A PHENOMENOLOGICAL EXPLORATION OF NURSING FACULTY'S EXPERIENCES OF ETHICAL CHALLENGES IN THEIR ADMINISTRATIVE DUTIES

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Dedication

I dedicate this dissertation to my mom, Annette Ver Woert. Because of you, I believe in unconditional love. As I walk my path, I pray my life sings the same lullaby of unconditional love that you sang to me. “I'll love you forever, I'll like you for always, as long as I'm living my baby you'll be.” Nothing can separate us from the Love of God.

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Abstract

Nurses in all practice settings experienced ethical challenges. The ANA further detailed the role of nursing administrative role functions in *Nursing Administration: Scope and Standards of Practice* (2016) and was largely written for nursing administrative roles in clinical settings. Nursing education literature focused on ethical challenges between the nurse faculty/student or nurse faculty/nurse faculty relationships. Subsequently there was limited guidance for how nursing educators should navigate ethical issues within their academic duties. The results of this study attempted to address gaps in nursing literature and respond to the international and domestic nursing code of ethics call for increased awareness, ethical leadership development, and application of nursing ethics in all settings. The purpose of this study was to explore the lived experiences of BSN and RN-BSN nursing educators with ethical challenges as they related to their administrative responsibilities in higher education, as well as potential ethical challenges as they pertained to the nursing program accreditation process. This study utilized hermeneutic, interpretive phenomenological design. The primary units of data collection within phenomenology consisted of a small number of individuals, primarily through in-depth, cross-sectional interviews. The results of this study suggested that when administrators encountered ethical challenges in their administrative duties, they included issues related to nursing program operations, legal and regulatory issues, and safety and risk management. Administrators were more likely than faculty to encounter conflicting regulatory requirements from NRB and specific concerns related to CCNE's Standard IIE. The specific sub-themes included conflicts with CCNE and NRB, COVID vaccine policies, competing loyalties, and leadership transitions.

Keywords: accreditation, higher education, nursing educators, nursing ethics, nursing faculty, nursing leadership, qualitative, phenomenology.

CHAPTER 1

Introduction

For over twenty years, the American public annually rated nurses as the most honest and ethical profession (Gallup, 2023). There were many opportunities for nurses to demonstrate their well-deserved heroism; however, there were many gaps within nursing ethics literature practically guiding nurses in the ever-expanding practice settings to maintain this respected position (Fowler & Davis, 2013; Redman & Fry, 2003; Tsuruwaka, 2017). Many practice-oriented disciplines, such as law, medicine, and nursing, developed professional ethical codes that encompassed expectations of the professional beyond core responsibilities. The ethical, social, and professional responsibilities of the nursing profession had rich historic roots in Florence Nightingale's pioneering work of 1859, *Notes on Nursing* (2012). The primary tasks of nurses in the Crimean War, as described by Nightingale, have remained central to nurses' roles in the 21st century: client advocacy, confidentiality, health promotion, disease prevention, and therapeutic use of self (Nightingale, 2012). The basic tenets of the nursing profession continued to weave a coherent thread in the fabric of modern-day nursing codes of ethics, situated around the world in diverse cultures and applicable in every setting of nursing practice.

From these historic roots, the global nursing profession subscribed to an international ethical standard for nursing practice. The International Council of Nurses (ICN) (2012) *Code of Ethics for Nurses* detailed the four fundamental responsibilities of all nurses: Nurse and People, Nurse and Practice, Nurse and the Profession, and Nurses and Co-workers. Nurses around the world have collectively agreed on ethical nursing behavior and the ultimate intent of the provision of nursing care. The ICN stated, "Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health, and to alleviate suffering. The need for

nursing is universal”' (2012, para. 1). Nurses around the world shared a united focal point: caring for clients.

The bedrock and ongoing source of ethical principles for American nurses has been the American Nurses Association (ANA) Code of Ethics (CoE) (American Nurses Association [ANA], 2015). The first American nursing code of ethics, the *Code for Professional Nurses,* was drafted in 1950, and has since served as the ethical standard for nursing practice (ANA, 2015). The ANA CoE outlined the agreed upon values, behaviors, and responsibilities of nurses, and although not legally binding, has served as a standard and aid in moral and ethical decision-making (Marquis & Huston, 2021). The nursing profession has offered varied practice settings, such as bedside nursing, nursing research, informatics, advanced clinical practice, and nursing education (ANA, 2015). Regardless of the nurses' professional role and practice setting, the ANA CoE has offered nurses a framework of principles, behaviors, and norms by which to practice (ANA, 2015).

Purpose Statement

The primary purpose of this hermeneutic, interpretive phenomenological study was to explore Bachelor of Science (BSN) and Registered Nurse (RN) to BSN (RN-BSN) nursing educators' lived experiences with ethical challenges as it related to their higher education administrative duties, and secondarily their experiences with ethical challenges as they related to nursing program accreditation, if any.

Research Questions

The research question that formed the basis for this study was: What are the lived experiences of BSN and RN-BSN nursing educators with ethical challenges as they related to their administrative responsibilities in higher education? A related secondary question was the

following: What are the lived experiences of nursing educators with ethical challenges as they pertained to the CCNE accreditation process, if any?

Nursing faculty and nursing program administrators were responsible for numerous aspects of nursing program administration (Bono-Neri, 2019). Due to the variety of administrative roles and potential corresponding ethical challenges that nursing faculty might experience in higher education, this research was exploratory in nature as opposed to focusing on one specific ethical issue (e.g., shared faculty governance, violations of academic procedure, process, or policy).

Nursing ethics historically focused on ethical dilemmas in clinical practice, but more research was needed on both nursing leadership and management ethics in clinical settings and in academia (Marquis & Huston, 2021). Clinical settings operated differently than higher education settings and might expect or reward different behavior. The values and beliefs of nurses' clinical practice, the academic discipline of nursing research, and the academic teaching professoriate were found to be unique and discrete cultures (Schriner, 2007).

For example, clinical nurses transitioning into academia needed clear organizational onboarding regarding the expectations, values, and reward structures of higher education; faculty members were rewarded for siloed productivity as opposed to the largely collective nature of healthcare teams with the clients as the central focal point (Grassley et al., 2020; Schriner, 2007; Tsuruwaka, 2017). However, while established medical centers had organizational structures in place to redress unethical behaviors (such as boards, committees, and institutional review boards), there was a lack of organizational structure in academic settings to systematically review concerns of ethical issues unless the issue was specifically about ethical research practices (Rhodes & Strain, 2004).

Nursing literature primarily focused on the ethical leadership of nursing leaders in clinical settings and acknowledged the limited literature and empirical understanding of how to recognize, articulate, and develop ethical leadership guidelines, consistently calling for additional research on ethical nursing leadership (e.g., Eide et al., 2016; Islam et al., 2018; Makaroff, 2014; Rushton, 2016; Storch et al., 2013). Furthermore, nursing literature and the international nursing code of ethics suggested a need for increased awareness of ethical standards amongst nurses, as well as for greater guidance regarding ethical leadership development and application (Eide et al., 2016).

For example, Eide et al. (2016) explored the nurse manager's intentional and strategic commitment to creating an ethical work climate, as opposed to the nurse manager's personal moral character, behavior, and conduct. *Leadership ethics* often referred to both leadership behavior and internal leadership character (doing *and* being) (Northouse, 2019). The variability and simultaneous imprecision within definitions and distinctions alone introduced many questions for nursing leaders. The functions of social ethics was active reform of the profession, the setting of aspirational goals, the challenging of conformity, and an "intentional, ongoing, critical self-reflection and self-evaluation of the profession" (ANA, 2015, p. 153). The ANA CoE offered principles for ethical nursing practice that applied to nurses in any practice setting.

The ANA CoE

The ANA CoE contained nine fundamental provisions and interpretive statements; each provisional statement articulated a unique aspect of nursing practice. The CoE's nine provisions (Appendix A) considered the fundamental values and commitments of the nursing profession (Provisions 1-3), professional boundaries and loyalties (Provisions 4-6), and the duties of the nurse that moved beyond client-care encounters, such as public policy, research, and public

health disparities (Provisions 7-9) (ANA, 2015). The ANA also developed scope and standards of practice for clinical practice subspecialties, such as plastic surgery, forensic nursing, and nursing administration.

The ANA CoE implicitly spoke to the role of nursing program administrators and faculty members in Provisions 7 and 9 (ANA, 2015). NivIn Provision 7 it said, "The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy" (ANA, 2015, p. v). Provision 7.2 spoke to the nurses' effort in contributing to the development, maintenance, and implementation of professional practice standards (ANA, 2015). For example, Provision 7.2 in the ANA CoE spoke specifically to the professions' duty to uphold standards in indirect and direct client care roles (e.g., bedside nursing, forensic nursing, correctional nursing, and nursing administration, etc.) (ANA, 2015).

In addition, the ANA CoE implicitly spoke to the role of faculty in Provision 9: "The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy" (2015, p. 151). For example, nurses could contribute to the profession of nursing by serving on institutional or agency policy committees within their practice setting; this might be interpreted as academic nursing program committees (ANA, 2015). Nurses within higher education could also advocate for the profession through their involvement in university-based committees, scholarly research, and service. Nurses participating in administrative duties acted in solidarity with the larger nursing profession to uphold the profession's values within state, federal, and global initiatives to bring health and well-being (ANA, 2016).

ANA's Guidance for Nurse Administrators

The ANA further detailed the role of nursing administrators in *Nursing Administration: Scope and Standards of Practice* (2016). Within the 2016 text, the ANA described nurse administrators as those who are "devoted to the design, facilitation, supervision, and evaluation of systems that educate [or] employ nurses [or both]" (ANA, 2016, p. 2). Nurse administrators could hold system-wide authority (e.g., national or governmental office), organization-wide influence (e.g., chief nursing officer, administrator nursing), or unit-or team-wide authority (e.g., unit manager, committee chair) (ANA, 2016).

As mentioned above, leadership and administrative skills might include advocacy, strategic planning, resource management, legal and regulatory compliance, and networking and collaborating (ANA, 2016). *Legal and regulatory compliance* referred to state, federal, and accreditation standards and regulations (e.g., Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA)) (ANA, 2016). The text explicitly stated that it was written primarily for nursing leaders in clinical settings; however, there were many opportunities within the nursing profession to expand conversations about ethical practice in non-clinical settings. For the purposes of this study, *administrative duties* were defined as, but not limited to, the following role responsibilities—a summarization of six standards of the ANA Standards of Practice for Nursing Administration which were presented in detail in Appendix B: assessment, identification of problems, outcomes identification, planning, implementation, and evaluation (2016, p. i).

Nurses were familiar using a shared language of the ANA CoE for navigating complex clinical responsibilities, and nursing educators could use the familiar framework to refocus on the "ultimate recipient of this educational enterprise – the patient" (Burger et al., 2014, p. 567).

Understanding nursing educators' experience of the tensions and opportunities of administrative and accreditation related duties generated useful data on two accounts. First, the ANA CoE remained the foundational moral benchmark for the nursing profession, whereby nurses in any practice environment upheld the profession's "values, obligations, ethical standards, aspirations, and ideals" (ANA, 2015, p. xxvii). Secondly, nursing accreditation standards were agreed upon standards within the industry for safe, quality, and professional nursing practice (Commission on Collegiate Nursing Education [CCNE], 2018b). The intersection of both moral and professional standards offered a unique perspective into the organizational and academic milieu of nursing educators.

Overview of Nursing Ethics in Administrative and Faculty Roles

Higher Education

Most literature available on the topic of ethics in the academic setting was student-centric, focusing on student moral development and the impact of student-professor relationships (e.g., Arslan & Dinç, 2017; Haghighat et al., 2020; Parker, 2017). Regardless of discipline, most tenure-track or tenured faculty members felt unprepared for the professional context of academia; most faculty were trained as researchers, or in the case of nursing, as clinicians, not as academic educators or administrators (Cox, 2016). Faculty members perceived administrative issues inherent to their work as highly stressful; specifically, the key sources of stress they cited were meetings, reports, additional pre-programmed activities, and co-workers who they perceived were not performing sufficiently (Berger Fadel et al., 2019).

Higher Education: Nursing

Academics in the field of medicine demonstrated a higher awareness of ethical responsibilities in an academic setting and felt more adept to respond to ethical responsibilities

than colleagues in other disciplines (Aydin et al., 2012). However, when nursing educators experienced a disconnect between what they believed was best for their academic program, students, or institution, moral suffering and ethical conflicts were likely to arise (Dalmolin et al., 2009, as cited in Barro Ribeiro et al., 2014). Nursing faculty became familiar with the organizational cultures of both healthcare and higher education.

Within the higher education industry, both institutions and the students they served faced significant financial pressures due to historical trends profoundly accentuated by the COVID-19 pandemic (Aristigueta, 2021). In clinical settings, frontline nurses experienced ethical dilemmas related to resource management, rapid development of policies and procedures, and lack of staff to provide high-quality care; likewise, nursing educators felt the same tensions (Liu et al., 2021). Furthermore, Cleary et al. (2012) discussed the impact of increasingly transitory, adjunct faculty and the ethical organizational culture of a nursing program, as adjuncts might be new to the formal environment and professional expectations of academia. Thus, adjuncts encountered greater risk of boundary violations with students.

In addition, nurses transitioning into nursing education were responsible for new administrative roles and responsibilities. Higher education institutions had financial needs that focused on recruitment and retention of students while nursing educators experienced conflicting concerns about student progression in an academic program with historically poor performance, remediation policies and procedures, institutional appeal procedures, and failure to prevent unqualified students from graduating (Ganske, 2010).

Nursing educators might encounter cultural dissonance within academia. For instance, faculty encountered tension when they experienced differences between the espoused values of the university or college of nursing (i.e., faculty hired for clinical expertise) and the cultural

reality of largely administrative, scholarly, and teaching duties (Schriner, 2007). Ironically, as nurses aimed to teach ethical behavior, some might have simultaneously experienced competitiveness, hyper-productivity, and individualism in higher education culture (Ribeiro et al., 2014). Higher education emphasized individual achievement as opposed to the collaborative clinical environment enriched by shared goals amongst nursing staff (Grassley et al., 2020).

Overview of Nursing Program Accreditation

Nursing faculty were responsible for numerous tasks, one of which included nursing program accreditation. As a profession, nurses were responsible to communicate standards to the public and include state nurse practice acts and federal regulations (ANA, 2015). Communicating standards to the public could include but was not limited to nursing program accreditation. National nursing standards stated that one core aspect of nursing program accreditation was an accountability mechanism for nursing programs, using the nursing program accreditation process to refine the value of their academic deliverable (both the quality, content, and rigor of the academic program and the performance of their graduates) to the primary stakeholders (e.g., nursing profession, consumers, employers, institutions of higher education, students) (CCNE, 2018a, p. 3). Within the field of nursing, three primary national accrediting agencies have existed: The Commission on Collegiate Nursing Education (CCNE), the Accreditation Commission for Education in Nursing (ACEN), the National League for Nursing (NLN) Commission for Nursing Education Accreditation (CNEA) (known as NLN-CNEA); all were recognized by the U.S. Department of Education (DOE) as specialized accreditors (Keating, 2015; Keaton, 2021).

CCNE served as an autonomous branch of American Association of Colleges of Nursing (AACN) and accredited baccalaureate and graduate nursing programs, postgraduate nurse

practitioner certificates, and hospital-based nurse residency programs (CCNE, 2021b). NLN-CNEA offered accreditation to certificate, diploma, vocational, RN-BSN, BSN, masters, and doctorate level nursing education; it became recognized by the DOE as a national accreditor in May 2021 (Keaton, 2021). ACEN accredited "clinical doctorate/DNP specialist certificate, master's/post-master's certificate, baccalaureate, associate, diploma, and practical nursing programs" (Accreditation Commission for Nursing [ACEN], 2021). Although ACEN offered accreditation to BSN programs, CCNE only accredited BSN, RN-BSN, graduate nursing programs, and clinical Doctor of Nursing practice (DNP), and, anecdotally, BSN programs prioritized obtaining CCNE accreditation. For example, nursing associate degree programs in Washington State were accredited through either ACEN or NLN-CNEA, and all BSN programs in Washington State were accredited by CCNE (CCNE, 2021a; National Council of State Boards of Nursing [NCSBN], 2021; Washington State Department of Health, 2022).

Several studies advanced the conversation on nurses' or healthcare providers' perceptions of accreditation in the healthcare setting (as opposed to an academic setting) for the purposes of improving client outcomes or enhancing organizational engagement (e.g., Bolsin et al., 2018; Sadiq et al., 2016; Walsh et al., 2010). As a topic, nursing program accreditation lacked both volume and quality of research (Richardson, 2015). Additionally, it appeared that no current research had investigated the intersection of nursing program accreditation and nursing ethics. However, some preliminary, historical data about faculty perceptions of effectiveness and level of involvement regarding the accreditation process was explored internationally, but no specific attention was given to the ethical challenges of accreditation or administrative duties. In Jordan, research findings indicated that the nursing program accreditation process was perceived as

unsatisfactory, due to inconsistent and non-comprehensive accreditation processes (Suliman, 1988).

More recently, Alaskar (2018) explored perceptions of Saudi nursing faculty and administrators regarding the accreditation process, their motivation and involvement, and the relationships between motivation and involvement in effort to predict motivation and involvement. The results suggested statistically significant differences between faculty and administrators' perceptions of the accreditation process and purpose of accreditation, positively impacted by increased age, type of institution, years of teaching experience, and level of education; however, no statistically significant difference was noted in relationship to motivation to engage in the process (Alaskar, 2018).

Background of Problem

Contextual Demands on Nursing Educators

Throughout the process of conducting this study, a global pandemic was occurring. COVID-19 was placing tremendous pressure on existing healthcare infrastructure (e.g., technological, human resource, and financial capital) to adequately address evolving global needs. Nursing leaders at every organizational level were required to effectively maneuver infection control regulations, as well as recruit, on-board, and replace staff, all while increasing quality and reducing harm (Poortaghi et al., 2021). COVID-19 required healthcare providers to ration resources that were known to enhance quality, and although best-practice was at the forefront of the caring profession, these ethical decisions were also weighted by potential issues of feasibility, productivity, and resource utilization (Novosel, 2020). The profession of nursing regulations, standards, scope of practice, code of ethics, and values were noted as structural protective factors during COVID-19, allowing for greater capacities for future resiliency and

adaptability (Halverson, 2021). However, the stress of maintaining these internalized beliefs in the midst of limited physical and human resources could create conflicted experiences for nurses.

Even before the pandemic, nurses were called on to address increasingly complex tasks with ethical implications, such as reforming public policy, engaging public health crises, and addressing equity issues within the profession and healthcare at large (ANA, 2015; National Academies of Sciences, Engineering, and Medicine, 2021). The impacts of COVID-19 had resulted in a greater focus on topics in nursing education such as compassion, adaptive problem solving and critical thinking, ethical reasoning, leadership development, and advocacy; nursing educators shouldered the responsibility to develop nurses who would anticipate and respond to future challenges and not simply react to immediate issues related to the global pandemic (Halverson, 2021). *The Future of Nursing Report 2020-2030* anticipated nursing schools will continue to be central players in developing nurses capable of addressing health inequities; the Committee authoring the report encouraged nursing program accreditors to clearly develop standards for nursing curriculum that addressed social determinants of health, environmental health, and trauma-informed care, faculty and student diversity, nurse self-care, and ethical practice (National Academies of Sciences, Engineering, and Medicine, 2021).

Within these varied settings and diverse roles and responsibilities, nurses in higher education felt the socioeconomic, administrative, and workforce pressures. Nursing faculty engaged a quickly diversifying educational landscape. Faculty members were asked to adapt to the economic downturns of the higher education industry, leverage technology, and meet evolving student needs. Ensuring student achievement required increasingly complex interpretation of data gathered from both traditional assessment methods (such as graded assignments) as well as forecasted interpretation of "adaptive learning technologies, artificial

intelligence, robotics, and mixed reality" (Council for Higher Education International Quality Group, 2019, p. 5). Nursing faculty had interfaced with the increasing technological changes in higher education.

Higher education offered a cyclical, repeatable rhythm of the academic year and a historically slow pace of change. However, due to legislated quarantine requirements, nursing programs around the United States rapidly shifted traditionally delivered clinical and didactic courses into remote (virtual) environments with only days or weeks of notice (Barton et al., 2020). Nursing educators strived to ensure uninterrupted curriculum and quality teaching practices, hoping to reflect the traditional classroom and clinically based methods of assessing student achievement; however, due to time constraints, faculty received varied levels of training and experienced a variety of attitudinal barriers (Funchal Camacho & Conceição, 2020). The "pedagogical chaos" of a global pandemic required nursing educators to reconceptualize new methods not only for immediate teaching and learning needs, but for the process of interpreting qualitative and quantitative data used in the accreditation process on the long-term effectiveness of these new methods on students, courses, and entire nursing programs (Barton et al., 2020).

Two mainstays of improving student learning outcomes–faculty engagement and expertise regarding the accreditation process–have remained steadfast (Kuh & Ewell, 2010). A primary responsibility of faculty included academic assessment and evaluation (Gaston, 2014). However, in addition to feeling unclear about weakly communicated standards and sensing dissonance between parent institutional values and program values, many higher education faculty had felt accreditors missed the complexity of higher education (Gaston, 2014). Aligned values amongst stakeholders were a key component to individual and organizational cultures

supporting moral courage, sensitivity to ethical challenges, and willingness to face conflict (Lachman, 2009; LaSala & Bjarnason, 2010).

It was commonly understood that nursing leaders' experiences with the dimensions of ethical decision-making in education was underexplored, despite the known challenges of ethical situations presented through competing or conflicting values between the nurse and their institutions (Gray, 2008). Use of the nursing process as a guideline for developing nursing practice standards spanned across many roles in nursing, including *Nursing Administration: Scope and Standards of Practice* (ANA, 2016). The nursing process described the significant actions taken by nurses in administrative roles: assessment, identification of problems, issues, and trends, outcomes identification, planning, implementation, and evaluation (ANA, 2016). Identifiable connections between standards of practice for nursing educators' administrative duties and potential ethical challenges existed.

For example, nurse educators in higher education settings collected pertinent data in a systematic process, leveraged data to identify problems, planned actionable steps, documented the plan transparently to stakeholders, utilized the knowledge for continued quality improvement, and synthesized evaluation data for ongoing, criterion-based outcomes (ANA, 2016). Ethical dilemmas presented organizational leaders with decisions shrouded in shades of gray, and often required contextual factor analysis; such factors included conflicting ethical principles, incompatible beliefs or values of stakeholders, regulatory requirements and organizational policies, and professional Codes of Ethics (Black, 2020).

Halverson (2021) suggested reflective, brave curiosity for nursing educators navigating COVID-19 using an analogy of sailing: how did the "vessel (the profession), the crew (nurses), the captains (nurse leaders), the act of sailing (caring) and navigational tools (guiding forces)[,]

and winds of change (contextual forces) impact the direction of nursing research, quality improvement?" (p. 661). The turbulent waves offered nursing leaders an opportunity to review nursing's professional values, code of ethics, regulatory demands, and accreditation with a new lens (Halverson, 2021). Amid several years of uncertainty, a more thorough understanding of faculty's ethical challenges impacted the higher education leader's ability to meaningfully engage both the problems and solutions.

Deficiency in Current Literature

The ethical challenges and the ensuing occurrence of moral distress within clinical practice were well documented in the nursing literature, and it has been further explored in Chapter 2 (e.g., Cino et al., 2018; de Casterlé et al., 2008; Eby et al., 2013; Fourie, 2015; Ganske, 2010; Barros Ribeiro et al., 2014). It was well understood in the clinical setting that nurses employed sophisticated critical thinking and ethical decision making to make complex clinical judgements regarding client care (Alfaro-LeFevre, 2019; ANA, 2015). The topics routinely addressed in nursing ethics literature encompassed many aspects of healthcare delivery and client care, such as data management and informatics, informed consent, scarce resource allocation, clinical and academic research practices, public policy formation, and death and dying (Tsuruwaka, 2017).

Nursing literature focused primarily on the external and contextual issues related to ethical nursing practice, specifically in clinical practice, and little was known regarding nurses' specific process of ethical decision making, in both individual and socially mediated (or group-based) contexts (de Casterlé et. al, 2008; Doane et al., 2016). While clinical practice held uniquely intense workplace pressures, so did nursing education. Studies exploring the ethical behavior of faculty members generally focused on faculty-student interactions, with

consideration of incivility, bullying, or retaliatory poor course evaluations (Arslan & Dinc, 2017; Palese et. al., 2018). Other articles explored the ethical issues of nursing educators regarding research science; however, little consideration was given to exploration of the attitudes of academic nurses toward academic ethics (Denat et al., 2018). The nursing faculty member encountered an assortment of ethical challenges: high workload, the tension of ensuring quality with scarce resources, and often lack of experience in the required academic skill sets (Grassley et al., 2020). Anecdotally, some of the largest student-professor interactions that distressed nursing educators included academic dishonesty, grade inflation, and incivility (Ganske, 2010).

Nursing leaders had less explicitly articulated ethical obligations than that of a bedside nurse (Marquis & Huston, 2021). The profession of nursing had to support nursing leaders, as the ethical challenges presented were indeed complex. Managers or administrators had to be committed to supporting the values of the parent organization (e.g., mission, strategic planning, cost containment), addressing the needs of community stakeholders (e.g., equitable access, diversity in hiring practices), and aligning their personal values that interacted with a complex system (Butts & Rich, 2020). Therefore, nursing management ethics and clinical nursing ethics had distinct challenges, and although significant research reflected the ethical dilemmas of clinical nursing staff, much less literature existed on the ethical distress of nursing managers (Marquis & Huston, 2021). These valuable topics focused on the interactions of faculty with students yet were not centrally related to ethical challenges related to the administrative functions of nursing educators, specifically academic programming, assessment, and evaluation; it was worth understanding the scope of ethical concerns that nursing educators attended to beyond direct student interactions.

Collings-Hughes et al. (2021) conducted a systematic review of over 1,000 articles regarding professional ethical codes of nursing and medicine to better understand healthcare professionals' knowledge, awareness, and use of professional ethical codes. The results of the literature review indicated healthcare professionals were aware of professional codes of ethical conduct and highly valued the codes but did not yet refer to the codes regularly for clinical practice and did not know the content of the codes or how to apply it (Collings-Hughes et al., 2021). Furthermore, minimal research existed regarding measuring the understanding of health professionals' understanding of the ethical codes content (Collings-Hughes et al., 2021). Nurses could develop their awareness of ethical issues and courage to act through developing their moral reasoning, understanding of the professional ethics of care, and competency in nursing knowledge and ethical issues (LaSala & Bjarnason, 2010).

Primary Philosophical Framework

Qualitative research has six primary features: belief in multiple realities, the researcher's commitment to choosing the appropriate qualitative approach for the given question, an honest representation of participants' reports, a minimal disruption when engaging the natural context of participants, acknowledgement of researcher's use of self in the research process, and lastly, using narrative-rich, participant commentaries when reporting data (Speziale & Carpenter, 2003). Phenomenology is a specific methodological approach to qualitative research; it is both a research method and a philosophical framework (Peoples, 2021; Polit & Beck, 2009).

Phenomenology came from the Greek word *phainomenon* which meant "appearance," alluding to a sense of knowing expanding beyond traditional empiricism; furthermore, it offers a methodology free from prejudgments and thus made an effective teacher for curious minds (Bottorff, 2015). Phenomenology was rooted in the Weberian tradition and built on the concept

of *verstehen*, the "interpretive understanding of human interaction" (Bogdan & Biklen, 1998, p. 23). It conceptually resides in both the fields of psychology and philosophy and explores the aggregate experiences of several individuals (Creswell, 2014; Qutoshi, 2018; Speziale, & Carpenter, 2003). It has also gained credibility as a method to explore human consciousness (Matua & Van Der Wal, 2015). Well-designed phenomenology offers accurate portrayals of a specific lived experience and generates "insightful reflections on the meanings of those experiences"' (Van Manen, 2015, p. 49). As a methodology, phenomenology approaches the human experience with as little rebuttal and value judgment as possible and aims to describe the phenomenon through observing, describing, and, at times, interpreting the phenomenon in context of a larger environment (Colaizzi, 1978).

When used as a philosophical framework within research, phenomenology had two primary origins: Husserl's transcendental phenomenological approach and Heidegger's hermeneutic phenomenological approach (Herskowitz, 2020; Oxley, 2016). The classic Hursserlian framework was descriptive in nature, whereby the researcher described a phenomenon as it appeared to the human consciousness (Qutoshi, 2018). The Hursserlian orientation relayed careful, detailed descriptions of participants' everyday life and senses (i.e., hearing, seeing, feeling, remembering) (Polit & Beck, 2009). However, the Heideggerian interpretive (hermeneutic) approach intended to provide a more accurate and detailed understanding of the meaning of the experience through words or sets of words by those who had lived experience with the phenomenon (Matua & Van Der Wal, 2015). Interpretive methods approached phenomena as contextually dependent and embodied (Valentine et al., 2018).

This study utilized the interpretive (hermeneutic) Heideggerian framework. The Heideggerian approach was developed by Gadamer, who developed the hermeneutic circle

(Gadamer, 1960/2004; Jahnke, 2012). The hermeneutic circle described the process of the researchers' understanding of the data (as opposed to a methodological technique) as an iterative process (Peoples, 2021). Phenomenology has been used in multiple nursing research studies and dissertations, specifically with faculty as the population of interest (Bottorff, 2015). Psychology, nursing studies, and educational research were steadily utilizing phenomenology as a method (Zahavi, 2019). One example of applied phenomenology in nursing included how nursing educators expressed their perceptions of student issues and how they attended to their needs; another study detailed nursing educators' experience with inclusive spiritual care (Bottorff, 2015). Due to the limited literature completed on nursing educators' perceptions of ethical challenges in academia an open, exploratory research method was preferred.

Summary of Methodology

A hermeneutic, interpretive phenomenological design was utilized to explore BSN and RN-BSN nursing educators' lived experiences with ethical challenges as it related to their higher education administrative duties, and secondarily their experiences with ethical challenges as it related to nursing program accreditation, if any. As a method, phenomenology is "a statement about what it means to exist in the world" (Valentine et al., 2018, p. 470). The primary strategy for data collection involved semi-structured, open-ended one-on-one interviews with nursing educators and nursing program administrators and field notes to add richness to the analysis of data.

Potential Significance

The potential significance of this study interacted with the emerging literature within leadership ethics as well as the more established field of nursing leadership literature. Leadership ethics was a growing field of applied ethics across disciplines, specifically exploring the

distinctive social nature of leadership and followership, which involved power dynamics, ego, self-interest, responsibility for others, and the complex management of conflicting group desires (Ciulla, 2014). Organizational leadership scholars called for greater precision in defining what constitutes ethical and unethical leadership, as well as practical recommendations for training leaders' ethical leadership frameworks within their various practice areas (Ciulla, 2014). Nursing ethics and organizational ethics were considered applied ethics, and ethical decision-making was used to solve problems occurring in a professional setting (Forrestal, 2016).

Within the field of nursing leadership, this study could support several key areas of known need for nursing educators and administrators. Nurses working in the university-setting had the privilege and professional commitment of socializing the next generation of ethical nurses (Barros Ribeiro et al., 2014; Boozaripour et al., 2018). Due to the close role-modeling relationships between nursing educators and nursing students, nursing faculty should continue to facilitate ethical sensitivity through conversations in the academic setting, thereby increasing the likelihood of incorporating ethical comportments into the organizational culture of a nursing school and increasing the likelihood of daily conversations about ethical issues (Palese et al., 2018). This essential task of imparting positive discipline-specific values to students was only as powerful as the faculty members' ability to recognize their personal ethics and behaviors (Sabouri et al., 2019).

Faculty members were generally hired based on technical or discipline specific knowledge and had little ethical preparation to participate in academia ethically (Sabouri et al., 2019). Despite clinical expertise, new nursing educators reported feeling like a novice in the academic environment and missed feeling like an expert (Grassley et al., 2020). According to Grassley, Strohfus, and Lambe (2020), nurses transitioning from the bedside into academia

gained new administrative skills and were entrusted with a variety of brand-new responsibilities which they might have been unprepared for. Nursing educators reported lower self-confidence regarding their academic role due to the lack of educational preparation (Schriner, 2007).

Nursing educators were responsible for a breadth of organizational commitments outside of traditional classroom and clinical instruction; faculty oversaw granular student development needs, academic advising, nursing program committee work, parent-institution committee work, as well as an in-depth curriculum development (Bono-Neri, 2019). Nursing educators autonomously managed multiple aspects of nursing education, they received little formal educational preparation or formal orientation to the academic responsibilities which endorsed feelings of role ambiguity (Hoffman, 2019). The results of this study could normalize some feelings of inadequacy that new nursing educators might experience and create supportive conversations between experienced and inexperienced educators alike of how to translate clinical ethical decision making in a new environment.

Ethical nursing leadership was an essential aspect of organizational leadership, as the leader could use their formal power to increase team-based trust and ethical decision making (Butts & Rich, 2020). Without insight and appropriate interventions regarding faculty's ethical challenges, educators might begin to withdraw from organizational activities, which resulted in tardiness, absenteeism, turnover, and attrition, thereby negatively impacting the standards of the institutions (Shapira-Lishchinsky, 2018). According to Sullivan-Marx (2017), the application of ethical frameworks provided needed direction and definition to nursing practice, nursing leaderships, and organizational leadership.

The significance of these findings might also become increasingly useful as the demographics of nursing educators in the United States was projected to become a more

inexperienced workforce. For example, Stubbs and Skillman (2020) disseminated a demographic profile of nurses in Washington State where the RN's total was approximately 90,975, as of May 2019. The nursing educators in Washington State consisted of 1.5% of the total practicing nurse workforce (Stubbs & Skillman, 2020). Of all the workforce practice settings, nursing programs held the highest percentage of nurses 55 years or older, and the average age of faculty is 54.5 years old (Stubbs & Skillman, 2020).

However, the aging nursing workforce was not unique to Washington State; nursing programs around the United States experienced similar human resource trends and challenges. Nationally, more than one-third of the nursing workforce was projected to retire in the next 10 to 15 years, including nursing faculty; a decline in nursing faculty would lead to a decline in cohort-sizes, and a decline in programmatic quality (Haddad et al, 2020). According to the AACN, 872 nursing schools identified over 1,715 faculty vacancies in the United States; the national nurse educator vacancy rate was 7.9% (Rosseter, 2019). Not only were RN's retiring rapidly, but many current nurses expressed disinterest in academic roles due to lack of equitable monetary arrangement in relationship to clinical or educational preparedness (Willingham, 2018).

The future of the nursing profession was directly linked to increasing the numbers of adequately academically prepared nurse educators; a common barrier for bedside nurses to consider entering the academy included concerns about the nature of the work and the work environment of higher education (Bagley et al., 2018). Specific areas of concern included the job's time intensive nature, the political emphasis on hierarchy and rank advancement, and beginning as a novice once again (Bagley et al., 2018). Cash et al. (2009) created an instrument sensitive to the key components related to recruitment and retention of nurse educators; one of

the six key categories included “nursing department program leadership,” specifically detailing the “knowledgeable and ethical nursing leaders” and “guidance in complex situations” (p. 385). High nursing educator attrition might contribute to a program’s overall comfort level and low experiential capital regarding administrative duties required of nursing educators.

Although novice educators were prepared with technical nursing skills, academic and didactic skills were often developed through trial and error. Furthermore, novice nursing educators required significant support in the overall programmatic curriculum and accreditation approval process (Baker, 2010). Amidst a nursing educators’ shortage, it was essential for retention that nursing leaders holistically addressed and optimized faculty retention efforts by providing transitional support for nursing educators regarding new (or increasingly complex) academic responsibilities (Grassley et al., 2020). Experienced nursing educators leaving the profession created a void of experience but invited the next generation of novice educators to take their place (Baker, 2010). Nursing leaders were primarily responsible for implementing and sustaining quality; ethical leaders knew both their obligation to the organization and community and held benchmarks for high-quality outcomes (Butts & Rich, 2020).

Due to the socialization and specification of the ANA CoE within the nursing profession, this study created additional opportunities for nurses to discuss administrative, educational, and professional ethical issues with a common language and framework. The research methodology was exploratory in nature, and the results would offer opportunities for fresh perspectives on shared experiences of nursing faculty, potentially generating useful conversations at nursing educator conferences (e.g., breakout discussions or poster presentations), published articles, and small-group discussions.

There were opportunities for *The ANA Nursing Administration: Scope and Standards of Practice* (2016) to expand direction for ethical role functions of nursing educators in higher education settings (e.g., traditionally delivered undergraduate to asynchronous online graduate level nursing program). In Chapter 2, Rosenkoetter and Milstead's (2010) *Nursing Educator Code of Ethics* will be discussed at further length, and this study could contribute to this important work. Additionally, the results might be insightful for CCNE and CCNE site accreditor teams in supporting faculty with the accreditation process. Lastly, this study aligned with the direction of AACN. AACN's recently revised BSN Essentials and organized the ten essentials around central concepts, one of which was ethics, specifically connected to Domain Five (Quality and Safety), calling nursing education to create strong connections between quality improvement and nursing ethics (American Association of Colleges of Nursing [AACN], 2021).

Definition of Terms

- *Administrative duties:* encompassing but not limited to safety, quality, risk management, client/population/employee advocacy, healthy work environment, strategic, financial, and human resource management, legal and regulatory compliance, and interprofessional collaboration (ANA, 2016).
- *Accreditation* (primary): also known as "institutional" or "regional" accreditation, voluntarily applied external standards to the entire institution; each program and activity of the institution was evaluated in light of the institution's holistic mission, values, and goals (U.S. Department of Education [DOE], 2020a).
- *Accreditation* (specialized): also known as "programmatic" or "secondary" accreditation applied to programs or colleges within a larger institution (U.S. DOE, 2022). Nursing programs were considered a professional school and thereby accredited through both

primary (or institutional) accreditors and the "specialized" accrediting agency (U.S. DOE, 2022).

- *American Association of Colleges of Nursing* (AACN): acted as a national voice for nursing education, healthcare policy, and an advocate for a positive image of nursing practice (AACN, 2019).
- *American Nurses Association* (ANA): a professional nursing organization and the voice of U.S. nursing, focused on cultivating standards for nursing practice, safe and ethical work environments, nurses' wellbeing, and healthcare policy development and advocacy (ANA, 2021).
- *ANA Code of Ethics:* referred to the framework based off the ANA, containing nine fundamental provisions and interpretive statements, providing a concise statement regarding professional nursing values, obligations, and duties, the importance of remaining loyal to the profession's nonnegotiable ethical standard, and an expression of nurses' understanding and social contract detailing their commitment to the American public and society at large (ANA, 2015).
- *Commission on Collegiate Nursing Education* (CCNE): acted as an independent arm of AACN and accredited baccalaureate and graduate nursing programs, postgraduate nurse practitioner certificates, and hospital-based nurse residency programs (CCNE, 2021b). CCNE accreditors referenced the AACN's *The Essentials: Core Competencies for Professional Nursing Education* (2021) when reviewing four-year nursing programs for quality curricular structures (CCNE, 2021).
- *Ethical competence*: recognition of ethical situation and utilization of reflection and decision making to make a justifiable decision (ANA, 2021).

