Ethical Values and Resolution of Ethical Value Conflicts by Nurse Educators

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at George Mason University.

By

Carolyn Zehr Lyndaker
BSN University of Southern Mississippi May 1982
MSN Troy State University May 1986

Director: Mary Cipriano Silva, PhD, RN
Professor College of Nursing and Health Science

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Fairfax, VA

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Dedication

I wish to dedicate this work to My Husband of 30 years:

Milford Ednor Lyndaker

This is for you dear with my heartfelt thanks!

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Abstract

ETHICAL VALUES AND RESOLUTION OF ETHICAL VALUE CONFLICTS BY NURSE EDUCATORS

Carolyn Z. Lyndaker, PhD

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Dissertation Director: Dr. Mary C. Silva

The purpose of this descriptive, qualitative study was to identify ethical values and ethical value conflicts encountered by nurse educators and to explore the resolution process of ethical value conflicts by nurse educators.

A sample of 47 nurse educators from National League for Nursing accredited baccalaureate programs in the Mid-Atlantic Region of the United States comprised the initial sample. From the initial sample, a purposeful sample of 14 nurse educators was selected for in-depth interviews. Data were collected from 10 face-to-face and 4 telephone interviews. A revised method of thematic content analysis outlined by Burnard (1991) was used for data analysis. Data analysis resulted in the emergence of multiple themes with the following conclusions: (a) nurse educators found that ethical value conflicts were inherent in interactions with students, were multifactorial in nature, and were created at

times simply by adherence to good nursing practice; (b) nurse educators were able to identify values in conflict as ethical; (c) nurse educators identified a process of actions to resolve ethical value conflicts; (d) nurse educators found that confronting and resolving ethical value conflicts was hard work and complex; (e) nurse educators used ethical principles and theories to guide them in resolving ethical value conflicts; (f) nurse educators experienced emotional reactions (moral distress) to ethical value conflicts and experienced moral distress throughout the process; (g) nurse educators experienced resolution when they believed they had acted in an ethical manner, had done all they could, ethical principles were followed, and/or outcomes were positive; and (h) decisions of the resolution process had consequences for faculty and students. In addition, the interview process allowed for exploration of many facets of the subject and assisted nurse educators in further introspection and resolution of their feelings.

Recommendations for nurse educators and the nursing profession, as well as further research, were discussed. Study results can be used for guidance in resolution of ethical value conflicts. Furthermore, schools of nursing, nurse educators, and health care agency personnel can use results from the study to examine behaviors critically and evaluate actions for ethical merit.

CHAPTER I

Introduction and Significance

Little is known about values, ethical value conflicts, and resolution of these conflicts by faculty in institutions of higher learning. Indeed, Counelis (1993) discovered that a computer search for empirical studies on moral behavior of faculty in universities and colleges did not reveal any studies related to moral behavior or any of the preceding concepts related to values. Dill (1982) further purported that academic norms limited the potential for developing ethical sensitivity and seemed to inhibit an analysis of the value conflicts continually faced by faculty members. He believed that faculty members' attitudes toward teaching had been most influenced by their own value orientation. As with faculty in other disciplines, little is known about ethical value conflicts and resolution of these conflicts among nursing faculty.

The lack of guidance in identifying and resolving ethical value conflicts for nursing faculty is unfortunate since faculty have the opportunity to model successful techniques of resolving conflicts to impressionable

students. Callahan (1982) emphasized the importance of role modeling by faculty in teaching ethical principles to nursing students: "A major mode of moral instruction in the university is . . . the kinds of moral example that professors themselves manifest" (p. 336). Fowler (1987, p. 25) further states that through ethical thinking, professional standards are set; these standards then become ideals toward which the professional strives.

Ketefian (1987) believes that it is paramount that nurses practice morally and that their behavior is based on higher levels of reasoning (thought and reflection) rather than on lower levels of reasoning (self-interest and pragmatic concerns). As nurses deal with their underlying values and acknowledge the values of others, they will develop the necessary skills to facilitate resolution of ethical value conflicts. This will ensure that the worth and integrity of the individuals involved in conflict situations have been preserved.

Silva (1990, p. 88) states that values' clarification is not enough in health care situations. Thompson and Thompson (1981, p. 3) add that values' clarification is not synonymous with ethical decision making. They recognize that an awareness of one's own values and moral position does not necessarily guarantee ethical decision making in practice. Circumstances may require action inconsistent

with the nurse's values or the nurse's values may be inconsistent with those of others. Tensions may result when values conflict, causing difficulty in resolution. In an earlier pilot study, Lyndaker (1992) found that even subjects with previous educational preparation in ethics reported frustration when they did not demonstrate ethical behavior, either by personal action or by action beyond their control. These difficulties in resolving ethical conflicts can result from an inability to make a decision or from an uncertainty over whose values should take precedence (Silva, 1990, p. 88).

Furthermore, Darling and Cornesky (1987) believe that management of conflict should be considered a major responsibility in academic health science organizations. Nurse educators are vulnerable to conflict due to the pivotal role they assume in educating and supervising students in the classroom and clinical areas. It is imperative that nurse educators recognize and understand this complex phenomenon and become familiar with varying techniques to resolve conflict (Booth, 1982). According to Curtin (1988), to resolve value conflicts in everyday practice, nurses need to identify values and commitments clearly, set priorities logically, and subject professional choices to critical analysis.

The qualitative nature of the study allowed nursing

faculty to identify ethical value conflicts personally encountered with students and subject their choices to critical analysis for ethical principles guiding behavior. Also, in response to the importance of nurses understanding and being skilled in the area of ethical practice, this study assisted educators in clarifying their ethical values and in determining whether their actions modeled ethical or unethical behavior. When nursing faculty act more strongly as moral agents, students may perceive themselves as more responsible individuals, capable of ensuring moral propriety of their own and their colleagues' behavior (Banja, 1991).

Purpose of the Study

Based on the preceding need, the purpose of the study was to identify ethical values held by nurse educators and to explore how nurse educators resolved ethical value conflicts.

Research Questions

Based on the purpose, seven research questions were raised: (a) What are ethical value conflicts experienced by nurse educators? (b) What criteria are used by nurse educators to identify a situation as a conflict in ethical values? (c) How do nurse educators in baccalaureate nursing programs resolve ethical value conflicts? (d) What factors influence resolution of ethical value conflicts by nurse educators? (e) What are ethical principles that guide the action taken

by nurse educators in resolution of ethical value conflicts? (f) What are inner conflicts experienced by nurse educators as a result of their action? (g) When do nurse educators feel they have reached resolution in the ethical value conflict?

Definition of Concepts

Due to the qualitative design of the study and to limit bias and preconceived thinking, there was no predetermined conceptual framework for the study. Instead the investigator allowed meaningful themes and patterns to emerge from the data. Inferences and connections could then be made. However, concepts used in the study are discussed to provide a point of reference for clarity of thought and understanding.

Ethics/Nursing Ethics

Ethics is a generic term for several ways of examining moral life (Beauchamp & Childress, 1994, p. 4). Thompson and Thompson (1981) define morals as the "oughts" and "shoulds" and ethics as the principles behind the "shoulds" (p. 1). According to Shelly (1980, p. 17), the goal of ethics is to ensure that right and good prevail. Because of incongruencies in definition, the terms "ethics" and "morals" are used synonymously in this study.

Veatch and Fry (1987, p. 1) state that the use of the term "nursing ethics" is controversial. One avenue of

thought is that the same ethical principles and moral issues emerge in health care regardless of role. Another avenue of thought is that nursing ethics is a subsystem derived from a larger, general system of biomedical ethics and is unique. For the purpose of this study, "nursing ethics" is used as defined by Flaherty (1982) -- "beliefs about moral values, ideals, virtues, obligations and principles identified by nurses as important" (p. 176). The methods of analysis, general principles, and purpose of nursing ethics are the same as biomedical ethics, but the context and often the content of decisions differ.

Values

Precise definition of "values" is a difficult undertaking, especially in a pluralistic society where there are great variations in belief systems (Levine, 1989). A value denotes worth or significance and is obtained in a process of growth and development (Fenner, 1980, p. 63). Values are concepts, ideas, behaviors, and significant themes that give meaning to our lives. Feelings and decisions are based on our values, but sometimes we are ambiguous about what it is we value (Uustal, 1977). Uustal further states that the clearer we are about what we value, the more able we are to choose and initiate a response that is consistent with what we believe. Scalzi and Nazarey (1989, p. 584) believe that once a value is internalized it

becomes a conscious or unconscious standard for guiding action. Reilly (1989) states that there is no single theory to help us decide the right thing to do. However, Thompson and Thompson (1981, p. 3), in their guidelines for identifying and analyzing ethical dilemmas for nursing practice, allude to values by including identification of personal values, value conflicts, and other peoples' values. In the Curtin and Flaherty (1982) book, "reconciling facts and values; holding multiple facts and values in tension" (p. 61), is considered one step in assessing ethical dilemmas. Because values are dynamic, Reilly (1989) gives nurses the charge to examine their value pronouncements to be sure they are indeed values, to assess their relevance to practice and to be ready to subject them to regular review as new knowledge occurs. For the purpose of this study, values are defined as dynamic concepts and ideas that provide a conscious or unconscious guide to behavior.

Ethical Values

To further distinguish a value as possessing an ethical component as opposed to personal or professional values, Beauchamp and Childress (1989, p. 17), in the third edition of their book, ask the question, What makes some principles, problems (values) and judgments moral? In answer to the question, they propose three criteria. Principles, problems (values) and judgments are moral when they: (a) are

accepted by person/society as supreme, (b) have universality, and (c) protect or promote human welfare. These are necessary conditions but are not sufficient to define ethical values. Fenner (1980, p. 22) views a system of valued behaviors and beliefs as ethical when based on what should be in matters of morals. Hogan and Dickstein (1971) define values as moral when used as criteria for choosing rules of professional conduct.

The American Association of Colleges of Nursing (AACN) (1987) has proposed values essential for nursing practice: (a) altruism; (b) equality; (c) esthetics; (d) freedom; (e) human dignity; (f) justice; and (g) truth. These values are further defined into professional behaviors. Of these values all but esthetics have an ethical component. Closely paralleling these values, Rezler, et al. (1990) measured the following ethical values in a study on professional decisions and ethical values in medical and law students: (a) autonomy; (b) beneficence; (c) confidentiality; (d) harm avoidance; (e) justice; (f) professional responsibility; and (g) truthtelling. For the purpose of this study, ethical values are identified as those values that are commonly applied to nursing ethics and are based on ethical principles such as autonomy, beneficence, nonmaleficence, justice, confidentiality, veracity, and fidelity (Fromer, 1980). In addition, respect for autonomy is included with

autonomy as an ethical principle used in the study.

Ethical Principles

The preceding ethical principles are further defined as they are used in this study: a) autonomy -- the affirmation that a competent adult has the right to make determinations about essential personal matters (Perlin, 1992, p. 9) and respect for autonomy -- a norm of respecting the decision making abilities of the person (Beauchamp & Childress, 1994, p. 38); b) beneficence -- promoting the well-being of others (Perlin, 1992, p. 10); c) nonmaleficence -- the obligation to protect persons from harm (Perlin, 1992, p. 10); d) justice -- being fair and respecting human equality (Perlin, 1992, p. 10); e) confidentiality -- the professional promise not to reveal information without consent (Perlin, 1992, p. 328); f) veracity -- the principle that values truthtelling and establishes honesty in personal relations (Perlin, 1992, p. 332); and g) fidelity -- being faithful to a principle or person (Perlin, 1992, p. 329).

Ethical Value Conflicts

Although the lists of values seem clear, applying them into daily practice and addressing the inevitable conflicts between the stated values has remained beyond the grasp of many nurses (Aroskar, 1982; Omery, 1985). According to Cushnie (1988), conflict occurs when individuals hold incompatible or seemingly incompatible interests, ideas, or

values. She further states that value conflict is the most complex type of conflict and identifies four sources of value conflict: (a) intragroup, (b) intergroup, (c) intra-personal, and (d) interpersonal. In addition, Scalzi and Nazarey (1989, p. 589) state that value differences do not necessarily imply value conflict. Values that are different may be compatible. The definition of an ethical value conflict used in this study is one by Megel and Elrod (1993): An ethical value conflict is defined as a "disagreement that occurs when the interaction of two or more independent people involve incompatible values in a situation where the overriding concern is determining the 'right' thing to do" (p. 8). Furthermore, Wright (1987, p. 25) proposes criteria for analysis of ethical theory which is adapted for the purpose of this study to analyze which value conflicts are ethical in nature: How do the consequences of the conflict affect its moral worth?

Moral Reasoning

According to Shelly (1980, p. 18), to make responsible ethical decisions, nurses must know what they value and why they value certain concepts, beliefs, attitudes, and behavior. Wright (1987, p. 7) purports that values influence ethical decisions by framing the problem, supplying alternatives and directing reasoning. According to Curtin (1982), ethical problems raise two questions for a

person: "How can I find an answer that will allow me to be at peace with myself? and How can I find an answer that will allow me to be at peace with others" (p. 43)? The answer to the first question results from a subjective analysis to determine the degree of congruity between a particular choice or action and the perception of right or wrong for the person. The answer to the second question requires some objectivity and includes a consideration of both duties or outcomes in the choice or action. Moral reasoning (also moral development and moral judgment) affects choice and action. It is a mental process that intervenes between recognition and reaction to a moral problem by which one chooses among one's own values to come to some decision as to the appropriate response and/or behavior (Omery, 1989).

Conflict Resolution

Conflict resolution (conflict management) is one method for choosing an appropriate response and/or behavior in a situation where ethical value differences occur. Scalzi and Nazarey (1989, p. 589) believe that resolution of value conflicts does not require one value winning over another, but rather an appreciation and understanding of value differences and a willingness to develop shared goals. However, conflict resolution may or may not lead to a satisfactory outcome. It may lead merely to a reduction of the problem.

Summary

Exploration of ethical values and their resolution is a topic of grave concern and importance. The pivotal role of nurse educators provides impetus for investigating their ethical behavior regarding resolution of ethical value conflicts. The diversity of defining ethical concepts further illustrates the complexity of this exploration. Chapter II focuses on a review of literature pertinent to this study.

CHAPTER II

Review of Literature

Although there is considerable literature written on ethics, the majority of articles have focused on theoretical frameworks, ethical decision-making models, moral reasoning, content of ethical problems, and educational programs to improve an understanding of ethics, rather than on moral behavior. Many of the studies conducted were based on hypothetical situations; it is only recently that researchers have begun to ask nurses to describe actual ethical conflicts that they have experienced in clinical practice (Aroskar, 1989; Megel & Elrod, 1993; Miya, Boardman, Harr, & Keene, 1991).

There are relatively few studies that have explored ethical decision making in actual clinical practice and fewer still that have addressed ethical value conflicts and modes of resolution related to these ethical value conflicts. Thus, this review of literature addressed the following: (a) identification of ethical value conflicts; (b) influencing factors/strategies guiding resolution of ethical value conflicts; (c) moral reasoning related to

resolution of ethical value conflicts; (d) ethical principles guiding resolution of ethical value conflicts; (e) internal and external consequences of the resolution process; and (f) methodological concerns regarding nursing research and ethics.

Identification of Ethical Value Conflicts

There is limited research in the area of ethical value conflicts. However, there are some studies that have compared values between groups of people.

Williams, Bloch, and Blair (1978) compared personal values (support, conformity, recognition, independence, benevolence, leadership, practical mindedness, achievement, variety, decisiveness, orderliness, goal orientation) of graduate nursing students with faculty and found that students' and faculty's values were more alike than different, even at the time of students' entry into graduate nursing programs. As students progressed through the program, the differences in values became even less. Thurston, Flood, Shupe, and Gerald (1989) examined personal and professional values of nursing faculty and compared them with entering generic nursing students. They found that responsibility, honesty, love, and forgiveness were the top four choices of faculty and students. Their findings concur with Williams, Bloch, and Blair (1978) that nursing faculty and students were more alike than different regarding their

values.

Garvin and Boyle (1985) viewed values as standards that guide behavior. However, empirical data to support this assumption are limited. Because research has shown that nursing students and faculty have similar values does not necessarily mean that behavior is guided by those values. Indeed, Hilbert (1988) surveyed 101 senior nursing students to determine the incidence of unethical behavior in the classroom and clinical settings. Results of the study showed that nursing students often engaged in unethical behaviors, especially related to dishonesty. Thirty-three percent of the students admitted getting exam and quiz questions from someone who had taken the exam or quiz earlier. In the clinical setting, over 44% of students admitted to taking hospital equipment home. This finding suggests that although results from Thurston, Flood, Shupe, and Gerald's study (1989) showed honesty as the value ranked second by students, this value was not consistently reflected in behavior.

Lewis (1976) believed that fewer conflicts were likely to develop when members of an organization had a homogeneous set of values. Ironically, to provide a strong nursing program, deans and directors preferred a heterogenous group of faculty (Milburn, 1987). In reality, Booth (1982) and Kielinen (1978) stated that conflict permeates all types of

relationships, with academia as no exception. Furthermore, in the works of Woodtli (1987) and Robbins (1978), the most disruptive conflict among nursing faculty centered around interpersonal issues, especially value differences. Although not directly involving nursing faculty, a clinical study supporting this finding was conducted by Miya, Boardman, Harr, and Keene (1991). They found that value conflicts related to interpersonal conflict occurred in 38% of situations faced by neonatal intensive care nurses. Although values described in the previous studies were not categorized as ethical, there are ethical implications inherent in values such as honesty.

There also appears to be confusion in the literature regarding what constitutes an ethical value. Theis (1988) studied faculty ethics by evaluating students' perceptions of unethical teaching behaviors encountered in the classroom and clinical setting. The majority of such behaviors identified involved lack of respect for students. Questions about whether the behaviors identified as unethical were, in fact, better described as unprofessional cast doubt on the study's validity and illustrate the confusion in evaluating behaviors with moral elements.

Zablow (1985) conducted a study for the purpose of determining the nature of the moral dimension in professional nursing practice. She found that what was

often cited as a moral situation was merely a difference of opinion. Zablow (1985) further found that even when the situation was clearly moral in nature, nurses had difficulty in identifying moral elements inherent in patient care situations and appeared to be confused as to what was the right thing to do. Although the sample consisted of nurses involved in direct patient care, the findings have relevance for nurse educators. Indeed, in an earlier pilot study, Lyndaker (1992) found that even nurse educators with education in ethics had difficulty in identifying ethical value conflicts.

Perhaps the closest identification of ethical value conflicts was found in a study done by Megel and Elrod (1993). The purpose of the study was to investigate conflicts, including ethical conflicts, experienced by quality assurance nurses. Conflicts were analyzed to determine the individual's ethical perspective, justice or caring. There was mention of ethical conflicts, such as confidentiality, truthtelling and so on, but the concern of the participants seemed to be more related to providing a standard of care in an equitable manner and maintaining interpersonal relationships. Although "traditional" ethical principles including confidentiality, fairness, truthtelling, autonomy, and patients' rights to quality care emerged from the study, additional exploration raises

questions about the ethical nature of the conflicts. Furthermore, patients' rights to quality care may be challenged as an ethical principle and caring may be challenged as an ethical perspective. In addition to the ethical principles reported by Megel and Elrod (1993), Miya, Boardman, Harr, and Keene (1991) found beneficence-nonmaleficence to be of primary concern for neonatal intensive care nurses. Research supports lack of clarity in identifying value conflicts as ethical. This lack of clarity in understanding, results in ambiguity in resolution of these conflicts.

Influencing Factors/Strategies Guiding Resolution of Ethical Value Conflicts

According to Cavanaugh (1991), there are few research studies that examine the nature of nursing conflict and how conflict is managed by nurses in the workplace. Megel and Elrod (1993) identified ethical value conflicts experienced by nurses and how nurses responded to these conflicts but the process was not discussed. Ravella (1985) also asked her study participants (some of whom were nurse executives) to identify ethical value conflicts confronted in their experience. She found that females reported moral conflicts associated with the responsibility perspective, that is, performance problems and integrity issues, and that males reported moral conflicts associated with the rights

perspective, that is stealing. However, resolution was not a part of the study.

In a study conducted to assess reasons used by mental health practitioners to resolve professional ethical conflict situations, Smith, McQuire, Abbott, and Blau (1991) found that although practitioners evaluated what should be done based on ethical guidelines, they were not always willing to implement this ideal. The study suggests that even though professionals tend to think in terms of formal codes of ethics and legal guidelines in determining what should be done, in actuality they are more likely to respond to personal values and practical considerations. Regardless of the fact that the Smith, et al. study did not address ethical values, it is possible that the same phenomena would occur where ethical guidelines were identified but were not implemented into practice.

In a study related to process, Carpenter (1991) reported a qualitative study conducted to examine the process of ethical decision making by psychiatric nurses. The author found that participants expressed feeling powerless in their present work situation, and 12 of the 20 participants did not act on their first choice of action. The study further supported the notion that ethical principles do not necessarily guide outcome in actual practice. Although the study identified an ethical decision

making process comprised of both cognitive and affective components, the findings can be compared with the process of conflict resolution as described by Barton (1991): (a) perception that a frustration has occurred; (b) conceptualization -- defining the conflict issue and considering alternatives and outcomes; (c) selecting the resolution strategy; (d) interacting through communication skills; and (e) identifying short-term and long-term outcomes.

In further exploring factors that influence how ethical value conflicts are resolved, resources, strategies and modes of conflict resolution will be considered. As previously stated, values held are not necessarily consistent with values applied (Thurston, Flood, Shupe, & Gerald, 1989). In concurring with this statement, Ketefian (1987) found that there was a significant difference between nurses' assessment of what they thought would realistically be done and what they would do in a conflict situation. Ironically, nurses in the study felt they would act in an ideal, professionally appropriate manner. Since the study used hypothetical situations, with the possibility of individual bias, differences between the real and the ideal behavior in actual clinical settings could be even more significant.

In a similar study, Moore (1991) found a significant

difference between the ideal and the real responses of all subjects to hypothetical ethical dilemmas. The sample was comprised of nursing students, but one would not expect a significant difference in responses upon graduating. Therefore, the results indicated the difficulty that nurses had in implementing ideal ethical behavior into the workplace. Factors influencing behavior were not discussed by Ketefian (1987) or Moore (1991).

In addition to the incongruence between values held and values applied, Barton (1991) stated that conflict-handling modes in daily decision making were influenced both by the individual and the environment in which that person works, thus supporting the findings of Carpenter (1991). Furthermore, Collyer (1989) said that an administrator's self-confidence and perspective heavily influenced the workplace environment. In regard to workplace environment, Riley (1991) cited congruence of institutional philosophy and climate with nursing's values, and Camunas (1991) cited superiors of the nurse executive and the politics within the institution as factors influencing decision making.

To resolve dilemmas, nursing executives most frequently relied on their own personal values, those of administration and those of professional colleagues (Camunas, 1991). In addition, Cushnie (1988) believed that trust, commitment, and communication were necessary components for resolving

conflict, with communication as the key component. Haw (1980), however, says it is a myth to believe that open communication and extended dialogue eventually will lead to effective resolution of conflicts. Furthermore, according to Kielinen (1978), real conflicts exist that cannot be communicated away. Lewis (1976) says that meeting conflict situations effectively requires considerable understanding and patience.

