



CHAPTER 8

Becoming a Transformative Nurse Educator: Untangling Ethics in Nursing Education

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“The Courage to Teach is for teachers who have good days and bad, and whose bad days bring the suffering that comes only from something one loves. It is for teachers who refuse to harden their hearts because they love learners, learning, and the teaching life. When you love your work that much—and many teachers do—the only way to get out of trouble is to go deeper in. We must enter, not evade, the tangles of teaching so we can understand them better and negotiate them with more grace, not only to guard our own spirits but also to serve our learners well.” (Palmer, 1998, pp. 1–2)

FOR THE AUTHORS OF THIS CHAPTER, all of whom have engaged in advanced nursing practice as educators and leaders, the words of Parker Palmer are meaningful. Having the courage to teach, and to do so ethically, is at the core of nurse education. In this chapter, we shift the ethical lens from clinical nursing practice to the practice of nursing education; we include the nuances and complexities of ethics in everyday teaching practice and leadership; and we draw on the concept of relational pedagogy, a perspective that nurse educators use to prioritize relationships over individualism. We use ethical decision-making frameworks to provide readers with guidance to enact ethical practice. Throughout this chapter, we acknowledge that nurse educators are advanced practice leaders, as their roles entail significant leadership responsibilities in Canadian health care and education systems.

Contemporary nursing education is an ethical practice (Ehrich et al., 2011), grounded in principles of social justice, safe, competent practice, and relational pedagogy (Bergum, 2003; Canadian Nurses Association, 2017; Hartrick Doane & Varcoe, 2015; Osman & Hornsby, 2017). Nursing education is also embedded in a labyrinth of neoliberalism (Darbyshire & Thompson, 2021; Goodman, 2014; Grant, 2014; Osman & Hornsby, 2017; Snee et al., 2021), including the corporatization of higher education (Rolfe, 2019), a severe shortage of nurses (Snee et al., 2021), and resource scarcity (Emanuel et al., 2020).

Nurses and nurse educators are among the most significant scarce human resources in health care. Currently, nurses are positioned as “heroes” as a way of rhetorically masking the many systemic resource failures during the COVID-19 worldwide pandemic (Einboden, 2020). In 2021, the British Columbia Nurses’ Union stated: “[O]ur health-care system doesn’t need more heroes. We need more nurses.” Leaving aside the problematic nature of the hero label, it is notable that nurse educators were rarely acknowledged as heroes during the global pandemic, despite their considerable efforts to ensure that learners’ education would continue as seamlessly as possible (Poindexter, 2021).

Nurse educators provide leadership in complex and diverse environments that present both challenges and opportunities regarding ethical practice. For example, in Cotter and Clukey’s

(2019) study of the cultural context of academic nurse educators, faculty described their interactions as “guarded, uncivil, and conflict avoidant within a bureaucracy of slow pace of work, resistance to change, heavy workloads, and requirements for scholarship that are not clear or consistently enforced” (p. 139). In addition, nurse scholars are critiquing academic scholarship as unchallenged dominant discourses and power structures that have supported Western, colonial, and gendered thinking above other forms of knowledge (Crosschild et al., 2021). In this milieu, what is valued is linked to problematic power dynamics, within a Western paradigm in which empirical knowing is respected over other ways of knowing such as “Black feminist ways of thinking and Indigenous cosmologies and epistemologies” (Crosschild et al., 2021, p. 3).

Overall, the proliferation of adherents of neoliberalism undermines critical scholarship. As Canadian nursing leader Michael Villeneuve (2017) notes, neoliberalism is a prominent and pervasive political ideology “where policies often tend to favour market forces and privatization” (p. 24). Neoliberalism has therefore become linked to the corporatization of higher education (Grant, 2014). Rolfe (2019) claims that nurse academics are torn between the values of the corporate university and the values of clinical practice; between “giving the customers [learners] what they want in order for them to secure well-paid employment and giving them what they need in order to be caring, compassionate and effective nurses” (p. 7). All of this is to say that academic life is complex and filled with both positive and negative relational, intellectual, and ethical encounters.

