CLINICAL NURSE EDUCATORS' BELIEFS OF THE VALUES AND ETHICAL PRINCIPLES OF THE PROFESSION OF NURSING AND THE IMPLICATIONS FOR CLINICAL EDUCATION

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A DISSERTATION

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Education in the
Department of Educational Leadership,
Policy, and Technology Studies
in the Graduate School of
The University of Alabama

TUSCALOOSA, ALABAMA

2021

ABSTRACT

Clinical nurse educators serve as role models, teachers, and visionary leaders who can pass on the values and ethical principles of the profession to future nurses. Without a clear understanding of these norms and standards, nurse educators will struggle to maintain expert nursing practice and create learning environments essential for the effective socialization of students into their future roles. The purpose of this study was to explore clinical nurse educators' beliefs about the values and ethical principles of the profession and examine how these commitments influence their clinical teaching practices as they seek to educate the next generations of nurses.

Six clinical nurse educators in a Bachelor of Science nursing program participated in this study. Utilizing a qualitative descriptive design, findings revealed core beliefs about the importance of integrity, patient rights, and duty to care. Honesty was identified a sub-theme within integrity; fair treatment, "do no harm," empowerment, and autonomy and advocacy were sub-themes of patients' rights; morality, compassion, and empathy were sub-themes of duty to care. Although these beliefs are broadly in line with National League of Nursing and American Nurses Association guidelines, participants only demonstrated a tacit knowledge of their professional codes. No one could offer an explicit explanation of the values and ethical principles central to professional practice. All understood it was their responsibility as clinical nurse educators to impart these values and principles to their students and were committed to doing this to the best of their ability. They understood the need to model professional practice and took time to discuss the moral imperatives behind their actions. However, without explicit

reference to received norms and standards, their instructional efforts rested mainly on the force of example, a *practice to theory* gap that undercut the future nurse's need for an informed and reflective understanding of professional conduct.

These findings reinforce the integral role played by clinical instructors in the preparation of future nurses, while highlighting the need for increased curricular and pedagogic focus on the values and ethical principles essential to the profession. Recommendations include the need for more thorough on-boarding programs and greater coordination with didactic faculty.

DEDICATION

This dissertation is dedicated to my family and friends who have been the best of the best. Your support and encouragement have helped to hold me up throughout this process. To Sara and Margee. My cheerleaders and the best pandemic workout crew a girl could ask for. To the Chicago Robinsons. Best. In-laws. Ever. To the McGee Clan. Thank you for your endless love and support…it's time to party! To my boys, Declan and Finn. I love you more! To Cecil. There are no words to say how much your love and support means to me. I love you. I am the luckiest.

ACKNOWLEDGEMENTS

To begin, I would like to thank Stephen Tomlinson for remaining my champion throughout this process and ensuring that I did not give up. His belief in my abilities and the importance of my work was unwavering. I would also like to thank the members of my committee: Drs. Michelle Cheshire, Ann Graves, Doug McKnight, Haley Strickland, and David Walker. Thank you all for your speedy response to any and all inquiries. To my Adult Health team…you guys are the best. Meridith, I have no idea how many countless hours you spent letting me vent and pushing me to the finish line. Holly, the best office mate anyone could ask for. To cohort five I am so glad to have been a part of your group and to have made it to the finish line to join the rest of you!

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CHAPTER I:

INTRODUCTION

Nurse educators are torchbearers of the nursing profession. The honesty and ethical standards of the profession of nursing has placed them at the top of the Gallup poll for every year, except one, since its addition to the poll in 1999 (Saad, 2020). As articulated by the National League of Nursing's (NLN) *Core Competencies for Nurse Educators* (Halstead, 2019), they must serve as role models, teachers, and visionary leaders who embody the values and ethical principles of the profession (Adelman-Mullally, Mulder, McCarter-Spalding, Hagler, Gaberson et al., 2013; Halstead & Frank, 2018).

Yet despite this central role, there is little research exploring nurse educators' understanding of and commitment to the values and ethical principles of the nursing profession. Even more elusive is research regarding the viewpoint of educators who work with nursing students in clinical settings, the clinical nurse educator. The purpose of this study was to understand clinical nurse educators' beliefs and commitment to the essential values and ethical principles of the profession and explore how this influences their clinical teaching practices as they educate the next generation of nurses.

The NLN nurse education competencies require nurse educators to understand the profession of nursing. Without a solid understanding of the profession, it is unlikely that nurse educators can maintain expert nursing practice (Benner, 2004) or serve as a role model of professional nursing and its values not only for students, but also for other health care

professionals, and patients and their family members (Halstead, 2019, Competency 1; Halstead & Frank, 2018, p. 27). Similarly, without an understanding of the profession, nurse educators cannot create learning environments to teach professional behavior and socialize nursing students into the role of the nurse (Halstead, 2019, Competency 2). That is, nurse educators must not only be a role model of the profession, but they must also find ways to intentionally teach skills, attitudes, values, and expectations of the profession to nursing students. Nurse educators are also called to be visionary leaders and transformational change agents to create a preferred future for nursing practice (Halstead, 2019, Competency 5). Nurse educators "should have a clear vision of professional nursing" and work with nursing students to not only see their vision of the profession as it currently is, but to also imagine otherwise about what the nursing profession could be (Adelman-Mullally et al., 2013, p. 30). To meet this visionary call, nurse educators must be able to "articulate and demonstrate [their] professional values" which "requires reflection and deliberate action" (Halstead & Frank, 2018, p. 27; American Nurses Association [ANA], 2015, Provision 9).

The relationship of nurse educators' knowledge, ideas, or commitment to the NLN competencies for nurse education is unclear. Given the absence of research in this area, it leads to more questions than answers: Are these the competencies and values that nurse educators embrace? Indeed, do they even know them? Nurse educators may have other notions of expertise or hold other nursing values as being more important. However, these questions have not been asked before in the nurse education literature. This study asked if and how clinical nurse educators draw upon the NLN competencies and values to guide their clinical education teaching practices.

Theoretical Framework: Nursing Code of Ethics and Values of Nursing Education

Nurse educators' understanding of and commitment to the profession of nursing should allow them to perform their duties as a role model, teacher, and leader such that their actions are aligned with the ethical principles of nursing (ANA, 2015) and the core values of nursing education (NLN, 2012; NLN, 2020). To explore current practices of clinical nurse educators, the ANA Code of Ethics and the NLN core values for nurse educators were used as the theoretical framework to guide the study and to analyze the data gathered. The goal of the ANA *Code of Ethics* (see Appendix A) is to "provide normative, applied moral guidance for nurses in terms of what they ought to do, be and seek" (ANA, 2015, p. xi). The Code of Ethics provisions state that health care is a human right and that patients have a right to health and self-determination (Provisions 1 and 8). Professional nurses recognize this human right through their primary commitment to the patient – be it an individual, family group, or community (Provision 2), nursing practices that respect the inherent dignity and worth of every person (Provision 1), compassionate relationships with patients and other health care providers (Provision 1), and advocacy for the rights, health, and safety of the patient (Provision 3). The Code of Ethics provisions also state that nurses have the obligation, authority, accountability, and responsibility to make clinical judgements, decisions, and actions to provide optimal care (Provision 4). Appropriate judgments, decisions, and actions are achieved through the maintenance of competence and professional development (Provision 5), the advancement of research, standards, and policy (Provision 7), and the nurses' integrity, good character, and obligation to an ethical workplace environment (Provisions 5 and 6). Taken together, these provisions lay a foundation for the nursing profession and provide a foundation for training future nurses by nurse educators.

The NLN recognizes the need for the ANA Code of Ethics to guide clinical practice but has also developed additional ethical principles for nurse educators based on the NLN core values of caring, integrity, diversity, and excellence (NLN, 2012). “Creating a culture of caring is a fundamental part of the nursing profession” (NLN, 2020) and is evidenced by active attempts to understand others’ needs through active communication and listening and creating an environment that assists those who cannot care for their physical and psychosocial needs (NLN, 2012). For students to learn caring behaviors, nurse educators should model the importance of engaging in relationship-centered interactions within an inclusive learning environment that encourages freedom to voice concerns and recognizes the importance of caring for self as a foundation to caring for others (NLN, 2012, pp. 1-2). Integrity is treating others with respect in the classroom and the workplace, taking responsibility for one’s actions, and advocating for professional values. To create opportunities for students to develop integrity, nurse educators must model “professional behaviors that demonstrate honesty, respect for self and others, accountability, and self-growth,” maintain the confidence of colleagues and students, demonstrate courage to advocate for professional values, and make decisions that reflect ethical principles (NLN, 2012, p. 2). Diversity supports inclusive environments, fosters open communication, and encourages teaching to meet the individual and cultural needs of learners. It also requires fair treatment of others regardless of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, and other ideologies. Excellence requires activities that promote professional growth, improvement, and understanding.

The ANA’s Code of Ethics and the NLN’s ethical principles for nurse educators do not offer an explicit prescription for nurse educators. Each does, however, provide foundational

principles within the nursing profession that can serve as guides to nurse educators as they strive to be role models, teachers, and leaders within the profession of nursing.

Clinical Nurse Educators and the Profession of Nursing

Clinical nurse educators are defined for this study as nurse educators who are employed by a college or university and instruct small groups of nursing students in a hospital and other clinical practice settings as they care for patients. Because clinical instruction relies heavily on practice, it is uniquely different from classroom-based nursing instruction, which is largely didactic and focused on facts, theory, and research. During clinical instruction, clinical nurse educators apprentice nursing students into the nursing profession and prepare nursing students for nursing practices through authentic, hands-on learning experiences in clinical settings (Collins & Kapur, 2014). In this way, the competencies presented for nurse educators and the values and ethical principles of the NLN and ANA, respectively, are particularly important for clinical nurse educators.

Teaching nursing in clinical settings requires clinical nurse educators to present the public and private faces of nursing to students (Risjord, 2010). The public face of nursing is that of the efficient, effective, and caring nurse who interacts with their patients, while the private face of nursing is that of the knowledge which is required to practice the profession. Combined these two faces represent the art and science of the nursing profession. Teaching nursing in clinical settings requires clinical nurse educators to not only bridge theory and practice, but to address theory-practice gaps (Adelman-Mullally et al., 2013; Becker & Neuwirth, 2002; Collier, 2018; Risjord, 2010).

There are two types of theory-practice gaps that clinical nurse educators must address: one of translation and one of relevance (Risjord, 2010). A translation theory-practice gap arises

in nursing education when what is learned in the classroom is not practiced in the clinical setting. A relevance theory-practice gap is one that questions the significance or usefulness of existing theory and research. Addressing these two types of theory-practice gaps is no simple matter. For translation theory-practice gaps, clinical nurse educators must highlight and remediate these gaps, which often run contrary to the practices that nursing students observe from other nurses in the clinical setting. To address the relevance theory-practice gap, clinical nurse educators will discuss ethical and advocacy questions, such as how to respond to potential patient safety issues, or why nurses care for all patients regardless of their personal religious or political beliefs. These discussions can take place at any time but are mainly addressed during pre-conference and post-conference sessions with nursing students where the clinical nurse educator can talk about ethics and nursing theory as they relate to principles of justice, the greater good, and caring (Kant, 1886; Aristotle, 2004; Sandel, 2009, Watson, 2002, 2007, 2009).

Because of the complexity of teaching the profession of nursing in a practice setting, clinical nurse educators are at the nexus of the profession of nursing, nursing practice, and nursing education. First, a clinical nurse educator must be an expert nurse whose competence and ability to make ethically sound, professionally competent decisions represents the excellence in nursing practice that is consistent with evidence-based nursing practice and the values and ethical principles of the profession. Anything less will undermine their ability to be exemplary role models for nursing students. A clinical nurse educator must be able to teach practices, values, and ethical principles of the profession by creating learning environments that present opportunities for nursing students to develop their practice and socialize them into the profession. Furthermore, when nursing students encounter practices in a clinical setting that are inconsistent with the profession of nursing, clinical nurse educators must be able to bridge

theory-practice gaps of translation and relevance. Finally, clinical nurse educators must also have a clear vision of the current and future state of the profession and be able to reflect on and articulate their vision and values.

Importance of the Current Study

National organizations, such as the NLN, have been extolling nurse educators' competencies for almost twenty years. However, after using multiple search terms and multiple databases, I was unable to identify any published research studies that explore the clinical nurse educators' (a) ideas, perceptions, or vision about the values and ethical principles of the profession of nursing, (b) commitment to professional ethics in nursing or nurse education, or (c) the ways such ideas affect their teaching. Indeed, what studies can be found in clinical nurse education invariably makes this case for more research in this field. For example, a recent structured review of clinical nurse education concludes by highlighting that, "Although clinical education can be considered the cornerstone of nursing education, only a small body of knowledge covers it, leaving multiple gaps in the literature" (Collier, 2018, p. 368). An expanded search for nurse educators more broadly conceptualized, or practicing nurses yielded similar results. A recent review of nurses' perceptions of their roles in patient care was only able to identify fourteen studies and concluded that more research is needed on this topic (Kusi-Appiah, Dahlke, & Stahlke, 2018).

The lack of research on clinical nurse educators' ideas about the values and ethical principles of the profession of nursing or its implications for educational practices indicates a deep chasm in the nursing education literature. This lack of research prevents the profession of nursing from assessing the current state of clinical educational practices or the competencies of clinical nurse educators. For a profession committed to the highest standards of evidence-based

practices, it is problematic that the voices and practices of clinical nurse educators are missing. Moreover, this points to a gap in how the profession of nursing itself is conceptualized and taught by clinical nurse educators. The nursing profession has allowed nursing organizations, such as the NLN and ANA, philosophers, and historians to describe, discuss, and maintain its educational and professional competencies. The voices of clinical nurse educators are missing.

Purpose and Research Questions of the Current Study

The purpose of this study was to begin to address the literature gap by exploring clinical nurse educators' perceptions of the values and ethical principles of the profession of nursing and how perceptions of these values and ethical principles of the profession of nursing influence their education practice. Specifically, this study addressed the following research questions:

1. What do clinical nurse educators believe are the values and ethical principles of the profession of nursing; and
2. How do clinical nurse educators' beliefs about the values and ethical principles of the profession of nursing inform their educational practices?

Method

To answer these research questions, this study used a qualitative descriptive methodological approach. Clinical nurse educators were interviewed and explored their perceptions of and commitment to the values and ethical principles of the profession, and how these perceptions and commitments shape how they teach nursing students in clinical settings.

Because of the dearth of research on this topic, this study was inherently exploratory, and a qualitative descriptive study approach was appropriate to gather data and interpret the findings. Qualitative description was an appropriate methodological approach because it, "is grounded in the general principles of naturalistic inquiry" (Colorafi & Evans, 2016, p. 18). Qualitative

descriptive studies are also well-suited to health science research because this approach allows for a thoughtful exploration of complex issues and concepts (Creswell, 2013; Colorafi & Evans, 2016) and a comprehensive summary of questions in the everyday terms of the participants in the study (Sandelowski, 2000). This approach is also appropriate because of the exploratory nature of this study and allowed the researcher to "stay closer to their data and the surface of words" (Sandelowski, 2000, p. 336) instead of attempting to find deep interpretation.

Participants

Participants are clinical nurse educators who are currently teaching undergraduate nursing students in clinical settings at a large public research university in the southeastern United States. Participants were recruited using the purposeful sampling technique of maximum variation, which allows the researcher "to explore the common and unique manifestations of a target phenomenon across a broad range of phenomenally and/or demographically varied cases" (Sandelowski, 2000, p. 338). Six clinical nurse educators participated in this study; this number of participants is consistent with other descriptive qualitative studies.

Setting

The clinical nurse educators who participated in this study teach courses that include clinical rotations to hospital settings, such as fundamentals, adult health, pediatrics, obstetrics, and complex client. These clinical nurse educators meet with their students in a variety of settings, including the clinical practice lab, simulation lab, and hospital settings. In accordance with Alabama Board of Nursing Administrative Code, the instructor to student ratio will never exceed 1:8 while in licensed hospitals which provide acute care (ABN, 2019). The amount of time spent in clinical settings varies per course, ranging from 32 to 180 hours over 12 weeks.

Materials and Procedures

Participants were identified and recruited via word of mouth and through email invitations. This purposeful participant sampling procedure is common in qualitative descriptive studies because it allows researchers to maximize the likelihood of identifying common and unique themes across a range of clinical nurse educators with a broad range of experience (Sandelowski, 1995, 2000).

After participants were identified, zoom interviews were scheduled to ensure the comfort and safety of the participants and the researcher as this research took place during the COVID-19 pandemic of 2020. Consistent with qualitative descriptive studies, interviews were minimally to moderately structured, open-ended (Sandelowski, 2000) and lasted approximately 45 to 60 minutes.

During the interviews, participants were asked background questions regarding their education and nursing experience. The purpose of these background questions was to 1) provide more context for their responses, 2) build rapport, and 3) help participants feel at ease before answering interview questions specific to their role as a clinical nurse educator and required honesty and openness. Next, participants were asked several questions to gather data for each research questions. Examples of the interview questions include 1) describe what you believe the profession of nursing to be and what elements make up the profession, including aspects that make a nurse good; 2) describe their role as a clinical nurse educator and elements that contribute to good practice in that role; 3) discuss any knowledge about the NLN core values for nurse education or ANA Code of Ethics, and 4) how they teach these values and ethical principles. Based on participants' responses, the interviewer explored in greater depths their initial

responses about the profession to clarify meanings. To complete the interview, participants were asked “is there anything else that you would like to share that I have failed to ask you?”

Analytic Approach

Content analysis was used to interpret the data gathered in this study. This form of analysis is suitable for this study as it requires a lower level of interpretation, allowing the subjects own words to not get lost in those of the researcher (Vaismoradi, Turunen, & Bondas, 2013). In a systematic review of 55 qualitative descriptive studies by Kim, Sefcik, and Bradway (2017), content analysis was the most common strategy used to analyze the data. Content analysis allows coding and categorizing of large amounts of data to find trends and patterns in participants’ words (Vaismoradi, Turunen, & Bondas, 2013; Pope, Ziebland, & Mays, 2006; Gbrich, 2007). The purpose was to examine what is said, by whom, to whom, to what effect (Bloor & Wood, 2006; Vaismoradi et al.; 2013). Content analysis is, “well suited to analyze the multifaceted, important, and sensitive phenomena of nursing” (Elo & Kyngas, 2008; Vaismoradi et al., 2011; Vaismoradi et al., 2017). It is also good for reporting common issues in data in previously unstudied areas (Green & Thorogood, 2004; Vaismoradi et al., 2017).

Assumptions

Assumptions made for this study were that the participants answered all questions with honesty and sincerity to the best of their ability. It was assumed that the participants were open to sharing their perceptions about and commitments to the nursing profession and reflecting on how these perceptions and commitments have shaped their experiences teaching nursing students in the clinical setting.

Limitations

Limitations of this study included the limited geographic scope of the study and potential researcher bias. Because this study took place at a single institution, the ability to generalize findings and recommendations is limited and the purposeful sample of clinical nurse educators may not be representative of all nurse educators. The personal bias of the researcher can also be a limitation. The researcher attempted to be aware of her positionality during the coding and interpretation of the data gathered and findings reported within the study.

Delimitations

The delimitations of the study include my own personal experiences. I have been a nurse for 13 years. Seven years were spent working in the operating room as a circulating nurse, and seven years have been spent as a clinical nurse educator on a medical-surgical ward. I also work at the institution with the participants of this study. My personal experiences as a nurse and as a clinical nurse educator helped me guide the interviews and understand the participants' experiences and perspectives in ways that others may not appreciate.

Conclusion

The role of the clinical nurse educator is essential to ensuring new generations of nurses are prepared to join the workforce and continue the profession of nursing. However, there is little to no research that asks clinical nurse educators about their understandings of the profession and values of nursing. This study begins to fill this gap in the literature. In Chapter II, I provide a brief history describing the current state of the profession and discuss the philosophical underpinnings of nursing values and ethical principles. Next, I explore the importance of the role of the clinical nurse educator as a model, teacher, and leader for nursing students as they are socialized into the profession. My analysis highlights the lack of research examining the extent

to which clinical nurse educators understand or practice their role when teaching nursing students, and revisits the purpose, importance, and research questions of this study. Chapter III provides greater detail on the qualitative descriptive methodology used to answer the research questions; including an account of the research setting, the recruitment of participants, the interview protocol, and the method of content analysis employed to analyze the data collected. Chapter IV reports the findings from the study. Chapter V discusses the findings and highlights implications for nursing and nursing education and outlines future research to continue to address this gap and work to promote the values and ethical principles of nursing across the profession and teach its values and ethical principles to the next generation of nursing students.

