FORMATION OF PROFESSIONAL IDENTITY AND EVERYDAY ETHICAL COMPORTMENT IN PRE-LICENSURE BACCALAUREATE NURSING STUDENTS: A GROUNDED THEORY APPROACH

by

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DISSERTATION

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy at
University of Texas at Arlington
May, 2017

Arlington, Texas

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ACKNOWLEDGEMENTS

This work was supported by the Bond Fellowship, given in honor of Dr. Mary Lou Bond, Professor Emerita of the University of Texas at Arlington College of Nursing and Health Innovation. I thank my committee chair, Dr. Susan Baxley, Clinical Associate Professor of Nursing, Retired, for her generous gift of time, encouragement and mentorship. I also thank my committee members. Thank you to Dr. Luzita Vela, Clinical Associate Professor, Department of Kinesiology, for her time and inspiring interest in applying this work to the formation of future athletic trainers. Thank you to Dr. Nelda Godfrey, FAAN, Associate Dean, University of Kansas School of Nursing, for believing in me and urging me to finish so that I might join the community of scholars engaged in the important work of ethical formation in future health care professionals. And finally, thank you to my research participants, a group of dedicated nursing educators. Their passion and love for their students was evident as they generously and enthusiastically gave of their time.

DEDICATION

I dedicate this work to many. To my mother and my parents in-law, who wanted to see me graduate, but who stand healed and whole in heaven today. To my father who set high standards and is proud of his "number one son." To my six children, ages 10-26, who grew up at the University and understood that late nights of reading, analyzing, and writing is just what Moms do, and to my husband David who provided loving logistical support throughout this process. Special thanks to my personal graphic artists, my son Ian and my brother-in-law Mark who worked with me to develop the graphics that make this theory clear to the reader. Although they may not know it, working with these gifted men was as important as writing in helping me understand what I wanted to say. This paper and the others that led up to it would not be what they are today without the research skills and editing craft of my dear friend, the world's greatest reference librarian Helen Hough. Though they are infrequently acknowledged, I am sure this is not the first dissertation that owes its completion to dozens of baristas and a few very special coffee shop managers who provided clean tables, electricity, Wi-Fi, food and lovingly crafted caffeinated beverages. The family members, colleagues, friends at church and in my community who encouraged me, and the teens who brought joy and adventure into my life are too many to name.

The journey to become a scholar is another kind of formation, and it wouldn't have occurred without the investment of a doctoral faculty team. I dedicate this dissertation to Dr. Jennifer Gray, who believed in the significance of this research, and whose admonishment to "stop reading and start writing" echoed in my mind as I worked toward completion. To Dr. Barbara Raudonis, whose reminder that "getting your PhD is a very special time in your life" brought perspective and energy when fatigue loomed. To Dr. Donnelle Barnes who brought

clarity and organization to my writing, and who could turn despair to doable by saying, “and now you can write these three paragraphs.” To Dr. Lauri John who invited me into the world of her research passion for my practicum course, and who always accompanied a ready smile with the words of encouragement, “You’re gonna make it kiddo.” Dr. Patricia Newcomb sharpened our thinking about the philosophical underpinnings and the finer details of our research questions, Dr. Daisha Cipher made complex statistical concepts accessible to a group of clinicians, and Dr. Joy Don Baker brought the practiced eye of a journal editor to our writing. None of them could do their jobs, and none of us would have started or finished the PhD program without the institutional knowledge and skilled system massaging of Vivian Lail-Davis, Administrative Services Officer of the College of Nursing Graduate Programs. To my classmates, collaborating with you, sculpting each other’s ideas, and cheering each other on was one of the great joys of earning a PhD. As a full-time faculty member throughout my PhD program, I am deeply grateful to my leadership team and teaching colleagues at the University of Texas at Arlington College of Nursing and Health Innovation for lightening my workload. And last but certainly not least, I dedicate this dissertation to the thousands of students who have taught me most of what I know, and who will keep me learning as long as I can stand in a classroom.

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LIST OF ABBREVIATIONS

ADN	Associate Degree Nursing
APRN	Advanced Practice Registered Nurse
BON	Board of Nursing
BSN	Baccalaureate of Science in Nursing
CBL	Problem/Context Based Learning
CNE	Certified Nurse Educator
CONHI	College of Nursing and Health Innovation
FAFEC	Framework for Apprenticeship in Formation and Ethical Comportment
FSMB	Federation of State Medical Boards
GT	Grounded Theory
IRB	Institutional Review Board
LPN/LVN	Licensed Practical Nurse/ Licensed Vocational Nurse
MSN	Masters Degree in Nursing
NCLEX	National Council Licensure Examination
NCSBN	National Council of State Boards of Nursing
PBL	Problem-Based Learning
RN	Registered Nurse
TERCAP	Taxonomy for Error Reporting: Root Cause Analysis and Analysis of Practice Responsibility
UCSF	University of California at San Francisco
UTA	University of Texas at Arlington

ABSTRACT

FORMATION OF PROFESSIONAL IDENTITY AND EVERYDAY ETHICAL COMPORTMENT IN PRE-LICENSURE BACCALAUREATE NURSING STUDENTS: A GROUNDED THEORY APPROACH

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Formation of professional identity in nursing students is a necessary prerequisite to skilled, ethical, expert nursing practice. Nurses who have not formed an ethical professional identity have a negative impact on the workplace environment and the quality of patient care. These consequences have led educators in medicine and nursing to reconsider the importance of teaching for formation of professional identity and of helping students learn the skills of everyday ethical comportment. Nursing educators lay the foundation for professional nursing identity formation that continues when new graduate nurses enter practice. However, contemporary nursing curricula lack deliberate attention to the formation of profession identity and ethical comportment in nursing students, and there is no theoretical framework that addresses both the process of formation of professional identity and the role of educators in bringing about formation.

In this grounded theory study 12 experienced nursing faculty members from four diverse universities in the southern United States were interviewed about how students change over the course of their nursing education and what education practices support these changes. The

resulting grounded theory provides a beginning framework to help nursing faculty members understand their role in educating for formation of professional nursing identity and everyday ethical comportment. Students enter nursing school with individual characteristics that impact their identity formation tasks, and then progress through stages of development in learning to think, feel, and act like nurses. Nursing educators influence the process of forming a professional nursing identity by understanding the student, creating a safe learning environment, providing developmentally appropriate support, and skillfully using appropriate pedagogies. Ongoing development of this grounded theory will continue with additional studies that include the voices of the students and new graduate nurses engaged in the development of identity as professional nurses.

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CHAPTER 1

Introduction

In 2008 the Joint Commission issued a new sentinel event alert to address disruptive behavior in healthcare agencies (The Joint Commission, 2008). In 2009, a state board of nursing (BON) in the U.S. cited a nursing program for severe incivility within the ranks of faculty and students. The BON threatened to close the nursing program if significant improvements were not demonstrated within a six-month period (Clark, 2013). In a study that included health care as well as business and public service organizations, Porath and Pearson (2010) found that incivility in the work environment leads to greater employee attrition, decreased concentration, creativity, respect, motivation, and decreased individual and team productivity. In the health care setting this translates to unsafe patient care environments resulting in deteriorating patient conditions and even patient death (Rosenstein & O'Daniel, 2005).

The severe consequences of incivility and disruptive behavior in health care professionals have led educators in medicine and nursing to reconsider the importance of teaching for formation of professional identity and of helping students learn the skills of everyday ethical comportment (Bebeau, 2006; Benner et al., 2010; Luparell, 2011; Pellegrino, 2006). However, contemporary nursing curricula lack deliberate attention to the formation of profession identity and ethical comportment in nursing students, and there are few studies on effective pedagogies for this purpose. There is no theoretical framework that addresses both the process of formation of professional identity and the role of educators in bringing about formation. In this grounded theory study I aim to begin development of such a framework from the perspective of nursing educators in pre-licensure baccalaureate nursing programs. In this chapter, I will present the

background and significance of the problem and propose a framework derived from existing literature. I will present the study purpose, study questions, and essential assumptions.

Background and Significance

Monetary costs for incivility can take the form of lawsuits and loss of customers, employees, and administrative time. These costs are estimated in the millions of dollars per annum in individual businesses and hospitals (Porath & Pearson, 2010; Rawson, Thompson, Sostre, & Deitte, 2013). The increasing prevalence of uncivil and disruptive behavior highlights the need to prepare nursing students with attention to their formation as professionals who engage in civil behavior, and who address incivility and disruptive behavior with the courage to change practice culture. The consequences of ignoring such formation in nursing education are dire.

Nurses and nursing students often fail to recognize a moral component in challenging clinical situations (Hunink, van Leeuwen, Jansen, & Jochemsen, 2009; Rushton & Kurtz, 2015). When conflicts do arise between internalized nursing values and the realities of clinical practice, nurses and students suffer moral distress, but are unlikely to take on the risks necessary to address the conflict (Kelly, 1993; Rushton & Kurtz; Woods, 2005). Further, nursing students often don't recognize cheating as dishonest. Instead, they view it as creating an unfair advantage for the cheater (Duquette, 2004). Students' unwillingness to report cheating, and nurses' unwillingness to address ethically incongruent care may also indicate that nurses are not prepared with the courage necessary to self-regulate practice (Duquette, 2004; Rushton & Kurtz; Thorpe & Loo, 2003).

Benner and colleagues (2010) in their landmark study of U.S. nursing education, recommend four essential shifts in the way nursing education is delivered. One key

recommendation is for a “shift from an emphasis on socialization and role taking to an emphasis on formation” (p. 86). Formation of professional nursing identity involves internalizing the virtues, values, and notions of the good that characterize nursing as a discipline (Benner et al., 2010; Crigger & Godfrey, 2011b, 2014) and “thinking, acting, and feeling like a nurse." (Godfrey & Crigger, 2017, p. 379). Everyday ethical comportment refers to behaviors that have a moral component and that express the internalized values and virtues of the professional. Benner and colleagues argue that such formation is achieved through three high level professional apprenticeships in knowledge, skilled know-how, and everyday ethical comportment. Apprenticeship means that learning is situated in experiences, within a community of practice, under the supervision of a master (Benner, et al., 2010; Mann, 2006). Additional recommendations for shifts in nursing education relate to integrating the classroom, lab, and clinical experiences so that students practice thinking about nursing practice in each setting. Nursing educators need to implement pedagogies for formation and for situating thinking in the clinical realm.

There are few studies on the effectiveness of teaching methods for formation of professional identity and ethical comportment (Benner, Sutphen, Leonard, & Day, 2010; Crigger & Godfrey, 2011; Woods, 2005). Benner and colleagues (2010) found that exemplar U.S. nursing programs use pedagogies such as situated coaching, modeling, and experiential learning effectively in clinical settings, but not in the classroom. Teaching formal ethics codes in the classroom does little to fundamentally change student values or identity (Benner, et al., Coulehan, 2005; Duquette, 2004; Enns, 2014). Formation is effected by the use of narrative (Benner, et al.; Oosterbroek, 2009), role modeling (Epstein, 2006; Kelly, 1992; Kenny, Mann, & MacLeod, 2003; Pellegrino, 2006), and modeling caring in the classroom through caring

behaviors toward students (Duquette, 2004; Labrague, et al., 2015; Mann, 2006; Oosterbroek, 2009). Several authors agree that reflection during and after experiences is a critical component of formation (Bebeau, 2006; Coulehan, 2005; Epstein, 2006; Mann, 2006). Finally, problem-based learning was found to support formation of essential values and inter- and intrapersonal skills in nursing students (Oosterbroek, 2009; Williams, et al., 2012).

Theoretical Perspective

In grounded theory studies, theory is grounded in the reality described by the research participants rather than being derived from assumptions that are not grounded in data (Glaser & Strauss, 1967). Human participants interact and construct shared social meanings; researchers inquire into these shared social meanings and use an inductive process to construct a theory based on the data (Corbin & Strauss, 2008; Milliken & Schreiber, 2012; Strauss, 1991; Wuest, 2012).

Grounded theory research does not start with *a priori* assumptions about theoretical concepts and their relationships to one another. What the grounded theory researcher does need is *theoretical sensitivity*, meaning enough knowledge of the phenomenon being studied to recognize concepts and their relationships as they emerge from the data (Glaser & Strauss, 1967). Using Walker and Avant's (2011) theory synthesis process, I drew on the theoretical and research literature, personal experiences from my early years as a nurse, and experiences as a nurse educator to develop a *Framework for Apprenticeship in Formation and Ethical Comportment* (FAFEC; Figure 1). It is what Glaser and Strauss (1967) would describe as a logico-deductive theory, derived by reviewing the literature and using a deductive process to describe the relationships between concepts. In this grounded theory study, the FAFEC serves

the purpose of assisting with theoretical sensitivity. I will use results of this study to guide further development of the FAFEC.

The FAFEC depicts how students form professional identity over time within the ethos of nursing, and the pedagogies nursing educators use to bring about this formation. There are several models of identity formation in the literature, but these models focus solely on the individual undergoing formation. The model here assumes that formation is a social process that occurs between the student, educators, and others in the learning environment. The model therefore integrates the role of nursing faculty in creating the educational environment and selecting effective pedagogies for formation of professional nursing identity. The goal of the model is to identify points where faculty can intervene to facilitate formation of professional identity and learning ethical comportment.

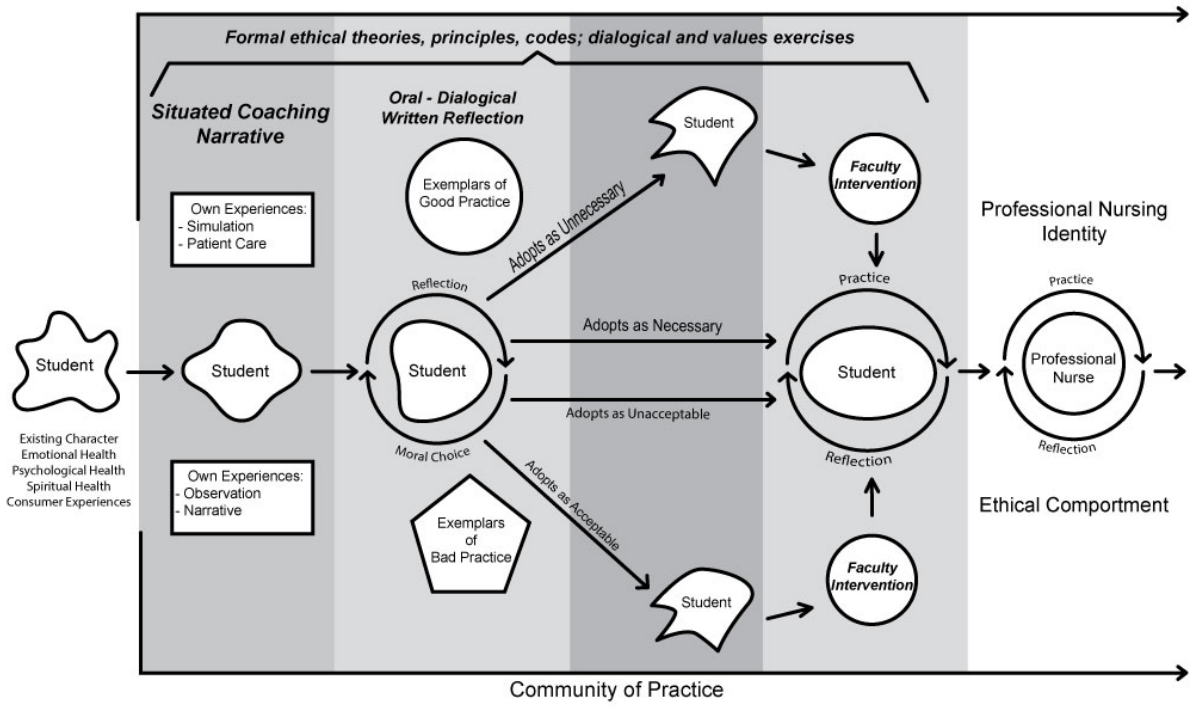

Figure .1 Framework for Apprenticeship in Formation and Ethical Comportment ©

A generally chronological movement through the Dreyfus five-stage model of skill acquisition is assumed, with students entering as novices and graduating and entering practice as advanced beginners (Benner, Tanner, & Chesla, 2009; Dreyfus & Dreyfus, 2009). Students enter the community of practice and begin formal and experiential learning in ethical comportment. Formation begins with experience and reflection. The model is open-ended to indicate that formation of professional identity is an ongoing process.

The model identifies two pathways. The center path is toward formation of identity as a professional nurse who engages in behaviors that are consistent with the ethos of nursing. The student is depicted as an unformed shape that progressively takes the form of a defined circle as the student develops a professional nursing identity. Students may also make ethical choices that put them on a trajectory toward formation outside the ethos of nursing, depicted by an undefined shape with round and sharp edges.

The model includes the *student*, an active moral agent who enters the community of nursing practice with an existing and unique set of experiences, values, and knowledge. Each student comes with a formed personal character, but an unformed professional nursing identity. Each student has a level of emotional, psychological, and spiritual health that will impact his or her ability to engage with, interpret, and integrate clinical experiences into a definition of self as a professional.

A second concept is *experiential learning.* Understanding of everyday ethical comportment is knowledge that is embedded in nursing practice and is, therefore, formed through experiential learning (Benner, et al., 2009; Benner, et al., 2010). Experiences include direct patient care, simulation, observation, and narrative. The experiences may be the student's own, or the experiences of others through observation and narrative. The faculty role includes

creating opportunities for experiential learning, providing narratives, and engaging in the practice of guiding students during their experiences, called *situated coaching,* (Benner, et al., 2010). In these experiences, students will be exposed to exemplars of both good and bad practice.

Circular arrows surrounding the forming professional nurse depict the cycle of practice and reflection. *Reflection* is the act of thinking through an experience, making value judgments about elements of the experience, and choosing whether or not to integrate behaviors and attitudes into one's comportment. Reflection can be internal and informal, formalized through journaling, or dialogical, carried out in discussion with others. It is through reflection that the student makes crucial ethical choices that affect formation of identity (Lewin, 1999). The student judges exemplars of good practice and adopts these behaviors as *necessary* or rejects them as *unnecessary* for future practice. Likewise, the student judges exemplars of bad practice and adopts them as *acceptable* or rejects them as *unacceptable* for future nursing practice. Practice is continued experiential learning in which the student applies the behaviors and attitudes resulting from reflection.

Formation continues through a cycle of practice, reflection, and adoption. Novice nurses need to spend a greater proportion of their time on reflection than experienced nurses do. Over time, everyday ethical comportment requires less and less reflection. It is behavior that flows out of a nurse's forming professional identity. The expert nurse engages fully in practice and uses focused reflection and deliberation only in unusual cases (Dreyfus & Dreyfus, 2004; Dreyfus & Dreyfus, 2009; Benner et al., 2009).

Faculty intervention is necessary when students demonstrate attitudes and behaviors that put them on a trajectory of formation outside the ethos of nursing. Interventions may include

coaching, counseling, or guiding the student in further reflection. Interventions may also include disciplinary or corrective actions taken when students engage in scholastic dishonesty or unethical practices in the clinical setting.

This framework represents a synthesis of the literature on formation of professional identity and ethical comportment in nursing education. It is grounded in the theoretical and research literature rather than in data generated directly from the experiences of nursing students and nursing educators. The framework will not be used directly to generate research questions. Instead it will be used to assist in theoretical sensitivity to concepts and their relationships present in interview data.

Purpose

The purpose of this study is to begin development of a theory of formation of professional identity and ethical comportment that is grounded in the experiences of contemporary nursing students and educators. Such a theory will help guide the practice of nursing educators. A fully developed theory will include data from students, practicing nurses, and educators. This initial study focuses on the experiences and beliefs of nursing educators teaching in pre-licensure baccalaureate nursing programs. A related purpose is to identify specific pedagogies used by educators to support formation of professional identity.

Study Questions

The intent of this study is to answer two broad questions about formation of professional nurses. Additional questions to stimulate further thought and discussion are listed in Chapter 3. The two broad questions are:

1. From the perspective of nurse educators, what is the process that nursing students go through as they develop new identities as professional nurses? And

2. What can nursing educators do to stimulate and support this process?

Essential Assumptions

Based on review of the literature, the following are essential assumptions in this study:

1. Becoming a professional nurse requires a fundamental change in one's identity, including changes in beliefs, values, and actions.
2. Identity formation is a social process that occurs over time as the subject interacts with people in his or her environment.
3. Formation of professional nursing identity within the ethos of nursing is a necessary prerequisite to developing expertise in nursing practice and providing excellent nursing care.
4. Professional nursing identity formation occurs through experiences within the community of nursing practice.
5. Nursing educators are significant influencers within the community of nursing practice.
6. The practices of nursing educators influence the formation of professional nursing identity in students.

Summary

It is critically important that nursing students form an identity as professional nurses and learn the behaviors that express this identity. Lack of formation of a professional identity and unethical comportment in the form of incivility and disruptive behavior results in unsafe environments for patients and unhealthy work environments for nurses. Nurses who lack a fully formed professional identity and the corollary ethical comportment do not continue in their development towards becoming expert nurses. Identity is formed through experiential learning within a community of practice. Nursing educators are the first nurses students encounter when

they enter the community of nursing practice, and nursing educators remain significant influences throughout the students' undergraduate education. However, theories on identity formation do not address the role of the nursing educators.

The purpose of this grounded theory study is to describe the process of formation of professional nursing identity from the perspective of nursing educators in baccalaureate nursing programs. An additional purpose is to identify the pedagogies nursing educators can use to effect formation of professional identity in pre-licensure baccalaureate nursing students.