Where Does Ethics Fit in Nursing Education?

It is imperative to focus a discussion about ethics in nursing education from the level of the individual through to socio-political contexts, due to the importance of social justice as a foundation on which ethical practice is enacted (Hartrick Doane & Varcoe, 2015; Kenny et al., 2010), and the need for nurse educators to engage in a “socially just pedagogy” (Osman & Hornsby, 2017). There are shortcomings in the prevailing individualistic ethics framework (Kenny et al., 2010) which require a recognition of the centrality of relation-

ships in education (Ikpeze, 2018; Zhang, 2021). Relational pedagogy and relational ethics are discussed by some authors at the interpersonal level (Bergum, 2003; Deschenes & Kunyk, 2020; Ikpeze, 2018), and by others more contextually (Aspelin, 2021; Hartrick Doane & Varcoe, 2013, 2015), emphasizing relationships in the socio-political and cultural contexts of education.

Within relational pedagogy, there is an emphasis on the relational space—that is, the space *between* learner and teacher (and others)—where power is enacted by those engaging in relationship (Bergum, 2003). There are varying theoretical perspectives on power, but we focus on relational power as enacted in a *relational space*, where power is shareable and mutually empowering (Qin, 2018). Notably, even though issues of power and hierarchies have long been known to exist in health care, they are seldom analyzed in traditional health care education systems such as nursing or medicine (Halman et al., 2017).

For clarity and inclusivity throughout, we use the terms “learners” to denote graduate and undergraduate students, and nurse learners; and “educators” to denote faculty members, clinical teachers who work with students and/or nurses, patient/client educators, as well as advanced practice nurses and leaders whose roles include education in some form.

A Call for a Focus on Ethical Concerns Within Nursing Education

While there is much written on ethics in nursing education, authors often focus on the teaching *of* ethics and teaching *for* ethical practice (Brown & Allison, 2013; Fowler & Davis, 2013). Little attention has been given to the many ethical concerns *within* nursing education itself. Fowler and Davis (2013) observe that significant attention is given to nursing education issues related to authorship, such as student cheating, at the expense of other ethical issues that are given little or no focus. For example, it would be rare to see the issue of faculty impairment explored in the nursing literature. These authors go so far as to suggest that “the entire domain of ethics in nursing education is, itself, taboo” (p. 129). As educators, we question why this is so, and ask if it is time to bring the “taboo” out in the

open. A first step is to make visible several relevant questions, including the following, which are related to the Ethics in Practice scenarios we describe in more detail later in the chapter.

1. How might educators enact their moral courage to address an issue with a colleague's practice that has come to light through a learner's concern?
2. How can educators respond when academic or clinical practice nurse leaders do not act on concerns, for example, bullying of learners?
3. How can educators and leaders use their collective voices to disrupt socio-political policies and practices that create moral distress for learners and educators, and have the potential to cause harm to health care providers, their clients, and families?
4. How might learners be supported in questioning, and ultimately addressing, a culture of poor practice in various contexts?

When grappling with questions such as these, it is important to uncover the theoretical and ethical guidelines that educators can use to enact their teaching practice at intrapersonal, interpersonal, and contextual levels (Hartrick Doane & Varcoe, 2015).

Theoretical and Ethical Guidelines for Educators

In this chapter, we focus on relevant theoretical perspectives in education, grounding our work and practice in critical pedagogy (Freire, 1968/2018). Using a critical approach enables teachers and learners to recognize education as social and political, to examine the effects of power and privilege in health care (Halman, 2017), and to question “what is, why it is so, and whether it must be that way” (Peters & Mathias, 2018, p. 63).