- *Ethical challenges:* a feeling of conflict between personal and professional values or professional and institutional values (Jameton, 1984). The broadest term was used to describe three main categories of moral and ethical problems, each of which had their own sub-definition.
    - *Moral uncertainty*: one was unsure which moral or ethical principles applied (Jameton, 1984). Those experiencing moral uncertainty might experience frustration and annoyance but were unaware the situation was situated within an ethical problem (Jameton, 1984).
    - *Moral dilemma:* one was faced with a situation with two or more choices, but there appeared to be inconsistent courses of action (Jameton, 1984). A central feature of moral dilemmas included indecision in the conflict, primarily due inability to make a decision that will be more correct than another (Barros Ribeiro et al., 2014).
    - *Moral distress:* one knew the right thing to do given the context, but institutional constraints made it nearly impossible to act (Jameton, 1984).
- *Ethical decision making:* the iterative, formal process of choosing between actions based on a system of beliefs, beliefs, and available options (Black, 2020, p. 376).
- *Ethical frameworks:* provided norms of behavior in social settings as well as offered systematic process for decision making regarding challenging issues; ethical frameworks were generally internalized and learned in early childhood and could mature throughout life (Resnik, 2020).
- *Ethical sensitivity:* recognition of moral issues, a necessary cognitive skill to employ ethical decision making (ANA, 2021).

- *Nurse administrator:* a nurse engaged in designing, facilitating, supervising, or evaluating systems that have educated or employed nurses or both (ANA, 2016).
- *Nursing faculty/nursing educators:* nurses with advanced degrees who have educated nursing students or nurses; for the purposes of this study, these terms would denote education occurring in higher education and would be used interchangeably.
- *Nursing ethics:* values, behaviors, ethical principles, and ethical standards to which nursing professionals aspired and by which their actions could be judged.

Organization of Study

This study included five chapters. Chapter One addressed the background of nursing ethics, ethical challenges for nursing faculty and nursing programs, the research question, the importance of the problem, and a definition of terms. Chapter Two included a literature review of ethical challenges of nursing faculty and the accreditation process in nursing education. Chapter Three described the philosophical framework of the selected methodology, sample population, methodology, data collection, and data analysis. Chapter Four discussed the results of data analysis. Chapter Five included a summary of findings and possible future research.

Conclusion

In conclusion, nursing faculty cultivated and sustained optimal learning conditions for students, whether in clinical or didactic learning; academic educators should have strived to ensure all nurse graduates acquire the knowledge, skills, and moral attitudes required for nursing practice (ANA, 2015). The ANA CoE (2015) set a moral precedent for nurses' behavior, and CCNE accreditation standards set academic benchmarks for BSN and RN-BSN nursing programs (ANA, 2015; CCNE Accreditation, 2018). This study utilized a hermeneutic, interpretive phenomenological design to explore the lived experiences of BSN nursing educators

regarding ethical challenges in administrative duties in higher education and CCNE nursing program accreditation in effort to support faculty in creating ethical healthy learning and working environments.

CHAPTER 2

Literature Review

The primary purpose of this study was to explore BSN and RN-BSN nursing educators' lived experiences with ethical challenges as it related to their higher education administrative duties and secondarily their experiences with ethical challenges as it related to nursing program accreditation, if any. This chapter has provided a brief overview of ethics, nursing ethics, ethical issues in higher education, and accreditation.

Ethics

Ethics came from the Greek word *ethos*, meaning "customs, conduct, character" (Northouse, 2018, p. 336). As early as 422 B.C., Plato grappled with defining and applying ethics to the lived experience. The meaning of *ethics* was like a Rorschach inkblot; some used their own personal definition while others referred to a prescriptive code of conduct, and others unassumingly assumed ethical decision-making was standard operating procedure requiring minimal exertion (Pearson et al., 2003). Ethical behaviors sought to "do the right thing", but ethical theory was not always able to identify what the "right thing" was (Marquis & Huston, 2021).

Within philosophical disciplines, ethical frameworks provided systematic study of one's conduct, which sought to distinguish between right and wrong or good and bad and serve as a guide for acceptable behavior within society (Butts & Rich, 2020; Marquis & Huston, 2021). Ethical theory and frameworks offered rules and principles in decision making, which essentially provided a foundation of what it meant to be a decent human being (Northouse, 2018). Ethical principles provided a cognitive structure for complex problem solving but did not offer prescriptive advice for situations (Burkhardt & Nathaniel, 2020). Ethical frameworks provided

norms of conduct in social settings as well as offered systematic perspective or methods for decision making regarding complex issues; ethical norms were generally internalized through formative childhood experiences, and moral development could mature throughout life (Resnik, 2020). Ethics reflected philosophically on societal and cultural traditions and used morality as a launching pad for asking questions like, "What should I do in this circumstance?" (Burkhardt & Nathaniel, 2020). The field of ethics included numerous theories with various principles emphasized and constructed in coherent and unique frameworks; depending on the theory and framework utilized, the nurse might reach a different conclusion and solution based on the differences of accentuated ethical principles (Benoliel, 1983). According to Jameton (1984), *ethics* was a more formal and abstract term while *morals* referred to personal values, yet these terms were often used interchangeably and "loosely distinguished" within Jameton's writing and other authors within nursing ethics (p. 13).

Durable Ethical Frameworks

Ethical inquiry generally followed three streams: normative ethics, metaethics, and descriptive ethics (Butts & Rich, 2020). Normative ethics described universally understood personal or collective values or both, behaviors, and character traits for ideal human behavior; for example, the ANA CoE posited a specific moral position on the nurse's role in providing compassionate care and relief of suffering (Butts & Rich, 2020). Normative ethics prescribed what should and should not be done or abided by the largely universal "norms" of society (Forrestal, 2016). Professional codes of ethics leaned heavily on this approach as this type of ethical inquiry prompted questions like, "What should I do and not do?" and "How should I be?" (Butts & Rich, 2020). Normative ethics focused on developing frameworks around widely accepted concepts such as telling the truth, charity, and kindness and was less concerned with

more controversial ethical and moral topics with varying perspectives (i.e., abortion) (Butts & Rich, 2020).

Within philosophy and healthcare, the term "applied ethics" was commonly used. Applied ethics consisted of professional ethics and the subsequent moral reasoning and ethical decision-making used to solve problems in a professional setting; it was often referred to in the fields of bioethics, business ethics, and organizational ethics (Forrestal, 2016; Murray, 2010). Normative ethical theories in action were considered applied ethics, thereby transferring an abstract social code into a real-life setting (Marquis & Huston, 2021). However, other philosophical approaches to ethics have existed. Based on the writings of Immanuel Kant, the deontological ethical theory (i.e., duty-based reasoning) suggested and evaluated actions as right or wrong, regardless of the consequence (Marquis & Huston, 2021). Deontology was the forerunner of the rules-based approach of ethical principlism (Butts & Rich, 2020).

Principlism applied four main principles: autonomy (respect for self-determination), nonmaleficence (do not harm), beneficence (do good), and justice (fairness); decisions were based on these agreed-upon norms (Beauchamp & Childress, 2019). Critiques of principlism suggested that the approach is simplistic and might have been inclined to use a casuistry approach (Murray, 2017). *Casuistry* referred to ethical decision-making on a case-by-case basis, which expanded decision making to consider laws, level of complexity, and situational context (Forrestal, 2016). Additionally, bioethics was a type of normative applied ethics and used both principlism and casuistry in ethical decision making (Forrestal, 2016). Ethical principlism was most frequently applied in bioethical situations and did not use one formal theory or methodology for decision making, but rather referred to principles and guidelines for justifying actions (Butts & Rich, 2020). The most common approach to teaching nursing ethics was

through applying ethical principlism in relation to clinical decision making and evaluating evidence-based practice (Black, 2020; Langford & Young, 2013; Murray, 2017).

The second stream of ethical inquiry was metaethics. Metaethics abstractly explores the meaning of words, such as *good*, *bad*, and *virtuous* (Butts & Rich, 2020). Descriptive ethics, the last stream of ethical inquiry, utilized research to explain or describe the behaviors of people, such as the behavior of nurses in professional and organizational settings (Butts & Rich, 2020). Descriptive ethics did not prescribe or forbid behavior and avoided value judgements (Forrestal, 2016). Some critics suggested descriptive ethics allowed cultural norms to determine what was right, resulting in ethical relativism (Forrestal, 2016; Murray, 2010).

These ethical frameworks were applied through theories, codes, and other formal and informal social constructs (Butts & Rich, 2020). When exploring the implications of applying an ethical framework or code of ethics, one might consider the difference between morality and ethics. A distinction existed between *ethics* and *morals*, although the words were often used interchangeably; *morals* were discreet "beliefs, behaviors, and ways of being" flowing from ethical frameworks and were process-related and actionable (Butts & Rich, 2020, p. 4). *Morality* referred to socially and culturally constructed traditions and norms (Burkhardt & Nathaniel, 2020). The social, cultural, and religious norms influenced and shaped personal standards of right and wrong; moral reasoning might have included values such as "a little white lie is ok but based on the circumstance" (Alfaro-LeFevre, 2019). Moral decision-making was social in nature; it generated cause-and-effect on others whether the decision was made in isolation or not which demonstrated "there is no such thing as private morality" (Billington, 2003, p. 21). Professionals opened their private decision making in a professional setting to public scrutiny (Jameton, 1984). According to Black (2020), ethical decision making was an exploratory and, at times, iterative

process of reviewing options to determine the wisest solution for a complex problem. Ethical reasoning was concerned with a systematic and formal study of criteria of justifiable actions, whereby a nurse might have said, “When I’m working as a nurse, I do not lie because of my commitment to the ANA Code of Ethics" (Alfaro-LeFevre, 2019).

One useful framework to explore the complexity of the academic nurses’ responsibility in administrative duties and accreditation is through an ethical lens. Bioethical concepts, such as autonomy, freedom, privacy, beneficence, offered a practice-based theory, thereby empowering faculty to make sound decisions and refocus as a team on the basic tenets of nursing practice (Burger et al., 2014). Furthermore, the profession of nursing expounded on these bioethical topics through the creation of the ANA CoE (ANA, 2015). The ANA CoE offered a model for nurses in all practice settings to 1) continually self-improve the profession of nursing; 2) create meaningful discourse and cast vision for a moral society; and 3) generate social activism and reformation in all aspects of healthcare delivery (ANA, 2015).

According to the ANA, nursing knowledge was developed through “abstract conceptualization, critical reflection, clinical innovation, and other means” (2015, p. 114). Moral knowing involved abstract thinking and encompassed and exceeded the obligatory principles of codes of ethics or conduct, inclusive of “voluntary actions that [were] deliberate and subject[ed] to the judgment of right and wrong”, and considered the outcomes of unpredictable, contradictory, and conflicting needs the professional nurse addressed (Carper, 1978, p. 20). Awareness of professional codes of conduct for nurses provided increased sensitivity to moral and ethical decision making and the responsibility attached to these choices (Carper, 1978). For an increasingly encompassing professional code that was “even handed” for all areas of nursing

practice, nursing research had to expand to advance the profession beyond clinical research into the social sciences and humanities (ANA, 2015, p. 115).

Historically, US society viewed the profession of nursing and nursing leadership as a moral high ground amidst leadership moral failures (Eby et al., 2013; Gallup, 2023). The trusted profession of nursing spanned many practice environments, including clinical practice, nursing research, and nursing education. Nursing educators collectively developed a unique and emerging professional identity and organizational culture within higher education, research science, and adult education (Bono-Neri, 2019). Consequently, each environment offered unique responsibilities to the public and ethical leadership challenges.

The search criteria for this literature included but was not limited to the various combinations of the following key terms: “faculty”, “nursing”, “academia”, “ethics”, “higher education”, “ethical issues”, and “accreditation”. The key words were chosen based on the research question and the scope of the research. The research databases commonly used included *CINAHL*, *Academic Search Premier*, and *ERIC*. Additional qualifiers included “peer reviewed articles” and a publishing date within the last ten years. In this dissertation, unless otherwise specified, *accreditation* refers to specialized accreditation. First, ethical challenges for nurses in clinical settings and nursing faculty in higher education are described, then primary accreditation, and then ethical challenges faced by higher education faculty. And lastly, an overview of specialized accreditation is presented, with connections made to nursing ethics in higher education.

Ethical Challenges

One of the primary historical authors for nursing ethics, Jameton, described ethical challenges as tasks related to academic research, dealing with difficult clients, giving unfortunate

news, informed consent, pain management, end of life treatment, political involvement, and use of technology (1984). Nurses could make ethical decisions to navigate said challenges through guided ethical decision-making processes (e.g., identify the problem, gather data, identify options, think the ethical problem through, make a decision, act and assess the impact), personal reflection, and an on-going study of the humanities (Jameton, 1984). However, nursing educators encountered different challenges than bedside nurses, such as working against the constraints of academic productivity, crafting interesting lesson plans, mastering pedagogical responsibilities, developing relevant content knowledge, and working in administration (Barros Ribeiro et al., 2014).

Nursing educators might have been reluctant to acknowledge ethical issues within the nursing curriculum and classroom due to how uncomfortable it felt (Bahr, 1991). Nursing educators were primarily responsible for developing and cultivating nursing students' understanding of nursing ethics; however, most medical professionals struggled with how to teach or assess these competencies (Lu et al., 2014). In the academic environment, nursing educators were frequently faced with unfilled faculty positions, thereby increasing disproportional workloads, poor compensation, and stressed interpersonal interactions (Dalmolin et al., 2009, as cited in Barros Ribeiro et al., 2014). Nursing educators might have perceived the academic workload to be unrealistic and unbalanced (Grassley et al., 2020). Furthermore, high nursing educators' turnover and the nursing shortage could lead to low experiential capital (Rosseter, 2019). There have been rising numbers of novice nursing educators and administrators who were responsible to lead the administrative duties and accreditation processes along with a need to support understanding of programmatic evaluation to obtain useful faculty participation

in the accreditation process (Ellis & Hallstead, 2012). Ethical challenges often corresponded with feelings of moral distress.

Moral Distress in Nursing

Jameton introduced the highly influential concept of nursing ethics and moral distress in 1984, and the topic had developed to include conversations within multidisciplinary healthcare teams. Jameton's (1984) formative description of moral distress was characterized by an internal challenge that arose when one has had a conflicting ethical or moral judgment about healthcare decisions that differed from others on the care team and thus perceived that institutional or systemic obstacles as preventing them from acting in alignment with their values. Nurses were uniquely positioned to experience moral distress given the intricacy and intersectional role-responsibility of the profession (e.g., responsible to client, profession, self, and institution) (Caram et al., 2021). Schluter et al. (2008) conducted a comprehensive literature review on the topic of moral distress and moral sensitivity and defined *moral distress* as "an emotion that is expressed when the moral complexity of a situation is not leading to a resolution, thereby having the potential to cause harm to the individual nurse" (p. 306). A precursor to providing client-centered care and successfully navigating the daily morally distressing issues was *moral sensitivity*, understood as one's ability to identify the presenting moral conflicts as such, as well as the interpersonal awareness of the impact of moral decision making as it pertained to others (Borhani et al., 2017).

Epstein and Hamric (2009) observed the layperson's understanding of the phenomenon was a feeling of psychological distress; while moral distress included psychological distress, moral distress was byproduct of both a felt violation of core values or duties and the perceived constraint of being able to take an ethical course of action. Scholars have continued to expand,

debate, and develop the conversation around moral distress. For example, more current definitions corroborated with the original definition of moral distress, e.g., a state of "physical, emotional, cognitive, and behavioral signs, caused by the inability to achieve a certain desirable level of care for patients due to internal and external conflicts" (Borhani et al., 2017, p. 497). Next, a brief introduction to the research conducted on moral distress in clinical practice will be provided, followed by moral distress and ethical issues in nursing education.

Promopahakul et al. (2021) conducted a mixed methods study regarding moral distress in Thai nurses in tertiary care in Thailand. The results concluded causes of moral distress strongly related to system-level failures and end-of-life and palliative care related decisions (e.g., organizational over-fixation on productivity at the expense of client care, unessential documentation requirements, high staffing ratios, aggressive medical treatment during medical futility) (Promopahakulet al., 2021). Furthermore, three key qualitative themes emerged as causes of moral distress: 1) powerlessness to meet high standards, and powerlessness to advocate for clients and families, 2) end of life and palliative care practices that prioritized aggressive medical treatments not in the best interest of the client, and 3) team-based issues such as poor communication, collaboration, inappropriate professional comportments, and incompetent team members (Promopahakul et al., 2021). Accelerated changes in technology, diagnostic predictive capabilities, economic reforms, and scarcity of resources were considered additional root causes of moral distress (Borhani et al., 2017).

Furthermore, in healthcare settings, ethical behavior was considered "standard operating procedure" and some healthcare professionals became defensive that special consideration should have been given to the ethical complexity of their work; however, healthcare existed as a service-oriented, people-centric industry while also an ethically complex multi-billion-dollar

enterprise (Pearson et al., 2003, p. 27). As healthcare teams became increasingly diverse, ethical decisions were made by groups of people with varying personal values; therefore, incivility, toxic leadership, or lateral violence did need not to be present for significant stress to occur (Butts & Rich, 2020).

Given the various causes of moral distress, there were several resulting impacts on the nursing profession and client care. According to Burston and Tuckett (2012), nurses experienced the consequences of moral distress both within themselves and the effects of moral distress on the system. Regarding the impact on "the self", this might have looked like anger, horror, anticipatory dread, loss of self-esteem, demoralization, resignation, depression, and personal and professional disillusionment (Burston & Tuckett, 2012). Nursing organizations that attended to nurses' moral distress on a systems-level could prevent nursing withdrawal from client care, burn out, or professional attrition entirely (Promopahakulet al., 2021). The impact of moral distress in both persistence and severity related to personal needs, motivators, characteristics, as well as the well-established relationship of levels of education and experience (where nurses more highly educated and experienced were more likely to experience moral distress) (Ramos Toescher et al., 2020a; Schluter, 2008). Nursing educators were highly educated and experienced and thus a seemingly highly vulnerable population for experiencing moral distress in a variety of educational, clinical, and administrative settings.

In parallel fashion, since the impact of moral distress was both on an individual and systems level, the interventions for moral distress followed similar themes (Burston & Tuckett, 2012). Individual interventions included increasing coping and communication skills; a collaborative approach referred to inter-professional conversations about client care, ethics education, mentorship, as well as the bold approach of requesting insight regarding moral

distress from client and family (Burston & Tuckett, 2012). Moral resilience and critical resilience acted as protective factors against moral distress (Rushton, 2017). For example, Ventovaara et al. (2021) researched pediatric oncology nurses in Finland by utilizing a cross-sectional research design to analyze nurses' perceptions of ethical climate and moral distress. Results of the study suggested a negative correlation between ethical climate and moral distress, nurses were profoundly impacted by supportive, competent workplace relationships, and manageable workloads offset the impact of moral distress (Ventovaara et al., 2021). Hamric's (2012) empirical review of nursing literature identified some qualitative results of possible root causes of moral distress, categorically including factorial internal to the caregivers (e.g., powerlessness or lack of knowledge), external factors (e.g., institutional constraints, incompetent peers), and clinical variables (e.g., futile treatment, false hope).

Moral residue occurred after a situation where the caregiver felt compromised or an internal sense of self-betrayal, thereby causing painful, on-going, concentrated emotions (Webster & Baylis, 2000). This lived experience might persist for years or a lifetime and had been described as ongoing uncertainty, guilt, and remorse (Webster & Baylis, 2000). Navigating moral residue required personal reflection, supportive and constructive feedback from peers, and institutional support (e.g., moral community) (Webster & Baylis, 2000). Moral residue was a central component of the crescendo effect (Epstein & Hamric, 2009). For example, a caregiver experienced unresolved moral distress, resulting in moral residue, and the residue progressively accumulated, thereby elevating and heightening the negative psychological experience to ethically charged situations (Epstein & Hamric, 2009). Nurses in all practice settings were exposed to ethical issues, and nursing educators faced unique ethical challenges in higher

education. Following the brief introduction to moral distress in clinical practice, moral distress and ethical issues in nursing education will be discussed.

Moral Distress and Ethical Challenges of Nursing Educators in Higher Education

In Chapter 1, an overview of the durability and applicability of a professional code of ethics was introduced. The ANA CoE contained nine fundamental provisions and interpretive statements; each provisional statement articulated a unique aspect of nursing practice (ANA, 2015). Each provision provided a concise statement regarding professional nursing values, obligations, and duties, the importance of remaining loyal to the profession's nonnegotiable ethical standard, and an expression of nurses' understanding and social contract detailing their commitment to the American public and society at large (ANA, 2015). While nursing education was not explicitly spoken to in the provisions, nursing administrators and faculty actively participated in maintenance and elevation of high-quality nursing care via quality nursing education. Nurses participating in administrative duties acted in solidarity with the larger nursing profession to uphold the profession's values within state, federal, and global initiatives to bring health and well-being (ANA, 2016). Within the code existed the larger consideration of social ethics, as nurses considered the organizational, national, and even global repercussions of the nursing profession (ANA, 2015).

The basic tenets of ethical principles appeared commonsense at best and belittling at worst; nevertheless, ethical issues continued to topple sophisticated organizations and challenge competent leaders on a regular basis (Resnik, 2020). Redman and Fry (2003) conducted initial work on commonly experienced ethical and human rights issues for nursing leaders, specifically nursing leaders in clinical settings. The study explored topics of prevailing ethical concerns from nurse leaders, as well as the level of disturbance with the issue; common issues within clinical

practice included protecting human dignity, informed consent, restraints, advanced directives, and staffing issues (Redman & Fry, 2003). Often the term *ethical issues* invokes images of nurses participating in assisted suicide, abortion, stealing narcotics, or abusing clients. However, Redman and Fry (2003) highlighted the far more routine and predictable ethical challenges faced by nursing leaders and suggested gaps in research identifying common ethical issues faced by nurses in non-clinical roles. The following section explores the ethical challenges faced by nursing faculty in non-clinical roles, specifically in academic settings.

Nursing Faculty

The following article specifically addressed the research topic of this study, and attention was given to exploring the author's work, as the topic itself had little nursing literature generated. Fowler and Davis (2013) conducted a comprehensive literature review of over 2,600 nursing articles regarding ethics in the educational environments; their analysis of the literature revealed nursing research focused primarily on single-issue topics, where and how nursing educators should have taught ethics to nursing students and how to integrate nursing theory into nursing ethics. Other topics, although of lesser focus within nursing literature, included whistle blowing, ethics of research authorship, and academic dishonesty, discrimination, faculty moral development, and incivility (Fowler & Davis, 2013). Few articles about nursing ethics in educational settings existed (Fowler & Davis, 2013; Gray, 2008; Schmitz & Schaffer, 1995). Moreover, nursing literature sparsely addressed taboo topics such as the impaired nurse educator (e.g., substance, mental illness, or cognitive decline), nursing faculty-student sexual relationships namely multi-generational lesbian sexual misconduct, or counseling students who were not a "fit" for the nursing profession (Fowler & Davis, 2013, p. 129).

Fowler and Davis (2013) considered the nature, scope, and frequency of issues that occurred within nursing education through typologizing common areas of ethical challenges, such as “nursing educational administration” and “faculty” and “profession, society, and global relations” (p. 129). The sub-categories included “conflict of interest”, “curricular bias”, “competing loyalties: profession, school, student, patient, and self”, “educational standards and accreditation”, and “professional standards and ethics”; the stated typologies directly pertained to self-reporting to peers through the process of nursing program accreditation (Fowler & Davis, 2013, p. 130). Although Fowler and Davis (2013) mentioned accreditation in a subcategory, no articles within the provided sources address this research topic, enhancing the awareness of the needed research.

Regarding gaps in the nursing literature, Fowler and Davis (2013) identified several emerging themes. First, nursing leaders had to embrace taboo topics, support research and scholarship on these topics, and reframe the fear of disclosure and exposure by viewing it as an essential aspect of professional self-regulation (Fowler & Davis, 2013). Additional research was needed to address personal and system-based issues common to nursing education broadly (Fowler & Davis, 2013). Some nurses noted that the “language of ethics is almost a barrier. People don’t understand it...or it is too difficult to articulate or perceivably dangerous for political reasons” (Makaroff et al., 2010, p. 571). According to Makaroff et al. (2010), unspoken aspects of a social experience might have often been referred to in reference to the client’s nonverbal cues and the nurses’ duty to explore, notice, and attend to these cues; however, there were many unspoken assumptions of nursing practice and, specifically, in the lived experiences of leveraging nursing ethics.

Nursing faculty also experienced challenges in comprehension of ethical issues. Lyndaker (1996) qualitatively explored BSN nursing faculties' experience identifying and managing ethical value conflicts as it related to nursing students. Lyndaker's (1996) research summarized the following experiences of nurse educators' criteria used to identify a situation as a possible conflict of ethical values. Nurse educators mentioned criteria such as "gut feelings," "inner turmoil…struggle," "right and wrong," "adherence to patient rights," "ANA Code of Ethics," and "difficulty in identifying situations as ethical in nature" (Lyndaker, 1996, pp. 31, 32). The findings of this study inferred that faculty used inconsistent, and often ambiguous, criteria, and potentially misunderstood ethics (such as citing ethical issues were right vs. wrong) (Lyndaker, 1996).

Gray (2008) explored this topic more broadly. They explored nurse leaders' experiences with the ethical dimensions of leadership in nursing education through qualitative, phenomenological interviews of four nursing leaders working in higher education and healthcare. The results indicated that nursing leaders' core themes of moral leadership as it pertained to nursing education were "integrity, justice, wrestling with decisions in light of the consequences, and the power of information" (Gray, 2008, p. 335). The study results identified the following subthemes: integrity (honesty, respect, standards of excellence, and courage), justice (fairness and challenging the 'we-they' dichotomy), wrestling with decisions considering consequences (appropriate actionable steps), and the power of information (dissemination versus confidentiality) and reading between the lines (Gray, 2008, p. 335). Justice, fairness, and confidentiality were consistent themes throughout the ANA CoE (2015) and applied to nurses in all settings.

Grason (2020) interviewed 11 nursing faculty using a qualitative, descriptive phenomenological design to better understand faculty's experience with teaching ethics. Nursing educators stated reluctance to discuss ethical issues with students in formal or informal settings due to feeling ill-prepared in ethics education and uncertain about baseline student knowledge regarding ethical issues (Grason, 2020; Robichaux et al., 2022). Faculty stated their ability to explain basic ethical concepts; however, the complexity of care required more than bare definitions when explaining or understanding a complex clinical problem (Grason, 2020). Furthermore, the study suggested ethical education in nursing school was given little more attention than as a "place holder" in the curriculum and largely deprioritized due to more technical teaching topics within nursing education (Grason, 2020, p. 508). Benoliel (1983) stated that integration of ethics content had to be reconceptualized from adding ethics to an already congested curriculum to weaving ethics into a range of content with moral and ethical reasoning and decision making which would specifically challenge students' old beliefs with complexities, frustrations, and moral ambiguity.

Grason's (2020) comments aligned with Fowler and Davis's (2013) statements about nursing educators' challenges with accurately assessing ethical issues; out of 100 ethical issues noted in nursing literature about nursing education, 70% were not moral dilemmas at all but rather moral failures (2013, p. 113). Therefore, the question was not what was right or good and conflicting normal and values, but rather failure to adhere to what was right and good and more aptly named as a "failure of moral character…or failure of virtue in nursing educational settings" (Fowler & Davis, 2013, p. 113).

Nurses in all practice settings and professional levels of competency needed guidance on how to apply nursing ethics to their setting, especially when it came to coping with stressors and

challenges. One study identified specific stressors for full-time BSN nursing faculty constrained to the four categories of classroom and clinical activities, administrative duties, and academia in general (Hinds et al., 1985). The findings indicated clinical as most stressful (25.9%), next academia (25.9%), with classroom (24.1%) and administrative duties tied (24.1%) (Hinds et al., 1985). Faculty endorsed developing innovative teaching methods as most stressful in the classroom, coordinating academic commitments with student needs as most stressful regarding academia, and power struggles and policies amongst faculty as most stressful related to administrative duties; data related to clinical stressors was excluded due to low agreement between participants (Hinds et al., 1985). There were many opportunities for nursing leaders to support one another in academia, especially because nursing faculty experiencing stressors might have felt a sense of moral distress.

Ramos Toescher et al. (2020b) explored moral distress amongst nursing professors, specifically the use of parrhesia as a form of coping; *parrhesia* was defined as a verbal expression of an ancient Greek democratic ideal to speak truth, even potentially at personal risk. Faculty worked in a variety of tenured, nursing faculty positions at public institutions and were surveyed using a qualitative, explorative-descriptive study (Ramos Toescher et al., 2020b). The research findings suggested three primary reflections amongst nursing faculty requiring their key morally distressing activities and approaches to cope with moral distress (Ramos Toescher et al., 2020b). Nursing faculty stated performance expectations and potentially upsetting situations such as interpersonal conflict, excessive tasks, or inadequate physical resources as causes for moral distress (Ramos Toescher et al., 2020b). Secondly, nursing faculty endorsed feelings of moral conflict in situations with conflicting personal, professional, or organizational values and asymmetrical power dynamics (Ramos Toescher et al., 2020b). And lastly, nurse educators stated

the powerful use of telling the truth, or *parrhesia*, even if the truth created a perturbed organizational or interpersonal dynamic, along with the benefits of reflection as a means of personal and organizational transformation (Ramos Toescher et al., 2020b). The results demonstrated that nursing faculty experienced distress when they felt unable to behave in alignment with their values, especially in situations that entailed risk (interpersonal rejection, side-lining, overlooking for promotion) and that the institution was unsupportive despite being notified of the problem (Ramos Toescher et al., 2020b). Nursing faculty possessed great transformational power if they chose educational activities focused on reflection of professional and pedagogical practice (Ramos Toescher et al., 2020b).

Identifying what triggered moral distress and how nursing faculty coped provided useful insights; Ramos Toescher et al.'s (2020a) research aimed to identify the most common sociodemographic characteristics of nursing faculty in public and federal universities and their corresponding self-reported experiences with moral distress. The results indicated that younger, female faculty with less professional experience placed nursing faculty at higher risk for moderate moral distress, as opposed to older male or female faculty with more work experience, who were more likely to experience milder forms of moral distress (Ramos Toescher et al., 2020a). The study did not focus on specific interventions to moderate the lived experience of moral distress of nursing educators in the university setting. The findings conflicted with Schluter et al. 's (2008) work endorsing higher levels of education and education increasing the likelihood of nurses experiencing moral distress. Greater studies were needed to consider cultural differences amongst nurses surveyed around the world, as Ramos Toescher et al.'s (2020a) study focused on Brazilian faculty, as well as differentiating potentially unique factors regarding

protective factors of moral distress for more experienced nurse educators as opposed to bedside nurses.

Duarte et al. (2017) explored moral suffering in nursing faculty educating nurse technicians. Duarte et al. (2017) used Jameton's (1984) definition of moral distress to describe moral suffering and stated the scope of moral distress/suffering expanded to anyone involved in providing care to clients, thus increasing the expansive potential for moral distress to be felt by students and educators, just as similarly as doctors and bedside nurses. The findings suggested two core themes. Firstly, nursing professors stated moral distress when students demonstrated perceived feelings of low engagement, commitment to the future profession of nursing, and a lack of professional comportment (e.g., student cell phone usage in class, boycotting or encouraging mutiny type behaviors related to tests, constant dissatisfaction with educational experience) (Duarte et al., 2017). Nursing faculty also stated moral distress when they felt students demonstrated a lack of commitment to the teaching-learning process (e.g., stagnation, self-indulgence, absenteeism, intellectual apathy, lack of basic studying and problem-solving skills) (Duarte et al., 2017). The results of this article suggested nursing faculty needed support in processing ethical issues related to teaching and instruction when students appeared disengaged, disinterested, or hardly committed, in a similar way a bedside nurse required support when caring for a medically complex patient with corresponding complex ethical issues present.

As previously mentioned, nursing literature offered thoughts regarding moral distress and ethical challenges of the nursing educators (e.g., Barros Ribeiro et al., 2014; Boozaripour et al., 2018; Ganske, 2010). Just as bedside nurses experienced moral distress and ethical dilemmas when they did not feel they were able to provide the best care possible, nursing educators experienced similar feelings of distress in academic settings (Ganske, 2010). It was no surprise

that faculty often felt more confident with ethical challenges in the clinical practice setting than complex, siloed administrative issues in higher education regarding finance, marketing, student recruitment practices, and faculty retention (Tsuruwaka, 2017). Some of the most distressing aspects of the nursing educators' experience included students' academic dishonesty, grade inflation, and incivility (Ganske, 2010).

Nursing Faculty and Nursing Students

Furthermore, nursing students had unique perspectives with ethical issues in the academic setting. Theis (1988) qualitatively explored nursing senior-level BSN students' perceptions of unethical teaching behaviors in the class or clinical setting and defined *unethical teaching practices* as behavior violating an ethical principle. Theis' (1988) findings suggested that students perceived ethical issues occurred in the clinical setting (50%), in the classroom (39%), and occasionally in relationship to administrative issues (3%). Students perceived that the primary ethical principles violated in both clinical and classroom settings were firstly respect for persons, secondly justice, and lastly, beneficence (Theis, 1988). Students cited specific issues related to lack of respect for clients/students, unfair and inequitable grading, and favoritism, and incompetent or incorrect teaching (Theis, 1988). Nursing educators have helped students identify ethical issues in clinical practice but had to also be aware of the student perspective and concerns in the academic setting.

Other issues might have arisen if nursing faculty felt their judgment were constrained from taking ethical action with a student-specific ethical issue due to departmental policies (Schmitz & Schaffer, 1995). Schmitz and Schaffer (1995) explored nursing faculty and students' actions to rectify ethical issues occurring in the student/professor dynamic, investigated the ethical principles selected for the proposed course of action, and predicted barriers to following

an ethically desirable course. The selected hypothetical problems presented to participants included inconsistent grading, conflict related to late paper policy, disagreement about the degree of clinical supervision required, student complaints about instructors or other students, unexpectedly low grades, and students' covering up for a peer's poor nursing care (Schmitz & Schaffer, 1995). Concerning barriers to ethical action, students reported twice as many barriers as nursing faculty; greater research was needed to understand the likely multifactorial perceived barriers of nursing students (e.g., developmental stage, power differential, etc.) (Schmitz & Schaffer, 1995). One salient data point was the consistent issue of "uncaring relationships" and the negative impact on ethical decision making; educators had to make it clear to students the level of care and intentionality involved in decisions that impact students (e.g., curricular topics, departmental policies, professional interactions) (Schmitz & Schaffer, 1995). Cultivating positive relationships with students decreased the perception of hierarchy and fostered more effective solutions.

The National League for Nursing (NLN) recognized the ethical issues that often occurred within the student population, such as but not limited to, academic dishonesty, incivility, lateral violence, breaches in confidentiality (through social media or otherwise) (NLN, 2012). Nursing students perceived nursing educators as ethical when they were up to date on subject knowledge, managed the classroom appropriately, respected students' personal lives and confidentiality, and demonstrated equal treatment to all students regardless of academic performance, race, religion, language, or sex (Arslan & Dinc, 2017). Students felt nursing educators demonstrated unethical behavior if they shared students' personal information with colleagues, admonished students publicly, left students alone in clinical settings, and arrived late or left early (Arslan & Dinc, 2017). Students also identified obscene or rude jokes, selling textbooks, or using university

facilities for personal use as unethical (Arslan & Dinc, 2017). The fear of poor evaluations limited nursing students from processing ethical issues with nursing educators (Palese et al., 2018). For instance, faculty might have also considered the poor performance of non-traditional adult learners or English as a Second Language (ESL) students and felt justified in giving passing grades due to competing family commitments and student loan accruals (Ganske, 2010). Although they were important aspects of the nursing faculty's role and responsibilities, these topics focused on the interactions of faculty with students and were not related to distress or ethical challenges related to administrative functions of faculty or academic programming, assessment, and evaluation duties.

Nursing Faculty and Accreditation

Students were not alone in their ethical challenges; faculty and support staff in traditional learning, online learning, and clinical environments may have also experienced similar ethical quandaries (Ethical Principles for Nursing Education, 2012). Cursory and generally brief preparatory coursework in nursing ethics and lip service to the ANA *Code of Ethics* supposedly fulfilled student needs and provided enough advanced guidance for faculty members; however, this approach was inadequate (Cino et al., 2018; Ganske, 2010). Nursing educators were specifically guided to include nursing ethics through curriculum, as the AACN *Essentials of Baccalaureate Education for Professional Nursing Practice* (2008) mentioned ethics numerous times (AACN, 2021). Although CCNE did not specifically mention ethics within the accreditation standards, CCNE did address the assumption of transparent reporting, trust, and professional integrity (CCNE, 2018a).

Nursing educators may have felt similar fears of exposure or weakness if they had communicated ethical challenges with a nursing administrator, colleague, or higher education

administrator. The nursing educators managing students or conducting academic research might have been more vulnerable and exposed to moral distress and ethical issues due to the level of responsibility and expert-status; thus, they experienced a decline in productivity, increased sensitivities to colleagues, and decreased enjoyment of the work itself (Dalmolin et al., 2009, as cited in Ribeiro et al., 2014). Nursing educators were aware of the moral competencies required of students to navigate these pressing social issues, but they simultaneously recognized the gaps in curriculum that would have supported students in developing a moral framework to aid them in attending to these concerns (Enderle et al., 2018).

In small schools of nursing, nursing educators might have represented the only content expert in their specialty, and this might have created a sense of isolation regarding processing content-based ethical concerns or team-based ethical concerns in their academic work environment; nursing educators were found to positively enhance ethical competence in nursing students (Palese et al., 2018). Greater support was needed for nursing educators to effectively leverage external accreditation standards, greater transparency and collaboration between nursing programs to navigate the complex process (Ralph et al., 2013). Nursing faculty were presented with a variety of opportunities for self-reflection, transparency, and collection within academia, specifically areas considered potential conflicts of interest.

Conflict of Interest

Erlen (1994) defined *conflicts of interests* as "opposing or compatible goals or benefits requiring an individual to make a difficult choice, namely when there are numerous positive outcomes or potential for self-gain" (p. 92). A discernible conflict that a nurse in an academic setting might feel is the possible benefits or opportunity for self-gain and compromising an internationalized personal and professional value of integrity and accountability (Erlen, 1994;

Fowler, 2013). For example, a conflict of interest was adapting research methodologies to less rigorous methods to complete research quicker, potentially resulting in an increase in rank, pay, and garnering necessary qualifications for doctoral positions (Erlen, 1994).

