Promoting moral imagination in nursing education: Imagining and performing

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Promoting moral imagination in nursing education: Imagining and performing

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Abstract

Moral imagination is a central component of moral agency and person-centred care. Becoming moral agents who can sustain attention on patients and their families through their illness and suffering involves imagining the other, what moral possibilities are available, what choices to make, and how one wants to be. This relationship between moral agency, moral imagination, and personhood can be effaced by a focus on task-driven technical rationality within the multifaceted challenges of contemporary healthcare. Similarly, facilitating students' moral agency can also be obscured by the task-driven technical rationality of teaching. The development of moral agency requires deliberate attention across the trajectory of nursing education. To prepare nursing students for one practice challenge, workplace violence, we developed a multimodal education intervention which included a simulated learning experience (SLE). To enhance the realism and consistency of the educational experience, 11 nursing students were trained as simulated participants (SP). As part of a larger study to examine knowledge acquisition and practice confidence of learners who completed the SLE, we explored the experience of being the SP through interviews and a focus group with the SP students. The SP described how their multiple performances contributed to imagining the situation 'on both sides' prompting empathy, a reconsideration of their moral agency, and the potential to prevent violence in the workplace beyond technical rational techniques, such as verbal de-escalation scripts. The empirical findings from the SP prompted a philosophical exploration into moral imagination. We summarise the multimodal educational intervention and relevant findings, and then, using Johnson's conception of moral imagination and relevant nursing literature, we discuss the significance of the SP embodied experiences and their professional formation. We suggest that SLEs offer a unique avenue to create

pedagogical spaces which promote moral imagination, thereby teaching for moral agency and person-centred care.

KEYWORDS
moral agency, moral imagination, nursing ethics, person-centred care, professional identity, simulated learning experiences

1 | INTRODUCTION

Workplace violence is a reality of contemporary nursing practice in Canada. On average, 26 nurses in BC (our province) suffer a violent injury every month (BCNU, 2017) and such statistics are similar across Canada (CFNU, 2017). Indeed, violence is shockingly prevalent for healthcare workers globally, with nurses being the most at-risk group (Mento et al., 2020). Nursing students witness this violence and sequelae during their clinical practice placements. In response to our own practice experiences and this stark reality, as educators we felt a strong moral responsibility to improve students' preparation for their clinical placements and future practice environments.

While working together at a college in Western Canada, we developed a multimodal violence prevention (VP) educational intervention, which included a simulated learning experience (SLE). The multimodal intervention involved education on various aspects of VP including prevalence, causes, safety, prevention, recognition, and de-escalation, using both classroom and small group settings. To enhance the realism and consistency of the educational experience, we trained 11 students to be simulated patients[1] (SP). To evaluate the effectiveness of the multimodal education intervention, we conducted a study to examine knowledge acquisition and practice confidence. We also conducted interviews and a focus group with the SP. The SP described how their multiple performances contributed to imagining the situation 'on both sides' prompting moral imagination, a reconsideration of their moral agency and the potential to prevent violence in the workplace beyond technical rational techniques, such as verbal de-escalation scripts. In brief, the empirical findings from the SP prompted a philosophical exploration into moral imagination and the development of moral imagination during nursing education.

Moral imagination is a central component of moral agency and person-centred care. Becoming agents who can sustain attention on patients and their families through their illness and suffering as *persons* involves using imagination; imagining the unique experience of the patient and their families and also imagining action based on these insights. Along with fostering moral communities and moral agency, exercising moral imagination is also an antidote to moral distress (Traudt et al., 2016).

The development of moral imagination and moral agency requires deliberate attention across the trajectory of nursing education (Benner et al., 2010). We summarise the multimodal educational intervention and relevant findings, and then, using Mark Johnson's conception of moral imagination and relevant nursing literature, we discuss the significance of the SP embodied experiences and their professional formation. We suggest that SLEs offer a unique avenue to create pedagogical spaces which promote moral imagination, in part by performing the embodied experience of patients or their family member, thereby promoting moral agency and person-centred care.

2 | BACKGROUND

2.1 | Background: The VP education

First year nursing students attended a VP lecture based on an evidence-informed provincial curriculum (HEABC, 2015), watched recorded demonstrations of the VP techniques created by the research team, and then practiced these techniques in a classroom setting. The students then participated in an SLE that involved: prebriefing students to prepare them for the learning and to create a safe learning environment; the SLE; and a guided reflection of the experience and learning both during and after the SLE. The goal for the SLE was for the non-SP nursing students to identify if an angry family member was in an emotional crisis or behavioural emergency and then respond appropriately using prescribed de-escalation techniques or withdrawing. Following the multimodal intervention students were required to write critical reflections (CRs) on their learning within 1 week as they moved into their 6-week clinical placement, a consolidation practice experience at the end of first year.

