



CHAPTER 7

Ethical Leadership at the Interface of the Nursing Profession, Organizations, and Health Care Systems

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“The ‘ethical space’ is formed when two societies, with disparate worldviews, are poised to engage each other. It is the thought about diverse societies and the space in between them that contributes to the development of a framework for dialogue between human communities.” (Ermine, 2007, p. 193)

AGAINST THE BACKDROP OF dynamic social and organizational transitions of the 21st century, in this chapter we provide an exploration of nurse leaders’ moral commitments across a range of organizational spaces, accountabilities, and tensions. Nurse leaders are poised to make significant contributions to health equity on a global scale, shift health care systems, address racism, and attend to pressing relational and human resource needs. However, within the profession of nursing, critiques and evidence have been mounting

for decades about the barriers and solutions to enacting ethical leadership in nursing and health systems. Nurses have long been concerned about systemic influences on nursing leadership, in particular on the capacity to fulfill everyday ethical accountabilities (Aroskar, 2006; Austin, 2011; Storch, 1994). Despite growing awareness and dissonance, nursing as a profession has not found a way to navigate and disrupt forces oppositional to ethical leadership.

Our central premise in this chapter is that the most pervasive challenges cannot be met by one nurse leader alone; rather, they require the voice and influence of the nursing profession itself. Given this premise, we discuss ways in which contemporary influences on the nursing profession and its governing organizations may lead to inaction and underperformance in enacting ethical leadership for health equity in the current global context. We present scenarios that expose issues of difference and power relations in individual and collective nursing leadership, and we propose questions to guide inquiry and reflections. We strive for clarity in distinguishing and recognizing those characteristics and qualities of ethical leadership in nursing as enacted within the health care system. We situate the discussion in historic and emerging contexts, and present theories and research that hold particular relevance for understanding ethical leadership in nursing. In so doing, we endeavour to explore and extend the conceptualization of ethical leadership in nursing in light of calls to action in health systems and public policy today.

In this new edition of the *Toward a Moral Horizon* text, we highlight leadership as central to the discussion of nursing ethics. Our focus in this chapter is related to the interface of the values of the nursing profession with current systems, organizations and governments. We strive to enhance understanding of the nursing profession as a moral community through exploration of the question: How do we envision ethical nursing leadership within the profession, as well as within health care organizations and global communities?

Ethical Nursing Leadership

The convergence of unprecedented events, including escalating climate change and the global pandemic, highlight societal health

challenges as current and pressing concerns for the nursing profession to address. Just prior to the emergence of the COVID-19 pandemic, the World Health Organization (WHO) highlighted the urgency for the nursing profession to address the global health issues of our time with the declaration of the year 2020 as the International Year of the Nurse and the Midwife (WHO, 2020a). This declaration was followed by the release of the State of the World's Nursing Report — 2020 (WHO, 2020b) and the Global Strategic Directions for Nursing and Midwifery (2021–2025) (WHO, 2021a). A compelling rationale for this spotlight on the profession is rooted in the conviction held by international governing bodies that “nurses are critical to deliver on the promise of ‘leaving no one behind’ and the global effort to achieve the Sustainable Development Goals (SDGs)” (WHO, 2020b, p. xii). The call to strengthen nurse leadership is in order “to ensure that nurses have an influential role in health policy formulation and decision-making and contribute to the effectiveness of health and social care systems” (WHO, 2020b, p. vii).

The emergence of the COVID-19 pandemic in early 2020 placed a spotlight on the global nursing profession in ways that had not been conceived of in the declaration. In addition, COVID-19 surfaced profound equity issues, including the value and urgency for sustaining a global nursing workforce, and a call for equity in access to knowledge and technologies required to protect populations. These issues include the development and distribution of vaccines and anti-viral medications. In many ways, the pandemic exemplifies the meaning of health equity, as WHO (2021b) deemed that “no one is safe until everyone is safe” (p. 1). A nursing call to action to promote equity in the face of the pandemic, and a looming shortage of health human resources, was a primary theme at the 2021 Congress of the International Council of Nurses (Chiu et al., 2022, in press). What we are witnessing is a convergence of calls for nursing influence on health equity within global systems that must be addressed not only by individual nurse leaders, but also by a powerful and morally committed nursing profession (Duncan, 2023).¹ With the exception of the Canadian Federation of Nurses Unions (2021), at the time of writing, we have seen relative silence on this issue from Canadian nursing organizations.

In Canada, the ethical imperative for nursing is exemplified in recently exposed instances of racist practices and attitudes among nurses in the treatment and care of Indigenous people. These instances have contributed to the critique of accounts of historical colonial influences in the development of the profession. This awareness has been growing among Canadian nurses, with recent high-profile events resulting in advocacy and declarations against anti-Indigenous and anti-Black racism in nursing and health care adopted by the Canadian Nurses Association (CNA, 2020a) and the Canadian Association of Schools of Nursing (CASN) in collaboration with 13 other nursing organizations (CASN et al., 2020).