Another example of conflict of interest for nursing faculty included those who attended a doctoral program with tuition remission at their workplace while subsequently navigating the new experience of being both colleague and student amongst their peers (Anselmi et al., 2010). The doctoral student who also worked as a professor might be competing against doctoral professors for grant monies or sit on or chair a committee alongside a doctoral professor (Anselmi et al., 2010). The doctoral student and doctoral professor might also be involved in providing peer evaluation (teaching, tenure, IRB approval, dissertation committee) to one another, and they may question how to provide unbiased feedback without relational fallout within the nursing department or larger institutional life (Anselmi et al., 2010).

Lazzari et al. (2015) conducted a comprehensive literature review of nursing research to better understand the professionals' knowledge about teaching nursing in higher education. A key theme included the conflicting roles that faculty faced in the multiplicity of administrative and emotional roles required (Lazzari et al., 2015). Nurses as clinicians often adopted and accepted an idealized and stereotyped maternal role (e.g., support, guidance, affection, and, at times, disciplinary action); however, this warm emotional connection might come into conflict when students demonstrated stubbornness, irresponsibility, or breaches professional agreements, knowingly or unknowingly (Lazzari et al., 2015).

Conflict of interests occurred in academic settings but were often underacknowledged, underreported, and largely unsearched (Erlen, 1994). However, a helpful consideration was that conflict of interests were not inherently bad, and they generally could be circumvented through

following policies, procedures, and administrative planning and awareness of the dynamic (Anselmi et al., 2010). Higher education practitioners might experience conflicts of interest if they served as a peer-reviewer on an accreditation team, knowing that their peers will review their institution in due time (Ewell, 2012). Within academic settings, Erlen (1994) proposed that faculty, administrators, and students critically evaluate their goals and responsibilities, as well as the cost involved for individual choices. At a systems-level, nursing administrators supported faculty and students by preventing conflicts of interest through carefully constructed policies, consideration of "blind" grading systems to avoid preferential treatment, mentorship, and faculty development (Erlen, 1994). Faculty could be supported by engaging group-based case studies, by first defining and clarifying potential conflict of interests in academic settings with group discussions about how to navigate them with a sense of personal and professional integrity (Erlen, 1994). The linkage between nursing faculty's experience with possible conflict of interests and lived experience of moral distress warranted further research within the field of nursing leadership.

Administrators and Directors

Administrators and directors in nursing programs were primarily responsible for budgeting and allocation of resources impacting a variety of stakeholders (Yeaworth, 1997). At a micro-level, administrators might allocate funding for research monies to recruit promising researchers while that money could be used to enhance existing, aspiring researchers within the department (Yeaworth, 1997). In even this small example, administrators faced a dilemma of resource allocation for the greatest return on investment while simultaneously demonstrating an understanding of the mission of the parent institution and the needs of existing faculty and enhancing the desirability of their current workplace to prospective, quality candidates

(Yeaworth, 1997). Scaled beyond the department, administrators made social, financial, and interpersonal calculations influenced by macro-level decisions, such as the parent institution's strategic plan and restructuring, funding, and donor support (Yeaworth, 1997). While the ideal approach to professional nursing practice implied patient care, healthcare reform, and nursing education were driven by ethics, not economics, administrators might experience distress due to the overarching economic directives set by parent institutions' emphasis on cost containment, national deficits, healthcare policies, and state-based funding (Yeaworth, 1997).

Code of Ethics for Nursing Educators

In 1983, Rosenkoetter, a nursing faculty member and administrator, developed a Code of Ethics for Nurse Educators, noting the applicability of the ANA Code of Ethics for the primary target audience, clinical, bedside nurses; but the ANA Code of Ethics neglected to capture some of the ethical concerns of nursing faculty and educational administrators. Rosenkoetter's (1983) Code of Ethics for Nurse Educators fundamentally reflected the International Council of Nurses and ANA codes as the basic building blocks of ethical conduct for professional nursing practice. In 2010, Rosenkoetter and Milstead revised the previous ethical code for nurse educators, acknowledging the significant impact of twenty-seven years' worth of changes in healthcare technology, public healthcare policies, globalization, and societal demands on the profession of nursing. Nursing faculty were now educating a highly mobile community of learners with emerging societal expectations, globalized values, norms, and ethical standards (Rosenkoetter & Milstead, 2010). The revised Code of Ethics for Nurse Educators, according to Rosenkoetter and Milstead, was as followed:

The nurse educator:

- Assumes responsibility and accountability for personal action and for maintaining competence in the practice of nursing education;
- Has an obligation to function as an advocate for students, as well as for patients, the greater community, and for the discipline;
- Strives to promote academic and professional values, including critical thinking, effective decision making, caring and respect, and excellence in education research and practice, while encouraging and maintaining the highest standards in the nursing program and the profession;
- Facilitates and guides the learning of students in order to ensure quality nursing education and to advance the professional practice of nursing;
- Equitably applies standards and expectations of performance;
- Models high standards and expectations;
- Demonstrates respect for confidential matters relating to students, patients, and families, as well as colleagues in the academic and health care communities;
- Contributes to the evolving body of nursing knowledge, skills, and attitudes;
- Safeguards the patient and the student from incompetent, illegal, or unethical practices of others;
- Acknowledges student contributions to research and scholarly publications, presentations, and professional activities; and advocates for students against exploitation or abuse;
- Utilizes technology appropriately in the conduct of research, educational activities, and nursing practice;

- Engages in ongoing self-evaluation and limits professional practice and teaching responsibilities to areas of personal competence;
- Models commitment to lifelong professional learning for professional growth, currency and competence;
- Demonstrates commitment to the profession through participation in professional organizations and by encouraging commitment among students to life-long learning and ongoing personal development;
- Demonstrates accountability to students, the academic community, the profession and society in fulfilling academic responsibilities by engaging in self-evaluation and peer review;
- Demonstrates respect for the beliefs and rights of students and their participation in nursing research and nursing practice, while evaluating them with fairness and integrity;
- Demonstrates respect for students and colleagues as individual contributors to the profession and greater society (2010, pp. 138, 139).

The above code and ANA CoE referred to competence and upholding professional values; however, competency is skill-based (Fowler, 2015). For example, a nurse could learn how to insert a nasogastric tube yet remain oblivious to the ethical complexities of the end-of-life client who was uninterested in full-scale interventions but had family advocating for aggressive treatment. Technical competency was not the refutable issue in this situation, but rather ethical sensitivity to the presenting ethical challenge. Equating quality client care (or quality nursing education) to numbers of professionals present with relevant competencies reduced the profession to laborers as opposed to clinicians and practitioners with expertise, skill, and knowledge (Izumi, 2012). Therefore, it was important that nursing faculty were allowed to

discuss the complexities of their administrative roles and functions, specifically when it came to the challenge of integrating nursing professional values within a larger institution, during a pandemic, and amongst one's peers in an openly visible and high-stakes arena.

Accreditation was a voluntary process which an institution completed an in-depth self-study and peer-review to determine institutional strengths, identify institutional weaknesses, create corrective actions, and plan opportunities for sustainable change (Kumar et al., 2020; Whitehead & Lacey-Haun, 2008). Accreditation was a form of quality improvement; and quality improvement efforts required more than competency and responsiveness to administrative mandates (Izumi, 2012). Nurses could move from compliance to engagement through being highly involved in not simply passive data collection but in developing the standards themselves (Izumi, 2012).

Accreditation added value to community stakeholders through intentional institutional-level reflection of current educational processes and protection for the community and consumer through maintenance and evaluation of high-quality education (Sosa Lopez et al., 2016). Accreditors assumed programs felt comfortable enough to disclose information meaningfully and transparently about successes and failures of the program (CCNE, 2018a; Kuh & Ewell, 2010). Accreditation also operated under the assumption that peer reviewers fairly appraised without bias. This form of transparent disclosure hinged on professional ethics and required nursing educators and peer reviewers to develop high levels of internalized professional ethics. When it came to self-assessment, it was reasonable to hold favorable views of ones' place of employment, to unconsciously highlight program successes, and to minimize program shortcomings (Mahon & O'Neill, 2020). However, past experiences, bias, or lack of insight on the process meant individuals were unskilled and unaware just how short-sighted self-assessment

was (Mahon & O'Neill, 2020). Accurate self-assessment of one's actions and competency had significant implications both at the bedside and in academia.

Previously in healthcare, moral and ethical frameworks flowed from the artificial differences between clinical and research ethics (Faden et al., 2013). However, new frameworks were emerging that considered the integration of clinical (applied) and research (academic) ethics. Faden et al. (2013) suggested an integration of this divide, increasing real-time learning and continuous improvement. A better understanding of a faculty member's perception could lead to a richer and more clearly directed accreditation process (Mullen et al., 2001).

Primary Accreditation

Overview of Primary Accreditation

Accreditation is an ongoing, voluntary process that has taken place in U.S. higher education for over 100 years (Billings & Halstead, 2015). There are two types of accreditation and vernacular across higher education varies. A college or university obtained institutional accreditation through an agency recognized and approved by the US Department of Education (U.S. DOE, 2021). Specialized or "programmatic" or "secondary" accreditation applied to programs or colleges within a larger institution (U.S. DOE, 2022).

Primary accreditation, also known as "institutional" or "regional" accreditation, applies external standards to the entire institution; each program and activity of the institution is evaluated in light of the institution's holistic mission, values, and goals (U.S. DOE, 2022). The goals of accreditation are to protect students and enhance institutions' overall quality (Flood & Roberts, 2017). The primary intent of higher education accreditation has been quality assurance; additionally, accreditation should contribute to a culture of continuous improvement through staff and faculty involvement (U.S. DOE, 2021). The process assesses the quality of an

institution based on established explicit educational standards; these benchmarks are enforced through national and regional agencies (U.S. DOE, 2021).

The United States was divided into six regions with respective regional accreditors and over 60 specialized accreditors in the United States (Schejbal, 2012; Selingo, 2013; U.S. DOE, 2021). Primary accreditors are private, nongovernmental agencies responsible for setting quality standards for institutions and ultimately are accountable to the U.S. Department of Education (U.S. DOE, 2022). Almost all other countries derived quality standards from the government, but the United States has a unique, decentralized, and peer-reviewed accreditation process (Wergin, 2012). Public agencies had less cause to intervene in programs due to the more stringent, ongoing, internal evaluation (Billings & Halstead, 2015).

Accrediting organizations in the United States have created specific standards to ensure that institutions and programs meet threshold expectations of quality and that they demonstrate improvement over time (Brittingham et al., 2010). It was important to define the seemingly ubiquitous term *quality*, which could have been interpreted abstractly and academically or practically and specifically. Educational quality was considered multi-dimensional, and therefore it was difficult to definitively articulate in one sentence. Based on a broad synthesis of the literature, Schindler et al. (2015) stated that over thirteen constructed definitions of "higher education quality" exist. A simplistic definition of *quality* was the fulfillment of an intentional mission or vision (Bogue, 1998; Schindler et al., 2015). From a student perspective, *quality* might also be coined synonymously as "excellence"; some college students defined *excellence* as "(good) standing and academic reputation of an institution" (Kumar et al., 2020, p. 152). Within education, *quality management* could refer to "an educational program's commitment to and strategies for collecting comprehensive information on the program's effectiveness in meeting its

goals and the management of its finding to ensure the continued quality of the program" (Keating, 2015, p. 350). Quality was also contextually dependent; examples of quality included comparison of the product to a standard, a comparative product, or consumer expectations (Keating, 2015).

The central goal of accreditation is ensuring institutions meet or exceed acceptable levels of quality (U.S. DOE, 2022). Primary accreditors focus on two main topics: institutional capacity (resources, processes, and financial, technological infrastructure, and personnel) and educational effectiveness; these foci aim to increase the relevance and responsiveness to institutions (Driscoll & De Noriega, 2006; Wolff et al., 2010). The six primary accreditors defined *educational institutional effectiveness* as the following iterative processes: "establishment of mission and goals, planning, expected academic and administrative outcomes, data collection, assessment of outcomes, evaluation of assessment findings, resource allocation in support of stated mission and goals, and continuous improvement in institutional performance" (Paton et al., 2014, p. 46). The six primary accreditors were private organizations and, thus, free to set their own standards; however, there was surprising consensus between the six organizations' standards nationwide (Molinero, 2013).

The primary motivators for improving academic quality and the development of relevant student learning outcomes were often linked to a positive institutional commitment or culture to improvement, as well as to achieving and sustaining regional and specialized accreditation status (Kuh & Ewell, 2010). Trachtenberg et al. (2018) stated that successful initial and ongoing completion of accreditation desirably aligned the university with highly desirable federal funding. Federal financial aid dispensation was legally tied to an institution's good standing with regional accreditation, thereby creating student access to federal and state grants and loans

(Flood & Roberts, 2017). Since over 69% of college students utilized either private or federal loans and accrued on average $35,000 of student loans, it was essential that students had access to financial aid (Student Loan Hero, 2019).

Numerous benefits existed because of obtaining primary accreditation. Accrediting bodies have directed specific interest to student outcomes and achievement metrics, such as course completion, graduation rates, and employment rates for alumni (Pham & Paton, 2017). Accreditation was considered the most reliable evaluation method to determine educational quality by some higher education practitioners (Cura & Alani, 2018). Some historical voices posited the benefits of accreditation; for instance, primary accreditation had been found to have had a positive impact on program development and the quality of faculty, organizational openness, and ability to access resources (Lejeune & Vas, 2009). Primary accreditation offered institutions the opportunity to shift from a "regulatory, once-a-decade, compliance-oriented process to a reflective, evidence-driven, and learning outcomes-based" process (Wolff et al., 2008, p. 24). Accreditation was largely concerned with "use of results" and "closing the loop," by which educational practitioners moved beyond simply collecting data to meaningful data collection and analysis (Driscoll & De Noriega, 2006, p. 16).

Furthermore, institutions participating in accreditation engage a cycle of continuous program development (U.S. DOE, 2021). Concerningly however, the process of accreditation has not inherently produced positive results and has been shown to deliver only modest improvement in student achievement and institutional effectiveness (Kumar et al., 2020). Impactful and consequential assessment practice require institutional leaders to use meaningful assessment data and craft actional plans oriented on the student (Kumar et al., 2020). Through intentional

accreditation processes and highly engaged faculty, institutions could conduct a reflective and iterative practice of self-improvement to benefit students and the institution.

Historical Background of Primary Accreditation

The United States' system of higher education has historically recognized accreditation as a trusted seal of collegiate quality; it involves a central process of periodic institutional self-study, followed by subsequent visits from external peers who evaluate the institution on an established set of standards (Bogue, 1998; Paton et al., 2014). Before the 1980s, accreditors were primarily concerned with resources and reputation, with little focus on quantifiable quality metrics (Wergin, 2012). In 1965, Congress enacted the Higher Education Act (HEA), thereby delegating federal power to accrediting agencies to provide oversight and ultimately prove as gatekeepers for federal funds (U.S. DOE, 2022). Over the past 40 years, increasingly diverse students with various levels of academic preparation migrated from smaller institutions to multi-school or multi-campus institutions, thereby increasing the need for accurately assessing student learning outcomes, institutional accountability, and accreditation (Kumar et al., 2020; Wolff et al., 2010).

In 2005-2006, the Commission on the Future of Higher Education, with the authority of the U.S. Secretary of Education, released the Spellings Commission Report, putting significant pressure on higher education and accreditation, specifically regarding accountability, greater transparency to the public, increased scrutiny to student learning outcomes, and expanded governmental oversight (Eaton, 2012). The Spellings Commission communicated a public and governmental distrust in higher education's promise to prepare students for industry (Murray, 2012). The report posited three core suggestions: realistic and clear learning standards, increasingly accurate assessment measures of student learning, and consequences for institutions

if established standards were not met (Murray, 2012). The increased focus on meaningful use of data analysis and interventions based on evidence relied heavily on leveraging technology, such as student record systems and institutional research offices (Brittingham, 2012). In response, the federal government continued to take a greater interest in tracking national quantitative data; schools were rewarded for improved graduation rates, career-oriented learning outcomes, and student retention (Trachtenberg et al., 2018).

Pressure to contain costs have continually increased in higher education while external stakeholders perceived the college experience as costly and unproductive; as tuition costs rose, families, students, and policy makers vocalized discontent (Balzer, 2020). Due to the public and government's concerns, accreditation continued to gain more visibility and relevancy for four main reasons: an economy dependent on college-education workers, increasing numbers of traditional and non-traditional students, lower international rankings of U.S. higher education, and funding (decreased state funding, increased federal regulation, and higher student loans) (Brittingham, 2012). Consumers were understandably concerned about the cost of obtaining a college degree, as total outstanding student debt in the United States recently surpassed one billion dollars (Federal Student Loan, 2022).

Policy changes impacted institutional engagement of accreditation (Fain, 2019). Historically, institutions could predict a classic ten-year accreditation cycle: the institution would gather steam for a required self-study, an accrediting team would visit, accreditation would likely be granted, and everything could "return to normal" (Bardo, 2009, p. 47). Increasingly, higher education administrators were expected to simultaneously operate a functional university and a highly rigorous process of quality improvement and diversify markers of learning, such as diplomas, badges, and certificates (Kumar et al., 2020).

In response to these public concerns, the Trump administration deregulated accreditation to increase institutional autonomy and flexibility (Fain, 2019). Effective in July 2020, some aspects of the deregulation included elimination of geographical borders for accreditors, which allowed institutions to seek accreditation outside of their region, as well as quicker federal approval processes of prospective accrediting agencies (Fain, 2019). However, higher education was decentralized from the federal government which allowed individual states to retain control over education, and therefore, a degree of variability of educational quality existed across the United States (U.S. DOE, 2022). During the 1990s and 2000s, primary and specialized accreditors became increasingly diligent in evaluating institutions based on specific student learning outcomes, assessment, and evaluation of outcomes and application of outcomes to an improved, educational practice (Wergin, 2012). The Biden administration crafted a learning agenda specifically focusing on student access, affordability, student success, and institutional outcomes (McCann et al., 2020). Therefore, colleges and universities could anticipate greater emphasis on institutional outcomes. The following section outlines the procedural steps of regional accreditation, the self-study process, and the peer-review process.

Process of Gaining Primary Accreditation

Higher education institutions in the United States have displayed accountability in three primary ways: through complying with federal regulation, by meeting the demands of the market, and engaging the peer-review process (Wergin, 2012). Demonstration of these key criteria includes institutional engagement of several key processes. First, the institution prepares a self-study report, measuring itself against the standards set by the external accrediting agency (Brittingham et al., 2010; U.S. DOE, 2022). Next, the accreditation agency selects a team of peer-reviewers to complete an on-site assessment; the peer-review team conducts a site-visit

which includes interviewing students, faculty, and other stakeholders (Education Next, 2018). After a satisfactory review, the agency grants accreditation both privately to the accreditation and publicly for consumer review (U.S. DOE, 2022). Lastly, the accreditation peer-review team analyzes the self-study and site-visit data and determines if the institution or department achieved accreditation; this process is then repeated every five to 10 years to remain accredited (U.S. DOE, 2022). These three steps were estimated to cost over $1 million, specifically in the form of administrator and staff time (Education Next, 2018).

Self-Study Process

Accreditation and re-accreditation utilize the self-study process in conjunction with peer-review, whereby evaluating the fulfillment of the stated mission of the organization and achievement of stated internal and external goals and standards (Molinero, 2013). The goals of planning for primary accreditation include (1) preparing institutional “soil” with communication of accreditation process and expectations, (2) sifting through the institution’s vast amounts of “dumbed data" and choosing only the best representations of institutional capacity and educational effectiveness, and (3) arranging said data into readable samples the accreditors could acknowledge (Driscoll & De Noriega, 2006, p. 53-54). The self-study report communicates the cumulative alignment of each department’s activities and outcomes in meeting the institution’s mission and goals (Hilliard & Taylor, 2010). The report includes the institution’s mission statement, undergraduate and graduate student learning outcomes assessment, prior accreditation feedback, and sustainable steps taken to address areas of improvement, as well as documentation of adequate resources and materials for the given academic environment (Hillard & Taylor, 2010). Best practices for writing a self-study include creating a sustainable institutional identity,

establishing core values that frame future actions, and engaging in continued self-monitoring mechanisms offered by the accreditation process (Martin et al., 2009).

Peer Review

Accreditation relies on rigorous self and peer-based assessment against specific external standards (Kumar et al., 2020). Collaboration between universities was built into the accreditation process through peer review. Peer review entails a delegate or team of reviewers from a commensurate university visiting an institution and reviewing them for the basic level of accreditation quality (Elgart & Wheelan, 2015). In the past, institutions would conduct a self-study every 10 years, and then one accreditation representative completed an on-site peer review within one day (Ewell, 2012). However, a shift toward the utilization of peer-review teams occurred due to multiple factors: regional accreditors transitioned from reviewing homogenous institutions to evaluating more diverse colleges and eventually, community colleges, and diverse perspectives were needed (Ewell, 2012). Therefore, multiple stakeholders engaged in the accreditation process; this included faculty, staff, students, higher education administrators, and peer reviewers (Hilliard & Taylor, 2010). Furthermore, institutions engaging the peer-review process reaped many benefits, such as extensive overview of the key aspects of the institution: institutional effectiveness, student success, institutional governance, and financial viability (Elgart & Wheelan, 2015). Additional benefits included a diversity in expertise, cost-containment, and investment in one's academic neighbor (Ewell, 2012).

However, as helpful as the diverse perspectives were, peer review might also contribute to maintaining the "status quo" and prohibit creative innovation (U.S. DOE et al., 2018). Other possible drawbacks of peer review include the limitations of faculty knowledge regarding assessment, evaluation, and expertise in current educational policy trends, thereby

unintentionally misrepresenting data for peer reviewers to interpret (Ewell, 2012). Another consideration for quality peer review was the level of preparation of the peer reviewers. For example, according to the Northwest Commission on Colleges and Universities (NWCCU), one of the seven institutional accreditors (previously called regional accreditors) recognized by the U.S. DOE, training for commissioners entailed a one-day orientation prior to completing a peer-review (Northwest Commission on Colleges and Universities [NWCCU], 2020). In contrast, international peer-review participants might receive multi-day or week-long training (Ewell, 2012). Historically, the peer review process was meant to communicate academic quality to prospective students, competing institutions, and community stakeholders; however, some critics suggested over time that the peer review process functioned as a primary gatekeeper to the institution's eligibility to federal funds (U.S. Government Accountability Office, 2017). Furthermore, over-reliance on peer reviewers might have a conflict of interest, as they were also judged by peers and ultimately, the DOE (Ewell, 2012).

Benefits of Primary Accreditation

Colleges, universities, and consumers have benefited from institutions internally and externally articulating ambitious student learning goals, as well as transparently reporting of meeting or falling below the established benchmark (New Leadership Alliance for Student Learning and Accountability, 2012). Furthermore, students can access Title IV financial aid and other state and federal aid through an accredited organization (Billings & Halstead, 2015). Kafaji (2020) discovered a statistically significant positive correlation between students' perceived positive benefit of accreditation and academic performance and career prospects, suggesting that students perceived studying at an accredited university as highly desirable and therefore studied harder which improved their future job prospects.

The Baldridge Model has utilized accreditation as a vehicle for organizational excellence and denoted seven primary collaborating categories essential for high-performance: leadership, strategy development, focus on the customer (student, stakeholder, and market), data analytics, attention on faculty and staff, operations, and focus on organizational performance results (Kumar et al., 2020). A clear and systematic approach to accreditation maximized the process and could lead to improvement in policies, processes, research, and teaching and learning (Kumaret al., 2020).

Not only have students and institutions benefited from accreditation, but communities also benefited from local, high-quality, accredited programs through the development of a highly educated workforce (Foreman et al., 2015). Although accreditation has benefited students, institutions, and communities, regional accreditation agencies rarely accredit new colleges or universities (Education Next, 2018). Institutions seeking accreditation for the first time or institutions seeking re-accreditation might encounter several barriers to accreditation.

Barriers to Primary Accreditation

Higher education administrators have reported exhaustion and fatigue as they attempt to meet numerous federal regulations (Stratford, 2015). One primary challenge for institutions seeking accreditation was the wide scope of standards and substandards. For instance, some institutional accreditors required that institutions comply with nine standards and over 250 subcomponents; the complexity of the process could contribute to leadership fatigue, unfocused vision for change, and ultimately, attenuated quality (Wolff et al., 2010). Blaich and Wise (2018) described accreditation as an iron triangle, by which institutions had to choose two of the three sides: scope, cost, or speed. Due to federal regulations and the chronic recession in higher education as an industry, most institutions are forced to pick a cheap, far-reaching swath of

institutional assessment processes (Blaich & Wise, 2018). One suggestion included retooling engagement periodically with mundane, standardized, repetitive, managerial tasks without losing functionality, in effort to avoid duplicity and burnout and enhance the time spent on administrative projects (Berger Fadel et al., 2019).

A second primary issue that institutions seeking primary accreditation consider is the cost. In the United States alone, colleges and universities spent over $27 billion trying to comply with the federal requirements, with $3 billion specifically allocated for regional accreditation and $3 billion for programmatic accreditation (Vanderbilt University, 2015). Not only is the cost of accreditation high, but many institutions' business models focus on funding faculty salaries, operational costs, and athletic programs (Martin et al., 2009). Institutions operate on an already thin margin, and expensive accreditation assessment reporting systems can total over $500,000 per institution (Vanderbilt University, 2015). Woolston (2012) found that the average direct and indirect cost for institutions seeking reaccreditation was $327,254 between the seven to 10-year accreditation cycle, thereby costing approximately $30,000-$40,000 per year to the institution (Elgart & Wheelan, 2015). These costs are not always immediately apparent to institutions beginning the accreditation process.

Higher education leaders might assume the process of accreditation is expensive and involved but might be unaware of the actual costs until in the process; however, faculty were often most aware of the costs of time and manpower (Elgart & Wheelan, 2015). Faculty might have been more aware because they contributed approximately 5,000 hours to institutional accreditation (Vanderbilt University, 2015). The process of accreditation was historically largely accomplished by faculty volunteers through institutionally based committee work (Elgart & Wheelan, 2015). Many people involved in the accreditation process endorsed the fear that not

even “110% of the time (dedicated to accreditation) would be adequate!” (Woolston, 2012, p. 123). Faculty and administrators have noted competing demands to complete the required accreditation work, teaching, and administrative duties (Woolston, 2012).

Institutions often subsidized accreditation preparation through committee work and received valuable consulting through the peer-review process (Ewell, 2012). An institution that hosted a peer-review team could be charged over $400,000 if each expert (administrator, presidents, faculty members) billed an individual consulting fee; peer review teams offered expert advice for a low, one-time bundled cost (Elgart & Wheelan, 2015). The cost of accreditation can be a financial drain with both short-term and long-term effects, as many institutions expend financial and human capital on obtaining accreditation and struggle to maintain the needed reserves to address unfavorable accreditor feedback (Flood & Roberts, 2017). However, advocates of accreditation reminded institutions that the time-intensive costs of accreditation ultimately helped institutions become more cost-effective over the long-term (Elgart & Wheelan, 2015).

Other challenges regarding accreditation exist. Once an institution or department has been reviewed, the accreditation agency maintains the power to grant accreditation and approve with conditions, probation, or denial/termination (U.S. DOE, 2021). Between 2009-2014, regional accreditors denied 1% of institutions applying for accreditation, and reasons for withdrawal or denial of accreditation generally focused on the objective financial viability of the institution, as opposed to potentially more subjective academic performance (Education Next, 2018). Although accreditation standards clearly encourage the institutions to address the needs of their community, institutions could fall prey to shifting their focus from the community needs to the community’s validation of their product (Chedrawi et al., 2019).

Perceptions of Accreditation

From a consumer, accreditor, and federal agency standpoint, accreditation enhances academic quality and protects the public from corruption (Billings & Halstead, 2015; CCNE, 2021; U.S. DOE, 2022). Multiple authors have explored both positive and negative faculty and student perceptions of accreditation (Buzdar et al., 2018; Cushing, 1999; Murray, 2012; Yüksel, 2013). Stakeholders in the process experienced the accreditation process with mixed feelings; some stated they perceived the process as prescriptive, forced, and stifling while others said it produces inspiration for excellence (Mullen et al., 2001). Naysayers suggested accreditation agencies were not agile enough to navigate the external factors of rapidly changing technology, funding disparities, increasing global market competitiveness, and rising expectations of consumers (Gaston, 2014; King, 2013). However, the process of accreditation was often cited as providing needed organizational-level reflection, peer-based feedback, and external objectivity regarding quality, governance, fiscal integrity, and student outcomes (King, 2013).

Administrators' Perceptions

Many administrators knew that almost all institutions received accreditation eventually, thereby denoting not all institutions were equal in caliber and quality (Murray, 2012). However, Lejeune and Vas (2009) further explored the perceived impact of the accreditation process on organizational effectiveness and culture by surveying 31 administrators and directors. The authors conjectured that the impact of accreditation increased openness to the positive aspects of organizational culture of external sources due to consistent review of external standards, greater internal cohesion within the team to reach a common goal, and greater formalization of internal processes; the study speculated accreditation strengthened internal structure, adaptability, and innovation while simultaneously increasing bureaucracy (Lejeune & Vas, 2009). Their results

suggested accreditation had a positive impact on some dimensions of organizational effectiveness and no impact on decreasing bureaucracy within the organizational culture (Lejeune & Vas, 2009). Accreditation had the highest impact on program development, quality of the faculty, social and community interaction, and the ability to access resources (Lejeune & Vas, 2009). Accreditation was also noted to correlate positively with cultural change and performance (Lejeune & Vas, 2009).

Although this research focused on nursing programs in the United States, some research had been conducted among international higher education administrators. Nigsch and Schenker-Wicki (2013) surveyed 117 international business school directors to explore if accreditation could support research performance and, consequently, institutional reputation. The results suggested international accreditation was positively related to research performance, enhancing alignment between an institutions' mission and actions, and recruitment of qualified personnel (Nigsch & Schenker-Wicki, 2013). As frontline workers in the accreditation process, faculty had unique perceptions of the benefits, challenges, and opportunities of accreditation.

Faculty Perceptions

Primary accreditation garnered a spectrum of emotions from faculty who engaged accreditation with a range of positive expectations, cynicism, or simply doubt in its effectiveness (Cushing, 1999; Murray, 2012, Yüksel, 2013). Due to increasing complexity in interpreting accreditation standards, the process required highly qualified and experienced personnel; although expert personnel assisted the process, there was a risk for limited ownership of the entire faculty, thereby creating "fringe faculty" involvement (Bucalos, 2014, p. 5). Therefore, useful accreditation processes had to include not only sensitive measurements of quality but increased faculty acceptance and agreement to engage the process (Murray, 2012). However,

faculty investment could be influenced by several factors. Faculty resisted the time-intensive and vulnerable accreditation process for numerous reasons, particularly their fear that the process would be used against them, as well as a heightened awareness of their own accreditation inexperience (Driscoll & De Noriega, 2006).

Young (1973) offers a historical perspective. Young (1973) compared the perceptions of 230 community college faculty members, administrators, and primary accreditation team members regarding benefits and procedures of accreditation, the institution's accreditation status, personnel interactions and accreditation, inter-institutional relationships, and philosophical perceptions of accreditation. This historical data suggested no statistical difference between faculty, administrators, and accreditation team members in any category (Young, 1973). However, more current research suggested that an educator's perception of primary accreditation was likely related to their level of involvement (i.e., teachers perceived accreditation more positively than parents of elementary students) (Bose et al., 2017; Cushing, 1999). The level of involvement included faculty involvement in individual courses, analyzing program policies and use of academic resources, and evaluating the program curriculum in totality (Bucalos, 2014). The more involved an educator was in the primary accreditation process, the more likely their perception was to be positive (Bose et al., 2017).

Accreditation skeptics suggested primary accreditation failed to protect students from low-quality schools; accusations suggested accreditation focused on the "wrong thing" (Murray, 2012, p. 54). Accreditation standards might bear little relevance to quality outcomes (e.g., number of books in the library, prescriptive class sizes, or number of faculty who are tenured) (Murray, 2012). Although faculty might struggle with the relevancy of academic standards, faculty morale and trust in the accreditation process improved as they contributed to successful

accreditation processes and saw the subtleties of data collection and analysis as useful the longer they were involved in the process (Bucalos, 2014).

Hail et al. (2019) studied 60 faculty perceptions of the national agency, Council for Accreditation of Educator Preparation (CAEP). Faculty perceptions of accreditation included positive status and prestige for the university and prestige for individual programs (Hail et al., 2019). However, faculty doubted the effectiveness of accreditation to sustain systemic change and consistently struggled with high workload (Hail et al., 2019). The study suggested that faculty and stakeholders held significant power over the institution's decision to pursue and gain accreditation, the need for appreciation for faculty work, and the organization's need to budget human and fiscal resources for the accreditation process (Hail et al., 2019). Ultimately, faculty's perceptions of specialized accreditation were likely linked to knowledge about the accreditation process (Cushing, 1999; Murray, 2012). Therefore, a better understanding was needed regarding faculty's perceptions of accreditation and corresponding challenges they encountered.

Student Perceptions of Accreditation

Student learning outcomes played a central role in the accreditation process, and therefore greater understanding of student perceptions of accreditation enhanced the leader's ability to meet unique student learning needs. Yüksel (2013) explored 26 students' perceptions of academic standards and quality. The findings suggested Turkish students associated the term "quality" with "reliability, qualification, and accordance with standards" (Yüksel, 2013, p. 10). However, terms like "quality" or "effectiveness" were often misused and poorly defined, even by professors and administrators, and greater care had to be taken to define the nomenclature of academic assessment and evaluation (Yüksel, 2013). Accreditation might often be used as a recruitment or marketing tool; as higher education became progressively competitive with

declining birth rates, universities might increasingly emphasize the socially perceived value of their accreditation status to recruit the best students (Chedrawi et al., 2019; Inside Higher Ed, 2018). Additional student perspectives regarding specialized accreditation are addressed in an upcoming section of the chapter.

Community Stakeholder Perception of Accreditation

The New Leadership Alliance for Student Learning and Accountability (2012) recognized the need to shape stakeholders' attitudes and professional norms for gathering and reporting student learning, as well as the need to increase the public's confidence in higher education. Bose et al. (2017) explored stakeholder perceptions of accreditation for kindergarten through 12th grade Christian schools in Latin America; although this article did not focus on higher education, useful insights of stakeholder perceptions emerged. The stakeholders were defined as parents, teachers, and school leaders. The results showed an overall favorable attitude toward accreditation; however, the perceptions of stakeholders varied. The following themes emerged: (1) stakeholders expressed the accreditation process had a positive impact on the school; (2) the accredited school had higher levels of quality; (3) ACSI was an appropriate model for Latin America; (4) other schools should go through ACSI accreditation because it helped schools improve; and (5) ACSI was a well-recognized organization, which inspired schools to achieve at higher levels (2017).

Advocates of accreditation reminded higher education leaders to be aware that consumers saw the "highlight reel" of quality rankings, from best to worst, which presented an overly reductionist approach to higher education assessment and evaluation (Eaton, 2012). Higher education leaders might have felt pressured to overly simplify the complexity of the assessment process to cater to consumer understanding, and focus on the most visible, lucrative aspects of

quality while neglecting holistic analysis of the institution. Murray (2012) observed that the public often perceived accreditation as valuable in paper-form only but doubted the significance of the quality improvement process (Murray, 2012). Accreditation maintained a tenuous balance between accreditors unveiling the deficiencies of an organization and attempting to provide space for adequate time and privacy to improve (Murray, 2012). Murray noted the public might have also perceived accrediting groups operating with conflicts of interest, as the accrediting group was made up of an elective group of academics, and accreditors might have felt sympathetic to their peers (2012). Public perception of accreditation was important to the public, to higher education practitioners, and to the DOE.

The DOE gathered data from stakeholders regarding their perceptions of accreditor recognition and processes, with a specific focus on minimizing repetitions and increasing innovation within accrediting agencies (U.S. DOE et al., 2018). Stakeholders recommended the DOE honor the independence of accreditors and institutions, improve the substantive change process to yield greater innovation, and place higher priority on the student experience (U.S. DOE et al., 2018). According to Payton et al. (2014), the federal government continued to increase the interdependence on primary accreditation, institutional performance, and transparency to the community; therefore, many colleges have been enhancing community-based partnerships and mutual interests. Stakeholder perceptions impacted current higher education policy and future trends and challenges in U.S. higher education.

Current Trends and Challenges of Accreditation and Higher Education

The United States' higher education landscape was shaped by public policies such as the 1862 Morrill Act to establish land grant colleges and the 1865 Higher Education Act aimed at funding black colleges and universities (O'Sullivan, 2015). Public policy continued to shape the

activities of accrediting bodies. Former President Obama declared the United States would "once again have the highest proportion of college graduates in the world" by 2020 (Obama, 2009). At the time, the United States ranked 14th in the world for proportion of college graduates, thereby emphasizing an area of equitable access to education, federal oversight on student retention and completion, and affordability (Meyer & Rosinger, 2019). A decade later, higher education and the role of accreditation gained additional focus from the next presidential administration. In response to President Trump's federal deregulation efforts, the U.S. DOE issued a reconceptualization for the already decentralized accreditation process (Kreighbaum & Fain, 2019). The Trump administration rolled back several of the initiatives from the Obama administration and narrowed the role of accreditors, thereby encouraging institutions to take more creative and innovative liberties in defining college credit and online and competency-based learning (Kreighbaum & Fain, 2019). Several notable and, according to some, deeply concerning policy changes included less regulation for accreditation bodies themselves, which increased the pool of recognized accreditors with limited experience of evaluating institutions; furthermore, programs could have undergone substantive changes without accreditor approval (Flores, 2019). Aspects of public transparency and accountability, which served as consumer guardrails, were under question with these policy changes (Flores, 2019; Kreighbaum & Fain, 2019).

Even prior to the Trump administration, pundits voiced concerns that accrediting bodies did not adequately address the quality control issues harming students, such as constraining costs, shutting down diploma mill universities, and therefore these bodies required active federal oversight (Molinero, 2013). With the transition from the Trump administration to the Biden administration, additional review was given to higher education and accrediting bodies. For

example, the Accrediting Council for Independent Colleges and Schools (ACICS), which was initially cited as ineffective in 2016 and given pardon by the Trump administration in 2018, was under review again in 2021 for progressive noncompliance with federal regulations, such as insufficient staff development and financial insolvency (McKinsey, 2021).