CHAPTER II:

REVIEW OF LITERATURE

This study explores clinical nurse educators' knowledge about the profession of nursing, its values and ethical principles, and implications for their clinical teaching practices. As a means to interpret clinical nurse educators' understanding of the profession, it is important to review the current state of the profession of nursing and how it came to be. The first part of this chapter provides a brief history of nursing and its professionalization in the United States. One characteristic of a profession is the development of a code of ethics. The second part of this chapter discusses concepts within moral philosophy to conceptually frame the code of ethics in nursing and as a means to interpret clinical nurse educators' understanding of nursing ethics. The third section of this chapter examines the educational expectations and competencies of clinical nurse educators as discussed in the nursing education literature and articulated by the National League of Nursing. This section, combined with the first two, provides a lens to interpret clinical nurse educator teaching practices.

Dimensions of Nursing as a Profession

Efforts to professionalize nursing in the United States were profoundly shaped by educator Abraham Flexner's description of the characteristics of a profession (Flexner, 1915; Risjord, 2010). According to Flexner, and other sociologists who took a functional, taxonomic approach, a profession is that which includes training, a systematic body of knowledge, ethical codes to guide practice, a service orientation, lifelong dedication, a common identity, and autonomy (Carr-Saunders & Wilson 1933; Cogan, 1953; Flexner, 1915; Goode, 1969;

Parsons, 1939; Pavalko, 1988; Schneider, 2016). In the brief history of the professionalization of nursing below, threads are present from each of these dimensions.

Service orientation and lifelong dedication have been present in nursing from the outset, as it was seen that the 'natural' lifelong duty and obligation of females was to care for their families. It was this duty that led to the first professed nurses in the United States, women who learned the skill of nursing at home or through domestic service and could then "profess" this ability as a trade (Reverby, 1987). As nursing developed, a woman's natural obligation to care became the foundational core of the first nurse training programs (Reverby, 1987) and continued through altruistic calls to serve others (Robb, 1903). Training is a consistent thread throughout the development of the nursing profession. How nurses should be trained was often contested, pitting nursing directors against physicians and hospital administration. This struggle led to the development of a common identity through the creation of national associations, licensure, and advocacy of state and federal policy to recognize the importance of licensure. Concurrent with the development of nurse training programs, was the establishment of a systematic body of knowledge. Early research in nursing was largely focused on nursing skills as opposed to theory (Mason, 2011; Risjord, 2010), and shifts in research and nursing science throughout most of the 20th century science were responses to more firmly establish nursing as a profession (Risjord, 2010). The history of nursing and its professionalization is complicated with many twists, turns, and diversions along the way. Attempting to organize nursing's history around the development of each dimension, creates a non-linear approach that is difficult for the reader because they often need the context from other points in time and other dimensions to make sense of the development. Therefore, rather than attempt to organize around each dimension, I attempt to take a chronological look at the history of the profession. Through this chronological approach, I

place emphasis on the role of education. As nursing education expanded, so did the profession. Today, education and training are vital components of the contemporary state of the nursing profession.

The Origin of the Profession of Nursing

The role of caregiver is one that can be traced to antiquity. Societies differed in the way these caregivers were chosen, be it through signs during birth which destined the child to a life of caregiving, the belief that women as mothers would nurture the sick as they did children, to the role of men as shamans and medicine men (Egenes, 2018; Henly & Moss, 2007). Education on how to care was handed down through generations, through observation, and by trial and error (Egenes, 2018). In Europe, the 16th and 17th centuries brought forth the establishment of hospitals and the formation of female nursing orders organized by church leaders (Catalano, 2019; Egenes, 2018). It was at this time that any male nursing orders gave way to the rise of all female nursing, one of the only roles women were allowed. However, the vast majority of nursing was done at home, by family members and friends, leaving those who were destitute and alone to seek health care in hospitals and through nursing orders (Catalano, 2019; Egenes, 2018).

In England, Catholic monasteries and convents which had provided care for those in need were closed during the Protestant Reformation, and nursing fell to “common” women (Egenes, 2018). These women were often from the lower class and had a reputation for lacking knowledge and good character (Pavey, 1953; Egenes 2018). Social reformers in England and Europe began a call for a transformation to this problem and in 1840 Elizabeth Fry founded the Society of Protestant Sisters of Charity, who received rudimentary nursing education through observation at London hospitals (Catalano, 2019; Egenes, 2018). More groups followed the path set forth by

Fry in England and Germany, establishing sisterhoods of women who not only worked as nurses but also spent time in prayer and religious studies (Pavey, 1953; Gallison, 1954; Egenes, 2018).

The mid-nineteenth century led to the transformation of nursing and nursing education by Florence Nightingale. Nightingale was born to a wealthy English family, but she renounced the typical life of an elite Victorian woman, choosing to devote her life to the betterment of humanity rather than the narrow duties of marriage. She trained with nursing sisterhoods in Germany, France, and England before the outbreak of the Crimean War in 1854. While the French soldiers had nursing nuns to treat them, the British soldiers had no nursing care. Through her upper-class status, she was able to gain permission to recruit other women of her class and go to Crimea and tend to the soldiers there. While there she was horrified by the conditions of the field hospitals for British soldiers. Nightingale believed that the environment was the cause of disease, as opposed to germs:

> In watching diseases, both in private houses and public hospitals, the thing which strikes the experienced observer most forcibly is this, that the symptoms or the sufferings generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different – of the want of fresh air, or of light, or of warmth, or of quiet, or of punctuality and care in the administration of diet, of each or of all of these. (Nightingale, 1860)

She focused her nursing on bringing order and cleanliness to the field hospitals. As a mathematician she was able to compile statistical data which showed that the changes she and her nurses made decreased the mortality rate of soldiers from upwards of 60% down to 2% (Lloyd, 2020).

At the end of the war Nightingale was a national hero in England and in 1860 she founded the Nightingale School of Nursing at St. Thomas' Hospital in London where she established a curriculum that combined theory and clinical experiences (Egenes, 2018; Lloyd 2020). By gaining funding from independent nursing organizations, Nightingale ensured,

through a lack of physician and administration oversite, that the educational focus was on student needs, not the needs of the hospital (Egenes, 2018; Mason, 2011).

Nightingale's curriculum was the foundation of the first nursing schools in Europe and the United States. She believed that nurses addressed environmental causes of disease, while the physician addressed the bodily causes (Nightingale, 1860; Risjord, 2010). This meant that nurses had autonomy and worked within their domain of expertise, separate from physicians (Risjord, 2010). While nurses would carry out physicians' orders, their professional autonomous duty was to the patient and the patients' environment.

Accordingly, the curriculum of the St. Thomas school focused on learning the proper, "moral, environmental, and physical order" to restore health (Reverby, 1987, p. 42). Nursing was a way for women to hone their feminine qualities of caring and virtue (Reverby, 1987). Nightingale not only sought to change the way nursing was done, but she also focused on ensuring the right type of woman was recruited changing societies view of a nurse to that of an, "educated, ethical, caring lady" (Mason, 2011, p. 6). When the British Nurses Association began to lobby for registration of nurses, akin to licensure, Nightingale was opposed to the idea. Registration would require the passing of an exam at the end of the students' training and may signal that their training was complete, not a vocation requiring lifelong development. Nightingale also feared that an exam would be unable to test the care and virtue required in nursing and in an article published under the name of her cousin she argued,

> No one will, at this time of day, deny that moral as well as professional qualities are everything in a nurse, that she has to be judged by her character and conduct as well as by her technical skill, by the possession of such qualities as kindness, patients, trustworthiness, self-control, discretion. How are these intangible things to be registered? (Bonham-Carter, 1888, p. 271)

She feared registration of nurses would also negatively affect working-class nurses who often lacked formal education and would have found a written exam to be a major barrier (Helmstadter, 2007). This could also lead to formally educated but poor practicing nurses, lacking in care and virtue (Bonham-Carter, 1888). While her arguments were not without their points, they largely fell on deaf ears and registration and licensure would be a major component of nursing's move toward professionalization.

History of Nursing in the United States

For most, the images and histories of the Civil War in the United States evoke the thought of North vs. South, the fight for the abolition of slavery and the lost cause argument of state rights. For nursing, it marked the beginnings of the professionalization of nursing in the United States. To tend to the soldiers who were casualties of the brutal and bloody battles that ensued, the United States Army established a Nurse Corps. This was one of the first major appearances of secular, paid nurses in the United States (Egenes, 2009; Schneider, 2016).

As the population grew following the Civil War two different types of nurses emerged: nurses who functioned as professed nurses in the community, often older widows who helped with the sick and needy, and those who worked in hospitals or homes for the destitute. Professed nurses were made up mainly of widows or other women who had a change in family status, leaving them in need of work (Reverby, 1987, 2011). These women lacked formal training but had the background of caring for family and friends (Reverby, 1987, 2011). Nurses in hospitals or homes for the destitute were reminiscent of those in England prior to social reformation, made up of, "drunkards and former convicts…prostitutes…that were given the choice of going to prison or into hospital service" (Egenes, 2018, p. 8).

After the end of the Civil War, the head of the American Medical Association called for training schools for nurses (Larson, 1997; Egenes, 2018). By 1873, the first programs of nursing were established at Bellevue Hospital in New York City, New Haven Hospital in Connecticut, and Massachusetts General Hospital in Boston. Each was modeled after the Nightingale School at St. Thomas' Hospital in London (Egenes, 2018; Mason, 2011; Reverby, 1987; Schneider, 2016). Following the principles laid forth by Nightingale, the curriculum adopted was designed to teach women to become nurses through the "disciplined honing of their womanly virtue" (Reverby, 2011, p. 105). Instruction stressed character development and an orientation to service based on duty. Nursing students were screened to ensure their character and commitment (Judd, Sitzman, & Davis, 2010). The first head of John Hopkins School of Nursing, Isabel Robb, articulated a vision for the profession, claiming that nurses must be altruistically motivated with the moral responsibility to care for others (Mason, 2011; Robb, 1903). These concepts led nurses to venture in to underserved communities and promote healthy lifestyles (Mason, 2011). Lilian Wald began the Nurses Settlement in New York City that served poor immigrant communities by teaching health and hygiene (Egenes, 2018, Mason, 2011). She promoted preventative health care and started a home health service, school nursing, and occupational health nursing programs (Mason, 2011).

Other hospitals followed suit, and soon nursing programs bloomed across the country, with approximately 400 established between 1890 and 1900 (Mason, 2011). While the Nightingale model had been used as a guide to create nursing curriculum, unlike Nightingales St. Thomas' School, these training schools were most often financially dependent upon the hospitals to which they were tied (Egenes, 2018). As such, the hospitals were able to influence the curriculum, turning instruction from the needs of the student to the needs of the hospital (Egenes,

2018). Physicians and hospital administrators worked to ensure that nursing schools and their superintendents remained dependent upon their authority (Reverby, 1987). Student nurses were used for staffing because of their cheap labor, obedience, and compliance; they hired very few nurses post-graduation (Egenes, 2018). Many of these early hospital-based schools had students working unsupervised for 12-hour shifts in the hospital or sent alone to care for patients in private homes (Kalisch & Kalisch, 1995; Egenes, 2018). The lack of guidelines uneven quality of hospital-based nursing curricula, poor working conditions, and lack of nurses input on the curriculum led to the formation of two nursing associations: the American Society of Superintendents of Training Schools of Nursing in 1893 (now known as the National League for Nursing [NLN]) and the Nurses' Associated Alumnae of the United States and Canada in 1896 (now known as the American Nurses Association [ANA]; Egenes, 2018).

One of the first goals of the ANA was to normalize the profession, and to do this they pushed for standardized nursing education and licensure (ANA, 2007; Group & Roberts, 2001; Schneider, 2016). This goal was strongly resisted by physicians and hospital administrators who worried about losing control over nursing programs and cheap labor the programs provided for the hospital. They worked against the ANA to ensure the first attempts to institute licensure were permissive but not mandatory. Nurses could be licensed as a registered nurse (RN), but there were no laws against practicing without a license (Schorr & Kennedy, 1999; Schneider, 2016). In 1903 North Carolina became the first state to legalize licensure in this stunted manner with the rest of the 48 states joining them by 1923 (Mason, 2011; Schneider, 2016). This established a pattern of hospitals and physicians working to placate nursing's governance while keeping them subservient to medicine.

While nursing reformers were struggling for increased professionalization through licensure another war interceded to increase the number of paid vocational nurses in the United States. In 1901, congress made the Army Nursing Corps permanent and, in 1908, the Navy Nurses Corps was established (Egenes, 1918). In 1914, at the start of World War I (WWI), fewer than 500 nurses were members of the Army Nurse Corps. The American Red Cross Department of Nursing began to recruit nurses for duty to the nursing corps, known as the United States Public Health Service (Egenes, 2018; Mason, 2011). By the end of WWI there were, "21,000 army nurses and 1,386 navy nurses" (Egenes, 2018, p. 16).

The struggle for standardization of nursing education and professionalization of nursing continued with the Goldmark Report led by nurse educator Adelaide Nutting. Published in 1923, it recommended educational standards for nursing, shifting the focus from patient care to education (Egenes, 2018). It called for the separation of nursing programs from hospitals and to universities (Mason, 2011). As before, hospital administrators resisted this change as they would lose their "free" labor force comprised of student nurses (Egenes, 2018). In 1928, yet another report – the Burgess Report – recommended increasing admission criteria for nursing schools together with a shift in focus to didactic education (Egenes, 2018). This initiative was also opposed by hospital administrators as it would decrease the number of students that hospital-based nursing programs would be able to admit.

While nursing reformers of the 1930s were unable to normalize the educational standards of the profession, war again proved to be an effective driver of change. The outbreak of World War II (WWII) led to the Bolton Act of 1943, which created the United States Cadet Nurse Corps and provided federal money to quickly prepare nurses to meet needs in wartime. The Bolton Act influenced nurse education by allocating funds to nursing schools, so they could

enroll more students. The program was open to women, 17-35 years of age and in good health, and did not discriminate along racial lines (Egenes, 2018; Mason, 2011).

At the conclusion of WWII, the ANA again pushed for more comprehensive licensure and by 1948 New York became the first state to require nurses to pass a mandatory licensure exam prior to practicing (Schneider, 2016). By 1970 most states had also passed laws requiring licensure exams (Egenes, 2018; Schneider, 2016).

Calls for educational reform in nursing education continued during this time. In 1948, the Carnegie Foundation funded *The Future of Nursing* by Esther Brown. This report recommended that schools of nursing should be autonomous from hospitals and hired educators with baccalaureate or graduate degrees. Brown also called for the recruitment of married women and of men into the profession. No matter the calls for nursing education reform and increased professionalization, university-based nursing programs offering baccalaureate degrees were slow to develop leaving hospital-based diploma programs as the main source of nursing education (Egenes, 2018).

In 1951 the post-World War II nursing shortage led to the need for more educational opportunities. To answer this need, the Associate Degree in Nursing (ADN) was established in the hope of quickly increasing graduates of licensed nurses, albeit ones with a narrower scope of practice than RNs, focusing on bedside nursing, akin to the current Licensed Practical Nurse (LPN) (Egenes, 2018, Schneider, 2016). The shorter duration of the ADN programs, compared to university-based baccalaureate programs, drove the popularity of community college based ADN programs grew opening the door to students who did not fit the mold as traditional nursing students. The rise of ADN programs led to a decline of hospital diploma programs. This decline

led to the closing of hospital-based programs or the joining of these programs with community colleges (Mason, 2011).

Even with the decline in hospital diploma programs, by the beginning of the 1960s, only 14% of nursing students were enrolled in baccalaureate programs (Egenes, 2018). To increase these numbers the Nurse Training Act of 1964 led to federal funding of nursing programs and an increase in graduate nursing programs (Kalisch & Kalisch, 1995; Egenes, 2018). Many of these graduate programs focused on nursing education or administration (Schoening, 2013).

In 1965, the ANA published the *Educational Preparation for Nurse Practitioners and Assistants to Nurses*. This report, known as the ANA position paper, like the Goldmark report before it, claimed nurses should be trained at institutions of higher education as opposed to hospitals. It also stated that the baccalaureate degree should be the minimal degree needed for professional nurses and the ADN the minimal degree for technical nurses (ANA, 1965; Egenes, 2018). And in 1969 the ANA called for a shift in graduate nursing education, away from education and administration and towards clinical specialization.

Both ADN programs and graduate programs grew throughout the 1970s, expanding advanced practice roles for nurses (Egenes, 2018). Regardless of the ANA's desire for more baccalaureate graduates, by the late 1970's the door opened by the ADN degree to the wider population of students ensured that ADN graduates outnumbered both diploma and baccalaureate programs (Egenes, 2018). Between 1979 and 1984 there was a sharp decrease in graduate programs offering nursing education degrees, as clinical specialization for advanced practice drove development. The result was a rising tension between education and specialization within the profession (McKevitt, 1986; Schoening, 2013).

The 1980's led to a nursing shortage as health care became more complex and the role of the nurse began to expand (Jacob, 2016). These issues have only increased leading to challenges brought by, "an aging population, a serious nursing shortage, generational differences in an aging workforce with poor prospects of replacements, high acuity and short staffing, conflict in the workplace, expanding technology, complex consumer health values, and an increasingly intercultural society" (Jacob, 2016, p. 18).

In 2008 the Institute of Medicine (IOM) and the Robert Wood Johnson Foundation (RWJF) partnered to help transform the nursing profession. In 2011 they identified four key messages:

> Nurses should practice to the full extent of their education and training; nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; nurses should be full partners with physicians and other health professionals in redesigning health care in the United States; and effective workforce planning and policy making require better data collection and an improved information infrastructure. (IOM, 2011, p. 4)

As the profession of nursing has struggled to gain status, nursing education has also changed to produce graduates who can meet the growing needs of the healthcare system in the United States. However, at present, this is a complicated task. According to the American Association of Colleges of Nursing in 2018, 75,029 qualified applicants were turned away from U.S. nursing schools, "due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors and budget constraints" (AACN, 2019). To meet the demand and address the current shortage of nursing faculty, college of nursing have increasingly hired nurse educators who have less formal teaching preparation, if any at all, than a generation ago (Schoening, 2013).

Values and Ethical Principles in Nursing

Nursing as an independent profession needs to have a basis in value judgments that goes beyond the technical service and womanly duty that defined its origin. The ANA code of ethics

was established to provide guidelines for principled practice—a dynamic document designed to evolve with social and nursing content change (ANA, 2015). Nursing has been called many different things: a human science, a human health experience, a helping profession, a moral calling (Newman, Sime & Corcoran-Perry, 1991; Keough, 1997; Adams, 2016; Risjord, 2010). Nursing cannot exist without interactions between nurses and patients and these interactions lead to ethical decisions being commonplace. However, the didactic nursing curriculum spends less time on values and ethical principles than it does skills, competencies, and charting (Catalano, 2019). This is problematic because, "an understanding of the underlying ethical principles, ethical theories or systems, a decision-making model, and the profession's code of ethics" are critical to nursing practice (Catalano, 2019, p. 123) The clinical nurse educator is in a position where their ability to make ethical decisions in educating students and through modeling their own behavior is critically important to uphold nursing's core competencies. The code of ethics, "informs every aspect of the nurses' life," (ANA, 2015, p. 10) and is non-negotiable. It is the foundation of, "nursing theory, practice and praxis in its expression of the values, virtues, and obligations that shape, guide and inform nursing as a profession" (ANA, 2015, p. 10).

Values

Values are the "ideals or concepts that give meaning to an individual's life" (Catalano, 2019, p. 124). "Professional values are standards for action that are accepted by the practitioner and professional group and provide a framework for evaluating beliefs and attitudes that influence behavior" (Weis & Schank, 1997, p. 366). They are learned, develop from personal experience, are the basis of behavior, and are seen through consistent behavior (Kratwohl, Bloom, & Masia, 1964; Raths, Harmin, & Simon, 1966). It is imperative to not only understand ones' own values, but the values of ones chosen profession (Ludoc & Kotzer, 2009; Thorpe &

Loo, 2003). “Nurses’ awareness of their own values and how these values influence behavior is an essential component of humanistic nursing care” (Elfrink & Lutz, 1991, p. 239). The importance of professional values in nursing arose because nurses continually face dilemmas in which they must use their professional values to resolve the dilemmas (Benner, 1985). The profession must, “continually emphasize the values of respect, fairness, and caring…in order to promote health in all sectors of the population” (ANA, 2015, p. 35). Also, for nursing students their values change and expand throughout their education, creating a need for instruction informed by the values of the profession (Weis & Schank, 2000). Nursing values serve to guide the ANA code of ethics and “are a reflection of the professional commitment necessary for socialization into (the) profession” (Ludoc & Kotzer, 2009; p. 279).