CHAPTER 2

Review of the Literature

This chapter begins with a discussion of the significance of formation of professional identity and ethical comportment in nursing students. Literature from nursing and medical education describing philosophical and theoretical foundations of professional identity formation and everyday ethical comportment is reviewed. The review continues with pertinent concepts and pedagogies that are used to bring about formation of professional identity and ethical comportment. Particular attention will be paid to classroom pedagogies, as opposed to pedagogies used in the clinical setting. The student population of interest is those seeking their first nursing degree at the baccalaureate level (BSN).

Significance

The term ethical comportment first appeared in the nursing literature in the 1980s to describe the way nurses expressed caring in their everyday behavior (Benner, 1991). However, studies on the effects of nurses' ethical comportment on patient outcomes are lacking. There is evidence in the medical education literature that more fully developed moral judgment and ethical comportment results in greater sensitivity to the needs of patients' families, and even to decreased risk of malpractice suits (Bebeau, 2006). What has been investigated in nursing are the effects of behaviors that are contrary to ethical comportment, described as *incivility* (Luparell, 2011) and *disruptive behavior* (Rosenstein & O'Daniel, 2005).

Clark (2013) describes civility in terms of mutual respect and willingness to find shared values and solutions even in the face of diverse experiences and perspectives. Conversely, incivility involves lack of value and respect for others. Incivility is expressed in rude verbal and social behavior and creates a stressful working environment (Clark). The operational definition

of disruptive behavior used in the study by Rosenstein and O'Daniel (2005) includes "any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment" (p. 19).

Workplace incivility has adverse effects on the well-being of new nurses (Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013), on empowerment and retention of new graduate nurses (Smith, Andrusyszyn, & Laschinger, 2010) and experienced nurses (Oyeleye, Hanson, O'Connor, & Dunn, 2013), and is a significant factor in burnout among Certified Registered Nurse Anesthetists (Elmblad, Kodjebacheva, & Lebeck, 2014). Incivility and disruptive behavior obstruct communication between health care providers, leading to adverse patient outcomes. Rosenstein and O'Daniel (2005) surveyed 1,509 nurses, physicians, and administrators in 50 hospitals to evaluate perceptions of the impact of disruptive behavior on nurse-physician relationships and on patient outcomes. Their findings raise concerns about patient safety in the absence of ethical comportment. The majority of respondents reported witnessing disruptive behavior from both physicians and nurses. Examples of disruptive behavior included yelling, intimidation, verbal abuse, disrespect for a nurse's or physician's judgment, and refusal to respond to calls or pages. The majority of respondents (60%, n = 892) reported observing disruptive behavior that could have led to adverse patient outcomes, and 17% (n = 245) reported being aware of specific adverse events resulting from disruptive behavior (Rosenstein & O'Daniel). Examples included delays in treatment, unnecessary complications and escalations in patient acuity, and patient death. The Joint Commission (2008) has recognized these behaviors in a sentinel event alert and now requires hospitals to provide a code of conduct and a process for managing disruptive behaviors.

Incivility in the academic setting is also a growing concern. Clark and Springer (2007) found that a majority of nursing students and faculty considered incivility a moderate problem in nursing programs. Examples of student incivility included cheating, inattention, side conversations, and using digital devices for non-class related purposes. Examples of faculty incivility included belittling students, being cold or inflexible toward students, constantly criticizing, showing favoritism, and expecting perfection (Clark & Springer; DelPrato 2013). Luparell (2011) argued that addressing incivility once nurses enter practice is inadequate. Educators should adopt a proactive stance that attends to the formation of ethical comportment in all nursing relationships, beginning in the classroom. Such a stance requires understanding the process of formation and knowledge of effective pedagogies.

Professional Identity Formation and Everyday Ethical Comportment

Before exploring effective pedagogies, it is necessary to identify the philosophical and theoretical foundations for ethics in nursing and describe the meanings of *professional identity formation* and *ethical comportment*.

Formation of professional identity has received greater attention in recent years in the professional education literature. Lee Shulman, who directed Carnegie Foundation for the Advancement of Teaching, oversaw a series of studies on preparing professional clergy, lawyers, physicians, engineers, and nurses. He noted that formation of professional identity was critically important but frequently neglected in professional education (Hamilton, 2011). Crigger and Godfrey (2014) developed a definition of professional identity that focuses on relationship to self and others: "an individual's perception of himself or herself, who, as a member of a profession, has responsibilities to society, recipients of care, other professionals, and to himself or herself"

(p. 2). Formation of identity requires gradually and purposefully becoming so invested in the values of the professional that they become “habits of mind and heart” (Wald, 2015, p. 701).

Formation of professional identity is distinguished from role socialization in that socialization involves learning expected behaviors and acting like a nurse, but may not require internalizing the values of a professional nurse (Benner, et al., 2010). Socialization refers to a learned set of external behaviors expected in a societal role (Crigger & Godfrey, 2011b). If the focus of education is on *doing* with no attention to *being*, the nurse becomes, in the words of Crigger and Godfrey, an “empty uniform with nobody inside, a doer of work who fulfilled a social role rather than a person of moral agency, integrity, and excellence” (p. 4). However, repeatedly playing the role of nurse helps internalize the role until it becomes part of identity, moving the individual from “doing” to “being” (Cruess, et al., 2014). In contrast to role socialization, which focuses on consideration of appropriate actions, identify formation also requires reflective practices of “thinking about thinking” and “feeling about feelings” (Wald, 2015, p. 702). Based on recent work in the medical education literature, Godfrey and Crigger (2017) have developed a clear and concise definition: "...professional identity in nursing is defined as a sense of oneself that is influenced by characteristics, norms, and values of the nursing discipline, resulting in an individual thinking, acting, and feeling like a nurse" (p. 379). This identity is embodied in the nurse’s *everyday ethical comportment*.

Comportment, simply defined, is behavior, but the connotation of the word goes deeper than external actions. The Latin and French roots of the word suggest that the behavior is an expression of what individuals carry with them internally (Simpson & Weiner, 1989). As mentioned above, role socialization may result in putting on behaviors from the outside, but formation of identity results in behaviors that express an internalized set of values, ethical

comportment (Cruess et al., 2015). For example, for the professional nurse, caring is not a series of acts but a way of being that is embodied in action (Oosterbroek, 2009). Clickner and Shirey (2013) conducted a concept analysis of a closely-related concept, *professional comportment*. Their definition focuses on collaboration and teamwork among health care colleagues. They propose a theoretical definition of professional comportment: "a nurse's professional behavior that integrates value, virtues, and mores through words, actions, presence, and deeds" (p. 108). The use of the phrase ethical comportment in the nursing literature originated with Benner. She offers a description that clearly encompasses thinking, acting, and feeling like a nurse:

> The term *ethical comportment* is used to refer to the embodied, skilled know-how of relating to others in ways that are respectful, responsive, and supportive of their concerns. *Comportment* refers to more than just words, intents, beliefs, or values; it encompasses stance, touch, orientation—thoughts and feelings fused with physical presence and action (Benner, Tanner, & Chesla, 2009, p. 280).

Everyday ethical comportment is sometimes referred to as *microethics* because refers to the series of small, context-based ethical choices that nurses make each day rather than the larger dilemmas that are often discussed in ethical case studies (Krautscheid & Brown, 2014). Ethical comportment can therefore be defined as behavior that aims to achieve good nursing practice and is rooted in a professional identity that includes the values of nursing. This behavior is exhibited in relationships with others in the clinical setting. Nurses make choices about the specific features of this behavior with sensitivity to variations in the context of patient care and collegial relationships.

Ethical Theories, Virtues, and Values

Nursing practice is complex, and incorporates multiple ethical theories (Crigger & Godfrey, 2011b, Johnstone, 2004). Deontology, or duty-based ethics involves rules and formal ethics codes. For example, a nurse has the duty to tell a patient the truth about his or her condition, even if the truth is distressing (Johnstone). Utilitarian ethics seeks to provide the most good for the most people, and is therefore concerned with outcomes. Nurses evaluating the cost-effectiveness of treatments are using utilitarian ethics (Johnstone). Biomedical ethics applies ethical principles such as autonomy, beneficence, non-maleficence, and justice to objectively analyze ethical dilemmas. When a patient refuses life-extending treatments, a nurse is faced with a dilemma between the principles of autonomy and beneficence. By objectively analyzing the ethical dilemma, the nurse might determine that the principle of autonomy is more important than beneficence and therefore decide to respect the patient's wishes (Johnstone).

Although each of these approaches informs nursing practice, they are not sufficient to support nurses in the daily moral and ethical choices needed to provide good nursing care (Benner, Sutphen, Leonard-Kahn, & Day, 2008). Ethical practice in nursing also encompasses an ethic of care and virtue ethics. Nurses apply care ethics in their daily practice, attending to variations in context while maintaining trusting and nurturing relationships. A nurse giving a patient difficult information would tell the truth, but would consider the patient's cognitive, emotional, and developmental state and would carefully choose the timing for the conversation, the tone of voice, whether to sit or stand, and whether to speak first to the patient privately, to the patient's family, or to all of them together. In a virtue ethics approach, choices are made based on the character of the decision maker (Crigger & Godfrey, 2011b; Johnstone). A nurse

approaching a patient or family with distressing news must possess character traits such as honesty, courage, and compassion.

There has been a great deal of discussion over the last two decades about moving medical and nursing education from the rationalist, analytic approaches of deontologic, utilitarian, and principle-based biomedical ethics toward a philosophy of virtue ethics (Crigger & Godfrey, 2011b; Gastmans, 2002; MacIntyre, 1984; Pellegrino, 1995; Pellegrino, 2006). The problem with rationalist approaches is that they often focus on rules (deontology) or outcomes (utilitarianism) with little or no attention to context or the character of the decision maker. In contrast, virtue ethics focuses on the character of the moral agent. It is the individual nurse who must navigate the day-to-day complexities of practice, and it is therefore crucial that he or she has internalized the values of nursing, notions of the good in nursing practice, and has developed the requisite virtues (Benner et al., 2010; Crigger & Godfrey, 2011b, 2014).

Whereas virtue ethics focuses on the inner character of the nurse, care ethics focuses on the relationship between nurses and those around them (Benner, 1997). It is important the nursing educators address both virtue ethics and care ethics. Teaching good character alone is necessary but not sufficient for developing ethical practice (Veatch, 2006). Veatch argues that "naked virtue" does not necessarily result in ethical practice because a person expressing an internalized character trait may fail to consider variations in historical and cultural context, resulting in wrong action. Consideration of context and a focus on interpersonal relationships are key features of an ethic of care (Woods, 2011). Woods argues that caring distinguishes the nursing ethic from ethical approaches in other disciplines, and that a full moral commitment to caring is necessary for effective nursing care. Importantly, Lechasseur and colleagues (2016) found in an integrative review that ethical sensitivity is foundational to ethical competence, and

this ethical sensitivity is dependent on functioning within an ethic of care. Banks (2010) suggests that the interpersonal focus of caring ethics with its emphasis on mutually respectful relationships and consideration of changing contexts may provide a way for members of different health care disciplines to negotiate the terrain between varying ethical models.

A shift from rationalist ethical theories to an approach that emphasizes care and virtue ethics requires identifying values and virtues that are important in nursing. Crigger and Godfrey (2010, 2011a, 2011b) list humility, courage, compassion, and integrity as important virtues in nursing. Some values described in the American Nurses Association (2015) *Code of Ethics for Nurses* are respect for human dignity (including moral self-respect), collaboration, life-long learning, protection and advocacy, authority, accountability, responsibility for actions and for the healthcare environment, and integrity. The American Association of Colleges of Nursing (2008) affirms that baccalaureate education should include the values of altruism, autonomy, human dignity, integrity, and social justice.

Formal ethics and values codes have a place in nursing education but the realities of practice require that educators attend to more than teaching what is on these lists. Ethics courses help students develop skills of reflection and of using models to think through ethical situations, but do little to impact actual ethical behavior (Cannaerts, Gastmans, & de Casterle; 2014; Vynckier, et al., 2015). Students need the vocabulary and reflection skills learned in ethics courses, but to learn ethical behavior, they need their faculty members to raise ethical issues in the context during patient care, and to model ethical behavior (Cannaerts, et al.). To complicate matters, nursing educators rarely teach about virtue ethics and care ethics because they themselves have limited knowledge of these ethical theories (Cannaerts, et al.)

Educators in both medicine and nursing have raised concerns about the contrast between the formal ethical curriculum that is taught in classrooms and the hidden curriculum to which students are socialized in practice. Nursing students and practicing nurses experience moral distress and do not know how or lack the moral courage to address instances of poor practice in the clinical setting (Rushton & Kurtz, 2015). Benner and colleagues (2010) described the frustration of students when practicing nurses belittled their attempts to apply theory and the nursing process in practice. Medical educators have observed that medical students learn that disrespect of patients and other professionals is part of medical culture (Stern, 2000), that loyalty to peers and superiors takes priority over self-regulation of practice through reporting unprofessional conduct (Bebeau, 2006), and that cynicism and pessimism are common ways of being among physicians (Coulehan, 2005; Kenny, Mann, & MacLeod, 2003).

In the face of the apparent conflict between tacit socialization into the nursing role and true professionalism, Benner et al. (2010) recommend a shift from role socialization to *formation* in nursing education. Educators work to transform lay persons into professionals who carry the values of the profession within themselves and uses those values to make dozens of decisions each day about behavior and interactions with patients, families, and colleagues (Benner et al., 2010; Crigger & Godfrey, 2014). This process is called formation of professional identity. Rhodes and Smith (2006) point out that the ethics of healthcare is different from the ethics of laypersons. Nurses and doctors do and talk about things that are not acceptable in everyday ethics. If ethical behavior is an expression of character, then a good layperson must undergo identity formation to become a good healthcare professional. Isolated courses in ethics are not sufficient. Formation is a developmental process that takes place over time (Cruess, et al., 2014; Hamilton, 2011). Therefore, attention needs to focus on professional identity over the entire

curriculum, with sensitivity to the developmental stage of the student (Bebeau, 2006; Benner et al., 2010; Rhodes & Smith 2010).

Scholars in nursing and medicine, as well as psychologists and ethical theorists, have described the typical progression of professional identity development. The chief shift is from concern over one's own needs to an altruistic concern for the patient. The formation of professional identity and values in pre-licensure nursing students typically moves from a self-centered to an other-centered focus (Enns, 2014; Hunink et al., 2009; Manninen, Scheja, Henriksson, & Silén, 2013). Other-centeredness initially focuses on the patient but as the student nears graduation and begins practice, focus expands to include the health-care team and other contextual factors (Duquette, 2004; Enns 2014; Hunink et al. 2009).

The movement from self-centeredness to putting the interests of others first is essential in formation of professional identity. However, the extremes of other-centeredness can also result in poor professional conduct. Bebeau (2006) found that among a group of professionals disciplined by their licensing boards, only three could clearly describe their professional role expectations. Those disciplined for Medicare fraud were acting out on the virtue of responsibility to the patient without consideration for the rules of the profession (Veatch, 2006). Altruism that excludes self-care is not realistic. Inadequate self-care results in high stress and low self-awareness, which in turn result in incivility (Clark, 2013; Epstein, 2006). Bebeau (2006) pointed out that students also need help in learning how to balance self-care and altruism.

Students may do the right things, but if they are not good people their right actions may be motivated by self-interest. For example, students may refrain from cheating on tests because they are afraid of getting caught, not because it is morally wrong to cheat. Conversely, as Veatch (2006) argues, virtue ethics is necessary but not sufficient for professional ethics education. In

other words, it's not enough for students to be the right sorts of people. Educators need to teach student how to do or say the right things. They need us to not only teach virtues, but to help them connect those virtues with the day-do-day ethical behavior expected of professionals. It is therefore essential that we deliberately address both development of professional identity and ethical comportment in nursing education. Skillful ethical comportment is learned by experience in a community of practice from other skilled professionals (Benner et al., 2009). The question then is not "How do we teach students *about* nursing values?" but "How do we help students transform their identities from laypeople to professional nurses, weaving the values of nursing into the fabric of who they are?" and "What opportunities can we provide for students to practice relational behaviors that express their emerging identities as professional nurses?"

Gaps in Ethical Formation in Undergraduate and New RNs

A review of the literature revealed gaps in the preparation of new nurses to navigate the daily ethical challenges of contemporary practice. Hunink, van Leeuwen, Jansen, and Jochemsen (2009) evaluated a random sampling of transcripts from third- and fourth-year students' post-conference mentoring sessions in the Netherlands. They found that only a minority of students identified challenging clinical situations as having a moral component, suggesting that students did not consciously apply ethical theories to their practice. In a review of nine studies from the U.S., U.K., Sweden, and New Zealand, Woods (2005) found that new and experienced nurses continued to report conflicts between nursing ethics and real-world practice, such as when nursing or medical staff disregarded patient autonomy, or when substandard care was observed. Nurses often dealt with these conflicts passively and suffered moral distress as a result, or simply worked around the existing systems. Likewise, in an earlier grounded theory study Kelly (1993) found that students expressed a sense of powerlessness,

noting that senior nursing students may have lacked the courage to speak up and act according to their values.

Students' attitudes toward cheating may also indicate a deficit in professional ethical development. Duquette (2004) found that students were frequently aware of cheating by classmates but did not report it. Students interpreted cheating as unethical not because it was dishonest or morally wrong, but because it gave the cheater an unfair academic advantage. Students nearing graduation and new graduates also considered the effects of cheating on competence to provide care. Study participants did not identify cheating as a breach in honesty unless prompted by the researcher. Students who observed cheating did not report it to faculty, raising concerns that these students are not prepared for self-regulation of the profession.

Using a convenience sample of students from their Canadian university, Thorpe and Loo (2003) compared the values of undergraduate nursing students (n=152) to management students (n=111) using the Life Role Inventory Values Scale. Student t-tests revealed significant differences in 8 of the 20 values. Nursing students placed a higher value on altruism and a lower value on advancement, autonomy, authority, creativity, economics, life style, and risk than did management students. Thorpe and Loo suggested that nursing students be trained in values and skills, such as risk-taking and creativity, that are necessary to advocate for patients and implement important changes in practice.

Gaps in formation and ethical comportment are evident when professionals undergo formal discipline by their licensing boards. Over the last decade, both the Federation of State Medical Boards (FSMB) and the National Council of State Boards of Nursing (NCSBN) have cooperated with studies to identify characteristics of licensees sanctioned by state licensing boards. Papadakis and colleagues (2004) compared the student evaluations of 196 controls to 70

graduates of the University of California at San Francisco (UCSF) School of Medicine who were disciplined by the Medical Board of California over a ten-year period. The likelihood of UCSF graduates being disciplined by the California State Medical Board doubled when unprofessional behaviors were noted in medical school evaluations (odds ratio, 2.15; 95% CI [1.15, 4.02]; p=.02).

In a follow-up study, the UCSF research team examined the text of medical student evaluations to identify unprofessional behaviors associated with future discipline by medical boards. Three domains of unprofessional behavior had statistically significant associations with later disciplinary action: (1) poor reliability and responsibility (p=0.00), (2) lack of self-improvement and adaptability (p=0.01), and (3) poor initiative and motivation (p=.04). Interestingly, failure to uphold the medical school honor code was not associated with later disciplinary action (p=0.11; Teherani, et al., 2005). Papadakis et al. (2005) later compared cases of disciplinary action (n=235) to controls (n=469) from public and private medical schools in diverse geographic locations. Findings in this expanded study indicated that physicians who exhibited unprofessional behaviors in medical school were three times as likely to be disciplined as physicians who did not exhibit unprofessional behaviors as students (odds ratio 3.0; 95% CI [1.9, 4.8]; p=<.001). Students whose unprofessional behavior was frequent or severe were more than eight times as likely to be disciplined (odds ratio 8.5; 95% CI [1.8-, 40.1]). Irresponsibility and the inability to improve oneself were independent predictors of disciplinary action.

Such studies evaluating the relationship between nursing student behaviors and future discipline are lacking. However, some demographic characteristics of disciplined nurses have been described. Zhong and Kenward, working with the NCSBN (2009) evaluated a sample of 531 cases of nurses disciplined in 2001 by seven state Boards of Nursing (BONs). Kenward

(2008) also reported findings from a review of data on 52,297 nurses disciplined by 51 state licensing boards from 1996-2006. The percentage of nurses disciplined almost doubled from 0.10% (n=3,193) in 1996 to 0.19% (n=8,131) in 2006 (Kenward). Employment setting and educational background influenced the likelihood of discipline. Less than 18% (n=95; Zhong et al.) of nurses disciplined held a bachelor's degree or higher. Nurses working in long-term care settings were more likely to be disciplined than nurses working in hospitals or other settings (Zhong et al.). Both reports indicate that LPN/LVNs were more likely to be disciplined than RNs or APRNs. The percentage of male nurses disciplined was disproportionate to the percentage of males in the general nursing population, with 16% (n=85; Zhong, Kenward, & NCSBN) to 18% (n=9,413; Kenward) of disciplined nurses being male, compared to 6% of all nurses being male.