Universities in the United States continued to become intermingled with global trends and geopolitics (Alexander, 2020). The U.S. student population also reflected an increasingly cross-cultural and intercultural demographic; one-third of all international students in the United States were from China (Altbach, 2019). Universities might overly depend on international students, specifically Chinese students; however, the income and predictability of this sector of student enrollment hinged on stable, mutually beneficial foreign relations (Altbach, 2019). COVID-19 has continued to impact travel for international students, and subsequently the demographics of higher education institutions have evolved. Stable foreign policy was only one component of higher education that leaders had to be aware of in relation to increasingly diverse student demographics (Altbach, 2019). As the student population within higher education has continued to diversify beyond the traditional high-school graduate to an influx of "non-traditional" adult learners, assessment practices had to also balance the needs of all students; curricular innovations might lower costs or increase learning outcomes for one set of students but negatively impact another segment of students (Hargrove, 2020). Innovation was "credit-bearing," as substantive changes in curriculum created a ripple effect in applying and maintaining accreditation (Hargrove, 2020, p. 74).

COVID-19 has continued to impact American students' access to higher education, recruitment efforts, and retainment in academic programs. For example, some colleges announced a permanent policy change in optional ACT/SAT scores for students' applying to

their programs (Washington State Council of Presidents, 2021). Evolving and often conflicting policies regarding masks and required vaccination of students, staff, and faculty continued to create a turbulent academic environment, potentially distracting from larger quality improvement issues (IHE Staff, 2021). Higher education faced several conflating crises: skyrocketing student debt, campus mergers and closures, and political pressures within the context of racial inequality and globalizing education (Alexander, 2020). Colleges and universities had enjoyed the spectrum of rapid rises in enrollment (e.g., GI Bill) however, enrollment had been declining since around 2011 and would likely continue to dip with dramatic implications on higher education (Alexander, 2020). Five specific trends highlighted the need for accurate student achievement metrics: unforgiving economic environment, technology-embedded and enhanced platforms, increased number of certifiers of learning (e.g., professional staff, interactive-software), increasing transparency in credentialing and accrediting bodies, and increasing student-based ownership of accumulated skills and skills (Kuh et. al., 2015).

As accreditation moved into the future, higher education leaders were called to grasp increasingly complex issues and demonstrate adaptability and forward thinking. Higher education leaders had to continue asking, "'What would be the best model of accreditation for five to 10 years from now' – not 'how can we make our old standards more effective'" (Wolff et al., 2010, p. 21). Higher education faculty held the line and pushed students to reach high academic standards; gathering, analyzing, and reporting evidence was the primary way faculty set ambitious and realistic standards (New Leadership Alliance for Student Learning and Accountability, 2012). The increased scope of academic credentialing options deepened the pool of assessment data and responsibility to protect student learning outcomes and maintain sufficient quality (Kuh et. al., 2015).

Higher Education Accreditation, Administration, Regulation, and Ethics

Leaders in every sector recognized the far-reaching implications of rapid technological changes, global pandemics, globalization, financial crisis, and racial conflict on their organizations, resulting in organizational leadership crises and searches for long-lasting meaning and mission fulfillment (Bolman & Deal, 2017). This crisis extended to the academic context, offering new challenges to faculty who were already overwhelmed by the difficulty of executing the central goal of higher education: the cultivation of socially responsible individuals through socially responsible educational processes (Chedrawi et al., 2019). The ascribed epistemology of an organization became the tacit guiding light to the student, which normalized the particular and expected way of relating to the world (Palmer et al., 2010).

The "trickle down" from "ontology through epistemology through pedagogy to ethics" suggested that the student, and thus the future, bore the brunt of unrecognized ethical issues (Palmer et al., 2010, p. 33). A key advantage of understanding the relationship between the intrinsic, ethical perceptions of academics in relationship to accreditation was the likelihood of increasing "scholarly yield," thereby the accreditation exercise offered useful quality improvement processes as opposed to a rubber-stamping timewaster (Luthar, 2017, p. 1156). To accomplish the purpose of higher education, faculty were ethically responsible for developing a level of pedagogical competence that would produce realistic, attainable learning objectives; this included a basic understanding of instructional methods appropriate for adult learners and the correct selection of teaching strategies for course content (Gandolfo, 1997). HEI's also had the ethical duty to set ambitious goals, not simply goals that historical data implied students could reach (New Leadership Alliance for Student Learning and Accountability, 2012).

Possible unintended consequences of accreditation on universities were faculty members placing greater value on research productivity instead of teaching and service (Von Bergen & Bressler, 2017). Another possible challenge for higher education leaders within the accreditation process includes the challenge of conflict of interest. Ethical dilemmas occurred when self-reporting to the public negatively impacted the organization's public image and financial standing (Butts & Rich, 2020). A potential outcome of faculty resistance to accreditation resulted in universities simply copying peers at accredited institutions or shapeshifting their mission, leading to institutional isomorphism (Chedrawi et al., 2019). Federally funded research programs required that institutions compete with institutional accredited contenders, thereby institutions might have attempted to "re-arrange institutional missions and policies to match these trends" (Gregorutti, 2011, as cited in Gregorutti, 2015, p. 424). Higher education was well versed in social demands to commercialize knowledge capital; however, federal kickbacks might have pressed universities to align themselves with missional models that did not always fit (Gregorutti, 2015). O'Sullivan and Curry (2015) suggested that university leaders wandered amongst the accreditation agencies and commercial rating organizations for validation; thus, the authors coined the term, "extegrity" to describe this process (p. 43). This type of validation seeking behavior placed organizations at risk for homogeneity while simultaneously polarizing the institution in an increasingly politically dichotomizing environment (O'Sullivan & Curry, 2015).

While crafting customized, intentional accreditation strategies became increasingly complex, institutions that overly relied on accreditors or federal oversight to "tell them what to do," reinforced compliance as opposed to internationalization of both organizational mission and academic quality (Kuh et al., 2015, p. 13). Ethics and compliance are not the same; ethics

programs address the values and norms of an organization whereas compliance programs catalog obedience to mandatory federal and legal requirements (Butts & Rich, 2020). However, compliance and ethics could work in tandem if compliance programs create and sustain organizational integrity, attention to details, and performance metrics; ethics can lift the eyes of the organization to missional ideals, careful contextual deliberation, and implementation of collective action (Pearson et al., 2003).

Faculty and administrators were not formally trained on ethical practices for grading, evaluating, and providing feedback to peers, professional confidentiality, and providing professional references for students; on an institutional scale other challenges existed, such as disproportionate faculty salaries, maintaining objectivity on tenure review, fiscal sustainability, racial tensions, conflict of interests within board of trustees, or lack of systematized review of tenured, endowed chairs (Keenan, 2019). Within higher education, medicine, clergy, and other forms of highly organized, hierarchical social stratified dynamics, Keenan (2015) suggested personal and professional accountability was largely vertical and validated by supervisors, chairs, or overseers; accountability in a hierarchical structure was rarely lateral and horizontally accountable to its students, parishioners, patients, and community stakeholders. Keenan (2019) posited that due to the lack of consensus or desire to define *university* (applied institutional) *ethics administrator*s, and *president*s; furthermore, administrators did not receive training and thus might have contributed to cultures that did not promote accountability and consciousnesses. Schrag et al. (2009) overviewed ethical tasks of academic administrators; going far beyond clerical tasks or resource allocation, administrators were tasked with moral recognition of problems such as sensitivity to discrimination amongst students. Secondly, administrators were responsible with taking an institutional point of view; administrators promoted the mission of the

institution, however conflicting that might have been if a faculty member had become an administrator and felt the stretch and shift of perspective (Schrage et al. (2009).

Fisher (2003) called for a Code of Ethics for academics in the first decade of the 21st century, citing the benefits as establishing a strong sense of professional academic identity, socialization, and enhanced public trust. Fisher (2003) proposed core principles for this aspirational code: concern for others, social responsibility to the community of interest and the parent institution, integrity in academic work, justice in issues in inequity through impartiality, and respect for all people. Challenges in drafting a code of ethics for academicians included variability in defining topics such as "respect" and obstacles in crafting a generalizable scope to encompass not only disciplines but also teaching, administration, and research functions (Fisher, 2003). Keenan (2019) spoke to institutional ethics as both a mechanism to prevent ethical issues as well as to respond to university scandals (e.g., campus sexual assault, cheating, nepotism, board members' conflict of interest, or poor treatment of faculty). Keenan (2019) noted with irony that discipline specific ethics were taught only within the university setting; however, universities, either individually or collectively as an industry, had agreed upon acceptable behavior for university-based ethics.

The American Association of University Professors (AAUP) crafted a statement of professional ethics for higher education professionals originally in 1966 and had since revised the document in 1987 and 2009 (American Association of University Professors [AAUP], 2009). Key themes included the commitment to advancement of knowledge and corresponding responsibility of stewarding self-discipline, respect, honesty, and freedom. Academic university staff were generally expected to demonstrate a minimum of eight moral values: objectivity, accuracy/thoroughness, independence, courage, credibility, reliability, respect for others, and

transparency (Nijhof et al., 2012). Professional experience within academia impacted facultys' comfort level with ethical issues. For example, professors were likely unaware of the full scope of their academic ethical responsibilities at the beginning of their profession; consequently, when they saw unethical academic practices, they assumed this questionable behavior was acceptable because they were inexperienced (Aydin et al., 2012). Facultys' sensitivity to academic issues increased positively with age and years of teaching experience (Denat et al., 2018).

Academic nurses perceived academic ethics with positive regard; tenured nursing professors were most sensitive to ethical issues in the academic setting, followed by assistant and associate nursing professors with doctorates (Denat et al., 2018). Overall, nurses who participated in conducting research stated that the highest levels of positive attitudes toward academic ethical values (Denat et al., 2018). Furthermore, academics were generally rewarded for obtaining grants, publishing, and other lucrative academic endeavors (Cox, 2016). Faculty were rarely rewarded for the quality or frequency of their (ideally) day-to-day activities, such as peer-review, mentorship, and high-quality teaching practice (Luthar, 2017). Consequently, the quality of these activities relied on the intrinsic values and personal character of individual faculty members (Luthar, 2017). Nursing faculty collectively created the culture that nursing students saw as the professional ideal by which to emulate, and ultimately, interact with clients; student's development was responsive to technical knowledge and, less visible but equally appreciable, moral development in self-determination, ethical inquiry, and integration of professional values (Benoliel, 1983). By upholding professional values, practitioners can positively impact institutional values.

Higher education leaders were empowered to address burnout, resistance, or disengagement at a macro-level and craft visible institutional commitment to ethical behavior

(Luthar, 2017). Organizational leaders carry an ethical imperative to consciously evaluate the impact of their organizations while cultivating an atmosphere of efficiency and effectiveness required to produce a high-quality product (Bolman & Deal, 2017). Faculty developers, either in positions of formal faculty development (such as administrator or program chairs) or informal positions of expertise at an institution, had to be aware of the unique ethical issues present in the academic setting (Gandolfo, 1997).

Specialized Accreditation

Schools or colleges, such as nursing programs within the parent institution, might gain additional accreditation, known as "specialized," "programmatic," or "secondary" accreditation (CCNE, 2018a; U.S. DOE, 2021). Specialized, programmatic accreditation is advantageous to the public, as consumers can identify programs that have voluntarily improved themselves (Billings & Halstead, 2015). The U.S. DOE (2021) delegated national authority to state or private accrediting bodies, such as regional or discipline specific agencies. Universities and colleges were categorically evaluated by institutional accrediting bodies on development and adherence to policies and procedures and alignment to internal and external standards; next, the institutional accrediting agencies determined if the institution was fully compliant, substantially compliant, or not compliant with each accreditation standard (U.S. DOE, 2022). For the purposes of this dissertation, the terms "primary" (in respect to institutional accreditation) and "specialized" accreditation (in respect to nursing accreditation) were used.

Specialized accreditation provides useful additional information to the parent institution regarding individual programmatic quality (Ewell, 2017). For example, business school administrators and directors in Europe stated that accreditation had the highest impact on program development, quality of the faculty, social and community interaction, and access to

resources as well as correlating positively with cultural change and performance (Lejeune & Vas, 2009). Research has demonstrated that achieving specialized accreditation had a positive influence on an academic program in several areas; benefits of specialized accreditation included involved advisory boards, clearer promotion and tenure guidelines for faculty, improved curriculum, and increased interest of highly informed prospective students and faculty (Von Bergen & Bressler, 2017). Barczykowski (2018) researched the 86 members of the National Association of Schools of Music (NASM), with a focus on the institutional perceptions of the benefits and costs of specialized accreditation. The study indicated that accreditation enhanced the reputation of the institutions, added programmatic value through the peer evaluation and self-study process, and positively impacted overall institutional effectiveness (Barczykowski, 2018).

Baker (2011) conducted a mixed methods study with six administrators of theological schools to discover their personal and professional perceptions of both regional and theological accreditation. Overall, these administrators stated that regional accreditation set realistic standards, believed it was not overly obtrusive, and felt institutions would be at risk for great harm if the accreditation process were removed (Baker, 2011). Their perceptions of specialized accreditation focused on the lack of innovation and inadequate diversity on the committee and board of the agency; these administrators reported conflicting perspectives of the value of specialized accreditation and if the process were removed (Baker, 2011). Pharmacy students perceived specialized accreditation positively, linking accreditation to higher quality academic programming, improved patient care, and greater educational opportunities (Wilby et al., 2019). However, students felt accreditation standards lacked rigor in requirements for foundational science content translating to clinical practice; they also perceived increased student workload due to accreditation standards (Wilby et al., 2019). Buzdar et al. (2018) offered an international

perspective on specialized accreditation. Their study surveyed 160 public and private graduate alumni in Pakistan and sought to explore the gaps between education students' educationally acquired attributes and industry required attributes and the influence of specialized accreditation on these gaps (Buzdar et al., 2018). The gaps were smaller among graduates of accredited programs, which suggested a positive effect of accreditation on the student outcomes of teacher education programs (Buzdar et al., 2018). Schools and colleges within a parent institution that might have sought specialized, discipline-specific accreditation included psychology, education, business, social work, and nursing.

Nursing Program Accreditation

Nursing programs are considered a professional school and thereby accredited through both primary (or institutional) accreditors and the "specialized" accrediting agency (U.S. DOE, 2021). As nursing has transitioned from an occupation to a profession, many exciting changes have taken place. One necessary stage of a profession maturing included self-regulation which serves as the professional basis for the development and enforcement of a professional code of ethics (Forrestal, 2016).

Additionally, sophisticated groups of content and practice experts exercise self-regulation through creating and enforcing standards for training programs, certifications, credentials, and licensure (Forrestal, 2016). Several regulatory branches exist within nursing and serve unique functions: professional regulation (e.g., standards of best-practice, evaluation of certification and competency), legal regulation (e.g., correct interpretation of state and national laws), regulations embedded into institutional policies and procedures, and self-regulation (group or personal accountability or both) (ANA, 2010). Professional standards are set by national accrediting

agencies, which accredit universities, faith-related, career-related, or technical institutions within a country (Keating, 2015).

According to the National Council of State Boards of Nursing, Nursing Regulatory Bodies (NRBs), also known as "state boards of nursing," are governmentally appointed agencies within the United States responsible for the regulation of safe nursing practice, protection the public's health, and evaluation of nursing program curriculum (NCSBN, 2023; U.S. DOE, 2022). Each state has a law called the Nurse Practice Act; these laws are enforced and revised by NRB's (NCSBN, 2023).

Nursing is regulated at the licensure, certification, and program accreditation levels; each process has a different purpose, philosophy, and legal standings (Barnum, 1997). ANA (2021) recognized the multi-factorial interplay required for professional self-regulation; prerequisites included rigorous objective data, autonomous nursing practice, and internally and externally driven influences (e.g., CoE, organizational policies and procedures, and legislative rules and regulations such as Nursing Practice Acts, accreditation, and administrative codes).

Accreditation is a major focus of health science disciplines, such as nursing, pharmacy, and medicine (Wilby et al., 2019). In the early 1900's, medically related programs (medicine, occupational therapy, and physical therapy) were jointly accredited through an "umbrella" approach to accreditation; however, as early as 1931, nursing programs (e.g., nurse anesthesia) began the initial stages of obtaining accreditation autonomously (Harcleroad, 1980). In the 1950s-1960s, a greater number of nursing programs in the United States began to respond to the published standardized curriculum and voluntary accreditation process set forth by the National League for Nursing (Egenes, 2017). In 1964, federal financial assistance for nursing students was linked to successful accreditation by the National League for Nursing (Harcleroad, 1980). In

1986, the AACN provided an educational framework for baccalaureate nursing education, and released revisions to the document in 2008, and most recently again in 2021 (AACN, 2021).

The AACN acted as a national voice for nursing education and healthcare policy, a funding source for large healthcare related grants, and an advocate for a positive image of nursing practice (AACN, 2019). CCNE periodically adapted accreditation requirements to include updates from the AACN *Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008; CCNE, 2018a; Frisch, 2003). CCNE accreditors referenced the AACN's *The Essentials: Core Competencies for Professional Nursing Education* (2021) when reviewing four-year nursing programs for quality curricular structures (CCNE, 2021b). Nursing programs seeking CCNE accreditation reviewed their curriculum considering AACN's ten essentials (e.g., Knowledge for Nursing Practice, Person-Centered Care, Population Health) in conjunction with the four CCNE standards (e.g., Program Quality: Mission and Governance).

The AACN's ten essentials set the standard of core knowledge required of a generalist, newly graduated pre-licensure nurse, and programs had academic freedom to shape specific program outcomes (AACN, 2021). In the recently revised AACN Essentials, nursing ethics was a featured concept and woven throughout the nine priority domains explicitly or implicitly (AACN, 2021). In Domain Three (Population Health), ethics was a core aspect of designing and managing equitable healthcare delivery. In Domain Five (Quality and Safety), AACN identified nurses as uniquely positioned and responsible to lead or co-lead teams enhancing safety, system effectiveness, and improved performance for individuals and teams (AACN, 2021). Domain Five closely corresponded with the direction of this research as it related to administrative duties and accreditation as a form of quality improvement. Domain Six (Interprofessional Partnerships) expounded on the crucial nature of integrating professional values (e.g., caring, altruism,

communication, ethical principles) within effective, team-based healthcare (AACN, 2021). In Domain Nine (Professionalism), AACN identified the application of ethical principles and demonstration of ethical behavior in nursing care as a core, entry-level competency for BSN nurse graduates (AACN, 2021).

According to CCNE, the accrediting agency had a "systematic, planned, and ongoing program of review to determine the effectiveness and appropriateness of the standards used in the accreditation process…every five years" (2021b, p. 37). Most recently in 2018, CCNE released revised standards for accreditation with the intent to further meet the changing needs of communities of interest (public consumers, the nursing profession, employers, higher education institutions, and students) (CCNE, 2018b). In the past, nursing program evaluation focused on the processes of delivering nursing education (student-centered learning and teaching processes); moving forward however, financial and educational trends emphasize student learning outcomes, graduate performance, and continuous program quality management and error correction measured against professional standards and competitors (Keating, 2015).

Nursing accrediting bodies include the ACEN and the CCNE (CCNE, 2018b). This study focused on Bachelor of Science (BSN) and Registered Nurse (RN) to BSN programs accredited through CCNE. Preparing for specialized accreditation is a significant aspect of the nursing educators' workload; as a team, nursing educators review national CCNE standards, reflect on their program's practices, analyze past actions, and strategically plan program development milestones (Haverkamp et al., 2017). Accreditation benefits students and stakeholders by providing reasonable assurance that programs offered quality degrees and engaged in ongoing quality improvement processes (Keating, 2015). Accredited nursing programs are more likely to

improve the overall curriculum with evidence-based interventions and peer review support as opposed to undertaking trial and error endeavors (Billings & Halstead, 2015).

Healthcare providers might be more accustomed to hearing about healthcare-based accreditation such as the Joint Commission (JC). JC has a strong US and international presence as a healthcare quality assurance agency and accreditor (The Joint Commission, 2021). However, bedside nurses reported varying degrees of acceptance and even awareness of healthcare accreditation; over 25% of bedside nurses had no knowledge of healthcare-based accreditation at one institution (Sadiq et al., 2016).

Nursing program accreditation is a vehicle for evaluating students' competency and readiness for nursing practice, and nursing programs also comply with the NRB for their state-based accreditation and thereby the allowance for students to take the NCLEX licensure exam (NCSBN, 2021). Nursing educators work within these systems to provide quality nursing education which equips nurses to solve brand new problems with new solutions. One of the quality assurance systems that nursing educators engage with a high-level of frequency is programmatic assessment and evaluation, primarily through the process of self-study for accreditation (Haverkamp et al., 2017).

During the unique financial and student pressures that higher education has recently experienced, nursing educators also prepared for accreditation. Planning for accreditation was rarely completed by one individual, but rather considered a group sport and completed by *ad hoc* teams or committees (Bendoly et al., 2010). Team-based groups negotiated programmatic-information management and prescribed norms of testing knowledge, determining what constituted credible data and how to truthfully interpret data (Schein & Schein, 2017). Transparent reporting meant more than not deceiving; it meant not promising more than the

program could deliver in a reasonable time, not doctoring up data, and giving constructive feedback to peers (Dalla Costa, 1998).

Process for Nursing Program Accreditation

As a team, nursing educators review the CCNE standards, reflect on their program's practices, analyze past actions, and plan (Haverkamp et al., 2017). Nursing educators and administrators hold unique roles in the accreditation process, and the responsibilities vary depending on the size and organizational structure of the nursing program. Administrators provide vision, leadership, technical expertise, and financial resources for on-going quality improvement efforts while faculty might work in a curriculum committee leading the total faculty in the accreditation process, or the committee might be solely responsible for the accreditation process with administrator oversight (Keating, 2015). The CCNE nursing accreditation process follows the following procedure: a nursing program writes a comprehensive self-study document, identifying areas of strengths and improvement and action plans; then a team of peer evaluators representing CCNE visits the program, analyzes the self-study document, and completes a written report for the nursing program and CCNE (CCNE, 2021b).

Next, the nursing program could respond to the peer evaluation report with additional evidence supporting compliance (CCNE, 2021b). Afterwards, CCNE's board reviews the peer evaluators, and CCNE committee's recommendations, and either grants, denies, or withdraws accreditation of the program (CCNE, 2021b). If a program were seeking initial accreditation, they might have been granted accreditation for up to five years, and programs seeking continued accreditation might have been accredited for a ten-year cycle (CCNE, 2021b; Ellis & Hallstead, 2012).

Nursing Educators Perceptions of Specialized Accreditation

Within clinical settings, an entire department is dedicated to compliance and hosts the office of a compliance officer. Compliance programs, or risk management programs, prevent unlawful situations and satisfies fulfillment of Medicare and Medicare requirements (Butts & Rich, 2020). Healthcare providers and administrators often have a conflicted relationship with compliance programs and might mirror the resistance of faculty. Faculty members in higher education frequently echo the begrudging sentiments, summarized as, "Do we have to?" (Pearson et al., 2003). Marquis and Huston (2021) highlighted the nurse administrator's leadership and management challenges, as their ethical challenges are both technical and complexly inter-personal; this dynamic applies to administrative tasks and accreditation.

Nursing educators hold a unique place in higher education, as they served as stakeholders in both clinical quality and higher-education quality improvement processes. A greater understanding of accreditation practices and protocols could lead to increased agreement from a variety of stakeholders. Faculty resistance to the arduous process of gaining and maintaining accreditation is well documented (Buzdar et al., 2018; Chedrawi et al., 2019; Driscoll & De Noriega, 2006; Murray, 2012, Yüksel, 2013). Faculty opposition to assessment and accreditation has reduced due to perceived authentic and meaningful use of the process, as well as alignment with professional values (Driscoll & De Noriega, 2006). The work required for assessment and evaluation could obscure or distract from using the data to improve student outcomes (Kuh et al., 2015). Skepticism and burnout in higher education related to the time-intensive accreditation process has abounded (Gaston, 2014). Nursing educators are no exception. Burgeoning academic responsibilities in addition to juggling clinical and didactic workloads might have minimized the energy required for transparent, thoughtful reporting. However, limited research is available

regarding faculty perceptions of specialized accreditation, and even less on the perceptions of nursing educators (Alaskar, 2018; Barczykowski, 2018, Richardson, 2015).

Research studies specifically about nursing program accreditation have generally focused on the procedural and process related aspects of accreditation as opposed to faculty perceptions about specialized accreditation (e.g., Ellis & Halstead, 2012; Halstead & Frank, 2018). Gropper's (1986) work provided a historical perspective into nursing education; the study explored 14 accreditation and non-accredited nursing programs for qualitative and quantitative quality program components. The quantitative indices of quality included faculty and student characteristics, student pass rates on licensure exam, and alumni employment records; qualitative indices of quality included administrators' opinions of why they did or did not seek specialized accreditation (Gropper, 1986). No differences of quality existed between accredited and unaccredited programs; however, small distinctions favored the accredited programs regarding faculty education preparation and retention of alumni in the field of nursing (Gropper, 1986).

More recently, Richardson (2015) surveyed six nursing school administrators in California regarding their perceptions of national nursing education accreditation and their quality standards. The study found that nursing school administrators valued specialized accreditation and a common indicator of quality, National Council Licensing Exam for Registered Nurses (NCLEX-RN), might not have been the most accurate measurement of programmatic quality. Overall, the nursing administrators endorsed satisfaction with specialized accreditation to ensure quality nursing education (Richardson, 2015).

Due to staffing shortages, depleted budgets, and invisible yet necessary workplace requirements, nurses have been increasingly asked to extend their work involvement beyond their defined duties (Aloustani et al., 2020). Employees complete voluntary work that was not

generally included in formal advancement with the organization, yet implicitly required for high-quality care (Aloustani et al., 2020). These extra-role behaviors have been found to create and sustain ethical climates and organizational citizenship behavior in healthcare settings (Aloustani et al., 2020). Aloustani et al. (2020) referred to this dynamic in a clinical setting however, the dynamic could apply to the academic setting as well. For most nursing schools, preparing for accreditation falls into the realm of extra-role behaviors. Redman and Fry (2003) found that nursing administrators most commonly cited staffing as one of their top ethical challenges; this could include extra-work duties, voluntary efforts, or other unrecognized work.

Nursing educators asked questions like, "'Do we really need it (accreditation)?' to 'Does it have to take so much time and energy?'" (Barnum, 1997). Interestingly, the highest achieving nursing programs were most likely to endorse the accreditation processes as redundant (Barnum, 1997). Redundancy further reinforced perceptions of ineffectual quality improvement processes and likely disincentivized nursing educators from engaging the process, as well as highlighting faculty time lost to prepare the self-report (Barnum, 1997). Faculty might have felt nervous when interacting with a peer review team, however, the intention of site evaluators was a respectful, honest culture of continuous quality improvement (Halstead & Frank, 2018). Site evaluators in NLN-CNEA were instructed to be vigilant against bias or comparison with their home institution (Halstead & Frank, 2018).

Internationally, nursing administrators shared similar feelings related to specialized accreditation. Suliman (1988) interviewed 58 nursing administrators regarding their interest and readiness for a nursing licensure exam and for consistent accreditation standards. The responses of the nursing administrators indicated that licensure exams served to protect public safety and the nursing profession (1988). Alaskar (2018) examined possible connections between

perceptions of the accreditation process and motivation and level of involvement of nursing educators in Saudi Arabia. The results of the qualitative study suggested statistically significant differences between administrator and faculty perceptions of accreditation purpose, process, age, type of institution, years of teaching, and years of education (Alaskar, 2018). The data did not suggest differences in the participants' motivation (Alaskar, 2018).

The diverse ecosystem of higher education sustained many unique habitats: universities, colleges, community colleges, and the ever-expanding online environments. According to Halstead (2017), the value of accreditation "relie[d] in the creation of a culture of continuous quality improvement" (2017, p. 181). The pervasive and ongoing culture built was the true hallmark of accreditation (Halstead, 2017). According to Ulrich et al., (2010), greater ethics education and support for nurses in clinical settings increased comfortability and reduced stress when dealing with bedside ethical issues; as nurses transitioned from the bedside into academia, enhanced comfort and reduced stress regarding ethics and supportive organizational cultures could support navigating academic issues with greater ease. Many nursing educators began the process of accreditation energetically and then lost heart (Ralph et al., 2013). Intentionally moving toward understanding how accreditation standards were interpreted by faculty and the front-line curriculum developers had remained vital to ensuring quality and decreasing variance (Ralph et al., 2013).

Chapter Two Conclusion

When workplace pressures mounted and faculty were called on to make complex decisions, nursing educators might have struggled to agree on personal preferences or interpretation; therefore, collegial agreement on shared ethical values proved essential in open, caring communication between faculty (Burger et al., 2014). Excellence resulted from the

connection felt between the tasks and a deeply felt purpose (Coffman & Sorensen, 2013). As nursing educators integrated nursing ethics into academic nursing responsibilities, they were positioned to translate the "art and science of human caring" into their unique practice setting (Burger et al., 2014, p. 567).

CHAPTER 3

Research Design and Methodology

The primary purpose of this study was to explore BSN and RN-BSN nursing educators' lived experiences with ethical challenges as it related to their higher education administrative duties, and secondarily their experiences with ethical challenges as it related to nursing program accreditation, if any. This chapter provides an overview of phenomenology as both a branch of philosophy and research method, the criteria of selecting research participants, the research design and methodology, and the steps taken to ensure credibility, validity, and reliability. This study utilized hermeneutic, interpretive phenomenological design for its research methodology to explore the experiences of BSN and RN-BSN nursing educators with ethical challenges as it related to their administrative responsibilities in higher education. This chapter defined and provided rationale for the chosen methodology and detailed the procedures for sample and site selection, specifics regarding instrumentation, data collection procedures, data analysis, validity, limitations, and ethical considerations.

"Methodology" refers to the specific research framework employed to gather, analyze, and interpret data; two primary branches of methodological inquiry exist: quantitative and qualitative (Creswell, 2014). Employing a qualitative research methodology refers to exploring a phenomenon holistically, through rich narratives and emerging research designs (Polit & Beck, 2009). Qualitative research closely aligns with a constructive worldview (Polit & Beck, 2009). Social constructivism considered an individual's subjective, diverse, and complex interpretation of their interactions within their social environment (Creswell, 2014). The intent of the constructivist's worldview is to inductively develop a pattern of meaning through the research process (Creswell, 2014; Polit & Beck, 2009). Research with a constructivist worldview

considers a phenomenon through gathering subjective data from small, information-rich sample sizes, with specific appreciation for the social nature of personal experience (Creswell, 2014; Polit & Beck, 2009).

When designing the study, the researcher considered various qualitative approaches. The phenomenological method allowed for an open-minded exploration of the personal experiences of nursing educators with ethical challenges as it related to their administrative and accreditation related responsibilities in higher education. Hermeneutic inquiry specifically explored the meaning and interpretation of how individuals experienced reality in their given context (Polit & Beck, 2009). A qualitative narrative methodology was not appropriate for this study as the method focused on the timelines and experiences of individuals or very small groups (Creswell, 2014).

Additionally, grounded theory was considered for this study; however, grounded theory described the psychological processes occurring in a social process and generated abstract theories (Polit & Beck, 2009). Generalized theoretical information did not meet the practical needs of nurse educators and, although intellectually stimulating, also did not address the literature gaps for continued practical insights on cultivating and supporting ethical nursing leadership. Furthermore, the focus of this research was about the individual experiences of nurse educators as opposed to the group dynamics involved in ethical challenges in academia. Nevertheless, this could be an area of further study. Ethnography explores cultural patterns of specific groups, and culture was not the focus of this research. Case studies were considered for this research as well. Case studies delve deeply into one or more individuals' experiences with a program, event, or process (Creswell, 2014). However, the aim of this research was to gain a larger perspective on nursing educators' experiences as opposed to specific procedures or one or

two specific institutions' experiences. Nursing faculty are often collectively involved in ethical challenges with a student or process, and the data would have likely been viewing a shared experience from different vantage points.

Phenomenology allowed for participants from numerous institutions and focused on their individual experiences since their social context aligned most closely with the research question. The next section highlights the key philosophical voices in the development of phenomenology, as both a philosophical tradition and applied research methodology within the social sciences, comparing the leading voices on the methodology, and providing rationale for the selected methodology.

Philosophical Worldview

As introduced in Chapter 1, phenomenology is both a philosophy and methodology (Crowther et al., 2017; Van Manen, 2016; Zahavi, 2019). The phenomenological researcher asks, "What is the nature or meaning of this phenomenon?" (Matua & Van Der Wal, 2015, p. 23). A phenomenologist assumes participants report their world not "as it [was]" but "as they [made] sense of it" and, therefore, seeks to "make sense" of participants' experiential reports (Babbie, 2014, p. 298). A phenomenological approach explores the dynamics of situations, the behaviors, the ways in which people made sense of the experience, and the arguments constructed to explain their actions, which was far more than transmitting factual information (Bogdan & Biklen, 1998).

Phenomenology assumes that participants make meaning out of their lived experiences and that their meaning-making affected their engagement with the phenomenon; encouraging participants to reflect on experiences provides them with an "intentional gaze", thereby opening them up to deeper meaning-making (Seidman, 2014, p.18). Hermeneutics describes core

concepts of the experience and explores the meanings of common life experiences that might not have been immediately evident to participants but could have been synthesized through narrative interviews (Lopez & Willis, 2004). The researcher would have engaged the interviews and observations through interpreting and describing the lived experience (philosophical approach), as well as used procedural methods for gathering the data (methodological stance) (Qutoshi, 2018). Phenomenology as both a philosophical approach and as a methodology operates from a genuine desire to gain understanding through an inquisitive (qualitative) lens rather than a (quantitative) "hammer" (Bottorff, 2015, p. 4). The procedural aspects of using a lens will be discussed later in this chapter. Van Manen (2015) suggested phenomenological research as a method to explore ritualized experiences (e.g., greeting someone or a common place work activity); the social ritual created stability to negotiate a chaotic world, and yet it held a deeper dimension of meaning. For example, if a nurse asked a patient "how are you?" and the patient responded, "fine!", then what was the purpose of the visit? (Van Manen, 2015, p. 10). Researchers utilizing the phenomenological method reference the philosophical origins of the method.

Edmond Husserl is considered the father of the philosophical roots of phenomenology; his work was adapted and further developed by his assistant and eventual departmental chair successor, Martin Heidegger (Zahavi, 2019). Husserl developed two central methodological procedures for phenomenology, specifically consisting of bracketing (or suspension) and epoché, which included a phenomenological reduction of ideas, personal bias, and assumptions (Merriam, 2009; Zahavi, 2019). Some researchers use the terms "bracketing" and "epoché" interchangeably. *Epoché* is a process of reductive analysis, sustained through a process called *bracketing*, which was a cognitive exercise of remaining neutral to belief and disbelief of the

existence or responses to the phenomenon under study (Speziale, & Carpenter, 2003). Researchers use bracketing to "maintain objectivity of preconceptions, attitudes, values, and beliefs… (and) ensure they [did] not prejudge the description of the phenomenon" (Bottorff, 2015, p. 4). Heidegger and Gadamer suggested that a researcher could not fully suspend all personal judgment and bias; rather, researchers could use the hermeneutic circle as an iterative process of understanding, interpreting, and meaning making of the data as a collective whole instead of disparate parts (Gadamer, 1960/2004; Jahnke, 2012). The method offers a conceptual framework for suspending judgment known as *epoché*.

Zahavi (2019) defined epoché as the conceptual performance of suspending personal beliefs to become increasingly independent from a dogmatic, naturalistic attitude and relationship with the world. Through suspension of bias and assumption, the process of phenomenological reduction attempted to isolate the pure phenomenon as opposed to reporting what was already known about the phenomenon (Speziale, & Carpenter, 2003). At the completion of the research process, the phenomenological researcher gathers all data, research experiences, preconceptions, assumptions, and new insights and analyzed the data holistically (Bottorff, 2015).

Within applied phenomenology in the social sciences and nursing, another prominent method was Giorgi's descriptive phenomenological method, which closely aligned with the Husserlian orientation; specifically, it provided "faithful descriptions of the essential structures of the lived experiences" (Zahavi, 2019, p. 123). A researcher using this approach describes rather than interprets the phenomenon, without adding to or subtracting from the results, and presents information that was general and systematic (Zahavi, 2019). Van Manen (2016) stated that hermeneutic phenomenology was a method of questioning as opposed to generating

conclusive and definitive answers, and he pointedly argued for epoché and reduction processes as central aspects of data analysis.

However, Heidegger's approach differed from Husserl's framework in both philosophy and methodology. The hermeneutic approach to interpreting the meaning of truth, which had original roots in biblical exegesis of Greek and Hebrew holy texts and through the work of Heiddeger and Gadamer, had branched out in application to philosophical works and social phenomenon (Gadamer, 1960/2004; Jahnke, 2012). Heidegger's lifework, *Being and Time* (1927), discussed the concept of Dasein. "Da" meaning "there" and "sein" meaning "being" cumulatively described an immersive human embodiment of there-being or being-there (Zahavi, 2019, p. 144). Heidegger's work was further developed by Gadamer's central work *Truth and Method* (2012). Heidegger and Gadamer critiqued the Husserlian methodology of bracketing and epoché, they believed the assumption that a researcher could fully suspend all personal judgment and bias was implausible and should be directed to utilize the hermeneutic circle (Gadamer, 1960/2004; Jahnke, 2012). Zahavi (2019) also rejected the need for bracketing and epoché in practical applications of the method but appreciated these essential procedures if applied in transcendental phenomenology.

A central aspect of Heidegger and Gadamer's work was the hermeneutic circle (Gadamer, 1960/2004; Jahnke, 2012). Gadamer (1960/2004) proposed a hermeneutic circle as a metaphorical, iterative process for understanding the meaning of the text (e.g., participant responses) and considering the whole data set, as opposed to individual parts without reference to one another. The researcher might not be able to anticipate biases or preconceived assumptions, therefore the researcher had to remain open to the encounter and experience of the participant (Oxley, 2016). Gadamer's (1960/2004) hermeneutic circle began at the researcher's

prejudices, or “narrowness of the horizon” of their understanding, therefore they will seek to expand their current and historical situation of the phenomenon in order to find “the right questions to ask” (p. 301). The hermeneutic circle encompassed three main steps: a naïve reading of data, a structural analysis of identifying patterns within meaningful units, and lastly, an interpretation of the whole (Speziale & Carpenter, 2003).

As referenced above implicitly, phenomenology as a method was divided into subcategories: descriptive and interpretive phenomenology (Sloan & Bowe, 2013). The Hursserlian researcher aimed to describe events, thoughts, or experiential reflections as they appeared, and refrained from evaluating (Qutoshi, 2018). However, an interpretive hermeneutic approach recognized that the researcher’s perceptions of the world were inseparable from the participant’s experiences, and, therefore, required a continually reflective, aware posture regarding pre-existing experiences and assumptions (Oxley, 2016). For this research study, interpretive (hermeneutic) phenomenology was preferred over descriptive phenomenology due to the additional attention given to describing *and* interpreting and understanding the phenomenon under study (Polit & Beck, 2009). Interpretive phenomenology shifted from intentional knowing to *being* whereby the research embraced a sustained open curiosity and self-reflection while also restraining past positions or projections in the research topic (Valentine et al., 2018).