There were few research studies that explored resources used by professional nurses in practice to resolve conflicts and ethical problems. In one such study, Aroskar (1989) found that community health nurses used religious values, life experiences, laws, and professional codes as sources of guidance when confronted with ethical problems. They turned primarily to nursing colleagues as resource persons for guidance but also used agency supervisors, administrators, friends and family as resource persons. Aroskar's findings support those of Camunas (1991). Since findings from these two studies showed that nurses depended on one another for help in dealing with ethical problems in practice, it is important that nurse educators identify ethical problems and learn an ethical decision making process for resolving these problems. Successful resolution strategies not only will lead to modeling ethical behavior for students but also will assist colleagues in the process.

In addition to resources utilized by nurses in addressing ethical value conflicts, studies on conflict management styles were analyzed to determine how modes of conflict management were used by individuals and how resolution of the conflict was affected. Bartol (1976) found that staff nurses in her sample (N=200) used collaboration most often to resolve conflicts, followed by compromise, forcing, accommodating and avoiding. In contrast, Booth (1978) found when studying 23 professionals, including some nurses, that accommodating was used most frequently, followed by bargaining, avoidance, confrontation, and forcing the issue. Findings from a study done by Marriner (1982) concur with Bartol (1976). Marriner (1982) also found collaboration was the most frequently adopted conflict management style used by 182 nurse managers. She further found that collaboration and compromise correlated most frequently with successful resolution, and that avoidance and competition were associated with unsuccessful resolution.

Holt (1986) conducted a similar study as Marriner (1982) but included intervening variables such as sex and age. Her findings do not support those of Mariner (1982). She found that the nurse managers (N=156) used compromise most often, followed by collaboration and avoidance. She further found that the variables of age and sex were factors

in the choice of conflict management style: (a) females were slightly less competitive and collaborative and slightly more avoiding than their male counterparts and (b) nurses over age 55 compromised significantly less than nurses ages 26-35. Holt (1986) also found that females used compromise more often than males to resolve conflict. She further found: (a) participants ages 35 years and under used competition, (b) participants 36 to 45 used compromise, and (c) participants ages 46 years and older used collaborating most frequently as their choice of conflict management style.

Cavanaugh (1991) conducted a study comparing conflict management styles of staff nurses (N=145) and managers (N=82). His findings do not concur with any of the studies cited above. He found that staff nurses and nurse managers most commonly used the conflict management style of avoidance. However, intervening variables such as age, sex, and so forth, were not discussed. Table 1 contains comparisons of conflict resolution modes between studies in order of frequency of use for each study.

Most of the studies cited were limited to the use of the five conflict management styles described by Thomas and Kilmann (1974). Because of the small sample size of Booth's (1978) study (N=23) and of incongruences in the findings of the studies, generalizability is limited.

Table 1

Comparison of Conflict Resolution Modes

Studies	Bartol	Booth	Mariner	Holt	Cavanaugh
Modes	Collaboration	Accommodating	Collaboration	Compromise	Avoidance
	Compromise	Bargaining	Compromise	Collaboration	Compromise
	Forcing	Avoidance	Competition	Avoidance	Accommodating
	Accommodating	Confrontation	Accommodating		Collaboration
	Avoidance	Forcing	Avoidance		Competition

Perhaps ethical values held personally by individuals influence the mode used in resolving conflicts. Collyer (1989) defined personal utilization of the five modes of conflict management in terms of concern for task and relationship. Avoidance involves a low level of concern for task completion and relationships. Accommodation involves a low level of concern for task completion and high concern for relationships. Compromise involves an equal but moderate concern for relationship and task completion. Competition involves high concern for task completion and little concern for relationship and collaboration involves equal concern for task completion and relationship. Perhaps personal ethical values could be a variable to consider in determining frequency of utilizing specific conflict management styles. Collyer's (1989) correlation of task completion and relationship with mode of conflict could

provide an explanation for the lack of congruence in the studies cited.

Moral Reasoning Related to Resolution of Ethical Value Conflicts

One of the assumptions of a study done by Felton and Parsons (1987) was that persons functioning at a higher level of moral reasoning lived by a code of moral principles that included respect for the values of others. Their results support the findings that students with more formal education demonstrated moral reasoning at higher levels than those students with less formal education. Formal education was a predictor of moral reasoning. Previous studies (Ketefian, 1981; Munhall, 1980; & Ravella, 1985) have identified congruency between the stage of moral reasoning and formal education. Findings from a study conducted by Cady (1991) showed similar results with registered nurses. In another study, Munhall (1980) found that there was a significant difference in level of moral reasoning between students and faculty; she inferred that increased levels of moral reasoning would increase the person's ability to solve moral problems.

However, Ketefian (1987) believed the assumption that persons at higher stages of moral reasoning were more likely to act morally was not based on a body of empirical evidence. In fact, findings from a study by Lawrence and

Helm (1987) investigating moral reasoning by nurses supported the view that a higher level of moral reasoning does not guarantee moral action. Nurses (N=258) attending a nursing ethics conference completed a researcher designed questionnaire inquiring into appropriate ethical actions a charge nurse would take in five different hypothetical situations ranging from a medication error to turning off life support. Inconsistencies were observed in the decisions the nurses made as indicated by a low Cronbach's alpha of 0.16 and low, non-significant correlations. Nurses' personal moral beliefs varied most of all in justifying decisions. The pragmatic concern for self-protection was not used consistently as justification for action. Hospital procedures, physician's rights, and authority failed to influence how nurses responded to ethical dilemmas. Respondents most consistently used legal responsibilities and patients' rights as justification for decisions. Although measurement of level of moral reasoning was not a part of the study, these nurses should have been using a consistent level of moral reasoning, nevertheless, they did not use any moral beliefs consistently as guidelines in making ethical decisions.

Omery (1985) further examined moral reasoning to determine principles used by 10 Intensive Care Unit nurses facing moral dilemmas in practice. Omery (1985) identified

two modes of reasoning: accommodating and sovereign. Accommodating reasoners adapted or reconciled their reasoning with the perceived norm of the identified group. Sovereign reasoners based their judgments on self-chosen and valued moral principles regardless of the potential for conflict with group norms or principles. These findings may explain the varied and inconsistent responses of research subjects previously described in the literature.

In further exploring moral reasoning underlying behavior, Riley (1991) conducted a study examining moral reasoning used by nurses in resolving conflicts. Nurse leaders used justice and care voices to respond to conflict and choice in the workplace. Ravella (1985) conducted a similar study involving nurse managers and both male and female business managers arrived at similar decisions to resolve moral conflicts, but the resolution process differed. Women approached the process from a caring/responsibility perspective while men used a rights perspective. Instruments that were used in the studies limited the choices to justice and/or care.

Although ethical principles guiding behavior were suggested implicitly in the previous studies, only one study (Ravella, 1985) included nurse educators as participants. Indeed, since research has shown a direct relationship between higher level of moral reasoning and higher level of

education, nurse educators should be functioning at a high level of moral reasoning. Whether this level of moral reasoning is translated into using ethical principles to guide their behavior in resolving ethical value conflicts in practice remains inconclusive.

Ethical Principles Guiding Resolution of Ethical Value Conflicts

As noted previously, the literature lacks guiding ethical principles for educators when value conflicts occur in the course of teaching nursing students. As part of a presentation at the annual meeting of the North Carolina League for Nursing in 1981, Rosenkoetter (1983) developed a code of ethics that provided guidelines for nurse educators in maintaining and promoting standards for nursing education. This code was revised at the First International Congress on Nursing Law and Ethics in 1982. However, it does not address value conflicts and no organized group of educators has adopted it.

A study conducted by Lutzen and Nordin (1993) identified benevolence as the pertinent characteristic of moral comportment of normal decision making within the nurse-patient framework in psychiatric nursing care. In another study, Christensen (1988) reported nursing service executives as using the principles of respect for persons, beneficence, fidelity, and justice when making ethical

decisions.

The literature is indeed limited in identifying ethical principles used by nurses. Furthermore, Beauchamp and Childress (1994, p. 67) consider benevolence a virtue and not an ethical principle.

Internal and External Consequences of the Resolution Process

According to Kielinen (1978), any state of conflict is a costly one, with anxiety as a particular kind of cost from conflict. Cahn (1987) studied inner conflict, described as "moral distress," experienced by nurses in the clinical setting. She found that inner conflict occurred between knowing the right thing to do but being unable to do it because of institutional constraints. Fenton (1988) further studied moral distress and found that nurses did indeed confront situations that challenged their moral beliefs and experienced emotional distress as a result of participation in situations that involved an ethical issue. She further found that personal and professional wholeness may be significantly compromised by ineffective resolution of the issue. In addition, Lutsen and Nordin (1993) reported that psychiatric nurses experienced inner conflict when professional responsibility to follow rules was different from the moral commitment to care about the patient. Although these studies were conducted in the clinical setting, nurse educators may find the same constraints in

their environment.

Conflicts may not be satisfactorily resolved. Furthermore, Robbins (1978) suggested that whether you engage in resolving or stimulating a conflict depends on the situation.

Kielinen (1978) questioned what happens when a faculty member remained in conflict even after attempts at resolution had been made. It is assumed that the conflict management technique applied to the situation will be successful, which may not necessarily be the case.

Leininger (1975) summarized the problem best when she said:

> We cannot always have and get what we want in the exact way we want it . . . However, we must not compromise easily or readily, but must make sound assessments and negotiate from a reasonable position of strength, social justice and with respect to our professional goals and interests. To yield professional values, ethics, major goals or aspirations may have serious consequences (p. 296).

In addition to the lack of empirical data related to resolution of ethical value conflicts by nurse educators, there is also concern related to research that has been conducted.

Methodological Concerns Regarding Nursing Research and Ethics

In suggestions for further research, Lawrence and Helm (1987) emphasized a need to ask professionals what they thought about a particular ethical situation and then work from their expressed perceptions rather than providing a list of quantitative responses. Their study documented the confusion nurses experienced in confronting ethical dilemmas, in particular the influence of personal moral beliefs on moral reasoning. The hypothetical nature of the study interfered with generalizability of the results. Also, reliability and validity of the tool was not addressed and the tool was limited to use in a single study.

Cassidy (1991) expressed several concerns that are supported in the review of the literature on ethical responsibility in nursing. She analyzed studies from seven journals that included variables such as moral behavior, moral reasoning, moral judgment, ethical choice, ethical action, ethical decision making, and attitudes towards patients' rights. She raised concern about the reliability and validity of measuring these variables with the use of instruments used in single studies such as Lawrence and Helm's (1987). Cassidy (1991) and Ravella (1985) believed that using Kohlberg's theory, or instruments based on his theory, may not be valid in studying nursing groups,

especially since gender differences exist in moral development. Furthermore, instruments used in the Cassidy (1991) and in the Ravella (1985) studies limited guiding principles of moral reasoning to those of justice and care.

Consistent with the findings of Omery (1985), Carpenter (1991), and Megel and Elrod (1993), Cassidy (1991) also found that nurses confronted ethical dilemmas in their practice and were aware of their ethical responsibilities. However, study participants may have experienced difficulty in using the language of ethics to define the dilemmas, which may account for the confusion and inconsistencies in the study done by Lawrence and Helm (1987).

Ketefian (1989) stated that the existing research on moral reasoning and ethical practice was noncumulative. She further stated that ethical practice was poorly conceptualized and the measures lacked reliability and validity. Her observation reflects the relatively recent interest in investigations in the area of ethical responsibilities and the emergence of the few studies of this type published in the literature. The existing research can, however, serve as a basis for future research.

Furthermore, studies (e.g., Ketefian, 1987; Lawrence & Helm, 1987; Moore, 1991) using hypothetical situations and a quantitative approach raise issues about familiarity of subjects with the dilemma to which they were asked to

respond. Attempts to quantify relatively simple responses to complex situations create measurement issues. Because of the inconsistencies reported by Lawrence and Helm (1987) and the concerns expressed by Ketefian (1989) that research is noncumulative, further research is needed. Cassidy (1991) suggested qualitative research as an appropriate method of exploring ethical responsibilities. Resolution of ethical value conflicts by nurse educators is one of these ethical responsibilities. The advantages of a qualitative approach for this study included: (a) the opportunity for nurse educators to identify and describe the ethical values and the ethical value conflicts that they actually encountered every day; (b) an open-ended exploration of ethical value conflicts that would better represent the complex nature of the topic; and (c) the possibility of identifying a contextual orientation for the investigation of ethical responsibilities by nurse educators that may be more appropriate than existing orientations.

According to Booth (1982), conflict is always present. Furthermore, there is a great urgency pervading institutions to seek modes of resolution in our exceedingly complex and stressful society. Cushnie (1988) identified value conflicts as the most complex type of conflict; one that requires a high level of motivation from the involved persons to solve.

Summary

The review of literature lacks substantive data on resolution of actual ethical value conflicts experienced by nurse educators. Indeed, there was lack of substantive data on resolution of ethical value conflicts by any educators. Although studies indicated that nurses did indeed encounter ethical problems in their practice, ethical values and problems confronted by nurse educators were not clearly identified. Furthermore, there was a lack of clarity in defining ethical components of value conflict. Narrative readings provided some information and assumptions about influencing factors and/or strategies used in resolution of conflict. However, there were few research studies that explored what actually occurred in the "real" world, thus providing a research basis for the assumptions. Ethical principles guiding decision making were implicit in some of the nursing research studies, but studies describing the relationship of theory to practice were limited. The use of hypothetical situations and a quantitative method of data collection limited the choices of study participants. According to Felton and Parsons (1987), the educational environment provides an opportunity for participation, shared decision making, and accountability for the consequence of one's own action. Also, because of the perceived autonomy in the role of the nurse educator, there

should be congruence between the ideal and real action.

Chapter III will discuss the methodology of the study, the research purpose and design, sample selection, data collection procedure, instrumentation, evaluative criteria for rigor, and procedure for analysis and ethical considerations.

CHAPTER III

Method

The purpose of this study was to explore experiences of nurse educators in encountering and resolving ethical value conflicts with student. Consequently, to provide for open-ended expression of perceptions and feelings in a familiar contextual orientation, a qualitative research design was used with inductive reasoning and descriptive analysis.

Sample

Convenience sample. All nurse educators employed in National League for Nursing (NLN) accredited baccalaureate nursing (BSN) programs (N=27) in a two state area in the Mid-Atlantic region of the United States and who met the following criteria comprised the targeted sample: (a) had a minimum of a master's degree in nursing, (b) were currently teaching in a baccalaureate nursing program, (c) had been involved directly with nursing students in the classroom or clinical area within the past two years, and (d) had experienced an ethical value conflict professionally with nursing students within the past two years. Of the 27 targeted schools, deans of 24 of the schools agreed for

their faculty to participate in the study, and 21 schools comprised the final, accessible sample. The convenience sample, however, consisted of nurse educators who met the preceding four criteria for the study.

In addition a purposeful sample of participants who agreed to share in-depth descriptions of ethical value conflicts they experienced also were selected.

Purposeful sample. This sampling technique was used to select participants who represented the full array of ethical value conflicts and who consented to be interviewed. With purposeful sampling, the researcher must use judgment to determine that the sample does indeed possess the characteristics needed for the study (Brink, 1991, p. 170). According to Morse (1991), a purposeful sample allows the researcher to select participants "according to the needs of the study" (p. 129). A purposeful sample is comprised of persons who possess the knowledge and experience necessary to provide the data for the study. This second phase of sampling allowed the researcher to deliberately seek participants with particular experiences; that is, purposeful sampling provided nurse educator subjects, typical and atypical, who experienced ethical value conflicts and resolution of these conflicts. Persons with atypical experiences also were included to understand the breadth of the phenomenon of resolution of ethical value

conflicts by nurse educators.

Twenty one of the 24 schools of nursing were represented in the sample. The response rate was difficult to determine because of discrepancies in numbers quoted initially by the schools; that is, some of the numbers of teaching faculty included those involved in graduate level programs. Out of the total number of educators contacted, 47 of them met the sample criteria and provided 89 ethical value conflict situations directly involving students. There were an additional five scenarios submitted that did not meet the study criteria, (e.g., were institutional rather than student conflicts or did not occur within the two-year time frame).

To provide a range of ethical value conflicts encountered by educators, the purposeful sampling selection process was as follows: (a) value conflict situations were evaluated for ethical merit by using criteria proposed by Wright (1987): How do the consequences of the conflict resolution affect its moral worth?; b) all ethical value conflict situations were coded with numbers and letters; c) individual value conflict situations were pasted on five by eight index cards; (d) these ethical value situations were then grouped according to similarity; (e) an ethical value, such as autonomy, that described each group was identified; (f) from each group, one or more situations were chosen that

represented the particular ethical value; (g) code numbers of the chosen situations were then correlated with names of participants and arrangements were made for interviewing. Distance was a factor in selection of some of the participants for the face-to-face interviews. All of the persons selected by this process agreed to an interview. Therefore, 10 persons participated in face-to-face interviews and 4 persons participated in phone interviews. Data saturation was reached upon completion of the 14th interview.

The purposeful sample consisted of female nurse educators representing 13 nursing programs, with two participants from the same nursing program. Their ages ranged from 32 through 66 years of age. Four participants were single and 10 were married. The highest degree held by the participants were: (a) 2 EdDs, (b) 2 PhDs, (c) 1 DNSc and (d) 9 MSNs, although four of the MSN individuals were currently enrolled in PhD programs. Two participants had diplomas as their initial undergraduate degree while the remaining 12 had graduated from BSN programs.

Areas of specialization represented in the study were diverse with 1 person specializing in maternal nursing, 3 in child nursing, 3 in adult nursing, 3 in psychiatric nursing, 6 in community nursing, 6 as educators, 1 as a clinician, 4 as practitioners, 1 as an administrator, 1 as a clinical

researcher and 1 as a clinical specialist. The preceding numbers exceed 14 because participants responded to more than one area of specialization.

The number of teaching years in the classroom and clinical areas ranged from 6 months to 32 years. However, two persons taught less years in the clinical setting than the classroom. Many faculty taught across curriculum levels. In the classroom setting, 4 faculty taught freshmen, 6 taught sophomores, 10 taught juniors, and 11 taught seniors. In the clinical setting, 1 faculty member taught freshmen, 3 taught sophomores, 8 taught juniors, and 13 taught seniors. Although the criteria specified teaching in a BSN program, some of the participants concurrently taught in the ADN program so data reflect those levels as well. Table 2 contains demographic data of the sample (N=14) who were interviewed.

Data Collection

Data were collected in a two phase process. During PHASE I nurse educators were asked to complete demographic and questionnaire forms for overview data (see Appendices A and B). PHASE I of the study allowed the researcher to survey the sample concerning a broad, general knowledge of ethical value conflicts and experiences that were considered typical.

During PHASE II, participants were interviewed using

Table 2

Demographic Data of Sample (N=14) Who Participated in Interviews

1. Age in Years

Range		30-66
Mean	=	43.7
Mode	=	41/43
Median	=	48

2. Marital Status	Frequency	Percent of sample
Single	4	28.5
Married	10	71.5

3. Highest Degree

MSN	9	65
DNSc	1	7
PhD	2	14
EdD	2	14

4. Undergraduate Degree

Diploma in Nursing	2	14
BSN	12	86

5. Area of Specialization*

Maternal Nursing	1
Child Nursing	3
Adult Nursing	3
Community Nursing	6
Psychiatric Nursing	3
Education Role	6
Clinician Role	1
Practitioner Role	4
Administrative Role	1
Clinical Researcher	1
Clinical Specialist	1

Table 2 (continued)

Demographic Data of Sample (N=14) Who Participated in Interviews

6.	Statistics	Number of Years Teaching in Classroom
	Range	.05-32
	Mean	11.43
	Mode	11
	Median	16.025
7.	Level of Students Taught in the Past Two Years in Classroom*	Frequency
	Freshman	4
	Sophomore	6
	Junior	10
	Senior	11
8.	Statistics	Number of Years Teaching in Clinical
	Range	.05-32
	Mean	10.9
	Mode	8
	Median	16.025
9.	Level of Students Taught in the Past Two Years in Clinical*	Frequency
	Freshman	1
	Sophomore	3
	Junior	8
	Senior	11

* % not calculated due to multiple responses

open-ended questions (Appendix C). This provided the investigator with an array of participants' ethical experiences that involved ethical value conflicts and the resolution of these conflicts.

Procedure

For sample selection, deans and directors of the identified schools (N=27) were written a letter explaining the study and were asked permission for access to their faculty for participation in the study. The letter was self addressed and stamped for easy returnability and provided responses for deans and directors to indicate their willingness of faculty to participate, the number of faculty teaching in their BSN programs, and the name of a faculty member to serve as a contact person (Appendix F). All of the schools responded to the initial letter, with 24 granting and 3 denying permission of access to faculty.

In each school willing to participate, packets of material were sent to the contact person for distribution. A brief explanation of the study was given to each nurse educator in the NLN accredited BSN programs in the identified region as provided by the schools. Faculty who met the sample criteria were asked to indicate their willingness to participate in PHASE I and/or PHASE II of the study by signing an informed consent form (Appendix E).

Participants who were chosen for interviews were

initially contacted by telephone to confirm their willingness to participate and to set up an appointment time. This was done at the convenience of the participant and was either conducted in their office or at their home, according to individual preference. Participants did not have access to the interview questions prior to the time of the interview and only one of the participants knew the actual situation that would be discussed. The initial contact between the researcher and participant varied. On one occasion, it involved a get acquainted time with tea and cookies. On another occasion, it involved a brief introduction prior to beginning the interview questions. Two participants expressed concerns about confidentiality and asked for a review of the informed consent form. In all cases the researcher explained the procedure for the interview and the follow up process for validation of content and interpretation of the interview data. The questions were asked in a matter-of-fact way. The researcher responded with nonverbal nods, gestures, and body postures. Clarification was made when requested and the interview progressed according to the discretion of the participant. The interview process became very individualized based on responses to questions. Many times the participants answered interview questions before they were asked. Although there was an interview guide,

additional questions were asked that evolved from the specific situation. All of the interviews were audiotaped.

The phone interviews were conducted in a similar manner without the personal presence of the researcher and participant. At the close of the interview, participants were asked how they felt about verbalizing the situation and if there was any additional information they wanted to add.

In the interview process, participants were asked several open-ended questions, with each research question represented by items on the questionnaire (Appendix C). Appendix D depicts the comparison between research and interview questions. The interviews were between 20 and 90 minutes in length and took place in the participant's school of nursing, home or by telephone. The focus of the interview (PHASE II) was to explore ethical issues and identify the process of reasoning and strategies used in resolving ethical value conflicts. Nurse educators were asked to describe a selected situation involving an ethical value conflict that occurred during their involvement with nursing students within the last 24 months. Each interview was audiotaped using a portable tape player and cassette tapes. Tapes were kept in a locked compartment, with only the researcher having access; tapes will be erased when no longer needed for research purposes. The investigator transcribed each tape verbatim and returned the written copy

to the participant for validation of content.