Drawing on the work of Freire, bell hooks (1994) positioned education as an act of freedom, acknowledging the intersections among anticolonial, critical, and feminist pedagogies, and citing the classroom as having the potential to house the most radical space in the academy. hooks (1994) described a pedagogy of engagement as

an inclusive space which is foundational for learning and action to occur. Rather than “safe” space, we use the term “safe(r)” to acknowledge the difficulty of guaranteeing safety for all, recognizing that safe for one may not be safe for another. Educators should strive for space that is as safe as it can be (Anderson & Riley, 2020; Carello & Butler, 2015; Deller, 2019; Mental Health Commission of Canada [MHCC], 2019). Ideally, educators work with learners to co-create a safe(r) educational space where diverse views are welcome, and teaching is action-oriented with the goal of transformative learning (Freire, 1968/2018; hooks, 1994). Educators who promote transformative learning believe in the potential of learners, so that learners can be confident in their own capacities to enact change at the socio-political level (McAllister, 2015). The notion of a socially just pedagogy has been discussed in non-nursing literature as one way to bring higher education back to its roots of social justice (Osman et al., 2018). Transformative learning intersects with socially just pedagogy to foster critique of current pedagogic practices and support educators to strive for education for social change. It asks them to consider “*what* they teach, *how* they teach, and *why* they teach” (Osman & Hornsby, 2017, p. 3, emphasis added).

In Canada, it is especially important that educators dismantle colonial ways of knowing, learning, and teaching (Canel-Çinarbaş & Yohani, 2019; Pidgeon, 2016; Stansfield & Browne, 2013), so that they can honour the 2015 *Truth and Reconciliation Commission of Canada: Calls to Action* (TRC). For example, call to action 24 states

We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. (p. 3)

To support nursing educators and academic institutions to take up the TRC (2015) calls to action, the Canadian Association of

Schools of Nursing (CASN, 2020) released a document describing strategies to address Indigenization, decolonization, and reconciliation. Embedded examples within three broad categories—foundational, recruitment, and curricular strategies—include the importance of partnerships, faculty/staff education, designated seats for Indigenous students, hiring and supporting Indigenous educators, and inclusion of Indigenous epistemologies and ways of being in the world.

Indigenization in higher education is complex and must move beyond tokenism to truly embrace Indigenous ways of learning, knowing, and doing (Pidgeon, 2016) to provide more holistic curricula in nursing education (Stansfield & Browne, 2013). This inclusion must be done in respectful partnership with Indigenous Elders and Knowledge Keepers so that there is minimal risk of appropriation or misappropriation of Indigenous Knowledge (Stansfield & Browne, 2013). We posit that by embracing anti-racist curricula and Indigeneity in nursing, educators can support the theoretical and philosophical commitments to ethical nursing education that are described in this chapter.

An Ethical Framework for Nursing Education

It is important for nurse educators to use frameworks to guide their practice. For example, the Society for Teaching and Learning in Higher Education (STLHE), a team of award-winning educators in Canada (Murray et al., 1996), has proposed an ethical framework for education. The STLHE framework has a series of nine principles for teachers in higher education, namely

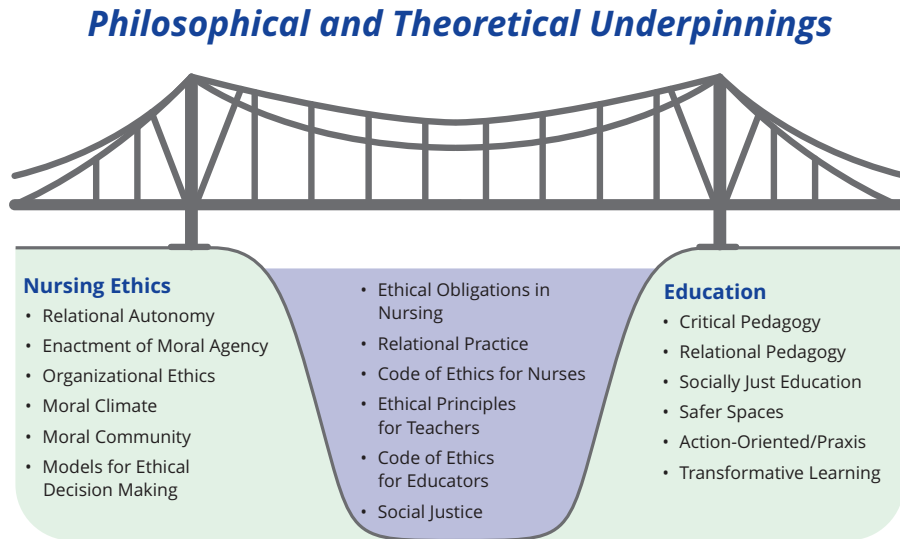
- competence in content
- competence in pedagogy
- skill at addressing sensitive topics
- commitment to supporting learners' development
- proficiency at maintaining professional relationships with learners
- confidentiality
- respect for colleagues