Purpose Statement

The primary purpose of this hermeneutic phenomenological study was to explore BSN and RN-BSN nursing educators' lived experiences with ethical challenges as it related to their higher education administrative duties, and secondarily their experiences with ethical challenges as it related to nursing program accreditation, if any. Refer to Chapter 1 (Appendix B) for the operational definition of administrative duties. Eligible participants included nursing educators

and administrators with full-time employment status at a BSN or RN-BSN, CCNE accredited nursing program, and administrators had to be considered in an administrator/department chair role. As a result of this study, organizational leaders can be better informed about academic nursing leaders' unique experiences with ethical decision making in a non-clinical practice area and the ethical complexities of administrative duties. Phenomenology illuminated commonly perceived activities with new eyes and in a fresh light (Polit & Beck, 2009).

Research Questions

The research question that formed the basis for this study was: What are the lived experiences of BSN and RN-BSN nursing educators with ethical challenges as they related to their administrative responsibilities in higher education? A related secondary question was the following: What are the lived experiences of nursing educators with ethical challenges as it pertained to the CCNE accreditation process?

A qualitative approach, specifically hermeneutic phenomenology, was most appropriate to address this research question. Faculty perceptions could not be measured easily which required additional detail to be obtained through interviewing, observation, and archival data collection (Creswell & Poth, 2018). As there was little research on the topic, a "flexible style of reporting findings [was] desirable" (Creswell & Poth, 2018, p. 46). The method aligned with the intent of the research question; whereby emerging perceptions of faculty became evident through the qualitative research process (Creswell, 2014).

About the Researcher

In nursing school, the researcher's understanding of ethical issues centered around "hot button" bioethical issues such as assisted suicide, abortion, and healthcare malpractice. However, as she transitioned from bedside nursing to academia, she became aware that ethical decision

making occurred on the sidelines of client care, embedded into the administrative landscape of healthcare and nursing education. From her observations, individual and collective ethical decision-making formed the social nature of a civil work environment, such as honest conversations about allocation of resources between teams and amongst the organization, transparency of concerns, and openness to feedback. As Gadamer et al. (2012) suggested, her own horizon broadened and expanded through her lived experience. The researcher learned nursing ethics was applicable to more than the clinical setting.

As a newly minted nursing faculty member, she participated in advising, coaching, and providing feedback to students who she felt concerned were developmentally unready for the professional responsibilities of nursing, academically or clinically ill-equipped, or behaviorally demonstrating a poor fit to the program's mission. Secondarily, she participated in the nursing department's Systematic Plan of Evaluation (SPE) soon after the program successfully completed another CCNE accreditation cycle. Engaging the SPE required new skills of understanding of academic programming and how to make meaningful use of assessment metrics.

As a bedside nurse, she participated in continuous quality improvement processes and began to frame academic accreditation in a similar light. Even for the most engaged nurse, quality improvement processes were mundane and tedious. Accreditation could be stressful, complex, high-stakes, and, potentially most challenging of all, a transparent process amongst internal and external peers. Receiving a performance review (e.g., as a bedside nurse from a manager or teaching evaluation from a peer as a nursing professor) on a personal level was stressful enough, but knowing nursing colleagues would peer review an accreditation report could present interpersonal conflicts of interest.

Within the profession of nursing, she noticed a positive professional norm of readily identifying ethical issues at the bedside and in clinical practice. The conversation was developed, normalized, and encouraged by research. Bedside nurses were encouraged that identifying an ethical issue did not mean they themselves were unethical, but rather sensitive, thoughtful, and courageous enough to identify an inherent aspect of the job. Because most nursing literature regarding ethical issues was client-centered, discussing ethical issues without direct client-care might feel superfluous or secondary to "bigger issues." Resources had been developed for clinical nurses regarding moral distress; hospitals created programs to support transparent conversations and recognize supporting nurses' skills in navigating ethical issues as paramount to retention and positive organizational culture. Within nursing education, it felt like a lag in acceptance of the experience of ethical issues, and this might have been due to the lack of conversation both in literature and professional conversation, as well as the absence of the "main character" of many ethical conversations, the client.

The researcher began to see educator and student interactions as parallel to nurse and client interaction at the bedside. In bedside nursing, the direct point of care was the client, and in nursing education, the direct point of care was the student. In bedside care and nursing education, the direct point of bedside care was only a sliver of the total picture and only one variable in high-quality student outcomes. In nursing education, student success was an intricate interplay of student-driven efforts and faculty work. Nursing educators were responsible for a large breadth of organizational commitments outside of traditional classroom and clinical instruction; faculty oversaw granular student development needs, nursing program committee work, institutional committee work, as well as a deep involvement in the well-being of the nursing program assessment and evaluation processes.

As an oncology nurse, she often felt severely unprepared for the ethical challenges she experienced daily. The ANA CoE proved a useful filter for many of the complex patient scenarios she experienced. As a new nursing faculty member, she wondered if the ANA CoE could provide guidance to the complexity of academic administrative duties, such as advising struggling, resistant students, documenting and evaluating student performance, course development, and accreditation, to name a few. Due to these parallels, she became curious about the ethical decisions that nurse educators faced in academia, specifically in administrative functions that occurred separate from direct student support. While she wrote this dissertation, there was a global pandemic. Nursing education had adapted as quickly as possible with curricular changes and emergency-state approval for virtual clinical experiences. Her concerns for program quality increased as nursing programs across the United States self-identified programmatic gaps before COVID-19, and the gaps now widened with another school year impacted by COVID-19. Due to these personal and professional experiences, she engaged the hermeneutic circle with intentionality throughout the process of data collection and data analysis.

Population and Sample

The primary guiding factor for participant selection in phenomenology is the criteria that all participants have experienced the phenomenon and are willing and able to describe their experience (Polit & Beck, 2009). Purposive sampling is the most common data collection method used in phenomenological research; participants are selected based on their knowledge and experience of the selected phenomenon, and data collection is sufficient when redundancy in responses occurred (Fain, 2020). Additionally, the subcategories of criterion and snowballing sampling were used for this research (Creswell & Poth, 2018; Polit & Beck, 2009). The population of the study was nursing educators and administrators in RN-BSN and BSN, CCNE

accredited nursing programs. A mix of both faculty and administrators was desirable; researchers utilizing phenomenology strive to gain numerous perspectives from participants who share the phenomenon from varying viewpoints (Polit & Beck, 2009). However, administrators are often asked to participate in research studies or surveys, and the introductory email included an invitation to the administrator or the opportunity to forward the research opportunity to someone in the department with CCNE accreditation experience or both.

Furthermore, the participants had to attest to a working knowledge of the accreditation process and an awareness of the ANA CoE and had to have been involved in at least one cycle of CCNE accreditation process. The participant's level of involvement in the accreditation process, gender, age, and years of experience at the university and in academia were also considered to ensure a variety of perspectives were included, as much as possible given the common, national-wide demographic constraints of nursing educators. All participants held active RN licenses in the United States and were full-time employees of their institution. The primary data source was individual interviews.

The phenomenological researcher typically gathers data from ten or fewer participants (Polit & Beck, 2009; Starks & Brown Trinidad, 2007). The number of adequate participants is reached when two criteria were met: sufficiency and saturation of information (Seidman, 2014). "Sufficiency" refers to an adequate number of participants; "saturation of information" refers to hearing duplicity of information (Seidman, 2014). Data collection was terminated when no new themes emerged, and the data were repeating; therefore, predicting the number of total participants in advance was challenging (Speziale, & Carpenter, 2003; Starks & Brown Trinidad, 2007).

Research Design and Methodology

This section briefly explains efforts to maintain ethical sampling procedures. There were several different data collections activities to consider which are addressed below: participant access, researcher-participant rapport, forms of data collected, recording procedures, and data storage (Creswell & Poth, 2018). Phenomenology involves using a "minimum structure and maximum depth" approach (Lester, 1999). Phenomenology as a method does not prescribe one discrete approach, but rather the method allowed for a range of approaches (Seidman, 2014). The goal in phenomenological data collection is to report perceptions and experiences "as they [were]," not as assumed historical experience (Gall et al., 2007). Various authors communicate distinct philosophical and procedural interpretations of the phenomenological method; therefore, the researcher had to be aware of the intent of the research question and aim of the study, as well as the original works on the methodology itself (Speziale, & Carpenter, 2003). Scholars in the field of qualitative research voice diverse recommendations for leveraging phenomenology as a method for data collection and analysis, and this creates design challenges in applied research settings (Jahnke, 2012). As a result, this chapter denotes specific and detailed processes to maintain credibility, validity, and reliability.

Data Collection

Qualitative data collection often occurs through personal interviews, observations, and analysis of written documentation of participants regarding their lived experience; this research study focused on purposeful, semi-structured interviews (Fain, 2020; Sloan & Bowe, 2013). The primary units of data collection within phenomenology consists of a small number of individuals, primarily through in-depth, cross-sectional interviews (Polit & Beck, 2009). Before gathering data, the researcher submitted the proposal to the Institutional Review Board at Northwest

University. While waiting for the IRB process to be completed, she networked with possible participants. Once IRB approval was obtained, the researcher sent each participant the IRB approved Informed Consent Form and Demographic Form (Appendix C); this document included information about the focus of the dissertation and the option to decline at any time or to respond only to individual questions. Utilizing purposeful sampling and the respective categories of criterion and snowballing, she made the request for an interview to the participants themselves via email, specifically outlining why the site was chosen, what activities would occur during the research study, if the study would be disruptive to the organization, and how the results would be reported (Creswell, 2014). If the participant did not respond within a week, she emailed again. A total of two attempts were made before contacting another site or faculty/administrator at the same institution, if applicable. The electronically signed Informed Consent Form verified their consent to the study. The researcher kept the Informed Consent forms in a password protected file.

Interview

The primary mode of data collection for this phenomenological study was interviews (Fain, 2020). Prior to each interview, the researcher journaled to identify personal biases or reflections from previous interviews, as applicable. Through journaling, she engaged her own "horizon" as a starting place for the hermeneutic circle (Gadamer, 1960/2004, p. 301). Before the interview formally began, the participant was provided with the nine provisions of ANA CoE (Appendix A) and ANA's Administrator's Scope and Standards of Practice (Appendix B). Although nursing educators and administrators were likely familiar with the ANA CoE, the form was provided as a resource to reflect on their experiences with ethical challenges grounded in the tenets of the ANA CoE.

During each interview the researcher took observation notes, and after each interview she completed a post-interview journal entry; this practice enabled her to make critical connections between what she learned from the individual, the aggregate population of the research, and applicability to findings in the literature (Bogdan & Biklen, 2007). Phenomenological analysis required active listening during an interview and researchers must consider more than the "face-value" of participant reports; however, researchers also have to avoid an over-identification or fusion with a participant's experience of the phenomenon (Fischer, 2005, p. 90). Instead, it is an exercise of imagination to "feel" or "imagine" into another's experience (Fischer, 2005, p. 90). The researcher used empathy and perspective taking to imagine the participants' relationship with the stated phenomenon (Fischer, 2005).

According to Harris (2014), well-organized research requires thoughtful planning and purposeful "decision requests" (p. 13). Decision requests informed the kind of information needed, the most appropriate method of study, and ultimately a well-written questionnaire (or interview questions, in this case) (Harris, 2014). The interview protocol for the current research questions (Appendix D) consisted of open-ended questions aligning with the research questions (Creswell, 2014). The researcher asked semi-structured, open-ended, clarifying questions, allowing her to follow the participant's lead; the sessions generally ended when the participants believed they had fully communicated their experience of the phenomenon (Speziale & Carpenter, 2003). To accomplish this, the researcher asked the participants if they had anything else to say before ending the interview. Furthermore, semi-structured interviews approached all questions flexibly, whereby the largest aspect of the interview was guided by a predetermined set of issues to explore without a required order of questions (Merriam, 2009). When clarity was required, additional probing questions were asked. Participants had to feel there was no "right

answer" and feel accepted through verbal, non-verbal, and emotive expressions (Bottorff, 2015). An observational protocol was designed as well, based on recommendations from Creswell (2014) and Bogdan and Biklen (1998) (Appendix E). Only participants willing to be audio recorded at minimum were eligible; ideally participants would allow for audio and video for observational data gathering. Each participant participated in an initial one-hour interview, which was audio and video recorded, or audio recorded at minimum and transcribed on Microsoft Teams. After the interviews were transcribed, the researcher reviewed the transcribed data along with the observational notes she took during the interviews. Although not compulsory, a second interview was encouraged in the event the participant had more to share after reflection.

In phenomenological research, the process of data collection is inseparable from data analysis, as the two processes happen concurrently; the importance of the ongoing reductive processing is essential (Speziale & Carpenter, 2003). Phenomenologists simultaneously collect data and make meaning; this concurrent process was used to specifically identify the phenomenon as it was experienced by the participants (Qutoshi, 2018).

Data Analysis Process and Procedures

Phenomenology utilizes an iterative, recursive, "rigorous, critical, and systematic investigation of a phenomenon" (Merriam, 2009; Speziale & Carpenter, 2003, p. 56). Through the process of data collection, answers, synonymously referred to as themes, categories, or findings, began to emerge (Merriam, 2009). In interpretive (hermeneutic) phenomenology, data analysis often surfaces multiple meanings to the phenomena and invites new understandings of a conventionally assumed experience (Crowther et al., 2017). Data analysis created detailed descriptions of the case and the setting (Creswell & Poth, 2018). A popular method for simplifying the qualitative data analysis entails organizing data, conducting an initial read-

through of the data, coding data based on thematic topics, choosing how to represent data, and lastly forming an interpretation of the data (Creswell & Poth, 2018). The following section details the process that was used in this study.

Organization of Data

After the interviews, the researcher reviewed the audio and transcript to check for the accuracy of the transcribed data and journal reflections, possible themes, ideas, and questions she wanted to ask the next research participant (Appendix E) (Merriam, 2009). After the researcher had interviewed at least two participants, she practiced a comparative analysis of the first interview and second interview and continued this process as she interviewed more participants (Merriam, 2009). Due to this simultaneous process of data collection and data analysis, the researcher planned future interviews based on what was discovered in the previous interview and to explore what she does "not yet know" (Bogdan & Biklen, 2007, p. 163). After verifying the transcriptions were accurate, the transcriptions were sent to the participant for review of accuracy and completeness. She offered a second, shorter interview seven to 10 days after the initial interview, in the event participants thought of topics after having time to reflect on the first interview. This allowed for the participants to address aspects of the initial interview they might have felt were incomplete or undeveloped and were also given an opportunity to amend the transcript with or without a second interview (Speziale & Carpenter, 2003). The data was stored in a password protected file, and all files related to the study were destroyed two years after the completion of the dissertation. To promote confidentiality, she assigned pseudonyms to faculty and the institutions.

Coding

Following organization of data, transcripts were re-read as a collective unit to examine tone, main ideas, themes, and descriptions (Creswell, 2014). Next, the researcher read the transcripts and reflected on the frequency of words or similar phrases across all participants and generated codes in NVivo 12. NVIVO is used to support the data analysis process through organization of large volumes of qualitative data. The data was analyzed for emerging themes, and the researcher focused on the meaning that the participants intended, as opposed to the meaning the researcher may have intended (Creswell, 2014). In this initial stage of data analysis, the researcher "[laid] out" all data and perceived all responses as equal, a process known as horizontalization (Merriam, 2009). Through this non-competitive, open-minded approach to data analysis, she was empowered to use imaginative variation, in which data was viewed from multiple viewpoints like "walking around a modern sculpture, seeing different things from different angles" (Merriam, 2009, p. 26).

Each response was compared against the other participants' responses to the same question. The data was analyzed using categorical aggregation; initial codes were generated and then reduced to a maximum of five main categories with subcategories (Creswell & Poth, 2018). Once the procedures for data analysis aligned with reflective analysis, whereby data was organized into segments or chunks, the researcher reviewed the segments for overall themes (Gall et al., 2007). She noted repeating words, thoughts, or relevant concepts from the literature; these codes were the basic building blocks for constructing categories (Merriam, 2009). A *category* in qualitative research was a relevant conceptual umbrella for multiple units of data and considered "responsive (or sensitive) to the research questions," exhaustive to all relevant data, and mutually exclusive (data fit into only one category) (Merriam, 2009, p. 185). The process of

coding and recoding occurred until all categories were saturated or no additional categories emerged (Bazeley, 2013).

Credibility, Transferability, and Dependability

The qualitative research process follows an iterative, fluid, albeit procedural chain. The researcher first gathers and analyzes data, then offers themes and interpretations of the data. As emergent themes surface, researchers ask if the "account [were] valid, and by whose standards?" (Creswell & Poth, 2018, p. 253). According to Colaizzi (1978), qualitative rigor and trustworthiness are increased when participant experiences are emphasized, as opposed to their theoretical or content-specific knowledge of the topic. Therefore, the researcher had intentionally chosen an appropriate research procedure and strived to maintain the procedure to communicate an exhaustive and undiluted report thereby representing the participants' perceptions (Speziale & Carpenter, 2003). In qualitative research, internal validity addresses concerns regarding how research findings aligned to reality (Merriam, 2009). Researchers enhance consistency, dependability, and reliability through the methods of triangulation, respondent validation, a reflexive exploration of the investigator's biases and assumption, and the audit trail (Bottorff, 2015; Creswell, 2014; Merriam, 2009).

Member Checking and Rich, Thick Descriptions

Comprehensive data analysis requires one to "dwell with" the data; through contemplative and intentional data analysis, the researcher stived to capture the relationships among participant statements and then identify how central themes emerged and might have been interrelated (Speziale & Carpenter, 2003, p. 70). The essential first step was faithful, detailed descriptions of the phenomenon, only then moving to interpretation *through the descriptions* rather than attempting to explain the phenomenon; one method of doing this was

including direct quotations and summarizing major themes with attention to vigilant reduction of bias (Qutoshi, 2018). The use of direct quotes illustrated the analysis and interpretation while transparently allowing the reader access to original data (Fain, 2020). Therefore, rich, thick descriptions of the qualitative interviews were supported through in-text narratives in Chapter 4, as well as notes from the Observational Protocol (Appendix E).

As mentioned above, interview transcripts were sent to participants post-interview for the opportunity to review semi-polished data (Creswell, 2014). The participants should have been able to discern that their experience was accurately captured and might have suggested clarifying statements (Merriam, 2009). The researcher's understanding was confirmed or amended based on participants' feedback; if a participant did not respond to member checking, the data could be consensually validated from people who have a similar experience (Benner, 1994). Interpretive (hermeneutic) accounts were evaluated as opposed to validated and tested (Madison, 1988, as cited in Benner, 1994).

Triangulation

An additional method used to capture reality and enhance internal validity was known as triangulation, which included analyzing and comparing multiple methods of data collection with varied sources of data such as interviews, observations, and audiovisual information (Crewswell, 2014; Merriam, 2009). One strongly recommended step for consistency and dependability within qualitative and phenomenological studies includes an inquiry audit, or audit trail; this systematic stepwise documentation allows an auditor to verify the process (Fox, 1987). Crafting a documented audit trail includes triangulation of data, daily reflective journals, insights, as well as accessible raw data, processes for data reduction, analysis, reconstruction, and synthesis (Bottorff, 2015). The researcher made an audit trail by documenting reflections, decisions, and

ideas throughout the data collection process; this was achieved by pre-journaling, documenting observational notes during the interviews, post-journaling after the interviews, and journaling through the analysis process (Merriam, 2009) (Appendix E).

Bias Reduction

In research methodology, *bias* refers to an instrument or question that results in a "misrepresentation of what [was] being measured in a particular direction" (Babbie, 2014, p. 253). Explicit forms of research bias refer to asking leading questions with a socially desirable answer or, more subtly, through the phrasing of a question slightly more positively or negatively (Babbie, 2014). Qualitative researchers can minimize bias through intentional reflection of their own values, adherence to a transparent procedure for data collection and analysis, and peer review of data findings or pre-publication manuscripts (Babbie, 2014).

Limitations

One of the limitations of the study was constraining the experience to CCNE accreditation, as opposed to programs who were accredited by another nursing accreditation body (e.g., ACEN). However, generalizability is typically not the purview of qualitative research; the responsibility for applicability depended on one's ability to provide enough information for the reader to determine transferability (Bottorff, 2015). Another limitation might have been the anticipated homogeneous characteristics of participants. The general demographics of nurses, and even more so within nurse educators, was largely homogeneous in categories such as age, ethnicity, and gender.

Another limitation might have been the researcher's positive perception of the accreditation process and personal experiences with ethical challenges of working within the constraints of the complex systems of higher education and healthcare. Phenomenologists

recognize and readily acknowledge their personal values and experiences brought to the study (Creswell, 2014). Interpretive (hermeneutics) assumes the researcher had prior experience with the research topic and brought their own collection of rich narratives (Polit & Beck, 2009). Interpretive phenomenology assumes some degree of expert knowledge on the part of the researcher and suggests this knowledge, when appropriately leveraged with self-awareness of bias, is useful and added valuable insight into meaning making (Lopez & Willis, 2004). Some phenomenologists (e.g., transcendental phenomenologists) postpone the literature review until after data analysis; the intention for this procedure is to decrease bias or preconceived frameworks on the part of the searcher (Speziale, & Carpenter, 2003). The primary bulk of the literature review for this study was completed before data collection and analysis.

Protection of Human Subjects

Due to the nature of interviewing nursing educators and administrators about their academic work through the place of employment, it was possible to discover potentially sensitive information for this study. Because of this potential, the researcher implemented the developed protocols to protect and ensure confidentiality of all participants. In addition to IRB approval, each participant was asked to sign an informed consent and given the opportunity to refuse to respond to any question. Confidentiality was provided for Microsoft Teams interviews, emails, and other personal communications related to the study. Participants were assigned a pseudonym to protect their identities. Specific care was given to avoid any intervention beyond interviewing through the processes listed above.

Summary

In summary, the purpose of this phenomenological study was to explore the lived experiences of BSN and RN-BSN nursing educators with ethical challenges related to their

administrative responsibilities in higher education; the related secondary question explores the lived experiences of nursing educators with ethical challenges as it pertained to the CCNE accreditation process, if any. This chapter detailed the chosen methodology, procedures for sample and site selection, specifics regarding instrumentation, data collection procedures, data analysis, validity, limitations, and ethical considerations.

CHAPTER 4

Findings

The primary purpose of this study was to explore Bachelor of Science (BSN) and Registered Nurse (RN) to BSN (RN-BSN) nursing educators' lived experiences with ethical challenges as they relate to their higher education administrative duties, and secondarily their experiences with ethical challenges as they related to nursing program accreditation, if any. This chapter first provides an overview of the participants' demographics and categorization of the frequency of responses, followed by a summarization of findings. The key themes described below explore the common responses to the two primary topics of the research protocol, which the researcher utilized to ask participants to describe their lived experiences as they pertain to ethical challenges related to 1) administrative duties and 2) nursing program accreditation. Chapter 5 further discusses the data with specific attention to how the data relates to literature.

Process of Data Analysis

The first step in the data analysis process was reading the transcript and listening to the audio recording of each interview individually multiple times and making meaning of each individual participant's perspective (Qutoshi, 2018). After individually analyzing the unique perspectives of each participant, the researcher analyzed the data for themes across each participant and categorized the themes in Chapter Four. The researcher reviewed field notes (pre- and post-journaling of each interview) when analyzing the individual participant interviews and then again when reviewing the interviews collectively (Creswell, 2014).

First, the researcher used the criteria of ethical challenges definition provided by Jameton (1984) to analyze the data. This process helped the researcher further understand if the definition adequately captured the lived experiences of nursing faculty and administrators, as well as held a

shared, cohesive understanding across the profession. Next, the researcher reviewed each transcript for participants' responses to Q1 and Q2 (Tables 1, 2 and 3) and lastly categorically aggregated the transcripts using the framework of administrative duties provided by the *Nursing Administration: Scope and Standards of Practice* (ANA, 2016).

The interview was then coded in NVivo 12. After individually analyzing each transcript for themes, the researcher analyzed the raw data as a collective unit (Creswell, 2014). The researcher compared each response against the other participants' responses to the same question; this generated initial codes and then reduced them to a maximum of five main categories with subcategories (Creswell & Poth, 2018). The following sections summarize the emerging collective themes and corresponding granular examples demonstrating the common experiences of nursing faculty and administrators related to ethical issues in administrative duties and nursing program accreditation.

Theoretical Framework and the Study Results

Researcher

The researcher operationalized the concept of Dasein by being prepared for each interview to enhance "being there" with each participant. Preparing for each interview by pre-journaling and reviewing relevant documents and the research protocol allowed the researcher to move from task-orientation more quickly to attempt to create a safe, supportive, and non-judgmental environment. The researcher also attempted to use Dasein by using clarifying statements as a means of therapeutic and non-judgmental communication. By clarifying or re-stating participants' statements, especially statements that might have been perceived as painful historical experiences or challenging leadership moments, the researcher aimed to support the participant to feel their lived experience and expand their own horizon of understanding of their

experience. The researcher attempted to identify biases and preconceived assumptions through journaling before and after each interview; however, the researcher was unable to anticipate all biases. As the researcher's biases arose in the interviews, she journaled and reflected to remain open-minded to the experience of individual participants (Oxley, 2016). The researcher's preconceived knowledge about the topic was assumptive in one key area. The researcher assumed that most, if not all, participants would identify ethical challenges in their administrative duties. However, the researcher had fewer assumptions regarding ethical challenges as it relates to CCNE accreditation. The researcher felt a bias initially when participants stated that they had never encountered an ethical challenge in their administrative role; the researcher assumed that clinical practice nurses would rarely report any ethical issues in their clinical practice. Due to the frequency of ethical challenges for bedside nurses, acknowledged or not, the researcher was curious when participants stated that they had never experienced any ethical challenges in the context of higher education.

The researcher's understanding of the phenomenon emerged through the process of data collection and data analysis. The researcher anticipated the theme of the COVID vaccine which the participants' responses validated; the themes of competitive clinical placements and NRB issues emerged as a surprise to the researcher. The recruitment of faculty due to CCNE's Standard II E was not surprising, but the researcher did anticipate more responses around retaining faculty or managing poorly performing staff. The researcher's understanding of the themes expanded from potentially more "hot button" issues such as financial integrity, poorly performing staff, or professional boundary violations to granular, day-to-day operations of a nursing program (e.g., finding and maintaining clinical placements, locating qualified faculty).

Participants

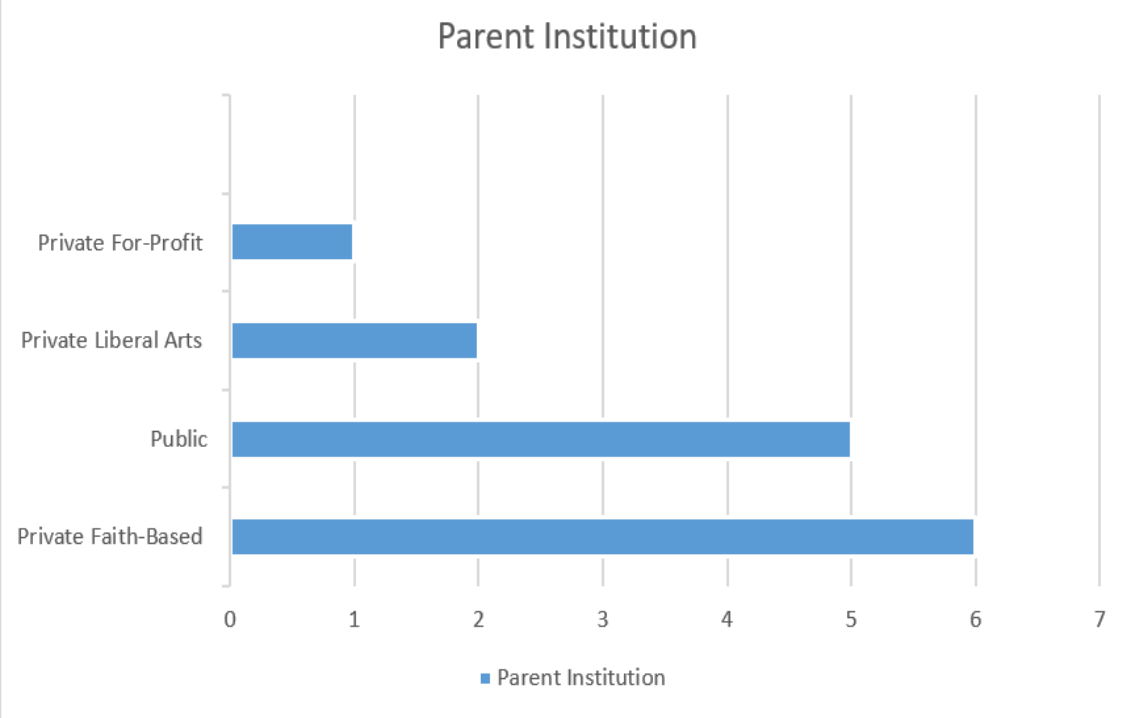
The participants' observed experience of Dasein appeared behaviorally variable since each person had their own past experiences and current experience engaging the research question; some participants appeared relaxed, eager to share, and incorporated humor or laughter when reflecting on past challenges; other participants appeared rushed and expressed lack of clarity on "how to answer" the questions while one appeared tearful and emotional when reflecting on the "lonely" experience of navigating the COVID vaccination mandate. Participants' sense of "being there" in situations that were not their making (e.g., inheriting programmatic issues from a previous administrator) found this particularly distressing and expressed responsibility to both address the error and maintain a professional sense of assumption of goodwill, even if this cost them reputationally.

Participant Demographics

Eligible participants for this study were nursing faculty and administrators at CCNE accredited schools in the United States. In total, the researcher interviewed 14 participants; 12 participants identified as female, and two participants identified as male. Thirteen participants identified as white/Caucasian while one participant identified as Black/African American. The average age of participants was 59 years old, had an average of 36 years of total nursing experience, and an average of 18 years of nursing education experience. The highest level of experience in nursing education was 49 years, and the least amount of time in nursing education was one year. Five participants worked at public institutions, six at private faith-based institutions, two at private liberal art institutions, and one at a private for-profit institution (Figure 1).

Figure 1

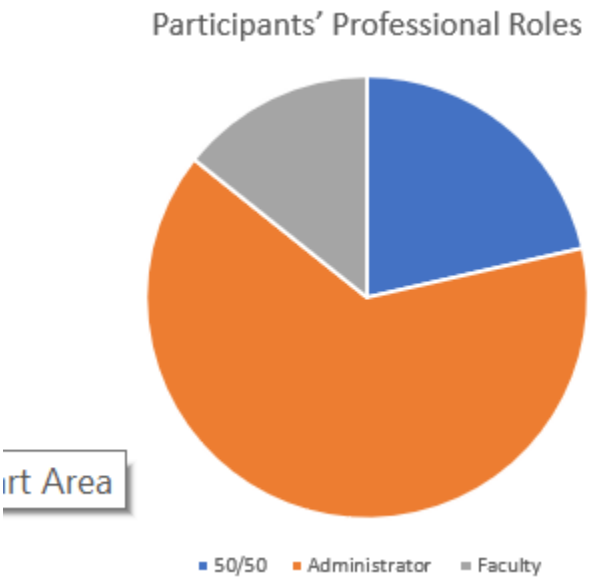
Parent Institution



All 14 participants were registered nurses, employed at a CCNE accredited school, and actively involved in the nursing accreditation process at their institution. On average, they reported spending five hours per week on CCNE related activities. One participant served as a CCNE site-evaluator and one participant as a CNEA site evaluator. Three participants held 50% teaching and 50% administrative roles; nine were full-time administrators (e.g., administrators, directors) and two were full-time nursing faculty in a teaching role (Figure 2). In summary, the majority of participants in this study were administrators or held formal administrative roles in addition to their teaching responsibilities (88%).

Figure 2

Participants' Professional Roles



Results

The following section provides an overview of the main themes that emerged following analysis of the data collected from interviews with 14 administrators and nursing faculty regarding the two primary questions in the research protocol. The first question (e.g., Q1 in Tables 1, 2 and 3) asked, "Have you experienced an ethical challenge in relation to your administrative duties? If so, could you describe in as much detail as possible a time that you experienced an ethical challenge as it pertains to your administrative duties?" The second question (e.g., Q2 in Tables 1, 2, and 3) asked, "Have you experienced an ethical challenge in relation to nursing program accreditation? If so, could you describe in as much detail as possible a time you experienced an ethical challenge as it pertains to nursing program accreditation?" The researcher shared the definition of an ethical challenge with each participant prior to beginning the interview. For this study, the definition of an ethical challenge was a feeling of conflict between personal and professional values or professional and institutional values (Jameton,

1984). The researcher also shared the key responsibilities of nurse administrators and respective duties, per the *Nursing Administration: Scope and Standards of Practice* (ANA, 2016). The primary duties included safety, risk management, human resources client/population/employee advocacy, legal and regulatory compliance, interprofessional collaboration, and operations and logistics (ANA, 2016).

The following section describes the information in Table 1. Table 1 refers to the interview protocol and summarizes the responses from participants. Nine out of 14 (64%) participants reported encountering an ethical issue regarding their administrative duties (e.g., Q1) in their lived experience. Combining those who immediately said yes and those who eventually said yes added up to10 out of 14 (71%) participants.

Seven out of 14 (50%) participants stated that they experienced ethical issues related to nursing program accreditation (e.g., Q2). Combining those who said immediately yes and those who eventually said yes totaled eight out of 14 (57%) participants. One (7%) participant was unsure how to interpret the question related to nursing program accreditation after clarification from the researcher. Four (29%) participants did not experience ethical issues related to their nursing administrative duties, and five (36%) did not experience ethical issues related to nursing program accreditation. Tables 1 and 2 display the aggregate responses of participants and their professional role functions, respectively.

Table 1

Research Protocol and Participant Responses

Responses	Q1 Administrative Duties	Q2 Accreditation
Yes, I experienced ethical challenge	9	7
No, Eventually Yes	1	1
Unsure	0	1
No ethical challenge in my lived experience	4	5
N=	14	14

The following section summarizes the data in Table 2. Table 2 displays participants' professional roles at their CCNE accredited school. As stated above, nine out of 14 participants (64%) were administrators/directors, three out of 14 (21%) held a 50% administrative role and 50% teaching role, and the remaining two out of 14 (14%) were full-time nursing faculty.

Only one administrator did not experience ethical issues in their administrative duties. Eight out of the nine (89%) nursing administrators and directors experienced ethical issues in their administrative duties. Six out of nine (66%) administrators experienced ethical challenges related to nursing program accreditation; three out of nine (33%) stated no ethical issues related to nursing program accreditation.

Two of the three (66%) participants who held a combined 50% administrative and 50% faculty role experienced ethical challenges related to their administrative duties, and one of three (33%) did not experience ethical issues related to their administrative duties. Two of the three (66%) participants experienced ethical challenges related to nursing program accreditation, and one of three (33%) was unsure. Both of the full-time faculty (100%) stated no experiences of ethical challenges in their administrative duties or nursing program accreditation.

Since most participants held administrative positions, the ability to discern if there were differences between the experiences of nursing faculty and nursing administrators was muted.

However, this data infers that administrators and directors may be more likely to encounter ethical issues or be more sensitive to the ethical nature of administrative decision making.

Table 2

Research Protocol and Participant Demographics and Responses

Responses	Q1 Administrative Duties			Q2 Accreditation		
	Administrator	50% Administrative 50% Faculty	Faculty	Administrator	50% Administrative 50% Faculty	Faculty
Yes, I experienced ethical challenge	7	2		5	2	
No, Eventually Yes	1			1		
Unsure					1	
No ethical challenges in my lived experience	1	1	2	3		2
N=	14			14		

Next, Table 3 details participants' responses and the type of parent institution they represented (Table 3). The largest demographic of participants in this study represented private, faith-based institutions (43%). Participants working at public institutions (e.g., state or community colleges) represented 36% of participants. Private, liberal arts institutions represented 14% of participants, and one participant represented a private, for-profit institution (7%).

Table 3

Research Protocol and Parent Institution

	Q1 Administrative					Q2 Accreditation				
	Public	Private Faith Based	Private Liberal Arts	Private For Profit	Total	Public	Private Faith Based	Private Liberal Arts	Private For Profit	Total
Yes, I experienced ethical challenge	3	5	1		9	3	4			7
No, Eventually Yes				1	1			1		1
Unsure					0		1			1
No ethical challenge in my lived experience	2	1	1		4	2	1	1	1	5
n=	5	6	2	1	14	5	6	2	1	14

Private Faith-Based

Participants from private faith-based institutions represented the largest demographic of participants and were the most likely group to report an ethical issue in both Q1 and Q2. The majority of participants from private faith-based institutions (83%) reported ethical challenges as it relates to administrative duties (Q1); furthermore, 66% of participants in this group reported ethical challenges as it relates to accreditation related activities (Q2). One participant was unsure if they had encountered ethical issues as it relates to accreditation duties (16%) and one participant reported no experiences with ethical issues related to accreditation duties (16%).

Public

Sixty percent of participants from public institutions reported they had encountered ethical challenges as it relates to both Q1 and Q2, and 40% reported no ethical challenges as it relates to both Q1 and Q2.

Private Liberal Arts

Two participants (14%) represented private liberal arts institutions; one participant expressed ethical issues as it relates to administrative duties (Q1) and one participant reported no ethical challenges as it relates to administrative duties (Q1). One participant initially reported no ethical challenges as it relates to accreditation, and later reported they had encountered ethical challenges related to accreditation (Q2). One participant reported no ethical challenges as it relates to accreditation (Q2).

Private For Profit

One participant in this study represented a private, for-profit institution. This participant initially reported no ethical challenges in their administrative duties, and later reported they had (Q1). As it relates to Q2, this participant stated they had not experienced any ethical challenges as it relates to accreditation duties.

hed In summary, Table 4 shows that administrators and faculty were most likely to encounter ethical challenges in nursing program operations, legal and regulatory issues, and safety and risk management. The following abbreviations are used in Table 4. Safety and Risk Management (S), Human Resources (H), Client and Population and Employee Advocacy (C), Legal and Regulatory Compliance (L), Interprofessional Collaboration (I), Program Operations and Logistics (P).