Supported by the NCSBN, Benner et al. (2002) embarked on an effort to develop an audit tool to systematically evaluate nursing errors. The Taxonomy for Error Reporting: Root Cause Analysis and Analysis of Practice Responsibility (TERCAP) is an audit tool for identifying both individual and system causes of nursing errors (Benner et al., 2002; Benner et al., 2006.) The investigators derived eight categories of nursing errors from a purposive sample of 21 discipline cases. It can be argued that each category has a connection to professionalism and ethical comportment, but one category is explicitly written in the language of ethics: "lack of agency/fiduciary concern" (Benner et al., 2002, p. 512). The investigators refer to the trust that is presumed between nurses and vulnerable patients and families. To prevent errors and reduce the risk of licensing board discipline, nurses must act as active and effective moral agents on behalf of the patient. The final TERCAP uses the category *Professional responsibility/patient advocacy* and specifies that nurses "have an ethical and fiduciary responsibility to advocate for their patients' best interests and well-being" (Benner, et al., p. 61). Subsequently, the Texas

Board of Nursing (BON) conducted a pilot project using the TERCAP to classify 260 minor practice breakdown incidents reported to selected hospital-based nursing peer-review committees. Almost 25% of the practice breakdown incidents in the sample involved professional responsibility/patient advocacy, second only to clinical reasoning in frequency. Likewise, failures in professional responsibility/patient advocacy were the second most likely to result in patient harm after clinical reasoning (Texas Board of Nursing, 2016). The Texas BON was among 25 US State BONs that submitted data to NCSBN for its 2014 report on use of the TERCAP. Among 3,075 practice breakdown incidents submitted, 73% involved professional responsibility/patient advocacy, making this the most frequent category related to practice breakdowns (Missouri State Board of Nursing, 2015).

Pedagogies for Formation of Ethical Comportment in the Clinical Setting

Few studies have been conducted on pedagogies that influence formation and ethical comportment in nursing students. In this section, pertinent studies from the nursing literature and selected literature from medical education are reviewed.

Enns (2014) conducted a grounded theory study to identify the process of professional identity development in undergraduate nursing students at a Canadian university. Difficulty in recruitment resulted in a convenience sample of only nine new graduate nurses. Enns also expressed concern that self-selection of participants and her role as their former instructor might influence results. She found that these students needed to deliberately practice other-orientation, such as overcoming shyness to take care of a patient. Manninen et al. (2013) described a similar barrier to other-centeredness. They conducted group and individual interviews with 18 final year students in a Swedish clinical education ward. Data were analyzed by three researchers and discussed until consensus was reached. The authors acknowledge the limitations of using

participants from a single clinical ward, but made efforts to enhance transferability by relating their results to theories of transformative learning. Students experienced ambivalence and a self-centered focus in their learning needs until they overcame a *threshold of uncertainty*. Students overcame this threshold when they spent extended time with patients and developed mutual relationships with patients (Manninen et al.).

Benner et al. (2010) conducted a mixed methods study, using the methodology of previous studies in the Carnegie Preparation for the Professions series. The first phase of data collection included classroom and clinical observations and focus group interviews of 586 students, faculty, and administrators at 9 schools of nursing known to exemplify excellence in teaching. Subsequently, the researchers developed on-line surveys to confirm the findings of their qualitative analysis. Surveys were completed by members of the American Association of Colleges of Nursing (n=123), the National League for Nursing (n=8,468) and National Student Nurses Association (n=1,648). The researchers found that formation of professional identity and ethical comportment are strengths of U.S. nursing programs, using pedagogies such as situated coaching, modeling, and experiential learning in the clinical arena. They concluded that, although effective in clinical settings, nursing programs in general do not effectively teach professional identity and ethical comportment in the classroom, and recommended that educators work to integrate students' classroom and clinical learning.

Pedagogies for Formation of Ethical Comportment in the Classroom

Benner et al. (2010) raised concerns over the practice of teaching abstract information in the classroom, such as categories of diagnoses or drugs, and assuming that students will be able to apply these abstractions when they reach the clinical setting. They found that teaching ethics in the classroom is typically approached the same way. Classroom instruction is limited to

ethical theories and ethics codes, with little opportunity for students to apply this knowledge.

Formal Ethics and Values Codes

There is little evidence that students change their values over the course of their nursing education (Duquette, 2004; Enns, 2014). Students tend to choose nursing because they already possess the values of professional nursing. In Enns grounded theory study on the formation of professional nursing identity, the initial *choosing nursing* phase involved students aligning their personal values, preferences, and attributes with an emerging understanding of the realities of nursing. Personal values that influence choosing the nursing major were frequently "caring" and the ability to "make a difference" (Enns, p. 50) and students described formal ethics codes as "essentially common sense" values that they already possessed (p. 54). Learning about these codes helped students align their existing values with the nursing profession and gave them a tool for reflection, but did not fundamentally change their values. Krautscheid and Brown (2014) exposed seven senior BSN students to a microethical dilemma in the simulation laboratory in which medication administration was interrupted and the students had to decide whether or not to leave the medication at the patient's bedside. Observation of the students and analysis of post-simulation interview transcripts indicated that students did not apply principals taught in formal ethics courses, and that didactic instruction was less influential than the personal background and experiences of the student.

Students learned a great deal from modeling, and used their existing values to judge good nurses and bad nurses. Advocacy was a new value to nursing students, as was the understanding of the complexity of knowledge and the high level of responsibility nurses hold (Duquette 2004; Enns, 2014).

Narrative

Narrative, the telling of one's stories, is a pedagogy that supports formation. Benner et al. (2010) noted that narrative pedagogies were among the most effective observed in their study, and recommended that faculty develop pedagogies that involve stories from nurses and patients, and provide opportunities for students to journal or tell their own stories. Engward (2010) collected narratives of ethical dilemmas from nursing students in the United Kingdom and engaged students in discussion groups around these stories. Engward analyzed transcripts from these discussions and found that discussion of these personal narratives allowed students to explore the tension between acting on an ethic of care and barriers present in the clinical setting. Such barriers include the lack of autonomy experienced by students and unit cultures that did not support acting on an ethic of care. These narratives also afforded students an opportunity to discuss exemplars of good and bad nursing practice. Oosterbroek (2009) noted that students experienced caring when nursing educators shared personal stories.

In the absence of experiential learning, students tend to experience classroom lectures on ethics (and every other topic) as abstractions (Benner et al., 2010; Coulehan, 2005). The use of narrative in the classroom helps bring these abstractions to life by engaging clinical imagination. Some nursing educators introduce narratives in the form of films. McAllister and colleagues (2015) described the use of three movies in an Australian nursing program. Although this was not a formal research study, they reported anecdotally that through viewing and reflecting on these films, students learned to value and respect others, to empathize with the patient, to believe that positive change is possible, to value spirituality, and to consider the ethical implications in complex patient situations. Oh, Kang, and De Gagne (2012) conducted an integrated review of articles on using films in nursing education, a practice they called *cinenurdication.* They

concluded that the use of films helps students improve critical thinking skills and develop ethical attitudes in a safe environment.

Benner et al. (2009) described the importance of narratives in developing ethical expertise and sharing that expertise among different nursing communities. The inability of medical (Bebeau, 2006) and nursing students to identify a moral component in daily ethical problems has been identified in at least two studies (Duquette, 2004; Woods, 2005). Stories provide students with the needed opportunity to practice moral imagination. In other words, students can learn a great deal about ethical comportment by hearing the stories of expert nurses.

Role Models

Role models are major influencing factors on formation in nursing students, with nursing educators being the strongest role models, followed by clinical preceptors and family or friends (Kelly, 1992). Observing the behavior of practicing nurses is an important part of formation for ethical comportment. Modeling helps students learn to navigate the context-dependent nature of clinical practice (Kenny, Mann, & MacLeod, 2003) Effective models inspire students by valuing the nursing profession, lifelong learning, and by valuing the student (Baldwin, Mills, Birks, & Budden, 2014). Clinical educators, whether good or bad, have a powerful impact on formation of professional identity (Pellegrino, 2006). Students use models in the academic and clinical settings to decide what kind of nurse they do and do not want to be (Baldwin, et al.) The most effective models are intentional about what they are modeling, explaining to students why they are doing what they are doing. In this way, they are also modeling reflective practice (Epstein, 2006; Kenny, Mann, & MacLeod, 2003).

Students learn about professional comportment from bad examples as well as from good examples of behavior (Arreciado Marañón & Isla Pera, 2015; Baldwin, Mills, Birks, & Budden,

2014; Benner et al., 2010). Models can teach the opposite of the virtues we are trying to instill. For example, language and behaviors that express disrespect for patients or other members of the health care team are often modeled in the classroom or clinical setting (Engward, 2010; Epstein, 2006). Educators carefully choose good role models when possible, and should help students learn from both good and bad examples (Bebeau, 2006; Coulehan, 2005). Nursing educators can be either good or bad examples. Students describe faculty members as either supportive and encouraging, or unwilling to empathize with student (Enns, 2014). Students note that when they make patient care errors they need faculty members to be supportive rather than punitive (Enns).

Pedagogical Caring

Pedagogical caring is an extension of modeling. Nursing educators model nursing behavior both in the clinical setting and in the classroom. Educators influence the formation of caring professionals by creating safe, caring educational environments (Mann, 2006). Embodied caring in the classroom is critical in the formation of caring attitudes and caring comportment in students (Duquette, 2004; Oosterbroek, 2009).

Shaha et al. (2013) used a community-based participatory research design to ascertain student perceptions of teaching excellence from a convenience sample of 41 baccalaureate, master's, and doctoral nursing students at one leading private nursing school in the U.S. Analysis of focus-group transcripts revealed that students want teachers who are well-prepared as educators, demonstrate creativity and courage, foster a collaborative environment in the classroom, treat students with respect, adapt to student needs, and recognize that nursing is a new language for undergraduate students. Enns (2014) concluded that nursing educators conveyed caring through showing interest in students, creating a safe learning environment of trust and respect, taking time to explore and meet student needs, sharing their own experiences, and

flexibility. Faculty model caring comportment by attending to these student needs. Students also described non-caring behaviors they observed in nursing educators and peers. Non-caring behaviors in the classroom included tone of voice, talking over others or having side conversations, lack of preparation for class, and faculty inflexibility. Importantly, Labrague and colleagues (2015) found in a multinational study that nursing educators' caring behaviors had a direct and positive effect on students' own ability to care in the clinical environment.

Reflection

Most authors in professional education describe the critical importance of reflection in the formation of professional identity, and the adverse effects of unreflective practice. In the words of Mann (2006), "Reflection is the engine that drives and the vehicle for turning experience into learning" (p.177). Epstein (2006) suggested that failures in professionalism are often unintentional and occur due to a lack of reflective practice. Reflection can be internal or it can be external in discourse with peers and faculty members or in formal writing assignments. Students perceive that their ethical learning happens in group discussions (Cannaerts, Gastmans, & Casterle', 2014). Bebeau (2006) points out that most students do make moral judgments, but do so in an unreflective manner. That is, moral thinking is there, but students need to be guided to reflect on what their judgments are and the criteria they use to make those judgments. Evidence suggests that structured reflection exercises facilitated by experienced educators enhance moral sensitivity. Reflective essays with faculty feedback enhanced students' ethical reasoning and judgment and support the formation of identity and of respect for persons (Bebeau).

Skills for reflection and self-assessment must be taught. Epstein (2006) offers suggestions for questions to use in written, verbal, or internal reflection, such as "How might my

prior experiences affect my actions with this patient?" or "How could I be more present and available to this patient?" (p. 138). Professionals need to learn and practice reflection before, during, and after events. The National Council of State Boards of Nursing (NCSBN, 2009) collected survey responses via e-mail in a longitudinal study on the development of competence in new nurses over their first five years of practice. Based on analysis of the responses, the NCSBN recommends on "an explicit focus on skills of self-reflection" (p. 24) because of the impact on developing competence. Epstein (2006) discusses the importance of mindfulness, meaning the habit of calmly reflecting in the moment on one's internal responses to a situation and the corollary actions. Self-awareness, self-monitoring, and professional identity are all built through reflection and discussion (Coulehan, 2005). It is equally important that educators and preceptors model reflection by verbalizing their own thought processes for students, and by engaging in reflective discourse with colleagues and students.

Benner et al. (2010) recommend that nursing education programs retain the practice of clinical postconferences, in which a clinical faculty member facilitates a discussion of the day's experiences with students. Asfour, Ahmed, and El Halim (2016) used a quasi-experimental pre- and post-test design to measure changes in the learning domains of knowledge, skills (practice decisions), and attitudes related to ethical comportment in 70 Egyptian undergraduate nursing students. In addition to didactic education on a code of ethics and ethical comportment, students recorded experiences with patients and engaged in both individual and group reflection. Changes were statistically significant in all three domains. Severinsson, Johansson, and Lindquist (2012) surveyed 151 Swedish nursing students about the effects of participating in a process-oriented group discussion facilitated by an experienced clinical supervisor. Students were surveyed in groups in 2004, 2008, and 2010. Dialogical reflection facilitated by an

experienced nurse impacted the students' professional identity development as well as their attitudes and behaviors when interacting with patients, families, and other members of the health care team.

Problem-Based Learning

Three studies, Arreciado Marañón and Isla Pera (2015), Oosterbroek (2009), and Williams et al, (2012) were found that investigated the influence of a specific classroom pedagogy on formation of professional identity, problem-based learning (PBL). PBL is a constructivist approach to learning in which students work in small groups to solve problems. Nursing educators act as facilitators rather than lecturers and offer feedback on group work (Oosterbroek). Oosterbroek conducted a focused ethnography on preparing students to care in a PBL classroom in Canada. Triangulation of data was achieved through participant observation of 77 fourth year students in PBL tutorial groups, interviews with 10 student participants, and a focus-group interview with 6 faculty members. Appropriate procedures to insure rigor were used, including attention to reflexivity, credibility, dependability, confirmability, and transferability. Oosterbroek found that PBL helped develop a caring environment of trust and respect. Faculty members could give attention to small groups of students and students could bond with one another. PBL students also learned about the importance of self-care.

Williams et al. (2012) also conducted a focused ethnography to find out what characteristics graduates of a Canadian university nursing program developed in a problem/context based learning (CBL) environment. The researcher initially intended to interview graduates with two to five years of experience. However, this approach did not generate an adequate sample, so all graduates of the nursing program were recruited. Eight focus group and 23 individual interviews were conducted. Data were analyzed using constant

comparative analysis by a team of researchers. Interviews were conducted until saturation was reached. Graduates with a range of experience believed that CBL helped them adopt essential skills and values, described in three main themes: "self-aware and self-directed critical thinkers, patient advocates engaged in evidence-based holistic practice, and interdisciplinary team members able to handle conflict" (Williams et al., p. 419). Among the values and skills identified were: life-long learning, ability to give and receive feedback, conflict-resolution, self-awareness of biases, advocacy, supporting patient autonomy, change agency, teamwork, leadership, respect, and awareness that their behavior represents the nursing profession.

A third focused ethnography was conducted with Spanish nursing students by Arreciado Marañón and Isla Pera (2015). Twenty-three third-year students were observed and interviewed about their perception of the importance of theory and clinical practice in forming a professional nursing identity. Of interest in this literature review, the participants all came from a university that used PBL to administer a competency-focused curriculum. Through PBL students developed habits of reflection and of considering multiple view points. Students reported that problem-based learning helped them develop confidence about their future practice because they understood that nursing practice involves finding information and considering the changing context in patient-care situations. They took the skills of reflection and of anticipating and adapting to change from the classroom to the clinical setting. Curiously, all three studies describe students working in teams to solve problems; none addressed the emerging literature on team-based learning.

Summary

This literature review has focused on pedagogies for formation of professional identity and everyday ethical comportment. Benner et al. (2010) conducted the only study found on

pedagogies for formation in U.S. nursing schools. Although informative, the study design described exemplars of excellence in nursing instruction and provided recommendations rather than measures of effectiveness. The impact of modeling on formation was noted in several studies. Students learn what kind of nurses they want to be or not be from good and bad role models (Arreciado Marañón & Isla Pera, 2015; Baldwin et al., 2014; Benner et al., 2010; Engward, 2010). Reflection in a group setting guided by experienced nurses was found to enhance professional identity and skills of ethical comportment in studies from the United Kingdom (Engward), Sweden (Severinsson, Johansson, & Lindquist, 2014) and Egypt (Asfour, Ahmed, & El Halim, 2016). PBL was evaluated in two Canadian studies and one Spanish study to determine its effectiveness in forming values and identity in nursing students (Arreciado Marañón & Isla Pera, 2015; Oosterbroek, 2009; Williams et al., 2012). Only one study included faculty perspectives (Oosterbroek). Most of the studies were conducted at a single school of nursing by a researcher who taught there. Samples were homogenous, with the majority of participants being white and female. This may reflect the historic demographics of nurses in the respective countries, but it may not adequately reflect the experiences of an increasingly diverse U.S. nursing workforce. The most pertinent studies were dissertations, indicating that this is an emerging area of research with a need for additional studies.

There are still many questions about the process of formation of ethical comportment in pre-licensure nursing students and pedagogies for bringing it about, especially in the classroom. Few studies exist on how educators and students perceive formation for everyday ethical comportment, or what educators do to bring about this formation. A grounded theory study using a sampling of faculty and students from different universities will build on existing studies, and will assist in identifying pedagogies currently used nursing programs.

CHAPTER 3

Methods

In this chapter, the ontological and epistemological assumptions of grounded theory (GT), and its fit for inquiry into formation in nursing education are described. The study design, including sampling, setting, ethical considerations, and data analysis plan are outlined. Considerations for ensuring rigor and delimitations of the study are also described.

The Philosophical Basis of Grounded Theory

GT is a qualitative research methodology that was developed by Glaser and Strauss (1967) in the 1960s. Philosophically, grounded theory is rooted in pragmatism and in the theory of social interactionism developed in the Chicago School of Sociology.

Ontology

Ontology is the branch of philosophy concerned with the nature of reality, of what exists (Grayling, 1995). GT as originally described by Glaser and Strauss (1967) was developed in reaction to a positivist turn in sociology. In contrast to the positivist belief that fixed truth could be derived logically from equally fixed *a priori* knowledge, grounded theorists took the position that the world was complex and ever-changing. The foundational concept of GT is symbolic interactionism, which describes the way in which people use symbols (primarily language) to create shared social meanings (Milliken & Schreiber, 2012; Wuest, 2012). Reality is socially constructed through a process of action and interaction in which human participants ascribe meaning to actions and negotiate shared meanings (Corbin & Strauss, 2008; Strauss, 1991). In GT the building blocks of a theory - concepts and hypotheses about the processes that connect them - are discovered, or grounded in data rather than logically derived from ungrounded assumptions (Glaser & Strauss, 1967).

Investigating the world through the lens of GT requires making several assumptions. These assumptions were primarily derived from the theory of action and interaction originating in the Chicago School of Sociology in the early part of the twentieth century, and attributed in large part to the pragmatist philosophers Dewey and Mead (Corbin & Strauss, 2008; Strauss, 1991). There are a number of the assumptions in social interactionism; five of the most pertinent are described here. First, the social reality experienced by individuals and groups is a function of the meanings individuals attribute to actions. Second, all action is interaction between individual or group actors and includes how they interact with their environments. Third, conflicts arise that require the actors to change their habitual actions or beliefs. Fourth, these changes occur through reflection, a process that requires time and is directed toward some new and preferred way of viewing the world. Fifth, when contingencies arise actors may change their responses at any time during the process. Underlying all of these assumptions are the beliefs that the world is complex, that context influences reality, and that process is important (Corbin & Strauss, 2008; Strauss, 1991).

Epistemology

Epistemology is the branch of philosophy concerned with the nature of knowledge, of how things are known (Grayling, 1995). Given the ontological view that reality is constructed by the actors within that reality, it follows that knowledge is also constructed as those actors assign meanings to their interactions with others and their environments. Epistemologically, GT relies on induction to construct theory from the available data (Glaser & Strauss, 1967; Mills, Bonner, & Francis, 2006). To pragmatists, knowledge is built on prior knowledge, and knowledge and action constantly influence one another (Corbin & Strauss, 2008). On an individual level, actors construct knowledge through the process of deliberating and ascribing meaning to actions and

interactions. Strauss (1991) notes that in Dewey's view, this deliberation is usually necessitated by a situation that conflicts with usual habits of action, and thinking is used to mentally experiment with various courses of action. This sort of thinking takes time, and the knowledge constructed by the thinker cannot be separated from its context (Corbin & Strauss; Strauss).

As researchers, grounded theorists gather data from these actors and identify themes, concepts, and the processes that connect them. The importance of the researcher as *knower* is acknowledged, what Glaser (1978) terms "reliance on the social psychology of the analyst" (p. 2). In grounded theory, the researcher not only works to understand and explain the data. The researcher must also engage in an internal critique of that understanding (Milliken & Schreiber, 2012). Validity in GT research is also based on the pragmatist philosophy that what is discovered actually plays out in real life. Grounded theorists do not purport to describe a fixed truth, but recognize that understandings are contextual, occur from a perspective, and may change over time as new discoveries are made (Corbin & Strauss, 2008).

Fit for Inquiry into Education of Nurses

GT is an appropriate fit for nursing inquiry because nurses, like sociologists, value context and perspective. The practice of nursing can be readily understood in light of social interactionism theory (Corbin & Strauss, 2008; Wuest, 2012). Nurses and patients, in the context of a health problem, interact with one another and the health care environment, negotiating goals and choosing actions directed toward a more desirable state of physical, psychosocial, or spiritual health. Nurses recognize that meeting individual patient needs is highly contextual, and integrate concepts such as developmental state, culture, and socioeconomic resources into their thinking.