2.2 | Background: The mixed-methods study

The primary purpose of the mixed-methods study was to examine the impact of the intervention on knowledge acquisition and practice confidence for first year students. Human Research Ethics approval was obtained from the educational institution and informed consent was ensured before data collection activities. All first-year students were invited to complete surveys before ($n = 87$), immediately post ($n = 31$), 6 months ($n = 9$) and 9 months ($n = 16$) following the intervention. Along with the surveys, we collected deidentified CR regarding VP from any consenting student participant ($n = 58$) 1 week post intervention. We conducted semi-structured interviews ($n = 5$) and a focus group ($n = 3$) with the SP students. With this subset of students, we explored two questions: What is the experience of

being a SP? How did being a SP facilitate uptake of knowledge and/or confidence in dealing with workplace violence?

The surveys were analysed using IBM SPSS Statistics for Windows (Version 21.0). Survey findings indicate an unsurprising correlation between an increase in students' knowledge and confidence after the pedagogical intervention ($p < 0.05$). The COVID pandemic interruptions resulted in delayed circulation of surveys and possibly contributed to significant attrition. A statistician was consulted and confirmed that, while the data set was not corrupt, there can be no significant claims of causation. The student CR assignments, as well as SP interviews and focus group deidentified transcripts, were analysed using Interpretive Description (Thorne, 2016), an approach consistent with our goal to develop knowledge relevant to nurses (and students) situated in a healthcare context. Interpretive Description also enabled us, as researchers, to not only draw from relevant literature but from our professional knowledge as well (Thorne).

Overall, as would be expected, the multimodal educational intervention resulted in increased knowledge and a shift in confidence of all of students who participated. Data in the CRs demonstrated a perspective transformation for most students. Of note, before the SLE some students rated their confidence as very high, although their CRs told a different story. Whereas some students began the simulation confident that they 'knew what to do', the experience of de-escalating the simulated family member was more challenging and much more emotional than they anticipated.

Analysis of the CRs also highlighted limits of the assignment tool itself as a way to promote a pedagogically meaningful and embodied reflective process. Of particular note is students' shock as they reflected on the prevalence (and normalisation) of violence within healthcare practice environments. While findings from the surveys and CRs provided some insights, SP students reported additional application and integration of the learning gained through their role as SP in the SLE in their subsequent practice experiences. The focus of this paper is on the findings related to the deep embodied engagement of the SP students throughout the process of the SLE.

2.2.1 | Simulated participants: On both sides

The 11 SP students prepared for their role as an angry family member of a patient in complex care by participating in a session led by the simulation leader, which included improvisational exercises. During the SLE, the SP repeated the scenario with groups of four to six nursing students. Nursing students were either playing the role of the nurse or were observers and the SP was the angry family member. Thus, the SP students observed the initial debriefing during the SLE with the other students' multiple times.

During our analysis of the SP student data, we realised their experience was much different than their counterparts. SP described their multiple roles as learner, observer, performer/actor, and family. In these diverse roles, the SP experienced being on both sides of the conflict with the related learning. The SP focused on their emotions associated with being the family member, such as anger and frustration, and also the evolution of those emotions through repetition with different students.

Although there was no explicit focus on ethics or moral agency during the pedagogical intervention, we discovered that, in addition to learning knowledge and skills related to workplace VP, the SP students described imagining the perspectives of the family member as well as subsequent alternative possibilities for compassionate action. Did we unintentionally create a space where their moral imagination was activated to consider nursing practice, as they described, 'on both sides?' We begin with our philosophical exploration of moral imagination and then connect this understanding of moral imagination with embodiment and moral agency. We then synthesise the relevant literature on moral imagination and nursing education, before refocusing on the imagining and performing of the SP.

2.3 | Moral imagination

The capacity of individual nurses to engage an active moral imagination informs how nurses enact their practice, develop strategies to act ethically, and communicate with persons and families (Scott, 1997). The ability of the nurse to 'identify imaginatively with the patient' and to empathise is the basis for understanding individual patient's needs (Reynolds et al., 2000, p. 236). Drawing on Johnson's work of conceptualising moral imagination as 'envisioning the full range of possibilities in a particular situation to solve an ethical challenge' (1993, p. 1), we reconsider the relationship between moral imagination and the embodied experience of the SP students engaged with(in) the VP SLE. Drawing on cognitive science, Johnson links moral imagination explicitly with embodiment, suggesting:

> Both our concepts and our reasoning about them are grounded in the nature of our bodily experience and are structured by various kinds of imaginative processes. Consequently, since moral reasoning makes use of these same general cognitive capacities, it, too, is grounded in embodied structures of meaning and is imaginative through and through. *This means that the quality of our moral understanding and deliberation depends crucially on the cultivation of our moral imagination* (Johnson, 1993, p. 1, emphasis ours).

Moral agents exercise moral imagination as they actively 'consider what moral decisions to make and what action to take' (Traudt et al., 2016). Developing moral imagination is foundational to becoming an ethical practitioner and for enacting moral reasoning, and therefore cannot be ignored or left unexamined in educational preparation for nursing practice.