- valid and fair evaluation of learners' work; and
- respect for one's institution (Murray et al., 1996)

The aforementioned theoretical approaches and ethical principles are, of course, illustrative examples, and readers may have their own tried and trusted approaches (see Appendix 8-1 for an individual exercise to explore what guides your teaching practice). Ethical situations in nursing education are increasingly complex (Rosenkoetter & Milstead, 2010), thus requiring educators to use systematic approaches in order to address them. Ethical frameworks can support understanding and action when educators are faced with an ethically challenging situation. Despite their importance, there is a paucity of ethical frameworks for nursing education. The work of Rosenkoetter and Milstead, revising a previous version of Rosenkoetter's code of ethics for nurse educators, is one of the very few examples. This has led us to propose a framework for ethical decision making in nursing education (see Figure 8-1). We based the framework on (a) our knowledge and experiences as nurse educators; (b) our knowledge and experiences regarding ethical decision making; (c) diverse literature sources related to nursing ethics and health care ethics; and (d) nursing and other education sources (for example, CNA, 2017; Fowler & Davies, 2013; Freire, 1968/2018; Hartrick & Doane, 2013, 2015; ICN, 2021; McDonald, 2013a, 2013b; Rodney, 2017; Storch, 2013a, 2013b). We hope that nurse educators and nurse leaders will find the framework in Figure 8-1 below useful in addressing ethical concerns in nursing education.

FIGURE 8-1

A Framework for Ethical Decision Making in Nursing Education



When you have an ethical concern, draw on the above philosophical and theoretical underpinnings, and use the four pillars of Concerns, Analysis, Options, and Actions. Ask yourself the questions below from the perspective of an educator, a learner and/or a leader.

Concerns

Analysis

Options

Actions

- What ethical concerns do I have in this education situation?
- What relevant information do I have and what, if any, information/data am I missing?
- What resources will I draw on to address this education challenge? (Intrapersonal, interpersonal, policy, academic institution and clinical agency guidelines, professional regulatory directives, and related provincial, national, and/or legal standards).
- What resources will guide my approach? (Ethical, pedagogical, relational).
- How will I determine my approach in this situation? Does my approach cover most aspects of the situation/actions/solutions? What will I do if my approach does not work? What will my alternate approach be?
- How will this process influence my practice as an educator and/or leader?
- What are the policy implications of this situation at institutional and socio-political levels?

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In what follows, we emphasize areas that are often invisible in the nursing education literature (Fowler & Davies, 2013). We focus on: (a) educator impairment; (b) teaching sensitive topics; (c) lack of response by a nursing leader in clinical practice to an educator's concern; and (d) inequities of care based on the socio-political context.

Ethics in Practice Scenarios

In Ethics in Practice 8-1, professional impairment is understood as a professional's inability, or lack of capacity, to engage effectively in practice. In our literature review, we discovered few studies where researchers explored impairment of nurse educators. Fowler and Davis (2013) found that educator and student impairment is invisible in the literature, although impairment in practice is well described. However, we located some studies related to impairment of nursing students (Dittman, 2015; Spier et al., 2000). While impairment in nursing is frequently associated with substance use (Contenta, 2019; Dittman, 2015; Dulaney, 2016; Spier et al., 2000), there are several other factors, such as work-related stress (Gustin et al., 2020), fatigue, and/or illness (Spier et al., 2000), that could also account for a professional's inability, or lack of capacity, to engage effectively in practice. One should avoid making assumptions throughout the analytic process.