Like nursing practice, the function of nursing education can be conceived as a process of actions and interactions among faculty members, students, patients, staff nurses, and other members of the health care team in which the students are challenged to ascribe new meanings to actions and transform into the self of a professional nurse. GT is an excellent fit for inquiry into how nursing faculty and nursing students interact with one another and their environment, the meanings they ascribe to the process, the actions they adopt as a result, and how they conceive the desirable state that is the end-goal of nursing education.

Sampling

The purpose of this study is to begin developing a grounded theory of formation of professional identity and everyday ethical comportment in pre-licensure baccalaureate nursing students from the perspective of nursing faculty members. Participants were interviewed in person, one-on-one using a semi-structured interview schedule. Interviews were recorded and transcribed. Participants were given an incentive gift card of $25 in appreciation for their investment of time.

Sample

The target population for this study was faculty members who currently teach pre-licensure baccalaureate nursing students in the classroom. Participants were recruited from two small faith-based liberal arts universities, one large public university, and one historically black university all of which were in the southern part of the United States. Male and female faculty members of any ethnicity were recruited. Like novice nurses in clinical settings, novice nursing educators are concerned with learning the rules and structure of academia, and are concerned with mastering academic tasks such as writing the course syllabus or grading. Novice nursing educators focus their energies on learning teaching strategies related to delivering content rather

than pedagogies for forming professional identity (Siler & Kleiner, 2001). Therefore, faculty members who had taught for less than three years were excluded from the study. Faculty members who taught exclusively in online platforms were excluded because the current study presumes that face-to-face classroom interaction is the normal setting for formation, and that pedagogies for formation of everyday ethical comportment in online platforms are variations on that norm.

Recruitment

Nursing deans at each of the targeted universities were contacted for permission to conduct interviews with their faculty. Information on the appropriate contact person and preferred methods of communicating with faculty were requested from the deans. Approval was obtained from the university research review committees or institutional review boards at the three universities where this was required. Once approval was obtained, the deans either forwarded a recruitment e-mail explaining the purpose of the study, potential risks and benefits, and time commitment (Appendix A) to potential participants, or provided me with names and e-mail addresses of potential participants. I e-mailed these participants directly. Faculty members interested in participating responded via e-mail and we corresponded to schedule a time and place to meet that was mutually agreeable. Once the first participant at each institution agreed to participate, she was asked to recommend two additional participants at each site.

Sample Size

In qualitative research, it is difficult to predict what the necessary sample size will be. Saturation, as Corbin and Strauss (2008) explain, goes beyond collecting and analyzing data until no new categories emerge. The researcher must also collect and analyze data until the categories can be well defined, variations in the categories noted, and relationships between them identified.

Purposive sampling of three participants from each of the four institutions resulted in a total of 12 participants.

Sampling Rationale

In GT research, purposive sampling is used. Recruitment is done in a deliberate effort to pursue information about the concepts the researcher is investigating. Purposefully sampling faculty from diverse types of universities helped to reveal practices and student characteristics that were similar or different across institutions. The institutions themselves were selected on the basis of geographic convenience.

Setting

The study was conducted at four colleges of nursing that provide campus-based baccalaureate nursing education in the southwest United States. Colleges in the study were accredited by an appropriate national nursing organization. These included one large public university, one small historically Black university, and two small faith-based liberal arts universities. Within these settings, a convenience sample of faculty was interviewed.

Interviews lasting approximately one hour were conducted in-person in a private room, usually in the participant's office. Personal experience has demonstrated that when faculty members are in their own offices, they readily find the teaching tools they usually use and offer explanations of how and why they use these tools. Member checking was done by contacting six of the participants by telephone at a later date to clarify and expand on interview data.

Data Collection

Demographic and interview data were collected from each participant. Memos and field notes are also important sources of data in GT research and were created after interviews and during data analysis. Field notes were written immediately following each interview. Initial

interviews were recorded and transcribed. After data analysis and development of the theory, follow-up phone calls were made for the purpose of member checking. Written notes were taken during follow-up phone calls.

Demographic Data

Participants were asked to complete a brief demographic data form before beginning the interview. These data included age, gender, and race/ethnicity. Information was also collected on years of nursing and teaching experience, type of teaching experience (clinical, classroom, or hospital staff educator), and levels of teaching experience (pre-nursing, junior, senior, or graduate). Finally, participants were asked if they hold the Certified Nurse Educator (CNE) credential, and whether or not they had formal training in education (see Appendix B). Additional information on the education level of participants and the courses they have taught appeared in the interview data.

Interview Questions

Participants were interviewed using a set of semi-structured interview questions designed by the principal investigator (PI) based on a review of the literature related to formation of professional identity and everyday ethical comportment. The interviews began with a brief explanation of the concepts being studied, followed by open-ended questions (See Appendix C). The initial questions for the participant, "How do you think students change from the time they start nursing school until they complete their nursing programs and become professional nurses?" and "What do you do as an educator in the classroom to help bring about these changes?" are open-ended inquiries to allow the participants to identify their beliefs about formation of professional identity and the strategies they use to bring about formation. After the first two interviews, it became apparent that it was helpful to begin the interview by asking the

participants to describe their students, their own clinical background, and the courses they teach. These questions helped situate the participants' thinking on their students and their own education practices. Follow-up questions were used as needed to stimulate further discussion. The questions "What do you believe the important values in nursing are?" and "How do you think students learn these values?" are related to the supporting constructs of ethical comportment and designed to help participants focus on the teaching of nursing values and the behavior that expresses those values. Subsequent questions addressed classroom teaching strategies, corrective actions taken when students do not comport themselves ethically, and barriers to teaching for formation. When appropriate, these questions were used to elucidate issues related to teaching for formation in the classroom. Questions related to emerging codes evolved over the course of the interviews and were used in gathering additional data.

Memos and Field Notes

Grounded theorists recognize that the expectation of complete objectivity in the researcher is unrealistic and emphasize instead the importance of thinking about one's thinking (Corbin & Strauss, 2008). Memos provide a place for the researcher to analyze the influence of personal experiences, beliefs, values, and biases. Memos created during data analysis are an additional and critical source of data in GT. These memos are a record of the researcher's thought processes, and serve multiple purposes. They aid the researcher in identifying questions to ask of future research participants and of the data itself. Memos also provide a place to record brainstorming ideas and thoughts about emerging concepts, properties, dimensions, categories, processes, and theoretical relationships.

Field notes included time, date, location, and initial impressions from the interview. Memos were used to record impressions from the data, note emerging questions, record new

codes and their meanings, track data analysis, record thoughts on additional literature to explore, and to list questions for later research studies. As concepts, and then categories emerged, questions were asked of the data and subsequent participants were asked specific questions to help inform the properties, dimensions, and relationships between concepts. Once the major categories and core category were identified, I returned to the interview data and theoretical memos to define relationships between concepts and categories. Additional pertinent literature was reviewed to confirm and further elucidate concepts and theoretical relationships. As relationships between concepts become apparent, an iterative process was used to assemble and revise a diagram of the theoretical framework. Collaboration with my committee and with a designer familiar with graphic representations of abstract concepts further supported development the theory.

Ethical Considerations

Approval for the study was obtained from the University of Texas at Arlington (UTA) Institutional Review Board (IRB). The UTA IRB determined that this study was exempt under federal guidelines for protection of human subjects. Additional approvals from the participants' home institutions were obtained from the dean at one institution, the research review committee of the College of Nursing at another, and the University IRBs of the other two sites. There was a small risk of psychological stress to the participants. The risk was minimized by conducting interviews in private, and in a non-judgmental fashion. Participants received a $25 gift card to a local restaurant or business in thanks for their investment of time. Participants may have also benefitted from the process of thinking about their teaching strategies. Development of a grounded theory of formation of everyday ethical comportment may benefit nursing educators and students by providing a framework for effective teaching.

Informed Consent

Participants reviewed a written consent form, approved by the UTA IRB delineating the possible risks and benefits of the study (see Appendix D). Protection of individual confidentiality and the right to withdraw from the study at any time was explained in the consent form. Verbal consent to participate and record the interviews was obtained and recorded as part of the interview transcript. Participants were given a copy of the consent form to keep, which included contact information for me, my committee chairperson, and the UTA Office of Regulatory Services. Participants were informed of the study procedures and the possibility of follow-up phone calls to check the accuracy of data. All participants agreed to accept a follow-up phone call and provided phone numbers, which were written down. The written phone list was shredded after member checking was completed.

Data Recording and Storage

Interviews were recorded using digital recording device and exported as MP3 files to a password protected personal computer. Recorded interviews were deleted from the recording device. MP3 files were imported into Express Scribe Pro software, version 5.88 and were transcribed by me using Microsoft Word. During transcription, identifying information was removed from the transcripts. Transcripts were then imported into nVivo for Mac, version 11.4.0. The nVivo file was password protected. When the interviews were transcribed and verified, and data analysis was complete the recordings were deleted from the Express Scribe Pro software. Institutions where the participants teach were identified only by type. A code was assigned to each institution (Public [P]1 or 2, Faith-based [FB] 1 or 2) and a number was assigned to each participant. Transcripts, field notes, demographic data forms, MP3 files, and notes from member checking were labeled with only the institution and participant code (e.g.

P1P2; FB2P3). No names or identifying information were used in the research report. During data analysis, interview transcripts were be stored on a password-protected personal computer. After data analysis was completed, interview transcripts are be maintained on a UTA encrypted computer in the UTA College of Nursing and Health Innovation (CONHI) building. Demographic data forms and notes from member checking will be stored in a locked cabinet in a locked office in the UTA CONHI building.

Data Analysis

I transcribed the first interview verbatim and then conducted open coding of the first interview and wrote a memo recording thoughts from this first analysis. Subsequent interviews were analyzed in a similar fashion using constant comparative analysis to compare new data to codes identified in earlier interviews and writing memos when appropriate. A researcher with experience in education and in qualitative analysis was invited to code the first two interviews and compare codes with me to verify appropriateness of analysis. The process of data collection, analysis, and theory development is depicted in Figure 2.

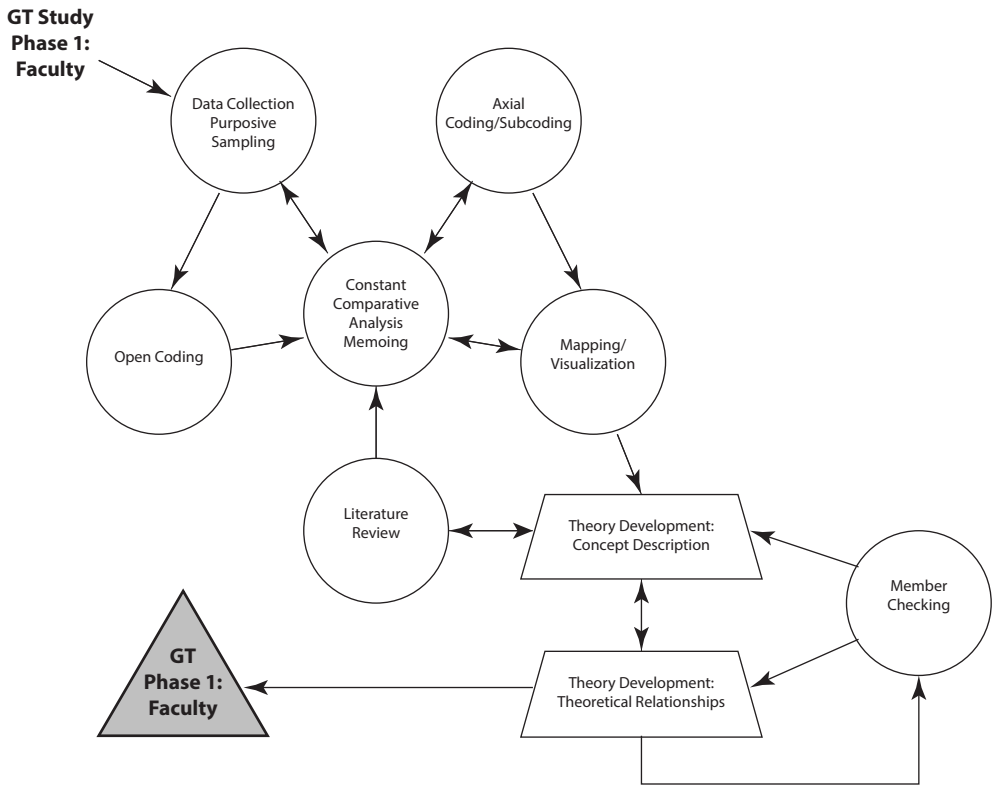

Figure 2. Data Analysis and Theory Development

Data were coded using nVivo for Mac, version 11.4.0. Over 130 codes were generated in the initial open coding of interviews. Constant comparative analysis was used to determine new codes or add to existing codes. Memos were made about potential relationships or duplications among codes, and about the need to seek out definitions and descriptions in the literature. After completion of open coding, axial coding was used to collapse some codes together. Other codes were grouped into larger categories, such as *Pedagogies*. Some codes, such as *Student characteristics* and *Sensitivity to students' developmental state* were broken into subcategories. Idioms that participants used to describe the process of formation were collected. Throughout axial coding and sub-coding, constant comparative analysis to the data was used to continue to elucidate concepts and relationships.

Descriptions of student characteristics at each developmental state were printed out and visually organized on a wall map. Tools within the nVivo software were used to analyze which codes relating to educational practices were used most frequently, and codes were further combined and education practice concepts described. Pertinent research and theoretical literature on emerging concepts was located, reviewed, and compared to the research results. Once concepts had been described, relationships between the concepts were explored, and concept descriptions were revisited for clarification. Discussions with committee members, colleagues, and a graphic artist were invaluable in clarifying theoretical concepts and the relationships between them. Finally, six of the faculty participants were contacted via telephone for member checking. Further data collected during these conversations was integrated into the grounded theory.

Rigor in GT is accomplished by conducting enough interviews to reach saturation, and conducting enough analysis to create a theory that fits the data and can be used by practitioners in the field being researched (Corbin & Strauss, 2008; Glaser & Strauss, 1967). A grounded theory is credible when it has *fit, work, relevance,* and *modifiability* (Artinian, Giske, & Cone, 2009; Lomborg & Kirkevold, 2003). Fit refers both to how the theory fits the data it originated from and to how the theory fits the real world situations to which it will be applied (Glaser & Strauss). Fit is foundational to work, relevance and modifiability (Lomborg & Kirkevold). Work means that "theories should provide predictions, explanations, and interpretations" of the phenomenon being studied (Lomborg & Kirkevold, p. 191). Relevance means that the theory is relevant to the important problems and processes of the phenomenon. In other words, a theory works and is relevant if practitioners can use it to guide their practice. Modifiability means that the theory is pliable enough to change and evolve over time as new data emerges (Lomborg &

Kirkevold). Rigorous analysis cannot be rushed; it requires time to think and to allow ideas and connections to emerge. Once a working theoretical framework was devised, the data were reviewed to see if they fit the theory and necessary revisions were made.

Credibility in GT may be evaluated by explaining the emerging theory to the participants and seeking their confirmation of fit, work, and relevance (Artinian, Giske, & Cone, 2009). As Corbin and Strauss (2008) point out, research participants may not be able to see how their individual experiences fit into the larger picture of the process being studied, but when they are presented with the finished theory, they can see their story within it. Six of the participants agreed to a follow-up telephone call to discuss the emerging theory. Participants consistently affirmed the fit, work, and relevance of the theory, making comments such as "That's my life in a nutshell; it's what I do every day;" "This is really challenging me as a teacher to say, 'what could I do better?'" and "I could see a lot of research projects coming out of this." Participants also added additional data during these phone calls that was integrated into the final theory.

Based on member feedback, a last review of theoretical memos, and review of the literature, a final schematic and written description of the theoretical framework was created. Analysis was completed by identifying further questions for research to continue development of a grounded theory of formation of professional identity and everyday ethical comportment because theory development is an ongoing process.

Delimitations

This proposed study is the first step in a larger program of research to discover the process of professional identity formation in pre-licensure students. The core category *Putting the Pieces Together* emerged from the data and a beginning theoretical framework from the perspective of nursing educators proposed. Limitations in the scope of this initial study resulted

in stopping data collection before the properties and dimensions of all the concepts were fully explored. Few new codes were identified after the analysis of interviews from the first three sites. New codes appeared after interviews at the fourth site, the historically Black university. I believe this is due to the broader diversity of students at this site, and these codes were combined with existing codes during axial coding. Based on the research data, properties of students are well described. Dimensions of these properties need further exploration via theoretical sampling and focused interviewing. Future studies will expand on this study to develop a framework that nursing educators can use to guide instructional design and bring about formation of professional identity in nursing students.

Summary

Little empirical evidence on formation of professional nursing identity exists. Investigation of this phenomenon requires a theoretical framework. Grounded theory methodology builds theory that is grounded in existing practices and relationships. Based on the sociological theory of social interactionism, GT is a good fit for investigating formation of professional identity and ethical comportment in nursing students because this formation occurs in the interactions between nursing students and nursing educators, as well as in interactions nursing students experience with patients, families, and other professionals in health care settings.

In this study, experienced nursing faculty who teach baccalaureate nursing students at two public universities and two faith-based universities were interviewed. Their views on how formation of professional identity occurs and how they as educators can effect this formation were collected using semi-structured interviews. Data were analyzed using constant comparative analysis, and additional data were sought from the literature and during follow-up phone calls

with participants. Concepts, some properties and dimensions, and relationships between concepts were described and a beginning theory of formation constructed. Member checking with participants was used to verify credibility. The resulting theory provides a framework for educators to use as they select and implement pedagogies to bring about formation of professional identity and ethical comportment in pre-licensure baccalaureate nursing students.

CHAPTER 4

Results

This grounded theory study aims to create a framework for nursing educational practice by answering two basic questions: 1) From the perspective of nursing educators, what is the process nursing students go through as they develop new identities as professional nurses?, and 2) What can nursing educators do to stimulate and support this process?

In this chapter I describe the research sample, list the nursing values that participants found important, give a broad overview of the theory, and describe the elements of the theory in detail including student characteristics at entry to the nursing program and at each level of the nursing program, and nursing education practices. I also discuss specific pedagogies that emerged from the data. Lastly, I describe barriers and supports to teaching for formation of professional identity that participants identified.

Sample Characteristics

Faculty members from two small faith-based universities, one large public university, and one small historically Black university in the southern United States were interviewed. Three faculty members with a minimum of three years of teaching experience were interviewed at each site. All four universities used the typical two-plus-two curriculum, with two years of liberal arts and science courses followed by two years of upper division nursing courses. However, all of the sites had at least one pre-nursing course in their curriculum offered at the freshman or sophomore level, either pathophysiology, pharmacology, or a course to introduce students to the nursing discipline. One site conducted their assessment course in the skills lab during the second semester of the sophomore year prior to students going to the clinical setting.

Table 1

Participant Characteristics

	N = 12
RACE	
White	10
Black	2
AGE (in years)	
	30-66 (M 49)
EXPERIENCE (in years)	
Years of Practice Before Becoming an Educator	2-25 (M 12)
Years of Teaching In an Academic Setting	3.5-30 (M 12)
EDUCATION	
MSN	8 (1 in a PhD program)
PhD	4
Graduate Courses In Education	12 (2 at the doctoral level)
Certified Nurse Educator (CNE)	4
CURRENT TEACHING SETTINGS	
Classroom	12
Clinical	12
Campus-Based	12
Online	8
STUDENT LEVELS TAUGHT	
Pre-Nursing	5
Freshman	3
Sophomore	7
Junior	12
Senior	10
Graduate	3

NURSING COURSES TAUGHT BY PARTICIPANTS		
Freshman Seminar	Medical Surgical Nursing	Critical Care Nursing
Pharmacology	Psychiatric-Mental Health	Community Health Nursing
Pathophysiology	Nursing Maternity/Obstetric	Leadership/Management
Medical Terminology	Nursing	Capstone
Assessment	Pediatric Nursing	RN-BSN Courses
Fundamentals of Nursing	Research	Graduate Courses
Health Promotion/Wellness		

Demographic characteristics of the participants are summarized in Table 1. All of the participants were female, culturally American, and ranged in age from 30-66 with an average age of 49. Years of teaching experience ranged from 3.5 to 30, with an average of 12 years of teaching in an academic setting. All of the participants had taken formal education courses at the master's level, and two had taken education courses at the doctoral level. All participants had earned graduate degrees. Four participants had PhDs, and one participant was in a PhD program. Four had earned the Certified Nurse Educator (CNE) credential. All of the participants had experience teaching in both the classroom and clinical settings. Teaching experience was represented from every level from freshman through graduate education and in every course in the curriculum.

Putting the Pieces Together

Formation of professional nursing identity is influenced by every student experience, classroom or clinical, didactic or experiential, formal and intentional or hidden and tacit (Benner, et al., 2010). If formation as a caring professional occurs within a relationship of caring between student and educator (Hawk & Lyons, 2008; Owens & Ennis, 2012), then a theoretical framework to guide educator practice should include both the students and the educators. However, most theories of identity formation in the literature focus on the individual forming the identity. I did not find any frameworks that integrate the role of the teacher facilitating that formation. Articulating a theory that considers both the development of the nursing student and activities of the educator will help guide nursing educators as they facilitate and support the formation of professional nursing identity in their students. In this section I discuss my findings related to students' characteristics and the role of nursing educators in formation of professional identity. I begin with an operational definition of professional nursing identity and a discussion

of the values that influence nursing identity. I then describe the grounded theory and provide detailed descriptions of the theoretical concepts.