Several accounts of racism in health care have been amplified in the media, including the blatantly racist and harmful treatment by nurses of an Indigenous woman, Joyce Echaquan, while she was a patient in the province of Quebec, Canada (CNA, 2020b). This was a stunning and pivotal moment for Canadians, and for nurses in Canada, to reflect on and accept the reality and trauma of racism, from which the profession of nursing is not exempt. National organizations including the CNA, in collaboration with the Canadian Indigenous Nurses Association (CINA) and other provincial and national organizations, initiated a call to action for “individual and systemic actions needed to decolonize the structures that impact the education, regulation and practice of the nursing profession and ensure that it can provide safe, compassionate and ethical care to all people living in Canada” (CNA [2020a], p. 2). The call for nurse leaders to counter racism and initiate decolonization is not new; rather, it is pervasive and ubiquitous to contemporary practice and must be seen as a central ethical commitment of all nurses (Crowchild & Varcoe, 2021). In coming years, it will be critical to monitor events and progress by nurse leaders for countering these influences on care and health. Such attention is particularly necessary in light of various national inquiries and calls to action with direct implications for the nursing profession (Truth and Reconciliation Commission of Canada Calls to Action, 2015). This social and political moment is indeed a clarion call for ethical nursing leadership.

Nursing calls to action within organizations and systems have been, for the most part, unheeded in recent times, although the measures they encourage have been vital to the safety of patients,

nurses, and the overall health of communities and populations (Bourgeault, 2021; Buchan et al., 2022). Calls to action over past decades have included recommendations to strengthen nursing leadership in practice settings and at senior levels of organizations and the health care system overall to increase opportunities for nurses to have voice and influence in health care decision making; and to promote safe and healthy practice environments for all (Canadian Nursing Advisory Committee, 2002; Duncan et al., 2014).

As a result of the above, questions arise: Why have these challenges been so difficult to address, or ignored, over the past few decades? What does that say about nursing leadership? In answering these questions, we will argue that individual nurses and the nursing profession must engage with new understandings and narratives of power—both in relationships and in the capacity for ethical leadership. Barbara Stilwell (2021) proposed, in her address to the International Collaboration of Community Health Nursing Research, that we embrace power not just as a noun, but in its more active, verbal form: “to power.” This means, in our view, that ethical leadership in nursing must be further conceptualized and realized as the imperative of nurse leaders in interaction with the values of the profession. A new narrative of power is required.

Contexts and Concepts of Ethical Leadership

Nurses take on leadership in diverse informal and formal roles. They advocate for standards of practice and serve on committees at various levels of organizations, from the point of care in health care settings to working with communities on directions for health and health care. Nurses who assume *formal* leadership roles are accountable for strategic influence, vision, climate, and quality in health systems. Formal leadership roles commonly assumed by nurses include practice leads and coordinators; program leads; and executive leads in health care organizations, nursing organizations, and governments. In 1994, Storch identified the levels of influence and accountabilities in nursing ethics at the micro level (individual point of care), at the meso level (organizational), and at the macro level (larger systems). Nursing leadership at the macro level is particularly critical to safeguard and advance ethical practice.

Nursing leaders who are required to shape organizations and systems face considerable challenges. For one, contemporary health systems are most often identified as program-related, with responsibilities that span nursing and other allied health professionals and programs. It is increasingly rare that nursing leadership positions are created where nurses are able to focus primarily on nursing issues and advancements. While we recognize the imperative of interprofessional practice and leadership within nursing, the absence of a dedicated focus on nursing per se creates a void in nursing leadership capacity. There has been some critique of interprofessional discourse with respect to a shift in managerial emphases on other professions or allied health disciplines, while nursing as a discipline and a profession may become less distinct and less represented in leadership (Duncan et al., 2014).

When we consider leadership at the meso and macro levels, there are accountabilities for creating a moral climate in health care wherein nurses and others are able to practice according to ethical values. Therefore, a central feature of ethical leadership is to create and nurture health care environments as moral communities (Austin, 2007), wherein there is constant attention to everyday ethics, and where nurses and others in health care teams and communities come together in reflection and dialogue over pressing moral dilemmas and tensions (CNA, 2017). The extension of a moral community to one that nurtures and supports each nurse, including nurse leaders, is an ethical responsibility for all nurses in the context of growing concerns about bullying and lateral violence (O'Flynn-Magee et al., 2021).

The essence of ethical nursing leadership is to lead in the development of moral communities through reflection on the ethics of everyday practice (Austin, 2007). As Austin suggested, "being ethical is never something that one possesses, it is the recognition of the messy and expanding interdependence of decisions, interests, and persons" (p. 85). Scholars in nursing ethics point to the need for nurses to be more involved in policy development and governance. Yet, an increased focus on managerialism limits the capacity of nurses to lead in the creation of moral health care communities for just and equitable systems of nursing and health care (Aroskar et al., 2004; Austin 2011; Shannon & French, 2005; Storch et al., 2013).

These critical insights have been articulated in the 2017 CNA *Code of Ethics for Registered Nurses*.

Canadian scholars and researchers in nursing ethics have investigated systemic and organizational influences on the enactment of ethical leadership (Rodney et al., 2002). Storch et al. (2009) led a national study into “leadership for ethical policy and practice” (p. 68). This participatory action research initiative included nurses from diverse walks of nursing—including academic, practice, and organizational leaders—to discern policy actions to improve the ethical climate in health care settings where nurses practice. Participants were offered opportunities for continuous reflection and discussion of ethical issues in everyday nursing practice, and the active listening presence of senior nursing leaders (Storch et al., 2009). Canadian nurse theorists Doane and Varcoe (2021) further contributed to the conceptual landscape of ethical nursing leadership using a relational inquiry lens to review the actions and behaviours of “nursing leadership in every moment of practice” (p. 402).