Nursing Code of Ethics

The code of ethics for nursing governs the profession and is frequently reviewed and updated to ensure relevance to current practice (Catalano, 2019). While not the only code of ethics for nursing, the ANA Code of Ethics (see Appendix A) is seen as the benchmark in the United States (Catalano, 2019). The first formal code of ethics for nursing was developed by the ANA in 1950 with its first major revision occurring in 1960. At this time the code included 17 provisions to guide ethical conduct, however they lacked interpretation (Epstein & Turner, 2015). A revision in 1968 included slight interpretations which could be used by nurses to guide ethical decision making; the provisions were also decreased from 17 to ten (Epstein & Turner, 2015). The 1968 revisions also moved the provisions to duty-based obligations and away from the generalized responsibilities of earlier editions (Epstein & Turner, 2015). The current code of ethics was adopted in 2015 after a four-year process. The process of revising the code began with the appointment of a Code Review Working Group, an online survey, and a recommendation by

the ANA Ethics Advisory Board for revision. The ANA President approved the revision process, establishing a Code Steering Committee who drafted the revision. This draft was posted, allowing public comment and suggestions prior to the approval of the revisions by the ANA Board of Directors (Epstein & Turner, 2015).

A code of ethics is a guide to help with ethical decision making as opposed to an article which gives answers to dilemmas (Catalano, 2019). Nursing ethics "comprise the profession's social contract: to do no harm, to act in the patient's best interests, to keep in confidence all private matters entrusted to one, to maintain competence, and to advocate for the patient's needs" (Curtin, 2000, p. 18).

Four Categories of Ethics

Understanding ethics and ethical decision making is important to understanding nursing's code of ethics. To begin we will look at four categories of ethics. The first is metaethics which is an umbrella term that covers the other categories of ethics. It studies the "nature of ethics and moral reasoning" (ANA, 2015, p. xii) and is concerned with "*how* do we know what is right and wrong" and "what is truth" (Catalano, 2019, p. 124). It looks to fundamental meanings behind language and words and is used to understand the other categories. Normative ethics is the second category and addresses the *ought* of ethical questions, what is *right* and *wrong*, *good* and *evil* (ANA, 2015). It addresses "what is *right* and *wrong* in human action (what we *ought* to *do*); what is *good* and *evil* in human character (what we *ought* to *be*); and *good* or *evil* in the ends that we *ought* to seek" (ANA, 2015, p. xii). Along with metaethics, it helps to develop theories and codes of ethics (Catalano, 2019). The third category is applied ethics which is the application of the "theories and systems of ethics" which come from normative ethics (Catalano, 2019, p.124) in a "realm of human action, such as nursing" (ANA, 2015, p. xii). Nursing and health care use

applied ethics most as it is what is used to resolve ethical dilemmas in patient care (Catalano, 2019). The final category is descriptive ethics which looks at society to see what ethical principles they uphold, as opposed to determining what they should do. These norms will be those that the majority value.

Key Ethical Principles

Several principles are used in ethics to resolve ethical dilemmas, times when a choice must be made on an action: autonomy, justice, fidelity, beneficence and nonmaleficence, and veracity. In nursing there are many different ethical dilemmas nurses can face. There is a constant struggle to make the correct choices for a multitude of patients. Even if they do not realize it the following principles may help nurses guide their decisions when presented with a dilemma. These ethical principles are woven throughout the ANA Code of Ethics. The principles are also based on theories from moral philosophy. Ideas from Immanuel Kant, utilitarianism, and Aristotle's virtue ethics feature prominently throughout these principles. Therefore, before discussing these ethical principles, it is important to take a moment to look at these theories to better grasp the foundational principles used to guide nursing.

Theories from Moral Philosophy

Immanuel Kant. Immanuel Kant proposed a theory of morality that sees service to others in the light of rational thought. Kant believed in respect for humanity and that justice, "requires us to uphold the human rights of all persons, regardless of where they live or how well we know them, simply because they are human beings, capable of reason, and therefore worthy of respect" (Sandel, 2009, p. 123). To Kant, "morality is not about maximizing happiness or any other end … it is about respecting persons as ends in themselves" (Sandel, 2009, p. 105). Actions have moral worth if they are performed for the right motive, not for the consequences of the

action but for the intention behind the actions (Sandel, 2009, p. 111). Actions can only have a moral worth if they are done out of the motive of duty (Sandel, 2009, p. 112). For Kant, moral action was governed by the categorical imperative, to act only on that action, "is represented as good in itself, and therefore as necessary for the will which of itself accords with reason" (Sandel, 2009, p.119). For Kant rational beings have dignity, and this dignity affords them an absolute, intrinsic value (Sandel, 2009, p. 122). Our duty as bearers of humanity is to respect our fellow human beings (Sandel, 2009, p. 123). Kant makes a distinction between respect and, "other forms of human attachment…love, sympathy, solidarity, and fellow feeling" (Sandel, 2009, p. 123). These other forms of attachment, while laudable sentiments, lead us to care for others because of who they are (Sandel, 2009, p. 123). Kant's belief in the dignity of humanity transcends *who* the individual is and calls us to, "uphold the human rights of all persons, regardless of where they live and how well we know them" (Sandel, 2009, p. 123).

Utilitarianism. In contrast to Kant's ethic of morality, utilitarianism moves the focus from individuals to that of the masses. The greatest good becomes the greatest happiness of all. Jeremy Bentham, an English philosopher, believed that "the highest principle of morality is to maximize happiness, the overall balance of pleasure over pain" (Sandel, 2009, p. 34). Moral and political life would be based on the belief that all like pleasure and dislike pain (Sandel, 2009, p.34). If this is true, then one would not defend rights or duties unless this defense would lead to happiness being maximized (Sandel, 2009). Individual rights are not the concern of Bentham's utilitarianism. While action does not occur for individual rights, the preferences of individuals are weighed equally. So long as one's preferences lie with the masses all will be well, however life may not be kind or happy for those that do not fall into the mass group.

John Stuart Mill, whose father was Bentham's secretary, tried to answer these issues and preserve Bentham's philosophy. He believed that "people should be free to do whatever they want, provided they do no harm to others" (Sandel, 2009, p. 49). Mill attempted to bring back the individual, believing that "respecting individual liberty will lead to the greatest human happiness" (Sandel, 2009, p. 50). In response to the single scale of values he believed that there are higher and lower pleasures which served as the basis for the promotion of human wellbeing.

Aristotle: Virtue ethics. The Greek philosopher, Aristotle, believed that ethical knowledge is experiential. One must have "experience of the affairs of life" (Nichomachean Ethics, 1095a). He believed that moral excellences and virtues "come neither by nature nor against nature, but nature gives the capacity for acquiring them, and this is developed by training" (Nichomachean Ethics, 1103a). For one to be virtuous they must deliberately complete virtuous acts. Virtue is defined as "a habit, disposed toward action by deliberate choice, being at the mean relative to us, and defined by reason as a prudent man would define it" (Nichomachean Ethics, 1107a). To be virtuous, one must act virtuously and know that what they are doing is virtuous. Aristotle identified two types of virtues: ethical and intellectual. Ethical virtues are made up of bravery, temperance, generosity, munificence, magnanimity, honor, good temper, friendliness, truthfulness, wit, and justice. Justice, while listed last, can be seen as a complete virtue, the chief virtue. It is "complete because he that has it is able to exhibit virtue in dealing with his neighbors, and not merely in his private affairs; for there are many who can be virtuous enough at home, but fail in dealing with their neighbors" (Nichomachean Ethics, 1129b). Justice, "alone is thought to be another's good…for it is another's interest that justice aims at" (Nichomachean Ethics, 1130a).

Intellectual virtues are the rational way the mind arrives at truth and consist of: "art, science, prudence, wisdom, and reason" (Nichomachean Ethics, 1139b). Of these prudence and wisdom are highly important. Prudence is needed to attain moral virtue and is needed to find the correct mean in all of ones' actions. Prudence "is a formed faculty that apprehends truth by reasoning or calculation, and issues in action, in the field of human good" (Nichomachean Ethics, 1140b27). Wisdom is linked to prudence because prudence allows one to attain wisdom.

While essential for professional practice, these moral theories are not easily translated into everyday nursing situations. For example, although human wellbeing—an imperative from utilitarianism—is sought, it is not desired at any cost. Individual rights, equality, and respect for persons must constrain nursing practice. Such ethical dilemmas are ubiquitous in these theories. Accordingly, to bring the guidance of the universal to the particular, the ANA offers a code of ethics built around essential principles derived from the theories discussed.

Autonomy

Autonomy is the right to make decisions on one's own, so long as those decisions do not infringe upon the rights of another. In Kantian ethics, autonomy is central to acting freely, following one's own moral laws to guide action (Singer, 2009). Patients have the right to make decisions about their medical treatment, even if it goes against medical advice. Nurses not only must respect a patients' autonomy, but they must also use personal autonomy to make decisions guided by moral responsibility. See Appendix B how autonomy and the other ethical principles are connected to the provisions of the ANA Code of Ethics.

Justice

Justice is treating others with equity and fairness. Immanuel Kant's moral theory holds that the dignity of humanity transcends *who* the individual is and calls us to "uphold the human

rights of all persons, regardless of where they live and how well we know them" (Sandel, 2009, p. 123). According to Aristotle, justice is the chief virtue one possesses. It is "complete because he that has it is able to exhibit virtue in dealing with his neighbors, and not merely in his private affairs; for there are many who can be virtuous enough at home, but fail in dealing with their neighbors" (Nichomachean Ethics, 1129b). Justice "alone is thought to be another's good…for it is another's interest that justice aims at" (Nichomachean Ethics, 1130a).

Fidelity

Fidelity requires "loyalty, fairness, truthfulness, advocacy and dedication in relationships" (ANA, 2015, p. 43). It is the "obligation of an individual to be faithful to commitments made" to self and others (Catalano, 2019, p. 127). A nurses' accountability stems from this concept and reflects their faithfulness to the profession. The idea of fidelity lends itself closely to Aristotle, being an ethical virtue.

Beneficence and Nonmaleficence

Beneficence calls for nurses to *do good* for their patients, while nonmaleficence calls for nurses to *do no harm*. Nurses act through holistic treatment of patients, treating both mind and body, using their skills and understanding to ensure the best for the patient and their families. This idea goes hand in hand with nonmaleficence, with the hope that doing good will lead to not doing harm. If harm occurs it should be balanced with the benefits of the action (ANA, 2015). Kant's ideas of justice along with the Utilitarian desire for good without harm are easily seen in these principles.

Veracity

Veracity is the concept of being truthful and not misleading. This concept can be difficult for nurses because many times they are the face the patient sees most often. There can sometimes

be a strain between what the physician is willing to disclose to the patient and the nurse must tread a fine line of what can and cannot be said. However, it is important to not give false hope or wrong information. This principle sees its basis in the ethical virtues of Aristotle.

Care

In addition to these core principles, the ANA Code of Ethics also incorporates other social and professional values. Particularly important, is the commitment to care. Nursing values and ethics are many times manifested in the idea that nurses care; this term being one that covers the ethical principles of the profession. Nursing proudly claims care as the center, the heart, of the profession. Care is a thread which is seen throughout the history of the profession of nursing (Adams, 2016). Care is used to describe what nurses are and what nurses do (Cloyes, 2002, p. 203). "Care is the essence of nursing and a distinct, dominant, central, and unifying focus" (Leininger, 2002, p. 192). The belief that nurses care is universally accepted, indeed expected, but it is also complex, contested, and multilayered, a "concept that refers not just to actions and activities, but to relationships and to values and attitudes about our responsibility for others and for our own being in the world" (Fine, 2007, p. 4). Caring can be seen as either a noun, the act of caring, or an adjective, displaying acts of "compassion, kindness and concern" (Adams, 2016, p. 1). Within the profession of nursing, care has transformed from the historic assumption of feminine virtue and obligation, to one of art and science, a mix of care as noun and adjective. Modern nurses care by respecting patients' autonomy, using justice to guide decisions, demonstrating fidelity to the profession, allowing principles of beneficence and nonmaleficence to guide practice, and ensuring veracity with patient interactions.

Clinical Nurse Educators and the Profession of Nursing

Nurse educators are torchbearers within the profession of nursing. They must serve as role models, teachers, and visionary leaders (Adelman-Mullally, Mulder, McCarter-Spalding, Hagler, Gaberson, et al., 2013; Halstead & Frank, 2018; National League of Nursing [NLN], 2012).

NLN's Competencies for Nurse Educators (2012) stated that nurse educators must "maintain the professional practice knowledge … [to] serve as a role model of professional nursing" (Competency 1). This is essential work of because:

> As a teacher of nursing, you will always be looked upon as a role model of professional values—not just among your students but also among the other health care professionals with whom you will come in contact. Your interactions with your students, patients and family members, faculty colleagues, and other health care professionals will be constantly observed by others. (Halstead & Frank, 2018, p. 27)

This is particularly true of clinical nurse educators who instruct in a practice setting. Unlike nurse educators who didactically teach in a classroom setting with a focus on facts, theory, and research, clinical educators prepare nursing students for nursing practice through experiential learning in clinical settings that requires clinical nurse educators to bridge theory and practice within their teaching (Adelman-Mullally et al., 2013; Becker & Neuwirth, 2002; Collier, 2018).

In order to bridge theory and practice, clinical nurse educators must model expert nurse practice (Benner, 2004). Expertise (and the learning and development that proceeds it) is developed through experience, or in the case of nursing education, clinical experiences. Procedural and scientific knowledge that is formal, explicit, and certain – the skills and knowledge necessary, but not sufficient, to be a nurse, are learned in these clinical practices. Wisdom of practice is also gained through experience and is demonstrated in clinical judgment

especially during rapidly changing situations, prioritizing the needs of the patient, patient teaching and counseling, and interactions with the families all of which highlight the complexities of patient care (Benner, 2001, 2004; Tanner, 2006).

This wisdom of practice also extends to other professional expectations. It may include attending to the little things that concern patients (Perry, 2009) or ethical and advocacy issues (such as responding and reporting potential patient safety). Nurse educators must also model professional learning behaviors such as lifelong learning and involvement in professional organizations (NLN, 2015, Competency 2). They must communicate how to work on an interprofessional team, how to skillfully question a physician's order, how to present patient reports using ISBARR (Introduce, Situation, Background, Assessment, Recommendation, Read Back) to other nurses and how this may differ when presenting patients to physicians (Adelman-Mullally et al., 2013; Benner, 2004; Enlow, Shanks, Guhde, & Perkins, 2010; Schneider, 2016).

Nurses' professional responsibilities are great. Clinical nurse educators' responsibilities are greater because their professional actions are always under the eyes of watchful nursing students. Students vicariously learn from role models, regardless of whether the instruction is intentional or unintentional (Bandura, 1965; Bandura, 2001; Gaberson & Oermann, 2010). In short, clinical nurse educators serve as a symbol that helps

> students envision what it looks like to be a professional nurse. Through words and actions, clinical faculty members portray professional nursing to novice learners. Thus, choosing words and actions that convey the responsibility, accountability, and opportunity of the profession enhances the meaning of 'nurse' to the students and patients with whom they interact. (Adelman-Mullally et al., 2013, p. 31)

Clinical Nurse Educators as Teachers of the Profession of Nursing

Not only must clinical nurse educators be able to model professional behavior, they must also be able to create learning environments within clinical practice so that they can teach

professional behavior and through this teaching socialize nursing students to the role of the nurse. NLN's Competencies for Nurse Educators (2015) state that

> Nurse educators recognize their responsibility for helping students develop as nurses and integrate the values and behaviors expected of those who fulfill that role. To facilitate learner development and socialization effectively, the nurse educator … [must] create learning environments that are focused on socialization to the role of the nurse. (Competency 2)

The clinical nurse educator must not only be a role model of the profession but also find ways to intentionally teach the profession. To do so, clinical nurse educators must be competent in the design, assessment, and evaluation of clinical curriculum using the best evidence-based practices (NLN Competencies 3 and 4). They must also be able to implement a variety of teaching strategies grounded in educational theory and evidence-based teaching practices to meet the individual and diverse needs of learners (Competency 1 and 2).

Another pedagogical tool that the NLN recommends is that nurse educators use their "personal attributes (e.g., caring, confidence, patience, integrity, and flexibility)" to facilitate nursing student learning (Competency 2). Interestingly, such tools are not unlike that which the Nightingale School advocated many years ago, namely that a nurse's good character serves as a foundation for nursing practice and its teaching. This serves as another example of the ways that care has been normalized within nursing and the nursing curriculum (Dahlke & Stahlke, 2017).

Clinical Nurse Educators as Leaders in the Profession of Nursing

Nurse educators are called to function as transformational change agents and leaders to create a preferred future for nursing practice (NLN, 2012, Competency 5). An integral part of creating a preferred future is sharing a vision of what that future will be (Kotter, 2012; Kouzes & Posner, 2007). As such, clinical nursing educators are leaders who "should have a clear vision of professional nursing and how it is enacted at the bedside – in real patient care settings" and work

with students to move beyond the technical skills of nursing to see the larger picture of the profession as it currently is and to imagine otherwise about what it could be (Adelman-Mullally et al., 2013, p. 30).

Being a leader is a choice (Kotter, 2012). Therefore, clinical nurse educators must intentionally choose to be a role model, effective teacher, and visionary leader. Such choice requires an ability to "articulate and demonstrate your professional values" and "requires reflection and deliberate action on your part" (Halstead & Frank, 2018, p. 27). The teaching of values and ethics is often the responsibility of clinical educators because it is typically unplanned, arises during professional interactions in the hospital, and is taught extemporaneously through informal instruction in the moment or during post-conference at the end of the day (Elfrink & Lutz, 1991; Martin, Yarbrough, & Alfred, 2003). The possibility of confronting ethical dilemmas with students in the hospital is great and leads to many opportunities for teachable moments with students. The question is whether or not the clinical nurse educator is articulating and demonstrating appropriate values and ethical principles while guiding students through these dilemmas.

Summary

Clinical nurse educators are at the nexus of the profession of nursing, nursing practice, and nursing education. Commitment to the competencies of nurse education requires expert knowledge and practice in nursing and education to be an exemplary role model for the profession of nursing and effective teacher for the future generation of nurses who will populate the profession. Such commitment also requires the possession of care as a personal attribute. However, it also requires an ability to articulate their professional values.

No matter their important role many nurses enter the education field with a lack of guidance and orientation, using past experiences to guide practice as a teacher, learning to teach through "trial and error on the job" (Scanlan, 2001, p. 242). Without formal education nurses who enter academia may lack development in the core competencies identified by the NLN (McDonald, 2010; Brown & Sorrell, 2017), even those with formal education may not be familiar with these competencies.

Conclusion

Nursing has struggled to construct its professional identity. The history of nursing in America shows how leaders and organizations like the ANA and NLN envisioned this process by evaluating the essential components of professionalism and characteristic of other fields (law, medicine, etc.). Further identified by Flexner (1915), these expectations are spelled out in mission statements, conceptual frameworks, standards of practice, codes of ethics, and the like. Education has been an integral component of its history, expanding from training programs in hospitals to advanced degrees at universities.

As the profession grew a focus on the values and ethical principles core to nursing were identified and continue to be a dynamic component of the profession. As societal change occurs nursing too ensures that they address these changes. Documents such as the ANA Code of Ethics offer guidance for nurses to inform their practice and assist with the resolution of ethical dilemmas.

The role of nurse education is to not only to transmit skills; professionalization also demands transmission of the values and ethical principles that inform professional practice. These concepts are not passed on solely in didactic activities of the university program, but more likely are the work of the clinical instructor who translates theory in to practice with students.

How do clinical nurse educators understand this professional expectation? What is their view of nursing values and the proper employment of ethical principles? How does this understanding inform their teaching? As recognized by the NLN in 2020, no research has been done which looks at clinical nurse educators related to their use and knowledge of their core competencies (Christensen & Simmons, 2020). Indeed, the NLN makes a call for research to make initial steps using descriptive qualitative studies (Christensen & Simmons, 2020), a description of one such study follows in the next chapter.