Identity is a complex concept. There are many definitions of identity in general, and of professional identity in particular. Godfrey and Crigger (2017) offer a succinct definition of professional nursing identity: "....professional identity in nursing is defined as a sense of oneself that is influenced by characteristics, norms, and values of the nursing discipline, resulting in an individual thinking, acting, and feeling like a nurse." (p. 379). To elucidate the influences described in this definition of nursing identity, participants were asked about values they believed were important for the students to learn. Values emerging from the data are italicized. Although participants generally agreed that most students come with some measure of these values, they need to be developed and formed into expressions that are appropriate for nursing practice. *Integrity* was an important value, but was more frequently described in terms of *trustworthiness* and *accountability*, particularly accountability for errors in patient care. Trustworthiness and accountability expressed in academic behaviors was also important. *Respect* for the value and dignity of patients, families, peers, and authority figures was a particularly important value. The ability to respect diverse others requires *open-mindedness* to many ways of believing and doing, which in turn helps students be *non-judgmental* in their approach to patient care. However, students cannot be open-minded and non-judgmental without a high level of *self-awareness.* Students can then shift from a naturally egocentric state to *other-centeredness*, with the ability to engage in *advocacy* for patient's needs and desires, even if they differ from what the student would choose for him or herself. Not surprisingly, *caring* was an important value to these participants. However, they noted that students needed to understand caring as an integration of skilled physiologic care along with comforting presence and

behaviors. Other values that emerged from the data were *lifelong learning*, *passion and vision*, and *service*.

There are three main elements of the framework *Putting the Pieces Together*© depicted in Figure 2: the student who enters nursing education with an existing identity and goes through a process of development in forming a professional identity, the nursing educators facilitating identity formation, and the nursing education practices used to facilitate formation. A fourth factor is the support provided by nursing school administrators. Nurses with a fully formed identity, in this case the nursing educators, are depicted as perfect circles. Students in the process of forming a professional nursing identity are depicted in an amorphous form as imperfect circles. Students and nursing educators are active agents in identity formation. Educators create a safe and caring educational milieu and implement educational strategies designed to support formation of identity. Nursing education practices include 1) understanding the student, 2) creating a safe learning environment, 3) providing developmentally appropriate support, and 4) using appropriate pedagogies. Students enter this educational milieu with existing identities, engage in learning activities, and make choices about adopting new values, attitudes, and behaviors that result in a predictable process of identity development.

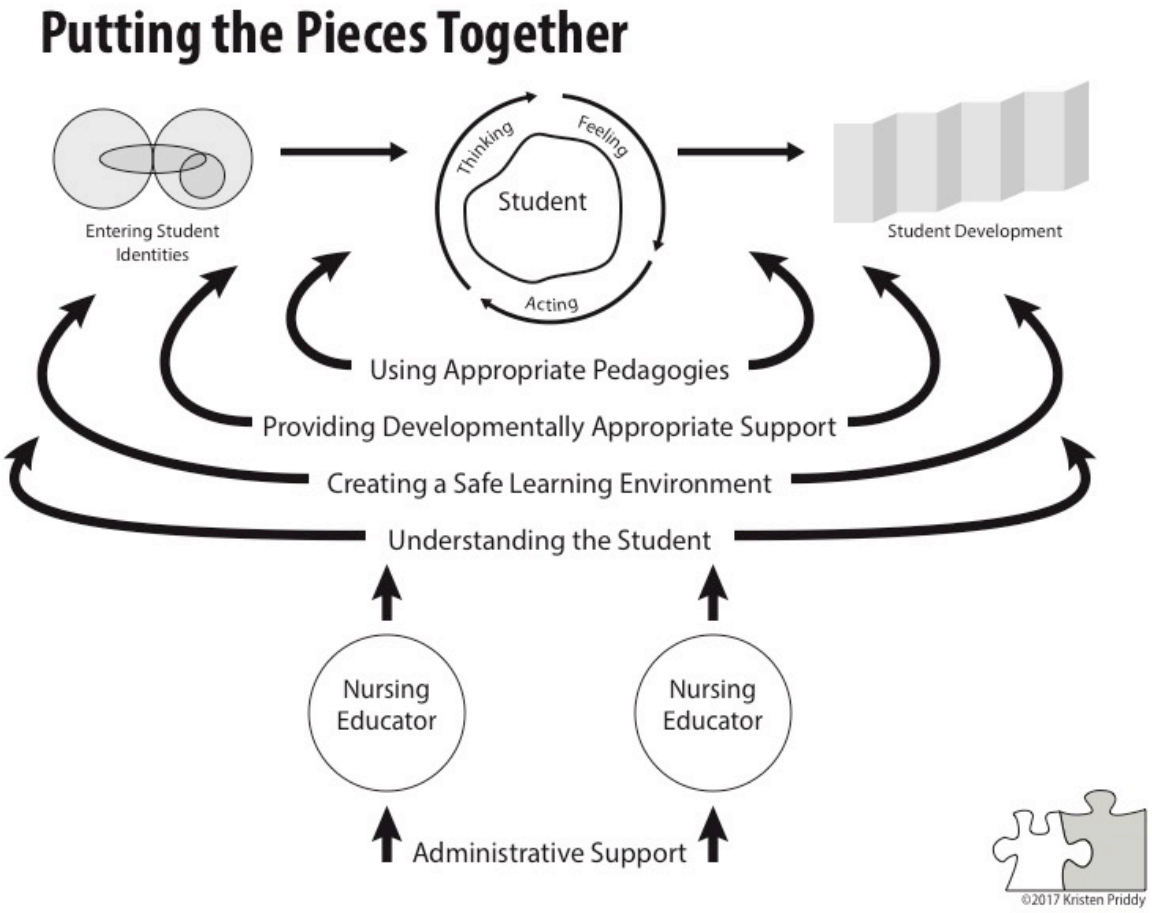

Figure 3. Putting the Pieces Together ©

I present more detailed descriptions of nursing education practices and administrative support later in the chapter. First I describe variations in student identity at program entry. I then describe broadly how students change in the way they think, feel, and act as they put the pieces together. I conclude with identifying barriers and supports to teaching for formation of professional identity and everyday ethical comportment.

Students

In grounded theory concepts are identified and then described in terms of their properties and the dimensions, or breadth of variations, of those properties. In this section, I will discuss the properties of students. However the word properties refers to the attributes of an object or

abstract concept. Because students are people, I choose to describe their variations as characteristics rather than properties.

Characteristics of entering nursing students. Students do not enter nursing school as blank slates. Providing developmentally appropriate support and creating a safe learning environment requires understanding the background and developmental state of the individual students entering the nursing program (Hawk & Lyons, 2008; Hult, 1979; Owens & Ennis, 2005). Participants described four types of students: traditional/emerging adult students, adult students, students transitioning from another role in health care to professional nursing, and vulnerable students (Figure 3). These students had unique characteristics in terms of entering identity and identity formation tasks, role demands competing with their education, and their existing framework for understanding the health care system. These variations impact the process of learning to think, feel, and act like a nurse.

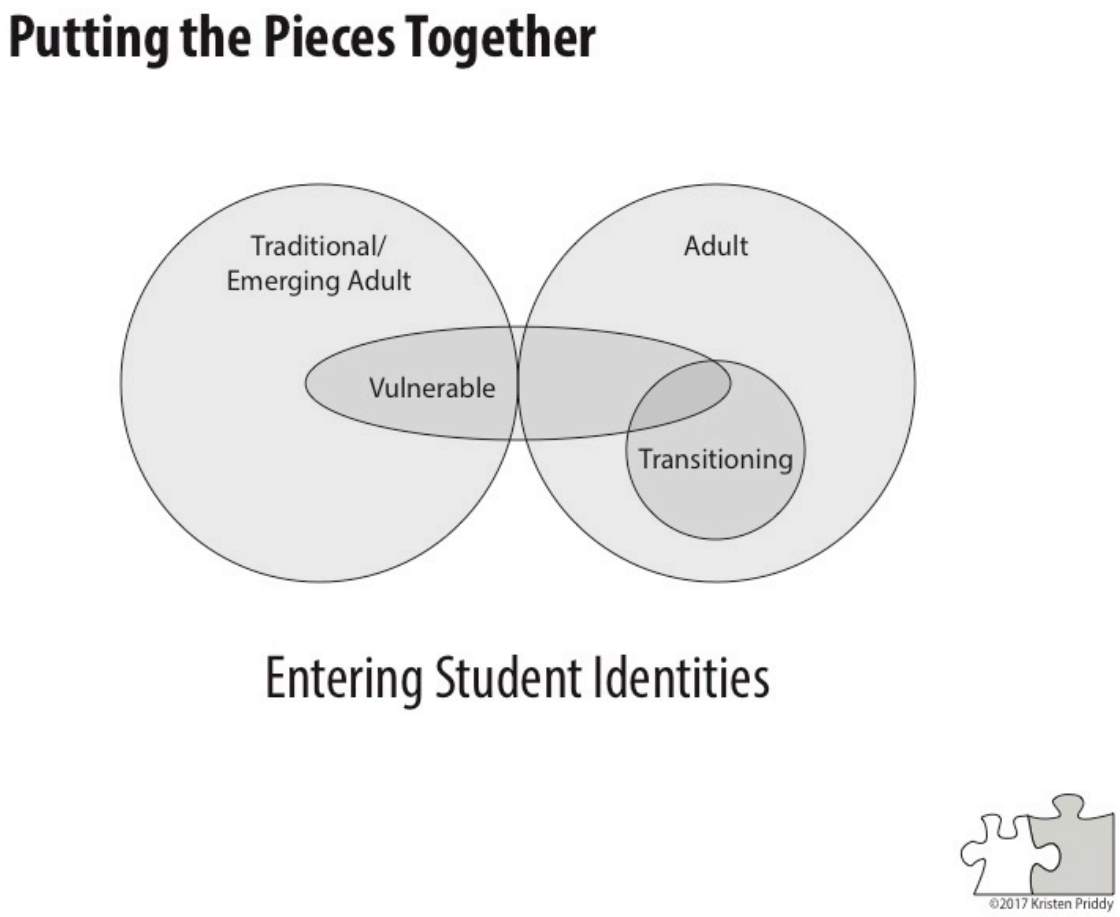

Figure 4. Entering Student Identities ©

Traditional/Emerging Adult students. Faculty participants from three of the schools described homogenous student populations comprised primarily of 18-22 year-old White female students from conservative, middle- and upper middle-class homes within a limited geographic area. These students have the dual task of forming their personal identities and their professional nursing identities. As one participant noted, these are not adult learners; they are older adolescents. These students often exhibit behaviors that are considered uncivil in the professional world, such as using cell-phones and other technology in class or arriving late. They are surprised at being held accountable for late assignments and tardiness. As a result of inexperience and sheltered upbringing, students' worldviews are naïve and narrow. These

students come into nursing with a desire to care for others without much exposure to how others live and view the world. They have usually not been exposed to the difficult circumstances encountered in nursing, and they lack a framework for interpreting the world of health care.

The lack of diversity in age, gender, socioeconomic background, and ethnicity in these students presents some challenges to expanding their worldviews. However, participants generally felt that these students had many advantages over other students. Without the competing responsibilities of adult students, traditional students are able to fully immerse themselves in the learning experience. Most of these students came from stable homes where they were nurtured and provided with supportive resources such as tutoring. Successful completion of university education was modeled for them. Consequently, they came to the task of formation of identity with rich personal resources and resilience. Faculty members at the faith-based universities described additional advantages in readiness for spiritual and ethical growth:

> They move into that seeking out ethical ways to impact caring roles. Those kinds of things come much more naturally because that's part of their life; for many of them it's been part of their life their whole life. So that it's kind of maybe easier to stretch them, to challenge them than in some places.

I suggest that a more appropriate term to describe students in this age group is *emerging adults*. Emerging adulthood, as described by Arnett (2000, 2015) is an extended period of exploring and establishing identity that begins at age 18 and ends between the ages of 25-29. Emerging adults are ready to explore love, work, and worldview. They seek meaningful, fulfilling work that is a good fit for their individual identities (2015). These ongoing explorations to find work that is the best fit may cause students to waver more in their

commitment to becoming professional nurses. On the other hand, the characteristic explorations of work and worldview and the desire to engage in meaningful work make this a fertile time for formation of a professional nursing identity

Adult learners. Adult learners, in contrast, come to nursing education with more established adult identities that include competing roles with family and job responsibilities. Their task is to integrate a nursing identity into their existing adult identity through coming to understand nursing and health care. Adult learners have the advantage of being able to prioritize because they are more adept at juggling multiple responsibilities than emerging adult learners. They bring life experiences and experiences as health care consumers to their learning, so they may already possess a mental framework for interpreting the health care system and the place of nursing within it. However, competing family and work responsibilities were generally described as disadvantages when compared to traditional students.

Students transitioning from another health care occupation. A subset of the adult learners included a small number of students transitioning to professional nursing from other health care occupations, such as licensed practical nurses (LPNs), first responders, nursing assistants, and other unlicensed assistive care roles. Formation of identity as a registered nurse presented particular challenges in this group because it required relinquishing an existing identity and altering an established framework for viewing patient care situations. Tower et al. (2015) describe a similar phenomenon in Australian nurses transitioning from other nursing roles to university nursing education. In addition to the academic challenges of adapting to the university and of competing family and employment roles, transitioning students experienced a sense of threat to their existing identities, including a loss of confidence in themselves as nurses and a grief response to their loss of identity. One participant in the current study had gone

through this transition herself and poignantly stated, “I did not become an RN until I got my master’s degree,” expressing her unwillingness to relinquish her former collective identity as a skilled and competent paramedic.

These students perceived themselves as different from the rest of the students and they tended to have unrealistic expectations of their classmates who did not have health care experience. Consistent with the findings of Tower et al. (2015), faculty participants in the current study reported that it took transitioning students some time to understand that the role of the BSN-prepared nurse was not the same as their current role and required expanding their thinking. They often struggled with taking on the roles of Registered Nurses (RN). For example, participants reported that LPNs had difficulty accepting the autonomy of the RN role. These students also struggled with relinquishing their former occupational identity to adopt the identity of professional RN.

Vulnerable Students. A final group of students, which I am calling *vulnerable students*, was described by the participants. These were students who experienced significant social, economic, and psychological barriers to forming a professional nursing identity. Many of these students came from historically disadvantaged groups including first-generation college students, minority students, and students with socioeconomic challenges. Some came from backgrounds of abuse and violence. These students needed to develop a secure and empowered personal identity to support the development of the professional nursing identity. It is important to note that vulnerable students can be found among traditional students, adult students, and students transitioning from a previous health care role.

In contrast to the bulk of traditional students, vulnerable faculty participants noted that students lacked adequate social support and models for completing a college education, leading

to self-doubt and fear of the unknown. Dependence on faculty role models raised the risk of blurring boundaries in the faculty-student relationship. Some students were described as coming from "rough backgrounds," or as being "really hard core." Students coming from environments of physical or verbal abuse were resistant to authority and lacked the skills for appropriate communication and conflict resolution. In some cases, families resisted the student's change in status. These students tended to be motivated by a desire to change their future. Students in this category often required extensive faculty support and referral to campus academic and counseling resources.

> We had one young lady years ago…she had been homeless for several years. She wanted to change her own life, and where she was going, so trying to be able to have contact with her, talk with her, saying, "You know that is not appropriate. It may have been appropriate before, but in the area that you're going into, that is not appropriate language, that's not appropriate dress. You have to learn how change to you." And so over a period of time of being able to work, not just me, but all of us working together as a unit, we were able to see a transformation and it was kind of like the caterpillar going from that and being able to watch her go into the butterfly, and actually being able to spread her wings and fly.

As this participant noted, students like the one described in this exemplar benefitted from going to school part time and extending the time for their formation by a semester.

Thinking, feeling and acting like a nurse. Godfrey and Crigger (2017) identify three expressions of nursing professional identity: "thinking, acting, and feeling like a nurse. (p. 379). From the perspective of the nursing educators in this study, the most profound changes occur in

the way students think. Participants used the phrase *putting the pieces together* to describe the basic process of learning how to think like a nurse.

Reflection (thinking) is essential to identity formation. Through reflection students choose actions to take and attitudes to adopt (Lewin, 1999; Wald, 2015). Therefore learning to think like a nurse may be viewed as the foundation of identity development. Learning to think, feel, and act like a nurse is a recursive process, depicted in Figure 2 by circular arrows surrounding the developing student. Thinking leads to decisions about how to feel and act. Feelings, or attitudes are adopted and become integrated into thinking patterns (Cruess, et al., 2014) Actions become habits, and gradually become intuitive and embodied in the individual (Benner et al., 2009). In the words of Aristotle, "these virtues are formed in man by his doing the actions," or in more contemporary language, "we are what we repeatedly do." (Durant, 1953, pg. 76)

Thinking. Four changes in student thinking that are necessary for putting the pieces together emerged from the data, 1) understanding nursing, 2) expanding one's worldview, 3) increasing complexity of thinking, and 4) developing more nuanced ethical thinking.

Understanding nursing. Interviewees observed that students enter nursing education with an inaccurate and simplistic view of nursing practice. Understanding of nursing practice is focused on tasks and hands-on skills, such as following doctor's orders, taking vital signs, or starting IVs. Students also have some conception of the caring aspect of nursing, but they don't understand the complex nature of caring, focusing instead on behaviors like holding the hand of a distressed patient. To learn to think like nurses, student must first understand that nursing practice is primarily cognitive in nature. Faculty participants noted that by graduation students progress to an understanding that nursing practice involves complex, context-driven thinking.

Expanding worldview. Students new to a nursing program often have a worldview that is limited by their personal experiences and cultural backgrounds. Their worldviews may be naïve, egocentric, and ethnocentric. Over the course of their nursing education, students progress to a worldview that encompasses more possibilities. They become open to multiple perspectives and ways of doing things. This open-mindedness is a necessary pre-requisite to giving non-judgmental care, considering variations in patient context, and tolerating ambiguity in ethically challenging situations.

Increasing complexity of thinking. Faculty participants believed that prior to entering the upper division of a nursing program students have received what has been a primarily didactic education with facts and concepts presented without a context for real-life application and learned mostly through memorization. In the beginning students are able to make few connections between the concepts they are learning. In the words of faculty, they are learning "piece-by-piece." Students gradually add layers of complexity to their nursing thinking, and by the time they graduate and prepare to enter practice, they have learned to make multiple connections and to consider many variations in patient contexts. The ability to consider these variations supports the development of a more sophisticated mode of ethical thinking.

Ethical thinking. When the ethical components of a clinical situation are brought to their attention, beginning students may be able to judge the situation as right or wrong. As their worldview expands and they build the ability to accept and consider multiple viewpoints, students move beyond this black and white thinking. They begin to develop some tolerance for ambiguity in ethical situations and approach such situations in a collaborative rather than a judgmental fashion.

Feeling. Increasing student confidence emerged from the data as the descriptor of *feeling like a nurse*. Participants described entering nursing students as overwhelmed by the demands of nursing education and the complexity of the clinical environment. As one participant put it, they abruptly move "from a constant routine to coming into nursing chaos where you have to think about so many different things." Students are fearful and feel awkward about touching and talking to patients. By their senior year, they are confident, calm, and focused on completing their education. However, as they near graduation and anticipate leaving school to enter the workforce, students experience a return of anxiety and fear.

Acting. Observable behaviors are expressions of internalized values. The actions described by the faculty participants that develop over the course of nursing education are expressions of two core professional values, autonomy and accountability. As feelings of confidence grow, students act with greater autonomy. It seems that practicing with increasing levels of autonomy and accountability in turn enhances student confidence. They become less dependent on faculty, and are more likely to seek out opportunities to learn in the clinical setting. Developing autonomy supports developing accountability. Professional nurses have a high level of accountability for practice, but students cannot realistically be held accountable for patient care. Instead nursing educators use behaviors such as being on time, complying with a dress code, or preparing for class as an analog of the accountability required of professional nurses, probably because these actions are concrete and easy to measure. Because the rigor of these expectations is new, educators may be flexible in imposing consequences. By graduation, students are held to a level of accountability that mirrors the expectations of state licensing boards.

Developmental characteristics of students at each stage. In the next section I discuss how nursing educators use knowledge about individual students and students' progress in development to support the process of putting the pieces together. To do this, there must be an understanding of each stage of development. I will therefore finish this section by describing the characteristics of students related to the four aspects of thinking, of feeling and acting, illustrated in Figure 4. Students have not fully formed their professional identity, so they are depicted as amorphous, imperfect circles gradually developing into complete circles. The image is deliberately presented in an uphill configuration, because participants consistently used vertical language to describe development of nursing identity, such as laying a foundation that would later be built upon, or starting at the bottom of a ladder and walking up the steps. Participants described these stages in terms of the semester placement in the curriculum, so I have labeled them as such.

