete program of ethics instruction, adapt that program for individualized curriculum implementation, and commit to exemplify and expect ethical behavior in the academic and clinical environments. Ryden, Duckett, Crisham, Caplan, and Schmitz (1989) suggested a multi-course sequential learning (MCSL) model for integrating content throughout the curriculum and used ethics as a prototype topic for integration. Rooted in

moral development theory, their work sought to demonstrate how to integrate ethics, while ensuring adequate coverage and minimizing redundancies. They furthered this discussion (Duckett & Ryden, 1994) in a collaborative project designed to highlight moral development across a variety of professions including nursing, teaching (primary and college), counseling, accounting, dentistry, medicine, veterinary medicine, sports, and journalism. My concern is that almost 20 years later, despite the introduction of models and the call for transformation of theory to practical application, there is still not intentional integration adequate to support the ethical development of nursing students.

If ethical competence is viewed as a process, and not an event, allowing for the development of ethical competence in stages over the course of the nursing curriculum provides significant opportunity for recognition, engagement, and critical reflection. In the current environment where liberal education is valued, it is important to note that numerous courses in general education promote the development of ethical competence. There must also be more integration of the Code of Ethics. Merely asking students to read the code or referring to the code in general terms for exemplars of ethical practice does not instill in students the living, breathing embodiment of ethical competence the public and the profession seem to expect from them.

The fact that three of the interview participants had a background in behavioral health nursing provides the rationale for this specific example. Nurse educators must keep in mind that the focus of baccalaureate nursing education is creating baccalaureate nurse generalists. Generalists, though not experts in behavioral health, possess core knowledge, skills, and attitudes traditionally explored in a behavioral health course—skills such as therapeutic communication, harm reduction techniques, and contracting. These

provide the impetus for driving development of ethical competence. In this particular example, success is not defined by creating psychiatric nurses, but instead in capitalizing on specialty-specific ethical examples to provide students the opportunity to consider ethical principles, dilemmas, and practice from multiple perspectives. The nurse educators in this research clearly identified isolated experiences they intended to offer or have offered their students. If we consider those experiences, account for liberal education, superimpose the ANA code of ethics, and integrate the academic and clinical environments, nursing education can guarantee the opportunity for the development of ethical competence in its new graduates. Providing ethics education does significantly impact on the extent to which nurses engage in ethical activism, where nurses attempt to make hospitals more receptive to their participation in ethical deliberations (Dodd, Jansson, Brown-Saltzman, Shirk, & Wunch, 2004). Ethics education also influences the moral action of practicing nurses, which is supported by the correlation between ethics education and nurses' reports of being more confident in their moral judgments, more likely access ethics resources, and more likely to take moral action (Grady et al., 2008). The impact on the practice environment could be considerable. This type of integrated education is possible. In fact, I would argue that we already have pieces of it strewn throughout nursing curricula.

I challenge nurse educators to consider a possible template (Appendix L) for education that integrates the components of ethical competence and strives to highlight ethical practice and foster the development of ethical competence. The curriculum depicted includes basic courses offered at many nursing programs. Individual programs would need to absorb or reallocate topics based on courses actually offered in their

individual nursing curriculum. The content included in this template is based on the information obtained from the nurse educators who participated in this study. The template incorporates what educators currently know about ethics and how they know what they know, thus demonstrating intentional development of deliberate action and associated goals (Carper, 1978; Chinn & Kramer, 2011). The actual ethics content included in a comprehensive integrated model would need to be considered in light of work done by expert nurse ethicists who have done work on outlining essential ethics content (Fry, 1998; Fry, Veatch, & Taylor, 2011; Hamric, 2001; Quinn, 1990). Lewis (2013, October) is currently in the process of creating an updated detailed list of expert-generated essential ethics content for BSN programs using the methodology and model introduced by Quinn. This is important research that, once published, needs to be considered in tandem with the results of my research.

Nurse educators have the clinical experience and the academic background to appreciate the palpable differences between the practice of nursing students and licensed nurses. Nurse educators are responsible for helping to bridge that gap. We can — I would argue that we must — create an environment and curriculum that fosters the development of ethical competence in nursing students in order to prepare nurses who are able to promote the well-being of patients and manage care in the complex healthcare environment, articulate a sense of purpose and responsibility, and positively impact on the profession of nursing as a whole.

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Appendix A
Quantitative Survey

Screening Questions 1-4 (**Determine Eligibility**)

1. In which state is the nursing program where you teach located?

- California
- Illinois
- Texas
- New York
- Other (**EXCLUDE**)

2. Which of the following best describes your teaching assignment? (You may choose more than one answer.)

- BSN** – Entry-level
****A PRE-LICENSURE BSN OPTION MUST BE CHOSEN OR THE PARTICIPANT IS EXCLUDED**
- BSN** – Accelerated
- RN to BSN or LPN to BSN
- Master’s – All tracks (examples: RN to MSN, Master’s, Entry-level Master’s)
- Doctoral – All tracks (examples: BSN to PhD, PhD, DNP)
- Other

3. Is your BSN program accredited by the Commission on Collegiate Nursing Education (CCNE)?

- Yes
- No (**EXCLUDE**)

4. What is your employment status?

- Part-time
- Full-time
- Other (**EXCLUDE**)

****If inclusion criteria have not been met for state, CCNE-accreditation, or employment status, participants will be informed that they do not meet the requirements, they will be thanked, and the survey will end/close.**

5. Which title best describes your academic appointment?

- Professor
- Associate Professor
- Assistant Professor
- Lecturer
- Instructor
- Other (please specify)

6. How long have you been in your current position?

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21+ years

7. How long have you been a nurse educator (total)?

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21+ years

8. What is the highest degree you have received?

- Bachelor's degree
- Master's degree
- Doctorate

9. Have you had formal education in ethics? If yes, please indicate which degree required coursework in ethics. (You may choose more than one answer.)

- Associate
- Bachelor's
- Master's
- Doctorate
- Post-doctoral work
- I have never had formal ethics education

10. If you received formal ethics education in college, please indicate whether the education was provided in a stand-alone course or if the ethics education was integrated into other courses. (You may choose more than one answer.)

- ADN: stand-alone course in ethics
- ADN: integrated ethics content
- BSN: stand-alone course in ethics
- BSN: integrated ethics content
- MS/MSN: stand-alone course in ethics
- MS/MSN: integrated ethics content
- Doctorate: stand-alone course in ethics
- Doctorate: integrated ethics content

11. Excluding the coursework mentioned previously, have you participated in any other ethics training in the past five years? (You may choose more than one answer.)