Table 4

Individual Participant Responses and ANA Themes

Ethical Challenges	ANA Themes						Ethical Challenges	ANA Themes					
Q1	S	H	C	L	I	P	Q2	S	H	C	L	I	P

1	Yes		X		X		X	Yes				X		X
2	Yes	X			X			Yes				X		
3	Yes	X		X			X	Yes					X	
4	No							Yes		X		X		
5	Yes				X		X	Yes				X		
6	Yes	X						Unsure						
7	Yes		X					No						
8	No, Eventually Yes				X			No						
9	Yes				X		X	No, eventually Yes				X		
10	No							No						
11	No							No						
12	Yes	X					X	Yes				X		
13	No							No						
14	Yes	X		X			X	Yes				X		
	5	2	5	0	6	0	0	0	1	0	8	0	1	0
N=14	36%	14%	36%	0%	43%	0%	0%	0%	0.07%	0%	57%	0%	0.07%	0%

The following section is an overview of data from Table 4. As stated above, Question 1 was as follows: “have you experienced an ethical challenge in relation to your administrative

duties? If so, could you describe in as much detail as possible a time that you experienced an ethical challenge as it pertains to your administrative duties?" The data from Question 1 demonstrated that the responses of ethical challenges related to, from highest to lowest, Nursing Program Operations and Logistics, then Legal and Regulatory concerns tied with Safety and Risk Management, next Employee Advocacy, and lastly Human Resources. As stated above, Question 2 was as follows: "have you experienced an ethical challenge in relation to your accreditation duties? If so, could you describe in as much detail as possible a time that you experienced an ethical challenge as it pertains to your accreditation duties?" The data from Question 2 demonstrated that the responses of ethical challenges related to accreditation, from highest to lowest, included Legal and Regulatory concerns, followed by Safety and Program Operations and Logistics. The next section discusses themes in greater detail.

Themes

Five main themes, or key categories, emerged from the data. They reflect the common contextual factors surrounding ethical issues that nursing faculty and administrators experienced: 1) CCNE accreditation, 2) NRB, 3) COVID-19 vaccine policy, 4) competing loyalties, and 5) leadership transitions.

Furthermore, an administrator or faculty member most likely encountered an ethical challenge related to nursing program operation, legal and regulatory compliance, and safety and risk management. Some of the topics that administrators and faculty shared pertained to ethical challenges regarding accidental inaccurate reporting to NRB and the corresponding ethical challenges to rectify the changes, competitive clinical placements, exorbitant costs passed on to students through student fees, faith-based institutions with beliefs that differed from clinical stakeholders, organizationally complex nursing school mergers, and unqualified students

progressing to maintain tuition-based revenue. The section below explores the additional sub themes. Furthermore, Chapter 5 will explore these themes in relationship to existing literature.

Ethical Challenges related to CCNE Accreditation

One of the primary research protocol questions related to CCNE accreditation. Participants who responded to ethical challenges regarding this question were all full-time administrators or held a 50% faculty and 50% administrative role; no full-time faculty identified ethical challenges related to Q2. The administrators shared an overview of challenges they encountered with CCNE nursing program accreditation. The contextual issues that arose in the administrators experiences with ethical issues related to CCNE corresponded to writing the self-study report, site visits, and recruitment of qualified faculty.

One administrator experienced three ethically challenging situations related to CCNE nursing program accreditation; the first experience was when the participant was a faculty member, and related to a self-study report that was a "fictional novel". The site accreditors identified the participant's institution as non-compliant with issues related to data management, analyzing data, and process improvement. Ten years later, the participant stated they had "made no more improvement…I tried to stay away because I was really uncomfortable when I read what the [self-study] committee wrote…[it] wasn't really true". The participant stated that they believed the study committee had fictionalized their activities in the accreditation report and was nervous to be associated with the final product.

This administrator mentioned how much they value the process of nursing program accreditation. The same administrator identified another instance of CCNE site accreditors and a corresponding ethical issue but reported they had a supportive team in that instance to report truthfully. The site accreditors noted the school stated that they had yearly advisory board

meetings yet lacked documentation of annual advisory board meeting minutes. The administrator stated, “They are going to nail you on it… [because the report said we met] every year, and I knew we didn’t.” Although it was difficult to write a follow-up report about the ways they did not meet the standard, the administrator reported being “comfortable [because] I can defend absolutely everything…nothing was made up”. The two above instances appear to be experienced differently for that administrator, due to the variability that one self-study “wasn’t really true” and the second self-study reflected honest self-report and “nothing was made up” and the administrator said they were comfortable with “getting nailed” because it helped them grow and improve as a program.

This administrator noted a third and most recent issue related to a CCNE site visit and identified this experience as the most distressing. This instance related to what the administrator supposed was an erosion of mutual trust. The site accreditors noticed a lack of benchmarks for student satisfaction; the administrator reported the site accreditors were “hinting” that the administrator could revise a document during the site visit and add benchmarks to meet the compliance standard. The administrator said, “Ethically, I couldn't do that…I'd rather identify that we don't have it and that's what they did. That ethical [issue]...really bothered me, they're hinting, hinting, hinting [to add in a benchmark].”

While the administrator relayed this situation, the researcher visually observed what appeared to be distress, potentially due to the trust and respect for the process, and a distress related to presuming the accreditors were inferring shortcuts were acceptable. Given the prior negative experiences this faculty member had with untruthful information on a self-study report, it is not surprising that this would be particularly challenging; the administrator had made every effort to be truthful and now remarked they were invited to be deceitful. In the first situation, the

administrator was a faculty member, and in this situation, the administrator was serving as the program administrator. The responsibility associated with being the program administrator may also have contributed to the greater experience of distress. The administrator and their team prepared for the CCNE follow-up report citing the program's noncompliance and prepared their response to set student satisfaction benchmarks, and the administrator was comfortable with resolving the issue in this way.

Additionally, the CCNE accreditors notified the administrator that the university website did not have the current CCNE statement with the opportunity to edit the website at that time but did not perceive this instance to be ethically charged.

> I did make a change because I thought it was silly and minor…they [the site accreditors] were apparently on our website about CCNE accreditation. We had an old statement [about CCNE]. ...We didn't notice it, and [the site accreditor alerted us]. … I just went ahead and edited it. … [It didn't create] a lethal error.

The administrator did not identify this as a distressing part of the experience but did express distress that the accreditors might be willing to look the other way for a day-of edit regarding benchmark data.

Two nurse administrators who reflected on their lived experiences of an ethical challenge explicitly processed the issue through the lens of the severity of the consequence and impact. The ethical framework of consequentialism is a framework available in ethical decision making, and Chapter 5 will discuss this topic more.

CCNE Requirements for Graduate Prepared Faculty: Standard II E

Another theme that emerged from the data was gaining and keeping compliance with the seemingly impossible criteria of CCNE's Standard II E. Several administrators mentioned Standard II E as a contextual factor of ethical challenges. CCNE Standard II E states:

> faculty are academically prepared for the areas in which they teach; and experientially prepared for the areas in which they teach…faculty teaching in the nursing program have a graduate degree. The program provides a justification for the use of any faculty who do not have a graduate degree (CCNE, 2018b, p. 11).

Administrators highlighted the specific challenge of recruiting enough graduate-prepared faculty to both satisfy CCNE and maintain their parent institution's tuition revenue expectations.

Several administrators mentioned that many nursing faculty are academically qualified to satisfy CCNE but may have not worked in a clinical setting for years or since COVID and may not be the best clinical faculty to meet student needs. One administrator reported this challenge:

> The NRB says clinical faculty does not need master's degrees. There's a dichotomy between having the right academic credentials and the right [clinical] experience. CCNE is telling us that they are academically qualified to do clinical while they're not [clinically qualified any longer].

This administrator expressed concern with the appropriateness of CCNE's standard and recognized upholding the standard may decrease the quality of student learning. In addition, another administrator posited that BSN-prepared nurse educators were inappropriately ignored as prospective, qualified candidates for clinical nurse instructor positions despite positive historical evidence of educating students effectively. This administrator identified an ethical dilemma of

turning away staff who performed to meet expectations in previous years but suddenly no longer satisfy external regulations. They said:

> I had to meet with some of our long-term adjunct clinical faculty and say, 'Are you willing to get a master's degree?' That's been a huge dilemma. We have no choice. We have to comply with that. And they're taking it out of our hands. What ethical dilemma is that? It's 'do no harm.' So that's become a huge dilemma.

This administrator reflected on the relational impact of complying with CCNE's standard.

Furthermore, another administrator remarked that Standard II E was founded on poor evidence and may ultimately negatively impact student learning by saying:

> When you look at the ethical component…does the use of those BSN faculty decrease preparation of…passing NCLEX? I stick with the no. Many of those faculty are amazing because they're still working on those units. …I have faculty who would meet the qualification to take a group to clinical, who haven't been at the bedside in ten years. But [making] sure we're giving them [the students] the best clinical experience is also important, so that's one current ethical dilemma that I know is not unique to us. I just really struggle with the ethics behind that.

Participants were located in both rural and metropolitan areas throughout the United States. One participant who has a 50% faculty and 50% administrator role stated that their physical location escalated the ethical tension in complying with Standard II E since they found it unsurmountable to satisfy given their rural context. For this participant and others, meeting the standard would require their university to reduce the number of nursing students admitted to the program which would exacerbate the projected RN retirement statistics, stating "it's not pretty." This administrator said:

> It's a huge ethical dilemma because this is [state]. There are not enough MSN-prepared people to even attempt to adhere to that. I would have to significantly reduce enrollment. That doesn't do our profession justice when we are still faced with the number of retirements. …And then if you put these additional constraints on our ability to produce graduates, we're harming the profession.

This participant expounded on the negative impact of the standard on population health long-term, questioned the current and future financial solvency of higher education, and the impact of a rapidly aging nursing faculty and workforce in general. An administrator explained that CCNE maintained a "business as usual" approach during COVID as it relates to hiring only masters prepared faculty and was unresponsive to nursing schools who were already struggling to meet the standard prior to COVID. Another administrator said:

> [The CCNE was tracking my friend, an administrator] on a near daily basis…'What are you doing to get more masters prepared (faculty)?' That's a barrier in [State] because only [less than 10% of State] nurses have master's degrees or above. CCNE has aspirational standards. . .meet them or perish.

The participant identified the high-stakes nature of complying with accreditation standards, and the corresponding and sustained external pressure to meet accreditation standards.

Another participant, who has a 50% faculty role and 50% administrative role, identified a similar challenge. They were located in a metropolitan area, and experienced such difficulties in meeting the standard, particularly during the height of COVID, that their only option was to turn to "a clever run around." The administrator assumed the responsibility of starting a new BSN program and appropriately staffing it, and these pressures were additionally compounded by the pandemic. They said:

> How are we going to educate our students if we can't get clinical placements; how are we going to proceed if we can't get master's prepared nurses…? There was an ethical dilemma within myself.

The participant mentioned the tension of finding clinical placements who were willing to welcome students when "people were wearing garbage bags to work" for personal protective equipment while simultaneously finding available graduate prepared faculty to teach during a pandemic. This participant's NRB approved nursing programs to utilize a clinical instructor (e.g., employee) and BSN supervisor (e.g., independent nurse educators on an independent contract basis) model to staff their clinical instructor positions. Nursing preceptors (e.g., bedside nurses) with two or more years of experience supplemented this model.

This participant noted the differences between the NRB and CCNE as they pertain to the eligibility of clinical instructors. The NRB allows for BSN-prepared clinical instructors and supervisors with two or more years of experience whereas CCNE requires a graduate degree for nurse educators (clinical or didactic). The state where the participant lives allows nursing schools to hire contract-based clinical instructors as well as part-time clinical instructors associated with the parent institution. This administrator identified a way to create a "clever run around" by reporting only clinical instructors who were employees of the parent institution to CCNE. They said:

> We had clinical supervisors who were not our employees. It didn't matter [to NRB] what their educational preparation was, as long as they were BSN prepared and they had two years of experience. What's the clever run around…? When I submitted…our clinical instructors [to CCNE], I only submitted our employees. I didn't submit the 15 other [supervisors] who were taking between one and eight students in a clinical group. I think

> that was an ethical violation on my part…not to just own up to it…[but] people [were] expecting us to pull resources out of the little, teeny bucket over there that doesn't have enough tuition in it. I stopped doing that because they caught on quick, and they said we don't care who these people are if they're employees or not. If they are touching your students, [they need to be master's prepared]. So instead of looking for the clever run around…we just owned up to it…So far, so good.

The administrator who identified a "sneaky work around" and the above administrator who "owned up" to a mistake and "got nailed" expressed a forward-facing mentality and communicated an intention to use the weakness as a way to grow their program while staying compliant to CCNE.

Another administrator recognized the conflict between meeting CCNE's standards while simultaneously addressing the parent institution's need for tuition generated profit. Their department developed a creative approach to meet conflicting needs amongst stakeholders. They restructured their tenure and promotion criteria to equally reward the on-going clinical competency of faculty without a requirement for other academic productivity or didactic teaching load. To attempt to meet the standard, they reported developing a new job description:

> We have a hard time finding all graduate prepared faculty to run our program and not to decrease enrollment. We developed a new job description for full-time clinical faculty. And those full-time clinical faculty only do clinical, and they're able to…take on a couple clinical groups instead of just one like our adjuncts. That way they're all masters prepared, and that decreases our need for non-graduate prepared faculty.

This program's approach to meeting CCNE standard required creative problem-solving and institutional support. Furthermore, administrators experienced numerous and at times, conflicting external regulations.

Incongruencies and Conflicting Regulations between NRB and CCNE

Another finding was the administrators' inclusion of issues with the NRB when asked about CCNE. As mentioned previously in Chapter 2, although NRB and CCNE have distinct requirements, several of the administrators combined the topics of nursing program regulation. One of the key themes the administrators noted was that nursing program accreditation and the NRB set differing requirements and standards. Consequently, nursing faculty and administrators experienced "confusion," "overwhelm(ing emotions)," and "frustration." Rectifying the impact of faculty's lack of understanding of when to communicate curricular changes to the NRB directly impacted one administrator's leadership transition into a director role. They explained:

> [I told the faculty that] anything you send to your accrediting body, you have to also send to the NRB. … [After revising the curriculum] they didn't tell the accrediting body or the commission…[and] some of the program outcomes were not measurable. …As the new administrator, you sometimes discover things that didn't happen prior to when you were on board. That becomes an ethical dilemma because you always want to show good faith to your faculty, staff, and administration at your school. I think that the ethical challenges are that people [do not understand] what the [state-based administrative codes] are and how they're interpreted.

The administrator needed to rectify these issues during the summer when faculty who had the information needed for the NRB report were off contract. This also placed them in a challenging position to respect faculty's time-off, gain compliance with the state, and maintain good standing

with the parent institution. They mentioned the challenge of working on a Plan of Correction for the NRB when faculty contracts are limited to the academic school year and are part of the union. This administrator postulated that there was potential for boundary violations of contract with the union and employee and communicated inappropriate expectations. Their unique challenge was their dual commitment to improving the program over the summer in order to remain compliant with the NRB and supporting the goals of the parent institution to maintain high-quality nursing programs.

Likewise, another administrator noted the challenge of being accountable to gather and interpret data for the NRB, CCNE, and the parent institution's assessment requirements. They said, "[We are] dealing with the NRB…[CCNE] Standard IV, in addition to university assessment." This administrator was referring to the compliance reports required from the parent institution and nursing regulatory agencies; the standards and data gathering processes required are often not aligned and thereby necessitate double regulatory compliance.

Reporting NCLEX Pass Rates to CCNE and NRB

In addition to ethical challenges meeting CCNE accreditation standards, administrators expressed concerns related to differing expectations for reporting NCLEX pass rates between the NRB and CCNE; NRB often requires nursing programs to report first-time pass rates as a quality indicator of student performance. However, CCNE allows a rolling average of NCLEX pass rates which includes alumni who have passed NCLEX but not on the first attempt. One participant with a 50% faculty and 50% administrative role expressed that the conflicting standards imply rolling pass rates meet a standard of success, yet they are penalized by writing a "70-page report" to the NRB to justify and "validate" the work the program is doing to improve NCLEX pass rates.

The following participant's quote expresses their ethical challenge of NCLEX pass rates at NRB level as constricting and incentivizes programs to admit large volumes of unqualified students without penalty for high student attrition. The programs might grade more severely earlier in the program to expel students who, despite their struggle, could be successful in order to protect their pass rates. This participant inferred their loyalty to support struggling students who pass NCLEX on a second or third attempt is penalized instead of recognized as a program fulfilling their ethical duty to students by stating:

> Why we are adhering to such a strict standard [with the NRB] and [NCLEX pass rates] as the only measure of quality…I could be a school with 100% pass rate and only graduate 30% of the students that enter my program, and I don't have to write a report that's 70 pages long. What's the ethics in that…? That's not ethical. There's an ethical challenge…potentially because of these standards…We're so disjointed as a profession.

Additionally, this participant was in an area of the United States where nursing schools in their region reported to two NRB and students were placed in two states for clinical sites. The neighboring NRB authorized clinical placements for nursing programs with adequate NCLEX pass rates and excluded schools who did not meet the NCLEX pass rate standards. This administrator knew of an area school that appeared to be purposefully reporting falsely high NCLEX pass rates in order to retain access to out-of-state clinical placements. The administrator said:

> There's this whole other ethical dilemma I'm experiencing…there's some harm in that. …If I were to say, 'Hey, what's going on?', they [would] lose access. And we're all competing for only X clinical sites [in the home state]. Then my students are harmed! I'm just staying in my lane. …I'm going [to] pretend like I don't know.

This participant identified their conflicting responsibilities within a large system: maintaining adequate clinical placements for their students, maintaining working relationships with other schools of nursing, and ensuring that their personal and professional values adhere to the ANA CoE.

NRB and Clinical Sites

Several administrators cited clinical sites as an environmental cause for ethical issues, both in student-placement and procurement of an adequate number of clinical sites to satisfy their program needs. For example, one administrator explained that the NRB contributed to professional competition by allowing other schools to "weigh in" on if their institution's new traditional BSN program should be launched, with the primary competitive motivator around clinical placements between existing programs and proposed new programs. This administrator said:

> [We got a] lot of negativity [at the NRB from other schools]. …'You're taking our clinical placements; we've had them for 30 years.' And I'm thinking, you've had them for 30 years but you have not increased diversity in the nursing workforce. So that was the crux of the issue. We are not here to compete. We are here to create [a nursing school] according to our mission, vision values and core themes…and that got [buy in] from all of the public members from NRB. They practically stood up and cheered. When I said that…the vote was seven to two. That is basic capitalism, if we meet the requirements of the NRB, then who are the other programs to say?

This administrator was the administrator of a brand-new program that focused on increasing diversity in the nursing workforce and believed the other nursing schools were pitted against a new program, namely because of scarce clinical placements; the nurse expressed the other

nursing schools were also in opposition to the entrepreneurial, free-market, capitalistic model higher education in the United States operates within.

Likewise, another administrator had a similar experience. The administrator explained it was an "ethical, tough" situation, as they oversaw an existing hybrid RN-BSN program with low enrollment. A nearby technical school with an RN program historically directed one third of their graduates to the administrator's hybrid RN-BSN program. Then the technical school, which was "3 miles away", applied to the NRB to start a fully online RN-BSN program, citing their rationale to be "increasing accessibility to students of lower economic backgrounds." The administrator's program did not receive funding from the state at that time while the technical college did; therefore, they charged $5,000 more than the area state or technical schools; the competing school believed their program would remove barriers for student success. However, the administrator's institution had scholarships for students in need and believed this rationale was not fully transparent. This administrator stated:

> [It created an] underlying ethical dilemma. …They wanted the increased revenue for their college, so it was a money issue, but it wasn't the issue that they were identifying. I saw their application as being an unreasonable expansion to make money that was going to hurt us, an established RN-BSN program.

The administrator filed a complaint to the NRB and challenged the application with the rationale "it would impact the program adversely." It was relationally challenging for the administrator because they were part of the search committee that hired the director of the competing school, and they remained regional colleagues. The administrator was "open and honest" with the competing school about their letter of challenge. The neighboring school's application is currently still pending with the NRB, and the relationship is "amiable". However, the

administrator does experience “tension” with the competing school’s director. The competing school did not write a letter of support for the administrator’s new master’s program, and the administrator believes it to be related to the above situation.

Communication amongst nursing schools and within nursing programs appeared to be an important factor when complying with NRB regulations. For example, one administrator mentioned that prior to their transition to administrator, faculty were unclear on how to accurately report clinical hours to the state-based consortium. The faculty had been reporting lab and simulation as part of the clinical (direct patient care) hours to the state-based consortium and reporting “over the amount of hours they needed for that clinical course.” The administrator’s concern was clinical “padding for those precious [clinical] spots.” When this was discovered, the administrator created a “standalone lab course” and recalculated simulation hours and clinical hours in effort to be “good stewards [of clinical placement sites] …that's an ethical thing.” Another administrator spoke to the legal/ethical issues that occurred during COVID by saying, “I felt a lot of struggles with clinical placements.” Another administrator believed the NRB was highly regulatory but unsupportive when it came to specific issues related to student progression, compounding the challenge for administrators to interpret regulatory standards. This administrator said:

> I emailed our NRB nursing education consultant yesterday about an unvaccinated student and said, ‘How do we place her so she can finish?’ She said, ‘She can't finish.’ ‘Can we put her back in community health or…virtual simulation?’ She hasn't got back to me…they're not good about answering specific questions. Does that mean I can interpret that how I want?

Nursing administrators want to create and maintain high quality nursing programs and comply with regulations, but two administrators mentioned the theme of struggling to interpret the regulations. The vague regulations place the administrators in a challenging position to interpret the regulation in their institution's favor, while being accountable for following their own sense of personal integrity. One of the themes from the data involves administrators' ethical challenges related to the COVID vaccine.

Ethical Challenges related to Upholding Differing COVID Vaccine Requirements

Several administrators mentioned ethical challenges related to their administrative duties included upholding the parent institution's policy on the COVID vaccine as well as the clinical partner's policy and attempting to find workable solutions for enrolled or prospective students.

Faith-Based Institutions and COVID Vaccine

Administrators at faith-based institutions experienced a unique pressure of stakeholders assuming that their institutions would be a place of refuge from the vaccine requirements. One administrator said:

> Administration didn't involve me in the COVID vaccine requirements for the university, which is fine in the long run… There's a medical exemption or a religious exemption, and the medical exemption is clear cut. The clinical sites are saying it's a previous anaphylactic reaction to a previous vaccine. …I'm the middleman. …I'm the one who gets to explain it… [Parents wanted to] transfer their children to [this institution] because it's a religious institution, and it will allow a religious exemption when actually it was the opposite. I got hung up on, and I got yelled at, and you just got to deal with it.

This administrator was grateful to be excluded from making the policy at the institutional level which allowed them to be more neutral and simply deliver the news to students or families who were upset by the news.

Likewise, another administrator who was in a 50% faculty and 50% administrator role was responsible for responding to concerns about the COVID vaccine from families, students, clinical partners, administration, and faculty. They identified a key stressor was limited time to make calculated decisions that could have long-range impacts. They said:

> That put me in a very challenging position because I'm very favorable to the vaccine. I knew because of our faith and the Christian Evangelical world...this was going to be a big challenge, and so we had lots of discussion up the chain of administration to determine can we require it? Can we require it for faculty? Can we require it of our [nursing] students…? They ultimately did let us require it. This was three weeks before the semester started that this whole thing blew up. …I sent out email information to students [saying], 'You must get the vaccine. You must do this quickly.' And not all faculty were in alignment with the requirement. …It's amazing that I'm still standing here. I think that was probably the most significant ethical challenge in my tenure at this point.

This participant appeared emotional while sharing this story; the stress of this experience was visible and appeared to resurface through reflecting on the painful experience. Furthermore, the administrator held her own faith-based beliefs and expressed it was "lonely at the top."

Similarly, another administrator identified a conflict regarding accepting unvaccinated students who may not be able to meet clinical course outcomes and progress through the nursing program. The administrator anticipated that clinical spots would be less willing to accommodate

unvaccinated students than the parent institution that was getting tuition money from these students. They said:

> As a university, we're not requiring the COVID vaccine, but the majority of our clinical partners are. We can educate you. But we can't actually…send you [to] any clinical sites unless you decide to [get vaccinated]. [Administration communicates] retention at all costs… [but] then we have all these other outside entities who create policies…that makes it hard.

Administrators experienced significant difficulties in communicating institutional and clinical stakeholders' expectations to students while supporting students in their "individual rights". Ultimately, they maintained a primary duty to patients. Administrators expressed the experience of being "torn" regarding the vaccination policies and acknowledged it was not a "black and white decision." One participant said "[not being vaccinated is] an ethical violation because you're taking care of vulnerable populations." Another administrator at a state-based school expressed the distress of personal character attacks regarding their administration of the vaccine policy and said, "Students, parents, calling the president's office, saying I was trying to kill their child. What is the right thing to do as a nurse? As a nurse administrator?" The administrators faced complicated ethical challenges because those in conflict with them bundled their administration of the policy with moral value-judgements. Another theme from the data includes the competing loyalties experienced by administrators pertaining to the parent institution, students, and the health of the public.

Ethical Challenges related to Competing Loyalties

The following section explores nursing faculty and administrators' experiences with ethical challenges within themselves or observing the experiences of others as they pertain to

competing loyalties. For example, one faculty member mentioned an ethical concern regarding potential nepotism; their administrator hired her daughter with very limited nursing experience as a program chair. This mother-daughter dynamic led to cloistered decision making between the two of them and negatively affected the nursing program's curriculum and self-study process.

Revenue Generation

Another subtheme noted was that nursing faculty and administrators reported assuming responsibility to their parent institution for fulfilling the mission and goals through financially sound academic programming and student retention. They also experienced a competing loyalty to patients and the profession of nursing, whether that be in meeting clinical requirements (e.g., COVID vaccine) or more abstract responsibilities of protecting the community from students who may not be a good fit for the profession.

One administrator experienced financial hardship by "one or two students who did not progress" and expressed, "We're so tuition driven, so there might be a little ethical problem going on with that as well." Another administrator experienced this tension regarding graduate prepared faculty required by CCNE. They said, "We still need BSN faculty to run our program. Do you [comply] with the CCNE standard and decrease your enrollment? That doesn't please your university when you are enrollment driven." These administrators identified implicit or explicit messaging from institutions about the importance of tuition-based revenue.

In addition, another administrator who was in a 50% faculty and 50% administrative role expressed the dual accountability to their institution as they developed a new program, and to the state as their institution received public funding. They stated, "It's been a bit challenging for me. This is the first time that I've done this kind of thing…I'm accountable to the NRB [and] I'm

accountable to the university." Student retention "at all costs" caused distress for this same administrator who said:

> There's an ethical conflict between... graduating someone who's never actually going to be able to utilize a degree…because we retained them at any cost and threw quality out the window for our profession. There's that push to increase retention in a way that conflicts with quality within nursing education. …As an administrator I had to write a report because of lack of preparation [of students from high school]. Then we're seeing decreased enrollment to the major…we can't just change our admission criteria. …ethically, I can't produce less prepared nurses or allow people who are not strong in sciences to come in and just take their money.

This participant who was in a 50% faculty and 50% administrative role shared that the administration perceived the nursing program as not networking with pools of candidates (e.g., local high schools or technical colleges) and questioned if they had been attempting to troubleshoot with other universities who were experiencing successful solutions for student recruitment. The participant identified this as a lack of "trust" and disregarded the networking done on the part of the nursing department to address these systemic, professional-wide challenges. They stated:

> I had to submit a report [about low enrollment], and it made me want to cry because my hands are tied. …I can't do anything. I'm stuck with adhering to our regulations. …I sat and cried one day because I was trying to finish this report. …There's nothing I can do. It's hard to maintain those standards when you have these other pushes coming from outside sources at the university.

This participant upheld the ethical duty of maintaining educational quality and developing "practice-ready" students to adhere to the ANA's *Nursing Administration: Scope and Standards of Practice* (2016) as "ethical stewards". However, they stated that an "ethical steward" would only progress students who will succeed in the nursing program.

Likewise, another administrator experienced conflicting loyalties regarding fiduciary responsibility because of a misunderstanding with upper administration. Since their institution did not provide a definition of what it considered a hybrid course, the administrator had listed the courses as hybrid. Consequently, students were charged hundreds and thousands of dollars for the same course that other students were not charged for. The president and provost called the administrator into a meeting and accused the administrator of attempting to "undercut the university's position" and an estimated $1,000,000 worth of tuition revenue. The administrator assumed a strong responsibility to "stand up" for students at the cost of being "called out" in meetings for "misunderstanding the definition" of how to code the classes. The administrator experienced this as very stressful and endorsed "not sleeping for a week". They maintained a primary responsibility to advocate for the students at personal risk of being seen as incompetent or disloyal to the parent institution.

Similarly, one administrator expressed that they were "caught in the middle" and recognized that individual rights (e.g., student) conflict with the greater good of a program or community. They said, "What's best for the institution and what's best for the individual? You know [what is best] for the individual, and then what's best for [the institution] and its reputation?" Overall, from the data, the researcher noted a theme of poor communication during conflict.

Several instances of conflict arose from the lived experiences of nursing administrators and faculty; the below stories did not meet the criteria for an ethical challenge; nonetheless, they left a negative and poignant impression on the faculty. When nursing faculty and administrators had conflict with upper administration specifically, to hear their concerns or discipline specific needs, they reported experiencing powerlessness to defend themselves. One administrator said, "[A colleague in another department] was so mad at me, she threw her books down and stormed out of the room, called my boss to come discipline me, and he [said], 'No, I was in the room, [the administrator] is right, you're wrong.'" Several administrators were concerned about "bad mouthing" incompetent faculty or faculty who did not understand a process or procedure, specifically as it pertains to regulatory standards. One administrator explained that CCNE accreditation preparation was done poorly and it was their responsibility to fix it by saying:

> Things didn't get done, and I didn't want to bad mouth them. I wanted to call them out on the carpet, in front of everybody and say, 'You didn't do your job', but I didn't. I tried to be as diplomatic as possible, saying [instead], 'There was some lapses.'

Regarding programmatic changes and reporting to the NRB, another participant who had a 50% faculty and 50% administrator role said:

> "I never want to throw the prior administration under the bus.…You never want to throw shame on the prior administration. …I know for a fact the prior administration didn't know [the process of reporting curricular changes to the NRB]."

Overall, faculty and administrators expressed a desire to protect their teammates and the processes they attempted, even if they were not correctly done, and hoped their administrators would do the same for them. In addition to experiencing competing loyalties within the

workplace, participants also experienced ethical challenges when their department transitioned leadership.

Leadership Transitions

Several participants cited a leadership transition, either their own or someone else's, as a situational factor for ethical issues. Two administrators inherited areas of non-compliance in their nursing program and accepted responsibility for rectifying it. One administrator shared their experience:

> I went to the Commission, and I said, 'I'm new here,' and they [previous faculty] didn't know that they had to get approval from the Commission first [before significant curriculum changes] …And unbeknownst to me, I didn't realize they had never gotten approval from the Commission. The Curriculum Advisory Committee [at the nursing school] had approved this, they've gone through the whole school system…everything. Then the Commission says, 'Whoa, you need to have that approved by us first.' We're still in a holding pattern.

This administrator taking on the new role was aware of the process and was responsible for not only communicating the expectations of the NRB but also diplomatically communicating the delayed timeline in terms that upheld the prior administration.

Likewise, another administrator shared a similar experience when CCNE alerted that their program was non-compliant regarding direct clinical hours for the MSN program and "threatened to shut [their program] down." This administrator said:

> Leadership had just changed. I was part of the new leadership that had to address the issue, but the tone and the letters that came from them [CCNE]…was different. …There was a different administrator and associate administrator during that visit, and that

> leadership had switched between the visit and this letter. Me and the new administrator were tasked with fixing it. It wasn't that the previous leadership did anything wrong. They didn't [know].

Both administrators in the above instances were responsible to address a problem that was unknowingly created by the prior administration, and their ethical issue appeared more around how to handle the situation fairly, as opposed to suggesting it was unethical or incompetent of the prior administration. Another administrator–a new faculty member and inexperienced at their institution–said, "We had not done what they [CCNE] was asking for in the standards. We had just not ever done it, and they identified that." All participants communicated an assumption of goodwill toward prior administrations' incorrectly navigating processes in relation to regulatory processes, and that accreditation was a learning process.

When the researcher asked another administrator if they had experienced ethical challenges in their administrative duties, they said, "Yes. Many of them." The most pressing example on this administrator's mind included a leadership transition between their university merging with another university. Identifying two different ethically challenging situations included in the process of the merger, they stated:

> I was in an ethical challenge between the administrators above me. …I am a department chair, but I have an administrator above me in the School of Health Professions who's not a nurse. I advocated [to become a] College of Nursing [instead of Department of Nursing] because we have programs all the way from BSN to doctorate in nursing practice. …I wrote a letter and explained we need to be a College of Nursing, and it was not taken seriously, and we were kept as a department. The ethical dilemma for me is do you stay [at that institution]? I think the ethical issue is your voice not being heard. I took

> it all the way up to the top, to the chancellor at the time, who is now retired. But it just fell on deaf ears. It's difficult when you're supposed to be the chief nurse administrator, but there's people above you telling you how you should do it.

This administrator expressed that their upper administration did not recognize School of Nursing as the scholarly discipline that it deserved to be as a College of Nursing. They also identified that the lack of responsiveness by upper administration to the persuasive and detailed research submitted as rationale for the name change created an ethical issue of one's voice being muted from important decision making.

The same administrator then noted a second situation related to who in the organizational structure was responsible for communicating with CCNE during the merger. The administrator said:

> The second scenario is similar, but it's a little different. I think it's a little different from the ethical dilemma there. …They had a chief nurse administrator, and I'm the chief nurse administrator [in the merger]. CCNE and [the parent institution] wanted to put the merger documents in because they were getting pushed from upper administration. [The other] chief nurse administrator is not a nurse…and she reached out to CCNE and was communicating with CCNE. Even though I was explaining that that should not happen, that we should wait. Maybe the ethical dilemma there is...When do I speak up? When do I not speak up? How do you speak up for what you want when you're speaking up to somebody who can fire you, and how do you do that in a way that's supportive of your students, your faculty, and staff. This is now my boss, right? The ethical dilemma is when do you speak your truth? ...I quit for a day and then everything started falling apart, and…I said, 'I better do this. If I don't do it, nobody will.'

The administrator identified an issue, structural in nature, and related to the organizational chart that was actively evolving during the merger. However, the researcher identified a similar sense of distress in both scenarios by the administrator's concern of "speaking up", albeit with personal risk attached but ultimately for the purpose of "being heard" and feeling understood. The consequence of "not feeling heard" when taking the risk to speak up presented the administrator with an "ethical dilemma." Jameton (1984) defines moral dilemma.

Table 5 references the subcategories introduced in Chapter 1, presented by Jameton (1984), for types of ethical challenges. According to Jameton (1984), moral uncertainty is one's uncertainty if an ethical principle is in conflict and the correspondence of frustration or annoyance; moral dilemmas are when one is faced with two or more choices, all of which include conflict and often the inability to make a decision; moral distress is knowing the correct course of action but external constraints make the correct choice almost impossible.

Table 5

Jameton's Categories of Ethical Challenges

Subcategories of ethical challenges	Data
Moral uncertainty	Some participants appeared to experience moral uncertainty; they had an openness to the research questions but were uncertain if there was an ethical component to their experience. Moral uncertainty was a theme noted in administrators reflecting on their experience with administrating the COVID vaccination policies. Several stated "stress" and expressed uncertainty about realistic alternatives to requiring the vaccine.

Moral dilemma	One participant with a 50% faculty and 50% administrative role had reason to believe a neighboring nursing school was purposefully inflating NCLEX pass rates in order to retain desirable out-of-state clinical placements. The participant identified whistleblowing would negatively impact their students; if the other school no longer had access to the out-of-state- clinical placements, it would increase the already competitive environment for local clinical placements.
Moral distress	Standard II E was a common theme of administrators who stated "understanding" the standard while also endorsing an inability to meet the requirement. Their understanding of the standard and their lack of resources to comply with the standard created distress.
Moral failure	There were instances of moral failure, when a right and wrong option did exist, and the right option was not chosen. One example was falsifying documentation regulatory documents by an administrator, or one participant's peers created a "fictional" self-study report.

Note. Adapted from *Nursing Practice: The Ethical Issues*, by A. Jameton, 1984, Hoboken, New Jersey: Prentice-Hall. Copyright 1984 by Prentice-Hall.

Table 5 showcases that all four categories presented by Jameton (1984) exist in this data set; the scope of experiences amongst the participants varies both in organizational complexity and in immediate or short-range solvability. The next section of Chapter 4 explores the experiences of nurse educators and administrators who reported not experiencing ethical issues, were unsure, or said they had not initially and then expressed concerns about an ethical issue later in the interview.

Unsure, Unclear, Not Initially but Eventually, or No Ethical Issues in Personal Experience

The following section summarizes responses from faculty and administrators who reported experiencing no ethical issues in their administrative or accreditation related activities, or they were unsure, or still unclear of how to approach the question after the researcher clarified it, or initially stated no ethical issues in their experience and eventually stated they had experienced what they perceived to be an ethical issue.

Unsure

One participant who was in a 50% faculty and 50% administrator role expressed ethical issues within their administrative duties as an administrator (e.g., COVID vaccine mandate for students who did not want the COVID vaccine) but was unsure if they experienced ethical issues pertaining to nursing program accreditation.

None Initially, Potentially Some Eventually

One administrator stated strongly that their administrative duties (Q1) had "many, many" ethical issues, specifically related to "not being heard" or having "formal power" between nursing leadership and upper administration; this administrator stated no identifiable ethical issues with nursing program accreditation (Q2) initially and then expressed ethical issues with "antiquated NRB regulations", believing these regulations constrained nursing programs from adapting to the current needs of the community and students.

Similarly, another administrator had not experienced any ethical issues related to nursing program accreditation (Q2) and initially said they had not experienced any ethical issues in their administrative duties (Q1). Later in the interview, the administrator shared an experience of when the NRB audited the Licensed Vocational Nursing (LVN) program and was looking for LVN advisory board meeting minutes. Due to the recent leadership transition, the administrator

had not prioritized LVN advisory board meetings; therefore, no advisory board currently existed. The administrator spoke with the Administrator of Students who agreed the participant could add the name of the LVN director to the RN meeting minutes even though they were not there. They were concerned if the NRB compliance consultant identified that the LVN program did not have an advisory board, it would then distract from the intent of the site visit: to see the three-year upward trend of licensure pass rates in the LVN program. The administrator stated they experienced this as an "ethical poke" and a "little twinge of unethical facilitation" and used that experience as a "wake up call to…improve the organization". The administrator processed the issue through the consequential impact of the decision, stating, "No students were harmed, and no faculty ([were harmed]". They also said that informal communication between the RN and LVN programs existed; it was simply not formalized and documented. This is the second instance when an administrator explicitly framed their ethical challenge through the lens of consequentialism.