That imagination is central to moral deliberation is not to say it is subjective, nonrational, or idiosyncratic (Johnson, 1993, p. 2). Rather, moral imagination is informed through metaphors lived and interrogated, narrative structures, and deliberations engaging embodied cognition. Therefore, moral theory, and we argue education for moral agency in nursing, must give intentional attention to the central role

of metaphors that shape our thinking and action, the 'narrative structure of our experience and to the narrative form of our moral deliberations and explanations' (Johnson, 1993, p. 177). Metaphoric reasoning engages experience and cognition, drawing out implications of action, probable consequences, and possibilities. Johnson (1993) contends that, in contrast to the dominant objectivist view of persons as moral agents and a self that is de-contextualised, the self is narratively constituted; moral agency is constituted by our social, historical, and teleological identities. Both imaginative frames and our narratives make up our understanding of the good and how to enact that. In situations that call for moral action, to do the right thing, individuals engage in both meaning-making narrations of potential options and engagement with 'wisdom' often presented in moral codes, the sedimented 'wisdom' of the profession (Johnson, 1993, p. 183). In contrast to privileging rational and objective or absolute moral theorising, Johnson argues that imagination has a constitutive role in moral action.

Moral imagination, for nurses, facilitates the identification of individual patient needs. As Pask (2001) further explains, a 'nurse's capacity to see what is morally salient in the care setting, and to understand their patients' needs, is the product of the control that they exert over their deliberations and of their ability to *exercise a capacity for moral imagination*' (p. 51, italics added). Moral imagination takes us beyond the notion of 'fellow-feeling' (e.g., Hume) to both imagining the others' experience, to imagine ourselves in their situation, and to imaginatively take up their experience, allowing us to therefore consider the potential implications and alternative responses (Johnson, 1993, p. 199; see also Traudt et al., 2016, p. 206, 210). Imagination is necessary for achieving understanding of the other, to attend to the other, but 'we must be careful in exercising our imagination that we do not assume too much' (Pask, 2001, p. 44). Traudt et al. (2016) integrate empathy, and also, the importance of 'ascertaining what the patient would want' (p. 206), for moral imagination. Ascertaining, to avoid assuming too much, involves asking, listening, and the communicative work of nursing (Traut et al., 2016).

Over the past decades our understanding of empathy has been informed by neuroscience and increasingly is associated with acknowledging, understanding and emotionally resonating with another (Soto-Rubio & Sinclair, 2018, p. 1430, see also Johnson, 1993, 2014, p. 199–201). Soto-Rubio and Sinclair (2018) remind us that empathy, sympathy, and compassion are concepts that are historically rooted in contexts, often conflated, and contested. Pask (2003) distinguishes compassion from empathy, in a philosophical analysis relating to moral agency, and suggests that compassion involves both affective dimensions (feelings) and ongoing active care responses regardless of feelings. Empathy, for Pask's analysis, involves both the 'sensitivity to current feelings' and also the ability to communicate understanding, in an attuned manner (p. 171). Regardless of the subtleties and dynamic conceptualisations, both compassion and empathy involve an 'imaginative awareness of the other's suffering (Pask, 2003, p. 44).

Moral imagination is intersubjective. Through intersubjectivity, humans acquire values, such as care or empathy (Johnson, 2014, p. 58). Johnson (2014) describes moral imagination as more than merely 'simulating a behaviour' as we are also 'intersubjectively coactive with others in creating a shared communicative and performative situation' (p. 58). Johnson's view of moral imagination is that of actively connecting with our context, with others. Therefore, we are reminded that an individual engaged in moral imagining is inextricably connected to and in-relation with both historical and emerging narrative frames (Johnson, 1993). Within a professional practice, individuals with diverse values and sources for their moral agency, cannot rely solely on their personal narratives. The student nurse develops values that are shared within 'communicative and performative' situations (Johnson, 2014, p. 58). Whereas historically the direction for moral agency was determined by religious ethics, often Judeo-Christian, or rationality (e.g., Kantian), the turn to moral relativism shifted the absolute from an authority to culturally derived values. Johnson (1993) argues both these 'Moral Law' theories reject the intersubjective, embodied imagination in favour of a normative source. Engaging in moral imagination as intersubjective and embodied demands intentionality in professional formation, in nursing education.

Ohlen and Segesten (1998) and Pask (2003) foreground the connection between moral practice and one's perception of self within their professional community, by seeing intrinsic value in their work, as being nurses. Pask (2003), drawing on Iris Murdoch, acknowledges that while there is a focus on *personal* identity, shaped by frameworks of value, the self is mediated by contextual forces (p. 173). We turn to Johnson (1993, 2014) for an understanding of these influences of historical and linguistic frames. Because moral imagination is shaped by the narratives individuals have lived by and lived through (see also MacIntyre, 1984), students engage with nursing shaped by existing frames. Therefore, the development of professional identity occurring during early nursing education builds on the narrative structure students bring to their learning, and nursing.

Nursing practice is imbued with the demand for moral imagination. 'What we need in such cases is a cultivated moral imagination for exploring the various courses of action open to us, for rehearsing possible relationships and forms of action …' (Johnson, 1993, p. 125). The deliberations of everyday nursing practice are enriched by consideration of the experience of the other and of the possible consequences of action. 'Moral imagination enables us to see a range of possibilities of the good under diverse and challenging circumstances' (Pesut, 2016, p. 32). Equally important is to then, using moral imagination, morally evaluate the numerous possibilities for action (Traudt et al., 2016). The SLE allowed these students the opportunity to explore multiple possibilities, using their moral imagination to 'try out' alternate avenues of action and learn from the results of those actions in a safe environment.