In addition, research conducted by international scholars Zhang et al. (2021) in a study of 525 Chinese nurses in 65 diverse tertiary hospital departments enriched our understanding of the relationship between ethical nursing leadership and nurses’ capacities for moral reflection and sensitivity at the point of care. Through structural equation modelling, these researchers demonstrated the mediating variable of ethical climate in the relationship between ethical leadership and nurses’ moral capacities at point of care. At the core of moral sensitivity was the individual nurse’s ability to reflect on and identify the fundamental ethical components of situations and actions. Zhang et al. demonstrated how ethical leadership was essential in establishing moral climates to ensure ethical nursing practice for all.

Research conducted by members of other disciplines, both in Canada and internationally, also informs our understanding of dimensions of ethical nursing leadership. For instance, in Canada, feminist researchers extended applications of feminist and relational ethics principles into health leadership contexts. These principles are essential to navigating areas of conflict, as well as values in tension and power (Sherwin & Stockdale, 2017). Public health ethicists provide essential insights into organizational and

societal determinants of ethical leadership. They emphasize the imperative to address social justice by considering the relationship between the good of the individual and that of the collective (Baylis et al., 2008; Upshur, 2002). Ko et al. (2018) conducted an integrative review of research on ethical leadership in other disciplines and countries that added to the understanding of the dimensions of a moral climate within organizations and systems. These researchers offered evidence that qualities such as upholding and enacting codes of ethics and actively voicing concerns about unethical behaviours at all levels of organizations and systems are central to leadership, as is the importance of role modelling consistent ethical behaviours in relationships and advocacy. Signs of a management climate bound by codes of ethics and standards include capacities for whistleblowing among followers, team cohesion, and voicing concerns as a group (Ko et al., 2018).

While these signs represent a flourishing moral climate, they are currently not abundant in nursing and health systems. Increasingly, nurses as individuals, including those in formal senior organizational positions, are not free to speak out on the fundamental issues at the heart of nurses' moral practice (Newton et al., 2012). The silencing of a strong nursing voice in the public arena, with respect to the expertise of nurses to lead in patient care and health systems, has also been pervasive during the pandemic (Pringle, 2021). Factors contributing to the silencing of the nursing profession, albeit complex, must be fully understood and reconciled.

Enacting the ethical dimensions of nursing leadership has always been challenging. These challenges persist despite years of tracking the impact of neoliberal ideology and managerialism on nursing practice and the profession as a whole (Austin, 2011; Duncan et al., 2014; Kirkham & Browne, 2006). Managerialism in health care and nursing systems is expressed in values of efficiency, and in the dominance of market analyses and forces that determine administrative structures and program outcomes often directed at rationing essential services (Newham & Hewison, 2021; Traynor, 1999). Managerial influences are seen in the introduction of professional managers, those with educational preparation in business, as the way to advance health systems. This trend is detrimental to the full engagement of nurses, and the profession of nursing, in

managing and leading according to professional values and standards (Shannon & French, 2005). Over several decades, this movement has also resulted in changes in leadership in the practice setting, including a loss of nursing management and leadership roles at the point of care, along with promoting the educational preparation of nurses with business degrees for leadership roles. Nurses in most health systems of today experience a disconnection between their practice as leaders and the values and directions of administrative and governance structures. If nurses are present at all in these structures, they are often there to represent a myriad of portfolios and issues that may or may not include the practice of nursing (Storch et al., 2013). As a result, many are unable to confront these managerial forces at the point of care or at the most senior executive levels of those organizations, where nurses constitute the majority of members.

Recently, theorists in nursing and management have been confronting the binary of management and professionalism, and are calling for new understandings and models where professional identities and values are realized within management systems (Mintzberg, 2017; Newham & Hewison, 2021; Noordegraaf, 2015). This includes an awareness that management and nursing leadership coexist; nurses who are managing teams, programs, or organizations have critical skills, knowledge, and ways of being to bring to these roles. For example, Mintzberg (2017) recognized the former leadership and management roles of head nurses as highly valued because of their intimate engagement with practice; their knowledge of the immediate day-to-day contexts of nursing practice; and their relationships and presence with nurses, patients, and others.

In our critique of managerial influences on health systems, and on the nursing profession and the enactment of ethical leadership, we distinguish between management and managerialism. Nursing management is a component of leadership required to shape and lead systems of care, while managerialism is an ideology that has transformed how management is enacted in public systems (Carroll & Shaw, 2001; Traynor, 1999). In order to navigate competing ideologies, nurse leaders must expand their critical awareness of managerialism and its impact on their capacity to enact ethical leadership. This requires a constant interaction with power in

relationships, including the development of ways to bring people and organizations together. The values of the nursing profession are instrumental to enacting ethical leadership. This requires the strength, vision, and strategic influence of the profession itself (Myrick & Pepin, 2019). At the same time, we are witnessing the erosion of the power of professional nursing associations with respect to advocacy for nursing values, issues, and dissenting views.