CHAPTER III:

METHODOLOGY

The purpose of this study was to explore clinical nurse educators' understanding of and commitment to the values and ethical principles of the nursing profession. The following research questions were addressed: (1) what do clinical nurse educators believe are the values and ethical principles of the profession of nursing; and (2) how do clinical nurse educators' beliefs about the values and ethical principles of the profession of nursing inform their educational practices? These questions were answered by examining the experiences of clinical nurse educators working in clinical settings with nursing students. Answering these research questions required a detailed understanding of the participants' beliefs and commitments to the nursing profession. To this end, I employed qualitative methodology to reveal these meanings and explain their efforts to pass on such values to their students in the context of clinical instruction. Given the paucity of research in this area, a qualitative descriptive design was most appropriate. This method structures a naturalistic inquiry in cases where "there is no pre-selections of study variable, no manipulation of variables, and no prior commitment to any one theoretical view of a target phenomenon" (Lambert & Lambert, 2012, p. 255) and allows for "a comprehensive summarization, in everyday terms, of specific events experienced by individuals" (Lambert & Lambert, 2012, p. 255). This necessary first step was essential in the development of understanding clinical nurse educators' beliefs about the values and ethical principles of the profession, and how these beliefs translated into common pedagogic experiences in clinical settings.

Settings and Participants

This study was conducted in the southeastern United States in a metropolitan area of approximately 200,000 people with a mixture of urban, suburban, and rural housing. The racial/ethnicity demographics of this district are 65% White, 32% African American, and 4% Hispanic or Latino. Almost 90% of the population has a high-school degree, and 30% hold a bachelor's degree. The median household income is $52,000 and 17% of the population lives in poverty. The regional medical centers that serve this area have over 800 beds, offer a full range of inpatient, outpatient, advanced services including oncology, cardiology, and robotic and minimally invasive surgery. It also has the most advanced trauma center in the region (United States Census Bureau, 2019). Regional medical centers create opportunities for clinical nurse educators and nursing students to teach and learn about the profession of nursing in a clinical setting that offers a full spectrum of healthcare services with opportunity for nurses to interact with patients with a wide range of health concerns, and from all walks of life: urban or rural, black or white, rich or poor.

The Clinical Nurse Educator

As defined earlier, the clinical nurse educator is a nurse educator employed by a college or university to instruct small groups of nursing students in a hospital and other clinical practice settings as they care for patients. Clinical nurse educators come from a variety of backgrounds prior to becoming teachers. A wide range of prior clinical experience is represented. While courses such as pediatrics and obstetrics require clinical educators with experience in these specialties, classes such as fundamentals and adult health can recruit educators from many backgrounds including medical-surgical, intensive care, operating room, and emergency departments. At the university where this study was conducted, clinical nursing educators are

required to have at least a master's degree in nursing, however there is no specific degree focus needed. A desire to teach, an advanced degree, and an unencumbered state nursing license are the main requirements. There are both part-time and full-time positions, each contracted on a one-year renewable basis. Full-time positions include requirements to attend faculty meetings, join college committees, and provide academic advising. Contract faculty attend a one-day college orientation which introduces them to job requirements and expectations. Specific content included in orientation includes a review of the mission, values, core content and program objectives of the nursing program, guidelines for student medication administration, student opinion of instruction forms, student evaluation forms, blood to blood contact and substance abuse policies for students, and a review of the ISBARR communication tool (Personal email on 7/5/2020 from dean who oversees undergraduate nursing education; Enlow et al., 2010). This orientation only occurs once, if the faculty contract is renewed there is no requirement to attend another orientation. Every year there is a general clinical orientation day which briefly reviews these same documents and addresses any program changes for clinical education. Depending on the location which the clinical faculty will work, there may also be an orientation provided by the clinical agency themselves covering their specific policies for clinical educators and their students. Any other course specific information is provided by the course leaders or the course clinical coordinator. This includes the course calendar, student evaluation materials, expectations of student performance, and any other relevant information for the clinical course component.

For the clinical nurse educator, so long as the clinical course objectives are being met, the ways with which they instruct students is left to their discretion, within the bounds of hospital policy and procedure. Pre- and post-conferences with students (times when the clinical instructor and the entire clinical group meet to discuss daily expectations and a daily debriefing) can be

very different from one instructor to the next. I have known some educators who prefer very long pre-conferences, having all students give in depth information about their patients prior to going on to the hospital unit; others who prefer short pre-conferences detailing patient assignments with patient reports delivered by the nightshift nurse. Post-conference can also vary in length and subject matter ranging from short reports from students to in depth discussion about a specific event to teaching sessions covering clinical diagnoses or skills. Students' clinical practice on the unit is also left to the personal interpretation of the clinical nurse educator. Students can work in pairs sharing one or more patients, or they can work alone with one or two patients. As students progress through the nursing program, their responsibilities should expand, and the clinical nurse educator should take into account their previous experience ensuring the student continues to expand experiences. For example, in *fundamentals*, students are expected to perform basic patient care tasks including bathing, glucose checks, and some medication administration for one patient on a medical-surgical unit. *Adult health* builds on fundamentals, and students are expected to expand upon these tasks and include all patient care and medication administration for up to two patients on a medical-surgical unit. Some educators may pair students together for the first day or until they are comfortable with not only patient care but computer charting and basic knowledge of the unit. Other educators may delegate a student to perform the role of a charge nurse ensuring all tasks are completed by students and reporting to the clinical instructor. Complex client builds on adult health, and students are expected to provide all patient care and medical administration for one patient in an intensive care unit in collaboration with the hospital nurse and clinical nurse educator.

For this study, clinical nurse educators were recruited from the large public research university located within this region. The clinical nurse educators met with their students in a

variety of settings including the clinical practice lab, simulation lab, and hospital settings. The focus of this study was on the time which was spent in the hospital. Participants could have taught in courses that included clinical rotations in hospital settings such as fundamentals of nursing, adult health, pediatrics, obstetrics, and complex client. Each of these courses has differing clinical hour requirements along with varied number students to be taught. In accordance with Alabama Board of Nursing Administrative Code, the instructor to student ratio never exceeds 1:8 while in licensed hospitals which provide acute care (ABN). The total number of students that a clinical nurse educator teaches over a semester varies per clinical course as does the amount of time spent in the hospital (see Table 1). Activities which occur in the hospital include the students being assigned at least one patient with whom they will manage care. Expectations of the students vary from course to course, but the role of the instructor remains much the same. Assigning patients, assisting with clinical skills, ensuring patients daily care (bathing, toileting), and medication administration are all overseen by the clinical instructor. As the students move through the curriculum, their roles should expand. A student in fundamentals performs less complex tasks and skills and requires more clinical supervision than a student in complex client.

Table 1

Number of Hours in Hospital Setting for Clinical Nurse Educators and Nursing Students

Course	Status	Max Number of Students	Clinical Hours for Students	Total Clinical Hours per Semester for Educators	Clinical Hours Per Week for Educators
Fundamentals	Part-time	8	64	64	16
	Full-time	16	64	128	32
Adult Health	Part-time	8	180	180	16
	Full-time	16	180	360	32
Complex Client	N/A[a]	24	80	240	20
Pediatrics	N/A[a]	36	32	192	16
OBGYN	N/A[a]	36	32	96	16

[a] Status for the course is not applicable as all educators have the same number of clinical hours regardless of status.

Procedures

Participants were recruited via word of mouth and through email announcements. Recruitment ensured participants are clinical nurse educators as defined for this study. The final participant population was contingent on those who volunteered for the study. It was anticipated that there would be between 4-6 participants. Ultimately, six clinical nurse educators volunteered and participated in this study. Descriptions of each participant are included in Chapter IV. Although there is no defined minimum or maximum number of participants for qualitative descriptive studies, a systematic review of the literature reveals that 33 studies out of 55 had between 8-20 participants (Kim, Sefcik, & Bradway, 2017).

As this study took place during the COVID-19 pandemic of 2020, zoom interviews were scheduled and conducted in compliance with university research protocol to ensure the comfort and safety of the participants and the researcher. Consistent with qualitative descriptive studies,

interviews were minimally to moderately structured, open-ended (Sandelowski, 2000) and lasted approximately 45 to 60 minutes.

Interviews

During the interviews, participants were first asked background questions regarding their education and nursing experience. Questions included their educational background, their area(s) of nursing expertise, their clinical nurse educator experience, formal training in nursing education, how long they have been at their current position, and the courses they have taught. See Appendix C for a list of the specific background questions. The purpose of these background questions was three-fold: 1) to provide more context for their responses; 2) to build rapport; and 3) to help participants feel at ease before answering additional interview questions. Establishing rapport and helping participants feel at ease was important, as the next set of interview questions were specific to their role as a clinical nurse educator and required honesty and openness.

Description of Interview Questions

To gather data for the research questions, clinical nurse educators were asked to describe what they believe the profession of nursing to be and what elements make up the profession including aspects that make a nurse good. Based on participants' responses, the interviewer explored in greater depths their initial responses about the profession to clarify meanings. Participants were then be asked to describe their role as a clinical nurse educator and elements that contribute to good practice in that role.

Participants were also asked to describe what they believe to be the values and ethical principles of the profession. To prompt participants, they were asked whether they had any knowledge about the NLN core values for nurse education and how they teach these values. Next, participants were asked about the ethical principles by sharing their knowledge of the

ANA Code of Ethics, what they believe are the main ethical principles, and how they teach these principles. To wrap up the interview, participants were asked "is there anything else that you would like to share that I have failed to ask you?" See Appendix D for a list of specific questions.

Data Collection and Data Preparation

All interviews were video recorded via Zoom. The audio was transcribed using Zoom's transcription feature. Once the audio transcription was received, I re-watched the video recording and cleaned the transcriptions to ensure a high-quality transcript without any errors. Transcription included a verbatim verbal account of the interviews. Notes were also taken during the interview to help contextualize what was said and the participant's physical reactions.

Becoming immersed in the data is important for qualitative descriptive studies, transcription allows for the researcher to read the entire interview multiple times to get a sense of the whole discussion (Vaismoradi et al., 2013). As is common with other qualitative methods, all data was collected prior to analysis (Chamberlain, Camic, & Yardley, 2004; Vaismoradi, et al., 2013).

Content Analysis

Content analysis, which aims to describe the conceptual form of a phenomenon, was used to interpret the data gathered in this study (Elo & Kyngas, 2008; Vaismoradi et al., 2013). This form of analysis is suitable as it requires a lower level of interpretation, allowing the subjects own words to not get lost in those of the researcher (Vaismoradi et al., 2013). In a systematic review of 55 qualitative descriptive studies by Kim, Sefcik, and Bradway (2017), content analysis was found to be the most common strategy used to analyze the data. Content analysis allows coding and categorizing of large amounts of data to find trends and patterns in the

subjects' words (Vaismoradi et al., 2013; Mayring, 2000; Pope, Ziebland, & Mays, 2006; Gbrich, 2007). The purpose is to examine what is said, by whom, to whom, and to what effect (Bloor & Wood, 2006; Vaismoradi et al.; 2013). Content analysis is "well suited to analyze the multifaceted, important, and sensitive phenomena of nursing" (Elo & Kyngas, 2008; Vaismoradi et al., 2011; Vaismoradi et al., 2017). It is also good for reporting common issues in data in previously unstudied areas (Green & Thorogood, 2004; Vaismoradi et al.; 2017) and uses the research questions as a guide on what to analyze (Elo, Kaariainen, Kanste, Polkki, Utriainen, & Kyngas, 2014).

An inductive approach, which moves from specific data to general "so that the particular instances are observed and then combined into a larger while or general statement" (Elo & Kyngas, 2008, p. 109) was used to analyze the data as there is little, if any, former knowledge about clinical nurse educators' understandings of the profession and ethics and values within nursing (Elo & Kyngas, 2008; Vaismoradi et al., 2017). Three phases of analysis were used: preparation, organizing, and reporting (Elo & Kyngas, 2008; Vaismoradi et al., 2013).

Preparation began by determining which unit of analysis was to be used. Because the interviews were recorded in zoom, both manifest and latent content were analyzed. Manifest content consists of the transcription of the interviews, while latent content includes looking at the physical reactions of the participants, or those responses which are unsaid. The next step of preparation was becoming immersed in the data, watching the video recording, and reading the transcript several times to begin to make sense of the information (Burnard, 1991; Elo & Kyngas, 2008, Polit & Beck, 2004).

Organization occurred by using open coding, where "notes and headings are written in the text while reading it" (Elo & Kyngas, 2008, p. 109). The transcripts were again reread, and

headings were continually noted until all content was covered (Burnard, 1991, 1996; Hsieh & Shannon, 2005; Elo & Kyngas, 2008). Coding sheets were employed to organize the headings that were identified during open coding and determine categories (Cole, 1988; Dey, 1993; Downe-Wambolt, 1992; Elo & Kyngas, 2008). Higher order headings were then used to collapse the number of categories by grouping them based on what is similar or dissimilar (McCain, 1988; Burnard, 1991; Downe-Wamboldt, 1992; Dey; 1993; Elo & Kyngas, 2008). Categories are necessary to describe phenomena, increase understanding, and generate knowledge (Cavanagh, 1997; Elo & Kyngas, 2008).

The next step in organization was abstraction, taking the categories generated and breaking them into three components: a main category, generic category, and subcategory (see Figure 1). Similar subcategories were organized together and placed under a general category, which were then organized with other general categories under a main category (Dey, 1993; Elo & Kyngas, 2008; Robson, 1993). Abstraction occurred "as far as it is reasonable and possible" (Elo & Kyngas, 2008, p. 111). Reasonable abstraction ensured working within the participants' responses and using my knowledge of clinical settings to make inferences. While some interpretation must take place, the goal was to stay as close to the words used by participants as possible.

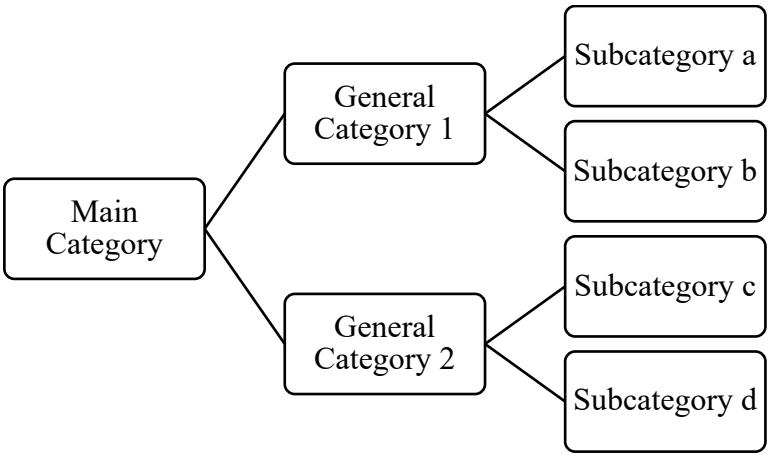

Figure 1. *Categorical abstraction in content analysis*

The final stage in data analysis is reporting the results. This should be done so that there is a clear understanding of how the analysis of the data occurred, looking at the process and result validity (Elo & Kyngas, 2008; GAO, 1996). Validity was determined by using member checking. Participants were presented with an initial write-up of their responses and included the categories and their meanings of not only the participants, but also of the overall categories and meanings across all participants. This allowed them to determine if I correctly interpreted their statements and allowed them to add anything that may have been missed (Birt, Scott, Cavers, Campbell, & Walter, 2016). To prompt them, I asked them to provide clarification for anything I missed or may have misinterpreted. During this second meeting, and after participants confirmed that the statements accurately reflected their beliefs and pedagogical approach based on their beliefs, I asked them to provide any additional examples of their clinical teaching that exemplified the categories presented to them. The purpose was to provide additional verification of the categories, their meanings, and resulting pedagogical practices.

Limitations

Limitations of this study included the geographical region from which the participants are located. Selecting participants from one large public research university in the southeastern

United States limits the ability to generalize beyond this one institution. Personal bias must be identified as an ethical consideration while coding the interviews. My goal was to share personal experiences as needed to help clarify questions only.

Limitations of qualitative description research include the large amount of data which was generated by the interviews with participants. As the sole interviewer and interpreter of the data, I tried my best to take personal bias into account since I did not have inter-rater reliability. I attempted to do this by reflecting on my positionality statement often as I was coding the data, trying to use participants verbatim responses as much as possible, asking participants to clarify meanings and provide examples in my original and follow-up member checking interviews, and limiting interjections of personal experience to provide context or interpretation of participants responses.

It is interesting to note that when I proposed the study, I thought that transcription time and cost would be a limitation of the study. I wrote

> Transcription of the interviews will be costly and time consuming. However, a transcription service will be used to expedite the return of the interview transcriptions to insure timely completion of the process. As soon as the first interview is completed the data will be sent to begin the transcription process, the same speed will take place after the subsequent interviews conclude. (Original Dissertation Proposal)

The artificial intelligence embedded within Zoom® video-hosting and recording technology eliminated cost and time. Audio transcription is included at no cost to me through my institution's zoom account. Further, the audio transcripts are available within minutes after concluding the interview. Although not perfect, the resulting transcripts allowed me to quickly clean any errors by re-watching the video recordings.

Delimitations

As a nurse I bring my own personal experiences in to the interview process. I have been a nurse for thirteen years; seven years were spent working in the operating room as a circulator and seven years have been spent as a clinical nurse educator on a medical-surgical ward. My experiences helped me understand the educators' perspectives in ways that others may not appreciate.

Ethical Considerations

Ethical considerations of this study included obtaining informed consent, ensuring participant confidentiality, and obtaining approval for the study by the Institutional Review Board (IRB) at The University of Alabama. Informed consent was obtained prior to the initial interview. Consent described the study components, including the right of the participant to withdraw from the study at any time. Participants were given the opportunity to choose a pseudonym to be used in the interviews. All participants declined to provide a pseudonym, so I created pseudonyms for them. None of the participants' real names were used in this study. All data was coded using these pseudonyms. All findings reported in Chapter IV and discussed in Chapter V also use these pseudonyms. The location of the interviews took place via zoom. All Zoom® data, videos and transcripts, are kept in my private University of Alabama Box account that meets FERPA and HIPPA security standards and any printed transcripts were in a locked cabinet in my locked office accessible only to myself. Approval for the study, research methods, and resulting presentations and publications, was granted by the Institutional Review Board of The University of Alabama prior to data collection.

CHAPTER IV:

RESULTS

This chapter presents the results of the descriptive qualitative analysis that was used to address the two research questions of this study. The research questions included the following:

1. What do clinical nurse educators believe are the values and ethical principles of the profession of nursing; and
2. How do clinical nurse educators' beliefs about the values and ethical principles of the profession of nursing inform their educational practices?

Demographic Background of Participants

The descriptive qualitative analysis was based on data from the interview responses of six participants: Ashley, Devi, Grace, Loretta, Joseph, and Margaret (all names are pseudonyms). All taught in the same nursing education program. They all have between seven and eleven years of nursing experience, and two and six years of clinical nursing education experience. All have a Master of Science in Nursing (MSN) degree or higher. One participant is working on a Doctor of Education (EdD) in Instructional Leadership with a concentration in Nursing Education, and three participants are working on a Doctorate (PhD) of Philosophy in Nursing. No participants have a nurse education certification, although three have an MSN in Nursing Education and one is working on an EdD in Nursing Education. Three participants teach in *Adult Health*, and the other three participants teach in *Fundamentals of Nursing*. A summary of their background is presented in Table 2 and a brief narrative description of each individual participant is given.

Table 2

Demographic Summary of Participants

Participant	Demographic Information						
	Years of Nursing Experience	Degrees	Nurse Education Certification	Current Course Taught	Other Teaching Experience	Current Clinical Teaching Unit	Past Clinical Teaching Unit(s)
Ashley	11	ADN BSN MSN EdD [a]	None [b]	Fundamentals of Nursing	Adult Health	MedSurg	None
Devi	10	BSN MSN PhD [a]	None [c]	Adult Health	Complex Client	Neuro & Cardiac ICU	Medical ICU
Grace	9	BSN FNP PhD[a]	None	Fundamentals of Nursing	Adult Health	MedSurg & ICU Step Down	None
Joseph	11	ADN BSN MSN DNP	None	Adult Health	None	Neuro MedSurg & ICU	None
Loretta	7	BSN MSN PhD[a]	None [c]	Fundamentals of Nursing	Adult Health, Complex Client	Cardiac & Respiratory Step-Down	Cardiac ICU
Margaret	9	BSN MSN	None [c]	Adult Health	None	Cardiac-Neuro & Orthopedic	None

Notes. ADN = Associate Degree of Nursing, BSN = Bachelor of Science in Nursing, FNP = Family Nurse Practitioner, DNP = Doctor of Nursing Practice. [a] Currently enrolled in degree program. [b] No Certification, but currently enrolled in an EdD in Nursing Education program. [c] No certification, but MSN in Nursing Education.