ETHICS IN PRACTICE 8-1

Educator Impairment: A Hard Conversation

You are an experienced educator and faculty member at a university school of nursing in Canada. You enjoy your work, your colleagues, and the undergraduate and graduate learners. You value teaching as a relational process and strive to be ethical in your everyday practice as a teacher, researcher, and administrator. For example, you engage with learners to co-create safe(r) spaces and you welcome learners' diverse views within these spaces.

You are in your office when a learner drops by to ask if they could speak with you about an issue they are facing. You invite them to sit down, and they express concern about a faculty member who arrives late to class, seems to lack presence when they are there ("spaciness"), provides minimal guidance and feedback on assignments, and shuts down questions when they arise.

Previously, this faculty member engaged with learners and teaching in ways opposite to what the learner describes is happening now. The learner believes they are not able to approach the teacher directly and are worried about the teacher, as well as the learners in the class.

FOR REFLECTION: ETHICS IN PRACTICE 8-1

After fully listening to the learner and clarifying any ambiguities, please use *A Framework for Ethical Decision Making in Nursing Education* to decide what to do.

There are several unknowns in this scenario, and one should not make assumptions. Perhaps the first question to ask is whether you are the right person to receive the concern. If not, support the learner to connect with the appropriate leader, and make sure the learner has the support and resources they need. Ensure confidentiality is maintained throughout the process.

If you are the right person to receive the concern, take a relational inquiry approach to communication, and consider ethical concerns at intrapersonal, interpersonal, and contextual levels for all involved (Hartrick Doane & Varcoe, 2015). This means looking at what is going on *within* individuals, what is going on *between* individuals, and what is going on *around* individuals (Hartrick Doane & Varcoe, 2015). As mentioned above, impairment in nursing is most often linked to substance use, but it is important to consider other factors, such as work-related stress, fatigue, and/or illness (as referenced above this Ethics in Practice narrative), that could also account for your colleague's change of behaviour.

Taking a relational approach to the situation will support a thoughtful and compassionate process. This will, for example, avoid the stigma and judgment that nurses with substance use issues can face from colleagues and others (Contenta, 2019). Rather than facing judgment, colleagues need advocacy, support, respect for their privacy, and kindness, similar to what would be offered if illnesses unrelated to substance use were at play (Dulaney, 2016).

Academic institutions and clinical agencies should have transparent and clearly articulated policies and procedures in place that provide direction for those who need to address educator impairment (Dittman, 2015; Spier et al., 2000). Such policies and procedures should be known to leaders, educators, and learners in advance of needing to use them. Substance use, and impairment more broadly, should be covered in curricula (Dittman, 2015) and educator meetings, not only as they relate to clients but also as they relate to nurses, educators, and learners. Alternate-to-discipline

(ATD) programs supporting nurses who are impaired are becoming common in nursing practice (Contenta, 2019; Dittman, 2015; Fauteux, 2022). We believe they should also be embraced in nursing education. There are many professional resources supporting impaired nurses who work in clinical practice, (e.g., British Columbia College of Nurses and Midwives [BCCNM], 2022a, 2022b; CNA, 2017, pp. 33–35), which could be modified for the nursing education context. Even though the triggers that lead to substance use may differ for nurse educators and other nurses, and similarly, consequences for patients and students are different, there is always a possibility that nurse educators and students are at risk of causing harm to patients when working/learning/teaching in the clinical area. Educators and leaders need to consider the question of readiness. As a professional group, are we willing to examine this issue in nursing education? If not, why not? What can we do about it?

Finally, educators and leaders should create and maintain a safe(r) space (Anderson & Riley, 2020; Carello & Butler, 2015; Deller, 2019; MHCC, 2019) to promote a positive moral climate and facilitate a sense of moral community. While leaders play a large role in the formation of safe(r) spaces, there are responsibilities for all concerned. These spaces may mitigate the underreporting of substance use and other issues among educators and learners, as well as provide the opportunity for non-disciplinary approaches to be used, and for non-disciplinary solutions to be found.