- Continuing education session(s)
- Case presentation(s)
- Webinar(s)
- Clinical ethics consultation training
- Other (please specify)
- No training in ethics in the past five years

12. Describe the focus of your ethics education during your pre-licensure (Diploma/ADN/BSN) nursing program. (200 character maximum)

13. Describe the focus of your ethics education during your graduate education. (200 character maximum)

14. Describe what you learned about ethics once you became a practicing nurse. (200 character maximum)



15. Does the pre-licensure BSN nursing program where you currently teach require a stand-alone ethics course? (You may choose more than one answer.)

- Liberal education/Prerequisite - general ethics course
- Nursing ethics course
- Bioethics course
- Other (please specify)
- My program does not require a course in ethics

16. If your pre-licensure BSN nursing program requires a course in nursing ethics, when is this course required (per the traditional curriculum plan)?

- Prerequisite course
- Freshman year of nursing program
- Sophomore year of nursing program
- Junior year of nursing program
- Senior year of nursing program
- Comment (if needed)

17. Which pre-licensure BSN course(s) do you regularly teach? (You may choose more than one answer.)

18. For each course chosen, please indicate the percentage of questions on your course examinations that specifically address ethics content.

Which pre-licensure BSN course(s) do you regularly teach? (You may choose more than one answer.)

For each course chosen, please indicate the percentage of questions on your course examinations that specifically address ethics content.

	Course(s) Regularly Taught	Percentage of Questions on Exams with Ethics Content
Pre-Licensure BSN		
Nursing ethics	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Nursing ethics	Percentage of Questions on Exams with Ethics Content - Nursing ethics <input type="text"/>
Foundational nursing	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Foundational nursing	Percentage of Questions on Exams with Ethics Content - Foundational nursing <input type="text"/>
Foundational nursing clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Foundational nursing clinical	Percentage of Questions on Exams with Ethics Content - Foundational nursing clinical <input type="text"/>
Health assessment	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Health assessment	Percentage of Questions on Exams with Ethics Content - Health assessment <input type="text"/>
Health assessment lab/clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Health assessment lab/clinical	Percentage of Questions on Exams with Ethics Content - Health assessment lab/clinical <input type="text"/>
Medical-surgical nursing	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Medical-surgical nursing	Percentage of Questions on Exams with Ethics Content - Medical-surgical nursing <input type="text"/>
Medical-surgical nursing clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Medical-surgical nursing clinical	Percentage of Questions on Exams with Ethics Content - Medical-surgical nursing clinical <input type="text"/>
Behavioral health nursing	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN -	Percentage of Questions on Exams with Ethics Content - Behavioral health nursing

Which pre-licensure BSN course(s) do you regularly teach? (You may choose more than one answer.)

For each course chosen, please indicate the percentage of questions on your course examinations that specifically address ethics content.

	Course(s) Regularly Taught	Percentage of Questions on Exams with Ethics Content
Pre-Licensure BSN		
	Behavioral health nursing	<input type="text"/>
Behavioral health nursing clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Behavioral health nursing clinical	Percentage of Questions on Exams with Ethics Content - Behavioral health nursing clinical <input type="text"/>
Pediatric nursing	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Pediatric nursing	Percentage of Questions on Exams with Ethics Content - Pediatric nursing <input type="text"/>
Pediatric nursing clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Pediatric nursing clinical	Percentage of Questions on Exams with Ethics Content - Pediatric nursing clinical <input type="text"/>
Women's health (L&D) nursing	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Women's health (L&D) nursing	Percentage of Questions on Exams with Ethics Content - Women's health (L&D) nursing <input type="text"/>
Women's health (L&D) nursing clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Women's health (L&D) nursing clinical	Percentage of Questions on Exams with Ethics Content - Women's health (L&D) nursing clinical <input type="text"/>
Geriatric nursing	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Geriatric nursing	Percentage of Questions on Exams with Ethics Content - Geriatric nursing <input type="text"/>
Geriatric nursing clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Geriatric nursing clinical	Percentage of Questions on Exams with Ethics Content - Geriatric nursing clinical <input type="text"/>
Capstone/Immersion course	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Capstone/Immersion course	Percentage of Questions on Exams with Ethics Content - Capstone/Immersion course <input type="text"/>

Which pre-licensure BSN course(s) do you regularly teach? (You may choose more than one answer.)

For each course chosen, please indicate the percentage of questions on your course examinations that specifically address ethics content.

	Course(s) Regularly Taught	Percentage of Questions on Exams with Ethics Content
Pre-Licensure BSN		
Capstone/Immersion clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Capstone/Immersion clinical	Percentage of Questions on Exams with Ethics Content - Capstone/Immersion clinical <input type="text"/>
Public health nursing	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Public health nursing	Percentage of Questions on Exams with Ethics Content - Public health nursing <input type="text"/>
Public health nursing clinical	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Public health nursing clinical	Percentage of Questions on Exams with Ethics Content - Public health nursing clinical <input type="text"/>
Transcultural/Global health/Vulnerable populations	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Transcultural/Global health/Vulnerable populations	Percentage of Questions on Exams with Ethics Content - Transcultural/Global health/Vulnerable populations <input type="text"/>
Management and/or Leadership	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Management and/or Leadership	Percentage of Questions on Exams with Ethics Content - Management and/or Leadership <input type="text"/>
Professional development	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Professional development	Percentage of Questions on Exams with Ethics Content - Professional development <input type="text"/>
Nursing research	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Nursing research	Percentage of Questions on Exams with Ethics Content - Nursing research <input type="text"/>
Pharmacology	<input type="checkbox"/> Course(s) Regularly Taught - Pre-Licensure BSN - Pharmacology	Percentage of Questions on Exams with Ethics Content - Pharmacology <input type="text"/>
Other (please specify)	<input type="checkbox"/> Course(s)	Percentage of Questions on Exams with Ethics <input type="text"/>

Which pre-licensure BSN course(s) do you regularly teach? (You may choose more than one answer.)

For each course chosen, please indicate the percentage of questions on your course examinations that specifically address ethics content.

Course(s) Regularly Taught	Percentage of Questions on Exams with Ethics Content
<input type="text"/>	Pre-Licensure BSN Regularly Taught - Pre-Licensure BSN - Other (please specify) <input type="text"/>

19. Please describe any intentional inclusion of ethics content in the pre-licensure BSN nursing course(s) you regularly teach (ex. learning objectives, teaching activities, projects, case studies).

20. What *knowledge* of ethics is required for nursing students to become ethically competent?

21. What *skills* determine ethical competence in nursing students?

22. What *attitudes* reflect the development of ethical competence in nursing students?

23. Would you be willing to participate in a phone interview to discuss the development of ethical competence in your students?