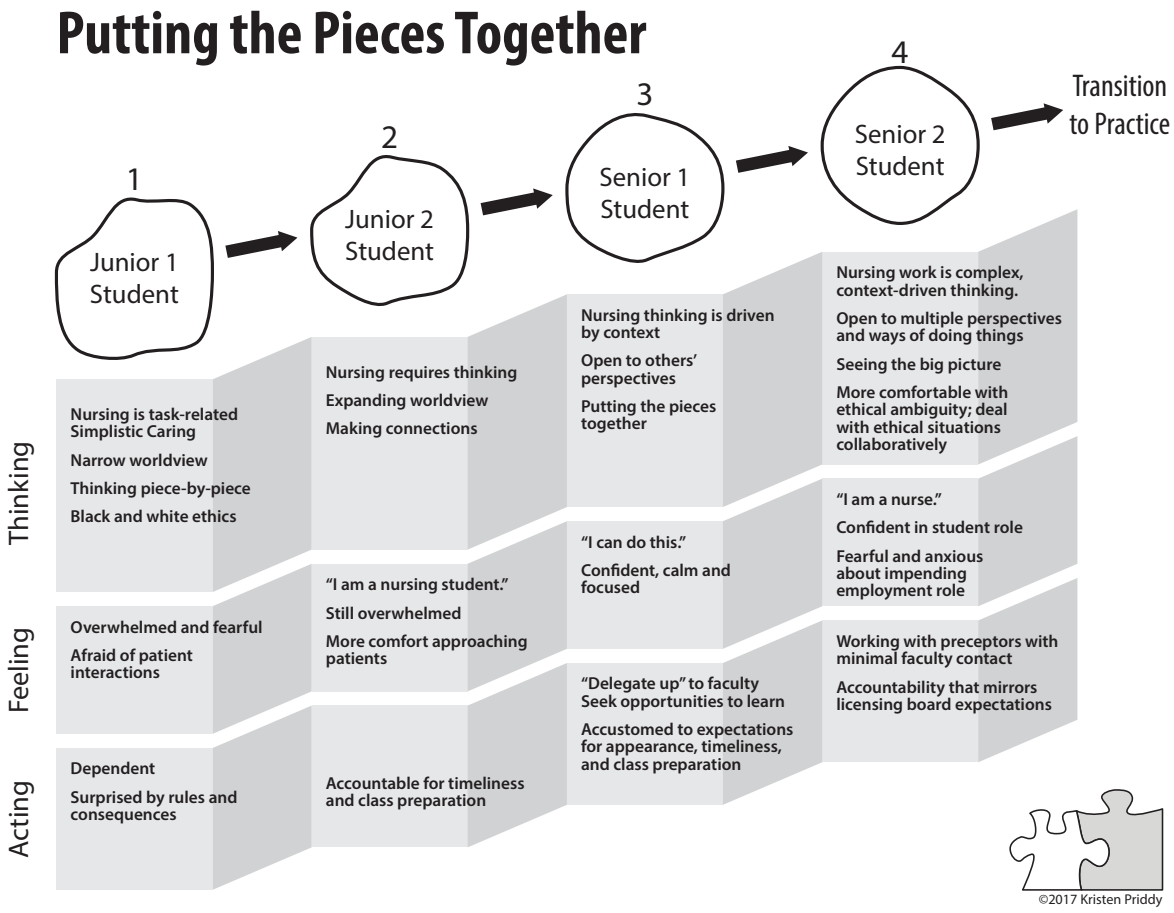

Figure 5. Student Developmental Characteristics ©

Pre-Nursing. Prior to entering the upper division of the nursing program, students have been exposed to abstract knowledge that is general to all undergraduate students, and more specific to students in health care professions, such as anatomy and physiology and microbiology. In many cases students have also taken at least one pre-nursing course that is specific to the nursing discipline, typically introduction to the nursing discipline, pathophysiology, or pharmacology. Students often experience their first extended exposure to what it means to think, act, and feel like a professional nurse during a pre-nursing course taught by a nursing faculty member. Although the knowledge gained in these courses is useful, it is abstract. Faculty participants describe this as a time of learning through memorization, with little

ability to internalize or apply knowledge. Unless they are among the relatively small group of students who are transitioning from another health care occupation, pre-nursing students have not had clinical experience to attach this knowledge to. Outside of clinical practice, students don't recognize that there can be variations in symptoms and responses based on individual patient context. As one participant put it, using the image of boat about to capsize when it has taken on too much water, students are "still listing about and thinking things are the same across the board." If they are put in a clinical situation, such as going on a medical mission trip, they tend to be very rule-focused and uncomfortable with variations in practice context. On the other hand, traditional/emerging adult students are also very open and enthusiastic about learning at this stage.

First Semester (Junior 1). Following completion of pre-nursing courses, students enter the first semester of their upper-division nursing program. They take courses focused solely on learning nursing practice, and have their first experiences in clinical settings with patient care.

Thinking. Students' understanding of nursing practice at this stage tends to focus on skills such as taking vital signs or inserting IVs. They have some understanding of nursing as a caring practice, but their view of caring is simplistic and limited to behaviors such as wiping a patient's brow or holding a hand. Students are just beginning to understand the challenging cognitive nature of nursing practice and to learn how to think like nurses. Students view patients through the lens of their own cultural experiences and may not have cultivated the self-awareness of biases that is necessary to render care in a non-judgmental fashion. The worldview of younger students from conservative backgrounds may be particularly naïve, and they must cope with exposure to experiences from which they had previously been carefully sheltered. Older students may or may not have a more open worldview or more cultivated thinking skills.

The thinking and actions of students at this stage had been well described by Benner, Tanner, and Chesla (2009) and Dreyfus & Dreyfus (2009). These students are novices; they think and act according to rules. Because they lack experience, their knowledge is disconnected from the many variations in patient context. In the words of these faculty participants, they are learning "piece by piece." Likewise, their ethical thinking tends to be black and white, and focused on making a judgment rather than considering multiple options for action.

Feeling. Students at this stage are overwhelmed by the demands of nursing education and by the complexities of the clinical practice setting. They are fearful of touching and talking to patients.

Acting. Understandably, these fears result in a limited sense of autonomy. Students want to follow faculty and be told what to do. One participant describes the insecure behavior of students encountering patients for the first time:

> It was real interesting taking them out for the very first day, and I would say, "Okay, we're going to go in and we're going to meet your patient, and then I need you to have a conversation with them, ask them some questions, help with their AM care and then you can glean some information." And so I'd go in with them and I'd introduce them to their patient, and tell them where we were from and I said, "Okay, I'm gonna leave you two together," and I'd walk out of the room feeling a presence behind me, and I'd turn around and I'd go, "Oh, you're still just standing here."

This lack of autonomy makes holding students to a high level of accountability unrealistic, or at least developmentally inappropriate. Nursing educators endeavor to acclimate students to professional accountability through academic behaviors such as complying with dress codes, being on time for class, and preparing for classes. First-semester nursing students are just being

introduced to these rules. Younger students may also be surprised when consequences are imposed. First-semester students need to be held accountable, but they also need some flexibility and low-stakes consequences.

In this first semester, students may begin to act like nurses. What they really achieve this semester is acting like *nursing students.* Students don the school nursing uniform and begin to carry and use nursing tools such as stethoscopes. Faculty participants observed that students begin to take on a collective identity as nursing students, distinguished from other students on campus by appearance and by the number of hours devoted to studying and to classroom, laboratory, and clinical experiences. They learn to manage the physical, cognitive, emotional, and time demands of nursing school. As the participants pointed out, nursing students are exposed to hard things that other undergraduates don't experience, and they must begin to develop some resilience.

Second Semester (Junior 2). By the beginning of the second semester, students have had some experiences with patients, families, and other members of the health care team, and have engaged in post-conference discussions and a variety classroom and laboratory or simulation experiences and assignments.

Thinking. Although still very interested in mastering hands-on skills, second-semester students are beginning to understand that nursing practice is primarily thought work. Students' worldview is beginning to broaden as a result of clinical and classroom experiences and they are starting to be more open-minded and accepting of patient choices that might differ from their own. Their thinking grows in complexity as they begin to use the separate facts and abstract knowledge from previous semesters to make connections.

Feeling. Students at this stage have taken on the identity of nursing student. They still feel overwhelmed, but are accustomed to approaching, touching, and interacting with patients.

Acting. Students still want clear direction from faculty members, and are more comfortable working with peers than working independently. Faculty members expect a higher level of accountability from these students and are less likely to accept tardiness or lack of preparation for class.

Third Semester (Senior 1). Between the end of the junior year and beginning of the senior year, faculty participants observed a developmental leap, particularly in the students' thinking and in their confidence.

Thinking. By this point, students understand that nursing thinking is complex, and that nurses with experience are considering multiple contingencies in their decision-making. Students have become more open-minded and accepting of others' values and perspectives. This semester is when "students really start putting the pieces together." In many nursing curricula, this is the semester that students take a course in critical care and have clinical experiences in intensive care units. Thinking becomes more complex as patient needs become more complex. One participant used interpretation of lab values to illustrate the increasing complexity of thinking. First- and second-semester students might need to identify normal lab values and common causes for abnormal lab values, recognize the need to alert someone of abnormal lab values, and perhaps anticipate appropriate actions to take in response to abnormal values. Third semester students in the critical care area need to consider multiple possible physiologic or pharmacologic causes for abnormal lab values, what affect these lab values will have on the patient, what adjustments they would need to make to their nursing assessment or nursing

actions, and how to collaborate with other members of the health care team in response to the lab values while respecting the patient's wishes.

Feeling. Even with the challenges of increasingly complex thinking, participants describe these students as more confident. Students start to verbalize, "I can do this."
The nervousness and excited energy of the first-semester student has been replaced with a calm demeanor and focus on completing nursing school.

Acting. Students become less dependent on faculty and instead seek out faculty only when they have questions about specific patient situations. This "delegating up" to more experienced nurses is a characteristic of advanced beginners (Benner, Tanner, & Chesla, p. 43-44). Faculty members are less inclined to answer questions for students. Instead, they will guide them to seek out information for themselves and fill in the gaps where necessary. Students at this stage take initiative to seek learning opportunities. By this point, students are accustomed to expectations for professional appearance, timeliness, and class preparation.

Fourth Semester (Senior 1). Students in the final semester of nursing school are preparing to graduate and leave the environment of faculty supervision to enter the work world. Most BSN programs include a course in leadership and management in this semester, and a capstone course in which students do concentrated clinical practice under the supervision of a nurse preceptor rather than a faculty member. Many nursing schools include a final course in professionalism. Although these courses go by different titles, they generally include opportunities for students to explore everyday ethical situations that may be difficult to navigate.

Thinking. Fourth semester nursing students understand that nursing is primarily cognitive work, and that nursing thinking is highly complex, is driven by multiple variations in context, and that there may be multiple appropriate responses in a clinical situation. Faculty participants

note that students might still be interested in practicing hands-on skills, but they are more likely to practice clinical thinking, considering contextual factors and practicing setting priorities. Students have experienced caring for patients from diverse backgrounds, and have become open to multiple perspectives and ways of doing things.

Students continue to "put the pieces together," developing the ability to "see the larger picture" of patient care during the extended clinical practice time in the capstone course. By this final semester, students have moved from a simplistic application of ethical principles to a level of comfort with the ambiguity of many ethical situations. Rather than labeling a situation as right or wrong, fourth-semester students are more likely to explore what is important to the family, educate the family members, and collaborate with other members of the health care team in decision-making, as illustrated by this exemplar:

> …back then they would look at some examples and then they would say, oh yeah, "That's not very ethical." Well then in [the senior] course we would be talking about, "Okay, now you're gonna be the nurse. And you're in this situation, it's a DNR, and the family's now looking you in the face and the person's not breathing and they're saying, "We want you to rescue them." Okay, ethically what do you need to do? I mean you have an order that says you're not to do anything. You have a family member here saying…" Then they start talking in terms of, you know I need to negotiate, I need to communicate, I need to collaborate, I need to explain things to them, I need to get the doctor back involved, and so seeing that they're coming up with those things.

Feeling. One participant noted the relationship of understanding nursing and nursing identity: "It's really later on in their senior year, when they're doing their leadership workshop where they're more on their own, that they finally start getting that identity that, 'This is what a

nurse is, and this is me. I am a nurse.'" Students at this level have developed confidence in their identity as nursing students and they are focused on completing their courses. However, at this point they also experience a regression in their confidence as they anticipate leaving school and taking on the role of Registered Nurse.

Acting. In the final semester, students typically work with preceptors in the clinical setting and faculty contact is limited to occasional site visits. In the classroom, faculty members support independent thinking and decision-making by posing questions, but not providing answers:

> Senior seminar, their senior capstone seminar, is really all about "Here are the questions, we're giving no answers." And I think that really, especially at the Senior 2 level is a good way, a good strategy for them because they know enough that they really can talk about, and they've had enough limited experiences they really can look at it and say, "Okay so here's what I saw, here's what I saw somebody else do."

Students nearing graduation are expected to behave in a manner that expresses the ethical character of a professional nurse. They are held to a level of accountability that mirrors that expected by their state licensing boards. Whereas faculty members would be uncomfortable failing a student in the first or second semester for unprofessional behavior, they are reticent to allow students who have not mastered ethical professional behavior to enter the world of clinical practice.

Graduation and Transition to Practice. The purpose of this study was to describe the formation of professional identity in pre-licensure nursing students. However, the participants often alluded to continuing formation of professional identity as student transition to professional practice. Students preparing to graduate and new graduates often experience fear and a feeling

of being overwhelmed that is similar to that experienced in their first semester of nursing school. Faculty participants consistently expressed the belief that nursing school lays the foundation for formation of professional nursing identity, but that much of the identity formation occurs in the first few years of practice. With this in mind, nursing educators try to support students by providing anticipatory guidance, letting students know that it may be some time before they feel comfortable in practice, sharing stories of their own "Aha moments" when they realized, "I am the nurse." Nursing educators stress the importance of lifelong learning by letting students know that the knowledge obtained in nursing school is only a very small portion of the knowledge they will acquire in their nursing career.

Nursing Education Practices

This section addresses the second study question, "What can nursing educators do to stimulate and support the process of formation of professional identity and everyday ethical comportment?" Nursing educators are the agents who intentionally carry out nursing education practices. Four nursing education practices emerged from the data, understanding the student, creating a safe learning environment, providing developmentally appropriate support, and using appropriate pedagogies. Figure 2 illustrates the nursing educators using these nursing practices to support the nursing students in formation of professional identity and ethical comportment. Each practice lays the foundation for the next. Broad curved arrows are used to suggest that these practices create an educational environment and that they are centered on the student.

Understanding the student. When asked what advice they would give a new faculty member about teaching for formation of identity, participants repeatedly referred to the need to know and understand the student population and the individual students. This means understanding where the students begin in terms of their existing identity as traditional/emerging

adult, adult, transitioning, and/or vulnerable students. It is also very important to be sensitive to the students' developmental state as they move through each semester of a nursing program. Some individual students have profound stressors in their personal lives. Faculty participants at the historically Black university particularly described the need to be aware of economic and social stressors in the lives of their students, so that resources could be provided and expectations adjusted where needed. Understanding the student requires being available, open-minded, non-judgmental, and willing to really listen:

> Because so many times I've met students in the course of these years, and I'm like "Uh, I don't' know if I can work with them," but you have to find where they're at and what their reasoning is behind that cold structure, 'cause sometimes it may be just their need to survive is what they're showing you, not the true person, and so sometimes you have learn the true person. So that compassion, being respectful, and able to listen and listen completely instead of just partially.

This kind of open-mindedness and sensitivity to students' individual needs provides the nursing educator with the information needed to create a safe learning environment.

Creating a safe learning environment. Formation of a new identity is a risky endeavor. It requires a period of psychological and social instability, and may entail a sense of mourning when a former identity is relinquished (Arnett, 2015; Tower, et al. 2015). The eventual development of expertise in nursing requires a full commitment to identity, which includes the willingness to take interpersonal risks to meet the needs of patients (Rubin, 2009). It is therefore critically important that nursing educators create a safe learning environment for students. Faculty participants described how they do this in a number of ways, but all depend on building a relationship of trust and caring with and between the students. Nursing educators give students

permission to make errors by explicitly explaining the potential impact on patients of not reporting errors and framing errors as learning opportunities. Nursing educators model vulnerability and use narratives of their own errors. They address issues of incivility within classes, verbalize the expectation that students will work with one another in a civil manner, and work to ensure that marginalized students have a voice among their peers in the classroom or clinical setting. Expectations for behavior are expressed explicitly to the class as a whole, but correction of individual behaviors is done in private.

Nursing educators express caring to students by getting to know their individual needs and referring them to appropriate academic or counseling support. The following exemplar illustrates the value of listening in a non-judgmental fashion and investing time in helping a student find resources:

> I have dyslexia, came through school with dyslexia, and I started noticing a pattern with [a student]. And if you read a question to her, she could answer it. If she read the question herself, then she had trouble. If she tried to answer her questions a lot of times she would get off on the little scribbling it on the Scantron…And so I went and I had a long talk with her. Come to find out she's always had trouble, but nobody had ever actually said, "This is the problem." So we talked some and she said, "This is the way it's always been," and she's an older lady, so she said, "I just thought it was just because of my age that was causing me to be stupid." And I said, "No, no one is ever stupid. It can be [possible] to change things, and we have to learn how to help you change."

This participant also encouraged the student to consult a physician for further diagnostics, consider medication for test anxiety, and seek accommodations for extended time on exams, with very positive results:

> now it's like, this whole turnaround…And she's changed her pattern of being able to study, and her grades are starting to show that process. So it just takes time.

Nursing educators endeavor to be approachable and open to questions. They also create a safe learning environment by understanding the student's developmental state and adjusting expectations accordingly.

Providing developmentally appropriate support. Nursing educators use their understanding of students' development to guide their relationship with students. Educators understand that first semester students are overwhelmed and fearful, so they provide emotional support and encouragement. They also provide clear direction as the first semester students enter the clinical environment. Senior students are offered less direction and fewer answers, and need less emotional support. Educators deliver information in accordance with the student's level of thinking. First semester students are still in the piece-by-piece phase of their thinking. Using the example of learning to interpret laboratory values, first-semester students are taught normal ranges for laboratory values and the basic causes of alterations in these values. By the third semester, faculty help these students consider lab values in a more complex patient care context and help them make multiple connections between causes of abnormal laboratory values, effects of variations in these values, possible treatments, and the potential therapeutic and side effects of these treatments.

Developmentally appropriate support may entail developmentally appropriate discipline. For example, faculty members introduce first semester students to expectations for being on time to class or completing reading assignments before class, but recognizing that these expectations are new they may be flexible in their responses when students do not meet these expectations. However, second semester students are expected to be fully prepared for class. As one

participant noted, faculty are reticent to fail students for unprofessional behavior in their first or second semester, but would be very concerned if they were seeing unprofessional or unethical behaviors as students near graduation.

The notion of faculty fit for each developmental level was a new and interesting finding. Participants repeatedly described the need for faculty in the junior year to be nurturing and flexible. In contrast, faculty in the senior year need to be able to hold students to a higher level of accountability as they prepare to enter the world of practice. New nursing educators are often expert nurses coming from clinical practice, or faculty members experienced in teaching senior or graduate students may be put in the position of teaching junior students. Participants described coaching these faculty members in developmentally appropriate expectations. Participants felt that the individual faculty member's personality determined their best fit. One third-semester nursing educator noted that she had tried teaching junior students, but could not cope with the students crying. She also described an incident when she failed to consider that a student was experiencing a patient death for the first time. Conversely, educators who teach at the junior level reported sometimes having difficulty holding students to an increased level of accountability.

Using appropriate pedagogies. Faculty implement pedagogies to help students internalize the values of the nursing profession and to develop an interconnected set of skills and behaviors that express those values. The most frequently described developing skill was critical and independent thinking. Students are also expected to develop critical self-awareness, including awareness of biases and of gaps in knowledge, and to respond to these self-critiques by changing themselves, adopting new attitudes and behaviors, or by seeking out information and help. Students need to develop communication skills and practice skilled patient interviewing

and negotiation. They also need to begin to learn skills for conflict resolution. Finally, students are expected to work effectively with teams of diverse individuals.

A number of pedagogies that support formation of professional identity emerged from the data. I have grouped these pedagogies into five categories, communicating expectations, modeling, pedagogical caring, experiential learning, and reflection. I describe each of these and how they relate to one another.

Communicating expectations. The simplest and most straightforward pedagogy is communicating expectations. Faculty participants explicitly identified behaviors that were expected of students in the clinical and in the classroom setting. Some of these behaviors were very objective and measurable, such as appropriate dress and being on time. Others were more subjective, such as expectations for mutually respectful communication and appropriate boundaries in relationships with faculty members. Faculty participants at some of the schools are developing evaluation forms or disciplinary forms with very specific descriptions of unacceptable behavior, such as eye rolling. Participants found that they needed to clearly describe expectations for use of cell phones and laptops in class and for use of social media. Educators also explicitly articulated the values of the nursing profession, such as valuing the dignity of every human being or the importance of lifelong learning.

Modeling. It is clear from the data that faculty believed modeling is the most powerful and effective way to teach for formation of identity. Although faculty participants did not use the phrase *everyday ethical comportment,* they are in fact modeling comportment, showing students how to behave in ways that express caring and other important values in nursing. Faculty deliberately use modeling in a number of ways in both the clinical and academic settings. None of the participants discussed modeling technical skills in the patient care setting. Instead,

they described modeling communication, caring and respect at the bedside. They also modeled clinical judgment by thinking out loud for students or reviewing how they made clinical judgments. Faculty participants also modeled a number of important aspects of working with the healthcare team, including how professionals address one another and communicate with one another, and how professionals confront and resolve conflicts. Faculty participants modeled collaboration in the academic setting by working together, verbally acknowledging each other's contributions, and speaking positively about one another in front of the students.

Sometimes doing the right thing involves taking some personal risks, and nursing educators also modeled this for the students. One participant described responding to a patient who was having a seizure in a hallway. Only one of her clinical students was present to see her interventions, but all ten students were in post-conference where she shared her insecurity about steps she had missed and fear that the patient may have had a do-not-resuscitate order. Nursing educators modeled making mistakes, using these opportunities to show that human error is inevitable and that admitting mistakes and addressing their consequences is critical for safe patient care.