In Ethics in Practice 8-2, we provide a scenario where educators would need to be skilled at addressing sensitive topics, illustrating the importance of principle three from the STLHE framework (Murray et al., 1996).

ETHICS IN PRACTICE 8-2*The Ethics of Teaching Sensitive Topics*

You are an experienced educator who provides professional development workshops for nursing staff at long-term care facilities. Today, for the first time, you are facilitating a one-hour dialogue about racism in nursing education. The session has been urgently mandated by the leadership team, leaving you with little preparation time. You know how important it is to work with the group, especially when addressing sensitive topics.

The session gets off to a good start, but after about 30 minutes you can feel tension in the room. Participants sound angry when they respond to questions posed by the educator in the large group, and the small groups do not appear to be well chosen. You are trying to understand what is happening when you notice one registered nurse (RN) looking tearful and heading for the door.

You excuse yourself to check in and they disclose that the session has been “awful” for them. Specifically, they feel triggered and do not want to work with colleagues who have just made racist remarks about Indigenous persons. The RN shares that they are feeling quite unsafe and would like to be excused. You agree and arrange to meet with them the following day.

FOR REFLECTION: ETHICS IN PRACTICE 8-2

Please use *A Framework for Ethical Decision Making in Nursing Education* to decide how to proceed.

There are varying forms of racism—individual/internalized, interpersonal, institutional, and structural (Bowen & Ward, 2021)—and one should not underestimate the prevalence of racism in nursing education. The academy has been embedded in colonialism, where knowledge, ways of knowing, and epistemology are narrowly conceptualized (Crosschild et al., 2021) and exclusive. To date, nursing has not prioritized confronting racism in nursing curricula (Blanchet Garneau et al., 2018). Consequently, there are calls to: (a) decolonize education curricula in nursing and other health professions (Blanchet Garneau et al., 2018; Canel-Çınarbaş & Yohani, 2019; CASN, 2020; Crosschild & Varcoe, 2021; Herzog et al., 2021; Pidgeon, 2016; TRC, 2015); (b) make curricula more inclusive in content, teaching, and learning processes (Canel-Çınarbaş & Yohani, 2019; CASN, 2020; Crosschild & Varcoe, 2021; Herzog et al.,

2021); and (c) design curricula to be explicitly anti-racist (Acosta & Ackerman-Barger, 2017; Blanchet Garneau et al., 2018; CASN, 2020).

Leaders should ensure that educators are well supported when asked to take on sensitive topics. They should provide education and professional development for educators who are delivering anti-racist content (Acosta & Ackerman-Barger, 2017). Educators should have thoughtful and well-informed resources to guide this work (e.g., Canadian Association of Schools of Nursing [CASN], 2020; EQUIP Health Care, 2017). Preparation is key. Educators need to anticipate what they might encounter and prepare thoroughly and thoughtfully. Doing so requires cultural humility (Herzog et al., 2021), as well as moral courage, and a deep commitment to engaging in anti-racist education.

Educators and institutions are obliged to cover sensitive topics such as racism, and it is crucial to build safe(r) spaces to do so; but safe(r) spaces may not always be easy or relaxing spaces (Anderson & Riley, 2020; Heath et al., 2017). One way to alleviate potential harm when addressing sensitive topics is to use a trauma-informed approach (Heath et al., 2017). Carello and Butler (2015) describe this approach in education as trauma-informed educational practice (TIEP); its purpose is “to remove possible barriers to learning, not to remove traumatic, sensitive, or difficult material from the curriculum” (p. 265). For example, the physical environment, teachers’ ways of being, and/or students’ communication styles can all present barriers to learning (Carello & Butler, 2015).