- Yes
- No

24. Please enter your name, email address, and phone number

A rectangular form with a dotted border. On the right side, there are three small buttons: an upward-pointing triangle, a square, and a downward-pointing triangle. On the bottom side, there are two small buttons: a left-pointing triangle and a right-pointing triangle.

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Appendix B

Guiding Qualitative Interview Questions (Draft)

1. What does ethical competence mean to you?
2. What is your experience with the development of ethical competence in your students?
3. How do you know your students are developing/have developed ethical competence? How do you know when a student is not ethically competent?
[KSA]
4. Does the concept of goodness relate to ethical competence in nurses?
5. Can you describe your personal level of ethical competence? When and how did you develop this competence?
6. In your dream world, how would you like to develop ethical competence in nursing students? What are the constraints/barriers?
7. What *knowledge* of ethics is required for ethical competence in nursing students?
8. What *skills* are required for ethical competence in nursing students?
9. What *attitudes* regarding ethics are required for ethical competence in nursing students?

Appendix C



INFORMED CONSENT FOR SURVEY PARTICIPANTS [ONLINE]

Department of Nursing

TITLE OF STUDY: Developing Ethical Competence: The Perspective of Nurse Educators from Pre-Licensure Baccalaureate Nursing Programs Accredited by the Commission on Collegiate Nursing Education

INVESTIGATOR(S): Dr. Lori Candela (Primary Investigator); Jennifer L. Bartlett Ph.D., RN-BC, CNE (Student Investigator)

For questions or concerns about the study, you may contact the primary investigator, Lori Candela at 702-895-2443 or lori.candela@unlv.edu and/or the student investigator, Jennifer Bartlett, at (440) 539-0299 or bartle57@unlv.nevada.edu.

For questions regarding the rights of research subjects, or any complaints or comments regarding the manner in which the study is being conducted, contact the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to describe the concept of ethical competence from the perspective of baccalaureate nursing faculty and describe current methods of integration and evaluation of ethics education in pre-licensure baccalaureate nursing programs. In order to understand how nurse educators develop ethical competence in their pre-licensure nursing students and establish baseline expectations regarding the ethical competence of new nurses, this research will be conducted using a mixed method approach. The first phase of this mixed method study includes an online survey designed to gather beginning information from nurse educators. The second phase of the study involves telephone interviews designed to more fully explore the concept of ethical competence.

Participants

You are being asked to participate in the study because you fit these criteria: part-time or full-time nursing faculty in a pre-licensure baccalaureate nursing (entry-level or accelerated/ABSN) program at a CCNE-accredited program in California, Illinois, Texas, or New York. You will be excluded from this study if you do not meet all of these criteria.

Procedures

If you volunteer to participate in this study, you will be asked to complete the online survey. The final question on the survey asks whether you would also be willing to participate in a personal phone interview. Your answer to this question may lead to follow-up contact by the student researcher. By providing your name, email, and phone number, your survey responses may be linked with your personal information by the student researcher. A separate informed consent procedure will precede any interview.

Benefits of Participation

There may not be direct benefits to you as a participant in this study. However, the study provides the opportunity for you to reflect on the concept of ethical competence, which may provide insight into your academic and professional role.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks. You will be disclosing personal information regarding your education, experience, and workplace.

Cost/Compensation

There is no financial cost to you to participate in this study. The online survey will take approximately 20 minutes of your time. If you agree and are contacted to participate in the telephone interview, an additional 45 minutes will be required. You will not be compensated for your time.

Confidentiality

All information gathered in this study will be kept confidential. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for three years after completion of the study. After the storage time the information gathered will be destroyed.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this survey or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV.

Participant Consent

I have read the above information and agree to participate in this study. I am at least 18 years of age. Completion of this survey constitutes consent.

Note: Based on the [Adult] Informed Consent Form from UNLV's Office of Research Integrity - Human Subjects
<http://www.unlv.edu/research/forms-unit>

Appendix D



INFORMED CONSENT FOR INTERVIEW PARTICIPANTS

Department of Nursing

TITLE OF STUDY: Developing Ethical Competence: The Perspective of Nurse Educators from Pre-Licensure Baccalaureate Nursing Programs Accredited by the Commission on Collegiate Nursing Education

INVESTIGATOR(S): Dr. Lori Candela (Primary Investigator); Jennifer L. Bartlett PhDc, RN-BC, CNE (Student Investigator)

For questions or concerns about the study, you may contact the primary investigator, Lori Candela at 702-895-2443 or lori.candela@unlv.edu and/or the student investigator, Jennifer Bartlett, at (440) 539-0299 or bartle57@unlv.nevada.edu.

For questions regarding the rights of research subjects, or any complaints or comments regarding the manner in which the study is being conducted, contact the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to describe the concept of ethical competence from the perspective of baccalaureate nursing faculty and describe current methods of integration and evaluation of ethics education in pre-licensure baccalaureate nursing programs. In order to understand how nurse educators develop ethical competence in their pre-licensure nursing students and establish baseline expectations regarding the ethical competence of new nurses, this research will be conducted using a mixed method approach. The first phase of this mixed method study includes an online survey designed to gather beginning information from nurse educators. The second phase of the study involves telephone interviews designed to more fully explore the concept of ethical competence.

Participants

You are being asked to participate in the study because you fit these criteria: part-time or full-time nursing faculty in a pre-licensure baccalaureate nursing (entry-level or accelerated/ABSN) program at a CCNE-accredited program in California, Illinois, Texas, or New York; completed online survey. You will be excluded from this study if you do not meet all of these criteria.

Procedures

If you volunteer to participate in this study, you will be asked to participate in a phone interview with the primary investigator. By agreeing to participate and providing your name, email, and phone number, your survey and interview responses may be linked with your personal information by the student researcher.

Benefits of Participation

There may not be direct benefits to you as a participant in this study. However, the study provides the opportunity for you to reflect on the concept of ethical competence, which may provide insight into your academic and professional role.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks. You will be disclosing personal information regarding your education, experience, and workplace.

Cost /Compensation

There is no financial cost to you to participate in this study. The study will take approximately 45 minutes of your time. An additional 15 minutes may be required for follow-up questions. You will not be compensated for your time.

Confidentiality

All information gathered in this study will be kept confidential. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for three years after completion of the study. After the storage time the information gathered will be destroyed.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may refuse to answer any interview question and may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:

I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

Signature of Participant

Date

Participant Name (Please Print)

Audio/Video Taping:

I agree to be audio taped for the purpose of this research study.