Students are also exposed to nurses and other members of the healthcare team who may be good models or poor models. Students are very ready to report bad modeling, and educators deliberately used these incidents to help students explore acceptable variations in approach to care versus unsafe care. These were also opportunities to model confronting bad practice, and to guide the students to reflect on what their own choices for practice would be.

Finally educators used modeling to help students learn how to cope with the rigors of nursing education and with future life as a practicing nurse. Narratives of clinical situations will be discussed later, but there is another form of narrative educators reported using: the personal

narrative. Nursing educators tell their own stories of overcoming obstacles to completing nursing education. These narratives are particularly important to vulnerable and historically disadvantaged students, especially when the faculty member shares the background of the student, as described by one participant:

> Without any kind of those people that I seen that said, "Okay one day I want to be like you" that had shared their journey with me and helped me through, I don't know if I would be where I'm at, so I try to share pieces with them without them knowing all my personal history,…but just, okay "I've been in your situation, I understand." Now I don't understand every single one, but I've had quite a bit of experiences that I can relate with them with, to just kind of push them along, say, "I know this is foreign, this is different. You might not know what's gonna happen at the end of the line, but I can let you know where you will end up being," and serve as that example for them. I get a lot of the comment of, "She gets me." …I guess it's because they feel like, "Okay well she's been where I've been and she understands."

Nursing educators also use personal narratives to model work-life balance, self-care, and personal resilience in the face of difficult circumstances.

Pedagogical caring. Pedagogical caring is the deliberate integration of a caring ethic into the teacher-student relationship (Hawk & Lyons, 2008; Hult, 1979; Owens & Ennis, 2005). It requires investment in that relationship, knowing and adjusting to individual student needs, an other-centered focus on the needs of the student, and engaging in dialogue with students. In other words, nursing educators teach caring by caring for and about students. Faculty participants described many examples of listening to a student, learning about that student's individual needs, and helping that student find support resources. Nursing educators model how to build a

therapeutic relationship by meeting with a student who is vulnerable or in distress, listening to the student, and allowing him or her to cry. The educator also models the way nurses access resources by referring students to academic support or counseling resources.

Pedagogical caring is powerful modeling. It is also critically important to creating a safe learning environment. Just as patients who experience uncaring nurses will feel unsafe in a health care environment, students who experience teachers who are inflexible, insensitive to their individual needs, or overly critical will not feel safe enough in the learning environment to take the risks that are necessary for formation of professional identity (Clark, 2013).

Experiential learning. There is no doubt that immersion in the clinical environment is where students really start putting the pieces together. In this environment, nursing educators help students navigate variations in context, using situated coaching to give students focused guidance on how to think and behave in particular situations (Benner, et al., 2010). However, students spend more hours in skills and simulation labs and classrooms than they do in clinical settings. Benner et al. (2010) recommended that nursing educators work to make teaching in these settings meaningful by helping students develop *clinical imagination*. Faculty participants used several strategies in classroom settings to situate students' thinking in the real world of clinical practice. Narrative, or story telling was very useful. Faculty participants described episodes from their own practice experiences or invited students to share clinical experiences with the whole class. These narratives served as vicarious experiences that nursing educators could use to guide students to think about appropriate responses and ethical implications. Narrative in the form of video clips from movies or YouTube videos were also frequently used. Simulation and case studies situated students' thinking in the clinical realm, requiring them to practice gathering information and making decisions about patient care.

Teamwork in the classroom can also be viewed as experiential learning. Students experienced solving problems in a group of individuals with diverse experiences and viewpoints. Faculty participants deliberately put students in teams that required them to work with others from different backgrounds or who had different life experiences. Effective teamwork in the classroom required the same attitudes of open-mindedness and mutual respect as effective teamwork in practice. At times, educators needed to guide students in changing their perspective about the peers they were working with. For example, international students experienced some discrimination from peers because their language skills caused them to read, think, and communicate more slowly than the rest of the group. The faculty member challenged the American students to consider whether they themselves could master the fluency to read a textbook in another language.

Reflection. Internalizing values and adopting new attitudes are moral choices that occur when students think about their experiences and decide which attitudes and behaviors to adopt (Lewin, 1999). Reflection involves purposefully thinking about experiences and deciding how to interpret them. This thinking may result in changes to future approaches to experiences. Reflection also serves to raise self-awareness and to evaluate one's effectiveness in the interpersonal relationships necessary in nursing practice (Bulman & Schutz, 2013).

Faculty participants sometimes created assignments for individual reflection by students, such as journals about clinical experiences. In one example, students were assigned a paper to write comparing two very different approaches to maternity care, the midwifery model described in a book written by a midwife, and the medical model they observed in hospitals. The assignment resulted in the students internalizing the value of patient advocacy:

> I have yet to have one student say, ”This one way is perfectly right, or this one way is perfectly right.” They generally have a meeting in the middle, but what they really walk away with is patient advocacy, and that’s just not what I was expecting, but it was a great bonus, because they really walk away with, ”I really want patients to know what their choices are, and I want to support them in what they want.”

Students engaging in scholastic dishonesty or uncivil behavior were sometimes assigned written reflections with the goal of helping them understand the implications of their choices and adopt ethically sound attitudes and behaviors.

Faculty participants also frequently engaged students in verbal reflection through dialogue. This might occur one-on-one as in the case of a student who was struggling with how to value and respect a prison inmate who was under her care. Group reflection occurs in discussions of clinical experiences during post-conferences and in the classroom. Dialogical reflection also occurs when nursing educators assign students to research and debate a controversial topic. Helping students move from casual conversations and shallow thinking to deep individual and group reflection requires posing the right questions.

Nursing educators facilitate real reflection by formulating questions and letting students seek out the answers, a pedagogy historically known as *Socratic questioning.* Paul and Elder (2006) offer the following definition:

> Socratic questioning is disciplined questioning that can be used to pursue thought in many directions for many purposes, including: to explore complex ideas, to get to the truth of things, to open up issues and problems, to uncover assumptions, to analyze concepts, to distinguish what we know from what we don’t know, and to follow out logical implications of thought. (p. 2).

Nursing educators in this study used Socratic questioning to cause students to reflect and ultimately to form their professional identities. One participant with many years of experience teaching in different settings put it this way:

> I think you then ask questions well. So that you don't give them answers. You ask them the questions that cause them to think because I don't think they can change internally if they haven't done the work of figuring it out. And so if you ask the questions well it causes them to have to think through "Why this way and not that way?" "What was the impact of this if I then do this?" So I think if I want to change the way they are actually internalizing something they have to do the head work themselves in their own head. And so I can't give them information. I have to ask the right questions to cause them to find the information, to find those answers. I think that happens in the classroom and in the clinical setting. Asking the right questions to cause them to find their own answers.

As this participant notes, skillfully formulating questions is important. It is equally important that students be allowed to do the thinking themselves rather than having answers provided by their teachers.

Correcting behavior. Ideally students enter and go through nursing education with character traits such as honesty, integrity, and the courage to admit mistakes. However, in the view of the participants, sometimes the stresses of nursing school exceed students' existing moral capabilities. In other cases, students simply have not had appropriate behaviors modeled for them. In the words of the faculty participants, some students wanted to do the right thing, but "they just didn't know how to behave." Participants at some of the sites described group cheating incidents in which students accessed exam questions either from other students or from the Internet. The cheating itself was of concern, but so was the failure to acknowledge the

wrongness of cheating or to report it to faculty. Participants also described students engaging in unprofessional or uncivil behaviors such as dressing inappropriately, being late, using digital devices rather than paying attention to patients or lecturers, discriminating against classmates, getting defensive or yelling when conflict arose, and in one case sexual harassment. Vulnerable students in particular struggled with appropriate problem solving and responses to authority, as in this exemplar:

> Well one of our students has a very difficult time controlling her attitude. She doesn't really know how to respond appropriately. Something in her upbringing… she had a very rough upbringing where she had to be very defensive, so she challenges authority. As far as professional boundaries or your chain of command, she doesn't respect them like she's supposed to 'cause she didn't really have the parental figures in her life to learn how to do that. So teaching her how to go up the chain of command, how to approach conflict without being derogatory, which is very unprofessional and can cost you your job, and how not to lash out at students, non-verbal communication, how that is perceived.

Faculty participants have realized that it is unrealistic to assume students know what attitudes and behaviors are expected of the professional nurse. Such assumptions are also inadequate for forming professional identity. Faculty members at some of the schools have begun addressing these behaviors by first examining the behaviors they themselves were modeling and changing them when appropriate. Some have also constructed or adopted evaluation forms, grading rubrics, or performance improvement plans that address professional behaviors. In the two cases of group cheating incidents, the dean spoke directly to the entire class about expectations for the remainder of their time in nursing school. Participants mentioned the importance of being very clear and direct about which behaviors are wrong, and

what the implications of these behaviors would be if these behaviors continued in the workplace. When needed, students were given clear instructions on how to behave appropriately. Some students required referral for counseling to address internal needs that were driving inappropriate external behavior.

Faculty participants preferred to correct students in private, although some issues such as one group of students discriminating against another were addressed in the classroom with student groups. Some students were directed to write reflection papers, with mixed results. Some reflection papers resulted in the student accepting responsibility for their actions and making plans to improve. Other reflection papers indicated that students still didn't believe they had done anything wrong. Participants were skeptical that students who didn't accept responsibility for their own wrongdoing would be safe and ethical nurses in practice.

Despite the implications of bad behavior, faculty participants also described their own failures to correct behavior. It was clear that most felt uncomfortable correcting behavior, for a number of reasons. Some felt that they had contributed to the student behavior through inattention or inexperience. Several had fears of damaging the teacher-student relationship. In some cases, students were so resistant to correction that they did not improve despite the best efforts of faculty teams working with them. The lack of clear tools for measuring and documenting unprofessional behavior was a frequently identified barrier. Finally, faculty participants identified the difficulty of failing students for unprofessional behavior due to a lack of administrative support. Students consistently prevailed when they appealed failing grades. With equal consistency, these same students failed to complete their nursing education or pass the licensure examination.

Barriers/Supports to Teaching for Formation

Participants were asked an additional question, "What makes it easier or harder to teach for formation of professional identity?" They identified several factors related to student characteristics, curriculum, and administrative support. Faculty participants felt that the nature of the student population made a difference in formation. Helping traditional students form a professional identity was easier because they have not yet fully formed their personal identities, and because they are more likely to have the time to devote exclusively to their education. Adult and transitioning, students have the challenge of relinquishing and reforming parts of their identity, and have less time and energy to devote to their formation because of family and work responsibilities. Vulnerable students must overcome personal barriers to form a professional identity, and may require intensive faculty support. However, faculty participants appreciated the availability of resources to support these students. Diverse groups of students with varying backgrounds and life experiences were perceived as more challenging to teach than homogenous populations. Teaching for formation was also perceived as more challenging in the first semesters when students have made few connections in their thinking and are still focused on tasks and skills, leading faculty to focus more on professionalism in the senior year.

Participants described the value of a cohesive teaching team and the importance of understanding what is taught at each level of the curriculum when teaching for formation of identity. As one participant noted, "I think when you have a faculty that grasps teaching across the continuum and they work together well you can thread it through the curriculum better." In smaller programs, faculty members might be very aware of the changes students go through because they teach beginning and graduating students. In larger programs, faculty members tend

to teach in only one year or semester and need to make a concerted effort to understand the work of their colleagues.

Time constraints were frequently identified as a barrier to teaching for formation of identity, either due to faculty student ratio or to pressure to include enough content in a course. A number of participants shared concerns like this one:

> And it's hard in our curriculum. We have a lot of stuff we have to cover so they can pass NCLEX [National Council Licensure Examination]. You know, that stuff's not on the NCLEX. I mean, not really, not that I can think of. Um, so it's hard to carve out time for things that aren't tied to our outcomes.

This comment highlights another barrier. All participants believed formation of professional identity was important, but many noted that it is hard to measure. It is therefore hard to "tie to outcomes." Nursing educators and especially those newer to the faculty role are likely to focus their time and attention on the more measurable cognitive skills.

Addressing professional identity formation was perceived as a more nuanced part of the educator role. Therefore faculty experience was described as an asset in teaching for formation:

> I think professional formation is the biggest part of our job, but I'm not sure all faculty realize that. Until they've been in it… I think more experienced faculty start to get it after about five years.

Nursing educators new to the faculty role often come directly from clinical practice where they have developed expertise in nursing thinking and patient care, but lack experience in educating students. As expert clinicians, new nursing educators are not likely to be sensitive to the learning needs of new students or to have the skills to address problematic student attitudes and

behaviors. It was clear in the data that only the most experienced participants felt comfortable correcting student behavior.

Finally, the role of the nursing school administrator was an important factor in teaching for professional formation. Faculty participants perceived some administrative actions as supportive of teaching for formation, and others as barriers. Faculty participants were troubled when administrators overturned student failures. Several participants described situations in which student failures due to unprofessional behavior in the clinical setting were overturned. In one such case, an instructor assigned a failing grade when she observed a student playing games on her cell phone when she was assigned to monitor a psychiatric patient. When confronted, the student failed to accept responsibility for her actions and described the psychiatric patient population using disrespectful terms:

> She passed, where I did not want her to. And that's what I found out, is that during their senior year they don't want to fail anybody. And, in clinical or in whatever, and I'm like "No if they can't meet their expectations or their clinical objectives they shouldn't pass."

To their credit, instructors and administrators worked together after this incident to develop clinical evaluation tools that clearly addressed professional behavior.

Faculty participants also described the impact of administrative support on teaching for formation of identity. One participant described the role of her dean in supporting the use of innovative pedagogies:

> I was fortunate to have a dean, who when I would learn something in class, she would let me experiment with it in the classroom, and so I've done a lot of the like flipped classroom and gaming and all kinds of stuff to see what would help my students the most,

and she was okay with it. I was thankful, 'cause it could have been something totally different. I could have had a dean who said, "No, get back in there and lecture." Participants also described the importance of the dean in providing resources such as continuing education, balanced workload, and time for professional development. Faculty participants appreciated deans who advocated for them and provided emotional support, affirmation of their work, and who created civil working environments.

Summary

I have described a beginning theoretical framework for formation of professional identity in nursing students based on the perspective of nursing faculty members at a diverse group of universities. I have described the characteristics and identity formation tasks of traditional/emerging adult, adult, transitioning, and vulnerable students as they enter a nursing program. Over the course of the nursing program, students learn to think, feel and act like nurses. They learn that nursing practice is primarily cognitive and they expand their worldview, becoming more open-minded. Their clinical and ethical thinking gradually becomes more complex. Students develop confidence and begin to think of themselves as nurses, functioning with increasing autonomy and accountability for their actions. Nursing educators facilitate these changes by understanding the student, creating a safe learning environment, providing developmentally appropriate support, and using appropriate pedagogies for formation of professional identity and everyday ethical comportment.

Application of this framework to guide nursing education practice has a number of implications. This research has also raised a number or related questions about formation of identity in various populations of nursing students. Implications and questions for further research will be discussed in chapter 5.

CHAPTER 5

Implications

Theory development began with the Framework for Apprenticeship in Formation and Ethical Comportment (FAFEC, Figure 1) that was developed deductively based on scholarly literature. The purpose of this study was to begin developing a theory of formation of professional nursing identity grounded in data. In this study nursing educators' perspectives on formation was investigated.

Interpretations

The process of forming a professional nursing identity is the process of "putting the pieces together," making more and more connections and adding layers of complexity to nursing thinking. The major findings in this grounded theory study include nursing educators' perceptions of both the characteristics of the students entering the program and of students at each developmental stage of the nursing program. The educators perceive that students undergo significant development in their thinking, acting, and feeling like professional nurses. Students' thinking changes in the way they understand nursing, their worldview, the complexity of their thinking, and the sophistication of their ethical thinking. They are progressively seen as feeling more confident, and they begin to act in ways that express autonomy and accountability. Nursing educators support and facilitate this process by understanding the student, creating a safe learning environment, providing developmentally appropriate support, and using appropriate pedagogies for formation of identity. Administrators support nursing educators engaging in these activities to teach for formation of professional nursing identity. Among the concepts in this theory, *understanding the student* and *providing developmentally appropriate support* stood out as significant teaching activities. The emphasis on these two points is consistent with

literature on formation of professional identity in other disciplines (Cruess, et al., 2014; Hamilton, 2011). Participants also described a variety of pedagogies for formation, barriers and supports to teaching for formation, and the challenges of correcting student behavior.

These findings align nicely with previous studies on education for formation of identity. Enns (2014) dissertation *Finding My Own Way* was the only recent grounded theory study of formation of professional nursing identity. Enns interviewed nine graduate nurses within their first year of employment about their experiences as students and new graduate nurses. Similarly to "putting the pieces together" in the current study, Enns noted that students began feeling more like nurses in the senior year when they began to "see the bigger picture" (p. 56). She noted that the identity of *nursing student* was temporary and distinct from professional nursing identity. As with the current study, Enns found that students developed a more accurate understanding of nursing, moving from a task-orientation and a simplistic view of nurses as a comforting presence to an understanding that nursing is knowledge work with a high level of accountability. Students needed nurses and faculty members to be empathetic, supportive and approachable. Failure to understand the student's perspective was a barrier to building a teaching relationship. Student participants in Enns' study described harshly punitive responses when they made mistakes, in contrast to the faculty participants in the current study who described the importance of creating a safe environment to make and learn from mistakes. Like the participants in the current study, student participants in Enns' study described exposure to good and poor role models. Student participants described the need to reconcile "incongruent behaviors" (p. 54) with nursing values and to make personal practice decisions based on these reflections.

The findings of the current study are consistent with the ongoing research describing the process of nurses moving from novice to expert. Benner, Tanner, and Chesla (2009) state

emphatically that it is not possible to complete nursing school and remain at the novice level. The novice phase occurs in the first year of nursing education. In this phase, nursing educators break information down into pieces that students can understand, with limited references to variations in context. Students are taught theoretical principles and rules to help them begin to interpret clinical situations. New graduate nurses are advanced beginners, and they begin to display some characteristics of advanced beginners in their senior year, such as an increasing sense of agency and the practice of *delegating up*, meaning asking for and relying on guidance from more experienced nurses. The basic social process described in the current study is *putting the pieces together*. However, because new graduate nurses are still advanced beginners, it might be more accurate to say that undergraduate students *begin* to put the pieces together. Benner et al. and their study participants use similar descriptions of developing clinical competence, noting that new graduate nurses who are still advanced beginners "cannot see 'the big picture,'" (p. 31) have a "fragmented or partial grasp of the patient's condition" (p. 31), and "perceive clinical situations as procedural or theoretical puzzles" (p.33). Consistent with the view of faculty participants in the current study, Benner et al. note that new graduates are still in the process of forming their professional identities.

The findings in the current study indicate that as students approach graduation and entry into practice without the support of their nursing faculty, they experience a return of anxiety that approaches what they experienced in their first semester. In the words of Benner et al. (2009), this translates into a "temporarily incapacitating anxiety" (p. 27) in the newly hired advanced beginner. This puts new graduates in the position of needing to act like a nurse without really feeling like a nurse. New graduates then rely on thinking like a nurse to interpret clinical situations and internalize knowledge and skills. Benner et al. (2009) also strongly advocate the

use of narrative pedagogy in nursing education. They recommend the use of two types of narrative: the clinical experience narrative of experienced nurses described earlier, and the use of patients' illness experiences. The need to focus more attention on an integrated approach to forming professional nursing identity, including the use of pedagogies such as narrative, was were further elucidated by Benner and colleagues (2010) in the Carnegie study.

The Carnegie studies on preparation for the professions culminated in the publication of *Educating Nurses: A Call for Radical Transformation* (Benner, Sutphen, Leonard, & Day, 2010). This was a large, national mixed methods study that included on-line surveys of 10,000 nursing faculty and students and interviews and focus groups at nine exemplary schools across several levels of education. The purpose of the study was to identify signature pedagogies in nursing education, and to provide recommendations for teaching for clinical competence and formation of identity. This was a key publication in informing my research questions, and my study results are consistent with those of Benner et al. in several ways. Consistent with the description provided by Benner and colleagues, faculty participants in the current study "deliberately foster the student's movement from a lay person's understanding of what nurses do to an insider's professional understanding of being a nurse and thinking like a nurse" (p. 179). As recommended by Benner et al., faculty participants in the current study are working to integrate classroom and clinical experiences to provide students with a sense of salience for what they are learning. Nursing educators are choosing pedagogies that situate students' thinking in the clinical arena. The pedagogies described in both studies include experiential learning, helping students develop clinical imagination, narrative, modeling (including modeling how to handle mistakes), leveraging poor modeling as a learning experience, individual reflection, and group reflection such as that done in clinical post-conferences.

Limitations

This study is limited by the small number of faculty members interviewed (12) and the relative homogeneity of the sample. There were no male participants, most of the sites had very homogenous student populations, and the interviews were conducted within a limited geographic area in the southern part of the U.S.

Theory development is an ongoing process. Over 130 codes were generated during initial coding, and new codes were generated through the last interviews. Interviews at the site with the most diverse student population were conducted and coded last, which may have contributed to new codes being generated at the end of initial coding. However, these new codes were subsumed into earlier codes during axial coding. Saturation in grounded theory also requires a full exploration of the properties and dimensions of each concept. There is adequate data to explore the properties and dimensions of some concepts, such as *modeling*. Other concepts, such as *vulnerable students* bear additional research. Theoretical sampling will can be used to explore properties and dimensions during ongoing grounded theory development.