Ashley

Ashley is a 33-year-old white female who has been a practicing nurse for the past 11 years. She graduated with her Associates Degree in Nursing (ADN) in 2009, followed by her Bachelor of Science in Nursing (BSN) in 2010, and her MSN in 2012. She is currently enrolled in her fourth year in an Instructional Leadership in Nurse Education EdD program. She holds no certifications in nurse education. She has heard of the NLN Core Ethics and the ANA Ethical Principles but does not know them and could not recite their expectations. She has a combined eight years of clinical practice experience as a staff nurse on a med-surg floor and as a clinical

nurse educator for a cardiovascular service line. She has been a full-time clinical nurse educator for three years. When hired, Ashley recalls having meetings but not an official orientation. These meetings were with the dean of the nursing school and included a clinical overview, where the dean discussed the mission and values of the school, clinical expectations, evaluation, clinical policies, standards, and expectations. She also met with the course leader to discuss specific information about the clinical classes she would teach. She has taught clinicals in *Adult Health* and is currently teaching clinicals in *Fundamentals of Nursing*. Her clinical teaching occurs on a med-surg floor.

Devi

Devi is a 32-year-old white female who has been a practicing nurse for the past 10 years. She received her BSN in 2010 and her MSN in Nursing Education in 2017. She is currently enrolled in her first year of a Nursing Practice PhD program. Other than her MSN in Nursing Education she holds no nurse education certifications. Devi had heard of the NLN core values but was unable to identify them; she had also heard of the ANA Ethical Principles and was able to name the principle of fidelity but no others. She practiced for a combined eight years as a staff nurse in a cardiac intensive care unit, cardiac catheterization lab, and as a hospital nurse educator. She was a part time clinical nurse educator for four years and became a full-time clinical nurse educator for her current higher education institution in 2018. She remembers being given a binder full of information during her orientation. She met with the Traditional BSN Coordinator to go through the material, which included clinical policies, evaluations, critical behaviors, and expectations. She has taught in *Complex Client* and *Adult Health*, and currently is only teaching in *Adult Health*. In the past she has taught clinicals on a medical intensive care unit (ICU) and currently teaches students on a neurological ICU and a cardiac ICU.

Grace

Grace is a 29-year-old white female who has been a practicing nurse for the past nine years. She received her BSN in 2011 and a degree as a Family Nurse Practitioner in 2015. She is currently in her first year of a Nursing Practice PhD program. She holds no certifications in nurse education. She did not know of the NLN Core Values and while she was aware of the ANA Ethical Principles, she was unable to name any of them. She has a combined nine years of nursing practice experience as a staff nurse on an orthopedic unit, as an assistant nurse manager of an orthopedic unit, an assistant nurse manager of a trauma unit, and as an internal medicine nurse practitioner. Grace was hired as a full-time clinical nursing instructor in January of 2020. She remembers her orientation included a meeting with the dean and assistant dean of undergraduate programs. She received a packet of information that included resources and policies, but it was not completely covered as they only spent an hour looking at it. She also had meetings with the course leader and the clinical coordinator of the class she was assigned to. She has taught in *Adult Health* as a clinical nurse educator and is currently teaching in *Fundamentals of Nursing*. In the past, she has taught clinicals on an intensive care step-down unit and currently teaches students on a med-surg unit.

Joseph

Joseph is a 32-year-old white male who has been a practicing nurse for eleven years. He received an ADN in 2009, followed by a BSN in 2014, an MSN in nursing administration in 2017, and a Doctor of Nursing Practice in 2020. He has no certifications for nursing education. He has heard of and worked with the NLN Core Values but could not name them. He also said that he has read the ANA Ethical Principles, remembering a one-page document that talked of issues like integrity, and promoting patient rights, wellbeing, and health. He has a combined nine

years of clinical practice experience including work in a cardiac stress lab, as a staff nurse in a cardiac ICU for three years before becoming the charge nurse on the same unit. He followed that by becoming a nursing director and finally a chief nursing officer of the hospital. Joseph has been a clinical nurse educator for two years. He remembers a one-day orientation that included a meeting with the dean and associate dean. He also met with the traditional BSN coordinator to go through a packet which contained expectations on how to act in a professional role, clinical policies, and how to handle emergency situations. He teaches clinicals in *Adult Health* on a neurological med-surg floor and a neurological ICU.

Loretta

Loretta is a 29-year-old white female who has been a practicing nurse for seven years. She graduated with a BSN in 2013, followed by an MSN in Nurse Education. She is currently enrolled in the first year of a Nursing Science PhD program. Although she has an MSN in nursing education, she holds no additional certifications in nursing education. She claims that she has seen the NLN Core Values and learned about them in her undergraduate nursing program but that she could not repeat them back "off the top of her head." She had the book for the ANA Ethical Principles from an undergraduate nursing course but does not know its contents. She has a combined five years of clinical practice experience as a staff nurse on a medical ICU, a cardiac ICU, a cardiac catheterization lab, and as a rheumatic disease infusion nurse. She began teaching as a part time clinical nurse educator in 2018, becoming full-time in the fall of 2019. She says she did not have a full orientation but that the mission, goals, and vision of the school were made clear to her. She was assigned a mentor for the classes she has taught to provide guidance about expectations but claimed it was never structured because she was encouraged by her mentor to rely upon her experience when teaching to meet expectations. She has previously taught clinicals

in *Adult Health*, *Complex Client*, and is currently teaching in *Fundamentals of Nursing*. Her clinical teaching currently occurs on a cardiac step-down unit and a respiratory step-down unit. In the past, her clinical teaching occurred on a cardiac ICU.

Margaret

Margaret is a 32-year-old white female who has been a practicing nurse for nine years. She graduated with a BSN in 2011 and an MSN in nursing education in 2017. Although she has her MSN in nursing education, she has no additional certifications in nurse education. She has heard of the NLN Core Values but has never read them. She also reported knowing about the ANA Ethical Principles but that has not read them and cannot explain what they involve. She practiced for a combined five years as a staff nurse on a respiratory step-down unit, on the float pool (nurses who work on any unit that need extra assistance), and in bed control. She became a part time clinical nurse educator in the spring of 2017 and full-time in the fall of the same year. She remembers a full orientation where she met with the dean and assistant dean. Policies and the mission and vision of the school were covered. She currently teachers in *Adult Health* and her clinical teaching occurs on a cardiac/neurological unit and an orthopedic unit.

Clinical Experiences

Participants for this study are currently teaching in one of two clinical courses: *Fundamentals of Nursing* or *Adult Health*. Although the courses serve different pedagogical purposes, both require substantial time in a clinical setting and are adjacent to each other (one semester apart) within the upper-level nursing education curriculum. *Fundamentals of Nursing* clinical nurse educators spend time with their students in the hospital setting, but they also work with them in a clinical practice lab learning skills they will use with patients. The clinical nurse educators in this course have eight days with the students in the hospital for a total of 64 clinical

hours. Units that are utilized for *Fundamentals* are medical surgical floors, not higher acuity intensive care units. *Fundamentals* is the first clinical course students have that brings them into contact with patients in the hospital. Because of this, students in *Fundamentals* perform tasks such as practicing assessment skills, daily care with bathing and toileting, and glucose monitoring. Students also have an opportunity to administer medications once the other skills and tasks have been practiced and mastered.

Adult health clinical nurse educators spend two days a week for twelve weeks with students in the hospital setting for a total of 180 clinical hours. This comprises work on medical surgical, intensive care, and intensive care step-down units, allowing for opportunities to care for higher acuity patients than fundamentals. *Adult Health* students are in their second semester of hospital clinicals, meaning they have successfully completed *Fundamentals*. Because of this progression, the expectations for students also increase. They not only are required to complete the tasks they performed in *Fundamentals*; they must also begin providing full care on one to two patients. This means they will administer all medications, perform daily care activities, and complete any other tasks that are needed. This entails that clinical nurse educators are responsible for ensuring that up to eight clinical students provide safe care for 8 to 16 patients.

Research Question One

What do clinical nurse educators believe are the values and ethical principles of the profession of nursing? To answer Research Question 1, participants were asked to identify values and ethical principles that they believed were important to the profession of nursing. During analysis, three major themes were identified: integrity, patient rights, and duty to care. Honesty was identified a sub-theme within integrity. Fair treatment, do no harm, empowerment, and autonomy and advocacy were identified as sub-themes of patients' rights. Morality,

compassion, and empathy were identified as sub-themes of duty to care. In the following sections, each theme and sub-theme is defined and described using participants' data from the interviews. At the end of the section, these themes are then compared to the NLN Core Values and ANA Ethical Principles.

Integrity

Five out of the six participants mentioned integrity, four mentioned integrity by name, and three used the phrase "do the right thing." Four mentioned it first among their discussion of values and ethics in nursing. Throughout it was identified as the driving force behind the imperative not to take short cuts, to follow orders as written, and to treat people well.

When asked about the values important to the profession of nursing, Ashley named integrity first. She defined integrity as not only doing the right thing, but said it is, "your character … I don't want to say being a good person, because what's a good person? That's relative, right? But just always striving to do what's best." Ashley said she teaches integrity through the way her students handle simple, daily tasks with their patients. Attention to morning care (e.g., baths, assessment, dressing changes) and physician orders is a key focus of this lesson. She explained that many times nurses or support staff will tell students that they can take shortcuts on tasks and how she does not allow that, teaching them that the right thing is to follow all orders as they are written. It is also not always taking no for an answer when it comes to daily tasks, such as baths.

> That's just so important that these patients that are in the bed, they're people too, you know, they need to take a bath. If they haven't had one in four days, they probably would like one. And so instead of just going in and saying, "Do you want a bath?" and they say no, we encourage them. "We can help you. How can we help you do this? Let us get some supplies. Let us help you up to the chair." So, for them [the students], I try to model that by, you know, we're going to take that extra step, we're not just gonna leave it at that. But we're not going to *not* [emphasis added by Ashley] do it today because that's not acceptable.

Margaret also listed integrity first when asked about values. She linked integrity to honesty. Integrity is "being honest and being responsible … doing what you say you're going to do and fessing up when you've done something wrong." She recounted a specific time her students learned a lesson in integrity when they accidentally pulled out a surgical drain from a patient during a bed bath.

> It got pulled out while they were bathing and turning and pulling sheets and so they came up and they're scared about it and I was like, okay, well, they have to go tell the nurse what happened. And they have to tell the truth because the doctor needs to know. Unfortunately, it was not a very friendly doctor. It was one that has a tendency to be mean. … But it was kind of one of those moments when you make a mistake, regardless of if you meant to or not. You have to fess up because your patient's life could be in danger. Yeah, they learned the hard way. And then we also learned to pay extra attention as to where the drain is when we're rolling people and shoving sheets and pulling sheets out from people.

Joseph claimed that integrity is the main value in nursing "because I think that that encompasses a lot of other actions and how you would do it." When asked to expand he explained that integrity involves

> …doing the right things even if no one's looking and even if it's the harder thing. It's kind of how I would describe that because I think that it applies to a lot of what nursing, the duties and responsibilities fall under.

Joseph elaborated that teaching integrity was one of the more challenging values to instill in students.

> It can be difficult to highlight sometimes because you're trying to get the difficult balance between pointing out integrity and pointing out the lack [of integrity]. … They'll [nursing students] come to you a lot and say, "Hey, why didn't they [nursing staff] do this, why didn't they do that." And they do this the right way or wrong way or whatever it may be and so I think it is a tough balance to meet without bashing that nurse and saying they don't have integrity or that they're not doing the right thing.

When asked to identify values in nursing, Devi identified integrity, but only after stating honesty first. She sees the two as similar concepts, "Integrity, I guess that's kind of honesty."

Like Ashley and Joseph, Devi also likened it to doing the right thing. Similar to Margaret's example, she stated that integrity is

> …doing the right thing and being transparent about doing the right thing. Like for instance, if you made a med error, not hiding it. Like coming forward about a mistake you made or for the benefit of the patient's safety or to decrease the risk of harm.

Devi's students work in a unit that requires a lot of interaction between the nursing staff and the students. Students are not allowed access to the computer charting system, and Devi relies on the nurses to be with the students while administering most medications. Because of this, Devi continually stresses integrity with her students since there are high risk medications that they cannot administer without her present. "They still have to abide my list of meds that they can't give without me checking them off first," she said. "I guess like having a conversation with them about like, being honest about not giving those meds and if you give that med you have to tell me and let me know."

Honesty. Five participants spoke of honesty as a value and ethical principle as a sub-theme within integrity. Honesty took multiple forms, for example, admitting when one does not know something, admitting when one makes a mistake, and having difficult conversations with patients.

Ashley and Loretta both spoke of the importance of admitting when you do not know something; for example, an order that one has never seen before, a skill that one has not performed before, or medicine that one has not administered before. Ashley said that asking for assistance when instructed to do a task was a necessity. Loretta added that this did not just pertain to students, but as clinical nurse educators as well.

> Being honest with your students when I don't know something because I don't know everything, and I never will. … Being an example to say, "Hey, it's very okay to be honest when you're unsure of something, because the risk is hurting somebody." And so,

> I think that's one of the most important values that a nurse can have is to be honest and open and transparent.

When speaking of values, Joseph, Devi, and Margaret all included honesty in their response. For Margaret and Devi, honesty and integrity were linked, with honesty as a component of integrity. When Joseph spoke of honesty, he spoke of how to speak honestly with patients and within the scope of practice. He shared an experience he had with a patient and their family. The patient was in the final stages of life and was currently a full code, meaning they would receive cardiopulmonary resuscitation (CPR) to attempt to extend their life if needed. CPR was administered throughout the shift, and the students were able to witness communication between the healthcare team and the family.

> Seeing that process of, kind of, managing expectations and talking through what was going on and how the honesty of it and the ability of the family to even see some of the code really kind of highlighted what was going on for the family.

Patients' Rights

The second theme identified was that of patients' rights. All six participants spoke of the importance of patients' rights, but their definitions and examples took on different forms including ideas of fair treatment, the importance of not doing harm while participating in patient care, autonomy of the patient, patient advocacy, and empowerment of the patient. Fair treatment is described as ensuring patients are seen as deserving of a high-quality standard of care, no matter who they are or their lifestyle. Doing no harm ensures that the nurse not only refrains from intentional or unintentional physical harm to the patient, but that they also refrain from any other harm including mental or emotional harm. Autonomy allows the patients to have control over their own health care decisions and advocacy calls for the nurse to ensure patients are able to make informed decisions about their care and represent their interests whenever they are unable to do so for themselves. Empowerment requires the nurse to ensure that the patient has

the knowledge needed to make informed decisions about their health and healthcare. As demonstrated in the sections below, although all participants identified the importance of patients' rights, they offered different and uneven responses about what patients' rights entailed.

Fair treatment. The belief that the patient is a human being, deserving of care regardless of who they are or what their lifestyle may be, was voiced by four of the six participants. The patient's life outside of the hospital and how it may conflict with the beliefs of the clinical nurse educator or student was discussed to convey the importance of not letting personal differences cloud treatment and interactions. Devi said she believes in "Teaching them [students] that you treat all patients the same, regardless of their background. And regardless of whether their background agrees with my own personal opinions." Ashley tells her students:

> This is a person, this is a human being, breathing in this bed. It doesn't matter outside of here what they have going on. It doesn't, it doesn't matter. We're not here to judge. We are here to take care of this patient in their time of need … because everyone deserves to be treated well. Period. No matter what.

Joseph shared similar sentiments as Ashley:

> I always try to stress to my students that every patient you take care of is somebody's mom, brother, dad, sister, uncle, spouse, child. And that we're going to care for them in a respectful way, whether or not you agree with their life or lifestyle.

Each of the participants shared a story that illustrated a unique situation that could have led to a patient receiving poor treatment because of perceived, or real, differences. Ashley recalled an example of a patient who she was warned against assigning to her students. The patient had been on the unit for a prolonged time and had a reputation among the nursing staff as being "grumpy." After she assigned the patient to a student, there was a teaching moment because not only was the patient grumpy, but the student also reacted in a poor way to the patient's attitude. She recalled,

> And he was one that I had to go in there and talk to him and you know he shared his grievances with me because I'm kind of the neutral person. And that's what I tell my students, I'm like your buffer. I'm happy to go in there. But he, some of his concerns were … I just still kind of think he could have handled himself a little differently. I can understand his frustration. I mean it was an interesting situation. The student and I, we had many conversations. This was one of many, but I just had to tell this student. Look, you cannot say those things in front of a patient, you cannot talk to a patient that way. That's not acceptable. And so that was just one of many behaviors that we had opportunities for improvement with.

For Loretta, it is also important "to not treat somebody different because of their background." When asked to describe an example of how she teaches her students she shared an experience that she had as an ICU nurse prior to becoming a clinical nurse educator. In her story, the patient's religious beliefs led to poor treatment from a doctor.

> When I was working in the ICU, I actually had a patient who was a Jehovah's witness and she was a female of childbearing age, and she had had some trouble with miscarriages and she had a really, um, dangerous bleed as a result of that. And because she lost so much blood, she came to the ICU, and I just happened to be her nurse that day. And one of the hospitalists was very demeaning to this woman. He had been very ugly to her and spoke down to her because she blatantly refused the blood because that was against what she spiritually believed. And so, in that instance, I had to stand up for the patient and what her wishes were and what she wanted, despite, you know, medical advice. And so, um, I did that for that patient and had to kinda have the difficult discussion with that physician. And then, because he wouldn't listen, we made the recommendation, the recommendation to call in, um, an OB GYN who came in and stood up for that patient as well. And we ended up successfully treating her without the blood. So, I use that story a lot to teach my students that there's going to be a lot of people that are different than you, because there were other people [staff] on the unit that were like, I don't understand why she wouldn't just get it. It's like a life and death thing, but, you know, for her religion trumps that medical diagnosis that she had. And we have to be able to step back and respect that.

Loretta was also able to recall another time that students were able to learn a lesson about fair treatment.

> [The patient] was from a mental institution. I can't remember which one. And he was, you know, coherent and everything, but extremely difficult to deal with because of his mental state. I think he was bipolar, and he had some other stuff going on and my students easily got frustrated with him and, or didn't want to go in the room because they knew it was going to be hard, but we'll use that as a teaching moment. That not everybody's going to walk in the door and be happy go lucky and agree to all sorts of

> care and whatever, people have different backgrounds. And, um, you know, maybe he's had a bad experience man, in and out of hospitals and different caring agencies. And so, we had that discussion and by the end of the day I think they realized maybe they weren't giving him the best care at first because of some of their, like some stigma that goes with, uh, mental disorders and things like that. So that definitely was a good learning moment for them as well.

Fair treatment of patients was also central to Joseph's example. His students were assigned a patient with HIV (a condition that can lead to prejudicial judgements).

> Initially seeing that the nursing student made a big deal, like came to me, we talked about it for a little bit. They're worried and so, you know, regardless I think there's a lot of stigma as to where those diagnoses actually come from because they're not all related to a certain type of patient. There are several ways they can get that but it automatically puts a stigma on the patient that that's what they have and so talking through that and talking to them, that that's the reason why we have standard universal precautions and that there's nothing additional you really have to do except follow standard universal precautions. It kind of helped ease that along because it created a lot more, generated a lot of worry immediately, but that was it. Didn't change how or what we did because that's what we follow regardless.

Devi gave an example of a time that she knew her students were going to be put in a position that they may judge the patient. The patient was the same age as the students and could be expected to stir some feelings of comparison. Because of this, she talked to the students prior to their meeting the patient, addressing what they might think and why those feelings had no place in the situation.

> It was more like a preemptive conversation. Just this past semester, [the patient] was like a 20-year-old who had a really rough past and who was homeless for several years and she was intubated and septic from endocarditis … like renal failure, septic, and the whole nine yards. And her mom was present but like they had not had a good relationship. And so, the mom really didn't know much about her daughter's health status because she had been distanced for a while anyway. So just, we had the conversation of, you know, like this person is your age and obviously, she's made some bad choices that's gotten her here but like you don't walk in with a judgmental attitude towards her or her family. Like, you treat her just like any other patient just like a little grandma who came in because she had a stroke or whatever.