Signature of Participant

Date

Participant Name (Please Print)

Please print this document, sign where indicated, scan the document (into a pdf file), and email the file to the student investigator, Jennifer Bartlett, at bartle57@unlv.nevada.edu

**Please keep a signed copy for your records.

Note: Based on the [Adult] Informed Consent Form from UNLV's Office of Research Integrity - Human Subjects
<http://www.unlv.edu/research/forms-unit>

Appendix E

CCNE-Accredited Nursing Programs

As of August 17, 2012		
STATE	NUMBER OF CCNE-ACCREDITED BSN PROGRAMS	NUMBER OF NLNAC-ACCREDITED BSN PROGRAMS
	http://apps.aacn.nche.edu/CCNE/reports/rptAccreditedPrograms_New.asp?sort=state&sProgramType=1#AK	http://nlnac.org/forms/directorySearch.asp
Alabama	12	3
Alaska	0	1
Arizona	5	0
Arkansas	4	8
California	38	2
Colorado	8	4
Connecticut	8	1
Delaware	3	2
DC	5	1
Florida	19	10
Georgia	14	11
Hawaii	2	2
Idaho	3	2
Illinois	29	7
Indiana	16	10
Iowa	15	1
Kansas	13	2
Kentucky	10	4
Louisiana	9	6
Maine	5	1
Maryland	7	4
Massachusetts	16	4
Michigan	19	4
Minnesota	23	1
Mississippi	6	1
Missouri	19	4
Montana	3	2
Nebraska	4	5
Nevada	4	2
New Hampshire	3	2
New Jersey	15	5
New Mexico	5	1
New York	38	11
North Carolina	15	5
North Dakota	4	3
Ohio	29	10
Oklahoma	5	12
Oregon	4	1
Pennsylvania	32	16 (1 closing 5-13 included)
Rhode Island	2	1
South Carolina	9	4
South Dakota	5	1
Tennessee	17	9
Texas	29	9
Utah	5	4
Vermont	2	1
Virginia	16	3
Washington	11	0
West Virginia	6	4
Wisconsin	19	0
Wyoming	1	0
	591	191

Appendix F

Email to BSN Program Contact

BSN Program Contact –

My name is Jennifer Bartlett and I am a PhD candidate at UNLV completing my dissertation. The purpose of this study is to explore *ethical competence* as described by those responsible for teaching in order begin to articulate how nurse educators develop ethical competence in their nursing students, and establish baseline expectations regarding the ethical competence of new nurses. Nurse educators asked to participate in this survey teach pre-licensure BSN students and are employed part-time or full-time at a CCNE-accredited program that is located in one of four identified states (California, Illinois, Texas, or New York).

The first part of this mixed method study includes an online survey. I would greatly appreciate if you would forward this link to *all full-time and part-time nursing faculty*. Please note that the first few questions of the survey will determine if the nurse educator meets the eligibility requirements.

Please click the following link to review the informed consent for this study and begin the survey: **LINK HERE**

The survey will only be available until 04-26-2013, so please complete it as soon as possible.

This survey should only require approximately 20 minutes of your time.

I truly appreciate your support of research!

Jennifer L. Bartlett MSN, RN-BC, CNE
UNLV School of Nursing – PhD Candidate

Appendix G

Comparison of the Nodes and Categories Identified for the Knowledge, Skills, and Attitudes Attributed to Ethical Competence

Knowledge	% Coverage (#Responses)	Skills	% Coverage (#Responses)	Attitudes	% Coverage (#Responses)
Foundational principles, theory	24.88% (58)	Foundational principles	1.42% (5)	Foundational principles, theory • Justice, access, fairness	6.32% (14) • 2.56% (8)
Code of ethics • Professional standards • Standards of care	15.69% (37) • 11.43% (25) • 0.91% (2)	Code of ethics • Professional standards • Standards of care • Clinical competence	9.58% (21) • 6.19% (14) • 2.69% (5) • 0.70% (2)	Code of ethics • Professionalism • Clinical competence	5.10% (10) • 3.77% (7) • 1.32% (3)
Decision-making • Critical thinking • Moral reasoning, integrity, purpose	9.74% (27) • 1.28% (3) • 1.06% (3)	Decision-making • Critical thinking • Problem-solving • Judgment • Reasoning : logical, clinical	16.79% (41) • 5.44% (16) • 1.66% (4) • 0.35% (2) • 1.37% (4)	Critical thinking, clinical judgment	0.58% (1)
Application in practice	9.68% (27)	Application in practice • Limitations	7.69% (13) • 0.66% (2)		
Personal awareness and development • Reflection	5.16% (15) • 0.65% (2)	Personal awareness and development • Reflection	5.21% (14) • 0.49% (2)	Personal awareness and development • Reflection • Positive attitude	12.80% (40) • 1.94% (10) • 1.85% (5)
Recognition of ethical dilemma or issue	5.41% (13)	Recognition of ethical dilemma • Handling dilemma	6.21% (16) • 1.56% (2)	Recognition of ethical dilemma • Viewing perspectives	6.56% (10) • 4.28% (6)
No answer (not clear, do not know, do not measure, a lot, not equipped)	9.36% (12)	No answer (not clear, do not know, do not measure, difficult to measure, all of them)	7.03% (9)	No answer (not clear, do not know, difficult to measure, attitudes)	4.93% (7)
Resources	3.21% (11)	Resources	2.59% (8)		
Legal	2.88% (6)	Legal	1.21% (3)		
Communication • Assertive, despite discomfort	1.42% (5) • 0.22% (1)	Communication • Assertive, despite discomfort • Advocacy • Listening • Asking questions • Coaching • Crisis intervention • Health literacy	20.39% (68) • 1.58% (4) • 3.00% (12) • 1.81% (8) • 1.29% (4) • 0.17% (1) • 0.07% (1) • 0.19% (1) • 0.07% (1)	Communication • Advocacy • Listening • Asking questions • Role-modeling	11.36% (27) • 3.45% (8) • 1.91% (5) • 3.88% (6)

Knowledge	% Coverage (#Responses)	Skills	% Coverage (#Responses)	Attitudes	% Coverage (#Responses)
		• Perceptive • Verbalizing feelings	• 0.78% (1)		
Academic environment	2.95% (5)	Academic environment • Measuring in students	7.49% (10) • 6.25% (8)	Academic environment • Measuring in students	4.21% (6) • 4.21% (6)
Cultural competence	1.62% (3)	Cultural competence	0.15% (2)	Cultural competence	0.75% (3)
Caring	0.25% (2)	Caring, compassion, empathy	2.31% (14)	Caring, compassion, empathy	10.42% (28)
Ethical behavior	0.78% (1)	Behaviors, response to situations	6.33% (11)		
Not possible for students	2.87% (5)				
Grieving	0.03% (1)				
		Organizational	0.50% (2)		
		Sensitivity	0.37% (1)		
		Exposure	0.78% (1)		
				Open-minded • Willingness	13.37% (30) • 1.09% (3)
				Patient focus • Holistic care • Separation of personal self	12.76% (28) • 0.78% (1) • 5.84% (10)
				Tolerance for ambiguity	1.61% (4)
				Avoiding endemic problem	1.25% (2)
				Cooperative	0.14% (1)
				Sense of right and wrong	0.10% (1)