Finally, this grounded theory study was explored from the perspective of faculty members, not of the students themselves. The perspective of faculty is necessary in forming a theory that explains formation of identity as a social process that occurs between educators and students. However, the theory is incomplete without the voice of those who are forming their identity – students and new graduate nurses. Ongoing development of this theory will integrate research on the perspectives of nursing students and new graduates as they transition into practice.

Implications for Nursing Educators

The aim of this study was to provide a beginning theory in order to help nursing educators understand the process of formation of professional nursing identity and their role in facilitating and supporting this formation. The practical application of this theory for nursing educators lies in how we interact with students and how we use effective pedagogies, such as those described in Chapter 4. Perhaps the most important findings in this study were the emphases on understanding the student and teaching with sensitivity to the students' developmental stage. In the next sections I discuss the implications for the nursing education practices of understanding the student, creating a safe learning environment, providing developmentally appropriate support, and using appropriate pedagogies. I include discussion of other theories that are pertinent to these practices. I conclude by describing implications for administrative support and identifying additional research questions.

Implications for Understanding Students

Emerging adults. Nursing educators would benefit from exploring some additional theoretical frameworks related to the findings in this study. Of particular interest is Arnett's (2015) work describing *emerging adults* as a developmental phase. In my experience as a university educator, there has been a lot of attention to adult learning theories. However, as participants have pointed out, many undergraduate nursing students do not fit the description of adult learners. Despite the significant numbers of emerging adults among nursing students, there are few studies on this population in the nursing education literature. A search of Google Scholar and the CINAHL and ERIC databases revealed a few such studies in other disciplines, and several on risk behaviors in this group, but no publications that directly addressed emerging adult nursing students. Arnett (2000) proposed that emerging adulthood is a developmental phase

starting at the age of 18 and ending somewhere between the ages of 25 and 29 when a sense of responsibility, self-sufficiency and financial independence is achieved (Arnett, 2015). Understanding the identity explorations of emerging adults would help nursing educators support students in forming a professional nursing identity. Committing to a professional nursing identity requires taking some personal risks (Rubin, 2009) and students in this developmental phase are willing to take risks in their identity explorations. They are exploring identity in three domains, love, work, and worldview. Expanding the worldview of nursing students and helping them understand the nature of nursing work are two important aspects of developing professional nursing identity. They want to do meaningful work that is a good fit for their identity. They are focusing their energies on their developing selves, on understanding who they are, and on developing life skills. This season of self-focus is an ideal time to engage in the reflection and developing self-awareness that are necessary for forming a professional nursing identity.

One of the frequent concerns expressed by faculty participants about professional behavior in this group related to the use of digital devices at inappropriate times. However, as Arnett (2015) points out, students in this age group have lived with technology their whole lives, and they tend to use technology in ways that build their social relationships. As nursing educators, we need to be sensitive to the role of technology in connecting students to their social support. I am not suggesting that we accept unlimited use of digital devices. We do need to help students understand how inattention to a person in favor of a digital device is perceived, but perhaps we need to do a better job of framing this in a way students will understand. Rather than taking an immediately punitive approach, we can use observations of escalating technology use as a signal that students may be experiencing heightened stress. A conversation from this stance provides an opportunity to build trust and address student needs while still setting boundaries on

behavior. We can also acknowledge and affirm their abilities to use technology skills in acquiring information, and guide them in skillfully choosing and using this information. Comfort with technology use also suggests that emerging adults can readily adapt to the technological demands of contemporary nursing care.

Vulnerable students. Vulnerable students described in Chapter 4 may come from environments of abuse or with significant barriers to pursuing higher education and a professional career. Vulnerable students may be traditional, adult, or transitioning students. Formation of a professional nursing identity is a particularly high stakes endeavor for these students because becoming a professional can transform their lives, allowing them to move to a life of social and economic stability. Arnett (2015) highlights several factors inherent in nursing education that can contribute to such a transformation. Cognitive abilities, a necessary prerequisite to nursing education, and participating in higher education were important factors in helping vulnerable adults transform.

Nursing educators can impact the third critical factor for these vulnerable individuals: having a person in their lives who cares about them, who can "provide support, encouragement, information, and guidance" (Arnett, 2015, p. 294). Faculty participants in the current study described such caring activities as they engaged with vulnerable students. It is therefore important that we as educators use our skills in assessing and building trusting supportive relationships with these students, while maintaining appropriate boundaries, much as we would with vulnerable patients. We might serve these students better by exploring what is behind inappropriate or unprofessional behaviors before imposing consequences. Again, I am not suggesting that we accept behavior that is clearly unprofessional. What I am suggesting is that we assess the gaps in students' personal identity formation and help them find the training or

other resources they need to grow and change. We need to raise our own awareness of campus and community resources to support students, and collaborate with university administration to enhance those resources.

Adult, transitioning, and diverse students. As noted by my participants, the majority of undergraduate nursing students are emerging adults. However there are still a number of adult students with multiple roles competing for their time and energy. As one participant put it, compared to traditional students, adult student "sometimes go further and achieve the same point but they're coming from a different direction." We need to be sensitive to the needs of these students in balancing their multiple roles and understand that a good part of their growth involves understanding health and the health care system. Students who have more life experience often have personal experiences with the health care system. We can make use of those experiences as a starting point to help them understand nursing practice.

Students transitioning from another health care occupation also come with a mental framework of how health care works and model of thinking that they have mastered. We need to be sensitive to the difficulties of relinquishing a hard-earned identity to take on a new identity as a professional nurse (Tower et al., 2015). Learning to think like a nurse typically requires increasing complexity in thinking. We will be better at helping these students transform their thinking if we understand the role they are coming from. We can model interdisciplinary respect by respecting their experience, learning *from* them, and being gentle in the way we guide them to new thinking. As one of the participants suggested, we can also show respect to these students and enhance their civility in the classroom by taking advantage of their experiences and encouraging them to help their classmates learn.

Finally, there are implications for teaching in settings with larger or more diverse student populations. The size and characteristics of student populations vary greatly across the US. Some nursing classes have fewer than 20 students; others have well over 100. Some have very homogenous populations; others have students with great diversity in age or students from a variety of countries and cultures. There are challenges in implementing pedagogies to simultaneously meet the needs of students with different life experiences. These challenges are not insurmountable, but they require creativity and a commitment to understanding students in their individual contexts.

Implications for Creating a Safe Learning Environment

Formation of professional identity requires that nursing educators engage in "a skillful mix of support and challenge" (Wald, 2015, p. 702). Nursing educators have the challenging task of simultaneously creating a safe learning environment and pushing students out of their comfort zone. Developing a new identity is a risky endeavor (Rubin, 2009; Lewin, 1999). It requires relinquishing the known and stepping out of one's comfort zone. Taking on a new identity requires significant personal risks, but those who do not fully invest themselves in the formation of an ethical professional identity will never develop fully into expert nurses (Rubin). Nurses are expected to have a high level of critical self-awareness, to notice and set aside personal biases, to admit when they lack knowledge or when they have made an error (American Nurses Association, 2015). Faculty participants regularly asked students to be vulnerable and open with faculty and peers when exploring their own responses to new and difficult situations. Students are expected to change themselves based on what they learn in these reflections, relinquishing familiar and perhaps deeply held beliefs to take on new attitudes and behaviors. They are expected to begin this deep personal growth even as they are entering the overwhelming

demands of first semester nursing school and the perplexing complexity of clinical practice settings. It is therefore critical that nursing educators become skilled in creating an environment that is safe for these explorations of identity (Benner, Tanner, & Chesla, 2009). *Pedagogical caring* and promoting classroom civility are two important activities described by participants and further supported within the education literature.

Pedagogical caring/respect. The concept of pedagogical caring appeared in the initial review of the literature within the medical education literature (Mann, 2006). Additional searches for literature on this concept were conducted during data analysis. Essentially, pedagogical caring means skillfully caring for and about the student in ways that are appropriate to the teacher-student relationship (Hult, 1979). Essential features of pedagogical caring include recognizing and valuing the student as an individual with sensitivity to the student's individual needs (Hawk & Lyons, 2008; Hult, 1979; Owens & Ennis, 2005; Wentzel, 1997), caring for the students as a group (Hult); open communication through regular dialogue (Hawk & Lyons; Owens & Ennis; Wentzel), and modeling respect of all persons during interactions with students (Hawk & Lyons; Hult; Wentzel). The value of pedagogical caring in nursing education is enhanced by the fact that these features mirror the caring attitudes and behaviors fundamental to professional nursing identity: understanding the individual or patient population in their unique context, using communication skills to establish trust, and respect for the dignity of all persons. Pedagogical caring therefore serves the dual purposes of creating a safe environment for learning and of modeling caring to nursing students. There is one feature of caring in the teacher-student relationship that differs from caring in the nurse-patient relationship, and that is the need to regularly evaluate performance. Evaluation is part of pedagogical caring, and students identify constructive feedback and praise from teachers as caring behaviors (Hult; Wentzel).

Despite the apparent value of pedagogical caring in education for formation of professional nursing identity, a search of Google Scholar and the CINAHL and ERIC databases revealed that there is a dearth of research on the topic in the nursing education literature. Most descriptive and research literature on pedagogical caring is written in the context of primary and secondary (K-12) education. Only a few articles on pedagogical caring in higher education and in medical education have appeared within the last ten years. This concept bears additional exploration in nursing education.

A caring environment supports a feeling of safety for students. An uncivil environment decreases feelings of safety and impairs communication (Clark & Springer, 2007; Rosenstein & O'Daniel, 2005). One faculty participant in this study noted that students avoid communicating with faculty members who are unapproachable or overly critical. Another described taking measures to address faculty attire and e-mail communication before expecting students to take on these professional behaviors. As nursing educators, we need to begin with ourselves in creating a civil learning environment. We need to be aware of behaviors that are perceived as faculty incivility and correct them. Incivility between students in the classroom also needs to be addressed. Several participants expressed discomfort in correcting student behavior, particularly in front of the class, pointing to the need to develop educator's skills to confront and correct student incivility.

Implications for Providing Developmentally Appropriate Support

Providing developmentally appropriate support was the clearest and most consistent concept that emerged from the interview data in this study. Consideration of a patient's developmental state is part of the complex, context-driven thinking inherent in nursing. We need to apply developmental thinking to our students, giving intentional and careful consideration to

their developmental states as we decide what and how to teach them (Cruess, et al., 2014; Hamilton, 2011). This requires understanding the individual student's context as well as the characteristics of thinking, acting, and feeling like a nurse that are usual for each phase of the nursing program. We need to view the courses that we teach not in isolation, but in their place along a developmental continuum. As noted by several faculty participants, collaboration and open communication between the faculty members across the curriculum facilitates understanding of student development and continuity in education. We need to align expectations with students' developmental states and make those expectations explicit. Nurses with clinical expertise who are new to the faculty role particularly need to be oriented to appropriate developmental expectations. Finally, we need to choose our words and how we talk about students carefully. Rather than saying, "These students can't think critically," we need to reframe our thinking to "My students are thinking/feeling/acting in a developmentally appropriate manner, and my job is to facilitate their growth to the next level."

Likewise, discipline and correction should be developmentally appropriate when students deviate from the expected path toward formation of professional identity by engaging in unprofessional behavior or scholastic dishonesty. I propose that members of a nursing faculty work together to develop shared expectations and appropriate disciplinary procedures for each level. There is also a need for clear, consistent procedures for documenting infractions. All this should be done with a view toward helping a student correct behavior and attitudes so that the student can ultimately form an ethical professional nursing identity. However, clear documentation can also serve to support removing students who fail to correct their attitudes and behavior and engage in repeated unprofessional behavior. Nursing educators also need to build their skills and comfort level in confronting unprofessional behavior. As noted above,

participants reported discomfort with confronting students, and this at times led them to avoid appropriate discipline.

Implications for Using Appropriate Pedagogies

Nursing educators have focused teaching strategies on developing analytic thinking skills (Benner, Sutphen, Leonard, & Day, 2011). The assumption seems to have been that adopting nursing values and forming a professional identity is implicit in the experience of nursing students. Given the importance of formation of identity in creating skilled nurses who practice ethically, I suggest that these activities need to be *explicit*. There are a number of pedagogies for formation in the literature, and several are described in this study, such as modeling, using narrative, and reflection. Nursing educators need to learn to use these with skill. To guide effective reflection, we need to work on our skills in Socratic questioning by learning to formulate questions that are "*systematic, disciplined,* and *deep"* (Paul & Elder, 2005, p. 2). Nursing educators can also actively engage in developing, researching, and disseminating innovative instructional strategies. Effectiveness of existing and new pedagogies needs to be researched. Several faculty participants identified difficulty in measuring outcomes related to formation of professional identity as a barrier to teaching. This requires developing clear instruments and other measurement strategies, such as narrative analysis of student reflection papers to evaluate student progress in formation of professional identity.

Administrative Support

Success in implementing this model requires the support of deans, directors, and other university administrators. Participants discussed two areas of support. Student failures for unprofessional behaviors are regularly overturned, leaving educators feeling that administrators

do not support their judgment. Participants expressed a need for affirmation from their deans, especially when student disciplinary actions were overturned by university-level committees. Participants described the positive support they received for using innovative teaching strategies and the value of resources to support continuing professional development.

Additional Research

This study was focused on development of professional identity in pre-licensure students in campus-based programs seeking the Baccalaureate of Science in Nursing (BSN) degree. Limitation to this specific population leaves a number of questions unanswered. How much formation occurs in associate degree nursing (ADN) programs? What additional formation occurs when graduates of such programs return to school to earn a BSN? The nursing shortage and the drive to increase the number of baccalaureate prepared nurses has led to the implementation of accelerated and on-line nursing programs. Given the importance of allowing adequate time for a student to form a nursing identity, do accelerated programs allow enough time for formation? If formation is a social process that occurs in the milieu of a teacher-student relationship, how can faculty in an on-line environment build these relationships and facilitate formation of professional identity? Is there more incivility in the on-line environment? If so, what are the contributing factors and how can civility be fostered in on-line learning?

Participants in this study and a number of scholars agree that formation of professional identity is not complete when a student graduates from nursing school. How much formation occurs in the transition to practice phase? How long does it take? What can be done to facilitate the ongoing process of formation of identity when new graduate nurses enter practice?

Other questions arose from the data. Several of the participants who had earned a master's degree in nursing education (MSN) reported that their programs did not equip them well

for teaching. They entered teaching practice without concrete skills required of educators, such as how to write test items, or how to translate a syllabus into a plan to teach in the classroom. This raises questions about the curricular content of MSN programs. What needs to be included in MSN education curricula? What would best equip novice educators for the teaching role? What motivates nurses to take on the faculty role? What is the process of learning the faculty role, taking on the identity of nurse educator? What kind of mentorship do new educators need?

A description of different types of nursing students also emerged from the data, along with related questions. How is the development of professional identity different in traditional students and adult students? How is the development of vulnerable students different than the development of other students? How can we best facilitate development in each of these groups, or in all of them together in one educational setting?

The limitations of this study should direct further study. Additional interviews using theoretical sampling to explore the properties and dimensions of theoretical concepts would enhance the rigor of this study. Theoretical sampling to include a more diverse group of participants, including male nursing educators and educators from a broader geographical area might also enhance the validity of the theory.

Development of a theory to guide nursing educators in teaching for formation of professional identity and everyday ethical comportment began with synthesizing the Framework for Apprenticeship in Ethical Comportment and Formation (FAFEC, Figure 1) from a review of the literature. In the current study, a theory was developed that is grounded in data collected from nursing educators. If formation of professional nursing identity is a social process that occurs within the teacher-student relationship, then the theory is not complete without the perspective of nursing students. The next phase of theory development will be further grounded

theory research into the experience of students as they go through the process of forming their professional nursing identity. Future study design will be informed by the findings of this study. Purposive and theoretical sampling will be done to elucidate the experiences of traditional, adult, transitioning, and vulnerable students at each stage of development. The theory will then be adapted to integrate the perspectives of these students.

Summary

Formation of professional identity in nursing students is a necessary prerequisite to skilled, ethical, expert nursing practice. Nursing educators lay the foundation for professional nursing identity formation that continues when new graduate nurses enter practice. This grounded theory study provides a beginning framework to help nursing faculty members understand their role in educating for formation of professional nursing identity and everyday ethical comportment. Students enter nursing school with individual characteristics that impact their identity formation tasks, and then progress through stages of development in learning to think, feel, and act like nurses. Nursing educators influence the process of forming a professional nursing identity by understanding the student, creating a safe learning environment, providing developmentally appropriate support, and skillfully using appropriate pedagogies. Grounded theory development is an ongoing process. Development of this grounded theory will continue with additional studies that include interviews with more nursing educators, as well as the voices of the students and new graduate nurses engaged in the development of identity as professional nurses.

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Appendix A

Telephone and E-mail Recruitment Script

Telephone and E-mail Recruitment Script

I am a PhD student at the University of Texas at Arlington. I am conducting a study of how nursing faculty help students become professional nurses who behave ethically in their day-to-day interactions with patients. The purpose of this study is to begin developing a grounded theory of formation of professional identity and everyday ethical comportment in pre-licensure baccalaureate nursing students. I believe such a theory will help nurses be more effective teachers, and will guide us in training the nursing educators of the future.

If you agree to participate in the study, we will find a time and place convenient for you to meet for a one-on-one interview that will last approximately one hour. I will record the interview and will also collect some demographic information. I may contact you within 1 year of the interview via phone or e-mail to ask you to review the conclusions I have drawn from the interviews for accuracy. I know that your time is valuable, so in thanks for your investment I am offering a $25 gift card.

You can contact me via e-mail or on my cell phone:

priddy@uta.edu

(817) 705-1010

Appendix B

Demographic Data Form

Demographic Data Form

What is your age?

Gender: Male Female

How would you describe your race or ethnicity?

How many years did you practice nursing before becoming and educator?

Have you been an educator in a staff development role? Y/N If yes, how many years did you teach in this role?

How many years have you been teaching in an academic setting?

What settings have you taught in? Please circle all that apply.

Classroom Clinical Campus-based Online

What levels of nursing students have you taught? Please circle all that apply.

Pre-nursing Freshman Sophomore Junior Senior Graduate

What courses are you currently teaching?

Have you taken academic courses to learn to be an educator? Y/N

Do you hold a Certification as a Nurse Educator (CNE)? Y/N

Appendix C

Interview Guide

Interview Guide

The purpose of this research is to discover ways nursing faculty bring about formation of *professional identity and everyday ethical comportment* in nursing students. Sometimes this is described as formation of professional character, or the way nurses relate to others to communicate caring. In other words, how do you go about teaching students how to be a nurse and how a nurse behaves every day?

You may have experience teaching graduate or RN-BSN students. Remember that the focus here is on teaching **pre-licensure nursing students** who are beginning their formation as nurses. I am particularly interested in how you do this in the **classroom**, rather then in the lab or clinical.

Consent to Record Interview

Do I have your permission to record this interview?

I may also take notes during the interview to help me remember our conversation. Do you have any objections to me taking notes?

Primary Questions

1. How do you think students change from the time they start nursing school until they complete their nursing programs and become professional nurses?
2. What do you do as an educator to help bring about these changes?

Follow-up Questions

1. What do you believe the important values in nursing are?
2. How do you think students learn these values?
3. How do you teach students how to act the way professional nurses act?

4. Can you give me an example of time that you used a specific teaching strategy for this purpose?
5. What has been your most creative approach to teaching students how to act like caring professional nurses?
6. What do you think is the most effective way to teach students how to act like caring professional nurses?
7. To what extent does your personal belief system inform how you teach nursing values and nursing care?
8. What makes it easier to teach nursing values and caring in nursing?
9. What makes it harder?
10. Can you describe a time when a student demonstrated problem behaviors, and what you did to help them change?
11. How or where did you learn these teaching strategies?

Appendix D

Informed Consent Document

Informed Consent Document

To the research participant:

I am conducting a research study of how nursing faculty help students become professional nurses who behave ethically in their day-to-day interactions with patients. The purpose of this study is to begin developing a grounded theory of formation of professional identity and everyday ethical comportment in pre-licensure baccalaureate nursing students.

If you agree to participate in the study, we will meet for a one-on-one interview that will last approximately one hour. I will record the interview on a password protected digital device and transcribe it. I will also ask you a few questions about your age and experience as an educator. I will keep all data collected on password protected or encrypted devices. I may contact you within 1 year of the interview via phone or e-mail to ask you to review the conclusions I have drawn from the interviews for accuracy.

There is minimal risk to you as a study participant. You may also benefit from discussing and thinking about teaching strategies. I will give you a $25 gift card to Starbucks, Panera Bread, or Walmart at the end of our interview in appreciation for the investment of your time.

Participation in this study is completely voluntary. Refusal to participate will involve no penalty or loss of benefits to you. You may discontinue participation at any time without penalty.

Questions related to this study may be directed to me, the principle investigator. Questions about your rights as a research subject may be directed to the Office of Regulatory Services at the University of Texas at Arlington.

Kristen D. Priddy, RN, MSN, CNS Principle Investigator PhD Student priddy@uta.edu (817) 705-1010	Susan M. Baxley, PhD, RN Faculty Advisor Associate Professor Clinical Nursing College of Nursing and Health Innovation sbaxley@uta.edu 817-272-2776	UTA Office of Regulatory Services (817) 272-3723