Instrumentation

The subjects were asked to respond to items on a questionnaire (Appendix A) that provided demographic data and identified ethical value conflicts experienced by nurse educators in their interaction with students (Appendix B). The demographic tool provided information about the subjects. The tools (Appendix A, B, and C) were developed with the assistance of several colleagues. Initially a pilot study (Lyndaker, 1992) was done. Eight subjects responded in written form to demographic data and open-ended questions. In addition to the collection of data, subjects were asked to provide suggestions related to question tool clarity, completeness and readability. Suggestions were incorporated into a revised instrument that was then distributed to 10 nurse educators who were asked to read the tool for clarity and understanding. Five individuals responded recommending changes primarily in format and wording of some of the questions. These changes were incorporated in the tool, thus establishing face validity.

As a part of the pretest for the dissertation, educators in one nursing program were asked to complete PHASE I of the process and respond to the following questions: (a) Was it readable? (b) Were you able to understand the content of the questions? (c) Was there

adequate space provided to answer the questions? and (d) Do you have any suggestions for improvement of the questionnaire? Five persons responded with suggestions leading to rewording of question number 4. These suggestions resulted in providing only one possible selection for question 4 rather than multiple selections. There were also minor grammatical corrections.

In addition, the interview questions and process were pretested and piloted with the investigator choosing a colleague as the first participant to be interviewed. Following the interview, the participant was asked: (a) how she felt the interview went; (b) did she feel comfortable with the interview; (c) was she given enough time to respond to questions; (d) did she feel the questions were complete, that is, gave her the opportunity to explore the phenomenon of resolution of ethical value conflicts, and (e) did she have any suggestions for improving the interview process. She felt the interview went well and said she learned more by verbalizing her responses to the interview questions than she had by writing responses on the informational questionnaire. She had no further suggestions to make.

Review of a study done by Carpenter (1991) provided a basis for the questions. Respondents in the study were asked to describe: (a) a situation that they felt represented an ethical problem (research question 1);

(b) their action in the situation (research question 3 a); (c) their reason for the action (research question 4 a); (d) what they would like to have done (research question 4 c 2); (e) their reasons for the desired action and for the difference between the desired action and the actual behaviors (research question 4 c 1 and 3). Additional questions pertaining to nurse educators in resolution of ethical value conflicts in the interview were: a) What criteria are used to identify the situation as a conflict in ethical values? (b) What factors influence resolution? (c) What are ethical principles that guide the action taken? (d) What are inner conflicts experienced by nurse educators as a result of their action? (e) When do nurse educators feel they have reached resolution? (f) What insights are gained that would assist in resolving future conflicts? and (g) How did talking about the situation affect them?

Evaluative Criteria for Rigor

According to Krefting (1991), qualitative research has been evaluated against criteria appropriate to quantitative research and has been found to be lacking. She further states that researchers need alternative models appropriate to qualitative designs that ensure reliability and validity without sacrificing the relevance of qualitative research. Furthermore, Walker (1987) believes qualitative studies to have high validity (defined as high relevance to the concept

studied) and low reliability (defined as difficulty in exact duplication of results). Sandelowski (1986) proposes criteria for evaluating trustworthiness in qualitative research and includes the following aspects: a) credibility; b) transferability; c) consistency; and d) confirmability.

Credibility. Credibility, rather than internal validity, is suggested as a criterion against which the truth value of qualitative investigation be evaluated. According to Sandelowski (1986), in qualitative research, the truth value usually resides in the discovery of human experiences as they are lived and perceived by subjects, rather than researcher-defined. Participants were asked to describe their "real world". To enhance description and interpretation of experiences in a meaningful way, the researcher asked two doctorally prepared nurse educators to independently analyze one interview and subsequent analyses were compared for validation of themes. In addition, the researcher made oral field notes into the tape recorder following each interview, reflecting on the verbal and nonverbal content of the interaction and personal response. Another method to enhance credibility was member checks by participants. Each interview was typed verbatim and returned to the participant for validation of content and for additional information. Following revision, each

interview was analyzed by the researcher with general themes, interpretations and observations noted. The analyzed interview was returned to the participant for member checking to ensure accurate translation of the informant's viewpoints into data. Assessment to see if data make sense through member checking decreases the possibility of misrepresentation. Credibility was further established by repeating questions and providing clarification for participants during the interview.

Transferability. Transferability is the second method of establishing trustworthiness in qualitative research. Transferability allows other researchers to make judgments about the value of the findings and the research in general. An accurate, precise description of the research process was provided in this study to establish transferability. Initially, to validate representativeness of subjects, the researcher read each ethical value conflict situation and tentatively identified groups of ethical values that were represented. The second step in the process of purposeful sampling involved a colleague who sat down with the researcher and discussed each situation and purposed groupings. This step resulted in the combination of ethical values, truthtelling and honesty into one group, and ethical values, justice and fairness into one group. From each grouping, situations were identified as typical or atypical

and were chosen as representative of the particular ethical value. The third step in the process involved another colleague who was given all the situations and was asked to independently categorize the situations into ethical value groupings and to validate the situations chosen for the study. This step resulted in a recategorization of some situations from beneficence to justice. The process also revealed that many of the situations illustrated more than one ethical value in conflict. The final step in the process was matching the codes of the selected situations with participants for the study.

Consistency. Consistency in qualitative research is achieved by creating a condition in which general findings can be repeated. In this study the methods of data collection, analysis and interpretation are described in detail. In addition, the researcher increased dependability of the study by: a) conducting each interview and asking clarifying question and b) transcribing each interview personally along with audiotaping verbal comments regarding themes and observations. The research plan also was scrutinized by members of the dissertation committee, which enhanced consistency.

Confirmability. Confirmability is purposed as the criterion of freedom from bias in qualitative research (Guba, 1981). This is attained when credibility,

transferability and consistency are established. Confirmability refers to the degree to which findings are supported by data collected and not by biases of the researcher. Instrument development is an important part of confirmability. Tools used in the study were piloted on three different occasions to enhance confirmability. Another method for establishing confirmability was member checks, which were used to validate content, interpretation and thoroughness of the interviews.

Analysis

For the purposes of this study demographic data were analyzed using measures of central tendency. There were a number of additional questions that were asked that will be reported at a later time; therefore, these questions do not appear on the questionnaire (Appendix A). Interview data were analyzed using thematic content analysis. The purpose of thematic content analysis is to discern and report how people construe their world from the way they talk about it. This method of analysis attempts to represent the thoughts and feelings of others in a systematic but honest way (Burnard, 1991). It is a means of data reduction necessary to see patterns and themes.

A revised method of thematic content analysis outlined by Burnard (1991) was used in this study. The revision resulted primarily in simplifying the steps in grouping and

collapsing data:

Stage 1: Memos and notes were made following each interview to note nonverbal affect and each interview was transcribed verbatim;

Stage 2: Written transcripts were returned to the participants for validation of content;

Stage 3: Transcripts were read and notes were made on general themes within the transcripts such as immaturity, frustration, avoidance;

Stage 4: Two doctorally prepared educators, who were familiar with the area of ethics, were asked to follow Stage 1 and Stage 3 preceding and generate themes independently for the first interview. The emerging themes were compared and were found to concur. The themes identified by the investigator were more extensive but included all of the themes identified by the two educators. The themes expressed by the two educators were congruent in content with minor differences in written expression;

Stage 5: To further enhance credibility, participants were asked to check the accuracy of the analysis by comparing their transcript with the theme describing it;

Stage 6: The list of similar themes were grouped under broad headings and repetitious data were "collapsed" further into similar and broader themes using the free form data base computer program, "askSam" (1993);

Stage 7: Using "askSam" key words were identified according to the list of theme headings with grouping of similar sections;

Stage 8: The writing process began with the first research question, until the whole project was complete. During this process, to decrease researcher bias, the researcher remained open to the need to refer to original tape recordings to stay closer to original contexts and meaning;

Stage 9: The researcher wrote themes alongside literature references to discover the relationship of these findings with previous work on ethical practice.

Ethical Considerations

The informed consent form briefly explained the purpose of the study and the data collection procedure. Explanations of how anonymity and confidentiality would be protected were also described. Completion of the informed consent form indicated that the subjects understood the study and agreed to participate (Appendix D). Strict anonymity could not be ensured in PHASE I because of the system of coding or in PHASE II because of identification by face or telephone interviews. However, in the transcribed text and in any speeches or writings that emerge from the study, participants will be protected by the use of codes. Results from the study will be reported in general terms to protect the identity of the subjects and will be shared

through normal scientific channels of dissemination. To ensure confidentiality, data has been kept in a locked compartment and only those persons directly involved with the study have had access to it. The research proposal received exempt status from the George Mason University Office of Research and the James Madison University Human Rights Review Board.

Summary

This chapter described the methodology used in this study and the specific research design. The study was qualitative in nature and the procedures for selecting the sample and collecting data were outlined. Ethical ramifications related to the study were noted. Issues related to evaluative criteria for rigor in qualitative research were discussed and a description of specific measures to enhance trustworthiness of the data was included. Data analyses procedures were described in detail. Chapter IV contains results from the study including a process of resolution model that emerged from the data.

CHAPTER IV

Results

The results presented in this chapter include the analysis and interpretation of data collected to describe experiences of nurse educators in identifying and resolving ethical value conflicts encountered with students. The analysis and interpretation of data were organized around the research questions of the study identified in Chapter I and the subquestions from the interview guide. Excerpts are typed verbatim with the omission of "uh's and "you know" and are examples of data that were extracted from 125 pages of single-spaced text. General themes that emerged from the data are then discussed. A process of resolution model that evolved from concepts defined in the review of literature and from the data themselves is also described.

Reporting and Analyzing Data

Reporting and analyzing data are organized around each research question.

Research Question 1: What are ethical value conflicts experienced by nurse educators?

Participants were asked to describe a situation with a

student where they experienced a conflict in their ethical values. There were 89 situations described by nurse educators who met the criteria for the study. The situations were analyzed to identify the ethical value that precipitated the conflict. The frequency of occurrence of these values from greater to lesser was as follows: (a) truthtelling/honesty/veracity; (b) professional responsibility; (c) justice/fairness; (d) harm avoidance/safety; (e) confidentiality; (f) beneficence; and (g) autonomy/respect for autonomy. Table 3 contains specific data related to ethical values where the participants experienced conflict. The ethical values are listed according to the identified groupings with the frequency of occurrence and the percentage of occurrence within each group and/or the total number. In some of the situations, more than one ethical value was in conflict. The groupings were done according to the value that took precedence. Truthtelling/honesty/veracity were represented in incidents involving: (a) cheating on exams and assignments, (b) lying about absences, immunizations, procedures and home visits that were not done, (c) plagiarizing written work, (d) being asked by staff in clinical facilities not to chart a procedure that was done or a medication error, and (e) questionable research practices, such as incomplete informed consent of

Table 3

Ethical Values Where Nurse Educators Experienced Conflict (N=89)

Ethical Value (with violation of value as subcategory)	Frequency	Percentage Group	Percentage Total
Truthtelling/Honesty/Veracity	30		
*Cheating	15	50.0	16.8
*Lying	7	23.3	7.8
*Plagiarizing	4	13.3	4.5
*Omission	2	6.7	2.2
Research	2	6.7	2.2
		^Total 100.0	33.5
Professional Responsibility	18		
*Inappropriate Behavior/student	7	39.0	7.8
Faculty complaints	5	28.0	5.7
Inappropriate Behavior/staff	2	11.0	2.2
Other issues	4	22.0	4.5
		^Total 100.0	20.2
Justice/Fairness	17		
Grading	6	35.0	6.7
Equitable workload	3	18.0	3.4
*Bias	3	18.0	3.4
Adherence to written policy	3	18.0	3.4
Lack of objectivity	1	5.5	1.2
*Responding to complaints about incompetent faculty	1	5.5	1.2
		^Total 100.0	19.3
Harm Avoidance/Safety	13		
Student deficits	4	31.0	4.5
Student neglect	3	23.0	3.4
*Unsafe staff behavior	3	23.0	3.4
*Lack of good student judgement	2	15.0	2.2
*Lack of student safety	1	8.0	1.2
		^Total 100.0	14.7
Confidentiality	5		
*Student right to confidentiality	3	60.0	3.4
*Client breach of confidentiality	2	40.0	2.2
		^Total 100.0	5.6

Table 3 (continued)

Ethical Values Where Nurse Educators Experienced Conflict (N=89)

Ethical Value	Frequency	Percentage Group	Percentage Total
Beneficence	3		
*Actions to benefit student	2	66.6	2.2
Actions to the client	1	33.4	1.2
		^Total 100.0	3.4
Autonomy	3		
*Client's decision making right	3	^Total 100.0	3.3
	^Total 89		^Total 100.0

* indicates purposeful selection of sample (N=14) for interview sample. ^Numbers have been rounded so totals = 100%.

participants.

Professional responsibility included a diverse array of situations that seemed to represent ethical value conflicts related more to professional conduct rather than other ethical values. Educators described situations where: (a) interactions between students were inappropriate, (b) students complained about other faculty members, (c) agency personnel's behaviors were inappropriate, and (d) issues surrounded pro life/pro choice stances and teaching about abstinence as a means of birth control.

Although justice and fairness are not synonymous terms, they were grouped in this study because of apparent connection with fairness as a component of justice. Issues

of justice and fairness centered around: (a) grading fairly, (b) sharing equally in the workload of a group project, (c) adhering to written policies, (d) questionable bias with minority students related to absences, (e) lack of objectivity by nurse educators when students present a different view, and (f) responding to complaints about incompetent adjunct faculty.

Harm avoidance/safety value conflicts included issues related to safety. Areas represented involved; (a) student deficits (e.g, learning disabilities), (b) student neglect (e.g, not attentive to client safety needs), (c) unsafe staff behaviors (e.g, unsafe practices), (d) lack of student judgment, and (e) lack of student safety (e.g., being threatened with a gun).

The value of confidentiality caused conflict when there was information divulged either by the nurse educator or by the student. In addition, nurse educators were concerned about how to disclose confidential information given to them by students without jeopardizing the faculty-student relationship.

The value of beneficence was used both in interacting with students and with clients. The conflict was between promoting actions to benefit individuals while maintaining group expectations and without jeopardizing the moral integrity of the nurse educator.

Issues dealing with autonomy involved clients' rights to determine procedures and treatments. There were other situations where respect for student autonomy was a factor to consider in resolution of the conflict. However another ethical value seemed to be take precedence. Therefore, there is no student subcategory under autonomy in Table 3.

From the sample of all the ethical value conflicts (N=89), 14 situations were selected as a purposeful sample. These situations were representative of ethical value conflicts experienced by nurse educators and were explored further by interviews. The (*)s in Table 3 indicate the subcategory from which the purposeful sample was chosen.

In the purposeful sample, then, participants described during the interview the incident that the investigator had selected and identified ethical values that were in conflict. Nine situations involved ethical value conflicts that occurred in the context of the clinical situations and five situations involved ethical value conflicts that occurred in the context of the classroom setting. Two of the situations did not involve a conflict directly between nurse educator and student but between nurse educator, student, and a third party. These situations were included because of their significance. Because of the sensitive nature of the situations chosen and to provide for anonymity and to protect confidentiality, the initial description will

be general. However, specific details will be disclosed in the context of the research questions.

Participants were asked to identify ethical values that were in conflict in the situations chosen by the investigator. They cited: (a) harm avoidance versus respect for student autonomy (an abusive staff member behavior was not reported); (b) harm versus harm avoidance related to inappropriate judgment (student assessed drug involvement as acceptable); (c) harm avoidance versus respect for student autonomy (an abusive home situation was not reported and student's life was endangered); (d) justice versus respect for student autonomy (a student assignment was fabricated as reported by a third party); (e) client autonomy versus paternalism by student (a terminally ill client refused food); (f) veracity versus dishonesty (a student handed in a paper written by someone else); (g) harm avoidance versus beneficence (a student was deemed incapable of performing safely due to personal problems); (h) dishonesty versus justice (a student was observed apparently cheating); (i) dishonesty versus veracity (a student was asked to omit writing a progress note about a procedure that was done); (j) prejudice versus justice (a minority student had not adhered to the attendance policy with potential grade reduction to failure); (k) justice versus respect for faculty autonomy (a student had

legitimate complaint about an adjunct faculty); (l) confidentiality versus harm avoidance (a student revealed suicidal plans); (m) breach of confidentiality (a student revealed to a psychiatric patient, behaviors of an acquaintance [of the patient] who was also under psychiatric treatment); and (n) inappropriate professional behavior by student and faculty colleagues (a student became involved in a nontherapeutic relationship with a patient).

Research Question 2: What criteria are used by nurse educators to identify a situation as a conflict in ethical values?

The interview question, what criteria did you use to identify the situation as a conflict in ethical values, was asked. Participants used a variety of criteria to identify the situation as a conflict in ethical values. Three participants mentioned a "gut feeling" while other inner feeling were mentioned.

> It just feels wrong. This is something that shouldn't happen.

One participant suggested inner turmoil by the following excerpt:

> I don't know what I should do. What's the best thing to do?

The following individual quotes expressed internal struggle:

> It simply was that as I reflected on it that I realized

I was feeling some emotional turmoil.

Probably because I felt an internal conflict myself and the student expressed conflict although not as much.

It was somewhat of a conflict within myself. It wasn't so much that I felt that the student and I were in conflict, but a conflict within myself of how do I handle this, now? How can I best work with the student, work as a shield and how do I sort through that myself?

The following excerpts illustrates using "right" and "wrong" as criteria.

The student came to me and said, you know this is wrong and I said, I agree with you. Even if you did wrong by not getting an order, it is even a worse evil to say that you haven't done it.

Well, for me, it's just very simple. There's a difference between right and wrong and what the student did was wrong and nobody cares about that. The student did something that was wrong and basically nobody did anything about it and she came out looking pretty good in the end.

Individual right's was viewed as a criterion to identify the situation as ethical in nature.

I think basically the right to choose to live or die was a major criteria.

Standards for nursing practice were used as a criterion.

I brought up the ANA definition of confidentiality and the ethical issue of breaking confidentiality which for the hospital was obviously what they were concerned about.

The following narrative of one nurse educator described very graphically the process of identifying the situation as

an ethical value conflict.

> I guess part of it is my own emotional feeling, my conflict within myself and it raised strong emotions. I get real upset I guess, because I feel that when I say that a student has graduated or completed the program in which I am instructor, then I feel like I'm saying that this person has integrity to meet the professional standards that we hold, so most of it comes from internal, not a check list or anything like that, but comes from internal feelings that I'm real uncomfortable and I don't know what to do, because I can't make my feelings feel better. It's very uncomfortable because I know what I'm saying. I'm accusing them of cheating and I know what the consequences are which is to be terminated from the program . . . and possibly from ever entering the profession and I don't do it lightly.

One participant expressed difficulty in identifying criteria used to distinguish the situation as ethical in nature.

> It was difficult for me to identify specifics. I knew what you were talking about immediately. Initially I probably would not have identified it as an ethical value conflict. I probably would have labeled it in a different way, transference/countertransference. Sort of a beginning student starting to deal with their own psychotherapeutic process, in relationship to feelings that would come up around that and that was probably why it was hard because I had to think about it differently.

In relation to identifying the value conflict as ethical, participants reported internal feelings or a general feeling of unease as significant. For some participants it was very clear that something was "wrong." Other participants used patient rights and standards of nursing practice as criteria for identifying the situation as a conflict in ethical values. One participant expressed

difficulty in identifying ethical components of the situation.

Research Question 3: How do nurse educators in baccalaureate nursing programs resolve ethical value conflicts? Subquestion a: What was your action to resolve the ethical value conflict?

Participants were made aware of the incident by student reporting, staff reporting, or personal observation. The following narrative illustrates several steps taken by a nurse educator to resolve an ethical value conflict: (a) **listening to the student**, (b) **identifying the problem**, (c) **counseling the student**, (d) **observing outcomes**, and (e) **reflection.**

> The student came to me the next clinical day after this experience [student had observed an incident of client abuse by a staff member] . . . She was sort of telling me, asking me to take care of it for her and I told her I could not do that for her that because it was second hand, I'm not the one that can do it, but I sensed that she was real uncomfortable with it and she explained to me that it was because she was also an employee. She was sure that this would absolutely destroy her potential career there and I said that was fine that if she couldn't approach the staff with it that I would go to the director of nursing with her or she could go alone but that I would not go for her that she had to come with me and she chose not to and I didn't have any ability to force her to do it and in hind sight my responsibility was to the patient and I should have forced her.

In a situation where a student's life had been threatened **collecting all the information, informing appropriate persons,** and **documenting** the incident were also

included.

> Well, the first thing I did was I collected all the information. I contacted her clinical instructor. I wrote a letter to the department chair. I wrote several letters to the student documenting, this is what you told me. This is what we talked about and this is what I recommend that we do. Did a lot of counseling with the student to get her through all the personal stuff that she was remembering from her history and helping her deal with that. I know we talked a lot about what was the best thing as a nurse to do and that ended up in a conflict. What was the best thing as a nurse versus the best thing as a student versus the best thing for the person. For her that was her reasoning.

Although the following account included **documentation**, the nurse educator had to take further action.

> In this situation, the contract that had been written for the student really wasn't working because even though we set goals, . . . the student was physically, psychologically unable to do that and so as a result of her breakdown on the unit, . . . with her subsequent hospitalization, we realized she couldn't complete her contract and we were going to do something else. At that point I knew I had to make a decision for patient safety, that it had been determined that the student really wasn't safe for whatever reasons to be in the clinical area and you have to make the decision to either pull the student or, in this situation, recommend a leave of absence.

In an incident involving a report of student lying by a peer, the nurse educator **counseled** the student to be accountable and/or confront the other student.

> I asked her if she would be willing to come to us formally in faculty and name the person or go to that person herself, and she said she would not because it had happened the previous semester and she did not think it was fair anymore to bring it up this semester.

However, the nurse educator acted indirectly in the

situation.

> I had about a 99% idea who that student was and I had her later in a clinical in public health and I was very careful to watch what she did and when she did it and alerted the possibility to the public health nurse, but there were no incidents but I just watched her real closely in that clinical.

Considering alternatives was suggested.

> Basically it was making sure she understood the chain of command and how you register a complaint or a problem that you are having and looking at the consequences, going to the professor, explaining to the dean and also going to the P_(school newspaper).

In the case of a minority student not adhering to the attendance policy, **clarifying policy** and **documenting information** were important actions.

> I called her in and talked about it and tried to make sure that she knew what the policy was and that she was clear on it, not just the implications, but the effect it could have on her grade if she is absent. At least from my perspective that seemed to be satisfactory and then I kept a record of this, you know that we had met.

In situations where ethical values differed, nurse educator participants used **listening** and **values' clarification** in resolution of the conflict.