2.4 | Moral imagination and embodiment

Our moral self-identity is composed simultaneously through both thinking and action together (Johnson, 1993). Nurse scholars drawing

on existential philosophy, specifically phenomenology, articulate the fit and utility of embodiment for understanding and improving nursing care (e.g., Bergum, 2013; Harrison et al., 2019)[2]. Nursing practice is often structured within healthcare settings that align with traditional medical views, which focus on the body as an object. Merleau-Ponty's phenomenology, building on Husserl, (re)focuses our attention to bodies as lived, perceiving, and inseparable from mind. Johnson (1993) foregrounds the inseparability of our sensing bodies, imaginative inhabiting the experience of the others, and imaginatively discern possibilities (p. 202). To repeat, concepts and our reasoning, our cognitive capacities are grounded in our bodies and imaginative, through and through (Johnson, 1993, p. 1).

Johnson (1993) asserts that moral imagination, as embodied, can have a profound effect on moral agency. That is, through interrogating embodied experiences and the context within which those experiences are situated one engages in moral deliberation. Following John Dewey, Johnson asserts that all human morality involves a human–environment interaction that commonly are habits, unreflective, and acquired through narrative structures. Emotions are intertwined with imagination and reasoning, to allow for moral deliberation (Johnson, 2014, p. 27). Cognitive science increasingly supports this conceptualisation through growing understanding of mirror neurons, language, and intuitive thinking (Kahneman, 2011).

2.5 | Moral imagination and moral agency

For us, a starting place for moral agency, which we see as an attribute of nurses' personhood, is 'the ability to fulfil ethical obligations and commitments' (McCarthy & Deady, 2008). According to Milliken (2018), in her revised definition of moral agency, the person as nurse, is moved to action on behalf of a patient resulting from insight into the ethical implications of a situation and the available courses of action, with a willingness to dialogue thoughts and concerns in an interdisciplinary context to achieve what is needed in line with patient and professional goals' (p. 5).

Pask (2001) repeatedly highlights the relationship between imagining and moral agency. She argues that a nurse's degree of receptivity to patients' points of view will inform compassionate and responsible nurse actions. This receptivity requires the nurse to bring 'an ability to see what is salient from the patient's point of view' as well as be 'sensitive to detail that indicates the patient's perspective, and that they are at the same time able to grasp the whole picture' (p. 42; see also Jantzen, 2019). Pask presents an example of a student whose behaviour was an exemplar of acting out of compassion and exerting moral agency, describing how she 'imagined what it must be like to be old and in hospital, to feel distress' (p. 43). It is worth reflecting on the relationships assumed between distress, moral distress, embodiment, moral imagination, and moral agency.

Peter and Liaschenko (2013), building on feminist moral theory, stress that moral agency occurs in a socially connected and socially embodied, relational context. For these authors, the social context is inextricable from our role as moral agents. Taking moral action does not guarantee an ethical end or outcome (Musto et al., 2021). While nurses are not necessarily able to repeat actions taken in unique situation for future success the outcomes of embodied moral agency in that particular experience can become part of a scaffolding to support future interactions. Moral agency in each situation is a 'range of possible actions' nurses can take (Musto et al., 2021). Teaching for this understanding of moral agency, and specifically moral imagination in the affective domain, requires pedagogy beyond learning moral theories and principles for ethical decision-making.

Questions remain. Johnson's (1993, 2014) moral imagination prioritises bodily experience (embodiment) in a social context. Johnson (1993) identifies physical, cognitive, social and ecological dimensions of human life (p. 240). There is no mention of two dimensions of the mind, body, soul, and spirit, foundational to some traditions (e.g., Indigenous, Judeo-Christian). His conceptualisation is deeply rooted in human as organisms, within systems of metaphors. How might nurse educators attend to the development of moral imagination for students with deeply held spiritual values? How does Johnson's embodied, imaginative moral reasoning inform nursing practice in pluralistic societies, with religious diversity, and complicated views of religion and secularism (Reimer-Kirkham, 2019)?

2.6 | Moral imagination and nursing education

Creating spaces for moral imagination allows nurses and nursing students to reach beyond themselves and the 'tendency for egoism' towards empathy and compassion (Pask, 2001, p. 45). The moral dimension of undergraduate nursing education has been discussed by a small number of nurse scholars for over 30 years (e.g., Callery, 1990; Gallagher, 2016; Hembree, 1988; Jaeger, 2001; van Hooft, 1990). Despite what appears to be an important thread over these decades, the number of focused studies providing evidence on effective approaches for teaching moral reasoning, moral perception, moral courage, moral sensitivity, moral agency, or moral imagination is relatively small (Krautscheid, 2017; Spekkink & Jacobs, 2021; Tanaka & Tezuka, 2021). Tanaka & Tezuka (2021) report non-traditional formats (e.g., SLE) for education for moral sensitivity, within the affective domain similar to moral imagination, is limited and of low-quality.