Appendix H

Guiding Qualitative Interview Questions

1. What does ethical competence mean to you?
2. What is your experience with the development of ethical competence in your students?
(clinical/classroom differences?)
3. How do you know your students are developing/have developed ethical competence? How do you know when a student is not ethically competent?
[Note: What actual action can/should/do nursing students take in response to ethical dilemmas]
4. Does the concept of goodness relate to ethical competence in nurses? Personal character? How do beliefs and values, both personal and professional, impact on the development of ethical competence in students? Impact on patient care?
5. Can you describe your personal level of ethical competence? When and how did you develop this competence?
6. In your dream world, how would you like to develop ethical competence in nursing students? What are the constraints/barriers? What measurement or tools do/could you use to ensure the development of ethical competence?
[Note: Models, theories, principles, definitions, frameworks]
7. What *knowledge* of ethics is required for ethical competence in nursing students?
8. What *skills* are required for ethical competence in nursing students?
9. What *attitudes* regarding ethics are required for ethical competence in nursing students?

Appendix I
Basic Rubric: Identification of Interview Participants

<p>Step 1. Review of responses to questions regarding knowledge, skills, and attitudes</p> <ul style="list-style-type: none"> • Content and Format <ul style="list-style-type: none"> ○ Common themes and/or categories represented – representative of the original sample ○ Unique idea(s) presented – word, perspective, articulation, new idea ○ Clear articulation of ideas ○ Responses to the three questions distinct (not redundant) 	<p style="text-align: center;">Yes/No</p> <p style="text-align: center;"><i>Yes</i> required for all 4 specific content areas</p>
<p>Step 2. Using their ID numbers only, compared the list of participants identified in step one to the list of survey respondents who agreed to participate in the interview</p> <ul style="list-style-type: none"> • Identification of the 18 respondents who met all of the criteria identified in step one • 10/18 had agreed to participate in the interview 	<p style="text-align: center;">10 interview participants identified</p>
<p>Step 3. Reviewed this list of 10 for state representation</p> <ul style="list-style-type: none"> • Noted that no respondents from New York included in this original list • Review of responses for respondents from New York who had agreed to participate in the interview • Identified the top two respondents (based on the criteria from step one) and added them to the 10 for a total of 12 potential interview participants 	<p style="text-align: center;">CA = 4 IL = 2 TX = 4 <u>NY = 2</u> 12</p>
<p>Step 4. Reviewed this list of 12 to ensure broad specialty representation</p> <ul style="list-style-type: none"> • 24 distinct courses/clinicals taught by potential participants • Nursing ethics (1), Foundations (2), Foundations clinical (2), Health assessment (2), Health assessment lab/clinical (2), Medical-surgical (2), Medical-surgical clinical (3), Behavioral health (3), Behavioral health clinical (3), Pediatrics (2), Pediatrics clinical (2), Women’s health (L&D) (1), Women’s health (L&D) clinical (1), Geriatrics (2), Geriatrics clinical (1), Immersion (1), Public health (1), Public health clinical (1), Transcultural/Global health/Vulnerable (1), Management/Leadership (1), Research (1), Advanced therapeutics simulation lab (1), Elective in addiction (1), Health promotion (1) 	<p style="text-align: center;">All respondents indicate teaching more than one course</p> <p style="text-align: center;">*24 courses represented</p>
<p>Step 5. Reviewed this list of 12 for degree representation</p> <ul style="list-style-type: none"> • Noted all three degrees represented (BSN, Master’s, Doctoral) 	<p style="text-align: center;">BSN = 1 Master’s = 6 Doctoral = 5</p>
<p>Step 6. Reviewed formal education and training for the 12 participants</p> <ul style="list-style-type: none"> • Review of formal ethics education and training in the past five years • Only one respondent had no formal education <i>or</i> no training in the past five years 	<p style="text-align: center;">No formal = 4 No training (5 years) = 2</p>

<p>Step 7. Ranked potential interview participants</p> <ul style="list-style-type: none">• Randomly chose one participant from each state who has a doctoral degree• Chose one participant from each state who has a master's degree (ensured broad course representation)• Included the lone participant with the BSN (CA; no formal/no training)• Included the remaining participant candidate with a doctoral degree (TX)• Randomly included remaining two respondents with Master's degrees	
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Appendix J

Email to Potential Interview Participants

XXX-

My name is Jennifer Bartlett and I am a PhD candidate at UNLV completing my dissertation. Last spring you completed an online survey regarding *ethical competence* and agreed to participate in a telephone interview. I appreciate your willingness to participate and I am contacting you set up a time to complete the interview.

In order to expedite this process, I ask that you please do the following:

1. Please read, print, sign, scan, and return the attached participant interview informed consent document (Appendix D). Please contact me if you would like technical assistance with the informed consent documentation. Please forward your completed informed consent document to bartle57@unlv.nevada.edu.
2. Please indicate how you would prefer to communicate to arrange the telephone interview. If you would like me to call you to set up a time, please email me your preferred phone number. If you would prefer, please send me 3-4 days/times next week August 18-August 24 when you have availability. I will email you to confirm your date/time.

The purpose of this study is to explore *ethical competence* as described by those responsible for teaching in order begin to articulate how nurse educators develop ethical competence in their nursing students, and establish baseline expectations regarding the ethical competence of new nurses. Nurse educators asked to participate in this survey teach pre-licensure BSN students and are employed part-time or full-time at a CCNE-accredited program that is located in one of four identified states (California, Illinois, Texas, or New York).

The first phase of this mixed method study includes an online survey designed to gather beginning information from nurse educators. The second phase of the study involves telephone interviews designed to more fully explore the concept of ethical competence. This interview is designed to require approximately 45 minutes of your time; an additional 15 minutes may be required for follow-up questions.

I truly appreciate your support of research!