> Part of what I did was just listen to what she had to say and then we basically spent a great deal of time just talking about this and I do know she was able to care for the patient and do very good nursing care. I didn't want to change what she was or what she believed so much as to help her be able to talk about these things and still give good patient care

> We discussed the situation, like the pros and cons, and the fact that the man was alert but that he was terminally ill with several different conditions and the fact that he had chosen a do not resuscitate (DNR)

> and we went over those steps versus the pros of making him live and we discussed the fact that since he was alert, you'd have to keep him restrained in order to force him to eat and what would be his quality of life if we did that at that point. So the student finally decided that we needed to do all that we can do but there is a point that the individual has to do themselves if they're alert as to whether they are going to take in food and how much are we going to support? So that was our final decision that it was his right.

The following narrative further emphasizes the teaching-learning process in dealing with the issue of professional behavior. The student was confronted about her behavior by both the nurse educator and student peers.

> I noticed her interactions with this particular patient, an 18 year old boy, were inappropriate right from the beginning and I didn't think too much of it because I figured that was my job to teach her and I got involved with her very quickly and spent a fair amount of time talking with her . . . making suggestions about how she might handle these kinds of things. It seemed every time I was in the clinical setting I was having a lot to do with K and every time I would talk with her she would be very responsive and I felt very good about the conversation and think that we had probably resolved the issue and then as soon as we would stop talking, she would go back and do something else that was inappropriate so I started to get more and more frustrated. I started to document. I then gave her a very clear message. . . . I started to recognize that this may be a continuing problem outside the hospital and I think I said to her, it just couldn't be and that if she decided to pursue that, she would fail the course and she got very upset with that. I decided to try to have a focused class on setting limits and I tried to use that as a learning experience for everybody. I went around the class. Finally I got to her and I said I think there is some relevance here to what's going on with this particular patient. Maybe this would be a good place to talk about it and get some help from people and she was angry at me for bringing it up but she seemed to have kind of gotten over that. The students talked

> with her. The students were very good. They gave her some very clear feedback, told her that there was an intimacy in her relationship with this young man that seemed very inappropriate and that she needed to back off.

In an incident involving cheating on an exam, the student was also **confronted** and a **report filed** based on circumstantial evidence.

> She was talked to by me and the dean. She was told what my suppositions were. It was explained to her that she would be watched very carefully.

In a situation where confidential information leading to potential harm for the student was shared, the participant **sought counsel** from a colleague.

> I think the main thing was talking it over with a colleague. Going to someone who I thought was a professional, who could not only counsel me but also help me deal with the situation.

Another participant also **consulted** a colleague in a situation involving a student handing in a paper written by someone else and then **confronted** the student indirectly.

> Well the first thing I did was I went to somebody on the faculty that I respect and I know that she is going to give me an honest response and who has the same values that I have about respect for people. The individual did not give much direction but she did show some empathy. The next time I saw the student, I said to her, why did you change topics? I was really interested in the topic you were working on and I thought you were making good progress and all of a sudden without us talking about it, you totally changed the subject of the study. . . . I'm not sure what cues she was responding to but she quickly abandoned that and we focused on the earlier work.

In one instance action was taken by the nurse educator

in response to directives from the clinical facility.

> But you see the conflict was with the student because of this incident, she had been discharged from the unit. The hospital didn't want anything more to do with her. It meant that she could not finish her clinical experience and because she could not finish her clinical experience she could not finish the course. It was not my individual decision, because of course, I couldn't make that, but I was considered the teacher of record so I had to give her the grade.

Actions taken by nurse educators to resolve ethical value conflicts were reported as: (a) listening to the student, (b) gathering and verifying information, (c) clarifying values, (d) identifying the problem, (e) documenting the problem, (f) informing appropriate persons, (g) confronting the student, (h) counseling the student, (i) seeking counsel, (j) considering alternatives, (k) observing outcomes, and (l) reflecting on the situation. Participants utilized these actions in differing degrees.

Subquestion 3 b: What strategies did you use?

Participants identified diverse strategies that were unique to each experience. One participant tried to use **professional responsibility.**

> I tried to put the ownness on her, that it was her responsibility, which felt comfortable to me until she did not accept that responsibility and I felt I had failed in my responsibility.

Another person used **personal power.**

> I know one thing thinking back on strategy, I don't think it was a threat that I did, but it was pretty much when I was talking to my dean, I told her that when I advise students in these support courses I'm

> really hesitant to advise them to take it at our university with this professor, that I would probably advise them to go to other nearby universities to take this course where they will learn something rather than have to be in fear and intimidated by a professor and under a lot of stress in a very important course.

Following a student's recommendation, the nurse educator **clarified course expectations.**

> She suggested that we be more clear as faculty about expectations. We had been making assumptions that if you are required to do a home visit, you do it and it seemed redundant and childish to say, we expect you to do these home visits but she helped me to see that is not redundant. It's necessary for some students to say, yes we expect you to do these things and it's considered a breach of conduct if you don't do these things.

In another situation, **expectations of the student were clarified.**

> We told her that from here on out, she had to sit in the front of the room. She had to be where she could be monitored by the instructor and we told her we were doing all of this.

Interpretation of policies was also considered important as a strategy.

> We [faculty] read the policies to make sure that I wasn't unskilled in the interpretations and we talked about it in our department meeting, not particularly in relationship to her, but in relation to what had happened with several students, at different levels of the program, just to be sure that all faculty were following or at least making sure that students knew what the policy was.

Interpretation of the situation, peer verification and taking a personal stance were described in the following excerpt.

> First of all it was grounding myself in my interpretation of reality by going, checking it out with a fellow faculty member. The second one was telling myself that I would not accept the fake paper and being committed to that and the third was to get back to the student and try to understand what was going on in the situation.

Taking time for discussion with students and colleagues and **reflection** were depicted as significant strategies in resolving ethical value conflicts.

> I am kind of in a nice position in that I have a lot of time to sit down and do one-to-one teaching and I think that has been most helpful when this kind of an issue has come up that I have been able to spend time, one to one with the student away from other people and having the opportunity to allow them to talk about personal issues clearly.

> I make my decisions best by talking them out.

> I think the first step was really talking it over with the student to kind of see how she felt about it and to let her realize that I was supportive of her.

> Discussion and almost self discovery by the student. Asking the questions and asking him to think through things. Basically just self reflection.

For one participant, the situation became so traumatic personally that she responded with, "Well, I got into **"therapy."**

Strategies used by nurse educators in resolving ethical value conflicts included: (a) encouraging student responsibility, (b) using personal power, (c) interpreting policies and situations, (d) communicating with student and colleagues, (e) reflecting, and (h) personal therapy. Participants were adept at identifying what should be done

and using their abilities to address the issue.

In addition to the strategies already mentioned, conflict management style was addressed in this study as a strategy used by nurse educators in resolution of ethical value conflicts. Excerpts are included that highlight components of modes of dealing with conflict. **Collaboration** appeared to be used by nurse educators most frequently. Equal regard for outcome and relationship are components of collaboration.

> I thought the student was trying hard and deserved to succeed. However, due to matters beyond her control, I had to withdraw her from clinical in order to protect the rights of the patient.
>
> So the student talked about it. His history was a paramedic and so he felt that no matter what the patient wanted, they ought to make him eat, so we discussed it and the fact that he was alert and that was a choice he could make.
>
> I think she had to go through the integral decision making process herself but I really feel bad. It's tough enough to be a student and to have to deal with the realities of life on top of that, but it really was a dilemma that she worked through. I kept regular contact with her to make sure that she did do alright with that.
>
> I think what was very hard in my perspective was to sort of listen to her, to hear what she was saying but also to attempt to keep her on tract with what the team was doing.
>
> I felt it was resolved because the student's response to our talk was to get back on track and do her work. I had respected her and held to the appropriate standards.

Again, **collaboration** was used by the nurse educator

who felt sorry for the student for giving her an F, but felt she had to go with the decision of the facility. However in the grade appeals process, the dean of the school of professional studies used **accommodation.** Accommodation occurs when there is low concern for task completion and high concern for relationship.

Accommodation was repeated when there was more concern for the student than the outcome.

> With her [the student's] low self-esteem and an uncomfortable unit to begin with, her [the student's] feeling that it would upset the apple cart was exactly right. It would have messed things up, big time for her in that respect.

In the following situation, **collaboration** was used with the student but **competition** was used with the adjunct faculty. Components of competition include little regard for relationship and high regard for outcomes.

> I think they [students] had done all they could and I felt like their complaints were legitimate. I told the student, if you felt like you had something legitimate and think that it was that serious then this would be another thing you could do [go to the school newspaper].

By coercion, **compromise** was forced on one participant by her dean. Compromise results from equal but moderate concern for relationships and task completion.

> She finally let me make the decision but there was a lot of coercion. I sent in a grade of F. She told me that she had told the student that the student would get a C- and the student had come to her because she had gotten an F.

The dean also used **competition.**

> The next thing was a deal was struck with the department chair that she [student] would not have to reregister for psych, meaning she wouldn't have to pay to retake it and she only repeated five clinical days whereas the original clinical course is 13 clinical days and she passed. She did not have to repeat the classroom component.

Compromise was also used in the following situation.

> I very much believe that students have the right to confidentiality and autonomy and I wanted her to make choices. But that day I got very concerned and so I went to him [a colleague] and said I've got a problem. . . . He said we've got to call the counselor and he made the call for me, which was probably the mistake.

Compromise was repeated in a situation where adhering to policies was less important than student completion of the program.

> I seriously doubt that she will fail the course unless she gets a low grade on the final. That's the only way it will happen. Because of low enrollments over the past five years, we try to keep all of our majors unless they have academic difficulty.

In the following account, the nurse educator described the use of **avoidance** by the dean with faculty conflicts and **competition** with student conflicts. Avoidance is used when there is a low level concern for both relationship and task completion.

> I just feel that she does not like conflict and she will avoid it, at all extent. I mean outside conflict. She does not mind conflict with her faculty. She will do whatever is least aggravating to the student and in that instance I get very frustrated because she puts the student needs above everything else, including integrity of the school and faculty.

In relationship to outcomes of the resolution process, collaboration and compromise seem to be most successful in outcomes with positive results, while accommodation, avoidance, and competition generally led to less successful outcomes. Faculty generally used collaboration in resolving ethical value conflicts. However, in some instances, more than one conflict management style was used.

Research Question 4: What factors influence resolution of ethical value conflicts for nurse educators? Subquestion a: How did you determine the action to take?

Internal and external sources were used by participants to determine their actions.

Self was used.

> I just thought about it. I didn't look for any resources which I should have.

In addition to self, **consulting someone** else was considered crucial.

> Just realizing that something had to be done. Feeling like inaction was a mistake. Just saying something had to be done and then talking with the other person. I made the decision after talking with them [other colleagues] about what needed to be done.

Recognizing the value of **student input** determined the action by one nurse educator. I based it on suggestions from students.

Immediate supervisors were approached for recommendations regarding actions to take in resolving

ethical value conflicts.

> I just went to our dean because she is my supervisor, my boss in charge of me and I respect what she says and I respect the actions that she takes and felt that If anything could be done from our department, it would be from someone with power like our dean.

> Once I found out that she was seeing him [the psychiatric patient] I went to the department chair and kind of relied on her to provide me with direction and guidance, which was a big mistake because most of the decisions that she made were really bad, and that's what I heard about in the letter from the board. Later someone suggested to me that the advisor may have told the student to go to the state board and the day before I left I confronted that particular person and she would not talk to me.

Agency Staff assisted in determining actions.

> A combination of my own value system but also the staff had pretty well decided also and the ethics committee of the hospital had taken that [same] viewpoint, but I would say more of my own point of view.

Additional guidelines were considered.

> We've tried to be sure that we meet our professional obligations but yet also avoid any potential conflicts in relation to civil liberties.

In addition to sources cited previously, nurse educators identified specific **standards** on which to base their action.

> Well, I've done a lot of reflection on evaluation and standards in education. I believe strongly that we have to adhere to certain kinds of standards and I think that true evaluation is important and so those were the values that I believe were affecting me. I think I'm the kind of nurse that always will try to figure out what is going on before I take a course of action so that was a guide. In part I was relying on the years of experience of teaching the university students and that worked for me.

Safety and **professional responsibility** were important to the following participant.

> I guess in all cases I sort of look at a hierarchy or what needs to happen as a safety issue and probably the next most important issue is, what can you help the student do when she is clearly, coming with her own set of issues and background, but my main goal is to help her learn what is appropriate care for someone like this.

One individual reflected on her **role** in determining the course of action.

> I did a lot of evaluation of my role in the situation and my role as course coordinator, which meant that I had a role in working with the clinical instructor as well as working with the student. The student who contacted me made my role as the role of a counselor. I also did not see my role as one to tell the student what to do. I could advise her and counsel her, to help the student with her own emotions that were being brought up, but also to tell her what I thought was appropriate for the benefit of the family and then to let the student make her own decision and then my role was to give support for that decision.

Empathizing with and **supporting the student** guided action.

> I knew what the student had gone through. She had the patient's request. She [the student] was a registered nurse. I thought that was certainly within her realm of practice that she hadn't gone outside of that, that she had gone outside of the agency rules unknowingly and I thought that even if she did it, glossing it over, hiding, it would not help.

Consideration of alternatives was deemed important in determining action.

> We have a number of options for students that need extra help. I can give a student an incomplete. In order to give an incomplete I have to really believe that they can do it. I usually try to problem-solve

> first. I usually say to students, we are talking about your clinical performance and your grade. If there is something going on in your personal life that you think might be affecting clinical and you share it, sometimes I can make an exception but it is up to you to decide whether you want to share it.

As factors in determining the action to take, nurse educators in this study used: (a) self, (b) student suggestions, (c) immediate supervisors, (d) agency staff, (e) guidelines, (f) professional standards, (g) role responsibility, (h) safety issues, (i) empathizing with and supporting the student, and (j) consideration of alternatives. The nature of the situation and the individuals affected seemed to determine the action to take.

Subquestion 4 b: How does this action compare with actions taken in the past?

In the majority of instances nurse educators reported that they had responded in a very similar manner as depicted in the following quotes.

> That's typical.

> They would be pretty similar. When we find out about a situation, we do what we can to find out about the situation but we don't press other students to report if they don't want to, and then we tighten up on supervision.

> Well, when it is this serious, we take it up with our superiors, particularly when it is related to contracts. I might say that I have been in nursing education for thirty years so I'm not a novice in these matters. I know someone else asked me if it happened before and I said yes, it happened once before in another school but it was over a medication error which is very easy to see.

Probably similar. I usually talk things over with someone else, get an opinion. I am learning though that honesty really is the best policy.

Similar, the student is always given more leeway than the instructor even to the point that we are not even allowed to accuse the student. We had some opportunities where several instructors have felt that the student has been drinking and we wanted to document it and were not allowed to.

Well, whenever I have students who pass the tests and seem to be in conflict with some of the policies, I don't think I have done anything differently than with this student. From the standpoint that I had called her in, talked about it, made notes about it, that kind of thing. My only real hesitancy is whether I really would carry anything out in regards to grade and quite frankly when you get down to a second semester senior and they are in the last class before graduation, I don't know whether . . . any of us would call a student on the line on an attendance policy.

I don't think it is much different, and maybe it's because it is community. I try to give the students as much freedom to practice as they can, as well as try to give them advice to direct them to appropriate literature resources to get some information that way, to have discussions about what is appropriate and why not. I have always tried to be advisor and counselor and teacher but let the students have the opportunity to make their own decision.

I think it is totally comparable. I tend to use self-reflection and questioning and try to have the student reason it out based on information of what we discuss.

However, in some situations, actions of nurse educators were different.

This is the first time I've told students to go public and go to a newspaper. I basically have told them to follow the chain of command.

There were some instances where I felt like I needed to include staff on the units and personally, that was because it was some patient care issue and that I needed to have their input because you can't work in a

> vacuum. So there have been other situations where I have gone to the nurses for either direction on how they would like me to proceed, support maybe with the student, suggestions.
>
> There have been many situations where students' standards have been very lacking and I've just simply said, this is unacceptable.
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> This student, I gave special consideration to and I went beyond the exceptions that I did make for other students in general because she was a very bright student. . . I really believed that if we could get control of these things, she could be successful.
>
> Well, this is the first time I had a [serious] problem with a student. Well, I had lots of advisees that had [personal] problems. If there's a problem I call them in and talk with them about it.

Eight participants responded to the chosen situation in a similar manner as with past conflicts. Six participants responded in a different way. Again, the nature of the situation and the individuals involved seemed to have a deciding influence on the course of action.

Subquestion 4 c: Were you satisfied with your action?

Subquestion 4 c 1: If yes, Why?

The majority of participants expressed satisfaction with their action. Satisfaction was expressed because the action was viewed as necessary.

> Yes I felt that under the circumstances, it was what had to be done. I felt sorry for the student because it stopped her career.
>
> Yes, I felt like I explained all the options, consequences to the student and I feel like going to the dean was [going to] someone who would listen and do what she could.

Student response was cited as an indicator of satisfaction with the action.

> Yes, the student actually mentioned it to me years later. She said that she really thought that it had been a good decision and she was happy that I had been supportive of her.

> Relatively, yes and part of that also was that I felt it was reenforced by staff actions and family actions. The discussion was because the decision was made. Yes, I think so and particularly with a student with his background where answers are always black and white. He felt that at the end of the rotation that was probably the most meaningful thing he did [recognizing the autonomy of the patient].

> In that situation, it was because she was able to come back and successfully complete the clinical requirements although I have to say that not every situation works out that well.

> I think so. I do think that maybe I could have done a few things differently but I think that ultimately the student was able to learn something and the patient was followed [situation where student did not view drug use as needing psychiatric treatment].

Professional responsibility as well as student response were addressed.

> Yes, I felt my accountability had been addressed because she was back on target and she has done her own work. I didn't have to confront her in the sense of saying, this is either plagiarizing or you have some ghost writer some place. Now I don't know, right now as I'm telling you about this, I'm also feeling some dilemma, you see, because I'm saying, O.K. you got off easy here. You didn't have to do the hard part, which was saying to the woman, you're lying here. So in a way, I sidestepped that issue by looking and focusing on what she was doing according to process. Now, I don't know if I was just darn lucky or if that's a good way to deal with it.

Open discussion of the issue assisted one participant

in feeling at least partially satisfied with her action.

> I'm satisfied from the standpoint that we have talked about it. I'm also satisfied from the standpoint that the faculty in the department have discussed the issue again because we have a student in a junior class who has missed numerous classes and she falls under the same kind of situation in terms of the handling of it. My sense from the discussions of the faculty is that it is unlikely that these students will be unsuccessful solely because of the attendance policy. When you've got something official and you don't follow it then you have to live with that consequence as well and we've chosen to do that.

Recognizing and respecting student autonomy was used as reasons for satisfaction for actions.

> Yes, I really feel comfortable with what I did and I would make the same decision. I feel comfortable when I let the student make her own decision because she is the person who is doing it. For a little while I was kind of upset that this woman [the wife] would continue in a dangerous situation, in an abusive situation, but again I felt the woman had reasons for that and she had financial reasons for staying in the home. The one thing that I'm not as comfortable with is that we had the student assigned in the situation [where a gun was visible].

> I think so. I felt we had done what we could according to her which was listening to her and giving her every opportunity to help us take this farther and she chose not to.

Subquestion 4 c 2: If no, why not and what would you have done differently?

Although there were no totally negative responses to this questions, there was ambivalence as expressed in the following quotations.

> Yes and no, I can't say I was completely satisfied with it because I never felt comfortable with it. But when I try to think about what I would do differently,

> I don't know except maybe force her to go down there [to the director of nursing] with her and it would have been put out in the open, I think. The conflict for me was that it never was reported.

In looking at what this nurse educator would have done differently, her response was:

> Well, in her background, she was sexually abused as a child and as an adult. I think that played a big part in taking responsibility. I don't think she was functioning as a totally mature accountable adult. I think I might consider with all students now, not just her, that as their supervisor, I'm the professional and they are the ones that are learning the profession and this was not a personal responsibility but a very professional responsibility, that she had to report this and that should have been made real clear to her that this is something we will do. Help her become the more mature professional but not assume that she could make that decision without being told and playing more of the supervisor role, even when autonomy is there, from a professional standpoint. They are learning. Somehow, I think I gave her the impression that she had the option and I should not have done that.

Responsibility of faculty as teachers and role models was noted in the previous excerpt.

> I'm glad that I did it. I wish I had been more honest with her, because that would have helped the trust relationship but yet I don't have regrets about choosing for her good over confidentiality. Another thing I wished I would have done, I should have called her and said I have contacted your counselor because I'm concerned.

One nurse educator felt she had done her part, although she would have preferred that the situation was confronted directly.

> I did as much as I could. Yes, I would have preferred that it would have gone to a full review board rather than just me and the student and the dean. We were

> taking a wait and see, and I don't like doing that because if we took a wait and see and we just slapped her hand and she did by some mechanism pull the grade up and was able to pass, I felt that was a real violation of what I was saying and she came very close. There was no recourse once the decision had been made that this grade would not be omitted from the rest of her grades, which was what I was asking for, that this exam be thrown out and she be given a retest by herself, a different exam.

Conflicting feelings were expressed in the following description.

> I suppose that I'm glad I stuck to my guns and fought it out. I'm not glad that I had to go through all of this. It's not what I call a learning experience and not something that I would wish on people. This is a tough question. I talked about it a lot, you know, the choice of having to either make the compromises and undermine your own integrity versus sticking to your guns and putting up with the consequences. It's not much of a choice.

In reflecting on what she would have done differently, she said,

> I should have gone to the department chair and I should have pulled her in very early and that would of, I think, helped me make a decision. I mean, probably the best thing to have done in this situation is to have backed off, to not have failed the student and to kind of let her go through.

Outcomes seem to determine level of satisfaction with actions. Nurse educators expressed feeling satisfied when they felt like they had exhibited appropriate behavior and students had responded with new understanding and learning. On the other hand, nurse educators felt ambiguous when outcomes were less than satisfactory.

Subquestion 4 c 3: What prevented you from taking the preferred action?

The major factor that interfered with the preferred action was lack of support from superiors, either within the nursing schools or higher levels. In the instance where there was evidence that the student was cheating on an exam, the dean of the nursing program made the decision to "wait and see" what happened. The following narratives illustrate the significance of the lack of administrative support for faculty decisions.

> One of the determining factors that is hard for academia to understand is the significance of the hospital's control of a student in a situation and the significance of that was that in the grade appeal process, the student appealed the grade to me and I would not change the grade. The second step in the grade appeal process is going to the director of the nursing program. She stated that she would not change the grade because we had made this decision. The third step was to go to the dean in charge of professional studies. Now you see, the dean of professional studies sided with the student and that is what caused a very large conflict. I personally did not feel it was totally his purview to say what the nursing department should have done because he did not understand.
>
> I went to my department chair, pulled her out of a meeting, and I said, we have a big problem and I talked with her about this student K and then we scheduled a meeting with the student's advisor and it seemed very clear to me that there was really very little discussion to be made around this and the decision was clear, but my department chair, it was not clear to her. She was not comfortable failing her. The general impression was kind of communicated that I was in the wrong. Somehow that I had done something wrong. It was not the student at all. I was being too harsh on the student. That my standards

> were too high. Finally, my department chair came to me and said that I would have to make the decision about what to do about K. Once that decision was made there was really nothing I could do but to fail her, so I did decide to do that. She filed a grievance against me.