Benner et al. (2010) connect moral education with professional identity formation (see also Apesoa-Varano, 2007; Crigger & Godfrey; 2014; Haghighat et al., 2020). Benner et al., in their expansive review of nursing education in the United States, recommend four key shifts to meet the demands of 21st century nursing practice. One of these shifts is 'from an emphasis on socialisation and role taking to an emphasis on formation' (p. 89). Pedagogies of contextualisation (pp. 48, 89) are highlighted throughout their recommendations. While experiential learning is critical, it is often associated with learning in the clinical setting; however, the authors also argue for more contextualisation in the classroom (p. 191). More recently, Simmonds et al. (2020) highlight the importance of integrating explicit pedagogical practices and

transformative learning as an avenue to support the professional identity formation of undergraduate students.

In all nursing practice situations, patients' and their families rely on nurses' moral imagination as well as knowledge and skilled know-how (Benner et al., 2010, p. 166). In Benner et al., a detailed discussion on teaching for moral imagination creates a picture of teaching for attentiveness and vigilance in nursing practice, the development of moral imagination through rehearsing, integrated teaching, contemplation of obligations, active learning, and dialogical and consciousness-raising questioning, such that students are required to confront gaps and examine assumptions. Teaching for moral imagination is focused on 'being' a nurse – defined variously as perceiving, thinking, acting, habitus, learning to use knowledge, and 'styles of practice' in unique situations (see also Thorne & Sawatzky, 2007). This type of being includes 'skills of involvement' – attunement and involvement with the situation at hand (Benner et al., 2010, p. 183). We consider this learning to be too important to be left to chance. Intention is required.

Given the socially connected and relational nature of moral agency (Peter & Liaschenko, 2013), the social context is iteratively (in) forming and transforming students through their identity formation. Sociopolitical forces, including technical rationality, instrumentalism, and regulatory control, and shifts in the public sphere have erased traditional narratives and reshaped ethics conversations, and therefore also teaching for moral imagination, moral agency, and ethical practice. This is particularly true in the current healthcare climate. Nursing education and the narratives that shape the curriculum development and delivery of individual programs directly form students' understanding of professionalism, identity development, and nursing care. Nursing students and educators are thus simultaneously engaging in two distinct contexts, the healthcare system and the postsecondary educational system. Both systems are laden with distinct obligations and commitments: for healthcare, the patient and their families; for postsecondary education, the students. For nursing students, their learning necessitates straddling contexts. Nurse educators, therefore, are engaged in shaping professional identities simultaneously within education institutions and practice environments. What both spheres have in common is the profound influence of technical rationality (Rolfe, 2019) and the erasure of traditional ethical modes of understanding (Johnson, 1993). By intentionally creating pedagogical spaces that explicitly address this issue, nurse educators can mitigate constraining factors and build a moral community that spans both spheres.

Benner et al. (2010) present a paradigm case of teaching for moral imagination. In this case the teacher aimed to teach, in the classroom setting, 'how to think ethically about taking care of patients' and 'how to separate their personal feelings from their professional responsibilities' such that 'once students understand how to think about ethical problems, they can act in an ethically responsible way' (p. 170). Moving away from personal feelings, and related behaviours, involves being able to understand the others' possible feelings, and perspectives; to be in someone else's shoes. With Johnson's conceptualisation of moral imagination, students' empathise, deliberate, and engage with the sedimented 'wisdom' of the profession.

However, for some nurses the managerialist influences or profit-orientation leads to moral conflict rather than 'outspoken involvement in the ethical issues associated with health care reform' (Drew, 1997, p. 422). For decades nurses have been writing about the link between growth in self-understanding (self-awareness) of personal values and examining these in light of nursing work, carried out within healthcare structures where efficiency is the implicit value and not patient centred care. Johnson (2014) reminds us that attending to our values 'is something we do' and moral imagination can be constrained by inattention to the conditions within a space that support uncontested uptake of normative habits (p. 72). Without explicit language, space and nurturing, this incongruence stifles the moral imagination of novice learners as they tend to 'adhere to the rules by necessity' while attempting to navigate the complexity of practice environments (Wocial, 2010, p. 99). Two strategies are commonly linked to teaching skills of perception, attunement, and involvement to support novice learners in this regard: reflective practice and coaching (Benner et al., 2010). What knowledge, skills, and dispositions do nurse educators need to develop to achieve these aims using strategies beyond reflective practice and coaching? How might classroom or lab learning inform moral imagination?