This situation that the administrator shared about reflected their personal involvement in a challenging situation, and this administrator expressed confidence in their ethical decision making to speak up if presented with a challenge that would potentially harm others. Likewise, several participants shared the theme of positive self-regard and a commitment to their personal integrity. Regardless of the story they communicated (e.g., they were responding to an ethical challenge created by someone else or at the center of the ethical challenge), they expressed they were confident they would speak up against an ethical issue.

No Ethical Issues in the Lived Experience

Four participants expressed no ethical challenges in their administrative duties, and five participants expressed no ethical challenges in their accreditation duties. One faculty member

identified that they had been in their full-time faculty role for two years, and self-reported this might have explained why they had not experienced ethical issues. They identified academic dishonesty issues, but expressed their institution had clear and fair policies to deal with academic dishonesty. Another faculty member mentioned that they had been at their institution for less than a year and self-reported that might have explained why they had not experienced ethical issues. This faculty member identified "learning curves" in their new role, but did not perceive those to be ethical in nature. Rather the "learning curves" related to improving communication, equitable financial compensation, and workload. They reported that the "present… transparent… welcoming... responsive… and supportive" upper administration were protective factors that prevented ethical issues.

Additionally, another faculty member strongly shared that professional "opportunities" related to quality existed in their administrative and nursing program accreditation, but did not perceive these to be ethical in nature. They "struggled with confidence" in creating high-stakes "tests and measurements" for first semester nursing students and stated being uncertain if other faculty threaded core BSN competencies in the curriculum after students left their first semester. Workload and "informal expectations" of representing the institution in the community without compensation also arose, but again, the faculty member expressed that this was an issue of professional role boundaries and not ethically charged. They reported issues of quality in clinical with students, academic rigor and curriculum scaffolding, and professional role boundaries as "opportunities" for greater quality of nursing education. They mentioned that when a CCNE site evaluator visited their clinical group, they coached the students on how to articulate clinical experiences as it relates to the CCNE standards. Although it did not "feel…genuine…and

authentic", the faculty member understood this experience to be coaching students how to express their learning in new terms to an unfamiliar audience.

Furthermore, another participant, also a faculty member, identified several communication breakdowns, student-related issues, or organizational hierarchy inefficiencies, but did not identify these categories as inherently requiring ethical decision making. An administrator identified ethical challenges within administrative duties, specifically "difficulties" with paperwork and bureaucracy, but did not identify any ethical issues related to nursing program accreditation. This participant expressed no conflict about being honest with the NRB about inaccurately filled out paperwork that delayed starting a new academic program. Although they saw this experience as "frustrating", they did not see ethical challenges related to it because of their readiness to communicate, and they would adjust their program planning timeline again if the NRB required it. Another administrator did not identify ethical issues within nursing program accreditation, yet they perceived a "disconnect between (the parent institution's) assessment and our outcome information (for CCNE)". Comparatively, some participants experienced several of these same issues as ethical challenges since they reported these were antiquated and constricting regulations that imposed on their academic freedom.

Another participant, also an administrator and a CCNE site accreditor, reflecting on their time conducting site visits, described identifying inaccuracies on self-study reports about the standard for graduate required faculty (Standard II E). When noting the inaccuracies during a site visit, the administrator interpreted the inaccuracies as misunderstanding the standard or writing the report with inconsistent data or interpretation of data. They said:

> I'm there for the school…to help them. …I've never put an ethical frame around it. I'll pay attention next time. Maybe I'm too trusting that the people I'm working with are coming from the same frame of reference that I am.

Conversely, the researcher identified this standard as an ethical challenge for administrators. Administrators did not identify an inability to comprehend the standard. After all, one stated the criteria was "loud and clear". Instead, they were unable to meet it.

For participants who reported no issues in their administrative and accreditation duties (both Q1 and Q2), the researcher reviewed their years of experience in nursing education for potential trends. Afterwards, the researcher concluded no trend indicated that years of experience in nursing education made a difference in ethical challenges (two FT faculty and one administrator who said no to both Q1 and Q2). Therefore, the only suggested meaning of this data is that faculty in this study were less likely than administrators to experience ethical challenges in their administrative or accreditation related duties or both.

The last two sections of Chapter 4 explore the powerful emotional experiences of nursing faculty and administrators related to ethical challenges in their administrative duties and nursing program accreditation as well as discrepancies in this exploratory data set.

The Emotional Lived Experience Regarding Ethical Challenges

Many of the participants faced challenging situations and identified and described difficult emotions. Participants also mentioned protective factors that helped them problem-solve existing ethical issues or come to a place of inner acceptance if the situation were ongoing or resolved in a way that may not be of their choosing, but they still aligned with their values.

Difficult Emotions

One administrator discovered early on in their leadership transition to administration that clinical hours had been accidentality miscalculated and reported to the state-based consortium. They described their lived experience as it relates to this situation as "disbelief" and they felt "dismay and overwhelm." Likewise, another administrator communicated their concerns about a subordinate who they believed might have submitted expense reports that were not valid. They explained it as:

> Emotionally draining…you're hampered in the work that you're doing. And to feel you're getting this constant nonverbal hostility directed toward you.…It's unpleasant to talk about. It's still upsetting. I don't have to [deal with] it anymore, except for the fallout from the experience and how it damaged the relationship.

Both of these instances described a momentary paralysis or diminished emotional state experience because of the incredible responsibility to handle the situation appropriately with limited information. The participants mentioned many instances that had a notably inequitable responsibility and power differential. For several of the participant's experiences, more responsibility did not equate to more authority.

Furthermore, the COVID vaccine was a theme that several administrators acknowledged held ethical challenges along with personal, painful "constant stressors. For one administrator who held a 50% faculty and 50% administrator role reported this time in their tenure still caused them to "get tearful…overwhelmed with all of it, and [feel] PTSD…the old adage, it's lonely at the top." This administrator mentioned "lots of pushback and angst" from students and families regarding the COVID vaccine mandate. They expressed that it was "incredibly difficult. I am very much a people pleaser…a non-confrontational type of person…my hands were tied".

Similarly, another administrator said, “I get to be the one to say sorry [there is a vaccine requirement]. That…caused a lot of sleepless nights”. The stressors of COVID on a nursing program were many and far-ranging beyond dealing with the COVID vaccine alone. These administrators were under significant workload and faced numerous, evolving problems with foggy solutions, COVID and non-COVID related.

In addition, one administrator stated the workload of being a nurse administrator created a lack of work-life balance, saying, “When would you like me to sleep at night? There should be 36 hours in a day.” Another administrator mentioned tiredness and awareness of being close to retirement and recognized a significant amount of energy is required to “stand up for the fight” of nursing program accreditation. Leadership transitions also appeared to be a precursor to participants’ experiencing ethical challenges. Another administrator identified an unanticipated departure of an associate administrator and described it as “panic…panic driven decision making and it was all I could do not to panic.” Abrupt leadership changes created a sense of panic if someone else was leaving, or guilt if the participant was the one to leave.

Moreover, one administrator experienced a lack of organizational communication within departments at the parent institution. Adding onto their frustration, this administrator’s colleague did not acknowledge a past agreement between the two of them in front of other organizational leaders. Although this situation did not fit the classification of ethical challenges, the administrator still felt emotional distress. They said:

> I [felt like I wanted] to punch you…I didn't want to put him on the spot...[but] I was still left to hang to dry.…I literally lost total respect from him at that point. I really struggled working with him…definitely distress, emotional distress.

This administrator expressed anger that the colleague from another department did not remember or communicate the loyalty and commitment of a prior understanding and the respect was broken. Another administrator offered a contrasting experience by sharing how positive staff interactions with staff in other departments created a protective factor in the midst of ethical challenges; protective factors will be explored more below.

Difficult emotions were also experienced by one administrator as it relates to accreditation related activities. The administrator mentioned after a successful CCNE site visit, the school received a letter one year later with serious concerns about their MSN program related to clinical hours for direct patient care. The administrator experienced the CCNE accreditors as "very rude" and took a "non-helpful stance" in their communication after a site visit. Consequently, the administrator stated they felt "angry...not happy." This administrator identified this was an ethical issue related to the delayed timeline and unsupportive nature of the feedback. The administrator expressed positive, albeit tired feelings about nursing program accreditation, and believed that unsupportive feedback diminished the ability of an institution to improve.

Lack of communication affected another administrator's experience also. At their previous institution, this administrator stated that the communication breakdown was unethical due to "not being heard…not being listened to". The administrator explained:

> I've been a nurse for 40 years. And I have lived with emotional trauma from moral distress for 40 years. …I think nurses have post-traumatic stress disorder of a different nature. That needs to be continued to be explored more.

This administrator further expressed how emotionally damaging it was to not feel heard by upper administration:

> I don't trust people. I don't trust anybody. I don't trust any faculty. I don't trust any administrators. I don't really trust anybody. I think that has created that emotional state for me to not trust people. I will trust you for the moment, so I'm kind to everybody and loving and caring to everybody. And I trust you in the moment. But I will never put my 100% trust in anybody because I've been burned too many times and hurt too many times.

Moreover, a lack of trust corresponded to the experience of helplessness for one administrator, who expressed their "hands were tied," and the attempts they had made to improve their program had gone unnoticed by administration, compounding the challenging emotions further. In contrast, communication that allows administrators to feel validated reduces the emotional distress. For instance, two participants reported "feeling heard" by upper administration empowered them to make high quality decisions. Therefore, working in a safe environment with open communication has served as just one protective factor against negative emotions.

Protective Factors and Coping Mechanism for Negative Emotions

A protective factor for the administrator who received a negative report for CCNE a year later was "not taking it personally." Another director who received executive coaching also identified this protective factor; the executive coach encouraged them to only communicate "the facts, ma'am,…when you take things personally, you become invested, and then the outcomes are not the way they should be." Additionally, the researcher noticed that the ability to separate oneself from the process receiving feedback and their personhood functioned as a sustaining force for participants.

Regarding the COVID vaccine, one participant who held a 50% faculty and 50% administrator role saw communication with stakeholders as a positive movement toward less emotional distress. They said:

> How can I work to communicate…efficiently, effectively, coherently...when they're [students are] not able to hear that much? What they're seeing is me not advocating for them or that I'm not supporting them, which...is not the case. …Some things that they [the students] were suggesting were unrealistic and would lead to another delay. I was just struggling…to make a good decision that made everybody happy. …my Achilles heel is my people pleasing nature, and having to realize that this is just going to be one of those times where there's going to be a large portion of people that are not happy and not in support of this decision...I still need to make it to move forward and move the program forward.

This participant expressed the importance of the personal awareness of stress triggers (e.g., feeling displeasure from stakeholders) and the protective factor of accepting there will be personal discomfort in order to move forward. In short, the personal acknowledgement of why the situation is personally and professionally difficult appears to be another positive factor in processing the difficult emotions. They also mentioned a more recent helpful factor was some of the students and administrators were beginning to understand her perspective and experience during that time:

> I've had several students that have since come to me and apologized… 'You were in a really hard spot'. That's helped me feel, 'They get it finally.' It's definitely led me to question if I want to stay in leadership, if I want to stay in administration. A lot of what

> leadership is making decisions that are not always popular…I'm glad to be on this side of it and glad to have some of the challenges recognized by students and administration.

As the participant accepted that leadership roles demand executing unpopular decisions, they allowed themselves to question if this level of stress was what they wanted long-term. They expressed the psychological relief of feeling understood by the stakeholders they experienced conflict with, even if it was later. Across the participants' experience, the feeling of being understood has emerged as an important component of coping with challenging emotions of ethical or professional communication related issues; Chapter 5 will explore this topic more.

Simultaneously, another administrator reflected on helping coping mechanisms amidst COVID. Feeling supported by upper administration was an important factor in sustaining clarity. They said, "I can still voice my opinion. I always have to take a step back and voice it in an appropriate manner, but I do feel very supported by the administration." This administrator also expressed how important interprofessional and interdepartmental relationships were in coping with COVID vaccine related stressors:

> You talk to people, [you] communicate, [you use] prayer. Prayer…and mostly talking to my colleagues about it…[even though] they can't do anything about it and they won't take those calls. I'm like, 'you guys don't have to take those calls. You refer those calls to me because you don't need to explain this. Let's have one voice doing it.' One member of the COVID committee, who is our chaplain, is just hilarious. If I'm really feeling lousy, I'll get an email from him that is just funny.…This isn't going to kill me. It's communication…and a lot of prayer.

This administrator worked at a faith-based institution and identified the pressures of administering the COVID vaccine policy with stakeholders who were confused and angry at

their institution's stance. Fortunately, they found the community of the other staff and faculty as a source of joy and their own spiritual practice of prayer as a gateway for making meaning out of the troubling emotions.

Meanwhile, one administrator demonstrated how working in unity served as a protective factor in their experience. They experienced the accidental inaccurate accounting of clinical hours and a poorly developed Systematic Plan of Evaluation. This administrator reiterated how important a "shared mental model" was when helping faculty understand the purpose of clear reporting to the NRB and how to regularly prepare for nursing program accreditation. They said,

> My biggest insight and take away is that communication is essential…you have to keep checking to make sure everybody's hearing what's being said. Because as humans, sometimes we take in things through filters, which means we hear what we want to hear, and we [have] pushed out the other as white noise, but it's important as a program across the board because we're the face of our program. …we're the face of nursing. …I think communication is key and that [is a] shared mental model.

This administrator emphasized the importance of facilitating team-based understanding of the accreditation process. Simply because a team is working on a group project does not mean that teamwork is happening. The administrator mentioned a way to overcome feeling overwhelmed and shocked was to "move to action… [to take] corrective action and move forward…and my prior experience as a nurse administrator [helps]." This administrator also cited an executive coach as a positive force in taking active steps to rectify that problematic and stressful situation.

Several administrators emphasized the importance of a forward-facing orientation on the problem: identify the problem and create a future vision of how to move through it. For example,

an administrator remarked staying aligned to their parent institution's core mission, vision, and values enhanced their confidence in making ethical choices:

> [Staying aligned with our mission, vision, values] made us feel more ethical and truer to what we said we were going to do…and I prayed…fervently. I don't know how many days in a row, probably…more than a year. I've barely relaxed…(laughs)

This administrator also recognized that people with credentials and skill sets in ancillary administrative roles within the nursing department were profoundly supportive, this contrasted with the experience of another administrator as stated earlier that demonstrated how negative relationships with administrative staff can "hamper" the work that needs to be done. Many of these positive, protective factors appear to relate to organizational culture, which Chapter 5 further explores.

Discrepancies in Data

The researcher noted several discrepancies within the process of data analysis between participants' experiences. Predominantly, some participants identified numerous ethical challenges in either their administrative roles or CCNE nursing program accreditation or both, and other participants did not identify any ethical challenges in their lived experience as nursing educators, administratively or otherwise. A second discrepancy noted in the data was some participants experienced "not being heard" by upper administration as an ethical challenge. Although other participants noted a similar experience without labeling it as an ethical challenge, as well as how they shared their experience, it did not appear to meet the definition provided for an ethical challenge but rather a problematic communication issue. When framed as providing bedside nursing care, nursing ethics may be more easily identifiable, but more challenging to identify when direct patient care is not present.

Furthermore, some participants identified communication issues and professionalism issues (e.g., quality, compensation, well-defined organizational roles and responsibilities for faculty and supportive staff) as ethical in nature, yet other participants strongly identified these were not ethical challenges.

Additionally, some participants expressed their fore-conception of the research topic at the beginning of the interview. For example, some participants explicitly stated at the beginning of the interviews that they had never encountered ethical issues and then later articulated mild to moderate ethical challenges; this may be related to, as Gadamer referred to it, their own horizon expanding as they had time to reflect on their experiences (Gadamer et. al, 1960/2004, p. 301). Some participants had time to debrief their interview with the researcher while other participants did not; the participants expressed a newfound awareness of nursing ethics pertaining to administrative duties. For example, one administrator reflected on their new awareness by saying:

> I would [like to] put the provisions of the ANA Code of Ethics on my wall and look at them every single day. I would be a better administrator because I know 'the what to do', but 'the how to do it'…that's what kind of cuts. How do you get it outside of you to do those things ethically? Especially pointing people in a particular direction. You realize how much power you have.

As an exploratory study, there is more to understand about the experiences of nursing faculty and administrators related to their ethical challenges and ethical sensitivity on a day-to-day basis.

Conclusion

The primary purpose of this study was to explore Bachelor of Science (BSN) and Registered Nurse (RN) to BSN (RN-BSN) nursing educators' lived experiences with ethical

challenges related to their higher education administrative duties and secondarily their experiences with ethical challenges as they relate to nursing program accreditation, if any. The researcher found that the commonalities amongst most participants included ethical challenges pertaining to the COVID vaccination requirement of clinical partners, CCNE Standard II E and the challenging recruitment of graduate prepared faculty, conflicting requirements between the NRB and CCNE, and competitive clinical sites, and competing loyalties between the institution and to students and patients; these situations shared some common contextual factors of recent leadership transitions. Some participants stated no experiences with ethical challenges as they relate to their administrative or accreditation related experiences and cited it might have been their lack of experience at their parent institution or in academia; however, this was not evident through the data.

CHAPTER 5

Discussion

The primary purpose of this study was to explore Bachelor of Science (BSN) and Registered Nurse (RN) to BSN (RN-BSN) nursing educators' lived experiences with ethical challenges as they related to their higher education administrative duties, and secondarily their experiences with ethical challenges in regard to nursing program accreditation, if any. In this study, *ethical challenges* were defined as a feeling of conflict between personal and professional values or professional and institutional values (Jameton, 1984). Appendix B outlines the Standards of Practice for Nursing Administration.

Chapter 1 outlined the purpose and need for the study; Chapter 2 provided an overview of current literature as it relates to the research question. Chapter 3 described the methodology which focused on the lived experiences of nursing faculty and administrators. The researcher followed Heidegger's hermeneutic, interpretive phenomenological approach; this methodology described and interpreted the phenomenon (Polit & Beck, 2009). In Chapter 4, the data was reported using rich, thick descriptions and analyzed (Polit & Beck, 2009). In Chapter 5, the researcher explores how the data relates to the literature in the fields of nursing and leadership studies and how the data either confirm or differ from what has been previously published as well as implications for practice. The connection between the data, research question, and purpose of the study are delineated in Chapter 5.

The majority of participants in this study were administrators or held formal administrative roles in addition to their teaching responsibilities (88%), and two participants were full-time faculty (16%). The majority of administrators (71%) experienced a variety of ethical challenges, but the faculty did not report ethical challenges in regard to their

administrative duties or accreditation related activities. The most common ethical challenges that administrators encountered related to their administrative duties included issues related to nursing program operations, legal and regulatory issues, and safety and risk management. As it pertained to nursing program accreditation, over half of administrators (57%) experienced ethical challenges. The specific themes for both Q1 and Q2 included conflicts with CCNE and NRB, COVID vaccine policies, competing loyalties, and leadership transitions. Table 6 offers a visual overview of specific themes described in Chapter 4.

Table 6

Themes Identified from Nursing Faculty and Administrators

CCNE	Standard II E Site visit and self-study process
Nursing regulatory bodies	Accidental non-compliance Differing expectations between NRB and CCNE Competitive clinical placement sites
COVID vaccine policies	Faith-based institutions Conflict with and amongst stakeholders
Competing loyalties	Revenue generation Caught in the middle
Leadership transitions	Bearing the responsibilities of past or current administrator's choices

Participants identified ethical challenges in Q1 (administrative related activities) and Q2 (accreditation related activities). Administrative duties and organizational culture appear to be

internally developed by parent institutions. Guidance for how nurse educators should navigate ethical challenges within higher education is loosely developed within nursing research, but broad extrapolations could be garnered from the ANA *Nursing Administration: Scope and Standards of Practice* (ANA, 2016), if nurse administrators were aware of the resource. As stated previously, this text is written primarily to offer guidance to administrators in clinical settings.

Accreditation duties are data driven and externally regulated, which offers faculty and administrators a degree of clarity on the expectations. However, multiple participants expressed confusion on how to comply with conflicting national accreditation standards and state-based regulations. The participants shared experiences that showed an interplay between informal and internal normed behavioral expectations and external, data driven conflicting national and state-based regulations.

Several participants had uneven interpretations of what constituted an ethical issue or uncertainty if they had encountered an ethical issue. Two participants mentioned their ability to "do the right thing" as a stabilizing feature in staying aligned to their personal and professional values. Participant's self-perception of identifying as an ethical person was also another notable factor, regardless of the severity or consequences of the ethical issue identified, or in one case, not identified by participants. The following sections explore the nuances of the data, connect the data of the study to literature, and offer suggestions for practice and future research.

Ethical Challenges and Ethical Frameworks

In this study, participants used a variety of ethical frameworks to make meaning of their experience. The researcher also observed variability in participants' interpretations of what they identified as ethical challenges. Additionally, the interpretation of the severity and the impact of

ethical challenges varied. Several administrators processed their experiences through the lens of consequentialism (e.g., there was "no harm" done to students or others in their organization). For example, one administrator quit for a day due to a lack "of being heard," contrasted by two administrators stayed with organizations that falsified information for regulatory bodies, and one administrator falsified information.

Jameton (1984) made distinctions between two primary ethical frameworks that competed to determine right from wrong: Mill's formulation of utilitarianism and corresponding consequentialism and Kant's formalism. Utilitarianism built on the concepts of making a decision that produced the greatest good for the largest number of people (e.g., consequentialism) (Jameton, 1984). Utilitarians might view telling a lie from two angles. Telling the truth instead of a lie had long-term benefits that outweighed immediate gains (e.g., establishing a trustworthy reputation), versus telling a lie might have had such a disastrous impact with no positive identifiable gains, thereby inferring that it is better to lie than to tell the truth (Jameton, 1984). It appears most participants in this study utilized consequentialism, specifically when discussing their decisions of whether or not to disclose information on the self-study reports or their framing of the COVID vaccine policies.

On the other hand, Kant's formalism is concerned with the intent of the action as opposed to its direct outcome; this framework might have been used when people acted on principle regardless of the personal consequences, and this is often in alignment with one's sense of personal self-perception and one's desire to act out of "pure motives" (Jameton, 1984, p. 148). This framework appeared to explain the participants' reported sense of positive self-regard and positive motives when they responded to their lived experience with this phenomenon; several participants stated they were "confident" in their ability to "do the right thing." Based on the

participant reports, it appeared that formalism was referenced as often for the ethical decision-making process as much as it was utilized for the framing of personal self-reflection.

In addition, Jameton (1984) introduced the term *moral uncertainty*, which is when someone is unsure of which moral or ethical principles applied. Some participants, mostly faculty members, responded to the interview questions with moral uncertainty. Some participants stated that they did not experience any ethical challenges initially, but later the interviewer identified an ethical challenge in their lived experience. The variability in participant responses relates to each participant's use and understanding of the definition of terms within the interview question.

The Use of Definitions

According to the ANA (2015), one of the first steps in navigating a clinical-ethical situation was to "identify if it [were] ethical, moral, practical, or relational" (p. xxi). Although the scope of this study was not focused on clinical-ethical situations, the importance of identifying the potential problem was essential. The ANA (2016) also directed nurse administrators to first assess an ethical situation. As participants reflected on their assessment of their ethical challenges, relational and communicative related stressors increased the problematic nature of several of the participants' experiences.

As previously mentioned, participants may have experienced a situation as an ethical challenge, but it did not meet the definition presented at the beginning of the interview. Additionally, when asked about the ethical issues in many of the interviews, faculty and administrators struggled to identify what the ethical conflict was specifically although they could identify it was challenging and felt distressing. Fowler and Davis (2013) suggested nurse educators could more accurately identify ethical issues in the clinical setting but struggled to

differentiate between moral dilemmas and moral failures; the results of this study suggest some participants felt moral uncertainty and that it may be challenging to identify ethical issues in a non-clinical setting.

As mentioned previously, Gray (2008) explored nurse leaders' experiences with the ethical dimensions of leadership in clinical practice and higher education. The nurse leaders identified as moral leadership included personal integrity, advocating for justice, an understanding of consequences of difficult decisions, and the appropriate sharing of information (Gray, 2008). Similarly, participants interviewed in this study mentioned their commitment to personal integrity or "doing the right thing." However, situations with right or wrong answers rarely constitute an ethical challenge or sufficiently address it. Similar to what Fowler and Davis (2013) identified, failing to "do the right thing" is a moral failure, not an ethical challenge. Lyndaker (1996) also identified poorly defined criteria for ethical values which increased the difficulty to correctly identify the primary conflict. This is problematic because identifying the core ethical issue at hand is one of the first steps in decision-making (ANA, 2015). Consequently, this lack of consensus can explain faculty and administrators' lack of understanding regarding ethical challenges.

Several participants shared experiences that did not meet the definition of an ethical challenge; instead, their distress was related to communication breakdowns between interprofessional team members in the higher education setting (e.g., upper administration or staff and faculty in other departments). Sharing the stories seemed to be a cathartic process of an unresolved or profoundly jarring experience. Conversely, one administrator shared a story that met the definition of an ethical challenge but did not self-identify their experience to be an ethical challenge. It appeared for many participants that if their experience held a "yuck factor,"

whether an easily identifiable ethical challenge, communicative issue, or breakdown in organizational structure, that left negative impression, or unresolved feeling, the participant perceived it as an "ethical challenge".

This is a useful insight for the profession of nursing and nursing leaders; exploring and differentiating between an ethical and communication issue can frame the solution and the degree of "yuckiness" or moral judgment attached to the experience itself. The definition itself appears to adequately capture the purpose of the study and explore the lived experiences of nursing faculty; however, nursing faculty can always come closer towards a shared understanding of what constitutes as an ethical issue. Additionally, some nursing faculty and administrators knew about the *Nursing Administration: Scope and Standards of Practice* (2016), and one participant who held a 50% faculty and 50% administrator role had a copy on their desk. Most participants verbally stated their familiarity with the ANA Code of Ethics and 9 Provisions (2015) (Appendix A); furthermore, several participants stated the *Nursing Administration: Scope and Standards of Practice* (2016) (Appendix B) was new information for them.

The *Nursing Administration: Scope and Standards of Practice* (2016) has created a strong foundation for providing needed, specific guidance for nursing educators. Nurse administrators in any setting respond to external demands but hold a unique position of leadership within a parent-institution and thereby create, respond to, and maintain the parent institution's mission, implicit and explicit values, and norms. While their role placed this study's participants in a challenging position at times, the protective factors they experienced also seemed to originate from the supportive organizational culture of their institution which is centered on shared decision making, clear communication, and responsive upper administration or supportive external relationships (e.g., a professional mentor or coach). These protective

factors and positive coping mechanisms supported participants in navigating uncertainty, socialized them with positive norms of a growth-mindset, and were internally (support within the parent institution from involved stakeholders) and externally (e.g., coach) validated positively.

Organizational Impact

The following section explores the factors that the participants most often cited as precursors to the ethical challenge and the organizational factors that appeared to support participants' experiences and feelings of resolution with an ethical issue. The key findings from Chapter 4 suggested that when administrators experienced an ethical challenge, it was most likely related to nursing program operations, legal and regulatory issues, and safety and risk management.

Within each of the above categories (e.g., operations, regulatory issues), communication breakdowns and inefficient or unclear organizational structure were contextual precursors of an ethical challenge. Although participants did not explicitly use the words "organizational culture" in their responses, many participants shared experiences that were linked to group dynamics, effective communication, and interpersonal normed behavior. These participants may have experienced communication misunderstandings as an ethical challenge or escalated them into an ethical challenge emotionally.

Organizational Culture Defined

Scholars within organizational leadership have explored the positive and negative impacts of organizational culture. Some of the foremost scholars, Schein and Schein (2017), defined *organizational culture* as a collective, learned approach to problem solving, which has worked well enough to pass on to new members, and built a pattern of normed beliefs, values, and behaviors that is eventually taken for granted. Schein and Schein's (2017) work has been

applied to bedside nursing, the business of healthcare (e.g., Cirka & Messikomer, 2012; Sawan et al., 2016; Sawan et al., 2018), and higher education (e.g., Bolinger & Burch, 2020; Corrigan, 2012). Organizational culture is an informal, yet perceivable, collective philosophy to approach everyday issues, problems, and opportunities. Furthermore, traditionally visible influences of organizational culture included the organizational mission and vision (Murray, 2017). The results of this study included ethical issues most commonly related to program operations, legal and regulatory issues, and safety and risk management, and each of these categories included the need for cohesive, unified problem solving and clear vision and goals.

According to Sabouri et al. (2019), cultivating an ethical climate starts with organizational leaders considering tactical considerations, i.e., strategic planning for incremental, sustainable change, up-to-date policies and procedures, clear communication of organizational values, transparent processes for faculty evaluation and promotion, equitable recruitment, and retention processes. However, organizational leaders should also consider ongoing feedback, continuous improvement, systemic processes for mitigating errors, and reward systems for ethical behaviors and role modeling (Sabouri et al., 2019). One of the faculty members who stated that they had not experienced ethical challenges identified their organization's clear and equitable policies as another supportive factor in an ethical culture.

Organizational Culture within the Nursing Profession

Furthermore, Schein (2017) explored occupational cultures, or micro-cultures (e.g., law, engineering) and suggested strong socialization of professional values cultivated during formative educational years may remain stable over time. However, macro-cultures (e.g., national and regional influences) create variations within occupational cultures. Organizational

culture within a hospital or higher education institution can influence the micro-culture of a specific department (e.g., nursing).

According to Haahr et al. (2020), ethical issues within in-patient settings were linked to staff and equipment shortages, unhealthy organizational culture, norms, and structure, and inadequate policies. Organizational issues included overly litigious charting requirements, conflicting professional values, and rigid standardization that compromised their basic nursing values. Similarly, Tavakol et al. (2022) explored the causes of moral distress for Iranian nurses; the results of the study concluded seven core causes of moral distress for this group of participants. Two causes of moral distress included organizational culture (e.g., physician dominance and resulting lack of nursing authority) and environmental and organizational factors (e.g., workload, staffing, poor facilities) (Tavakol et al., 2022).

The results of this study suggest nursing faculty and administrators experienced similar obstacles as clinicians (staffing, lack of nursing authority, conflicting professional values). Unhealthy organizational culture and poor teamwork appear to be contextual factors surrounding moral distress or ethical issues.

Organizational Culture: Teamwork and Shared Governance

Organizational culture informs teamwork; how teams engage in group work was formed through a shared reality, thereby highlighting the relevant social and technical information, and when to determine when enough action had been taken or if action should be taken at all (Schein, 2017). The results of this study suggest protective factors against ethical challenges include strong communication amongst an interprofessional team (e.g., upper administration) and "shared mental models." In this study, whether nursing faculty were working on nursing program operations, logistics, or accreditation, shared governance ensured effective goal-setting and

realistic objective attainment (Ralph et al., 2015). Shared governance created a sense of ownership and authority over their routine work environment and the factors that most frequently impacted them (Bolman & Deal, 2017).

Psychological Safety, Power, and Communication

Similarly, Avey et al. (2012) demonstrated the interrelationship between ethical leadership and ethical organizational culture, providing evidence for a positive relationship between employee psychological well-being and job satisfaction. A mediating leadership intervention included encouraging employees to voice constructive criticism within a team, enhancing a feeling of psychological safety (Avey et al., 2012). Sağnak (2017) found that strong organizational and ethical culture cultivated voice behavior (e.g., constructive discourse) amongst followers.

Furthermore, Edmondson (2018) conducted research in large healthcare institutions regarding medical errors. The results of the study demonstrated stronger teams (e.g., greater mutual respect, collaboration, and confidence) made more mistakes. After additional blind-data collection from a second researcher and data analysis, it became clear the stronger teams simply reported more errors, double-checked each other's work, and felt comfortable with transparently disclosing errors for the purpose of prevention and quality improvement (Edmondson, 2018). In this study, two faculty members who reported not encountering ethical challenges cited their supportive upper administration, feeling understood, and their lack of experience as potential factors for their protection against ethical challenges. Although the data set is limited, other participants who cited ethical issues identified unsupportive upper administration or "not feeling heard" as correlational reasons in their experience with ethical challenges, suggesting psychological safety as a factor in nursing faculties' experience with ethical challenges. The

participants who identified an ethical challenge or negative experience with upper administration framed it as a downstream issue that was their responsibility as opposed to a potential systematic issue.

Schein (2017) also recognized the concept of psychological safety as an aspect of healthy internal integration of cultural norms. For participants who reported the stress of "not being heard," the phenomenon of psychological safety is an important consideration of which leaders should be aware. Hofstede (2011) explained the notion of *power distance*, the acceptable degree of psychological distance or nearness deemed normal within a hierarchical organization. The ANA CoE acknowledged the essential functionality of hierarchies and power structures for goal-achievement by saying, "Without power structures, meaning and value structures are dead in the water" (ANA, 2015, p. 156). However, the more complex a task is, the more likely subordinates rely on interdependence between teams and become more vulnerable to poor collaboration (Edmondson, 2018; Schein, 2017). Nursing program accreditation, nursing program operations, and navigating a global pandemic require complex team-based short- and long-term decision making, planning, and adaptive execution of plans. Several administrators mentioned the positive impact of group-based decision making both among faculty and supporting staff.

As it relates to upper administration, organizational power-structures within the workplace can influence the free-flow of information; faculty "pushing back" on upper administration can have both social and political risks. Within the workplace, people engage in small yet consistent social risks each day augmented by change or uncertainty and form adaptive learning behaviors such as asking for help, feedback, and solution experimentation (Edmonson, 2002). Individuals have implicitly perceived and cognitively managed the safety of their risks through assessing the overall psychological safety, which was a socially, group-developed

construct (Edmonson, 2002). Within the social nature of team-based work in a nursing department, individuals considered what can be "won or lost" before speaking up, and psychological safety within the organizational culture inferred individuals felt secure that they would not be punished for speaking up about areas of concern or need for improvement (Sağnak, 2017). For instance, one administrator quit for a day due to the distress of not feeling heard and stated the negative impact of losing the team (e.g., what is lost) as the reason for returning to work the next day. Another dean identified the inter-personal calculations necessary for remaining compliant with state-based regulations when their faculty was off contract. The administrator needed the information but did not want to damage the trust of faculty during their time off or violate the union contracts of faculty.

A Framework for Daily Ethical Issues: Power, Control, and Values.

The reality of ethical issues is multifactorial. and a simplified framework of organizational and personal variables supports engagement in an otherwise overwhelming topic. Worthley (1999) offers a "prism" model for organizational leaders to reflect on the daily, monotonous, and often easily missed ethical issues. The factors include *power*, *control*, and *values* (Worthley, 1999).

Power

Organizational leaders must be aware of the daily ethical issues related to power; their influence and position affect many individuals, both in scope and impact (Worthley, 1999). An awareness of power dynamics can positively impact subtle, yet informative interpersonal interactions that communicate trust and mutual respect or intimidation and disregard. For example, a leader with an understanding of power can more effectively navigate interoffice fallouts and allegations of favoritism (Worthley, 1999). Within this study, several administrators

identified an awareness of their lower positional power in respect to higher education executive administrators, as well as endorsed feelings of "responsibility" and "accountability" to manage mistakes or organizational challenges. The concept of psychological safety is also embedded within the delicate interplay of power dynamics. The participant who identified the distress of "not feeling heard" provided a poignant example of how mismanaged power dynamics led to employees quitting, in this participant's case, only temporarily.

Control

Control within healthcare directs and manages teams toward ongoing competence, effective and efficient deliverables, and fair and equitable work environments (Worthley, 1999). Formal control includes accreditation standards, hierarchies, and policies and procedures; informal control includes organizational norms for rewarded or punishable behaviors (Worthley, 1999). Participants in this study identified numerous challenges related to professional state and national based quality control mechanisms. They noted both formal control (e.g., NRB's and accreditation) and informal control. Participants identified formal control mechanisms as numerous, redundant, and frequently incongruent with other regulatory requirements or the reality of resource availability. Some factors that participants mentioned regarding informal control included positive influences such as communicative upper administration and "shared mental models" to engage in ethical decision making. The participant who quit after "not feeling heard" may have had an awareness of informal control that existed in the dynamic between them and their upper administration that prohibited "pushing back" any further.

Values

And lastly, healthcare ethics must consider institutional and personal values; values inform expectations and responses to control and power (Worthley, 1999). Several participants in

this study identified their desire to "do the right thing" and the primacy of upholding nursing values (e.g., upholding the primacy of safe-patient care as it pertains to administrating COVID vaccine requirements). Several administrators identified a value for accreditation because they saw it could "[make the program] better" even though it was difficult. Utilizing this framework can organize the process of ethical decision-making through practical methodologies like checklists, predetermined probing revealing questions (e.g., viable alternatives, motives), and principle-based inquiry (e.g., identifying the ethical principle(s) in conflict) (Worthley, 1999). These methodologies can be useful when solving ethical challenges for numerous stakeholders at an institutional level.

Organizational Culture and Institutional Values

Leaders of ethical organizations are able to identify areas of conflict between actual and ideal organizational behavior and seek to resolve and manage the difference between espoused and actual values (Pearson et al., 2003). Nurse administrators expressed the ethical challenges of supporting students and prioritizing their learning and betterment while being aware of tuition-generated income and their NCLEX pass rates. Although the participants mentioned many aspects of the open-systems they worked within (e.g., numerous departments at the parent institution, state-based agencies, hospitals, national accreditor), the sense of personal responsibility and conscientiousness for the ethical challenges was noteworthy. Conscientiousness was an aspect of individual behavior that motivated individuals to fulfill obligations and could enhance connectivity between group members (Bendoly et al., 2010). Personal responsibility and conscientiousness are vital to individuals holding responsibility for their189ctionns and they were expressed by numerous participants, especially administrators who were responsible for enforcing the COVID-19 vaccine policies.

Some faculty experienced workloads as an ethical challenge while others did not. However, administrators experienced it differently, as they were closer to the proximal cause of the workload issue, and they cited it as CCNE Standard II E. A dynamic of higher education organizational culture has been the tendency to delegate work to a small number of productive and qualified faculty, increasing the workload of competent yet struggling individuals (Shapira-Lishchinsky, 2018). This approach has placed undue responsibility on highly engaged faculty and created an unhealthy unilateral organizational culture (Coffman & Sorensen, 2013). During a time of scarce and competing resources, organizations had to strive for cultures embracing mutual respect and candor, and those who might have felt they had little or no resource might sabotage the group's efforts, passively resist, withdraw, or demonstrate budding militancy (Bolman & Deal, 2017). As administrators reported more experiences of ethical challenges relating to adequate staffing, it would be worth researching further what they experienced from the group dynamics of overworked faculty. Participants also stated an "overwhelming" workload associated with preparing for and maintaining accreditation and state-based requirements.

Accreditation and Quality Improvement

Within healthcare, quality improvement efforts included national benchmarking set by organizations such as the JC, the Centers for Medicare & Medicaid Services, the National Committee for Quality Assurance, and the Agency for Healthcare Research and Quality (Marquis & Huston, 2021). Within higher education, accreditation is one of the main tenets of quality improvement. Accreditation prompts a regular review of the program's mission, vision, and goals and nursing educators to come to consensus for appropriate measurement criteria demonstrating alignment with external standards and the program's mission (CCNE, 2018a).