In another instance, the nurse educator was disappointed with the action of the student as portrayed in the following description.

> In my opinion her first moral concerns were her reputation, her job security. That type of personal concern she had was being overridden by my concern for the patient and I believe she should be an advocate for the patient and the staff needs were not as important at this time. She didn't take responsibility when it was all said and done.

Results from this study indicate that the crucial factor in blocking the preferred action was decisions made by administrators. When faculty were given autonomy to exhibit ethical behavior and were supported by their superiors, satisfactory outcomes occurred. However, when there was intergroup or intragroup conflict, the outcomes were less than optimal and in one instance was destructive.

Subquestion 4 c 4: What resources did you use to assist you in taking the desired action?

Nurse educators listed past experiences, research, faculty colleagues, clinical agency personnel, direct superiors, written policies, formal grade appeal process, legal counsel, spiritual counsel, and the code for nurses as resources that directed their action. In the following

scenarios, several resources were reiterated.

> I used my neighbor, who is a policeman, to give me the legal options that we had and the agency [public health department]. I contacted the agency and my department chair.
>
> It involved the entire college, other students and it involved a very impressive lawyer.

Participants were further asked if there would have been additional resources available to assist them in resolving the ethical value conflict. They replied that in using hindsight, other resources were available. One participant wished she would have been more aware of the legal requirements in reporting child abuse.

Greater enforcement of the honor code and more faculty autonomy were mentioned.

> I think we need a tighter code. I don't feel that a third party who has not been intimately involved in the process should make the decision. I think it should go to the full board for review.

Written resources were seen as helpful by the following participant.

> Well, I said reading wouldn't change my values, but reading might help me to learn a little more about how dangerous bulemics are. I haven't learned completely to know all the cues of a suicidal patient and I could stand to do some more reading about that. I thought, any idiot could pick up on those cues but on the other hand I struggled with whether or not to do something because I thought, maybe she's just trying to scare me. So resources that would teach me more about identifying suicidal patients would be good.

Other educators were viewed as potential resources as expressed in the following narrative.

> I suppose only to validate with somebody in another school of nursing. They might have some similar kind of policy. We have several faculty that have faculty outside of nursing who kind of do that in an informal kind of way.

In addition, the need for preparation in confronting ethical situations was emphasized.

> There are other people in the clinical area who I'm comfortable in approaching and I need to do that, as well as having my ethics course this semester has refreshed my memories as to what the differen principles are. I think in ethical decision making, you really have to talk about things ahead of time. You can't just get to the situation and go in cold. Of course, every situation is different but be prepared to treat each individual situation and respect other opinions.

Perhaps available resources were expended.

> I think we probably exhausted them and I say that because it wasn't my decision.

Time constraints prevented the use of additional resources.

> Actually not. I could have gone back and talked to colleagues if I had a chance to do that, but I really did not have a chance to do that.

Nurse educators in this study had access to resources such as legal counsel, colleagues, and written material. Proactive rather than reactive planning and increased use of the honor code were additional resources that could have been used in resolving ethical value conflicts. There are ethical encounters, however, that require a decision to made at the moment, causing any additional resources to be futile.

Research Question 5: What are ethical principles that guide the action taken by nurse educators in resolution of ethical value conflicts? Subquestion a: What, if any, ethical principles did you use in the action taken?

Faculty were guided by ethical principles although they could not necessarily name them. As one nurse educator phrased it,

> If I used them, they were unconscious. I tend not to pay much attention to ethical principles. I feel like I live by ethical principles based on my faith, but it feels like an academic exercise to me. I assume I work from a very ethical framework, but I don't think about labeling them.

Another participant considered many factors.

> I think I tried to look at the value of this and the repercussions of this to her, to the school, to the patient. Because I think you have to look at the ethics of all three. Because you have the ethical standards of the college which is to back the student, you have the ethics of the hospital, which is to protect the patient and you have the student who wants to go ahead and you have the faculty member who is trying to mediate everybody.

One participant was very clear in identifying some guiding ethical principles but was less clear in defining others. The following excerpt highlights beneficence, honesty, and professional practice as guidelines.

> I value beneficence, to do good, to do what is best for the individual, my own, being able to be honest with myself. I don't know what that is called, self-integrity, my own integrity and as a professional I felt that I had a professional responsibility as far as an instructor and a nurse.

In addition to professional responsibility, another

nurse educator recognized harm avoidance as an important guiding principle.

> Integrity, safety for patients, both as a student and in the future and I guess the ethical code of a professional, that other nurses will have to rely on her.

Harm avoidance was also used in relationship to the student in the following description.

> I was very aware of not wanting to just kind of destroy her self-esteem, by saying, what on earth is this?

In the following scenario, the nurse educator details the principle of harm avoidance as crucial in the student-patient interactions.

> That definitely was an issue with this patient. I mean, she was definitely doing harm to this patient. She was creating a huge wedge between him and the health care system. I mean in the long run, I think she was very destructive to this young man's health care.

Fairness was mentioned in the following synopsis and harm avoidance, benevolence, and utilitarian theory were alluded to.

> I guess I'm most concerned about fairness and I guess you would say the greater good. Those two things have to be balanced I think. The greater good to society and the patient versus fairness to the student and benevolence to the student. You often try to provide real supportive learning environments for students but at some point they have to be able to perform and we can't just be mothers to them but we have to also be evaluators so that unless you can really start showing us that you can be in the clinic or approaching competency in your practice, you can't perform the certain standard.

Fairness was connected with justice in the following excerpts.

> I try to look at always to be fair. I guess with fairness goes justice. If she had missed four clinical days, I think we have to do something but four lecture hours? As long as you can pass the course I guess it's O.K.

> I think the students consider me a challenging instructor but that I'm fair. I believe that they believe that students who aren't doing the work and aren't making the grades shouldn't pass. They want justice.

> Yes, justice and we talked about harm avoidance, and justice is really something that permeates the whole thing. What's fair and how's the fairness in it all?

> Certainly there was justice because there was the justice of the student in the conflict of the family.

Autonomy and respect for autonomy were used as guiding principle in the following examples.

> I think I tried to use autonomy to where the student would take responsibility and then register a complaint and talk to the correct people rather than I take over for them.

> Well of course, autonomy. I just use that so much I don't even think about it, and again do you let the family be autonomous in their decision making or do we step in and press charges and like the government take over their autonomy. [paternalism]

> That [autonomy] would be it, except that she didn't take responsibility when it was all said and done.

> I very much believe that students have the right to confidentiality and autonomy, deciding what is best, making their own decisions, having control of their own lives and I wanted her to make choices, to get treatment, to get counseling. Those values were in conflict with beneficence; the need to do good and to keep her well and happy.

> I think the choice of self determination but also the conflict with our goals to preserve life, not to take life, so that is always a conflict between the two.

In addition to beneficence and justice, veracity and accountability were identified in addition to beneficence and justice as ethical principles guiding action.

> There was the principle of veracity and accountability. I think we identified beneficence, to do no harm to the student. The principle of justice by the way is one that I think about and care about an awful lot although I don't know that I entirely understand how that plays out in the student-teacher relationship except just treatment for all the kids.

Utilitarian theory was again implied.

> I think clearly, what's best for as many people in the situation as possible and I think that is what motivates decisions that we make on an ongoing basis.

> What is the one where you talk about the lesser harm to one individual versus the whole group?

In data from the study, nurse educators cited beneficence, harm avoidance, autonomy, respect for autonomy, justice, and veracity as ethical principles they used for guidance. Integrity, fairness, and accountability were also identified as ethical principles. Integrity is defined as adhering to a standard of values and would probably be considered a virtue rather than an ethical principle. Fairness is sometimes connected with justice although the terms are not synonymous. Fairness is usually conceptualized as an ethical value. Accountability can be considered a component of integrity. The code of ethics was

also used for guidance. Although it is not an ethical principle, it is certainly a standard for moral behavior. Utilitarian theory was also used in resolution of ethical value conflicts.

Subquestion 5 b: How have you learned to use these ethical principles?

One participant described very aptly the **influence of early environment** on her acquisition of ethical principles.

> I think it's probably something that started when I was very young and I have always been fascinated by the fact that there are, and I didn't even know to call them principles, but there are guidelines that we choose that are bottom line for us that guide our behavior and that we recognize that there are other people who don't live by those principles and therefore it definitely changes the way they approach things. It very much started when I was young because of the way I was raised, the church I was raised in, the way that I was encouraged and able to argue and discuss pros and cons.

Another participant elaborated further alluding to the influence of **culture** with the following description.

> Upbringing, background, I came from a family that put honesty and truth and relying on your word very high. If you made a promise, you kept it and then of course schooling, all the way through from elementary school on up. I was from a rural community and ethical values tend to be high in those small communities, farm communities, where your word is taken more than a written statement, where much is done on a handshake. So I think I was raised to be highly ethical and then my profession that I chose to go into, nursing and then into education. Those values are reenforced not only in your practice but also in your education. Lots of themes of ethics and morals through each course and sometimes specific courses dealing only with that.

The concept of **reenforcement** is reiterated in the following narrative.

> Environment is strong as a concept and so from where I come from, I think that it clearly is something that is probably taught in varying degrees and we reenforce throughout, including that it was taught and reenforced in nursing school.

In addition to background, **Christian principles, formal courses** and **experience** were cited by one nurse educator as sources of learning ethical principles.

> O.K. I'm a committed Christian. I've been in a group that studied discipleship extensively. I very carefully weigh many ways of behavior and how to make choices. That in addition to the way I was raised which was in a Protestant Church. But in addition to that when I was at ____ on the faculty which was for 13 years, our students did take biomedical ethics and we studied Beauchamp and Childress. I didn't take the class but I read the books. _____ _____ was on the faculty, a person known around the community as an ethicist. When I was a young nurse I did a lot of work in the research unit and we actually had an ethicist on staff who looked at hard decisions along with other things. All the folks I've interacted with all my life, if they have cared about these issues, have of course influenced me.

Formal education courses were again expressed as a source for learning ethical principles.

> I had a course in my master's program on ethics. I guess I've always just had a sense, a strong sense of right and wrong. I have always had a very high moral code and in fact most people tell me it's too high and it's always tough when you are out of step with everybody else. I think everybody else's is too low, in fact, rather than I'm too high.
>
> One thing that I remember that has helped me is when I had a student teaching class in my master's program, we went over ethical issues like this between teachers and students and that was very helpful to me and also

> the fact that now when I teach this class, we role play situations like this and discuss them and talk about them and that has made it helpful for me when students do come to me.

Trial and error was a learning tool.

> Trial and error. I really am observing what other people do, asking like the dean, what would you do in this situation? Do you think I handled this correctly? or what is another way that I could handle this? Were my actions appropriate here or were my actions appropriate there? A lot of trial and error. A lot of how would I feel if I were in that situation.

The following account further demonstrated **trial and error**, as well as role modeling, as learning experiences.

> I have learned through experience, trial and error and role modeling. I had a faculty member who was experienced in curriculum and in working with students and I use to go to that faculty member when I had problems and talk it over with her. I have had other deans, though, that I did not feel comfortable taking a problem to until I had figured out the solution or the action, because their behavior was not positive and if you told them what the problem was, they would freak out so I learned to only tell the dean about the problem when I had corrected it but I have had other role models who I felt like I could talk about a concern with and say what do you think we should do and I got feedback from them.

Ethical principles were learned through family values, environment, informal and formal teaching, religion, culture, life experiences, role modeling, trial and error, and reenforcement. Learning through role modeling stresses the need for ethical behavior by persons who are in teaching, leadership and administrative roles. Learning by trial and error raises the concern of how many errors are made before ethical behavior results.

Research Question 6: What are inner conflicts experienced by nurse educators as a result of their action? The interview question, did you experience any inner conflicts as a result of your action was asked.

Subquestion a: If yes, would you describe the inner conflicts?

Twelve of the 14 participants stated that they experienced inner conflicts as a result of their action. The inner conflict was experienced in various ways by them. One participant described her feeling of helplessness by saying:

> I always felt, even as we were doing it, that somehow I was responsible for making sure someone knew about this, that something was done so that it would not happen again by those particular staff, and it really surprised me that somehow I wasn't able to make something happen.

One participant experienced inner conflict because of the ramification for the student.

> I felt sorry for the student and I guess the results to her were a little more than I thought they were in the beginning.

Another participant described her feeling for students in greater detail.

> I'm always uncomfortable confronting a student with a cheating situation because I always feel like what if I'm wrong and this either changes them if I was wrong, maybe their career would end right there and I would feel bad, of if I was wrong, even though it didn't end their career, it made them somehow handicapped for the rest of there career. Even if I think I'm 100% sure, I still have that, what if I am wrong?.

Frustration was experienced by two participants.

> I felt frustrated that at one level I couldn't go back and confront the student.

> Just being a bit angry and frustrated about the situation. It's just irritating to think that you can't seem to solve it without getting yourself in a win-lose situation.

Having to address issues personally was a source of inner conflict with one nurse educator.

> I think it would be impossible not to. Clearly the student raised some issues within myself as far as what is acceptable as recreational. When do things become a problem as far as drug use is concerned?

The problem of caring versus objectivity provided a source of disharmony for the participant as quoted in the following narrative.

> I felt bad after looking back later that I hadn't been more honest. I also really cared about this person and had some struggle about whether my caring made me less professional than I should have been in my decision making. How deeply can you get involved with someone to the point where you don't think objectively anymore?

Ramifications of decisions had significance as described in the following accounts.

> It's always that conflict of, if you know that I'm a health professional, something could be done to prolong that person's life versus if they choose not to do that. I think you always have that conflict of wondering well if we let him do this will two weeks down the road, will he regret the choice he made? I think also the conflict is a legal one. Are you going to have legal support in that choice?

> I think I experience inner conflict all the time when I deal with students. I really agonized over the

> student because she would come in my office and with tears in her eyes, she'd say, I have to finish this semester. If I fail, this is my last chance. I was really afraid. First of all I felt that I was dealing with a student who was very fragile emotionally and psychologically and maybe something I would do would in the very worse case scenario cause her to have another nervous breakdown.

One participant experienced inner conflict with her personhood.

> I had serious questions about myself. Certainly my worth as a teacher, my worth as a person. My self-esteem took a major blow, I mean my job. What was I going to do?

One nurse educator was concerned about how the incident would affect the clinical facility.

> If you want that contact of students with the agency, I hate to say I had to think about that.

Inner conflict was indeed experienced by nurse educators as a result of the action they took. Participants described feelings of helplessness, need for empathy, and frustration. Dealing with issues on a personal basis and ramifications of decisions were sources of inner conflicts. The concern of remaining objective while demonstrating caring was also reported as a source of inner conflict.

Subquestion 5 a: With whom or what did you have the inner conflict? Why?

Two persons identified inner conflicts with the student.

> I think that there was probably some sort of conflict with the student partially because we were disagreeing

> to some extent and whenever I feel like I'm in disagreement with somebody, I feel like there's a conflict. I think ultimately we were able to work past that and find what needed to happen for the patient and not getting any worse than just disagreeing, but it certainly produced some feeling.
>
> With her for not taking responsibility that I wished she had, and probably with myself for not handling it the way that I would have in hindsight, and then coming back to the unit with that woman and knowing that she was there, that other students would see her behaviors with staff and patients.

For one participant, she experienced conflict with agency personnel. She stated,

> I thought it was completely off the wall for her to suggest that the student erase it.

Participants experienced inner conflict with their department heads.

> As we progressed through this it just became very clear to me how weak she was and this created a lot of distance between us and that whole lack of support that was evident from her.
>
> I guess I resented the dean for making the decision. Many times she does it in the interest of the student and not in the interest of the instructor.

In addition to involving the nurse educator, inner conflicts also included other individuals. Participants cited students, agency personnel and department heads as additional points of contention.

Research Question 7: When do nurse educators feel they have reached resolution of the ethical value conflict? The interview question, do you feel you have reached resolution of the ethical value conflict? Subquestion a: If yes,

describe how this resolution occurred within yourself.

Ten of the fourteen participants felt that they had reached resolution. Three participants felt that they had partially reached resolution and the fourteenth participant had not reached resolution. The following participant reached resolution through the process and ultimate decision.

> This is difficult to express because there are values of three groups involved, hospital/nursing, college/faculty, student/nursing. I as a faculty member felt I was in the middle trying to interpret each to the other. The ethic of utilitarian-greatest good for the greatest number was separate for each group and was in conflict. This is a fairly new position for nursing education since we have moved into a college setting and are not fully autonomous. Nursing education had not put down the consequences (we now have). The hospital was focusing on being afraid of being sued by the patient when it was his [the patient's] girl friend's confidentiality that had been broken. The college faculty was making decisions for nursing that was not in their purview over matters they did not really understand. I felt it was not in my place to make the decision about the student's future, but the nursing department's. They made a decision which was overruled by the colleges grade appeal process which has the final word, which I now need to go along with as the greatest good for the greatest number.

Several of the participants reached resolution as a result of the positive outcome for the student as expressed in the following narratives.

> If the student was comfortable with the outcome and we had done what we could to change, to put more checks on things and to confront where we knew we could without using another student's reporting of the situation, I think we had done what we could and it wasn't the kind of thing that we felt we could do

anything more about. I think the student grew in realizing her responsibility to confront when she sees a need to confront.

By telling myself that responding wrong was better than not responding at all. By reminding myself of her eventual crisis and successful treatment. She sees me in a positive way now. It is easier for me to feel good about the whole thing. If she still resented me I would not have resolved it as easily.

The students made it through the course and were somewhat pacified and this next group of students are not having as severe problems as the last group.

The student came to me with the concerns and talked about feeling that the patient care was inappropriate. Basically I listened to her and talked with her extensively and we talked about her relationship to the patient and then she went back out to do patient care and she was able to come back and feel good about what she was able to do and she ultimately didn't feel as if it was as much of a conflict for her in the care that she was giving and she liked this. So I think that's where the resolution came in, that the student was able to say that it wasn't a critical issue for her.

I felt like it was resolved because the student's response to our talk was to get back on track and do her own work. I had respected her and held to the appropriate standards. As a matter of fact, the young lady is really doing phenomenal poetic stuff. I mean she's learned a lot.

Yes, in this particular situation with this happy ending. I was trying to remember how I felt when I asked her to take a leave of absence and I guess I felt that she was unsafe and it was really my responsibility to protect the larger, to decide in favor of the larger good. My greater responsibility to society, my greater responsibility was to patient safety and I had no choice at that point with the actual situation. We had just reached the point where anything could happen and she couldn't be there and we didn't have an alternative so we just kind of reached resolution about it.

Interestingly enough, the student requested the

> supervisor to call the physician who was delighted to give the order.

One participant reached resolution as a result of a negative outcome for the student indicating that justice had been done.

> I did when she failed the semester. She was close enough that had she passed subsequent exams she would have stayed in the passing range and then I don't think I would have felt so good about it.

When the outcome was right for the patient, the nurse educator reached resolution.

> I think because as time went on with him in particular, the choice was correct and surprisingly allowing him to make the choice then, he later did start taking in some food but it was his choice. Someone did not go through with the tubes. He was getting IV fluids all along which he allowed but that action prevented his anger so that helped me to realize that his choice was right.

In the following three narratives, participants expressed ambivalence about resolution of the ethical value conflict.

> The immediate situation, yes, the global situation, no. The immediate situation being that the student is not in the situation anymore and that will not occur again in that particular situation. The global situation being that we are still sending students into the home. It's still going on. The conflict comes with, how can I get the student these experiences, these very valuable experiences and still keep them alive?

> To whatever degree it could be reached. I don't think it's resolved because nothing was ever said and the staff person is free to do it again. But I've accepted that it happened but I'm not ever going to do anything else about it except in terms of the future.

> Yes, but I'm not sure what will happen in the course of events. I think we might be back to square one again and unless the faculty decides to really hold to the policy, I think the question we will be asking in the situation is, is what are we going to do now and I think the students will be in a situation saying, well, I can do whatever I want to. I think we have another student that we will have to wait and see what happens and my feeling is that nothing is going to happen.

Research Question 7 b: If No, describe why you felt unable to resolve the conflict.

The final participant described reasons why resolution has not been reached in her situation.

> We had a big meeting with the state board, my lawyer and myself and we came away from there with my lawyer saying very clearly, you're being scapegoated. The fight is with the University and I can't defend you against that. I just got my license in this state, maybe six weeks ago, and I really wanted to put all of this behind me and it was difficult to do when I couldn't get my license, but once I got my license, I felt a lot better. But now I still have this second case which may or may not happen. I also have the two year waiting period and I have to go back into the classroom in August and start teaching and I am freaked out about this. I am so uptight and so stressed and so kind of crazy about this whole thing that I am not sure I can be appropriate in the classroom unless I know there will be somebody there that not only will support me but to make sure that I'm O.K. in the classroom.

Resolution occurred when outcomes seemed to be fitting for the situation. Resolution did not occur when there remained unrest with the ongoing ramifications of the resolution process.

Subquestion 7 c: What insights have you gained from this conflict resolution to assist you in resolving future

conflicts?

Nurse educators in this study keenly described insights they had acquired in the experience of resolving ethical value conflicts.

The process can become very complex when other value systems influence the outcome.

> That it is very complex when it is involved with the hospital, when it's involved with academics, other than nursing. There are much more ramifications than if you were failing a student in an english course.

Recognizing diversity of ethical values was significant as expressed in the following narratives.

> Being a new clinical instructor, every situation seemed to be insightful for me. I couldn't in every case predict what was going to happen and I didn't realize that students were going to have different sets of variables to use and so forth which I guess in some ways I did, but when you are faced with that reality, it isn't as easy so I feel like over the semester I have learned a lot simply because learning can continue as long as I can do this.

> We can't make assumptions about students' integrity and to make assumptions because this is a private, church related school, one can expect more honesty perhaps than a public school, may be true but not to assume it.

> That there's another person involved in it, that you can't necessarily depend on the other person to ethically feel the same responsibility you do.

Going beyond recognizing that acting on values is a personal experience, to actual observation for students for evidence of lack of ethical consciousness was important to guide future conduct.

> I guess trying to be more cognizant of the signs and symptoms that go along with a student who was maybe having some difficultly with integrity and maybe intervening and getting them some help counseling wise, to counsel her in a means that maybe this type of profession isn't for her or that if she feels that strongly that she needs to cheat that maybe she needs some professional counseling in that area.

Assisting students in learning ethical behavior and reenforcing actions indicative of ethical consciousness was further supported.

> I think the one thing is helping the students to work it through. Within the health care team, there is an increase in allowing patients to make choices and that is something that I can see and the other thing is that I think there is more research used to violate this point of view and I think those are the kinds of things that I brought into the discussion, rather than my own gut feelings.
>
> I think that it is important to support the student and her values. That is probably the most important thing.

Time for processing and reflection was discovered as important.

> I would say, I need a little time to make the decision. I'm not very good at making ethical conflict decisions right on the spot and then to be real upfront with all parties involved about what my decision is and my reasons why, I think is the best policy but that's what I learned.