More recently, the value of employing SLEs in nursing pedagogical context to underscore the complexities of nursing as a moral practice has been examined (e.g., Ayed et al., 2021; Chen, 2011; Harvey et al., 2021; Honkavuo, 2021; Kirkpatrick et al., 2020; Krautscheid, 2017; Mackey et al., 2014; Sedgwick et al., 2020; Spekkink & Jacobs, 2021; Wilt, 2012). Outcomes of such studies claim that students experience increased self-awareness (Ayed et al., 2021; Kirkpatrick et al., 2020), empathy (Ayed et al., 2021; Mackey et al., 2014), confidence in ethical decision-making (Harvey et al., 2021; Krautscheid, 2017) and providing patient-centred care (Ayed et al., 2021). The integration of didactic pedagogy (Harvey et al., 2021), theory (e.g., ethics of caring, Honkavuo) and the affective domain with SLEs increases confidence, knowledge, and selfunderstanding (Kirkpatrick et al., 2020; Krautscheid, 2017). Simulation education and simulation research allows for students and participants to engage in experiences that would not normally be possible (Vemuri et al., 2020), such as potential violence in the workplace. SLEs, based in experiential learning, engage the affective domain (Slavich & Zimbardo, 2012). Including performing arts techniques in conjunction with students participating as simulated participants also shows promise as an avenue to promote self-understanding, empathy, and recognition of the effects of nurses' communication towards patients (Harvey et al., 2021; Mackey et al., 2014). Central to SLE learning, specifically for self-understanding, is the integration of prebriefing, debriefing, and reflective practice (see Harvey et al., 2021).

Although experiential learning, in the form of SLE, has the potential for perspective transformation, we cannot be naïve to the problems. A key challenge to SLE arises from a tension between the idea of standardisation and personalised care (Taylor, 2011). To support realism and support the aims for SLEs, like the VP SLE,

simulation educators have implemented actors and standardised patients into medical and nursing education. The purported advantage of SLE is for 'keeping it real,' while protecting patients in the clinical setting. Taylor (2011) argues, however, that SLEs incorporate multiple and conflicting ideals (pp. 137–139). There are limitations to both realism and, in the case of both VP and ethical challenges, assurances of safety or absence from suffering.

2.7 | Imagining and performing: Simulated participants in a VP simulation

In our multimodal VP pedagogical intervention, the simulated participants played multiple roles. The SP students were conscious of simultaneously learning, performing, watching, and also being watched. The SP students experienced being on both sides of the conflict and the learning. The SP students were performers, being in their bodies, improvising, reacting, responding, 'making it real' and 'taking it seriously'. Being an actor or a performer required engaging with a range and depth of emotions, including being frustrated, sad, angry, helpless, afraid, surprised, and calming down. The SP students were able to identify the morally salient details of the SLE and imagine far more than the intended goals of the exercise as they developed the capacity for moral imagination through acting and performing the SP role. The SP students embodied experience combined with their moral imagination provided powerful insight into 'being in someone else's shoes'.

Our study findings suggest that something as seemingly simple as a student acting the part of an angry family member transforms their understanding and compassion towards the other. Although we cannot predict this will be carried forward into these students' future practice, we do believe that this transformation may contribute to continuing to 'be in someone else's shoes'. In our focus group, although a very small sample, this played out directly in their clinical practicum in the following semesters.

The SP experience in our study aligns with Johnson's (1993) assertion that embodiment and moral imagination can have a profound effect on moral agency. That is, through interrogating embodied experiences and the context within which those experiences are situated, the SP student could engage in moral deliberation. The SLE allowed these SP students the opportunity to explore multiple possibilities, using their moral imagination to 'try out' alternate avenues of action and learn from the results of those actions in a safe environment. Johnson's (2014) recognition of the intersubjectivity of learning values through interpersonal relations, communication and performance (p. 58) is fitting. The SLE allowed the SP students to gain further insights through the intersubjectivity experienced with varied responses of the other students as they performed with them and provided feedback to them spontaneously.

The SP students were able to experience both facilitators and barriers to choosing responses. These students began to reimagine different ways of engaging with such patients – in ways that we understand as ethical and more holistic. Milliken (2018) suggests that helping nursing students become aware of the role of context can positively contribute to better moral decision-making (p. 4). In contrast to the student-learners, who prepared exclusively through the cognitive domain, the SP role required an affective, embodied response – anger from the perspective of the 'other' which created a disorientating experience prompting CR (Cranton, 2016, p. 73). We discuss the role of training for 'being in someone else's shoes', of repetition on imagining possibilities, and of embodied engagement on perspective shifts, and then offer some implications for nurse philosophers and nurse educators.

As the SP students imagined and performed as an angry family member, they gained insight and shifted their focus from the de-escalation techniques to empathy, and moral imagination. The SP students were provided with explicit training and direction to 'get into character' and 'be' the angry family member. When preparing for their performance, the SP students were tasked with imagining: What is it like to have your loved one not cared for as you would expect? What is it like to have your time and your expectations set aside by healthcare staff? What does this feel like? When you feel like this, how might you act? What if this was you, and your grandma? This imagining was highly effective. During interviews, some of the SP students recounted previous experiences with a loved one in a similar setting as the SLE. The students often described their own and their families' experiences and stated they brought that into the performing to 'make it real'. Seeing that 'other side', that is imagining the other's perspective, allowed the opportunity to gain empathy for an angry, aggressive and potentially violent family member. This empathy was said to influence how one SP would act in future clinical setting.