Ethical leadership in nursing is supported by philosophical perspectives, including critical and feminist world views, and, as developed by nurse scholars, a perspective on feminist relational ethics and Indigenous cultural understandings (Bergum, 2013; Bourque-Bearskin, 2011; Doane & Varcoe, 2021). Feminist theorists view relational theory in ethics as a means of addressing global issues and helping to build communities for social justice (Sherwin & Stockdale, 2017). Relational and communitarian perspectives inspire the call to action for nurses to act globally to create universal health access. Together, these perspectives encompass the critical view of power in relationships and the call to build relationships across difference while leading according to professional values.

Ethical leadership also means advocating for policy agendas that align with the profession and nursing codes of ethics. Policy advocacy may be viewed as leadership ethics in action, and requires new theoretical and methodological perspectives (Chiu, 2020). For example, in examining theories for advancing policy advocacy in nursing, Chiu observed that ethical knowing is not only integral to policy advocacy; an ethical perspective is core to social justice and equity values and commitments. Such attentiveness to ethical knowing also extends to policy solutions for social change. Nurses leading systems and organizations are calling for principled action in reforming community-based systems of care, which have been given short shrift in current times (Caxaj et al., 2020; Lefebvre et al., 2020). It is also incumbent on nursing organizations to base policies and positions on the ethics and principles of the profession (Copeland, 2020). Ethical inquiry into situations where leaders have successfully advocated for professional values and practice standards provides insights into how leadership can be supported and enacted in present day challenges, as the following exemplar illustrates.

Historic Exemplar of Ethical Nursing Leadership: “I Care That VGH Nurses Care”

This exemplar of nurses confronting the Vancouver General Hospital (VGH) bureaucracy was highly visible over four decades ago in media and public arenas. However, few public records or publications have emerged; those which are known to exist are less accessible due to the loss of nursing archives. It is fortunate that Verna Lovell (1981), a nurse and sociologist, was able to document the entire situation. She published a rigorous analysis of what transpired in a case study titled “I care that VGH nurses care!” This publication is, to our knowledge, one of the few exemplars of meso level organizational nursing leaders standing together in the corridors of power of a large health care organization in order to enact essential improvements in patient safety and nursing practice. We contend that the case study has relevance to nursing today and provides useful ethical insights for nursing leaders.

Of note in this leadership scenario is the courage exercised by nurses in leadership positions—including the clinical directors of surgical nursing, medical nursing, psychiatric nursing, and obstetrical and gynecological nursing, in taking a stand for patient care. These nurse leaders resigned from their positions in opposition to the failure of the VGH board of trustees and the senior executive team to hear growing concerns about the safety of patient care across the institution. Several head nurses followed suit.

The Director of Nursing, Mary Richmond, resigned in December of 1973, after “she was unable to make changes she regarded essential” (Lovell, 1981, p. 26). A new operational plan for VGH was conceived shortly after Richmond’s departure, and nurses did not have a say in the appointment of her successor. This became a central issue in the dispute. The remaining nurses stood together and focused their advocacy on patient care. They formed the Committee of Concerned Nurses, which engaged hundreds of nurses in public awareness campaigns and assemblies. The group used established channels within the organization and government to present documented incidences of compromised patient care standards. When the nurses’ concerns fell on the deaf ears of senior

executives and government officials, they effectively engaged the public through the media.

In her analysis of the power dynamics between the nurses and the VGH president and board of trustees, Lovell (1981) sheds light on the means of “coercive control” leveraged against the Committee of Concerned Nurses. She suggests that VGH’s managerial reaction was punitive because the Committee challenged “the normative order” and “by virtue of its very existence, was considered deviant” (p. 40). Control measures ranged from “failing to regard as legitimate” the claims of the nurses, to “scolding,” “shaming,” “intimidation,” and “censuring” them, and “praising” those who “told the other side of the story” from what the Committee presented (Lovell, pp. 40–43). Descriptions and evidence of how these control measures were manifest is likely one of the most significant exposés of a narrative of power that has persisted in the world of nursing, and one that must be confronted today.

The efforts and stance of the nurse leaders garnered the support of other organizations, including professional associations of the day—the Registered Nurses Association of British Columbia (RNABC), the Canadian Nurses Association, the International Council of Nurses (ICN), the BC Association of Social Workers, the faculty of the University of British Columbia, and others. The core group communicated with the Canadian Council on Hospital Accreditation and challenged VGH’s accreditation because of a lack of nursing positions and unsafe staffing levels.

Of particular note was the role and contribution of the RNABC. This professional association provided immense operational support for organizing and communicating concerns, as well as political influence, by bringing the voice of the nursing profession, including its standards and ethics, to the fore. Also noteworthy is the connection and commitment of the RNABC to advocacy efforts in the interest of patient safety. The RNABC had, in the fall of 1976, established a “Safety to Practice Program” which was supported by a resolution in 1976: “That RNABC place increasing emphasis on assisting members to take effective action to ensure that the settings in which they practice make competence possible” (RNABC, 1976, p. 4). This in itself is a powerful reminder of the need to act together as a profession in the interest of patient safety through advocacy and

courage in leadership at a systems level. It is of concern that this level of attention to systemic influences on patient safety seems absent in today's arena of evolving nursing organizations and their respective mandates for regulation and professional practice standards.