Do no harm. Four of the six participants indicated that not only must nurses grant the same rights of fair treatment to all patients, but they must also do so in ways that do not harm

patients. Ashley succinctly stated, “Do no harm. That's what we're here for.” Devi echoed that statement, claiming nurses are to “do no harm, to always act in the best interest of the patient.” Loretta agreed but elaborated by combining the directive with the importance of fair treatment.

> But you know, we kind of take an oath to do no harm, right? … so always choosing the options that are going to protect the patient and not do harm to them and, and to not treat somebody different because of their background and, um, all of those things.

Margaret also recognized the principle of doing no harm. When asked to explain what she thought that meant in nursing she stated, “We don't do anything that will kill your patient. I mean, it’s emotional too.” She went on to describe an encounter between a physician and a patient that she and her students witnessed. The physician came in to speak to the patient and immediately began stating that they needed to lose weight. It was not just his words, but his tone that proved problematic. After he left, the distressed patient told Margaret and the student about how she had already lost a lot of weight and was continuing to do so. But the physician never asked so he did not know. This led to a valuable lesson for the students, to ask questions and receive a better picture of the patient’s history. “So no, doing no harm is, it's mental, physical, emotional, all encompassing.”

Devi discussed how “do no harm” also applies to when nurses take the easy way with students keen to practice a skill.

> There have been multiple situations where the nurse has said like, hey, I need labs drawn and he hands me a butterfly and [the hospital’s] policy is if their IV draws you can draw them from the IV...so there's been several times where like it wasn't necessary to stick them...Let's try that [drawing from the IV] first. Okay, that [the IV] drew. Sorry you don't get the opportunity to butterfly.

Autonomy and advocacy. Autonomy and advocacy are listed together as a sub theme of patient rights because of their interconnected application from the participants. Autonomy of the patient was mentioned only by Devi and patient advocacy was mentioned by Devi and Grace.

Devi spoke of the importance of autonomy and advocacy and how it can be a complicated ethical principle. She shared a story of a patient who suffered a traumatic injury years ago which meant he needed to live at a nursing home to receive full-time care. It also left him with limited communication abilities, mainly shaking his head yes or no. His health meant he was in and out of the hospital regularly and his family was very knowledgeable and involved in his care. The students noticed that when the patient was alone, he was in a good mood and when his children came to visit, he became visibly upset. The patients' children were very positive, telling their father to keep fighting and pushing for every treatment. Alert to his unhappiness, the students came to Devi to see what they could do to help him.

> I had to have a conversation with them about you know unfortunately, he doesn't really have a say. The family gets to make the decisions for him but if you've been taking care of that patient for a long period of time, … you can't day one, say, "Hey, he doesn't want that." But if he had been there for weeks. If you've had that patient multiple times and you've built a rapport with that family and that patient, at that point, that's when you start having those conversations when you build some trust with family members.

Because of this patients' inability to make autonomous decisions on his health care, it led to an opportunity to teach the students how to become advocates for the patient.

Grace spoke of the importance of advocating for patients. She said advocacy is not something she realized would be such a large part of her profession.

> You're going in to be a nurse, you know, you want to help people. But you don't realize that you're going in to fight for people too and I feel like that falls under there, you know, making sure that you're doing the right [thing], that holistic care, not just doing the task, but also thinking them through and making sure that that that that patient is getting the best care.

Empowerment. Empowerment is a sub theme of patients' rights because increasing patient's knowledge of their health and healthcare options was identified by two of the participants as an essential role of the nurse. Margaret said that patients should be part of the decision-making process in their own health care decisions. Loretta elaborated as follows:

> It kind of goes back to the saying, right, if you know better, you do better. And a lot of times you're seeing these patients, who have never had the opportunity to learn the things that we know. And that can be for a variety of reasons, but sometimes you're the only person or the first person to sit down and give them some education on what's going on in their life, their disease process, their medicines or whatever. I really think that our role is to prevent them from coming back, give them the tools necessary to be independent and to make healthy decisions and give them the knowledge to do that.

Duty to Care

Duty to care was identified by each of the participants as a virtue and ethical principle in nursing and clinical nurse education, but the sources of the duty to care varied along three sub-themes: morality, compassion, and empathy.

Morality. Ashley described feeling morally bound to address something that is not right. She believed this is part of who she is and the reason that she is a good nurse. She strives to do right by her patients and by her students, ensuring that her students know the reasons behind the good actions, and the reasons why certain things are not good.

> I mean, I've had difficult patients before, but there's never been a situation to where my spirituality and religious beliefs have ever interfered with my ability to provide care for patients. I just, I really try to go into it with an open mind. And you know? We're all different. We're all unique. We're all made that way. If you believe this, like, that's your truth. You're not wrong for believing that, you know, and it's not my job to try to influence that. I'm here to take care of you. Yeah, I've never really had a situation where that was a problem. Yes, they have these physical issues going on, but you know if they're acting out there. There's always something behind it. I just try to approach it...as caring as I can be [in] attitude and open mindedness. ... The difficult patients. They just want to be heard.

Loretta also feels that being a morally good person is critical to being a good clinical nurse educator and nurse. She defines moral goodness as, “being honest, being kind, being empathetic, all of those things are kind of what people think a nurse should be or why we're the most trusted profession.” She explains that moral goodness is important in nursing because

> …As a nurse, I think for sure that, yes, it's obvious that we do a lot of physical care, but behind every physical intervention … the patient is a human and they have feelings and thoughts and emotions, strong emotions… tied to these physical interventions we do

> because they're human and we feel things. And I think that we do people a disservice, if we don't care for the whole being, you know?

To elaborate, Loretta created a hypothetical situation, speaking of a patient who may be in the hospital for the first time, needing a blood transfusion.

> How does that really make that person feel? Are they terrified because they've never been in the hospital and had that done? Are they scared because they're worried about how much it's going to cost? … I think that's what drives me as a person because I would feel absolutely alone if the person caring for me couldn't care for every part of me. … I definitely think it's what led me to be a nurse and I think that's part of my personality as a whole. I don't think that everybody has to have that exact personality trait to be a great nurse, but I do think that you will find parts of that personality trait and all nurses in some way or the other.

Grace believes that morality is the most important value for nursing, and the one she most tries to instill in her students. She said that moral actions are those where you have a choice to do right or to do wrong, and if the wrong thing is done that you must admit you did it. Her notions of right and wrong are reminiscent of integrity and honesty, however, she was unable to clearly separate these ideas from her thoughts on morality. When pressed to further define what she meant by the term morality Grace had a hard time putting it in to specific terms. During her member checking interview, she was able to further define it as providing holistic care, fair treatment, and acting as a patients' advocate. While this definition of morality is not consistent with other interpretations of that term, it is her definition and demonstrates how morality is the most important value in nursing for her. She said that she does not believe morality is any easy concept to teach, so she tries to show her students the difference between right and wrong, and how sometimes that is a subtle difference. As an example, she shared an experience with her students where there was a patient with dementia who relied upon the staff to feed them and get them out of the bed to move around. The patient had been placed in a corner room, away from

the nurses' station. The students were frustrated with the treatment this patient was receiving and they took action.

> My students … stepped up to fight for that patient … they talked with the nurse about what they could do to get her up and what they could do to feed her and ways that they can incorporate like, you know, the PCT going in there. It was like a really cool moment for me to watch them get it, they got it in that moment.

Compassion. The concept of compassion was also mentioned by four participants. However, there were varied interpretations of what it meant to be compassionate among the participants.

Loretta believes compassion is trying to see where the patient, or their family, is coming from. Understanding that they may react in a completely different way than you would. She shared an example of a patient her students cared for who was in the cardiac ICU after suffering a massive heart attack, one that left him in a state he never woke up from. During his time on the unit the students witnessed his siblings fighting over his estate, while the patient was still alive, if unresponsive. The students were disturbed by what was happening and questioned why they would even allow the family to visit the patient. Loretta used this as a teaching moment on compassion.

> And I just kind of had the conversation with them that every person that you make is not gonna handle grief or stress like you think that you would…these people were obviously still hurting. But they definitely showed that in a very different way. And instead of just kind of brushing them off and being like, 'Oh, you're, you're no good to him anyway'… I just encourage [the students] to let them in the room if they weren't disturbing the patient. Get them involved in the care and tell them about what's going on and show them the same compassion and the same empathy you would with somebody who was maybe demonstrating stress in the way you expect them to. And I think that was a good … it was a little hard lesson, but I think it worked.

Loretta believes that compassion makes it easier to be a nurse and that a without it the profession would be miserable.

> It is very difficult to care for sick people and their family members and all of these people are in really high levels of stress. So, we never really get to see the best side of somebody because of that. You really have to have a compassionate personality to deal with those high, stressful situations.

Margaret believes compassion is a concept that lives on a spectrum between empathy and sympathy. Where she sees sympathy as a dangerous concept in nursing, something that is too emotional to remain professional, compassion is a compromise.

> Compassion is understanding that they [the patient] may not have had any kind of control for where they're at right now. Something may have happened to them that is outside of their control or they may not have had the education … so you do have to show them some compassion, show them grace, show them mercy.

Margaret also admits that it is not always easy to have compassion for all patients. In the case of difficult patients, it becomes a case of "tough love." The nurse must explain:

> "All right, you can either help and you can let us do our jobs or I don't understand why you're here if you don't want help. I'm here to help you and I'll help you all day long. But if you're going to fight me every turn of the way we are going to have a come to Jesus." And I've done that before. And my students witnessed it … but I teach that you shouldn't treat people based off of what your thoughts are, because you don't always know the whole story. Yeah, sometimes they're just old and ornery and you have to tell them what for.

Grace defined compassion as

> …Recognizing that someone is in a state … that that person doesn't necessarily want to be in or that that person is … in a hurt state or fragile state. And reaching out to that person in that fragile state and sharing … helping to make things better for them, reaching out that across that barrier, and helping to make things better.

To explain, Grace shared a powerful example of how an act of compassion to a patient was witnessed by her students.

> My students had this patient that was sobbing when we went in there because physical therapy was trying to get her up and she couldn't get up. I said, "What's wrong? What's going on?" And I knelt next to her because she was like sitting on the side of the bed and they were just trying to kind of force her up and she was half laying on pillows. And she said, the doctor just came in and told me that I would never walk again because of everything going on.

> And I looked at her and I said, “Listen to me. These are not words that you are going to live by. Those words are not going to define you, those are fighting words. Those are words that tell me that you are going to work harder than you've ever worked before. To prove him wrong. So, even if you don't get up today, it does not matter. You try your hardest and maybe tomorrow you get up. But these are not words that you are going to let defeat you.” And my students were in there because they had [to] call me in there to come help them. I like look back and I kind of could tell in their eyes how powerful of a moment that we get to experience. She [the patient] was crying, her mom was crying, the physical therapists were crying, I was crying. And so, you know, how cool is that, how cool is that we get to experience that.

Empathy. According to Loretta, empathy is the ability to “care for that person and feel for that person, with whatever emotion they're going through.” She gives an example of a situation where a patient had a heart attack that left them in a coma and his wife of 60 years was at the bedside.

> I don't know what that's like because I'm 29, but I can empathize with her as a person. Because there's a lot of people in my life that I love, and I would never want to see harm done to them and the trauma of that happening. So I can emphasize with the love a person has for their family member. And I think that we do that every day as nurses.

It is important for Loretta to talk about these situations with her students because their age generally means they do not have the life experiences of their patients, but that does not take away their ability to empathize. Through these conversations she teaches her students how to relate to their patients, allowing them to empathize through their humanity. Devi echoes Loretta’s thoughts. She states that her students should

> …At least attempt to connect with them [patients] on an emotional level while they're taking care of them and not that they put themselves in their shoes because I think as a 20-year-old student it's impossible put yourself in the shoes of a 75-year-old man. I don't have that expectation of them. But that they, in addition to all of the nursing skills and the nursing concepts and the diagnoses that they, again, just recognize how traumatizing, it can be for them as patients.

Grace, Margaret, and Joseph also identified empathy as an important value and they understood empathy as the ability to put yourself in another person’s shoes, while sympathy meant feeling sorry or pity for another. Grace thought sympathy comes more naturally to

students and that it takes experience to be able to transition from a sympathetic to an empathetic response: “It's one of those things that we talk about. With sympathy, I feel like a lot of times your job is impeded; where empathy, you can still rationally think. It's not just feeling sorry and going from there.” Margaret agreed that sympathy is problematic: “Sympathy is a dangerous word that I don't like my students to get too caught up in. It doesn't help them [patients]. You can have empathy. Don't be sympathetic.”

One way Joseph teaches his students the concept of empathy is to educate them about some of the larger issues that can lead patients to have different health issues. He speaks of a patient that presented with diabetic ketoacidosis because they were not taking their insulin regularly. The students could not understand why the patient would not treat their blood sugar appropriately, only to find out that the patient had been rationing their insulin because they could not afford it. Talking about ideas of justice and public health helps him to lead his students to a more empathetic understanding of healthcare in the United States and with the complex issues patients often face.

Comparison of Participants Responses to the ANA and NLN

When comparing the participants responses to the NLN Core Values and the ANA Ethical Principles there are instances when the participants were able to explicitly discuss the values and ethical principles, instances when they were tacitly discussed, and other instances when they were not discussed at all (see Table 3). For example, the core value of care was explicitly discussed only by Devi, while it was tacitly discussed by the rest of the participants. Diversity was tacitly discussed by all participants through the examples they provided. Grace was the only exception who did not discuss diversity at all. Integrity was explicitly discussed by

all participants, except for Grace who discussed it tacitly. Excellence was tacitly discussed by all of the participants.

Table 3

Comparison of Participant Responses with NLN Core Values and ANA Ethical Principles

	Participants					
	Ashley	Devi	Grace	Joseph	Loretta	Margaret
NLN Core Values						
Caring	T	E	T	T	T	T
Diversity	T	T	--	T	T	T
Integrity	E	E	T	E	E	E
Excellence	T	T	T	T	T	T
ANA Ethical Principles						
Autonomy	--	E	E	--	T	T
Justice	T	T	T	E	T	T
Fidelity	T	E	T	T	T	T
Beneficence/Nonmaleficence	T	T	T	T	T	T
Veracity	T	T	--	T	T	T

Notes. E = value or ethical principle explicitly discussed by participants. T = value or ethical principle tacitly discussed by participants. -- = value or ethical principle not mentioned or discussed by participants.

The ANA ethical principles of autonomy and justice are common words in general use; however, fidelity, beneficence, maleficence, and veracity are not. As such, they were not readily, reliably, or explicitly identified by the participants. The most common principle explicitly voiced by participants was that of autonomy. Although the most common principle, it was only explicitly discussed twice by Devi and Grace. It was tacitly discussed by Loretta and Margaret and was not discussed by Ashley or Joseph. Justice was explicitly recognized only by Joseph and tacitly discussed by the rest of the participants. Fidelity was explicitly named by Devi, but she was unable to define it. Fidelity was tacitly discussed using other words by all other participants.

Beneficence and maleficence were likewise tacitly discussed by all participants. Finally, veracity was tacitly discussed by all participants except Grace who did not mention it.

While the explicit terms fidelity, beneficence, maleficence, and veracity were not employed, the participants did use and discuss ideas that capture the essence of these principles. Fidelity is "loyalty, fairness, truthfulness, advocacy and dedication in relationships" (ANA, 2015, p. 43). Many of these characteristics were identified and discussed throughout their interviews. Of the six, four mentioned fair treatment, five mentioned honesty (truthfulness), and two discussed advocacy. Beneficence is to do good, while nonmaleficence is to do no harm. Three of the six talked about doing the right thing, while four specifically stated nurses must do no harm. Veracity is to be truthful and not misleading and five of the six explicitly identified honesty as a principle in nursing.

Accordingly, while the explicit knowledge and language of the ANA ethical principles was not always employed, the meaning behind these terms demonstrate a tacit, and occasional explicit, knowledge of the values and ethical principles as summarized in Table 3. These results also demonstrate that participants' definitions, examples, and sources that form their tacit understanding of the values and ethical principles of profession vary widely by participant. They lacked a shared vocabulary about the values and ethical principles and acknowledged that their understanding did not come from a study of the NLN core values or ANA ethical principles.

Research Question Two

How do clinical nurse educators' beliefs about the values and ethical principles of the profession of nursing inform their educational practices? The values and ethical principles identified by the participants greatly inform their educational practices. All six members claim that these commitments are the greatest factor guiding how they educate their students. The

intimacy of this relationship was demonstrated in the proceeding section and by the use of examples drawn from their teaching practice to illustrate their values.

This section examines participant responses about the ways in which values and ethical principles inform their educational practice. Three themes emerged: embodiment, purpose, and responsibility, which also has a sub-theme of translation.

Embodiment (Role Modeling)

All participants identified the importance of embodying the type of nurse that they want their students to become. Their focus was to ensure that their students can observe them as they model professional practice; not just to demonstrate how to perform certain skills, but the values and ethical principles central to nursing. They believe their actions are critical for nursing students and are a vital instructional component of their teaching practices. Ashley said, "I don't have to sit and teach them if I'm kind to someone…those are things that they see…I think they learn from that." Participants indicated that modeling the values and ethical principles occurs through several pedagogical practices without conscious thought as they practice nursing, through sharing of stories, or by conscious reflection of an occurring event or practice.

Their embodiment of the values and ethical principles of the nursing profession is evident in the many of the examples previously discussed in this chapter. Role modeling is present when Ashley advocated for daily care of patients and when she showed students how to navigate interactions with difficult patients. Loretta provided examples of modeling when she shared her story of the patient refusing blood because of their religious beliefs; when she helped her students care for a mental health patient; and when she taught students to have empathy for the family of a dying man. Devi was a role model when she advocated for patients to not receive invasive procedures and when she preemptively prepared her students to care for a patient many

may have pre-judged because of her age and history. Joseph demonstrated how to navigate interdisciplinary care and family members of a patient receiving CPR. He also modeled how to not fear and judge patients with diagnoses such as HIV. Margaret modeled honesty when she showed her students how to admit a mistake when they accidentally removed a surgical drain. Grace embodied compassion when she sat with a patient and told her to fight to get better and took pride in students who demonstrated advocacy for a patient with dementia.

The participants were also able to readily identify additional examples. Ashley said that every morning she does rounds with her students, going with them to introduce herself to their patients.

> I coach up the students [to the patients] and say, "... they're great nurses [the students] and they're going to take good care of you today and I just talk to them [the patient]. I'll tell the students, when you first go in, don't need anything from them [the patient], just go in and establish that good morning … because you are going to need stuff from them [the patient] all day.

Ashley set the tone by showing her students in those initial interactions the positive, caring behaviors she expects them to practice. By being kind to the patients, staff, and interdisciplinary team, her students can learn from her example. She also talked about how she showed her students the correct way to react when they do not know how to do something:

> I tell them I learn just as much from them as they learn from me. And I have no problem with saying, you know, I'm not familiar [with a task], let's go learn together. Let's go seek someone out and let's find out what we need to do.

Like Ashley, Devi also is a role model of duty to care through her interactions with patients. She explained a process of scaffolding designed to guide the development of skills and values. Opening a conversation with the patient, she lured a student into joining and then backs off, stepping back in only when necessary to achieve the ends of care. Devi also shared that students do not always know what they can and cannot do when communicating with patients.

> I'm super sarcastic and dry with patients. And this think the students don't all the time expect that and so those patients that like to poke back, that like to be sarcastic back, I take full advantage of that … I think they [students] just don't realize that sometimes you can do that. Now, that's also learned, you have to read the room and figure out if the patients going to be offended by that or not, but I think they just a lot of times don't realize that they can do that. You can just talk to people.

Margaret was concerned to not only model duty to care values, but to also encourage their use by her students. She was careful to provide praise when they were apparent and raise questions when absent.

Loretta shared an example of a time she was able to consciously model the values and ethical principles of patient rights and the duty to care with her students. The students had a patient who was refusing all medications. She informed the students that she would talk to the patient before allowing him to do this with them. Loretta and the students went to the patient's room and she sat down to have a conversation with him. He started to open up to her and she said,

> We got a little laugh here and there, laughter is the best medicine sometimes, and so we slowly eased into the topic of why he didn't want to take his medicines. And he revealed to me why that was and when I sat down with each drug and explained exactly what it did and how quickly they would work and how this is the only thing kind of holding him up, his whole attitude change, you know? And he was like, okay, yeah, I'll take them.