Acting as the SP provided repetition and allowed the SP students to build layers of experience over a short timeframe (see also Pask, 2001, p. 45). In addition to the affective, embodied response discussed above, through repetition of the SLE scenario the SP students experienced the SLE in a deeper way than the other 140 nursing students. They acknowledged that the repetition provided an emergent and improvised dynamic which, in combination with watching others, provided greater learning that their student participant counterparts. The SLE allowed for pause, feedback, advice, and multiple do-overs. We observed that the unintended effects of repetition supported an appreciation of diversity within contextualisation.

While the overall context of the scenario was said to be 'fixed,' the SP students were able to see how small changes in the environment, the spatio-temporal frame and the influence of multiple players opened up new possibilities and new problems. The SP students observed that context is influenced by human actors and structural factors that may or may not be under their control. These include physical layout of the space, policies, and the number of staff that might be available to assist them. Context plays a key role in enacting moral agency, often in terms of contextual barriers and facilitators. A SLE provides the possibility for repetition within a spatio-temporal frame unlike lectures, virtual SLEs, or even the clinical educational environment itself. The SP students recognised

that there was no single correct way to enact moral agency, but rather a plethora of possible avenues of action. There was some indication that in their future practice they would be better prepared to think through challenges, to 'see, and to be receptive to those cues through which the perceptions of others are made known' (Pask, 2001, p. 46); and then to deliberate safe action within the spatio-temporal frame to mitigate suffering of others.

In both actor and observer roles, the SP students described how they felt themselves responding to the other students' (the imagined healthcare workers) approaches to them. They gained insight into the usefulness, or not, of the varying students' responses. They reflected on how their emotions were strongly influenced by the responses and actions of the other students. This is not to say they evaluated their peers, but rather they observed how 'that person's response would most surely make it worse' or that certain student's 'body language was heightening my anxiety'. One SP student expressed surprise at how quickly some students 'put up walls' or became 'defensive'. In addition, the SP students also discussed how, despite the scenario requiring them to maintain their anger or become increasingly aggressive and potentially violent, there were instances where student responses caused them to 'calm down', which they also stated they 'felt' in their bodies. As one SP student stated, it was 'hard to stay mad' in that situation. SP students also talked about the visceral reactions they had to ineffective responses to their anger.

The SP students came to understand both sides of the conflict, felt increasing empathy for both the patient and family member, and made observations of their peers' responses based on their embodied insights. The SP students began to question, with no direction from the instructors, the moral significance of the social and power differentials between multiple players portrayed in, and implicit to, the scenario. One of the SP students, who was of small stature, observed during the SLE that she believed her size was constructed differently by various students. She describes how tall, strong male students positioned themselves physically in a way that she thought to herself, 'Hey you are just making this worse. You are making me very angry. This isn't working'. Together, this embodied engagement promoted their own perspective shifts.

2.8 | Implications for nursing philosophy and nursing education

We began the project with a sense of urgency and moral responsibility to prepare students for violence in the practice environment. Study findings suggest that students' knowledge and confidence increased. Additionally, the SP experience also contributed to the development of moral imagination, a quality that may contribute to the prevention of moral distress, an equally significant problem for nurses (Traudt et al., 2016). Three practices important to moral imagination (Traudt et al., 2016, p. 206) were also evident in the SP experience of the SLE: empathy (putting themselves in another's shoes), ascertaining what someone else would want, and envisioning possibilities or other ways of preventing anger, frustration, and potentially violence in the healthcare setting. We propose that SLE, and specifically, student participation as SP, is one answer to the question of how to do ethics education in Sedgwick et al. (2020).

The SLE offers a pedagogical space for the development of moral imagination, transformational learning, and the formation of professional identify. In our analysis we began to trace the ability to articulate their emerging views of their own identity as caring, empathetic, and morally responsive nurses. Some of the SP students further described this in their practice educational settings. In this way, their professional identity was being shaped by the impact of this learning experience. Forming professional identity involves acquiring 'new habits of thought and action' while 'relinquish[ing] old habits and perceptions' (Benner et al., 2010, p. 166). 'Moral imagination enables our ability to see, and to be receptive to those cues through which the perceptions of others are made known to us' (Pask, 2001, p. 46). Involving students as simulated participants is particularly well suited to achieve this aim. Through such processes, students are supported to reflect upon what is good nursing practice in order that they can reimagine relationships and responsibilities that relate to the complexity of care for a broad spectrum of patients and their families (Benner et al., 2010). However, the critical role of training, improvisation, and becoming an actor cannot be dismissed. Nurse educators should not ignore the importance of the embodiment, emotions, and empathy of those 'acting' as patients.

Realism, consistency, and standardisation are key values in simulation education. The use of 'real people' in our VP simulation recentred the individual (the SP student), within an imagined milieu of family, caregivers, persons, and the 'care system.' The realism we refer to here is not 'how well the performance corresponds to some reality' but rather how it reflect the emotions and embodied experience for the student (Taylor, 2011, p. 150). In contrast with the goal of standardisation, the SLE were highly personal, both for the simulated nurse and the simulated family member. Although the SLE was highly-structured, in keeping with recommendations from Honkavuo (2021), it was the improvisational acting and performing that promoted transformative learning for the SP. Careful philosophical exploration of ideas of realism, standardisation, and embodied learning is needed to inform integration of SLE in nursing education.