Jennifer L. Bartlett MSN, RN-BC, CNE
UNLV School of Nursing – PhD Candidate
bartle57@unlv.nevada.edu
(440) 539-0299

Appendix K

Matrix of Themes and Subthemes by Interview Participant

Themes	Participant A	Participant B	Participant C	Participant D	Participant E
Who students are	X	X	X	X	X
• Upbringing	X	X	X	X	
• Self awareness	X	X	X	X	X
• Characteristics	X	X	X	X	X
◦ Character		X	X		X
◦ Goodness	X		X	X	X
◦ Honesty	X	X		X	
◦ Empathy	X	X	X	X	X
Religion/spirituality	X		X	X	X
• Religion	X			X	X
◦ Golden Rule	X				X
• Spirituality	X		X		X
Nursing role	X	X	X	X	X
• Moral community	X	X	X		X
• Service	X	X	X	X	X
• Hidden relationship			X	X	
Power	X	X	X	X	X
• Powerlessness	X	X	X	X	X
• Potential power	X	X	X		X
Experience	X	X	X	X	X
• Clinical	X	X	X	X	X
• Age	X	X	X	X	X
Barriers	X	X	X	X	X
• Knowledge deficit	X	X		X	X
• Content overload	X	X	X	X	
• Nurse practice issues	X		X	X	X
TOTAL QUOTES	12	9	10	12	11

X = Addressed by Interview Participant
 X = Addressed by Interview Participant
 AND Quoted in Body of Paper

Themes	Participant A	Participant B	Participant C	Participant D	Participant E
Role of the Nurse Educator in the Development of Ethical Competence					
• Teach students: It's not about you	X	X	X	X	X
• Provide intentional and explicated integration of ethics	X	X	X	X	X
• Introduce ethical terms early	X	X	X		X
• Foster insight beyond belief systems	X	X	X	X	X
• Capitalize on situations	X	X	X	X	X
• Role-model	X	X	X	X	X
• Identify the fakers and praise the performers	X			X	

X = Addressed by Interview Participant

Appendix L

Curriculum Template for the Promotion of the Development of Ethical Competence

Basic Course Description	Course & Clinical (Practice/Simulation) Content [Based on survey responses and interviews]	ANA Code of Ethics (2001) – Provision Number/Name
Nursing Theory or Fundamentals	<ul style="list-style-type: none"> • ANA code of ethics introduction • Patient Rights introduction • Theoretical foundations and philosophical roots of nursing ethics • Basic ethical principles including autonomy, beneficence, nonmaleficence, and justice • Introduction of terms including: ethical dilemma, moral distress, moral courage, advocacy, morality, right/wrong, intraprofessional collaboration, organizational ethics, just culture, right to decide, veracity, honesty, confidentiality, dignity, integrity, accountability, empathy, compassion, caring, moral agency (CCNE) 	1.1 Respect for human dignity 3.1 Privacy 3.2 Confidentiality 4.2 Accountability for nursing judgment and action 5.1 Moral self-respect 6.1 Influence of the environment on moral virtues and values 9.1 Assertion of values 9.2 The profession carries out its collective responsibility through professional associations 9.3 Intraprofessional integrity
Health Assessment	<ul style="list-style-type: none"> • Interviewing techniques – ethics therein • Ethics of documentation and error reporting • Confidentiality • Therapeutic communication techniques • Cultural competence introduction 	1.2 Relationships to patients 2.1 Primacy of the patient’s interests 2.4 Professional boundaries
Medical-surgical	<ul style="list-style-type: none"> • Ethical dilemmas including end-of-life situations and treatment/no treatment situations, futility, transplantation • Informed consent practices – basic requirements, capacity, exceptions • Referrals and resources – clinical ethics consultation, palliative care, chaplains, risk management • Ethical behaviors and clinical expectations • Critical reflection: self-awareness, evaluation • Differentiate ethical issues from other issues and employ ethical decision-making model 	1.3 The nature of health problems 4.4 Delegation of nursing activities
Community/Public Health	<ul style="list-style-type: none"> • Specific potential ethical issues involving noncompliance, and ethics related to epidemiology and communicable diseases • Introduction of terms including: social justice, distributive justice, utilitarianism, vulnerable populations, and health disparities • Public perception and role of the nurse • Differentiate ethical issues from other issues and employ ethical decision-making model 	8.1 Health needs and concerns 8.2 Responsibilities to the public 9.4 Social reform

Basic Course Description	Course & Clinical (Practice/Simulation) Experiences [Based on survey responses and interviews]	ANA Code of Ethics (2001) – Provision Number/Name
Mental Health	<ul style="list-style-type: none"> • Legal protections for persons with mental illness • Specific potential ethical issues including consent/capacity issues, involuntary care, restraints/seclusion, paternalism, confidentiality, and harm reduction • Differentiate ethical issues from other issues and employ ethical decision-making model 	
Women’s Health or Labor and Delivery	<ul style="list-style-type: none"> • Specific potential ethical issues involving fetal demise, Catholic implications, end-of- life decisions juxtaposed with new life, genetics/genomics, preterm infants/edge of viability, artificial reproductive issues, embryo ownership/storage, surrogacy, right to life and human dignity, and abortion consent • Differentiate ethical issues from other issues and employ ethical decision-making model 	
Pediatrics	<ul style="list-style-type: none"> • Specific potential ethical issues involving fetal development, congenital abnormalities, end-of-life care for children, abuse, parenting, differing wishes (parent, child, healthcare team), advocacy in pediatrics • Differentiate ethical issues from other issues and employ ethical decision-making model 	
Nursing Ethics	<ul style="list-style-type: none"> • Focus on nursing ethics - relationships • Differentiate ethical issues from other issues and employ ethical decision-making model • Review of ethical theory as needed • Focus on everyday ethics; inclusion of classic ethical dilemmas • Intense review of ANA code of ethics • Review of resources available to nurses • Specific ethical concepts including organizational ethics, conflicts and breakdowns, advocacy; moral distress, moral courage, bioethical dilemmas, informed consent, alternative treatment issues, stem cell research, therapeutic and reproductive cloning 	<p>1.4 The right to self-determination 2.2 Conflict of interest for nurses</p>
Leadership or Management	<ul style="list-style-type: none"> • Specific potential ethical issues involving daily nursing practice, organizational ethics, nursing leadership • Risk management – root cause analysis, error prevention • Environmental scan – ethical implications 	<p>1.5 Relationships with colleagues and others 2.3 Collaboration 3.4 Standards and review mechanisms 3.5 Acting on questionable practice 3.6 Addressing impaired practice 6.2 Influence of the environment on ethical obligations 6.3 Responsibility for the health care environment</p>