REFLECTIVE QUESTIONS

1. *How does the exemplar of nursing leadership at the Vancouver General Hospital resonate with the contexts and challenges of today?*
2. *Was ethical leadership enacted in this situation? What characteristics stand out?*
3. *What are the implications of this situation and the narratives of power it represents for ethical nursing leadership today?*

Codes of Ethics: The Nursing Profession as a Moral Community

We now turn to the exploration of how codes of ethics inform and support nursing leaders in organizations, and societal contexts. The values of the nursing profession in Canada are articulated in the Canadian Nurses Association's (CNA) *Code of Ethics for Registered Nurses* (2017), and globally, in the recently revised International Council of Nurses' (ICN) *Code of Ethics for Nurses* (2021c). The CNA recognizes the need for nurses, regardless of position, to continuously reflect on how they are enacting their ethical commitment to practice and to the persons, families, and communities they serve. Today, these pressing moral concerns are constant in the face of limited nursing resources, pandemic challenges, and racism in practice environments. However, it is important to acknowledge that along with these challenges are unlimited possibilities for elevating the moral climate of all communities; this is envisioned as a primary nursing leadership role in enacting "everyday ethics."

The 2017 CNA *Code of Ethics* refers to the issue of power and the need to recognize and attend to "power differentials among formal leaders, colleagues and students" (p. 13). Further, the 2017 CNA *Code of Ethics* addresses the principles of justice as they pertain to the recognition and respect of Indigenous-specific history and inter-

ests, including direct reference to the requirement that nurses do not discriminate. The 2017 version of the CNA *Code of Ethics* does not explicitly refer to the issues of colonization and racism; however, it is likely that the next version will be extended to recognize the evolution of thought and commitment in the nursing profession in Canada. In addition, the 2017 CNA *Code of Ethics* includes visionary direction for leadership and action during pandemics, and in those instances where nurses must take action to address unsafe or unethical care. These scenarios have increasing relevance in the contemporary leadership context.

A revised edition of the ICN *Code of Ethics* was released at the 2021 ICN Congress. Highly relevant to framing nursing leadership at the level of the profession, this revised code of ethics emphasizes the integral role of the professional nursing association in establishing wide-ranging ethical accountabilities for safe and high quality practice and health systems. The relationship between nurses and the profession features prominently in this revision. This emphasis extends to nursing leaders in the creation of roles, relationships, and directions for nursing organizations as they evolve with disparate and sometimes competitive mandates. It is essential for nurse leaders to ensure that organizations governing or regulating nursing practice uphold the values of the profession. It is incumbent on nurse leaders to “promote participation in national nurses’ associations to create solidarity and cooperation to promote favourable socioeconomic conditions for nurses” (ICN, 2021c, p. 16). In summary, authors of nursing codes of ethics are clear in calling for nurses to engage in new narratives of power by advocating for equity in health and for justice in the human rights issues prominent in the nursing profession itself, including the promotion of ethical nurse recruitment and migration (Buchan et al., 2022).

Nurse leaders in the 21st century require the relational commitments and competence to develop inter-organizational relationships while recognizing disparate agendas and values. Inter-organizational relational competence is particularly relevant in leadership today, and is required among those who hold senior formal positions of leadership in the profession of nursing (ICN, 2021c). Also, in recognition of broad mandates for ethical leadership, The Canadian College of Health Leaders (CCHL) *Code of Ethics*

(2021) outlines the ethical standards pertaining to individual, professional, organizational, and community relationships for health care leaders. The CCHL *Code of Ethics* specifies the value of collaboration at all levels as essential to fulfilling the social mandate for ethical leadership, once again recognizing the importance of reflection, dialogue, and public participation as essential to leadership in health systems. This view is consistent with nursing codes of ethics in that individual leaders, in their enactment of leadership, must include professional, organizational, and community commitments and relationships. New understandings of ethical leadership, and awareness of responsibilities to build and sustain relationships within and between organizations, are needed. As discussed, codes of ethics provide specific direction for these leadership roles.

Discord and Discontinuity in Nursing Organizational Mandates

ICN's (2019) strategic priorities of the socio-economic welfare of nurses, the profession of nursing, and nursing regulation are conceptualized as three pillars that must work in concert in order for the nursing profession to fulfill its social mandate for global health. Therefore, nurses who lead nursing organizations must commit to these essential mandates at the local, national, and international levels, and they must ensure a level of collaboration that fulfills the synergistic interrelationship of these priorities at operational levels. For instance, as patient safety issues continue to grow, organizations that regulate nursing practice must work synergistically with nursing organizations that promote the advancement of the profession and the socio-economic welfare of nurses. This level of inter-organizational collaboration must occur in order to attend to the systemic influences on patient safety by implementing progressive care delivery models, advocating for resources necessary for safe practice, and ensuring that nurses' rights to safe and optimal working conditions are upheld (Borgeault, 2021; Traynor et al., 2014).

Despite the recognition of the three pillars as a unifying framework, one that has served the nursing profession and the public for over a century, there is an unfortunate, growing disconnection between nursing organizations as they evolve with

separate mandates (Duncan et al., 2015). As a result, nursing organizations have lost some important connections with each other and with nurses. These disconnections have reduced the capacity of the profession to speak, influence, and advocate for health systems and conditions of health equity. In fact, individual nurses' levels of engagement with the profession itself is in peril, as membership models are threatened while regulatory systems become increasingly focused on a single mandate of regulation and increasingly divorced from professional self-governance as a guiding principle (Duncan & Whyte, 2018).