Moreover, the definitions of "educational quality" and "ethical challenges" proved to be equally ubiquitous, abstract, and contextually dependent for participants and even more confusing when exploring the concepts simultaneously (Fowler & Davis, 2013; Keating, 2015; Lyndaker, 1996; Schindler et al., 2015).

A helpful aspect of accreditation is the reliance on data and metrics. Data has depersonalized conflict while allowing conflicting ideas to remain on the table; leaders could continue to reorient their group to fact-based data (Valine, 2018). When administrators (one of which was a CCNE site evaluator) noticed accreditation self-studies were done incorrectly by previous administrators and faculty, they interpreted it as a misunderstanding of data analysis as opposed to intentional deception; this allowed them to create a forward-facing mentality of how to support the process moving forward. An interesting finding is that all administrators reported an understanding of the CCNE criterion, yet they reported inabilities to sufficiently meet the standards. One administrator identified that they understood CCNE's Standard II E but found a "sneaky work around."

Ethical Challenges regarding Accreditation

Rule bending, or workarounds, according to Collins (2012, p. 14), were generally seen as socially acceptable "to get the job done." Within nursing, rule bending behaviors were acknowledged, but scant research existed on the specifics of rule bending in applied nursing practice or nursing educators (Collins, 2012). Nurses in a long-term care faculty crafted a "work around" for borrowing and returning controlled substances for patients when external pharmacy services were delayed (Collins, 2001). The state surveyors enacted licensure disciplinary actions against the nurses (Collins, 2001). Nurses might violate standards of professional practice

knowingly, generally with the benefit of the good of the patient, workflow, or unit in mind (Hutchinson, 1990).

Furthermore, expert nurses in clinical settings were especially vulnerable for rule bending, as they had the ability to manage complex care, and could evaluate risks of their behavior and working around a problematic system (Collins, 2012). Nurses have acknowledged rule bending is not ideal, and that it was a "quick fix" to an organizational or system issue they perceived they had no control over (Collins, 2012, p. 15). Collins accurately suggested that rule bending is a delicate subject matter for nurses, and one not spoken in "polite society" (2012, p. 15). Participants in this study identified ways in which they, or another nearby nursing program, "bent the rules" in order to maintain their good-standing with the state regarding NCLEX pass-rates or CCNE's Standard II E.

Numerous administrators mentioned a scarce supply of nursing faculty and their conflicted experience between regulatory demands and the parent institution's expectations. Nursing programs are intimately connected to the larger parent organization through resource allocation, organizational mission alignment, and goals. According to Butts and Rich (2020), managers were positioned to support both the mission and the operational functions of the parent institution, balance the expectations of stakeholders, and remain aligned with their personal values. The administrators' experiences of feeling "in the middle" of budgetary needs and student outcomes is consistent with Ganske's (2010) findings. Ganske (2012) cited that the parent institution wanted to recruit and retain students while nursing educators worried about student progression, fair and equitable policies, and, at times, the helplessness of graduating students who were poorly fit for the profession of nursing. The prepotency of ethical issues noted

in nursing program operations demonstrates this as a unique challenge result in the lived experience of ethical challenges.

Another ethical challenge occurs when a person or entity violates ethical values. Healthcare providers in academic settings have learned the wide-spread social norm of "not being a tattletale," obedience through a highly hierarchical, professional chain of command, and feared being perceived as disloyal to their team if they felt unease or aware of unethical practices (Rhodes & Strain, 2003). Leaders who were aware of the unconscious calculations done by team-members recognized creating psychological safety was not about "being nice," but rather psychological safety allowed the productive free-flow of conflicting ideas and enabled teams to move from the simply collegial "comfort zone" to a compelling discourse of areas of learning and innovation (Edmondson, 2018, p. 16). This applies to the challenges reported by administrators who struggled to communicate errors they found in the self-study accreditation process.

For example, a participant who held a 50% faculty and 50% administrator role identified another school of nursing incorrectly reporting their NCLEX pass rates to the NRB in order to retain out-of-state clinical placement options. This participant identified numerous relational and departmental risks of reporting; the primary issue was their desire to protect their nursing students from negative outcomes. Healthcare faculty rarely served as whistleblowers when they saw unethical behavior in academia as they lacked an understanding of the importance of this role in the university setting, a context that differed so much from a medical setting (Aydin et al., 2012).

Nursing programs and external regulatory agencies look at NCLEX pass rates and student attrition as internal markers of nursing program quality. These categories are professionally

valued to determine what content knowledge areas, professional comportments, or technical skills are lacking in cohorts in order to supplement the curriculum moving forward. However, the NCLEX pass rates are the current external validation of a program's quality, both for prospective students and faculty, hiring clinical partners, and surrounding nursing schools. One participant mentioned that although passing the NCLEX is an important aspect of an alum's nursing critical judgment, it is likely a one-dimensional programmatic quality indicator. Nursing students could attend a poorly designed and operated nursing school and pass the NCLEX through sheer willpower; therefore, NRB and national accreditors should explore additional ways to assess program quality.

Several administrators who expressed ethical challenges with accreditation cited contextual issues with faculty knowledge and competency completing the often long and complicated, self-study. The administrators experienced the ethical challenges centered around their responsibility to fix it quickly and accurately, maintain positive relationships, and communicate the standards, as opposed to experiencing the ethical challenges as the lack of correct information they inherited from a previous system. The administrator who mentioned how important a "shared mental model" was amongst faculty in continual improvement of nursing program curriculum and accreditation speaks to how groups co-create reality, highlight important information, and reward processes and communication styles that meet that end. Through organizational culture, shared language and frameworks have been created and sustained (Schein & Schein, 2017). When faculty utilized a shared ethical framework, the framework facilitated creative solutions to complex dilemmas while "avoiding a prescriptive path" (Burger et al., 2014, p. 567).

Competency

Nurses at the bedside experience moderate levels of ethical conflict; the most significant organizational impact was the perceived professional incompetence of nursing peers, subordinates, and physicians (Saberi et al., 2018). Interestingly, participants specifically did not report incompetence; one administrator experienced an ethical challenge with a faculty member who was "mean" to students yet highly competent.

Some administrators identified ethical challenges as it related to their accreditation process since they were the ones to find the self-study was done incorrectly or curricular changes were unreported to SRB. One administrator emphatically reported it was "everyone's job" to understand the accreditation and SRB requirements, and the lack of knowledge capital on these topics led them to be non-compliant and increased their workload. Jameton (1984) and the ANA CoE spoke to the idea of competence, predominantly as it referred to nurses in clinical settings. However, this is an important concept to consider for nurses in non-clinical settings who carry the responsibility of educating future nurses and experience the impact of how their quality improvement processes affect nursing students, patients, and public health.

According to Jameton (1984), competency was unquestionably important in any nursing practice environment; however, competency was contextually dependent. It interfaced with external factors beyond an individual's control (e.g., staffing numbers, availability of supplies and break times, the specialty and equipment one was trained for) (Jameton, 1984). Through self-regulation, an important concept of the profession of nursing, nurses could address their incompetence by learning the emerging skills required of them or finding a role that fits their current skill set (Jameton, 1984).

Since Jameton's (1984) reflections on nursing competency, the ANA *Nursing: Scope and Standards of Practice* (2021) has provided additional guidance for the profession of nursing in every setting. Provision 4 spoke to the accountability and responsibility to make safe actions (ANA, 2021). According to the ANA, professional competency is defined by regulatory agencies; ironically, regulatory agencies appear to be a common test of faculty's professional competency (ANA, 2021). The ANA held a similar position to Jameton (1984) by also recognizing "competence is situational, dynamic, and both an outcome and an ongoing process" (ANA, 2021, p. 53).

More specifically to this topic, the ANA (2016) *Nursing Administration: Scope and Standards of Practice* spoke verbosely to professional competency of nurse administrators. The text identified the tremendous impact nurse administrators have on promoting health through systemic leadership and identified continuing education, certifications, and benchmarking organizations for administrator competencies (e.g. American Organization of Nurse Executives). The nurse administrator has the responsibility to self-regulate their own competency and support the on-going development of employees in meeting adaptive problems, and all administrators facing ethical challenges identified a growth-mindset toward the problems they faced (ANA, 2016). In times of tension, nursing educators can find common goals, agreements, and motivations for accreditation and quality improvement efforts through shared ethical frameworks and a healthy organizational culture.

Ethical Challenges regarding Quality Improvement

Nursing programs use accreditation as a form of quality improvement which includes the prevention, identification and rectification of errors. Henneman and Gawlinski (2004) explored the models for errors and continuous quality improvement in healthcare. Although the authors

applied Enthoven's Classification of Causes of Errors in high-risk, clinical settings, this model could apply to quality improvement processes in higher education. Enthoven's model classified causes of errors as technical, organizational, or human error (Henneman & Gawlinski, 2004). Participants reported a variety of different errors that occurred in their accreditation process, namely organizational and human errors.

Henneman and Gawlinksi (2004) considered technical failures as an active, system error, such as lack of equipment or software and organizational failures as latent, system errors that occurred due to lack of policies, training, procedural guidance, and human error as an individual, active error and due to lack of knowledge or competencies. Participants reported system failures as faculty misunderstanding or being unaware of regulatory requirements, state-based regulations, or curriculum development. The scope of this study did not include faculty training regarding accreditation processes, although this would be a useful direction of future research. System failures could also include administrators' conflict with complying with CCNE's Standard II E. Participations also reported human (individual) errors, as it specifically relates to individual prior knowledge or competencies regarding the accreditation process.

When it came to quality improvement efforts, some leaders worried that a culture of psychological safety implied quality became secondary to comfortability or an "anything goes" mentality (Edmondson, 2018, p. 17). Rather, psychological safety enabled teams to embrace candor, openness, mutual respect, and the freedom to challenge and check each other's thinking (Edmondson, 2018). Organizational teams with a high degree of psychological safety and comfortability with "interpersonal riskiness" could avoid classic social dynamics, such as an over attention to the reactions of others and under attention to safety and quality (Edmondson, 2018, p. 7).

As cited earlier, Ramos Toescher et al.'s earlier work (2020a) concluded that years of experience might be a protective factor to experiencing moral distress. Although the scope of this study was not measuring moral distress, it was not conclusive that years of professional experience in higher education had any impact on whether participants experienced an ethical challenge or not. However, this study does suggest that the type of professional role (e.g., faculty or administrator) may impact the prevalence of experiencing an ethical challenge. Continuing education for faculty regarding state and national based regulations is essential to prevent unintentional human errors in continuous quality improvement. The implications of this research can support healthy organizational cultures, positive teamwork, and meaningful quality improvement processes.

Implications

The results of this study offer several positive contributions to nursing practice in a variety of settings, including academic settings, in state-based regulations, and national accreditation standards. Nursing faculty and leaders in clinical and non-clinical settings have many opportunities to develop and encourage ethical organizational cultures. According to Sağnak, "ethical leaders [drew] attention to ethics" (2017, p. 1102). Nursing leaders who are aware of common ethical challenges in their practice setting and discern the ethical principles available to them to rectify the situation will be more likely to engage as opposed to avoid the ethical challenge, as well as support their colleagues in ethical decision making.

Within academia, nursing faculty might consider how nursing students are socialized to identify, address, communicate, and solve ethical challenges. Firstly, the results of this study suggest that participants held an uneven understanding of what constitutes an ethical issue. Greater attention can be given to this topic in nursing education, both in pre-licensure programs

and in continuing nursing education for registered nurses. Additional research in this area will help nursing faculty in supporting and educating nursing students, as well as develop experientially appropriate continuing education opportunities for practicing nurses. Creating lower-stakes opportunities in psychologically safe environments (e.g. simulation) to reflect, discuss, and learn about ethical issues could enhance ethical sensitivity and mature ethical decision making in both students and experienced nurses.

Secondly, several participants displayed important and noteworthy behavior. Positive self-regard emerged as an important factor when reflecting on the ethical issue, and this appeared to be paired with the lack of "intent to harm." If a participant was involved in an ethical challenge but did not intend to create a harmful consequence or did not notice harm after the fact, they reported an overall sense of positive self-regard. Being a nurse is deeply personal and often a reflection of deeply held beliefs to care for all people. Therefore, socializing nurses with ethical training and reflective exercises that allows for the recognition of personal biases while the outcomes of ethical decision making remain separate from personal identity appears to be a direction that could positively retain nurses who experience the "yuck factor" as well as empower nurses to engage ethical issues with greater openness. Being involved in an ethical challenge, making a mistake, or acting in a way that does not reflect the personal values and ethical principles does not mean that the nurse is damaged and unable to make ethical decisions moving forward. Positive regard for oneself, despite challenging situations and outcomes appears to reduce defensiveness and create a learning mentality when future situations arise.

Thirdly, nurses have used their organizational and professional leadership role to create and maintain healthy organizational cultures and educational innovation (ANA, 2016). Another consideration is building a healthy occupational culture, specifically how the profession of

nursing and healthcare organizations respond to errors related to clinical practice. For example, RaDonda Vaught was found guilty of criminally negligent homicide and felony abuse for an unintentional medication error in 2022 (Harrington, 2022). Within nursing education, it is important to explore what mechanisms there are available to address ethical issues with students and non-student related issues. Furthermore, the nursing profession should explore what it can reasonably expect from nurses, nurse executives, and employers in every setting with the dramatic changes due to COVID.

Finally, nursing leaders who collectively shape nursing occupational culture, should consider what can be done if nurses feel their reasonable expectations are not met. Any response to these concepts is not prescriptive; instead it would likely be emerging and different than it was twenty years ago when nurses first became rated as the most trusted profession in the United States (Gallup, 2023). The implications of the study also open further opportunities for research, as well as limitations to the study.

Limitations

The study had several limitations related to methodology and participant selection. One limitation included the unevenness of interpretation across participants regarding the definition of an ethical challenge. The differences in how participants interpreted the definition of an ethical challenge and how it related to their experience varied since some participants experienced communication or organizational structural issues as ethical in nature, yet other participants experienced similar situations and interpreted it as “an opportunity” or assumed benevolent intent. The purpose of the study was to explore the experiences of participants with ethical challenges and not to evaluate participants' understanding of ethical issues or their

understanding of the definition itself. The results of this study are not generalizable due to the small sample size, although useful information can be transferred to inform future studies.

The exclusion of schools not accredited by CCNE, part-time faculty, and faculty who only work with associate, masters, or doctoral programs also limited this study. In an effort to represent the experiences of participants and limit researcher bias, the researcher gave attention to including rich, thick descriptions of participants' reports. The researcher gave each participant the same orientation to Appendix B and the definition of ethical challenges. The phenomenological method allowed the researcher to maintain a curious mindset to all participants' responses and aimed to internalize Heidegger's concept of Dasein ("being there") (Zahavi, 2019, p. 144). Through "being there" the researcher was able to, over the course of the study, learn and grow in understanding the multiple experiences of nursing faculty and administrators.

The researcher aimed to cultivate a virtual environment where participants felt comfortable to "make meaning" out of their lived experiences and develop a research protocol that set an "intentional gaze" on a daily experience that might not have been automatically viewed with an intentional lens (Lopez & Willis, 2004; Seidman, 2014, p. 18). Throughout the process of data collection and data analysis, the researcher engaged the hermeneutic circle–the iterative process of understanding individual texts and aggregated themes through multiple reviews of data (Gadamer et al., 1960/2004). The hermeneutic circle allowed the researcher to remain open to responses, as all personal biases and assumptions were impossible to predict before this exploratory study (Oxley, 2016). The results showed that several participants engaged their own hermeneutic circle by stating they had not experienced an ethical challenge but with further exploration shared an ethical challenge.

Recommendations and Future Research

The following section offers recommendations for practical application of the results of this study in nursing practice, as well as suggestions for complementary future research to broaden this topic. The number of participants offers themes useful to make improvements in management and organizational structure; thus, further research should be done to explore large-scale improvements to nursing practice and administration.

Organizational Structural Recommendations

Several administrators across the United States reported that CCNE's Standard II E was an unrealistic standard to meet the demands of vacant nursing education positions, let alone the population health needs for nurse practitioners and administrative roles requiring graduate prepared nurses in clinical and healthcare industry settings. To solve this, parent institutions could consider hiring MSN prepared clinical instructors without didactic course load or parent institution committee-based assignments or both. The clinical instructors' schedule could allow them to support more than one clinical group at the same institution while maintaining clinical relevance. Additionally, with a clinical-specific schedule, these instructors could also support students of different cohorts (e.g., junior and senior level nursing students); this scaffolding could increase skill-building and faculty's knowledge of student needs over a period of time.

As a practice-oriented discipline, this may also be a positive recruitment tool for nurses who would like to teach but are less interested in higher education administrative duties or grading essays. Faculty are promoted and rewarded for productive scholarly endeavors such as publications, presentations, and research. Nursing faculty who enjoy the stability of promotion or tenure are more likely rewarded for the higher education industry standard promotion criteria or social respect among academicians than for ongoing clinical relevancy in a specialty. Tenured or

tenure-track faculty may develop a socially and economically rewarded academic skill set while losing a clinical skill set; simultaneously, the institution relies on them more heavily to teach clinical rotations to fulfill CCNE's requirement. Furthermore, building a reward system for full-time clinical instructor roles addresses professional rewards (e.g., promotion and tenure) as well as meets practical needs of adjuncts who may be interested in a full-time clinical role but would like to be eligible for health insurance.

Currently, nursing faculty and administrators struggle with recruiting and retaining faculty who meet the trifecta of professional expectations: academically qualified, confidence in their expertise, and clinically relevant. Furthermore, some NRB allow for BSN prepared "supervisors" with at least two years of experience to teach clinical even though CCNE's standards require MSN prepared instructors for clinical and didactic. This is not available in all states, and NRBs and CCNE could further explore this model to simultaneously meet the demands of nursing education and RN faculty retirements. If CCNE does not see this as a feasible option, they could consider a delegation and mentorship model.

Delegation remains a core nursing skill when providing high-quality care (Marquis & Huston, 2021). During a current and forecasted nursing shortage, institutions are training bedside nurses more carefully on how to augment delegation skills to maximize the nurses' scope of practice and effectively utilize assistive personnel. The regulatory environment at the accreditation and NRB level might consider working creatively to develop mutually beneficial relationships between clinically qualified BSN-prepared nurses and nursing faculty, leveraging the same partnership model as RN and assistive personnel. For example, states could consider a regulated pilot program. A one-to-one mentorship model could be utilized, where a nursing faculty member is paired with one BSN-prepared nurse "supervising" instructor and the number

of viable nurse educators could double in a given state. The far-reaching implications of increasing the amount of available nursing instructors could help institutions accept more eligible nursing students, remain financially solvent, and support population health efforts by producing more new nurse graduates.

Student learning outcomes would be tracked through the accreditation process; if there were a documented decrease in student learning using more BSN-prepared clinical instructors that are supervised by nursing faculty. institutions could create curricular, clinical, or simulation-based adaptations. Another positive benefit could be allowing the parent institution to fulfill its desire to utilize adjunct faculty as a form of cost-containment; this initiative would increase the program's ability to maximize student enrollment. Additionally, nursing schools are fertile places for BSN-prepared nursing instructor recruitment; many students bond with nursing faculty in a specialty of their personal interest. Consequently, nursing faculty could advertise the ability to mentor BSN-prepared faculty with two years of experience as a clinical instructor and maintain relationships with alumni. This enhances institutional loyalty amongst alumni and enriches the profession of nursing through sustained mentorship and connection after graduation and early career transition. Because of the potential of employment two years post-graduation, alumni may also be positively influenced by nursing faculty to work as BSN-prepared clinical instructors and additionally, empowered to attend graduate school.

As it pertains to undergraduate and graduate nursing education, ethical leadership could be developed through a competency-based approach. One method for supporting adult learning as it pertains to ethical decision is low or high-fidelity, standardized patient-based case studies, or virtual simulation that directly address ethical nursing leadership. This competency could be

reinforced in graduate nursing curriculum as it pertains to healthcare policy, advocacy, management, and healthcare administration.

Lastly, leaders must be prepared to address the rare direct ethical violation. As mentioned earlier, proactive approaches to preventing ethical issues occur through the cultivation of Just Culture, but Just Culture is also an essential component of addressing ethical violations. Just Culture offers a systematic framework for responding to at-risk behavior.

One possible objective tool was developed by the North Carolina Board of Nursing (2020); the tool was developed for responding to problematic issues with nursing students in clinical settings but could be also adapted to working with nursing professionals in a variety of clinical and non-clinical settings. The tool identifies mitigating and aggravating factors, human error, at-risk behavior, and reckless behavior. The tool numerically calculates the approach that the leader and support team should take (e.g., coaching, reinforced learning, disciplinary action, or remediation). However, this tool would need to de significantly developed as the function of the tool is directed toward students in clinical settings and not oriented towards "confidentiality, fraud, theft, drug abuse, diversion, boundary issues, sexual misconduct, mental/physical impairment" (North Carolina Board of Nursing, 2020, p. 2). The tool remains useful for two reasons. Firstly, the purpose of the tool is to differentiate mistakes made from human error versus at-risk or reckless behavior, and secondly, a fair and objective response from nurse leaders which leads to a Just Culture.

Future Research

The results of this study offer several areas of future research. One of the key limitations of the study was participants would identify an ethical issue and struggle to identify how it matched the definition of the study provided by Jameton (1984). The scope of this study was the

self-reported experiences of faculty and administrators with ethical challenges; however, there should be further exploration of participants' baseline knowledge of identifying ethical issues and the training they have received regarding nursing ethics. Based on the size of the data set and limited number of nursing faculty compared to administrators, it was inconclusive whether the participants' years of experience impacted their understanding of the definition provided.

Future research could enhance the results of this study and Schmitz and Schaffer's (1995) work. Though they did not specifically focus on nursing, Schmitz and Schaffer explored ethical issues that higher education students and faculty faced. These authors explored the practical steps to address ethical issues, the specific ethical principles selected to address it, and any barriers that participants anticipated (Schmitz & Schaffer, 1995). Future researchers could retroactively explore the specific steps taken to address ethical challenges identified by nursing faculty, known barriers, and the ethical principles or frameworks utilized to solve the presenting issue. Because the ANA offers scope and standards of practice guidance for various subspecialties (e.g., forensic nursing), it should include nursing education should be included as a unique and distinct area.

Although there is guidance for administrators, there are limitations in *Nursing Administration: Scope and Standards of Practice* as it pertains to nursing education, specifically regarding taboo topics, curricular bias, and conflict of interest (ANA, 2016). Research and curriculum development for nurses to identify ethical issues is also needed. In short, literature could address the nursing perspective in higher education more often. After all, nurse administrators reported the highest occurrence of ethical challenges; thus, additional research should be done to better understand unique opportunities and challenges of nurse administrators within higher education specifically. The protective factors noted by participants would be

interesting to further explore, as this would help nursing administrators and upper administration within higher education better understand how to strengthen nursing departments.

Additional research could include participants who said they did not experience ethical issues in their administrative duties or accreditation activities. Since nursing education has national standards (albeit differing state regulations) and thus similar challenges for nursing programs across the United States, further understanding of their institutions' respective institutions' organizational structure, processes, and culture would be helpful.

Previous studies have explored similar topics using qualitative, exploratory designs (Grason, 2020; Gray, 2008; Lyndaker, 1996). There is considerable opportunity to develop quantifiable tests and measurements for better understanding nurses' knowledge of ethical issues, thereby supporting nursing education at all stages of professional development.

Likewise, additional exploration of ethical sensitivity of nursing faculty and administrators is also needed, especially as it relates to the generational cohorts within the current and future workforce. As it relates to the retirement of the Boomer generation and the entrance of Generation Z into the workplace, it is important to consider the occupational cultural shifts likely to occur (Elmore & McPeak, 2019). The data from this study suggests that whether something is an "actual" ethical issue or if it is perceived as such, the impact left some participants considering transitioning out of their role or quitting their role temporarily. Generation Z's expectations for transparency are also connected to ethical expediency and elastic morality (Elmore & McPeak, 2019). As a profession, nursing has an opportunity for growth as it relates to communicating existing challenges, known systems failures, and projected downturns more transparently with financially invested stakeholders and increasingly transitory employees.

Another consideration for future research is to conduct group interviews of participants from different institutions. This study utilized individual interviews. Before individually interviewing each participant, the researcher reviewed Appendix B and the definition of ethical challenges. Some participants arrived at their interview with notes and specific experiences they had been reflecting on prior to the interviews. During their interviews, some participants appeared to become more reflective: although they initially reported never experiencing an ethical challenge, after verbally processing, they stated they had experienced one. Moving forward, interviewing a group of participants may be helpful on several accounts. First, it may provide a supportive, exploratory environment for participants to hear others share similar experiences. Second, it may generate helpful and creative solutions for ethical challenges that could be presented to institutions, NRB, or regulatory agencies to improve nursing education. A cautionary consideration of this approach includes people may feel guarded when asked to share ethical challenges without full anonymity.

Finally, future research could explore the same research question in different regions of the world, with adaptations given to the accrediting agency specific to that country. The researcher has had the opportunity to interact with nursing faculty from Kazakhstan and Taiwan, and it appears similar professional opportunities and ethical challenges exist within nursing education around the world. Therefore, capturing the global experiences of ethical challenges of nursing faculty would enrich the field of nursing ethics. Bowman and Deal (2017) suggest:

> The most important responsibility of leaders is not to answer every question or get every decision right. They cannot escape their responsibility to track budgets, motivate people, respond to political pressures, and attend to culture, but they serve a deeper and more

> enduring role if they are models and catalysts for values like excellence, caring, justice, and faith. (p. 396)

Nursing faculty and administrators have the unique opportunity to improve individual patients' physical health, implement population health initiatives, and engage public policy; but most importantly, nursing faculty care for the heart and spirit of students and patients alike.

Conclusion

The purpose of this study was to explore the lived experiences of nursing faculty and administrators as they pertain to ethical challenges in their administrative duties, and secondarily to ethical challenges as they pertain to the CCNE accreditation process. The results of this exploratory study suggest that when administrators encountered ethical challenges in their administrative duties, they included issues related to nursing program operations, legal and regulatory issues, and safety and risk management. As it pertains to nursing program accreditation, most administrators experienced ethical challenges. Administrators were more likely than faculty to encounter conflicting regulatory requirements from NRB and specific concerns related to CCNE's Standard IIE. The specific sub-themes included conflicts with CCNE and NRB, COVID vaccine policies, competing loyalties, and leadership transitions. Lastly, participants from private, faith-based institutions were most likely to encounter ethical challenges as it pertains to both administrative and accreditation related activities.

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Appendix A

American Nurses Association Code of Ethics Nine Provisions

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

Provision 2: The nurses' primary commitment is to the patient, whether an individual, family, group, community, or population.

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

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

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

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

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

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

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

Reference

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Appendix B

Standards of Practice for Nursing Administration

Standard 1 **Assessment:** The nurse administrator collects pertinent data and information relative to the healthcare consumer's health or the situation.
Standard 2 **Identification of Problem, Issues, and Trends:** The nurse administrator analyzes the assessment data to identify problems, issues, and trends
Standard 3 **Outcomes Identification:** The nurse administrator identifies expected outcomes for a plan tailored to the system, organization, or population problem, issue, or trend.
Standard 4 **Planning:** The nurse administrator develops a plan that defines, articulates, and establishes strategies and alternatives to attain expected, measurable outcomes.
Standard 5 **Implementation:** The nurse administrator implements the identified plan.
Standard 5a **Coordination of Care:** The nurse administrator coordinates implementation of the plan and associated processes**.**
Standard 5b **Health Teaching and Health Evaluation:** The nurse administrator establishes strategies to promote health, education, and a safe environment.
Standard 6 **Evaluation:** The nurse administrator evaluates progress toward attainment of the goals and outcomes.

The following list offers some but not all the role functions of nursing faculty.

- Collects and assesses pertinent data
- Analyze qualitative and quantitative data to produce reports for internal and external use, including accreditation
- Academic program planning, implementation, and evaluation
- Develop and administer academic policies; support and monitor faculty, staff, and students in efforts to maintain alignment with policies and procedures
- Recruitment and program marketing
- Develop and coordinate logistics for course and clinical requirements
- Develop and support efforts for new course offerings, new program, and program revisions
- Serve as a liaison between clinical partners and community of interest with the nursing program
- Recruit and develop adjunct faculty
- Perform other administrative and analytical duties supporting the academic mission of the nursing program
- Plan for nursing program operations
- Propose, recommend, and monitor budgets
- Ensure compliance with state, federal regulations, as well as other regulatory agencies as needed.

Reference

American Nurses Association. (2016). *Nursing administration: Scope and standards of practice* (2nd ed.). American Nurses Association.

Appendix C

Informed Consent Form and Demographic Form

Northwest University

5520 108th Ave. NE

Kirkland, WA 98033

A PHENOMENOLOGICAL EXPLORATION OF NURSING FACULTY'S EXPERIENCES OF ETHICAL CHALLENGES IN THEIR ADMINISTRATIVE DUTIES

Danette Ver Woert

Center for Leadership Studies

You are invited to participate in a research study being conducted regarding the lived experiences of BSN and RN-BSN nursing educators with ethical challenges as it relates to their administrative responsibilities in higher education. A related secondary question is the following: What are the lived experiences of nursing educators with ethical challenges as it pertains to the CCNE accreditation process, if any. This study is being conducted by Danette Ver Woert at Northwest University, in conjunction with the researcher's dissertation research. The results from this study will be utilized for dissertation research and potentially publication and/or conference dissemination and may be presented within a variety of nursing education forums (formal and informal). You were selected as a possible participant in this study because of your unique perspective and experience as a nurse in academia and involvement in the accreditation process.

The Northwest University Institutional Review Board has approved the study. To qualify for participation, you must be an adult age 18 or older. Completion of this study typically takes approximately one hour and is strictly confidential. Your responses will be treated confidentially and will not be linked to any identifying information about you. Your identity will be confidential and only known by the researcher. The summary of the data (e.g., themes, main ideas, and ideas) will be written broadly enough to protect your identity. Participants will only be identified by "faculty member" or "administrator," all other identifiers will be kept anonymous. All data collection and submitted survey information will be stored on the researcher's personal OneDrive and NVivo 12 accounts; these platforms are accessed through a personal device that requires a password and biometric authentication and is stored in a locked room. All data forms and information will be destroyed by May 2025; de-identified data for possible future articles will be retained. Please read the information below and ask questions about anything you do not understand before deciding whether to participate.

PURPOSE OF THE STUDY

The research question that forms the basis for this study is: What are the lived experiences of BSN and RN-BSN nursing educators with ethical challenges as it relates to their administrative responsibilities in higher education. A related secondary question is the following: What are the lived experiences of nursing educators with ethical challenges as it pertains to the CCNE accreditation process? Eligible participants will include nursing educators and administrators with full-time employment status at a BSN or RN-BSN, CCNE accredited nursing program in the United States, and administrators must be considered in an administrator or department chair role.

PROCEDURES

If you volunteer to participate in this study, we ask you to do the following things:

INTERVIEW(S)

Participate in an initial one-hour interview, which will be at minimum audio recorded, with the option of audio/video recorded on Microsoft Teams and transcribed. Following the interview, you will be offered the transcript for review of accuracy, meaning, and completeness. Coding will be completed in NVIVO 12 A second, shorter interview is also encouraged (but not compulsory) 7-10 days after the initial interview, in the event you would like to discuss additional topics or explore a previously discussed topic. If you are not willing to be audio recorded at minimum, unfortunately you will not be eligible to participate in this research study.

WRITTEN RESPONSE

After all the initial interviews have been conducted, you may be asked to answer (in writing) a clarifying question or provide further detail to a specific response.

POTENTIAL RISKS AND DISCOMFORTS

You will self-disclose voluntarily what you would like to share. If you disclose illegal activity, you could be at risk of criminal or civil liability, damage to employment, financial loss, or undue embarrassment. If during the interview, illegal behavior is disclosed, the researcher will report to the appropriate institutions as required by law. This research project deals with sensitive topics (e.g. ethical issues), and you have full autonomy to self-disclose the level of information you feel comfortable sharing. The risks encountered may cause uncomfortable feelings such as emotional distress due to answering questions of a personal nature. To manage this risk, you have the option to decline to answer any specific question, take a break during the interview, and/or

discontinue your participation in the overall study. If content of the interview causes you significant distress, please contact Northwest University counseling agency NUHope at 425-889-5261 for support in the Seattle area, or Psychology Today for access to therapists across the United States, or the suicide crisis hotline at (800) 273-8255. Any cost associated with counseling would be your responsibility. No deception is involved.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Your participation in this research study will provide an indirect benefit to you, contributing to a greater understanding of nursing educators in the United States of America. Although the results will lack participant, characteristic, and location identifiers, the aggregated themes regarding nursing faculty's perceptions of ethical challenges in academia will provide information, insight, and idea-sharing.

PAYMENT/COMPENSATION FOR PARTICIPATION

You will not be paid for participating in this research study.

CONFIDENTIALITY

Due to the sensitive nature of the research topic, the results of the study will be written broadly to protect identifying traits of participants or their work environments; furthermore, the research will be gathered from participants from the entire United States to further protect participant's identities. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only as required by law. The personal information, research data, and related records will be coded with assigned pseudonyms, positions, and departments, thus your identity will not be revealed at any time in this process. You have the right to review and/or provide feedback regarding the audio/video recording, in addition to the transcript at any time in this research process. Only the researcher

will have access to the audio recordings, interview transcripts, and if applicable, written responses which you provide. All data will be saved in a secure data-sharing folder on a password protected personal computer. Participation in this study is voluntary, and you may elect to discontinue the questionnaire or interview at any time and for any reason. You may print this consent form for your records. By selecting "Yes, visual and audio" or "Yes, to audio only" in the link provided below, you are giving permission to use your responses in this research study.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you have the right to decline to participate in the study at any time without any consequences. You may also refuse to answer any questions you do not want to answer and remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

If you have any questions about this study, please contact the principal researcher, Danette Ver Woert. If you have further questions, please contact the dissertation chair, Dr. Ben Thomas, Associate Provost, ben.thomas@northwestu.edu. You may also contact the Chair of the Northwest University IRB, Cheri Goit, at irb@northwestu.edu.

Thank you for considering participation in this study. If you choose to be a participant in this study, please complete the short two minute electronic informed consent and demographic form.

I have explained the research to the subject or their legal representative and answered all their questions. I believe that they understand the information described in this document and freely consent to participate.

_____ _____ _____

Signature of Principal Investigator Date Time

Danette Ver Woert, Candidate Ph.D.

Northwest University

5520 108th Avenue NE

Kirkland, WA 98033

425-889-6374

danette.verwoert@northwestu.edu

Appendix D

Study Interview Guide and Protocol

The research question that forms the basis for this study is: What are the lived experiences of BSN and RN-BSN nursing educators with ethical challenges as it relates to their administrative responsibilities in higher education? A related secondary question is the following: What are the lived experiences of nursing educators with ethical challenges as they pertain to the CCNE accreditation process, if any?

Researcher Activities

- Pre-journal
- Take observational notes during interview
- Post Journal

Opening Questions

- I'd love to get to know you a little more first, and then I'll explain a bit more about the study. Can you tell me about your current role?

Opening Directions

- Allow them to review Appendix A and B.
    - For this study, these are defined as:
        - Ethical dilemma or challenge is defined here as a feeling of conflict between personal and professional values or professional and institutional values.
        - According to the ANA, administrative duties encompass but not limited to safety, risk management, human resources (recruiting, hiring, developing,

firing faculty), client/population/employee advocacy, legal and regulatory (e.g., state, federal, accreditation) compliance, interprofessional collaboration, nursing program operations and logistics (budgets, developing new courses, serve as a liaison between program and community of interest, develop and maintain academic policies)

- Do you have any questions about the consent form, the purpose of the study, or other questions before we start?

Administrative Duties

- **Can you tell me about the administrative responsibilities involved in your current role?**
- **Have you experienced an ethical challenge in relation to your administrative duties?**
- **If so, could you describe in as much detail as possible a time that you experienced an ethical challenge as it pertains to your administrative duties?**
    - What happened?
    - What else was happening at this time that might have influenced the experience/phenomenon
    - Can you identify the title, role, or position of those involved?
    - What did you do?
    - Describe what that was like for you.
    - How was your emotional reaction to the situation?
    - What was communicated or what messages were understood?
    - What do you feel like was the primary ethical challenge presented?
    - As you reflect on the situation, how do you experience it now?

Nursing Program Accreditation

- **Can you tell me about your involvement in the nursing program accreditation process?**
- **Have you experienced an ethical challenge in relation to nursing program accreditation?**
- **If so, could you describe in as much detail as possible a time you experienced an ethical challenge as it pertains to nursing program accreditation?**
    - What happened?
    - What else was happening at this time that might have influenced the experience/phenomenon
    - Can you identify the title, role, or position of those involved?
    - What did you do?
    - Describe what that was like for you.
    - How was your emotional reaction to the situation?
    - What was communicated or what messages were understood?
    - What do you feel like was the primary ethical challenge presented?
    - As you reflect on the situation, how do you experience it now?

Participant Debrief Opportunity

- I'd like to offer a time to debrief the questions we discussed if you have the time.
- **I'm curious if you have new insights that occurred during the interview?**
    - What was your experience like answering these questions?

- Do you have any worries or concerns regarding the interview or what you shared?
- Do you have anything more to add?

Researcher Reflection Post Interview

- Summarize the interview and highlights of what was learned, unexpected themes, emotions, or happenings.
- Journal thoughts about potential biases, first impressions, relevant contextual information, and outside forces that could have impacted the interview, or even the flow of the interview.
- Any challenges that occurred within the interview that could provide additional insight when analyzing the data (e.g., the need to revise questions or flow moving forward to the next interview).

The questions that are **bolded** are considered essential; the non-bolded questions are considered probing questions that will be asked if additional information is needed.

Appendix E

Observational Protocol

Site

Date

Participant

Pre-interview Journal

- Prior thoughts, biases

Interview

- Reconstruction of dialogue
- Description of Physical Setting
- Non-verbal cues
- Environ Observations
- Accounts of Particular/Significant Events in Administrative Duties Accreditation Process
- Speculations, Feelings, Problems, Hunches, Prejudices

Researcher Reflection Post Interview

- Highlights of what was learned, unexpected themes, emotions, or happenings
- Journal thoughts about potential biases, first impressions, relevant contextual information, and outside forces that could have impacted the interview
- Any challenges that occurred within the interview that could provide additional insight when analyzing the data (e.g., the need to revise questions or flow moving forward to the next interview)

Transcription Reflections

- Document insights, questions, and highlights about transcription of interview

Comparative Reflections

- Insights from simultaneously analyzing previous interviews with most recent interview