Basic Course Description	Course & Clinical (Practice/Simulation) Experiences [Based on survey responses and interviews]	ANA Code of Ethics (2001) – Provision Number/Name
Research	<ul style="list-style-type: none"> • Specific potential ethical issues involving ethical, legal, and moral issues inherent in the research process, discuss the role(s) of social justice as it relates to ethical, legal, and moral issues in research, protection of human participants, examples of ethical/unethical research • Evidence-based practice 	3.3 Protection of participants in research 7.1 Advancing the profession through active involvement in nursing and in health care 7.3 Advancing the profession through knowledge development, dissemination, and application to practice
Capstone	<ul style="list-style-type: none"> • Specific potential ethical issues involving clinical practice experience of students • Professional organizations – purpose, benefits • Critical reflection: self-awareness, evaluation • Review of the role as a professional nurse • Moral community of nursing 	4.1 Acceptance of accountability and responsibility 4.3 Responsibility for nursing judgment and action 5.2 Professional growth and maintenance of competence 5.3 Wholeness of character 5.4 Preservation of integrity 7.2 Advancing the profession by developing, maintaining, and implementing professional standards in clinical, administrative, and educational practice

Jennifer L. Bartlett PhD(c), RN-BC, CNE

Current Position	Year
Assistant Professor (Part-time) WellStar School of Nursing Kennesaw State University 1000 Chastain Rd NW Kennesaw, GA 30144	Fall 2013
<hr/> Education <hr/>	
PhD – Focus in Nursing Education <i>University of Nevada Las Vegas Las Vegas, Nevada</i>	Expected Fall 2013
MSN – Focus in Nursing Education <i>Old Dominion University Norfolk, VA</i>	2009
BSN – Certification in Gerontology <i>Cleveland State University Cleveland, OH</i>	1995
<hr/> Certifications/ Licenses <hr/>	
Certified Nurse Educator (CNE) – National League for Nursing	2010-2015
Medical-Surgical Nursing – Board Certification #2009008505 <i>ANCC</i>	2009-2014
License to Practice as a Registered Nurse: #RN233639 <i>Georgia Board of Nursing</i>	2013-2016
CPR – BLS Instructor <i>American Heart Association</i>	2012-2014
CPR – ACLS Instructor <i>American Heart Association</i>	2013-2015
NIHSS Certification	March 2010

Recent Academic Role	Year
<p>ASSISTANT PROFESSOR (PROMOTED TO ASSOCIATE PROFESSOR FOR 2013-2014) <i>Bon Secours Memorial College of Nursing (BSMCON), Richmond, VA</i></p>	2006-2013
<p>Job Description: Functions within the framework of the philosophy and goals of Bon Secours Richmond and Bon Secours Memorial College of Nursing. Participates in the assessment, planning, implementation, analysis, and evaluation of the curriculum. Responsibilities include teaching, service, practice, and scholarship. Practices nursing according to the Code for Nurses of the American Nurses' Association. Participates in the faculty and school organizations, and forms responsibilities with the professional community. Interprets and articulates the curriculum to students, alumni, cooperating agencies, and other stakeholders. Embraces the philosophies of caring and servant leadership.</p>	
<p>Teaching Assignments: Primary faculty/lecturer in the Adult Medical-Surgical course (NUR 3111), lead faculty in Competencies course (NUR 3104; a skills-based, laboratory/clinical course). Guest lecturer in several other courses.</p>	
<p>Curriculum Development: Core member of BSN-Builders, a committee focused on development of the new BSN curriculum 2008-2010. Engaged in development of program outcomes, individual course objectives, and syllabi as a whole, including preparing all documents for submission to the VA Board of Nursing. Led a special committee dedicated to the review of course syllabi, intended to ensure appropriate intention and content. Personally involved in the development and implementation of four new courses (two Medical-Surgical and two Competencies, skills-based courses). Also co-chair of a special committee charged with development, implementation, and evaluation of a clinical evaluation tool.</p>	
<p>Program Improvement: Chair of Program Improvement Committee 2008-2012. Led the faculty through extensive education and data collection – provided support, education, and creation of documents used in CCNE self-study (resulted in accreditation of the new BSN program). Liaison with all departments (program and college) – institutional effectiveness focus. Although not implemented on a mass scale, developed a working knowledge of WEAVE assessment and planning management tool. Assisted with interviewing and onboarding the Director of institutional Effectiveness (new position).</p>	

Strategic Planning: One of two faculty members hand-chosen to create a strategic plan for the college; worked in conjunction with other departments, under the direction of the Provost to develop mission, vision, and philosophy statements. Required an eight-month commitment – extensive interaction between this committee and the faculty at-large.

Service:

Ethics Committee Sitting member of the Bon Secours Richmond Ethics Committee (since 2009). Engaged in the development and implementation of educational activities. Nurse Planner for the Ethics of Caring 2013 National Nursing Ethics Conference. Formal Clinical Ethics Consultation training – 2 year program completed May, 2013; curriculum planner for 2013-2015. Served as a clinical ethics consultant for Bon Secours Richmond.

MRMC Education and Research Council Strategic Quality Planning (SQP) meeting (Summer 2012) - 2-day planning meeting - served as nurse/ethics consultant - completed ongoing work and was asked to join the MRMC Education and Research Council as a faculty representative August, 2012. Group identified a PICOT question – led the group through a formal literature review and development of a literature review table. Served as a facilitator and mentor at a workshop dedicated to staff completion and submission of abstracts to the Magnet Conference. Nursing Grand Rounds presenter - Ethics FAQ presentation April 2013.

College Service Faculty representative on Faculty Member Search Committee – engaged in all interviews and in applicant presentations; Gallop Action-Plan Committee Member – represented the faculty and created a detailed action plan; Faculty representative on Academic Counselor Search Committee – engaged in the preparation of questions and in all interviews.

Other Professional Experience	Year
CLINICAL INSTRUCTOR <i>Health Educators Inc., Richmond, VA</i> Maintain certifications in BLS and ACLS American Heart Association (AHA) Courses. Promote AHA standards of care while instructing students from all levels of practice.	2006-2013
REGISTERED NURSE (AGENCY) <i>American Critical Care Services, Richmond, VA</i> Worked in multiple medical-surgical and critical care units in Richmond hospitals.	2006-2008