After leaving the room, she was able to have a discussion with her students about how his refusal most likely stemmed from him feeling out of control and disconnected from his own care. Loretta finished by saying:

> I think that was a really good example for the students of how to treat people like people. And how to include them and how to be empathetic. Was it annoying? He wouldn't take this medicine, sure. It made us about an hour late for meds, but at the same time, we had to have some grace and some compassion for what he was all going through and talk through those things. And at the end of the day, it was better for the patient. And the meds worked and they got to go home.

The participants also highlighted that nurses on the floor also act as role models for the students, regardless of whether they know it or not. Joseph also acknowledged the importance of role modeling, but highlighted different pedagogical practices in which he, and other nurses on the floor, act as role models. He discussed how he uses stories to teach his students about the profession. He also discussed how he also teaches by having students observe other nurses on the hospital floor.

> A lot of it's going to be from either discussing past experiences and how they, my experiences, and how I've utilized those things [values and ethical principles]. Discussing of how they either used them during clinical days or found opportunities for them to exemplify those things or point out when nurses on the floor do those things.

Grace identified yet another pedagogical practice to act as a role model for students through reflection on actions and observations throughout the day with her students during post conference. She wrote down notes throughout the day of the situations which may have occurred and then makes sure to have time where they can discuss. She said they covered what occurred during the day and she asked, "What are your thoughts on it? What was right? What was wrong…and they usually can identify those areas of who they want to be in those situations."

Purpose

Three of the six participants explained that their values and ethical principles gave educational practices purpose. The participants discussed how this essential task, over and above the scientific knowledge and know-how of nursing practice, was vital to the quality of nursing. Helping students come to this understanding gives the clinical nurse educator a sense of purpose, even a calling, in life. They saw their role in the nurse education program as deeply significant and rewarding. For Ashley, being a clinical nurse educator is a calling. She hoped that this shows in how she teaches her students and she believes it is what makes her good at her job.

> I'm knowledgeable. Yes, I have the background. I can do this stuff. I can walk the walk, talk the talk, but I also care about them [students] and I want to do right by them and my patients. So, I think that makes me a good instructor.

Loretta and Grace did not claim that nursing is a calling, but the values and principles they prized still have a great purpose in their teaching practices. Loretta believes that it is her purpose to teach from a patient centered approach.

> I do feel like I teach with a very patient centered approach…I'm always bringing it back to what's best for the patient, what's safest for the patient. How can we care for them outside of their physical needs? Because that's something…I wasn't prepared for. So, I want to do that a little bit different since I'm the teacher now.

Grace said that these values and ethical principles are "at the forefront of what I teach, because at the end of the day, they [values and ethical principles] are protecting the patients." For her, the values and ethical principles are the reason she is a nurse and she feels lucky to be able to pass these on to her students.

Responsibility

Three of the six participants spoke directly about their responsibility as clinical nurse educators to teach their students about the values and ethical principles of the nursing profession. As clinical nurse educators, they have a distinct sense of obligation that it is their job to teach nursing values. They also acknowledged that these values are not learned from a book or classroom lectures, but from experience. They discussed how it is their responsibility to ensure students come to a practical understanding of personal commitment to the profession. Joseph believes this is one of his most important responsibilities as a clinical nurse educator because these values are the foundation of the nursing profession. As such,

> It's a primary driver into how I teach, because if I want to promote safe practices and growth as a nurse, then you have to build the foundation. … If you build it on shortcuts and poor practice, then they don't have as much opportunity for growth.

For Ashley teaching students goes beyond teaching them skills. She feels charged with the responsibility to teach them how to treat people and how to do what is right.

> I'm here to teach and show them different ways, different lenses to look through because different patients have different situations. And I think that would do them a disservice if I just poured all my beliefs onto them and didn't let them explore and figure things out on their own.

Devi concurred. While she wants to give students opportunities to practice skills, like starting an IV, she was more concerned with ensuring her students are good people who care for their patients and are helpful to coworkers. She made a powerful statement when she said:

> You literally are seeing patients on what might be the worst day of their life. … They have entire lives that they lived before you saw them when they are swollen and on a ventilator. They have careers, they have families. They're not just this body in a bed and you have to approach conversations and treatment with a mindset that they're not just an experiment for you.

Translation. The sub-theme of responsibility was identified as that of translation of the material they receive in their class to actual nursing practice. Three of the six participants expressed that it was their responsibility to take what students are learning from nursing textbooks and lectures and to put it into practice.

Loretta said that she uses post-conferences with her students as a time that they share their patients' diagnoses and what happened during the day.

> I think it's really much easier to learn the pathophysiology of something as opposed to learning how to care for somebody who's been through a lot of different things and who is facing those ethical different things. … I always talk about that and try to pull the pieces of the puzzle together for the student. Like, how did you attend to those needs today other than the physical ones? What about their mental state? What about their spiritual needs? I always just try to tie it together like that and it's really interesting to see the students be like I've never really thought about that before, because you can't really necessarily learn that from a book. You have to see it in a real-life situation. So that's something that we do every day that I think naturally helps them to learn those concepts.

Margaret also sees it as a primary job responsibility as a clinical nurse educator to take what they learn in the classroom and translate it into appropriate practices for different patients.

> Our job in clinical is to help translate what they're getting in class to what it actually looks like in the hospital but also teaching students that not everybody is going to respond the same to the same things. I think another big thing is making sure students understand the whys behind what they're doing in the hospital, because if you don't understand the why, you can really screw stuff up … our job is also to give them that hands-on real-world experience and help to build their confidence and independence without them making mistakes.

Margaret also said that students

> …hate to hear me ask the question, "Why?" It's my favorite question and they hate it. You can already see it in their eyes after the first couple of weeks … but after a while they know I'm going to ask the question, "Why?" They know it's coming, so that's probably the best way is to have them talk it out and connect the dots.

Devi summarized the central importance of clinical nurse educators by explaining how they are responsible not only to connect concepts and knowledge learned from the classroom to the clinical floor, but that they must do so while also teaching them the vital soft skills, including communication, which are equally important.

> We should be teaching our students how to think deeper about their patients and teaching them how to connect concepts and knowing how to take those concepts and translate that into skills and preemptively knowing what's going to be happening with their patients while also teaching them the caring factor and teaching them just how to interact with people. Half the time they don't even know how to go in and have a conversation with somebody that they don't know … Learning how to just talk to people and how to deal with hard things and how to professionally handle death and working through all of those other concepts and things that you come across as a nurse that you're not really taught from a textbook.

Relationship between Participants' Educational Practices and NLN Nurse Education Principles

The NLN claims that nurse educators should be role models of the professional values of nursing, create learning environments to teach professional behavior, socialize nursing students into the profession of nursing, and intentionally teach the skills, attitudes, values, and expectations of the profession (Halstead, 2019). These expectations are of particular concern for clinical nurse educators because students' clinical education is a cornerstone of nursing

education where students receive hands on instruction at the bedside of the patient (Collier, 2018). Participant responses demonstrated that these six clinical nurse educators understand and embrace this message. The examples they shared demonstrate the many ways they sought to be role models of the profession to their students. As Ashley shared, many times these opportunities occur from students observing everyday normal interactions with others on the floor, and how kindness, for example, does not have to be explicitly taught if it can be vicariously learned when they see it happening. Devi and Ashley discussed modelling communication skills that incorporate nursing values. Loretta explained the importance of showing students how to connect with the patient on a personal level by gaining their trust. Participants also shared examples of how the values and ethical principles give purpose to their educational practices. For Ashley this means that nursing is her calling and she feels that it leads to her ability to care for students and patients. Loretta sees her purpose to teach with a patient centered approach, something she did not feel she was prepared for when she finished school. Grace believes the values and principles of nursing are the reason she is a nurse and enjoys the ability to share them with her students.

Responsibility was discussed through ideas of obligation to teach the values and principles of the profession that could not be learned through didactic instruction. Joseph sees these norms as foundational to the nursing profession, and therefore believes it is his responsibility to them on to his students. Ashley and Devi believe they are responsible for ensuring their students gain these values and principles, not just skills. Translation, the subtheme of responsibility, was identified as helping students apply what they had learned in class to the real world of nursing. Loretta used post-conference time with students to make the connections. Margaret described her job as asking the students why and ensuring they understand how an individual may respond differently than described in a textbook or large auditorium PowerPoint

lecture. And Devi repeated that connecting the concepts and knowledge from class is the fundamental role of a clinical nurse educator. This is the only way the soft skills of patient care can be taught, where the values and ethical principles are learned.

Summary of Findings

Chapter IV attempted to answer the two research questions of this study: what do clinical nurse educators believe about the values and ethical principles of nursing and how their beliefs about the values and ethical principles affect their teaching practices. A generic descriptive qualitative analysis of participants found that participants discussed the values and ethical principles in terms of integrity (honesty), patient rights (do no harm, autonomy, advocacy, and empowerment), and duty to care (morality, compassion, empathy), which are aligned with the NLN and ANA. Further, that these values and ethical principles were the primary drivers of their teaching as it relates to embodiment, responsibility, purpose, and translation. Chapter V discusses how these findings can inform nursing education and nursing practice.

CHAPTER V:

DISCUSSION

Despite the central role of the clinical nurse educator as a torchbearer of the nursing profession who must be role models, teachers and visionary leaders, embodying the values and ethical principles of the profession (Adelman-Mullally, Mulder, McCarter-Spalding, Hagler, Gaberson et al., 2013; Halstead & Frank, 2018 Halstead, 2019), there is little to no research which explores their understanding and commitment to the values and ethical principles of nursing. In a structured review of clinical nurse education, Collier (2018) stated, "Although clinical education can be considered the cornerstone of nursing education, only a small body of knowledge covers it, leaving multiple gaps in the literature" (p. 368). This study aimed to begin to fill the gap in this knowledge. I explored the clinical nurse educators' beliefs about the values and ethical principles within the profession of nursing and how these beliefs affected their educational practices.

This chapter will summarize and discuss the findings from each research question of the study, examine implications for practice, and propose future research from the findings and the implications

Discussion of Research Question One

What do clinical nurse educators believe are the values and ethical principles of the profession of nursing? Analysis of interview data revealed that study participants held core beliefs about the importance of integrity, patient rights, and duty to care. Honesty was identified as a sub-theme within integrity; fair treatment, "do no harm," empowerment, and autonomy and

advocacy were identified as sub-themes of patients' rights; morality, compassion, and empathy were identified as sub-themes of duty to care. These values and ethical principles are in line with the NLN and ANA guidelines for professional practice. Indeed, all participants understood that an essential task of their work as clinical nurse educators was to impart these standards to nursing students.

While these themes and sub-themes are in line with the meaning and intent behind the guidelines of the NLN and the ANA, I argue that it is tacit knowledge that governs their nursing practice, not a well-formed explicit foundational knowledgebase. First, only two participants claim to have seen the NLN core values and only one has read the ANA ethical principles. The others were unable to recall ever seeing the NLN or ANA guidelines. Their understanding was clearly developed from personal experience. Second, the themes stated above and described in chapter four were not always explicitly stated by the participants. I attempted to use participant language as much as possible but had to synthesize at times. The themes were identified to capture the meaning of participants' responses during data analysis, and the themes and associated meanings were verified through member checking in the follow-up interviews. Even with the additional synthesis, the only themes that explicitly aligned with the NLN guidelines were duty to care and integrity. Other themes such as "do no harm" and compassion are definitions of nonmaleficence and beneficence, respectively, but participants were unable to utilize such language.

Ever since Nightingale, nurses have struggled to establish their autonomy and control over their own conduct. The development of professional codes of conduct was critical to this standing, and yet knowledge of these values and ethical principles must be strengthened, even among nursing educators. As Catalano (2019) argued, practice based on tacit knowledge, that

lacks without a reflective understanding of foundational the values and ethical principles, poses a significant problem for the profession. Practice, including norms of conduct, should be informed by theory. This lack of understanding is especially problematic for clinical nurse educators, as it may impede, impose, or undermine their efforts to impart these values and principles to students. Without a solid understanding of the profession, it is unlikely that nurse educators can maintain expert nursing practice (Benner, 2004), or have the ability to create learning environments to teach professional behavior and socialize nursing students into the role of the nurse (Halstead, 2019, Competency 2). Without this explicit knowledge, clinical nurse educators will not be able to overcome the pressing problem of the relevance theory to practice gap (Risjord, 2010). As discussed in Chapter I, a relevance theory to practice gap is one that questions the significance or usefulness of existing theory and research. To overcome this gap clinical nurse educators must have a clear vision of the profession beyond technical skills and must have an understanding of the values of their profession so they can discuss ethics and nursing theory with their students (Adelman-Mullally et al., 2013; Ludoc & Kotzer, 2009; Thorpe & Loo, 2003). The participants in this study lacked such an understanding. This conclusion highlights opportunities for improvement on at least three levels: 1) on-boarding orientation and continuing education for clinical nurse educators; 2) the curricular focus on values and ethics within advanced nursing degree programs; and 3) across the profession itself.

Training

The results indicate that although the participants work within the same institution, there is little focus on the importance of values and ethical principles during clinical education. The orientation received prior to starting as a clinical nurse educator was not consistent and did not create clear, if any, expectations about the importance of clinical nurse educators knowing and

teaching the values and ethical principles as essential to their role. Moreover, within this study, there was little, if any, coordinator effort within the college of nursing to teach or support clinical nurse educators in meeting expectations of their role. As a result, individuals were left to forge their own path. Through the interviews, it was revealed that the participants have done an excellent job attempting to transfer the values and principles they believe are important to their students. They use role modeling, personal stories, observation of other nurses, and discussion to continually reinforce these values and principles. And while they find great importance in doing this, there is no way to tell if it was just happenstance that this was important to these participants.

Curriculum

Beyond orientation, the findings from this study also indicate that nursing curricula does not appear to effectively instill the values or ethical principles of nursing in its graduates. The participants of this study are expert nurses. Each has an advanced nursing degree. Four of the six participants have, or are currently working on, an advanced degree with a focus on nurse education. Despite expertise in practice and the highest levels of training in nursing education and nursing science, they lacked explicit knowledge about the values and ethical principles of the profession; not one participant was able to explicitly name more than two core values or one ethical principle.

This result clearly indicates that the values and ethical principles are not covered adequately in advanced nursing degree program curricula, or alternatively, the pedagogy employed is not effective. Regardless of cause, colleges of nursing need to examine the extent to which the values and ethical principles of nursing are taught, and how to more effectively teach for deep understanding and transfer in practice and clinical education settings. This result also

confirms the concern that the core competencies outlined by the NLN would not be well developed in those without formal education if those that do have advanced degrees still lack familiarity with them (McDonald, 2010; Brown & Sorrell, 2017). Of the few participants who were aware of the NLN and ANA documents, none were able to articulate clearly what the values and principles are, showing only a superficial understanding.

Professional Identity

Finally, these results also highlight a potential problem within the profession of nursing. One aspect of a profession is a guiding set of principles to guide ethical practice. As stated in Chapter I, the nursing profession has been identified as the most trusted profession in the U.S. every year, except one, since they were added in 1999 (Saad, 2020); however, if the profession is to maintain this status, we need to have a foundational understanding of the values and ethical principles which guide us. The findings of this study need to be replicated for generalizability but seem to indicate that the nursing profession most likely also suffers from a lack of explicit knowledge regarding the value and principles. It was surprising to find that the participants of this study, all advanced degree nurses, most with a nurse education focus, could not articulate a reflective understanding of the values and ethical principles of their profession. If these expert practicing nurses with advanced nursing degrees do not know the values and ethical principles of nursing, then it raises a serious concern that most practicing nurses will not know them either. The code of ethics is non-negotiable and serves as the foundation informing the nursing profession (ANA, 2015, p. 10). If the profession is full of nurses who are unaware of the values and principles, the very foundation of the profession is at risk. Nurses need a reflective understanding of the theoretical commitments in order to cope with complex and involved ethical decisions. The gap is dangerous as practice barriers can be tied to local experiences and

personal prejudices rather than the obligation to base decisions on the values and ethical principles central to the profession.

Discussion of Research Question Two

How do clinical nurse educators' beliefs about the values and ethical principles of the profession of nursing inform their educational practices? The clinical nurse educators interviewed largely practice with concern for the values and principles of the profession. They also see it as their responsibility to teach these values and principles to their students. They understand that they must teach the core values and ethical principles to students and they are committed to doing this to the best of their ability. They take this role seriously, clearly understanding that they must perpetuate values and ethical principles in order to enable the student to be a professional. They are aware that students are always watching them, vicariously learning through their embodiment of the nursing role, regardless of whether their actions are intentional or unintentional (Bandura, 1965; Bandura, 2001; Gaberson & Oermann, 2010).

The NLN's second core competency calls on nurse educators to create learning environments within clinical practice so that they can teach professional behavior socializing nursing students to the role of the nurse (NLN, 2015). They must choose words and actions that convey the responsibility and accountability of the nurse within the profession to students and patients. (Adelman-Mullally et al., 2013). They must make clinical rotations as meaningful as possible and share their knowledge about all aspects of a nurses' role from communicating with patients to properly treating them.

This focus on sharing their knowledge through modeling and creating learning environments reinforces the claim of the NLN that clinical nurse educators are the torchbearers

of the profession. It also reinforces their integral and critically important role in the education and socialization of nursing students into the profession.

Because clinical nurse educators play such a central role in nursing education, they must be educational leaders who provide a bridge from the classroom to the clinical environment. To do so requires that clinical nurse educators have the ability to "articulate and demonstrate [their] professional values" with deliberate action and reflection (Halstead & Frank, 2018, p. 27). These skills must also be sensitive to their students' beliefs, which will change and expand in the course of instruction as they come to appreciate the norms of the profession (Weis & Schank, 2000). As discussed in the previous section, the clinical nurse educators in this study were unable to explicitly articulate the values and ethical principles of nursing. Without the foundational knowledge of the professional values, clinical nurse educators will not be able to fulfill their role as torchbearers of the profession. They may be able to teach the skills and model the values and ethical principles, but clinical nurse educators without an explicit knowledge base will be unable to bridge the relevance theory to practice gap or fully socialize students into the profession and its practices.

Although clinical nurse educators lacked explicit knowledge of the NLN and ANA codes, their nursing and teaching practice demonstrated a tacit knowledge about the values and ethical principles of the profession. The disconnect between tacit and explicit knowledge of the values and principles as laid out by the NLN and ANA indicates a disconnect between the theory and practice.

This finding indicates a *practice to theory* gap with the values and ethical principles of nursing. A *practice to theory* gap occurs when one is able to behave or function in ways that are consistent with theory but is unable to demonstrate the knowledge of why they are behaving or

functioning in that capacity. This is the opposite of a *theory to practice* gap which occurs when a person has knowledge of how to behave or function, but practices in ways that are not consistent that knowledge.

The participants' nursing practices are broadly in line with the NLN and the ANA standards, but they are unable to teach the reasoning behind them because of their lack of explicit knowledge about the profession. As a result, participants in this study teach the practice but not the theory of nursing. Clinical nurse educators have this responsibility because they must show how actions are informed by professional expectations. Practice without knowledge of the professional renders nursing a trade, rather than a profession.

Speaking from personal experience, the first day with students in a clinical setting is incredibly overwhelming. The realization that you are responsible not only for your students but also their patients can be staggering. You must instruct up to eight students in medication administration, skills, time management, interdisciplinary communication, delegation and the overarching values and ethical principles of nursing practice. But that responsibility is only half of the job. Clinical nurse educators are also responsible for caring for the students' assigned patients as well as ensuring safe practices by the students and monitoring the care given by the nursing staff of the hospital. It is mentally and physically exhausting and not for the faint of heart. Entering this situation with no more than a one-day orientation, which mainly looks at policies, does not set the clinical nurse educator up for success in general, much less focus on the values and ethics of nursing practice.

The participants in this study had a great sense of dedication to not only their profession, but to their students. They understand that the students are not coming out of the classroom with the ability to transfer what values and principles they may learn into their own practice. Values

and principles cannot be taught effectively if practice does not pick up where textbook learning ends. The clinical nurse educator's role is vital, but they need more training and support. Importantly, they should also work more closely with the core didactic faculty. The coordination of theoretical and practical instruction on values and ethical principles should be a central focus of nursing programs.

The students are not getting the theoretical basis for the actions they are observing, and so all of the clinical nurse educators' work could be lost on the students. The students could see teaching moments as an opinion of their clinical nurse educator and not an obligation of the very foundation of the profession they will be entering. This idea will be further discussed in the following section.