The role as an advisor was further evaluated.

> Well, I feel like you need to be very careful, measure the advising suggestions that you give to students. It's a fine line as far as being there to help the student but then giving them the power. My fear is that students will think, I came to you for a problem and you didn't solve it. You let me down versus trying to help the student solve the problem. So just trying to develop that fine line that you walk on is

something that I'm always trying to work on.

Use of power was analyzed further.

> I think we ought to help students look at the power that each one of them has. I think they often feel powerless in a sense and don't realize the power that each has both with other students and with and over clients and within the nursing system and they have more power than they think. I think we probably need to help them to look at power and how they use it. We also need to help them realize that the actions now are basically as important as the actions they take as a professional after graduation. They are not going to increase in integrity just because they graduate. Probably talking about it more.

The role of the advisor, plus an awareness of inherent student problems and the complexity of the process, were examined.

> I'll tell you a couple of things. I felt that in that situation I had gotten kind of close to the student and I was worried that would color my ability to make the right decision and I guess I thought that I needed to maintain some distance and not get myself in the situation again where I was working so close to that student that I couldn't make the tough decision of failing the student or asking for the student to take a leave of absence, so I was a little leery of getting too emotionally involved. Because the outcome was ultimately successful, I like to believe there is always a second chance to offer to the student even though they feel like they have been devastated and this is a failure and they are never going to recover from it. I like to tell students that there is always a second chance. There are also things in students' lives that are obstacles that they cannot control. I guess just the whole process of counseling the student, writing the contracts, keeping administration informed, getting as much advice from outside resources that I could and so on, that process if you do it, it's a lot of time. It's a lot of effort. It's a lot of work but if you go through that process, you will reach the resolution that you want to get to. It requires a time commitment and an effort commitment on the part of the faculty but that process can work

and it can help you have confidence in your decisions.

Adherence to written policy was considered significant for future reference in resolving ethical value conflicts.

> There are logical consequences and I think of the faculty and I think in situations with students we have the responsibility to, at least if we are going to set things down, we do them and if what I'm going to do is not that then there's no sense in making the policy.

Introspection resulted in greater understanding of approaches to conflict situations.

> I'm still unsure, I feel good about this situation. I know about myself that if there is a way around direct confrontation that I'll probably take it. There's a part of me that sees that as weakness and there's a grain of self-doubt. I realize I've told you when it is necessary, I'll confront and do whatever, but a part of me is that I want to do that and I don't know if that's a defect or I suspect instead I should just say well this is me and this is the way I go at it and look at the strengths and the advantages of doing it the way that I do.

Recognizing intrinsic factors in providing independent practicums for students was an insight expressed in the following account.

> It reminded me that we're not sending our students always in safe situations and it's interesting that this occurred just about the same time that the person in the emergency room shot all the people so I was able to use that to illustrate that nobody is safe anywhere and we have to remember that everywhere we go and always be on our toes, so it certainly changed the way that I approached the situation. I know this and I forget it sometimes, that students carry their own baggage and it reminded me of that again, that things have happened in their life and I know that and I still forget it.

However, the participant did express some doubt about

the validity of the situation.

> The other thing that crossed my mind was, and it bothered me that I did it, I guess that is very ethical, but I thought, all you have done all semester is brush me off and maybe you are trying to teach me a lesson and I can't ever validate that. There will probably always be a doubt in my mind, but I have to believe her and had to act on that and I treated it as if it did occur and I went with all the assumptions that it did occur. There will always be a question mark in the back of my mind, are you really telling me the truth and that bothered me that I did that. What her behavior told me was that she was nonchalant and she seemed to be an emotional type person. Now maybe she had gotten all that behind her when she called me and I said something like, you must have been frightened. Well, no. I thought, if someone had a gun at your head, surely you were frightened. The behavior just did not seem appropriate but again that might have been because I didn't know her.

The results of giving the student too much advantage affected future actions for the following participant.

> My big mistake in the whole thing was in not failing her. I should have failed her the second or third week when she was not doing what I told her. I did myself no good by trying to work with her. That is where you get yourself in trouble, in giving them the benefit of the doubt. In my current job, I do not let anything go past me and I confront everybody. I try to do it in a gentle, caring way, but I do not let somebody get away with a look and I don't know if that is going to pay off but I think it will. There was an incident last week so I'm getting on top of things really fast and I'm discussing it with them and if we can't work it out then I will ask for a three-way meeting with the boss. I think that people are less likely to take advantage of you if they know that you are not an easy target. I do work on aggression and violence. I have this whole conceptualization put together that people act aggressively to get what they want and they can be very intimidating and push, and even within this professional arena we're dealing with people like that and I think that it is very unfortunate that society has gotten to this point, but I am beginning to learn that you can't be an easy mark

for people.

In a post script she very graphically and poignantly described further insights.

> I feel like I could go on and on - trying to make sense of all this. However, I like my job a lot and am very glad that I left my last job and left academia. I also did learn a lot; I will never again allow myself to become a scapegoat. In fact, I see a faculty member here who I believe may become a scapegoat. I have befriended him and tried to introduce some of the issues that he has to be aware of. I have not told him of my background. Maybe it is true that adversity builds character. I know that if I survived this experience, I can survive anything. I tell people now that once you have been in hell, everything else is relative. Once upon a time, I used to have a lot of requirements for a job. Now I am more easily pleased - I only want a job where I don't have to talk with my lawyer every week. I am the kind of person who learns and so I often wonder how this experience will shape me in the long term. There is no doubt that it will!

As a result of insights received from the resolution process, participants introduced a variety of strategies to reduce the occurrence of unethical behavior.

> At that point we were putting exams on the desks and then they would go sit. Now we are doing it in alphabetical order, so that each student is not put next to a friend, etc. So we tried to institute some measures to try to cut down on the cheating because it still continues.
>
> Well, what happened is that in class, the faculty made a deliberate kind of a surprise discussion item about what seminars and workshops they had gone to and what they thought about them and started with the people who had not gone so that they did not have time to think about it. The students who had gone enjoyed that greatly. There was not any further confrontation on that although one student asked for a recommendation for the permanent file from a faculty member, who said she could do that but she would have

> to in a sense mark her down on integrity because of certain suspicions and ideas she had that things weren't done.

In addition, to promote student safety, the nurse educator introduced specific guidelines in her course.

> I have added a very lengthy discussion in the course pack on safety and protecting yourself. The text we use has a bit of discussion on safety and I also have a memo that I address to students that they are going perhaps, into a more dangerous area. I don't believe it's more dangerous because it's every bit as dangerous to work in a hospital, I think but I want them to be very aware. They need to be safety conscious and I have students give me suggestions on how to increase their safety.

The process of resolution of ethical value conflicts was a learning experience for the participants. They not only discovered the existence of diversity in values but also the need for awareness of potential traits indicating unethical behavior and reenforcing manifestations of ethical conduct. Self-reflection was a facet of the learning experience, especially in the obligation of remaining objective as an advisor and mentor. Nurse educators became more aware of personal problems of students that affect their choices.

As the interviews progressed, it became evident that the impact of the resolution process not only went beyond nurse educators but also resulted in consequences in the student-faculty relationship, student behavior, and perceptions from other students and adjunct persons.

Therefore results are further discussed related to faculty-student relationship, additional effects from outcomes and role modeling.

Faculty-student relationship. The ongoing relationship with the student was approached. The following narratives suggest positive outcomes from encounters.

> I think it probably deepened it because I understood more of what she was feeling and her experience. She came to me several times later on with other frustrations. I felt like it opened the door for communication. It certainly didn't help my relationship with the accused student. It did and it didn't. I was watching her very closely, in a sense waiting to catch her, but in doing that, I saw more into who she was and could feel more empathy for her.
>
> I think she became more honest with me. She got more professional help and therefore needed me less but when she did see me there was no more beating around the bush and that was partly because of her therapy. She was starting to be more honest with herself.
>
> In some ways I think it might have made our relationship better. She had been, I thought, pretty open even though she had some different opinions about what care might have been given. She was pretty open to hearing what I had to say and so I think that ultimately things added up for her fairly well. I don't think she changed her view particularly about her own drug use. I think she might have realized that maybe it was a problem for some other people, but not for herself. So I don't know if it was a complete insight but she was able to make that delineation.
>
> I think our relationship stayed good but she kind of saw me as a helper. I certainly wasn't in the same capacity as her therapist because I was the decision making person but I think it was good.
>
> I don't think it did change. She was my advisee and we were on a committee together this year, getting ready for graduation and she will come to me and ask me questions.

She approached me for other issues. She is continuing through the program and I really think that it strengthened her ability and skills in her relationships.

It made it very positive. I was like a mentor in the situation and I haven't seen him now but I see it as being a very positive relationship.

In other accounts the relationship was less favorable.

Well, we had already decided that I have as minimal contact with her as possible because she had already accused me of being against her from the start. This situation only made her feel more so, that I was out to get her and she brought it up several times throughout the summer when we met with her to reconcile that this was the final grade and that she was not allowed to come back.

There has been no relationship. Fortunately I have not had to deal with her at all.

The choice the student made directly affected her current performance.

The student was doing very well on the unit until this experience and then she deteriorated and she was not a real high self-esteem person, but after it happened, she really fell apart and was not able to do well on the unit.

Choices also affect future perceptions and actions. I think she was a very troubled kid and I'm sure that this is not going to be the last of her problems because she was very resistant to getting any kind of help. She made no movement toward resolving her health issues. I think that is an important issue for her, an important issue for nursing. We've got one more nurse out here that's kind of on the edge. Something's going to happen with her and I would guess that it would probably be drugs.

The relationship of faculty to the student underwent change as a result of the student's actions.

Not only is some child out there probably still

> getting abused by the staff member but she's probably seeing things that she's not doing anything about. When the student came back later, I did not necessarily want to be around her. I didn't want her to be there. I didn't want to help her and that's too bad. I wanted her out of my life. When I've had situations that are unresolved, it just makes all your future interactions with that individual twice as uncomfortable.

Additional effects on outcomes. Modeling ethical behavior provided an example for the agency to strive toward.

> I think it was probably a learning experience for the agency as well, as I have not been asked to do that again. The student also by the way, was getting a job in this particular agency, and that was another fear of hers that she would jeopardize that because she was negotiating at the time.

The investigator asked how the student complying with the request of the agency to not chart what she had done would have affected her future. She replied,

> I think she would have still gotten the job. I think it might have been hard for her to stand up for herself on a day-to-day basis. The supervisor would think that she could ask her to do that and she would do it.

Choices of the dean affect outcome.

> I just feel that she does not like conflict, I mean outside conflict. She does not mind conflict with her faculty. But conflict with a student or a student's family, especially when they say they are seeking legal counsel, that will immediately stop the process.

Role modeling. Because of the significance of role modeling it is discussed specifically. Some persons are in positions where they inadvertently model unethical behavior.

Students are exposed to poor role models and not only observe inappropriate behavior but may be disappointed when ethical practice is not followed or may use it to their advantage.

> I think role modeling is important. I don't think I did it very well. If you are not going to be the one to role model, it would be important to have a good role model. I never would have picked this person for a student to watch.

> I think faculty have a responsibility there. They [students] felt I handled it. They were disappointed at the outcome of the process and they voiced that verbally. I guess I feel when integrity is jeopardized or questioned, then not only the school is questioned, me as a faculty and my standards are questioned and I think there are major ramifications in role modeling that we uphold as high standards as we can and expect our students to reach towards them and to learn them but I think as instructors, as teachers, as mentors, we have to already possess those things and I don't always see that.

> I think that it is no accident that when the student complains to the department chair that she gets a grade change from an F to a D to a C and then life goes on as usual and that instead of redoing 13 days, she [the student] does five and so there was no reason to think that she wouldn't get what she [the student] wanted from me. She wanted me fired and my license removed.

> After the grade appeals committee overruled the grade, the student responded with, "I lost a whole year because the nursing faculty messed up."

Although nurse educators are considered the experts there may be a sense of self-doubt and the potential for negative role modeling.

> I think we are all flawed and that we make poor judgments in our ethical decisions. In other words, who am I to have the final judgmental position on

another person?

The significance of role modeling ethical consciousness was verified by nurse educators in the data.

Although research questions did not address the effect of verbalization on the participants, because of the emotions generated during the interview process and for debriefing purposes, participants were asked to discuss how talking about the situation affected them. Responses were diverse. Positive learning was experienced.

> I didn't know what I would learn from the original Phase I of the project, but I've learned a lot out of this [PHASE II]. It actually made me explore it a lot more than I probably had. Actually, the question about the future, what would you take from this to your next experience and you always think that you learn from everything, but I really hadn't thought too much in terms of what would I do again in the same situation because I wouldn't want to have a similar outcome if it was the same type of thing given that there was a third person.

> It has helped to some degree for me to clarify my thinking. But I think it probably pointed out to me some of the things I need to do, like the steps of dealing with it with the students. Some of the naming of values for instance that came into play in the situation and I think I need to do more study as far as actual documentation of what is important in the issue.

The value of verbalization was expressed.

> It's nice to share a problem with someone else, besides your own faculty. You tend to get real wrapped up in your own problems and I think one of the things that's helpful is that there are probably others out there feeling the same kind of problems so my sense is not to be alone with them.

> I know when I first started filling out your survey,

> all of those feelings came back. That probably answers one of your questions of how have I resolved it. The fact that it did get me upset all over again says I probably haven't resolved it and I probably never will even though what I wished would have happened was for the student never to finish the program. Talking about it helps because as faculty, we talked about it and were all frustrated and made comments like, let's take a vote. It always ends up this way. We were real frustrated. I think talking to someone outside sometimes helps because you've asked some questions that made me think about why and where, and even though it has been several semesters, it's still something that influences the way I deal with students. It's an area that I evidently associate with a high amount of emotional value and therefore I guess I put a lot of investment in it and I think one way we learn to deal with issues is to talk about them and to rehash them and to say what if? What if we had done something different?

The interview process assisted nurse educators in focusing on the situation from an ethical perspective.

> I didn't really look at the decisions that I've made from an ethical perspective. I guess I have a general sense of wanting to be fair and wanting to be a responsible teacher and wanting to make sure that students are learning competencies. It made me think about it from an ethical perspective. I hadn't really done that. I don't always respond to surveys but I really thought this was important because I believe that we have to make some hard decisions as faculty, especially as I told you, I'm in this unique situation. I teach the senior level and I feel that students often get pushed up and then it's like the buck stops here and I find myself having to make decisions about passing or failing students and I probably fail more students than any other faculty, not because I'm awful but because I am in that position and because there is a point where you either allow the student to go forward and you release them out in society or you stop it. This is where it stops and you have to take a stand. So I think this is an important topic and I don't think I have ever really read much about it so that's why I thought it was an important topic. It is something that I deal with a lot but I haven't really thought about it much from an

> ethical perspective. So it's been good in that it made me think about it from an ethical perspective.
>
> I didn't even look at the situation as an ethical situation. It made me go back and reflect on it. It made me think of how it could have been handled differently and made me more aware of my actions, how they affect people, to not just shoot from the hip, but really think about how to approach situations.
>
> I think it is helpful. I think filling out the form [PHASE I] just served one step and then I think talking about it [PHASE II] adds some more pieces. It's also very helpful to be able to talk to someone and get clarification. Because sometimes you're just writing and thinking, I wonder what she really wants. That was hard, but I think it's good because it gets you to think differently. When it initially occurred, I probably would not have identified it as an ethical value conflict, so I had to think about it differently.

The following excerpts described the interview process as helpful in resolving the situation.

> I talked about it so much with the people that provided the counsel that it is not new. I feel like this situation has helped me in terms of resolution.
>
> It actually has been very pleasant, sort of a catharsis. You're an excellent listener. I'm asking myself, why has this been so pleasant? Because principles and issues like this matter? Yes, they do matter.

In the following scenarios, in addition to other positive outcomes, introspection resulted from the interview process.

> I have good feelings about what happened in the long-run with that person and we're, as a department, very proud of having gotten her through it and sometimes, with some people who you put so much time in, you wonder if you get anywhere and she's obviously one of those people that three years down the road, it was worth everything we ever did. Talking about it makes

> me more aware of my own tendencies to not be completely honest about decisions I make about students. Sometimes to make things happen or let things happen and not be up front about why and how I'm doing that. Cause it's easier. It's easier just not to tell them and it takes time to tell them and it makes you vulnerable. I would be uncomfortable with blatant lying. But I'm not as uncomfortable about just not telling people and that has gotten me in trouble before. It did in this case.

Although the interview process did not elicit new information, it did cause some emotions.

> It hasn't been a particular problem because I have just gone through all of this on Thursday with the committee. But it does raise some of the anxiety that obviously is there because it isn't resolved yet and I don't know how it is going to be resolved.

In another response, although strong emotions were evident during the interview process, the participant implicitly expressed the therapeutic effect of verbalization.

> It brings it all back. It makes me upset. It makes me angry all over again but I suppose in the long-run that is good because it is helpful. It's not as intense as it was a couple of months ago.

Other nurse educators experienced minimal effect from the interview process.

> Maybe made me more aware of the need to talk to faculty colleagues, although we do that a lot. I'm not sure. It wasn't a big incident for me. It didn't deplete me of energy.
>
> It's interesting to think about it. I hadn't thought about it for a while.

The amount of personal investment and energy during the resolution process of the ethical value conflict seemed

to influence the degree of effect on the nurse educator. When the incident was perceived as a major breach of ethical conduct, the participant experienced intense emotions, such as anger, frustration, sadness, and fear, during the interview process. In contrast, nurse educators who considered the incident a less major breach of ethical conduct exhibited less intense emotions.

Themes

In many situations, it was possible to code a section of transcript fairly predictably since certain themes typically were linked with specific research questions. While some themes literally emerged from the data, others were implicit in the narratives. Thus, although some themes are highly descriptive, others are more abstract. General themes from this study's narrative data are listed in the following section and are generally organized around the research questions although there are not well defined boundaries.

Descriptive themes have been extracted from the data to provide meaning for the experiences of nurse educators in resolution of ethical value conflicts. The list is extensive indicating the scope of the subject.

Research Question 1: What are ethical value conflicts experienced by nurse educators?

(1) Nurse educators encounter ethical value conflicts

with students. These ethical value conflicts involve truthtelling/honesty/veracity, professional responsibility, justice/fairness, harm avoidance/safety, confidentiality, beneficence, autonomy and respect for autonomy.

(2) Ethical value conflicts may be created simply by adherence to traditionally good nursing practice.

(3) Ethical value conflicts usually encompass more than one value and more than the nurse educator and student.

(4) Values of nurse educators and students may differ; many factors affect the acquisition of values.

Research Question 2: What criteria are used by nurse educators to identify a situation as a conflict in ethical values?

(1) Nurse educators identified situations as conflicts in ethical values by internal standards; inner turmoil and recognizing that something was "wrong".

(2) Nurse educators identified situations as conflicts in ethical values by external standards; patient rights and standards of nursing practice.

Research Question 3: How do nurse educators in baccalaureate nursing programs resolve ethical value conflicts? The actions described by nurse educators could be reduced in number. However, to emphasize the process,

they are listed in expanded form.

(1) Nurse educators identified a process for actions to resolve ethical value conflicts:

(a) Open-communication with student

(b) Gathering and validation of information

(c) Identification of the problem

(d) Utilization of resources

(e) Documentation - Informing appropriate persons

(f) Confrontation

(g) Counseling the student

(h) Consideration of alternatives and outcomes

(i) Support of students in decision when appropriate

(j) Reflection

Research Question 4: What factors influence resolution of ethical value conflicts by nurse educators? Factors that influenced lack of resolution also surfaced in the study and are reported here.

(1) Confronting and resolving ethical value conflicts is hard work and complex.

(a) Nurse educators struggle with scope of responsibility.

(b) It is sometimes easier to pass a student than to fail the student.

(c) Nurse educators struggle with the question of how involved can one become with a student and still

remain objective.

(2) Students come with personal problems that affect their judgments and ability to choose professional behaviors.

(a) Nurse educators not only teach nursing but also try to work with students with multiple personal problems.

(b) Clinical experiences may raise personal issues that affect students' reactions.

(3) Students have power that can be used as a positive influence or a negative, aggressive force.

(4) Nurse educators are made aware of some incidences only because they are reported by the student.

(a) Faculty must rely on personal integrity of students which may not be acted upon.

(b) Students are not willing to name other students exhibiting unethical behavior.

(5) Ethical behavior is a personal responsibility. One cannot depend on others to act ethically.

(6) Nurse educators are aware of their responsibility to model ethical behavior and to engage students in values' clarification, critical thinking, and problem solving to enhance ethical conduct.

(a) Role modeling is an important aspect of learning ethical behavior.

(b) Students are not always exposed to positive role models.

(c) Nurse educators also come with personal needs and problems.

(7) Nurse educators are aware of their responsibility to protect society from unethical practitioners.

(a) Students are expected to approach ethical standards.

(b) Students who are not meeting minimum standards should not be allowed to progress.

(8) Nurse educators use a variety of resources to assist them in resolution of ethical value conflicts.

(a) Although colleagues and immediate superiors are generally effective resources, this assumption cannot be made.

(b) Nurse educators are not necessarily given autonomy in resolving ethical value conflicts.

(c) Nurse educators develop strategies to problem solve ethical value conflicts, especially when optimal resolution has not been attained.

(d) Modes of conflict resolution are used by individuals involved in the situations.

Research Question 5: What are ethical principles that guide the action taken by nurse educators in resolution of ethical value conflicts?

(1) Nurse educators use ethical principles and ethical theories for guidance in resolving ethical value conflicts.

(a) Justice is important to students. They want to know that their completion of assignments mean something and that students who do not deserve to pass, don't pass.

(b) Fairness is important but not to the extent of compromising values.

(c) Respect for autonomy of students versus harm avoidance of clients is a value conflict, as is provision of optimal learning experiences for students versus harm avoidance of students (keeping students safe).

Research Question 6: What are inner conflicts experienced by nurse educators as a result of their actions?

(1) Inner conflicts (moral distress) are experienced by nurse educators as a result of their action.

(2) The degree of inner conflict is influenced by the severity of the conflict, the lapse of time since occurrence, and outcomes of the conflict.

Research Question 7: When do nurse educators feel they have

reached resolution of the ethical value conflict?

(1) Resolution is reached when nurse educators believe they had done all they could, ethical behavior is modeled, ethical principles are upheld, and/or outcomes are positive.

(2) Decisions of the resolution process have long-term consequences.

  (a) Affects faculty-student relationship

  (b) Impacts student performance and future behavior

  (c) Affects personhood of nurse educator

  (d) Influences agency personnel

(3) Conflict is an opportunity for growth. Nurse educators gain many insights from their experiences.

Other

(1) Utilitarian theory was used as an influencing factor in resolution of ethical value conflicts by nurse educators.

A total of 22 themes emerged for the 7 research questions. In addition to themes that emerged, a model depicting the process of resolution by nurse educators also was an outcome of the research questions.