CLINICAL INSTRUCTOR – NURSING EDUCATION <i>Cleveland Clinic, Cleveland, OH</i> Functioned autonomously as the primary coordinator of Undergraduate Nursing Student Programs sponsored by Cleveland Clinic. Clinical Instructor for Critical Care, Cardiac and Medical/Surgical Areas. Centralized orientation. CE developer and reviewer.	1999-2006
CLINICAL INSTRUCTOR – ADJUNCT FACULTY <i>Cuyahoga Community College, Cleveland, OH</i> Clinical Instructor primarily on Medical-Surgical Nursing Units at multiple hospitals in the Cleveland area.	2001-2006
CLINICAL INSTRUCTOR – ADJUNCT FACULTY <i>Cleveland State University, Cleveland, OH</i> Critical Care Instructor on a cardiac step-down unit at MetroHealth.	2000
CLINICAL INSTRUCTOR – ADJUNCT FACULTY <i>Ursuline College, Pepper Pike, OH</i> Critical Care Instructor in multiple ICUs at Cleveland Clinic.	1999/2002
REGISTERED NURSE <i>Cleveland Clinic, Cleveland, OH</i> Worked primarily in the Surgical Intensive Care Unit – cross trained to the Medical Intensive Care Unit and Neurologic Intensive Care Unit, some experience in various Cardiac Intensive Care Units.	1995-1999
NURSING UNIT ASSISTANT <i>Cleveland Clinic, Cleveland, OH</i> Worked primarily on a Medical-Surgical Nursing Unit as a nursing assistant.	1990-1995

Clinical Areas of Specialty

<u>Ethics</u> Clinical Ethics Consultation Training – Ethics Consultant Local and National Presentations Dissertation work in Nursing Ethics	2011-2013
<u>Medical-Surgical Nursing</u> Medical-Surgical Nursing Clinicals – Foundational and Advanced Board Certified in Medical-Surgical Nursing	2001-2013 2009
<u>Critical Care</u> Critical Care Nurse – Surgical Intensive Care Unit (primary unit) Critical Care Nurse Educator Agency Critical Care Nurse	1995-1999 1999-2006 2006-2008
<u>Gerontology</u> Gerontological Studies Program Certificate Medical-Surgical Nursing – geriatric focus	1995 2001-2013

Areas of Interest - Research

Ethics, Nursing Education — Curriculum Development,
Competencies/Skills Training, Technology, Critical Care, Diabetes

Honors and Awards**Year**

Educator of the Year <i>Bon Secours Memorial College of Nursing</i>	2010/2011
Community Partnership Award for the Cleveland Clinic & Cleveland State University Academic Partnership Program: The Experiential Program <i>Cleveland, OH</i>	2004
Cleveland Clinic Bruce Hubbard Humanitarian Award — Humanitarian honor for extraordinary, compassionate care	1996

Presentations (Does not include guest lectures at BSMCON)

Bartlett, J. L., Stuart, K., Belde, D. (2013) *Informed consent in clinical practice* [Poster Presentation]. Bon Secours Richmond Health System 3rd Annual Nursing Research and Evidence-Based Practice Symposium: Richmond, VA.

Bartlett, J. L. Stuart, K., & McKinley, E. (2013). *Nursing Grand Rounds: Panel discussion on nursing ethics*. Presented at the MRMC Nursing Grand Rounds: Richmond, VA.

Bartlett, J. L., Stuart, K., Belde, D. (2013) *Informed consent in clinical practice* [Poster Presentation]. 2013 National Nursing Ethics Conference: Los Angeles, CA.

Bartlett, J. L. & DuBois, K. (2013). *Conference breakout session: Case discussion*. Presented at the 2013 National Nursing Ethics Conference: Los Angeles, CA.

National Nursing Ethics Conference (March, 2013). Nursing Planning Committee; Designated Nursing Planner for American Association of Critical-Care Nurses (AACN).

Bartlett, J. L. (May 6, 2010). Steps to become a nurse. *WTVR – Wake up Virginia* [Television broadcast]. Richmond, Virginia: CBS Broadcasting Inc.

Bartlett, J. L., & Frisch, N. (2004, March). Impacting student achievement: Job imbedded professional development. Presented at the Cleveland State University Partnership Conference: Cleveland, Ohio.

Presentations – Regular BSN Guest Lectures at BSMCON

Bartlett, J. L. (2011-2013). *Carper: Ways of knowing*. Presented each semester to the students in Foundations of Nursing (NUR 1100), BSMCON: Richmond, VA.

Bartlett, J. L. (2010-2013). *Insulin: The good the bad and the ugly*. Presented each semester to the students in Pathopharmacology I (PHR 3104), BSMCON: Richmond, VA.

Bartlett, J. L. (2012). *Multisystem [critical care] concepts: Hemodynamics, trauma shock, SIRS/sepsis, burns, and advanced medication math skills*. Presented each semester to the students in Adult Nursing Science II (NUR 3112), BSMCON: Richmond, VA.

Bartlett, J. L. (2011-2012). *MedMath: Beginning medication math skills*. Presented each semester to the students in Competencies I (NUR 2103), BSMCON: Richmond, VA.

Publications

Non-Juried work

Bartlett, J. L., Soat, M., & Solomon, D. (2004). Orientation program spiced with international flavor. *Nursing Spectrum*, 5, 32-33.

In Development

Bartlett, J. L., Thomas-Wright, J., & Pugh, H. (2013). *How do you know when it's okay to cry: The use of simulation*. Manuscript in progress.

Bartlett, J. L. (2013). *Front-loading skills: The benefits and challenges of a competencies course*. Manuscript in progress.

Stuart, K., Bartlett, J. L., Belde, D. (2013). *Informed consent in clinical practice*. Manuscript in progress.

Professional Association Membership

American Nurses Association – 02219179	2012-present
American Society for Bioethics and Humanities – 00052669	2010-present
National League for Nursing – 441085	2006-present
Sigma theta Tau International – Honor Society of Nursing – 0219464	1995-present
<i>Nu Delta Chapter</i>	

Recent Professional Development Activities

15th Annual Meeting of the American Society for Bioethics + Humanities (ASBH): Tradition, innovation, moral courage. <i>Atlanta, GA</i>	October 2013
Bon Secours Richmond Health System 3 rd Annual Nursing Research and Evidence-Based Practice Symposium [Nurse-driven protocol for treatment of asthma in the pediatric emergency department, Conceptual model for academic-service partnership, Is the temporal artery temperature an accurate reflection of a core temperature in the adult perioperative patient, Early mobilization protocol for the hospitalized elderly, Health literacy and formatting discharge instructions] <i>Bon Secours Richmond, VA</i>	May 2013
Ethics of Caring 2013 National Nursing Ethics Conference <i>Ethics of Caring, Los Angeles, CA</i>	March 2013
Clinical Ethics Consultation Training – Practical Training Clinical Ethics Consultation Training – Theoretical Training <i>Bon Secours Virginia, Richmond & Norfolk, VA</i>	2012-2013 2011-2012
Bon Secours Institute: Facilitative Leadership <i>Bon Secours Institute, Richmond, VA</i>	July 2012
Progression in Nursing: Virginia Plan <i>Bon Secours Memorial College of Nursing, Richmond, VA</i>	June 2012
Pharmacology Workshop <i>Bon Secours Memorial College of Nursing, Richmond, VA</i>	May 2012