Nursing organizations in Canada have evolved over the past fifteen years (Whyte & Duncan, 2017). In 2021, a landmark change in the constitution of the CNA resulted in the loss of a century-old membership model for provincial and territorial associations. The model had ensured a connection between nurses across the country, and was part of nurse registration (Villeneuve & Guest, 2021). This recent change challenges the strength and viability of a unified national voice for nurses in Canada through the CNA, and their connection to the global nursing community through the ICN. The full implications of these changes for the nursing profession and those it serves have yet to be fully recognized and critically examined in Canada and beyond. The moral community of the nursing profession is enacted through formal, integrated, and collaborative networks and organizations committed to the values of the profession. In light of discord among nursing organizations, we challenge the emerging and narrow vision of regulated nursing practice when it is seen in disconnection from the mandate of professional associations. The challenge is to launch a rigorous research program about the impact of emerging regulatory systems on the profession of nursing and its capacity for safe and quality patient care.

Finally, we observe that Part II of the 2017 CNA *Code of Ethics* constitutes the essence of ethical nursing leadership, as it identifies "ethical endeavours related to broad societal issues" (p. 18). Yet, it also identifies these essential aspects of ethical nursing leadership as outside of regulated nursing practice. Given the call to address broad societal influences on equity, racism, and human rights—and their integral relationship with safe and ethical nursing practice—

we contend that this exclusion from what it is considered “regulatory” in nature must be critically and urgently re-examined. We argue that this exclusion of social justice and advocacy from regulated and accountable nursing practice lacks congruence with the conceptualization and enactment of ethical nursing leadership. This is, therefore, an area in which the nursing profession could lead change and transformation—in determining what constitutes ethical nursing practice by ensuring that future revisions of codes of ethics represent the social justice issues of our time. It is essential that codes of ethics are *not* narrowly conceived as regulatory instruments; codes of ethics for nursing must be supported by a nursing profession engaged and invested in ethical leadership in all realms of nursing practice, including advocacy for the promotion of social justice and health equity.

Cases of Ethical Nursing Leadership

To highlight and reflect on contemporary ethical challenges, three cases involving nurses working in advanced practice and leadership roles at meso and macro levels of health care and political systems are presented. The capacity for reflection is foundational to nursing ethics, and for leaders, these reflections must extend to organizational and global contexts. Reflection on values in tensions, differences, and narratives of power must be pursued for deeper understandings. We offer a series of questions to guide inquiry into these cases, and we suggest ethical models for reflection, including those appended in the 2017 CNA *Code of Ethics* and others described in Chapter 1 of this book. These models can be used by advanced practice nurses and leaders for ethical reflection that guides analyses of goals, relationships, values, and decision making. Such analyses can be extended to community and systemic levels, providing emerging insights for leaders and organizations. In Ethics in Practice 7-1 below, as you read the scenario, imagine that “you” are the Chief Nurse Executive in a Canadian health region.

ETHICS IN PRACTICE 7-1

Nursing Voice and Presence in Organizational Governance

In my role as Chief Nurse Executive in a Canadian health region, it is my privilege to represent nurses and other allied health professionals at the most senior executive level of a health authority in a large urban centre. My commitment in this leadership role is to enact participatory leadership by connecting and listening to nurses across the organization about their issues and pressing concerns. In recent years, I have advocated for nursing knowledge and advancements in professional practice.

In this role, I also bear witness to the erosion of nursing human resources with the loss of roles such as advanced practice nurses and clinical nurse specialists. Under the guise of an intent to “recognize scopes of practice,” this erosion and loss of advanced practice leadership results in the shifting of tasks among categories of nurses and health care attendants without due consideration of the implications for roles, unique contributions, and leadership within a team. I recognize that these trends prevail across the system of acute institutional care, long-term care, home care, and public health settings of care. Introduction of new care delivery models is at times advocated for and supported by nurses in managerial positions who seek to maximize efficiencies. Further, human resource allocations are made without due consultation with nurses, review of literature, or evidence and evaluation frameworks that identify impacts on care and health outcomes, including but not limited to the safety of patients and nurses.

As the most senior leader with a nursing portfolio, I am morally compelled to address issues that are adversely influencing nurses and nursing practice across the organization, and to bring awareness and strategy to the most senior levels of the organization. My actions include tabling issues related to nursing practice concerns, proposed strategies, and evaluation by the senior executive team. These actions are often met with the response: “You are too focused on nursing, and you must take a broader view of other health team members and issues across the organization in order to lead effectively.” The implication of this response, which is common discourse, is that leaders who bring nursing-specific issues to the fore are inwardly focused on serving the nursing profession over broad health care delivery issues and concerns.

In discussion with other nurses in positions such as mine, I recognize that this situation is not unique: the lack of focus on nursing and its priorities is prevalent in health organizations. As a group of nurses with a mandate to represent nursing at senior levels of organizations, we lack a professional forum for reflecting on and addressing the day-to-day ethical issues in nursing practice, the profession, and standards of safe practice. We recognize the growing urgency and intensity of nursing issues during the **COVID-19** and opioid pandemics, and how the sustainability of the future nursing workforce must be supported with evidence-informed policy solutions.*

As leaders, we do not always agree on a course of action—whether it is best to confront issues and bring strategies for change, or uphold institutional directions and not “rock the boat.” Through further discussion, we also recognize that regulatory organizations in nursing no longer take a systems view on professional practice, and that new forms of professional organizations are emerging. However, the influence of these factors on everyday ethics and professional practice and leadership is unknown at this time. Equally distressing is our lack of opportunity to engage others in the organizations, including nurses in senior management positions and government, in reflection, dialogue, focus, and change.