Not surprisingly, educators may be reluctant to address racism and resistant to participate in teaching an anti-racist curriculum (Acosta & Ackerman-Barger, 2017). These topics can be intimidating, especially without support. However, educators have a responsibility to interrupt and disrupt racist discourses when they encounter them (Blanchet Garneau et al., 2018). Learners and educators should have resources in place (Anderson & Riley, 2020; Heath et al., 2017) for follow-up support. There needs to be institutional support to organize dialogue about racism and to be proactive in these initiatives. Crosschild and Varcoe (2021) call on nurse leaders to “tackle Indigenous-specific racism in healthcare and education through policy and education ... with a collective

commitment to antiracism and decolonization at every level in education, research and practice” (p. 147).

In Ethics in Practice 8-3, we focus on a situation in which a senior RN is involved with a group of undergraduate students on a medical clinical unit. Two of the students approach their clinical instructor (CI) and report that they are experiencing bullying from the senior RN. The students do not believe that they can speak directly to the RN; they are in a “power-over” situation. The CI approaches the nursing leader on the unit, but reporting the concern does not appear to change anything.

ETHICS IN PRACTICE 8-3

Sweeping a Complaint Under the Carpet

You are the patient care coordinator (PCC) on a unit where there is a group of nursing students engaged in their 10-week clinical placement. You hope they will get their full-time hours, as there have been many student placement cancellations because of the global pandemic. You arrive one morning to a message from the students’ CI asking if they might speak with you. This is unusual so you hope everyone in the group is well.

Just before lunch, you have a chance to call the CI into your office, where they disclose that two students are being bullied by one of the RNs. You do not want this issue to escalate, so you reassure the CI that you will investigate the concern. However, you plan to have only a cursory talk with the RN (someone you are very confident in), because “rocking the boat” is not on your agenda today.

Two weeks later, nothing has changed, and the two students continue to feel belittled, humiliated, and afraid to ask questions. The RN’s bullying has not only put the students’ learning in jeopardy, but also risks lowering the quality of their patient care. The CI requests another meeting, so you know that you need to rethink and change your approach.

FOR REFLECTION: ETHICS IN PRACTICE 8-3

Please draw on *A Framework for Ethical Decision Making in Nursing Education* to plan for the meeting.

Researchers report that bullying is experienced by 50% of Australian students (Birks et al., 2017), 35% (Birks et al., 2017) and 42% (Tee et al., 2016) of students in the United Kingdom, 89% of Canadian students (Clarke et al., 2012); and more recently, 70% of students in

eastern Canada (MacDonald et al., 2022). Nurses and nurse educators have a long history of bullying (Daly et al., 2020), and some authors suggest that it is worsening (Birks et al., 2018). Even though zero-tolerance policies are recommended as potential solutions, they can give a false sense of reassurance that bullying is not happening. But the bullying may have gone underground (Borgwald & Theixos, 2013), or is being ignored (Hutchinson & Jackson, 2015).

There are guidelines in the anti-bullying literature that point to effective strategies. For example, cognitive rehearsal—a strategy that gives learners an opportunity to practice pre-designed scripts aimed at responding to bullying—is a helpful educational activity that has been successful in tackling bullying (Fehr & Seibel, 2016; Griffin, 2004; Griffin & Clarke, 2014). However, cognitive rehearsal is a strategy aimed at bullying at intrapersonal or interpersonal levels; bullying is a multi-faceted phenomenon, steeped in power structures and dynamics, and made more complex by the covert nature of many bullying practices (Hodgins et al., 2020; Hutchinson & Jackson, 2015).

It is crucial to also acknowledge the “need for organizations to move beyond the current individualistic understanding of bullying towards a more nuanced understanding of how anti-bullying policies and procedures are themselves an exercise in institutional power protecting and reinforcing dominant power structures” (Hodgins et al., 2020, p. 265). Bullying can become a legitimized form of power enactment, discouraging internal reporting and negatively affecting the “ethics and safety culture” within an institution (Hutchinson & Jackson, 2015, p. 20). For example, bullying that is ignored, silenced, or used when providing performance reviews can position the bullying as legitimate behaviour within the culture of the group. Hodgins et al. (2020) maintain that policies to address bullying are often designed to protect the organization rather than the person being bullied, and this may be why it is not uncommon for leaders to respond by doing nothing. When this occurs, it is important to acknowledge that the issue may be as a result of anti-bullying policies at the level of the institution, rather than what is included in more general nursing resources, such as national and international codes of nursing ethics, and guidelines of professional associations. (BCCNM, 2022b; CNA, 2017, pp. 33–35).