Philosophical examination of moral imagination has not taken a central role in the area of nursing ethics. Scott (1997) and Pask (1997) are unique in their philosophical exploration. Although highly relevant to teaching for moral agency and good nursing, Sellman's work (2011) is silent on the role of embodiment and moral imagination. Chen (2011) follows a similar approach we have done here, connecting simulation-based training with conceptualisations of moral imagination, drawing on Scott and Nussbaum. Recent work in relation to simulation and moral imagination is empirically focused and most lack the level of philosophical thought needed. Macintyre (1984) and Johnson (1993) called us forward from emotivism and the atomic, selfinterested objective moral agent (Johnson, 1993, p. 148). Sellman (2011) has uniquely engaged Macintyre's (1984) work but lacks the attention to current pedagogy and predates new foundational work

(Milliken, 2018). We invite those engaged in the areas of nursing ethics, nursing philosophy, and the broader discipline of philosophy to carry this beginning exploration forward. Specifically, how can philosophy assist nurse educators in examining the 'narrative context within which the [nurse] self as a moral agent develops' within deliberate pedagogical activities (Johnson, 1993, p. 149)?

As ethics education was not an explicit aspect of the VP educational intervention and SLE, we view this as a cautionary tale. We wonder what narratives nurse educators implicitly convey in the common use of highly technical, individualistic, decision-making SLEs, not unlike our own multimodal education intervention, which had the goal of students' discriminating between emotional crisis or behavioural emergency and deploying prescribed de-escalation techniques. We are reminded that, as educators, we are *always* teaching ethics and notions of what 'good' nursing is. Moral education is embedded in every scenario with the educator's reaction providing intentional and/or unintended modelling of professional action. How might reliance on managerialist or prescriptive scripts be shaping professional identities away from the more challenging need for moral agency, through moral imagination? We challenge nurse educators to constantly interrogate teaching plans and educational activities by enacting our own moral imagination to create spaces where explicit education for moral practice can flourish.

3 | CONCLUSION

Aimee Milliken concludes her paper on refining our understanding of moral agency, with this statement: 'Preparing nurses … to act as moral agents must take the role of the environment into consideration. … No one in healthcare works in a silo; the way moral agency is conceptualised and taught must reflect this necessary fact' (2018, p. 5). In this multimodal learning experience, we believe that the SP students, through an embodied learning activity, developed deeper understanding of the ways in which both imagining the perspective of the other and the context shaped their ethical understanding of a situation. In turn, they also recognised the myriad of ways in which their actions and responses can shape the context and the possibilities for their own moral agency.

At the heart of this transformative learning experience is the relationship between the performing art, of being the angry person, and imagining both what this feels like and also how an understanding of another's perspective shapes nurse-patient interactions. The development of the nursing student's professional identity (self-perception) involves perspective transformation (Cranton, 2016), in this case through an embodied experiential learning experience that provided space for moral imagination.

To return to Milliken's definition of moral agency, we highlight the potential 'resulting from insights into the ethical implications of a situation' (2018, p. 5). We believe that the SP students developed insight, through their imagining and performing, into the ethical implications of the situation. Thus, there are indications that these students' future practice will contain the space to imagine multiple possibilities and be informed by this transformative learning experience. Indeed, we must encourage this.

SLEs, through their embodied engagement with learning, offer a unique pedagogical space for nursing students to develop moral imagination, which is foundational to 'ensuring the patient's goals and wishes are central' (Milliken, 2018, p. 6). As Milliken argues, this refocusing for nursing ethics on the persons and their perspectives provides a more nuanced and realistic understanding of the moral agent in the healthcare system. Moral imagination is an integral component of moral agency and person-centred care and can be taught. Nursing educators must therefore recognise and also respond to the embedded nature of ethics and the questioning and critiquing associated narratives that are always present, across both post-secondary (academic) and nursing practice settings.

Nurturing sustained attention on the recipients of care, their families, and on the contexts of care is required. We invite all nurse educators to give sustained attention the ethics and microethics of pedagogical practice, across classroom, lab, simulated, and practice settings. This sustained attention for fostering moral communities, enacting moral agency, and exercising moral imagination models what is needed for the flourishing of patients, their families and communities and the nurses caring for them (Traudt et al., 2016).

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

No data are available.

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ENDNOTES

[1] Lewis et al. (2017) recommend the use of the term simulated participants for those trained to portray a patient (or family, we presume) in simulation. In the majority of the literature reviewed, the term standardised patients is used consistently. By using the SP abbreviation in this paper, the reader is invited to use their preferred terminology for what fits with the SLE. In our SLE, the trained students were not patients, in the traditional sense. The use SP is plural (as per simulated participants).

[2] We recommend Harrison et al. (2019) for an excellent analysis of Merleau-Ponty for nursing.

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