REFLECTIVE QUESTIONS

1. *What would constitute ethical leadership in this situation?*
2. *What roles do nurses in formal leadership positions at micro, meso, and macro levels play in making decisions about care delivery models, and how do they enact ethical leadership in these situations?*
3. *What is the role of the nursing profession in enacting ethical leadership, and what directions do codes of ethics provide?*
4. *What perspectives and values best inform ethical nursing leadership in this instance?*

* To read more about the opioid crisis, please see Chapters 9 and 10 in this textbook.

ETHICS IN PRACTICE 7-2

Advocacy for Global Equity: The Voice of the Nursing Profession

Since the COVID-19 pandemic began unfolding early in 2020, there has been a growing recognition of the equity issues in nursing and health systems in Canada and globally. Nurses responsible for staffing are charged with recruiting more nurses from less well-resourced countries in order to meet current demands. At the same time, there is an emphasis on securing vaccine supplies that will protect all Canadians, including children, with primary series and boosters. Along with the rise of the sixth wave of the Omicron variant of concern in Canada is the recognition of the issue of global vaccine equity: “No one is safe until everyone is safe” (WHO, 2021b, p. 1). The World Health Organization has launched a campaign for vaccine equity, noting achievable strategies

through sharing vaccines, resources, and intellectual knowledge for sustainable production of what is needed in countries across the globe.*

A team of APNs in a public health unit charged with coordinating the local response to the pandemic in a large urban centre in Canada notes the lack of a professional nursing voice on the equity issues associated with the experience of the pandemic. They are also aware of how public health nurses and nursing students are witnessing inequities in care and health during the pandemic and experiencing moral distress (Wros et al., 2021). Nurse leaders are troubled with this lack of nursing advocacy at a time when the profession lays claim to holding values and principles of social justice and equity.

One of the nurses attends the 2021 ICN Congress, where there is widespread attention on the injustices inherent in nursing recruitment, mobility, and access to vaccines and treatments specific to the pandemic (ICN, 2021a). The nurse conveys this perspective to other public health nurses and asks why these issues are not exposed in the profession and society at large. Collectively, the nurses discuss ways to promote awareness and reflection on the responsibilities of the profession to provide leadership for equitable and evidence-informed solutions to sustaining a global nursing workforce. They consult international policy documents that clearly outline the ethical issues associated with nurse migration and sustaining and retaining nurses (Buchan et al., 2022).

REFLECTIVE QUESTIONS

1. *What would constitute ethical leadership in this situation?*
2. *What resources might advanced practice nurses draw upon to inform ethical leadership in these situations?*
3. *What is the role of the nursing profession, and how can it support ethical leadership for global health equity?*
4. *What perspectives and values best inform ethical nursing leadership in this instance?*

* See WHO (n.d.).

ETHICS IN PRACTICE 7-3*The Future of Nursing Education*

As chairperson of a Bachelor of Science in Nursing (BScN) program in a Canadian university, I am approached by government policy officials in the ministries of health and advanced education to increase nursing program enrolments by 25% in order to respond to the growing shortage of nurses. In addition, the provincial government is recommending implementation of a nursing program that is reduced in length and focused on immediate and visible staffing challenges, primarily in highly acute critical and surgical areas. University administration is aware of issues that could arise from these suggestions for change to the nursing program; however, they wish to respond to government requests and, therefore, want to increase nursing seats in the BScN program. The administration also supports my advocacy for increased graduate enrolment to prepare faculty and researchers.

As I think through options and potential responses to university and government leaders, I am approached by faculty and students who have heard about these changes. They are concerned about having fewer faculty to teach students; reduced capacities for practice placements in all areas of the health system; existing nurse staffing challenges; and student and patient safety. We also realize that the proposed program changes will not prepare students to (a) lead programs of care in primary and community health settings; (b) adopt a critical lens on power and technologies; or (c) lead for culturally safe systems of care.

I am a member of a council of nursing education leaders in one Canadian province where I hear the same concerns raised by colleagues. At a recent meeting of the council, leaders from member schools of nursing discussed the warning issued by the Canadian Association of Schools of Nursing (2021), that nurses will not be adequately prepared in shorter, less rigorous nursing education programs. Further, a policy brief by the ICN (2021b) calls for global investments in nursing education—including providing financial support for students and increasing the faculty complement—as progressive and visionary strategies for ensuring a well-prepared nursing program.

As nursing education leaders, we recognize that the shortage of nurses, including nursing faculty, has been predicted for decades and exacerbated by the pandemic. This shortage has resulted in a priority being set, with nursing education receiving an unprecedented amount of attention from policymakers. This immediate and urgent attention to policy in nursing education by governments, health, and educational institutions raises questions of how nursing education leaders can, and must, influence the future directions in nursing programs and curricula that will determine the care and health of populations for decades to come. We weigh the options while recognizing our roles as employees of educational institutions with immediate accountabilities to government for enrolments and graduations.