Process of Resolution Model

The model that emerged inductively from data from the study of resolution of ethical value conflicts by nurse educators is a dynamic model. The model reflects the

complexity of the phenomenon and the continual evolution that occurs as nurse educators encounter ethical value conflicts. Concepts are defined in the context of the study and connections are inferred. Figure 1 presents a schematic drawing of the model.

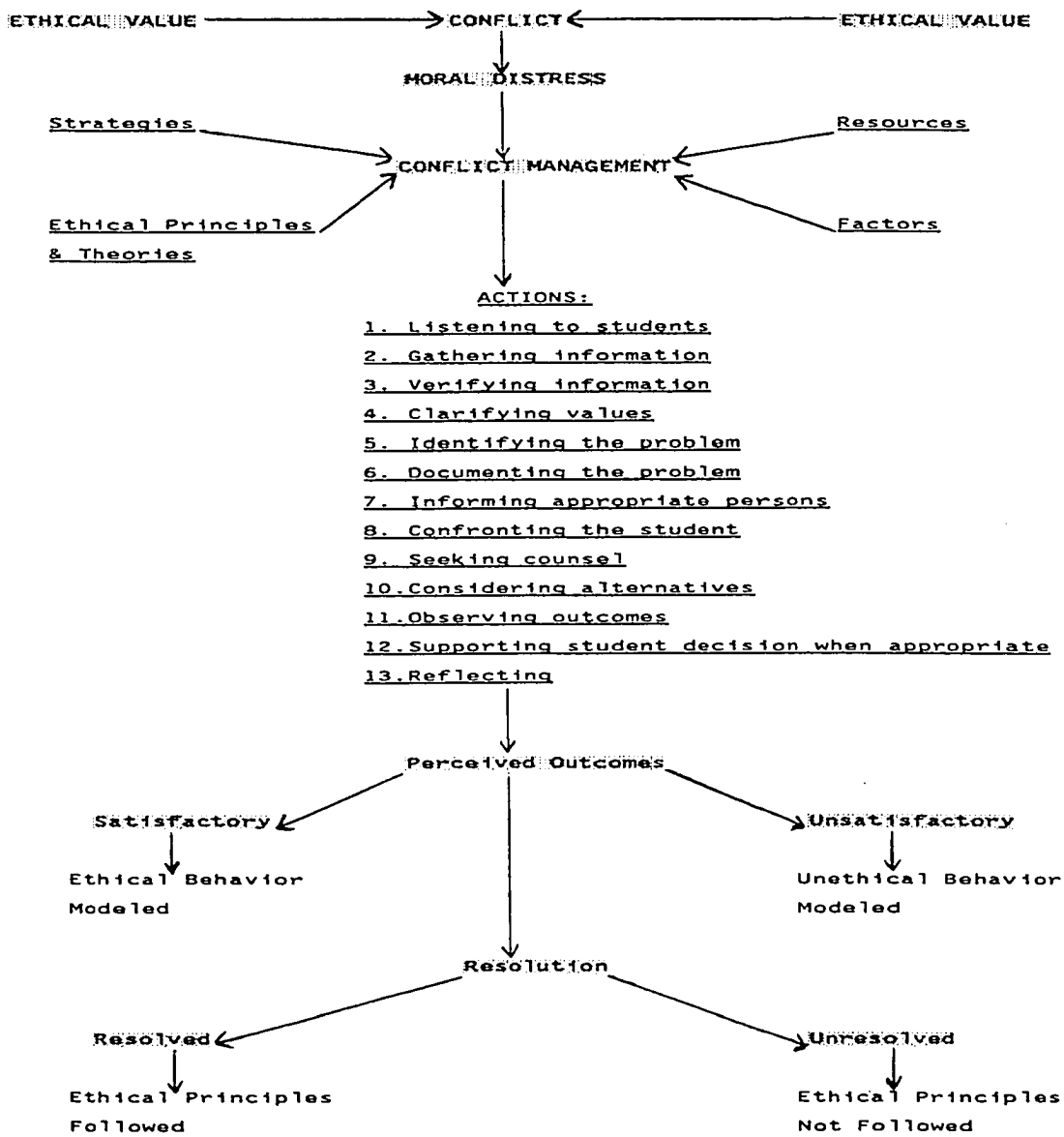
The process of resolution model is presented in a linear manner that does not depict the interaction of the individual components and the feedback that occurs during the process. Ethical values produce conflicts that are identified by a feeling of moral distress. Moral distress occurs when individuals realize that an ethical value conflict has occurred. This distress can continue throughout the process. Conflict management becomes a necessary tool in resolving ethical value conflicts. Factors, strategies, resources, and ethical principles and theories influence conflict management.

Factors that assisted nurse educators in determining the action to take were use of self, colleagues, immediate supervisors, fellow colleagues, and guidelines and standards. In addition, concern for safety and professional responsibility, considering alternatives, and considering student outcomes were also deciding factors.

Although nurse educators experienced difficulty in identifying strategies used in conflict management, professional and personal power, clarification,

Figure 1

A Process of Resolution of Ethical Value Conflicts by Nurse Educators



interpretation, and discussion and conflict resolution modes were utilized in the process.

In addition, nurse educators used past experiences, research, faculty colleagues, clinical agency personnel,superiors, written policies, formal processes, legal and spiritual counsel, and standards for nursing practice as resources in the process.

Ethical principles and theories were used to guide resolution of ethical value conflicts by nurse educators. Principles used by nurses were justice, beneficence, nonmaleficence, autonomy, veracity, and respect for autonomy. Utilitarian theory was also used by nurse educators to guide resolution of ethical value conflicts.

Nurse educators identified a process of actions for the resolution of ethical value conflicts. The model depicts these actions and the connection between conflict management and outcomes. Outcomes were either satisfactory or unsatisfactory. Satisfactory outcomes were dependent upon student, faculty and client responses and resulted in positive role modeling. In the 4 situations where unsatisfactory outcomes resulted, 3 were dependent upon decisions by superiors and resulted in unethical role modeling. Both satisfactory and unsatisfactory outcomes led to personal growth and problem solving by nurse educators.

Nurse educators felt they had reached resolution when

they had done all they could, had role modeled ethical behavior, ethical principles were upheld, and/or outcomes were positive.

As stated by Booth (1982), conflict is always present and there is great urgency pervading institutions to seek modes of resolution in an exceedingly complex society, diffused with stress. Study results suggest a process of resolution for nurse educators. Moreover, although ethical behavior is considered imperative in the practice profession of nursing, continuing the ethical battle may exact a high price.

Summary

In this chapter the results of the analysis and interpretation of data collected to describe the experience of nurse educators in identifying and resolving ethical value conflicts were reported. Data were organized around each research question. Since additional responses were solicited regarding outcomes, responses were organized under appropriate headings. The process of resolution model that has emerged from this study has been discussed and portrayed in a schematic drawing. In many instances this study's findings that were supported by narrative statements have not been documented by any research or have not been reported in previous research studies. At other times results from the study either concurred with or did not

support earlier research. Chapter V will focus on discussion of results that emerged from this study. These results will be reported with references to literature sources. Results that have not been previously based on research will also be noted. Conclusions, recommendations for nursing and future research, and limitations of the study will also be detailed in Chapter V.

CHAPTER V

Discussion, Conclusions, Recommendations, and Limitations

This study described the experiences of nurse educators in the context of identifying ethical value conflicts and the process of resolving them. The specific research questions were: (a) What are ethical value conflicts experienced by nurse educators? (b) What criteria are used by nurse educators to identify a situation as a conflict in ethical values? (c) How do nurse educators in baccalaureate nursing programs resolve ethical value conflicts? (d) What factors influence resolution of ethical value conflicts by nurse educators? (e) What are ethical principles that guide the action taken by nurse educators in resolution of ethical value conflicts? (f) What are inner conflicts experienced by nurse educators as a result of their action? and (g) When do nurse educators feel they have reached resolution of the ethical value conflict?

Any study of health care ethics involves individuals, each one bringing to the situation a preconceived set of values. With all of these values influencing nurse educators, resolution of ethical value conflicts may seem an insurmountable task. The investigator tried to be very

aware of her own likes, dislikes and prejudices as she related to participants. She was impressed with the openness, honesty and eagerness with which participants shared deeply moving accounts of their experiences. Nine of the participants in the study were strangers to the investigator so the rich data that resulted was related to a variety of factors in the interviewing process. There was an element of trust that prevailed each interview allowing participants to share sensitive information with the investigator. This was both humbling and rewarding for the investigator. The participants shared from their souls, through tears, evidences of anger, frustration, disgust, and disappointment with voice inflections and body language. They openly expressed their struggles with personal failures or errors in judgment. They seemed eager to tell their story and perceived the investigator as a nonjudgmental listener, fellow colleague, and a legitimate source to divulge confidential information. They were interested in talking about their experiences with the hope that it would make a difference. In the typed interviews, several of the participants expressed concern about their speaking style, for example, sentence fragments, and extra words. They were concerned that the written document would be a reflection on their intelligence.

The participants were very encouraging throughout the

process by sending notes, extra information and expressing general interest. The investigator sensed at times that the participants were interested in receiving answers from her. On rare occasions, this was done only after the interview was completed. The investigator tried to be supportive of the turmoil participants were experiencing as they relayed their stories.

The investigator attempted to conduct each interview in the same manner. There were some variations in order of question dependent upon participant responses. For some participants the incidence was not initially perceived as ethical, but they were excited to discover that the situation was indeed ethical in nature and they had actually responded in an ethical manner. Some of the participants seemed to consider it a privilege to have been chosen to be interviewed recognizing that ethical issues are important, while others were willing to support research efforts by the investigator. All of the participants invested a great deal of effort into answering the questions and assisting the investigator in collecting complete data. The concepts that were discussed were complex and difficult to articulate verbally.

Initially ethical concepts which emerged from the data are discussed with references to literature sources. Discussion of further findings are organized around the

general themes that are highlighted with bold print with subthemes in italics. References are made to literature sources when available with emphasis on previously unsupported findings.

Ethics/Nursing Ethics

Nursing ethics are defined by Flaherty (1982) as "beliefs about moral values, ideals, virtues, obligations, and principles identified by nurses as important" (p. 176). This definition was indeed supported by the study and serves as the guiding standard in the study. Participants were aware of the standard of moral behavior in a practice profession such as nursing. They did not view the incidences in the "oughts" and "shoulds" as isolated cases but as indicative of underlying behavior that translated into practice. As one participant stated, "Perhaps cheating on an exam would not be as significant in an English class, but what will happen behind closed doors in a hospital room if a wrong medication is given?"

Ethical Values

Ethical values have been defined by Scalzi and Nazarey (1989, p. 589) as internal standards for guiding action. Hogan and Dickstein (1971) described values as moral when used as criteria for choosing rules for professional conduct. In this dissertation, nurse educators had internalized values and used them to guide conduct. As one

participant stated, her values may not be written in stone but she had a standard of professional conduct that she lived by and she did not expect her values would undergo significant change. Participants in the study were also very conscious of their responsibility to protect and promote human welfare, which Beauchamp and Childress (1989, p. 17), use as one criterion for identifying values as moral. Ethical values that nurse educators identified as in conflict paralleled very closely the ethical values found in a study of medical and law students (Rezler et al., 1990): (a) autonomy; (b) beneficence; (c) confidentiality; (d) harm avoidance; (e)justice/fairness; (f) truthtelling/veracity; and (g) professional responsibility. Although integrity is considered the primary virtue and not an ethical value, participants mentioned integrity as basic to ethical behavior and it was generally connected with truth telling and veracity. Beauchamp and Childress (1994) define moral integrity as "soundness, reliability, wholeness, and integration of moral character" (p. 471).

Nurse educators also used the ethical theory of utility as a factor influencing the action to take. Utilitarian theory is defined by Beauchamp and Childress (1994) as a consequence-based theory. This is explained further as, "the right act in any circumstance is the one that produces the best overall result" (p.47).

Ethical Principles

Ethical principles guiding behaviors of nurse educators in this dissertation were identified as justice, beneficence, nonmaleficence, autonomy, and veracity and parallelled those identified by Christensen (1988). In addition, respect for autonomy as defined by Beauchamp and Childress (1994, p. 38) was also used by participants in the study.

Ethical Value Conflict

Scalzi and Nazarey (1989, p. 589) state that an ethical value conflict occurs when there is a disagreement over what is "right" to do. Nurse educators in recognizing their responsibility to the student and to society experienced these disagreements. Although ethical value conflicts between nurse educators and students involved interpersonal issues, intrapersonal, intragroup and intergroup interactions (Cushnie, 1988) were also significant, especially in relationship to outcomes of the resolution process.

Moral Reasoning

Level of moral reasoning was not measured in this study. However, as earlier research (Ketefian, 1981; Munhall, 1980; & Ravella, 1985) indicated, level of moral reasoning and level of education are positively related. Therefore, one would expect deans and directors of nursing

programs to use at least comparable or perhaps higher levels of moral reasoning than nurse educators since deans and directors of BSN nursing programs would likely be doctorally prepared. In at least two situations in this dissertation, nurse educators performed at a higher level of moral reasoning than their superiors. This finding supports a concern voiced by Ketefian (1987) as to congruence between level of moral reasoning and moral action. Because of the incongruence between level of moral reasoning and behavior, moral reasoning is not included in the model as an influencing factor in resolution of ethical value conflicts.

Conflict Resolution

In addition to interpersonal, intrapersonal, intragroup and intergroup issues, resolution of ethical value conflicts was affected profoundly by administrative support and peer role modeling. Participants used conflict resolution strategies such as collaboration, compromise, avoidance, accommodation and competition. In approaching situations, nurse educators reflected on the questions raised by Curtin (1982), "How can I find an answer that will allow me to be at peace with myself? and How can I find an answer that will allow me to be at peace with others" (p. 43)? Unfortunately, in some situations, peace would not be an outcome. Most of the participants experienced internal and/or external conflict as a result of the action.

Themes

As Booth (1982) believed that conflict permeates all types of relationships including academia and Ravella (1985) found, the study also showed that **nurse educators do encounter ethical value conflict with students.** In some instances, *ethical value conflicts may be created simply by adhering to traditionally good nursing practice.* Although earlier research (Theis, 1988; Zablow, 1985) reported confusion in identifying value conflicts as ethical, nurse educators were able to identify situations as ethical. In some instances nurse educators had labeled the ethical value by a term used in their particular area of expertise. Ethical values that were represented in the study were similar to those measured in a study conducted by Rezler et al. (1990): (a) autonomy; (b) beneficence; (c) confidentiality; (d) harm avoidance; (e) justice; (f) professional responsibility; and (g) truthtelling. Fairness was included with justice; honesty and veracity were included with truthtelling; and respect for autonomy was included with autonomy. Benevolence, integrity and caring were also mentioned as values, but are generally perceived as virtues rather than values. The investigator also found a strong connection between ethical values and ethical principles with only minor differences emerging.

Cushnie (1991) cited four sources of value conflicts:

(a) intragroup, (b) intergroup, (c) intrapersonal and (d) interpersonal. Although the interpersonal element was present in all of the conflicts in the study, intrapersonal, intragroup and intergroup sources were also present. *Ethical values usually encompass more than one value and more than the nurse educator and student.* Nurse educators occupy a pivotal role in educating and supervising students in the clinical and classroom areas as suggested by Darling and Cornesky (1987).

Although Williams, Bloch and Blair (1978) and Thurston, Flood Shupe and Gerald (1989) found that students and faculty were more alike in values than different, the study showed that *values of nurse educators and students may differ.* According to Silva (1990, p.88), difficulties in resolution can result from uncertainty over whose values should take precedence. Findings from this study supported the previous statement but generally did not support the following statement by Scalzi and Nazarey (1989): Resolution of value conflicts does not require one value winning over another, but rather an appreciation and understanding of value differences and a willingness to develop shared goals.

Nurse educators had difficulty identifying criteria used in determining that a situation was a conflict in ethical values. However, they were able to describe how

they recognized the situation as an ethical value conflict. **Nurse educators identified situations as conflicts in ethical values by inner turmoil, recognizing that something was "wrong", patient rights, and standards of care.** The emotional response concurs with similar findings from a study done by Carpenter (1991) where clinicians experienced varied emotions when the awareness of the incident occurred. Recognizing that something is "wrong", patient rights and standards of care were not explicitly stated in the literature as criteria for identifying a situation as ethical.

As Wright (1987, p. 7) stated, values influenced ethical decisions by framing the problem, supplying alternatives and directing reasoning. This was found to be true in this study as **nurse educators identified a process for actions to resolve ethical value conflicts.** Actions from the study were comparative with Barton's (1991) description of the conflict resolution process:
(a) perception that a frustration has occurred;
(b) conceptualization - defining the conflict issue and considering alternatives and outcomes; (c) selecting the resolution strategy; and (e) identifying short-term and long-term goals. Although a study conducted by Carpenter (1991) explored ethical decision making and used events with a negative impact on the clinician's practice, many of the

resulting actions were supported in the findings of this study: (a) identifying the problem; (b) validating information; (c) considering alternatives and outcomes; (d) choosing options and acting on choice; and (e) reflecting. However, the process that has emerged from this study is more complete: (a) listening to students; (b) gathering and verifying information; (c) clarifying values; (d) identifying the problem; (e) documenting the problem; (f) informing appropriate persons; (g) confronting the student; (h) seeking counsel; (i) considering alternatives; (j) observing outcomes; (k) supporting student in the decision if appropriate; and (l) reflecting.

Furthermore, Cushnie (1988) identified value conflicts as the most complex type of conflict requiring a high level of motivation from the persons involved to solve. Indeed, nurse educators found that **confronting and resolving ethical value conflicts is hard work and complex.** Although this theme is implicit in some of the research studies (Carpenter, 1991), it was explicit in this study. In addition, *nurse educators struggle with the scope of their responsibility, nurse educators find it is easier to pass a student than to fail them, and nurse educators struggle with the question of how involved can one become with a student and still remain objective.* In reflecting on level of involvement with students, this question is perhaps related

to the clinical study conducted by Riley (1991) where she found nurse leaders used justice and care voices when responding to conflict, reflecting the balance between justice and care. The process of resolution of ethical value conflicts is further complicated because *students come with personal problems that affect their judgments and ability to choose professional behaviors.* Choices that students make may be determined by whether they are accommodating reasoners, who based their behaviors on conformity to the perceived norm of their group; or sovereign, who made judgments based upon self-chosen and valued principles, as identified by Omery (1985). Subthemes; *nurse educators not only teach nursing but also try to work with students with multiple personal problems* may raise issues that affect student reactions to ethical situations contributing to the complexity of the resolution process. These factors seem to be known in academia but are supported in this study based on data.

Nurse educators are made aware of some incidences only because they are reported by the student. *Nurse educators must rely on the personal integrity of the student which may not be forthcoming.* Although, Thurston, Flood, Shupe and Gerald (1989) found that students chose responsibility, honesty, love and forgiveness as their top values, the investigator found that dishonest behavior by students

occurred at the greatest frequency, concurring with results of a study done by Hilbert (1988). In addition, the ethical value, professional responsibility, occurred at the second highest frequency. These findings suggest that there is a substantial difference between ideal and lived responses of subjects as verified in studies conducted by Ketefian (1987), Moore (1991), and Smith, McQuire, Abbott and Blau (1991). Furthermore, because *students are not willing to name other students exhibiting unethical behavior,* this omission causes real concern. Many times students do not realize that **they have power that can be used as a positive influence or a negative, aggressive influence.** Although there are many studies measuring values over time, comparing values between groups, and identifying values, there are few studies that identify the frequency of nonreporting of unethical behavior by peers.

The nonreporting of unethical behavior by students may be related to an ethic of care described by Beauchamp and Childress (1994, p. 85) where the relational component is the basis for action. However, with the emphasis on caring as a central core in nursing, one would expect caring to emerge as a major theme among nurse educators. References to caring, such as willingness to act on behalf of a person, was implicit in some ethical value conflicts related to harm avoidance. However, the ethic of caring was not explicit in

the results of this study. Ironically, in the situation where the personhood of the nurse educator study participant was almost destroyed, the nursing curriculum was based on a theory of caring. Hence the connection between theory and practice remains in question.

In continuing to explore ethical behavior, Curtin (1982) posed two questions: "How can I find an answer that will allow me to be at peace with myself? and How can I find an answer that will allow me to be at peace with others" (p. 43)? Her first question especially supports the theme, **ethical behavior is a personal responsibility,** while her second question supports the remainder of the theme; **One cannot depend on others to act ethically.** Although moral integrity is a desired virtue, this study showed that one cannot assume that moral integrity is an integral part of nurse educators, nursing students, or nursing administrators' behaviors.

Also in relation to ethical behavior, Banja (1991) stated that when nursing faculty act more strongly as moral agents, students may perceive themselves as more clinically responsible individuals, capable of ensuring moral propriety of their own and their colleagues' behavior. Certainly the converse is true, that when nursing faculty do not act strongly as moral agents, students may not perceive themselves as clinically responsible. However, as the study

showed, many factors other than moral behavior of faculty affect moral conduct of students.

Although modes of conflict resolution were not explicitly differentiated in the study, they were implied in the process. *Modes of conflict resolution are used by individuals involved in the situations.* Since all the participants were female and were not separated according to ages or administrative roles, results from studies (Holt, 1986 & Cavanaugh, 1991) using sex, age and role as variables were not considered. However in terms of success, findings from this study concur with Bartol (1972) and Marriner (1982) that compromise and collaboration were most successful and avoidance and competition least successful in resolving conflict. Because of the influence of conflict-handling modes by the individual, the environment in which the person works (Barton, 1991), superiors and the politics within the institution (Camunas, 1991), *nurse educators were not always able to take the preferred action. Critical factors in preventing the preferred action from occurring was lack of respect for the nurse educator's judgment and lack of support from superiors.* This further supports findings by Carpenter (1991) where participants experienced feeling powerlessness, especially in relationship to environmental constraints, and viewed lack of influence as an obstacle in seeing their first choices through to

completion. However, decisions of superiors as an obstacle, was not specifically mentioned. Again, *nurse educators were not necessarily given autonomy in resolving value conflicts, as proposed by* Felton and Parsons (1987). Conversely, when nurse educators felt support and respect from their immediate superiors, they experienced autonomy in conflict resolution and satisfaction in the outcomes. Furthermore, *although colleagues and immediate superiors are generally effective resources, this assumption cannot be made.* In fact, in considering the participants who mentioned trial and error as a means of learning ethical behavior, one wonders how many errors are made before ethical behavior results.

Nurse educators are aware of their role to model ethical behavior and to engage students in values' clarification, critical thinking and problem solving to enhance ethical conduct. Nurse educators truly struggled with the sometimes turbulent waters of ethical conduct to set professional standards as ideals for students to attain. This concurs with Fowler (1987, p. 25) who stated that through ethical thinking, professional standards are set. Supporting this theme, Callahan (1982) emphasized the importance of role modeling by faculty in teaching ethical principles. Furthermore, Omery (1985), Carpenter (1991) and Megel (1993) found that nurses were cognizant of their

ethical responsibilities. Thompson and Thompson (1981, p. 3) also recognized that an awareness of one's values and moral position does not necessarily translate into practice. However, values' clarification was used by nurse educators in a very beneficial way to assist students in determining which value should take precedence.