Implications for Practice

Practice to Theory Gap

There is nothing more important to the profession of nursing than a reflective understanding of its own nature and purpose. Nurses, especially in a healthcare setting, have to know their role. They must understand their accountability for these standards of professional practice. Such knowledge must be an included in the curriculum of undergraduate and advanced degree nursing programs. Past research has often been concerned about a theory to practice gap where nurses and nursing education is focused knowledge and the skills required to be a nurse, but ignores the ability to make ethically sound, professionally competent decisions.

The results of this study demonstrate that the participants do their best to embody the tacit wisdom of the profession of nursing, including its values and ethical principles. However, they do so without a well-grounded explicit understanding of values and ethical principles of nursing. This results in a practice to theory gap where clinical nurse educators try to practice and

teach the values and ethical principles of nursing but are unable to share an explicit explanation of the foundational commitments underlying the nursing profession. Indeed, by all accounts they do not know what makes nursing a profession. While their tacit knowledge of the core values and ethical principles is commendable, it is not sufficient to instill theory-generated practice required of modern nursing. The clinical nurse educators interviewed for this study gave powerful examples of their ability to not only embody the core values and ethical principles, but to enforce their use by students. However, when asked to share the "why" behind their reasons, they were not able to give an answer based on foundational principles. If a student were to ask why they need to do good, the answer from their clinical nurse educator looked only to received practice, not the ethical principle of beneficence.

There is a critical difference that needs to be highlighted between a moral imperative and a decision to act based upon professional codes. A moral imperative is a personal belief that leads to action, while decision making based on NLN and ANA codes is not determined by the individual, it is required by the profession itself. This distinction is of vital importance. Decisions made by all nurses, especially of clinical nurse educators in charge of teaching nursing students, must be led by the values and ethical principles of the profession itself. When students ask for the whys behind action the answer must be rooted in the professional code, not the moral imperative of an individual nurse or clinical nurse educator.

If clinical nurse educators do not have a firm understanding of the foundational values and ethical principles of the profession, their students, in turn, will not have the foundational knowledge necessary for practice. The practice to theory gap implies that while the students will see and learn something of good practice, they will not be able to champion the profession. Without this theoretical basis, the work that the clinical nurse educators do could be lost on their

students. When students ask the question, “Why must we…” and they hear the answer, “because you should,” that can be interpreted as an opinion. They could then interpret the instruction as a suggestion, dependent upon their personal views. For example, the fair treatment of a patient who is HIV positive as the result of IV drug use may be seen as a choice, one that could be disregarded if their own beliefs told them a patients’ lifestyle was wrong. Explicitly justifying decisions based on professional obligation makes difficult discussions pedagogically easier. In this situation, a clinical nurse educator can say, “it does not matter what I personally think about the behavior of the person for whom I care. I treat them fairly because it is what nursing requires. This is called justice and it is one of the core ethical principles of nursing that defines who we are and what we do as a profession.” It also creates greater opportunity to teach professional practice and gives more weight to these discussions. The clinical nurse educator would be able to point out that choosing to treat a patient differently because you agree or disagree with their behaviors is not a choice. It is what nurses do, because they are professionals. If students are unable or unwilling to practice the profession in this manner, then they should reconsider whether the nursing profession is right for them. Students must be able to distinguish between personal imperatives and professional obligations. This explicit teaching of core values and ethical principles requires a pedagogical shift in the way these values are taught for the participants in this study.

Clinical Nurse Educators as Integral to Nursing Education

Clinical nurse educators are the torchbearers of the nursing profession and as such should have much more involvement in planning, assessment, and engagement with other faculty in the teaching program. They are not just appendages, embodiments of the disconnect between theory and practice. Their role is integral, and they have a much more important role to play than the

one they currently have. The values and ethical principles of the profession are practiced in the clinical setting making them critical to not only the educational programs they work for but for the profession itself. The findings of this study give evidence of the ways clinical nurse educators create powerful opportunities to teach students the values and principles of the profession in ways that lectures alone cannot do. We cannot have preparation programs that divide theory and practice. The faculty have to come together through collaboration to integrate skills and knowledge in productive ways. That means taking the contribution of the clinical nurse educator much more seriously.

This should start with a stronger onboarding process when clinical nurse educators are hired. The lack of preparation prior to beginning their work does not meet the demands of their pivotal role within the program. They need more insight and training on how to educate students about the values and principles, and their implementation in practice. Their commitment would be a big step toward strengthening their political understanding of nurses as members of the professional body.

Implications for Future Research

Generalizability and Replication

This was a small study, recruiting only six participants from one institution. However, the findings suggest the value of expanding the research questions to other institutions and other parts of the country. To do this, the study needs to be replicated to determine the validity of the results presented in this paper. Determining the tacit knowledge versus the explicit knowledge of clinical nurse educators will help determine in different social and cultural contexts how widespread the concerns of this dissertation may be. Not only is the knowledge of other clinical nurse educators needed but also the nature of onboarding processes at other institutions.

Recollection of the participants' orientation to the role of the clinical nurse educator was vague. The participants did not go through an extended orientation and what they do recall differed from one another, even though they were all hired into the same program. Only three of the six remembered going over expectations of their role. Nursing needs to examine on-boarding in greater depth both with this and other institutions to examine the extent to which the values and ethical principles are part of the process. Looking into what other institutions may do differently around orienting clinical nurse educators into their role can help guide new practices.

Curriculum Changes

Nursing professionals also need to look at the curricular problem that was identified. We need more insight in to how we can effectively teach values and ethical principles. It is a gaping hole in our curricular knowledge. How are the values and ethical principles of the profession taught? Two future studies can be identified.

The first set is to examine the extent to which the values and ethical principles are embedded within undergraduate and graduate nursing programs. This needs to be looked at all program levels extending from ADN through PhD programs. It is not just a matter of curricula content, but also the effectiveness of institutions. Improving the way that they are taught values and principles may be especially important in the development of professional practice.

Secondly a set of studies could examine how to best teach the values and ethical principles of the nursing profession. If the results of the studies about the prevalence of values and ethics indicate that they are present within the curriculum, but not effective, then that is the starting point to determine effective ways of teaching them. However, if they are altogether missing, then the process of curricular reform will need to be engaged to find space within the curriculum to teach them, and once space is created for these topics, we must study how to

effectively teach the values and ethical principles. One place to begin identifying effective approaches to teach the values and ethical principles is the practical knowledge of clinical nurse educators. As current programs do not seem effective in conveying the values and ethical principles of the profession, perhaps faculty should entertain new approaches to the curriculum that recognize the key role played by clinical instructors. What can we learn about what they are doing, how can we expand on it, and how can we integrate it into our preparation programs? The educators interviewed for this study shared powerful examples of how they use many different opportunities and tactics to teach their students much more than just the skills needed to be a successful nurse. These examples need to be shared with others, not only new hires, but those who have been clinical nurse educators for a long time. Having opportunities to learn from each other will make for better experiences for the students and will allow them to get more out of their education, leading to better members of the profession.

Program Organization

Nursing professionals also need to take a deeper look at the organization of nursing programs themselves. Two set of studies have been identified to create a better understanding of schools of nursing. Aside from the curriculum for students, it is important to determine the organizational commitment to, and cultural norms around, the ways values and ethical principles are instilled in and upheld by faculty. In addition, it would be beneficial to learn how the didactic and clinical faculty coordinate instruction for students. The first study would look at the stated aims, methods, and content of instruction of the values and ethical principles by the institution and of faculty members. It would examine the institution's structural commitment to the values and ethical principles and its cultural everyday taken-for-granted norms, practices, and meaning systems around the values and ethical principles. This study would also explore the extent to

which the values and ethical principles are stated, discussed, and utilized during the onboarding of all faculty, with particular emphasis on the professional and pedagogical importance of deep and meaningful learning so nursing students transfer the values and ethical principles into their practice as they are socialized into the profession. Determining whether these are done, whether they are done successfully, and in what ways they can be done successfully will help create consistent practices which can be shared with other colleges of nursing to further grow and strengthen the profession.

The second study would be concerned with the coordination between the didactic and clinical nurse educator faculty. Though I did not ask directly ask participants in this study, I have extensive instructional and practical experience at the participant's institution. Courses such as *Fundamentals of Nursing* and *Adult Health* are led by didactic faculty who teach theory in the classroom. The didactic faculty are in charge of instructing their clinical nurse educators and communicating their clinical expectations of the course. From the classroom to the hospital floor, clinical nurse educators are tasked to bring the lessons students are learning didactically into the clinical setting. If the course is covering the respiratory system, then clinical educators are encouraged to assign patients with respiratory conditions to their students. This is possibly a difficult task when clinical nurse educators are assigned to any unit other than one focused on respiratory conditions. If students struggle on tests, then clinical nurse educators are often tasked to do more to fill the theory to practice gap. They are encouraged to use post conference time to go over the lessons learned in the classroom to help increase student comprehension, even if this does not speak to what the students actually did or witnessed in the clinical setting that week. Often these conversations between didactic and clinical faculty only take place when the students test scores are lacking. There is not a continual conversation between the two focused on the

actual experiences of the students, the struggles the clinical nurse educators may be encountering., or the ways that clinical experiences can inform didactic teaching.

The NLN states that clinical nurse educators play a primary and central role for preparing students for professional practices. The results of this study confirm the integral role of the clinical nurse educator and their commitment to teaching and the profession. However, their wisdom of practice and clinical teaching is subjugated to the theory, didactic power point teaching, and objective test scores. They are left to plot their own course and only seek assistance when necessary, often when something has gone wrong and a policy must be interpreted.

This study only examined one institution. Exploring other institutions to see how their didactic and clinical faculty work together to run courses would be helpful. Perhaps the institution in this study is an outlier and can learn from a study of other institutions. However, if this is the norm across institutions, then the relationship between didactic faculty and clinical nurse educators will need to be re-examined to meet the professional teaching obligations outlined by the NLN.

Conclusions

The NLN's Core Competencies for Nurse Educators (Halstead, 2019) call clinical nurse educators to serve as role models, teachers, and visionary leaders who embody the ethics and values of the profession (Adelman-Mullally, Mulder, McCarter-Spalding, Hagler, Gaberson et al., 2013; Halstead & Frank, 2018). However, research on the role of the clinical nurse educators is largely absent (Collier, 2018). This study aimed to begin to address this gap in the literature.

The participants showed great commitment to the values and ethical principles of the profession of nursing. However, they practiced and demonstrated this commitment tacitly, lacking explicit knowledge of what these values and ethical principles are. Clinical nurse

educators are called to share the values and principles of the profession of nursing with their students, and in so doing support the perpetuation of the profession itself. Without the foundational knowledge of the values and ethical principles the very foundation of the profession of nursing is at risk. Clinical nurse educators are on the front line working with students but teaching via tacit knowledge introduces a practice to theory gap which may undermine instruction, limit their ability to effectively educate their students, and represents a threat to the profession. Work needs to be done to make the role of clinical nurse educators integral and central in nursing education. This requires making instructional expectation about the profession, and any additional needed training, part of a reimagined and consistently applied onboarding process. Moreover, coordination and collaboration between clinical nurse educators and didactic instructors within courses needs to be explored and ways for improvement determined. Clinical nurse educators have a more important role and a larger voice about the education of nursing students than they currently play; they must not take a backseat to didactic teaching. There is almost sole focus on test scores and preparation for the licensure examination, there is little to no focus on students' ability to uphold the foundation of the nursing profession by the way they understand and practice the values and ethical principles they pledge at graduation to uphold. This focus needs to shift. Clinical nurse educators should be the heart of any school of nursing, and it is time they have a voice and receive respect for the responsibility of their role within nursing. The profession demands it.

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APPENDIX A:

PROVISIONS FOR THE CODE OF ETHICS FOR NURSES (ANA, 2015)

Provision 1 – The nurse practices with compassion and respect for inherent dignity, worth and unique attributes of every person.

1.1 Respect for Human Dignity

1.2 Relationships with Patients

1.3 The Nature of Health

1.4 The Right to Self-Determination

1.5 Relationships with Colleagues and Others

Provision 2 – The nurse's primary commitment is to the patient, whether an individual, family group, community or population

2.1 Primacy of the Patient's Interests

2.2 Conflict of Interest for Nurses

2.3 Collaboration

2.4 Professional Boundaries

Provision 3 – The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

3.1 Protection of the Rights of Privacy and Confidentiality

3.2 Protection of Human Participants in Research

3.3 Performance Standards and Review Mechanisms

3.4 Professional Responsibility in Promoting a Culture of Safety

3.5 Protection of Patient Health and Safety by Acting on Questionable Practice

3.6 Patient Protection and Impaired Practice

Provision 4 – The nurse has authority, accountability, and responsibility for nursing practice: makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.

4.1 Authority, Accountability, and Responsibility

4.2 Accountability for Nursing Judgments, Decisions, and Actions

4.3 Responsibility for Nursing Judgments, Decisions, and Actions

4.4 Assignment and Delegation of Nursing Activities or Tasks

Provision 5 – The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

5.1 Duties to Self and Others

5.2 Promotion of Personal Health, Safety, and Well-Being

5.3 Preservation of Wholeness of Character

5.4 Preservation of Integrity

5.5 Maintenance of Competence and Continuation of Professional Growth

5.6 Continuation of Personal Growth

Provision 6 – The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work settings and conditions of employment that are conducive to safe, quality health care.

6.1 The Environment and Moral Virtue

6.2 The Environment and Ethical Obligation

6.3 Responsibility for the Healthcare Environment

Provision 7 – The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

7.1 Contributions through Research and Scholarly Inquiry

7.2 Contributions through Developing, Maintaining, and Implementing Professional Practice Standards

7.3 Contributions through Nursing and Health Policy Development

Provision 8 – The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

8.1 Health Is a Universal Right

8.2 Collaboration for Health, Human Rights, and Health Diplomacy

8.3 Obligation to Advance Health and Human Rights and Reduce Disparities

8.4 Collaboration for Human Rights in Complex, Extreme, or Extraordinary Practice Settings

Provision 9 – The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

9.1 Articulation and Assertion of Values

9.2 Integrity of the Profession

9.3 Integrating Social Justice

9.4 Social Justice in Nursing and Health Policy

APPENDIX B:

ETHICAL PRINCIPLES WITHIN NURSING AND THE RELATED PROVISIONS FROM THE ANA CODE OF ETHICS (ANA, 2015)

Ethical Principles	Related Provisions from the ANA Code of Ethics and Examples
Autonomy	**1, 2, 3, 4** **1.4: The Right to Self-Determination**. "Patients have the moral and legal right to determine what will be done with and to their own person" (p. 2). **2.1. Primacy of the Patient's Interests**. "Honest discussions about available resources, treatment options, and capacity for self-care are essential" (p. 5). **3.2: Protection of Human Participants in Research**. "Individuals have the right to choose whether or not to participate in research as a human subject" (p. 10). **4.1: Authority, Accountability, and Responsibility**. "Nursing practice includes independent direct nursing care activities" (p. 15).
Justice	**1, 2, 3, 8, 9** **1.1: Respect for Human Dignity**. "A fundamental principle that underlie all nursing practice is respect for the inherent dignity, worth, unique attributes, and human rights of all individuals" (p. 1). **2.1: Primacy of the Patient's Interests**. "Commitment of nursing to the uniqueness, worth, and dignity of the patient" (p.5). **3.1: Protection of the Right of Privacy and Confidentiality.** "Patient rights are the primary factors in any decisions" (p. 9). **8.1: Health is a Universal Right**. **9.3: Integrating Social Justice**. "All nurses…must anchor students in nursing's professional responsibility to address unjust systems and structures" (p. 36).

Ethical Principles	Related Provisions from the ANA Code of Ethics and Examples
Fidelity	**1, 2, 3, 5, 8** **1.2: Relationships with Patients**. "Nurses establish relationships of trust" **2.1. Primacy of the Patient's Interests**. "Honest discussions about available resources, treatment options, and capacity for self-care are essential" (p. 5). **3.1: Protection of the Right of Privacy and Confidentiality**. "Nondisclosure of personal information that has been communicated within the nurse-patient relationship" (p. 9). **5.3: Preservation of Wholeness of Character**. "Nurses have both personal and professional identities that are integrated and that embrace the values of the profession" (p. 20). **8.2: Collaboration for Health, Human Rights, and Health Diplomacy**. "Nurses must lead collaborative partnerships to develop effective public health legislation, policies, projects, and programs that promote and restore health, prevent illness, and alleviate suffering" (p.32).
Beneficence & Nonmaleficence	**1, 3, 6, 8** **1.3: The Nature of Health**. "Nurses are leaders who actively participate in assuring the responsible and appropriate use of interventions in order to optimize health and well-being of those in their care" (p. 2). **3.5: Protection of Patient Health and Safety by Acting on Questionable Practice**. **5.4: Preservation of Integrity.** "Nurses are obligated to provide for patient safety, to avoid patient abandonment" (p. 21). **6.2: The Environment and Ethical Obligation**. "Obligations are often specified in terms of principles such as beneficence or doing good; nonmaleficence or doing no harm" (p. 23). **8.4: Collaboration for Human Rights in Complex, Extreme, or Extraordinary Practice Settings**. "Nurses must engage in discernment, carefully assessing their intentions, reflectively weighing all possible

Ethical Principles	Related Provisions from the ANA Code of Ethics and Examples
	options and rationales, and formulating clear moral justifications for their actions" (p. 33).
Veracity	**1, 2, 3, 5** **1.4: The Right to Self Determination**. "Patients have the moral and legal right…to be given accurate, complete, and understandable information" (p. 2). **2.1. Primacy of the Patient's Interests**. "Honest discussions about available resources, treatment options, and capacity for self-care are essential" (p. 5). **3.2: Protection of Human Participants in Research**. "Participants or legal surrogates must receive sufficient and materially relevant information to make informed decisions" (p. 10). **5.4: Preservation of Integrity**. "Nurses may face threats to their integrity…such (as)…requests or requirements to deceive patients…nurses have a right and a duty to act according to their personal and professional values" (p. 20).

APPENDIX C:

BACKGROUND QUESTIONS

1. What year did you graduate from undergraduate nursing school and what school did you graduate from? Advanced degree?
2. Do you have any formal training/certifications for nurse education?
3. What was the first job you had after graduation? What unit(s)/specialties have you worked on since that time?
4. How long have you taught at the University? Specifically, how many years have you taught in the clinical setting?
5. What is your role in the nursing program?
6. How were you oriented after you were hired? What do you remember of your orientation?
7. Do you know the mission of the nursing school?
8. What course(s) have you taught in? What was your role: didactic, clinical or both?
9. What course(s) do you currently teach in? How long have you taught in this course(s)? What is your role? What hospital(s) and unit(s) do you take your students to?
10. How many hours do you spend with students in the clinical for your course(s)?

APPENDIX D:

INTERVIEW QUESTIONS

1. What is your understanding of the profession of nursing?
2. What are the elements that make nursing a profession?
3. What do you believe makes a good nurse?
4. What do you believe your role as a clinical nurse educator is within the profession?
5. What are the elements that you believe make you a good clinical nurse educator?
6. What are the values and ethical principles of the profession?
7. What values do you think are important to the profession?
8. Do you know the NLN core values for nurse education?
9. How do you teach those values (personal or the NLN) to your students? What do you draw upon?
10. How well do you know the Code of Ethics as defined by the ANA for the profession of nursing? Can you share some of the provisions?
11. What do you believe are the main guiding ethical principles in the profession of nursing?
12. What do you draw on to teach those ethical principles to your students?
13. How do your beliefs about the values and ethical principles of the profession inform your clinical teaching practice?

APPENDIX E:

INSTITUTIONAL REVIEW BOARD APPROVAL FOR STUDY

THE UNIVERSITY OF ALABAMA | Office of the Vice President for Research & Economic Development
Office for Research Compliance

October 21, 2020

Sarah Robinson
Department of ELPTS
College of Education
Box 870302

Re: IRB # 20-10-3968: "Clinical Nurse Educators' Beliefs of the Values and Ethical Principles of the Profession of Nursing and the Implications for Clinical Education"

Dear Ms. Robinson:

The University of Alabama Institutional Review Board has granted approval for your proposed research. Your application has been given exempt approval according to 45 CFR part 46. Approval has been given under exempt review category 2 as outlined below:

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

(iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

The approval for your application will lapse on October 20, 2021. If your research will continue beyond this date, please submit the annual report to the IRB as required by University policy before the lapse. Please note, any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Please use reproductions of the IRB approved informed consent form to obtain consent from your participants.

Sincerely,

[redacted]

Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer

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