REFLECTIVE QUESTIONS

1. *What would constitute ethical leadership in this situation?*
2. *What resources are available to support advocacy for nursing education standards and quality?*
3. *What is the role of the nursing profession in enacting ethical leadership?*
4. *What perspectives and values best inform ethical nursing leadership in this instance?*

**Conclusion: On the Horizon
of Ethical Nursing Leadership**

In conclusion, we return to the question we posed in the introduction to this chapter: How do we envision ethical nursing leadership as enacted by the individual nurse leader in concert with the nursing profession as a whole? As we have theorized in this chapter, the relationship between leaders and the profession must be strong when facing health challenges and opportunities. As custodians of the nursing profession, leaders must acknowledge the moral courage and tenacity of nurses in the evolution of the discipline and profession of nursing. Virtues such as courage and integrity in upholding professional nursing values are required to enact ethical nurse leadership, as recounted in the cases presented in this chapter. We focused particularly on the historic case of nursing leadership at the Vancouver General Hospital in 1978, amidst the earliest appearances of what came to be recognized as managerialism in health care systems. This exemplar of nurses advocating for nursing issues and patient safety indicates how leaders gain power and influence through engagement with the knowledge, standards and codes of ethics, and relational strengths of the nursing profession.

Nurse leaders and their respective communities, at all levels of organizations, must lead with world views that transform and sustain respectful participatory systems where nurses and those they serve have voice and influence. To these ends, nurses must consider diverse ideologies and adopt critical perspectives and

strategies for countering the influences of managerialism on their values and leadership. Drawing upon these perspectives will enable nurses to consider other world views in order to inform new ways of being in a changing world (Chinn, 2013; Crowchild & Varcoe, 2021; Doane & Varcoe, 2021; Rich, 2007).

Further, the profession must grapple with the contemporary challenges of preparing and supporting nurse leaders with courage and commitment to honour the values of the profession and global calls to action. This means that creating spaces for dialogue and building relationships in order to reach across differences—at individual, organizational, professional, and community levels—are foundational accountabilities in ethical nursing leadership. As described in the VGH exemplar, nurses at VGH were skilled in communicating patient safety and nursing practice issues in the public sphere. It is essential that nurses in all roles, including students, develop the capacity for voice and influence in various forms of media communications in order to articulate and expand awareness of complex ethical issues. These competencies must be taught, practiced, and supported (Buresh & Gordon, 2000).

Calls for nurse leaders to lead ethically are clearly focused on valuing and engaging nurses in voice and influence, creating a participatory culture in order to ensure sustainability of the professional values and ethics in morally dynamic systems of care. A new narrative of power is required as the profession critically examines how it enacts its values and relationships within the global community of nurses. For example, our [Duncan's and Newton's] graduate students in nursing have told us how their nurse leaders demonstrated compassion for both nurses and patients during the difficult months of the COVID-19 pandemic. These same nurse leaders now need communities of compassion for themselves in the long road to build systems of care and extend a vision for renewal of care delivery. Relational leadership, rooted in feminist and critical philosophies, underpins values required to develop moral communities of influence (Chinn, 2013). Feminist understandings inspire collectivity and capacity for nurses to lead organizations with a spirit of creating space and respect for diverse mandates (Bergum, 2013; Sherwin and Stockdale, 2017). Further, Indigenous perspectives inspire leaders to create space for reconciliation and

anti-racism (Ermine, 2007). Indeed, there is a call to action for nurse leaders in Canada to lead in the anti-racist movements and decolonization of nursing and health systems (Bourque Bearskin, 2011; Crowchild & Varcoe, 2021).

Finally, leaders of nursing organizations, in particular, must create space for dialogue and ethical discernment among regulatory, professional, and union mandates. Otherwise, fragmentation and loss of voice and influence within the nursing profession—with attendant blows to nurses' capacities to live their values—will continue. At stake is the power and moral agency of nurses, who are an urgently needed, essential global force for achieving the most profound and pivotal health goals for the future.

QUESTIONS FOR REFLECTION

1. *Discuss the meaning of a new narrative of power in ethical nursing leadership. How might this new narrative serve to counter managerial ideologies in health care systems?*
2. *What are the exemplary features of nursing organizations required to support ethical nursing leadership in health systems and organizations? What will this require of leaders of these present-day nursing organizations?*
3. *APNs are accountable for negotiating ethical challenges that arise with a focus on both patients/populations as well as the system within which they are embedded. What supports are required to enact their moral agency as APNs to attend to such responsibilities? How can APNs balance these (sometimes) competing priorities while also advocating for nurses and the creation of a mutually supportive community?*
4. *Canada has recently hired a Nursing Officer in the federal government with the accountabilities for establishing a vision of leadership and policy influence for nursing in the country (CNA, 2022). How would you advise this most senior nurse to build capacities for the ethical nursing leadership required to sustain and strengthen the profession and develop capacity within governments?*
5. *What research agendas are required to inform ethical nursing leadership in the next decade?*
6. *How can the nursing profession as a moral community nurture and support its leaders in building a community of dialogue and respect among nurses in relationship?*

Endnotes

- 1 See Chapter 20 in this textbook for more on Global Health.

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