Moreover, findings from a study done by Christensen (1988), where nursing service executives used principles of respect for persons, beneficence, fidelity, and justice when making ethical decisions, can be generalized to nurse educators. Implied in the identified principles is professional responsibility, concurring with the theme, **nurse educators are aware of their responsibility to protect society from unethical practitioners.** Furthermore, Ketefian (1987) believed that it is paramount for nurses to practice morally. Teaching students ethical behavior is especially important in view of findings from a study done by Smith, McQuire, Abbott and Blau (1991). They found that although practitioners evaluated what should be done based on ethical guidelines, they were not always willing to implement the ideal.

In considering actions, **nurse educators use a variety of resources to assist them in resolution of ethical value conflicts.** Findings from the study supported resources identified by Aroskar (1989) and Camunas (1991):

(a) personal values; (b) professional colleagues, friends, and family; (c) religious values; (d) life experiences; and (e) professional codes. Nurse educators also used written policies, legal counsel, and research as resources.

Actions are also guided by ethical principles. **Nurse educators use ethical principles and ethical theories for guidance in resolving ethical value conflicts.** Guiding ethical principles were identified as autonomy, beneficence, harm avoidance, justice, and veracity as defined by Fromer (1980) and Perlin (1992). Respect for autonomy (Beauchamp & Childress, 1994 p. 38) was also used in this study. This finding supports results from studies by Christensen (1988) where beneficence, fidelity, and justice were used; Miya, Boardman, Harr and Keene (1991) where beneficence-nonmaleficence were used; and Megel and Elrod (1993) where confidentiality, fairness, truthtelling, and autonomy were used. Subthemes that emerged from the general theme were *justice is important to students. They want to know that completion of assignments mean something and that students who do not deserve to pass, do not pass; fairness is important but not to the extent of compromising values; and respect for autonomy of students versus harm avoidance of clients is a major issue, as is provision of optimal learning experiences for students versus harm avoidance of students.* These subthemes did not seem to be documented in

previous research studies.

Inner conflicts (moral distress) are also experienced by nurse educators as a result of their action. Results from this study concur with a statement made by Kielinen (1978), that anxiety is a particular kind of cost from any state of conflict. This study further supports findings from Fenton (1988) where moral distress may occur by being involved in an ethical issue and from Cahn (1987) where moral distress was experienced by nurses in the clinical area between knowing the right thing to do but being unable to do it because of institutional constraints. Furthermore, Lutsen and Nordin (1993) reported that inner conflict was created when professional responsibility to follow rules was different from the moral commitment to care about the patient. Results from a study done by Carpenter (1991) concurred with all of the studies mentioned. Although these studies were conducted using nurses in the clinical setting, nurse educator experiences were similar.

Cushnie (1988) believed that trust, commitment and communication were necessary components for resolving conflict, with communication as the key component. Kielinen (1978), however, said that real conflicts exist that cannot be communicated away and Haw (1980) further stated that it is a myth to believe that extended dialogue will eventually lead to effective resolution of conflicts.

The following themes, **resolution is reached when nurse educators believe they had done all they could, have modeled ethical behavior, and/or outcomes are positive** and **decisions of the resolution process have long-term consequences,** support the previous statements and further concur with findings from studies done by Fenton (1988) and Carpenter (1991), who found that personal and professional wholeness may be significantly compromised by ineffective resolution of the issue. Furthermore, although Leininger (1978) seemed to imply that it is in yielding professional values and ethics that serious consequences result, this study in fact supported the opposite. The most dramatic consequences resulted from the nurse educator remaining true to ethical and professional values. In addition, *impact on student performance and future ethical behavior* has not been addressed in previous research.

Although conflict resolution can bring about serious consequences, **conflict can be an opportunity for growth. Nurse educators gain many insights from their experiences.** Results from this study support the statement that conflict is inevitable so it is imperative that nurse educators recognize and understand this complex phenomenon and become familiar with varying techniques to resolve conflict (Booth, 1982). Furthermore, the learning and growth that takes place not only contributes to increased recognition of

ethical value conflicts but provides guidance for resolving these conflicts.

In addition to the themes that emerged from the study, the qualitative approach suggested by Cassidy (1991) as an appropriate method of exploring ethical responsibilities was indeed accurate for this study. The qualitative design allowed for clarification by participants and freedom in responses. The value of this approach concurs with findings from a study conducted by Carpenter (1991) where she found that talking with others served to clarify the issue in most cases and allowed for reconsideration. Moreover, at the time of the interviews, participants spoke of emotions they still felt as they talked about the incident. Hence, the interview process provided the opportunity for increased awareness, exploration, and introspection of ethical practice and assisted in resolution. In addition, the interview process provided the participant to follow the criteria set forth by Curtin (1988) to resolve value conflicts: identifying values and commitments clearly, setting priorities logically, and subjecting professional choices to critical analysis.

Conclusions

The study showed that ethical matters are important to nurse educators. They do not take their role as an educator lightly but struggle with ethical matters and are very

cognizant of their responsibility. Nurse educators found that ethical value conflicts were inherent in interactions with students, were multifactorial in nature, and were created at times simply by adherence to good nursing practice. Furthermore, nurse educators were able to identify values as ethical.

Moreover, nurse educators found that confronting and resolving ethical value conflicts was hard work and complex. Many times the conflict encompassed more than the student and nurse educator. Environment, politics, and institutional constraints are some external factors that affect the process and outcomes. Nurse educators also found that students had power that was used as a positive influence or as a negative, aggressive force.

In addition, nurse educators used a variety of strategies and ethical principles to guide them in resolving ethical value conflicts. These were learned over time and were implemented in varying degrees and at different times. Nurse educators found that justice was important to students and respect for autonomy of students versus harm avoidance of clients was a major issue. Closely paralleling this issue was concern for provision of optimal learning experiences versus harm avoidance of students.

In addition, nurse educators experience emotional reactions to ethical value conflicts. These occurred at the

onset, during the conflict, and even after the conflict has been resolved. Intensity of reactions in the aftermath seem to be directly related to the perception of overall outcome of the resolution process, with lack of support from colleagues and administrators as a critical factor in causing negative outcomes. Lack of respect for the nurse educator's judgment and autonomy led to serious repercussions. One nurse educator's personhood was severely compromised. In contrast, when the nurse educator had support from other colleagues and administrators, the outcome was generally positive.

Resolution was reached in the ethical value conflicts when nurse educators believed they had done all they could, had acted in an ethical manner, ethical principles had been followed and/or outcomes are positive. Conversely, when outcomes were negative and ethical principles had not been followed, resolution was not reached. Decisions of the resolution process had long-term consequences for students. Thus, students' behavior were affected by their choices and they were exposed to either ethical or unethical modeling.

Nurse educators gained many insights as a result of resolving ethical value conflicts. These insights can be used when encountering future ethical value conflicts, therefore minimizing the learning that takes place by trial and error. They evaluated their own reactions and reflected

on what they could have done differently. They also looked for additional resources and alternative actions.

In addition, the qualitative design of the study encouraged participants to describe the resolution of ethical value conflicts in the context of academia. The interview process allowed for exploration of many facets of the process and assisted nurse educators in further introspection and resolution of their own feelings.

The model that emerged from the study is suitable for guiding the process of resolution of ethical value conflicts for nurse educators. It is a dynamic, evolutionary model with the components of the concepts continually in motion with interactions dependent upon the players involved in the ethical value conflict.

Recommendations for Nursing

The literature lacks substantive data on resolution of actual ethical value conflicts experienced by nurses. Due to the pivotal role of nurse educators, it is important that they have at least a beginning understanding of the phenomenon. The study conducted by this investigator contributes to both nursing education and ethical literature. Based on what is known about the lived experience of nurse educators in resolution of ethical value conflicts the following recommendations are proposed.

To better prepare nurse educators for ethical

encounters within the profession, an increased awareness of the hard decisions that they will face in confronting value differences is paramount. It is unfortunate that much of the learning comes from trial and error. Provision for understanding and exploration through simulated experiential learning interactions should be available. Nurse educators also need resources, especially colleagues, who will challenge them to model ethical behavior. In addition, they need the opportunity to "tell their stories." Students also should be exposed to more role-play of common ethical problems in nursing to facilitate preparation for ethical conduct. Continued accountability for student behavior is imperative. Nurse educators must be prepared to protect society from unsafe practitioners.

Nursing administrators should also be aware of the power they possess in managing conflict situations. Nursing is noted as a caring profession and nurse administrators should implement ways to model caring with faculty. Faculty autonomy should be respected and ethical behavior should be reenforced. Likewise, faculty should be supportive of each other. Nurse educators who are seeking positions in academia would do well to learn about the ethical environment and culture of the nursing school and the institution before making a decision regarding employment.

Nurse educators and nurse administrators also need to

use introspection to evaluate their conflict management styles to develop modes that produce successful outcomes. They need to be aware of the ramifications of actions and recognize that long-term positive and negative consequences can result. They also need to be cognizant of student coercion and not allow themselves to become a pawn in a game of politics and power.

For the ethicist, further insight into the area of ethical value conflict is available. The model provides a process for resolution of ethical value conflicts showing the relationship of various components of the process.

Recommendations for Future Research

This study was conducted with nurse educators in NLN baccalaureate programs in the Mid Atlantic region of the United States and could be replicated to include other programs across the nation. This study explored perceptions of nurse educators and also could be replicated using nurse administers and other individuals, rather than students.

Although the study implicitly explored moral reasoning and modes of conflict resolution, a comparison of levels of moral reasoning with modes of conflict resolution could provide additional insights into the conflict resolution process. The population for such a study could include nurse administrators, nurse educators, and students with comparison between groups.

Another study which could provide significant data would be the exploration of ethical behavior by nursing students and/or practitioners where the frequency of observing unethical behavior would be explored. This could then be compared with the frequency that the behavior is reported. Reasons why unethical behavior is not reported could also be a part of the study. Another variable that may influence frequency of reporting unethical behavior is personal power. A study exploring perceived power of nursing students and practitioners could provide significant results.

Additional areas of study could be a comparison of held values and lived values or a longitudinal study comparing student behaviors with practitioner behaviors. Because of the importance of exposing students to facets of ethical behavior, a study investigating the most effective learning tools and environment would result in significant contributions to teaching ethical behavior.

Due to the low response of PHASE I returns in this study, an investigation of what types of research potential subjects respond to, would provide important methodological data for researchers. Researchers could then use the results in developing tools that are user friendly.

Finally, the resolution model that emerged from the study is in its infancy and needs further investigation. It

is recommended that the connections between concepts be explored.

Limitations

The investigation has several limitations: (a) The study is retrospective in nature so subjects may have experienced distortion of memory, however, many of them referred to documentation to refresh their memory; (b) respondents may have chosen to give only positive experiences, however, the researcher chose persons with less positive experiences; (c) the researcher may have shown bias in the interviewing process and in interpreting data; and (d) respondents may not have responded with honesty.

Summary

Nurse educators are involved in the resolution of ethical value conflicts. This study systematically explored and described the experiences of 14 female nurse educators in identification of ethical value conflicts and the process of resolution. Twenty-two general themes emerged from the data. In addition a process of resolution of ethical value conflicts by nurse educators, based on concepts defined in literature and redefined in the academic setting with additional components emerging from the data, was depicted. The design of this study was qualitative. A purposeful sample was selected from the population of nurse educators from NLN baccalaureate nursing programs in the Mid Atlantic

region of the United States. The study used semi-structured interviews conducted by the investigator. Each interview was between 20 and 90 minutes in length. Data analysis was guided by a revised method of thematic content analysis outlined by Burnard (1991). Due to the qualitative design of the study, nurse educators were able to relate experiences and express their perceptions in a familiar context. Therefore, data resulted in findings which were not based on previous research. The subject is one of grave importance, not only because of the influence of nurse educators upon students, but also because of the affects of unethical behavior in a practice profession such as nursing. Therefore, the study has made a significant contribution to nursing knowledge in general and to research in nursing ethics in particular.

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Appendices

Appendix A

PHASE I (Part 1)

Demographic or Informational Questionnaire

Please circle, check or insert the appropriate responses.

1. Age: _____

2. Gender:
   a. Female
   b. Male

3. Marital Status:
   a. Single
   b. Married
   c. Divorced
   d. Widowed

4. Highest degree:
   a. MSN
   b. DNSc
   c. PhD
   d. EdD
   e. Other (Specify)
   _____

5. Undergraduate Degree: (Circle all that apply)
   a. Diploma in Nursing
   b. AD in Nursing
   c. BSN
   d. Other (Specify)
   _____
   _____

6. Area of Specialization: (Circle all that apply)
   a. Maternal
   b. Child
   c. Adult
   d. Community
   e. Education
   f. Clinician
   g. Practitioner
   h. Administration
   i. Other (Specify)

7. Number of years you have taught in the classroom: _____

8. Level of students you have taught in the past two years in the classroom: (Circle all that apply)
   a. Freshman
   b. Sophomore
   c. Junior
   d. Senior

9. Number of years you have taught in the clinical setting: _____

10. Level of students you have taught in the past two years in clinical: (Circle all that apply)
    a. Freshman
    b. Sophomore
    c. Junior
    d. Senior

Thank you for completing this questionnaire. Please continue with PHASE I (Part 2).

NOTE: There were additional questions on the questionnaire that provided data that is not included in this dissertation.

Appendix B

PHASE I (Part 2)

Please identify up to three situations regarding students' behavior in the past two years related to classroom or clinical teaching where you have experienced a conflict in your ethical values. Describe, in concise statements or phrases, the interaction (directly with a student) in which you perceived an ethical conflict occurred and the outcome. Please write clearly and use only the spaces provided.

1. Check one: Classroom ____ Clinical ____ Code _____

2. Check one: Classroom ____ Clinical ____ Code _____

3. Check one: Classroom ____ Clinical ____ Code _____

Appendix C

PHASE II

Guide for Questions for Interview Based on Research Questions

1. What are ethical value conflicts that nurse educators experience?

   a. Briefly describe the incident (described in Appendix A, part 2) that has occurred within the past two years where you experienced an ethical conflict in values in your role as an educator with a student.

   b. What ethical values were in conflict?

2. What criteria did you use to identify the situation as a conflict in ethical values?

3. How do nurse educators in baccalaureate nursing programs resolve ethical value conflicts?

   a. What was your action to resolve the ethical value conflict?

   b. What strategies did you use?

4. What factors influence resolution of ethical value conflicts for you?

   a. How did you determine the action to take?

   b. How does this action compare with actions taken in the past?

   c. Were you satisfied with your action?

      1) If yes, why?

      2) If no, why not and what would you have done differently?

      3) What prevented you from taking the preferred action?

4) What resources did you use to assist you in taking the desired action?

5. What are ethical principles guiding the action taken?

a. What, if any, ethical principles did you use in the action taken?

b. How have you learned to use these ethical principles?

6. Did you experience any inner conflicts as a result of your action?

a. If yes, would you describe the inner conflicts please?

b. With whom or what did you have the inner conflict? Why?

7. Do you feel you have reached resolution of the conflict?

a. If yes, describe how this resolution occurred within yourself.

b. If no, describe why you felt unable to resolve the situation.

c. What insights have you gained from this conflict resolution to assist in resolving future conflicts?

Appendix D

Comparison of Research Questions and Interview Questions

Research Question	Interview Question
1. What are ethical value conflicts experienced by nurse educators?	PHASE I (Appendix A) Please identify up to three situations regarding students' behavior in the past two years related to classroom or clinical teaching where you have experienced a conflict in your ethical values. 1. a. Briefly describe the incident. 1. b. What ethical values were in conflict?
2. What criteria are used by nurse educators to identify a situation as a conflict in ethical values?	2. What criteria did you use to to identify a situation as a conflict in ethical values?
3. How do nurse educators in BSN programs resolve ethical value conflicts?	3. a. What was your action to resolve the ethical value conflict? 3. b. What strategies did you use?
4. What factors influence resolution of ethical conflicts by nurse educators?	4. a. How did you determine the action to take? 4. b. How does this action compare with actions taken in the past? 4. c. Were you satisfied with your action? 4. c. 1. If yes, why?

Research Question	Interview Question
	4. c. 2. If no, why not and what would you have done differently?
	4. c. 3. What prevented you from taking the preferred action?
	4. c. 4. What resources did you use to assist you in taking the desired action?
5. What are ethical principles that guide the action taken by nurse educators in the resolution of ethical value conflicts?	5. a. What, if any ethical principles did you use in the action taken?
	5. b. How have you learned to use these ethical principles?
6. What are inner conflict experienced nurse educators as a result of their action?	6. Did you experience any inner conflicts as a result of your by action?
	6. a. If yes, would you describe the inner conflict please?
	6. b. If yes, with whom or what did you have the inner conflict? Why?
7. When do nurse educators feel they reached resolution of the ethical value conflict?	7. Do you feel you have reached resolution of the conflict?
	7. a. If yes, describe how this resolution occurred within yourself.
	7. b. If no, describe why you felt unable to resolve the situation.
	7. c. What insights have you gained from this conflict resolution to assist in resolving future conflicts?

Appendix E

Informed Consent Form

I am Carolyn Z. Lyndaker, a doctoral candidate at George Mason University. The chairperson of my dissertation committee is Dr. Mary Silva. I am seeking faculty participation in my dissertation. The purpose of my research is to identify the process nurse educators use in resolving ethical value conflicts in their interactions with students. Your dean has granted permission for you to participate in the study.

Criteria:

To participate in this study you must:

a. have a minimum of a master's degree in nursing;
b. currently teach in a baccalaureate nursing program
c. have been involved directly with nursing students in a classroom or clinical area within the past two years; and
d. have experienced an ethical value conflict professionally with nursing students within the past two years.

Procedure:

If you meet the requirements and agree to participate, you will need to answer the enclosed demographic form and questionnaire (PHASE I) and return it to me in the stamped enclosed envelope by no later than **MARCH 25, 1994**. The demographic form and questionnaire that asks you to identify ethical value conflicts you have experienced in clinical or classroom situations, should take no longer than 30 minutes to complete.

Faculty who have identified ethical value conflicts will be purposely selected to provide a full array of multiple experiences and may be contacted for further follow up interviews (PHASE II). If you consent, the interview will be scheduled at your convenience and will take place at your school. The interview will take approximately 60 minutes to complete and will be audiotaped using a portable tape player and cassette tapes. You will be given the opportunity to read the transcribed interview and comment on it. Tapes will be kept in a locked compartment with access by the researcher only and will be erased when no longer needed for research purposes. In addition, all information will be kept strictly confidential in a secure place and

only those persons directly involved with the study will have access to the forms.

Ethical Considerations:

Participation in the study is voluntary and you may withdraw at any time and for any reason without penalty. Complete anonymity cannot be assured because of the coding system and the possibility of the follow-up interview.

Results from the study will be reported in general terms to protect your identity and will be shared through normal scientific channels of dissemination. At no time will any study report identify any participants. There are no direct risks to you, but for those who request it, a benefit will consist of an abstract of the completed study.

Voluntary Participation:

If you agree to participate in PHASE I only, please sign under PHASE I on the informed consent form, complete Part 1 and Part 2 and return them in the enclosed stamped envelope by **MARCH 25, 1994**. If you agree to participate in both PHASE I and PHASE II, please sign under PHASE II on the informed consent form, complete Part 1 and Part 2 and return them in the enclosed stamped envelope by **MARCH 25, 1994**.

Should you have any questions or comments, I may be reached at [redacted] University Office of Research at [redacted], should you have questions or comments regarding your rights. This project has been reviewed according to George Mason University procedures governing your participation in this research.

INFORMED CONSENT FORM - PHASE I

I have read this letter, comprehend it, and realize that complete anonymity cannot be assured. I agree to participate in PHASE I only of this study.

_____ Date _____
Signature

_____
Printed Name

_____
School of Nursing

Code Number _____

INFORMED CONSENT FORM - PHASE II

I have read this letter, comprehend it, and realize that complete anonymity cannot be assured because of the possibility of a follow-up interview. I agree to participate in PHASE I AND PHASE II of this study and understand that I may be selected for an interview.

_____ Date _____
Signature

_____
Printed Name

_____
School of Nursing and State

_____
Phone Number

Code Number _____

If you are willing to participate in either PHASE I or PHASE II of this study, would you like an abstract of the completed research? _____ yes _____ no

Appendix F

Dear Dean or Chairperson;

I am Carolyn Z. Lyndaker, a doctoral candidate at George Mason University. The chairperson of my dissertation committee is Dr. Mary Silva. I am seeking faculty participation in my dissertation. The purpose of my research is to identify the process nurse educators use in resolving ethical value conflicts in their interactions with students. This is an area that is unexplored and will add to the body of nursing knowledge.

I would like to use your faculty as part of my study. The process would include completion of PHASE I, Part 1 and Part 2 that consists of a demographic tool and questionnaire and the option of consenting to be interviewed, PHASE II. I am enclosing the tools with this letter.

Will you grant permission for your faculty to participate in this study? _____ Yes _____ No

If your answer is yes, would you designate one faculty member to serve as contact person?

_____

How many faculty (full- or part-time) do you have currently teaching in your BSN program? _____

Please return this form, regardless of your response, by **January 19, 1994**, by refolding the paper so my address is visible. Thank you for taking your time to complete this form.

Vita

Carolyn Zehr Lyndaker was born on June 1, [redacted] in Lowville, New York, the daughter of Elias and M[redacted]a Zehr. She is married to Milford E. Lyndaker and they have three children: Keith, Cheryl and Brent. Mrs. Lyndaker graduated from High School in Lowville, New York. She received a diploma in nursing from the House of the Good Samaritan, Watertown, New York in 1963. She was employed as a staff nurse for one year at Lewis County General Hospital in Lowville, New York, for three years at Rockingham Memorial Hospital, Harrisonburg, Virginia and for eight years at Jefferson Memorial Hospital, Meridian, Mississippi. Mrs. Lyndaker received her Bachelor of Science degree from University of Southern Mississippi, Hattiesburg, Mississippi in 1982 and her Master's in nursing degree from Troy State University, Troy, Alabama in 1986. Mrs. Lyndaker was employed by the Meridian Junior College where she taught certified nurses aides and licensed practical nurses. She also taught at Livingston University, Livingston, Alabama for three years in an Associate of Science Degree Program. More recently (nine years), she has been an active faculty member in the nursing department at James Madison University, Harrisonburg, Virginia, serving on many university committees. Mrs. Lyndaker has been active in community service, having served on the board of the Harrisonburg Pregnancy Center and as a volunteer for several organizations. She is an active member of her church, serving as chairperson for several committees, adult sunday school teacher, pastor's wife, care group leader and coordinator. She has been an active member of the Virginia Nurses Association serving on the Legislative Committee and has served as advisor for the Virginia Nursing Student Association, James Madison University Chapter. She is also a member of Sigma Theta Tau, International Association and the Mennonite Nurses Association. Mrs. Lyndaker received a traineeship from George Mason University for completion of the dissertation and a dissertation scholarship award from Epsilon Zeta Tau Chapter of Sigma Theta Tau International.