Such resources can be useful for nurses in responding to bullying in general, especially when leaders respond by doing nothing about the bullying that is occurring.

O'Flynn-Magee et al. (2021) argue for the importance of doing *something* to effect change, rather than doing nothing. Naming a behaviour as bullying, and acknowledging its ethical context, can have a powerful effect on recognition and acknowledgement of the issue by individuals and institutions. However, naming bullying may also uncover resistance to addressing it at individual and institutional levels. Institutions need transparent and easily accessible policies and procedures explicitly naming bullying as unacceptable; reviewing an institution's core values should be the first step in the process (Hodgins et al., 2020). This requires institutional and leadership support to initiate and maintain anti-bullying policies, procedures, and processes. Similar to the previous situation about racism, educators may be reluctant to address bullying and participate in teaching an anti-bullying curriculum. As with racism, educators have a responsibility to disrupt bullying interactions when encountering them. Institutions should have both proactive and responsive supports and resources in place (Anderson & Riley, 2020; Heath et al., 2017; O'Flynn-Magee et al., 2020) that aid in the prevention and management of bullying. Institutions should also provide follow-up for learners, educators, and leaders such as the PCC in the scenario above. Educators and leaders have a unique opportunity to shape the future of nursing practice cultures so that bullying is no longer accepted as a practice norm. When nurse leaders receive complaints, they need to listen and do something (Crosschild & Varcoe, 2021), thus nurturing positive moral climates in nursing education and practice.

In our own work to address bullying in nursing education, prioritizing learner/educator partnerships from the outset has strengthened the credibility and thoroughness of our work. Our partnerships have fostered mutual learning between learners and educators, as well as strengthening collegial relationships, and sharing an ongoing commitment to our work together (Poon et al., 2022). We have learned that partnerships can benefit not only learners and educators, but also education institutions (Cook-Sather et al., 2014).

In Ethics in Practice 8-4, we describe a complex ethical situation at the socio-political level. At times, learners may be unaware of the complex contexts in which decisions, protocols, and policies are enacted. One example of that complexity is ensuring that Canadians have appropriate access to health care in the case of medical assistance in dying (MAID). We use this situation as an illustrator for the ethical considerations that nurse educators and learners need to address.

ETHICS IN PRACTICE 8-4

Difficulty Accessing Health Care

You are the supervising educator for a group of RN learners who are completing their advanced practica in two locations: a rural community setting and a rural hospital setting. They are learning a great deal and are well supported by the RN staff. The hospital to which they are assigned is faith-based, and individuals who request MAID can neither be assessed for, nor receive, MAID in this institution. While these policies are mandated in this facility, some faith-based health care institutions do offer MAID (Sarick, 2020).

The RN group has debated the issue of access to MAID in class, thus promoting critical pedagogy and education for social change. One of the RN learners is caring for someone who is about to request MAID in the small rural hospital where they are currently hospitalized. The RN learner comes to you, as their educator, to help advocate for their client's request to have MAID in a place where the client is known and feels secure.

FOR REFLECTION: ETHICS IN PRACTICE 8-4

Please use *A Framework for Ethical Decision Making in Nursing Education* to decide how you will respond.

In Canada, MAID became law in 2016, giving adult Canadians the legal right to access MAID as a health care entitlement if they meet the eligibility criteria articulated in federal legislation (Pesut et al., 2020; Schiller et al., 2019). Nurses grapple with the diverse moral challenges embedded in decisions to participate or not in MAID (Pesut et al., 2020). Nurse leaders in the area of MAID are instrumental in making sure that patients can access the care they need (Thiele & Dunsford, 2019), and they also provide nurses with

morally safe spaces to learn through dialogue about any aspect of MAID (Beuthin & Bruce, 2018; Thiele & Dunsford, 2019).

In education, when complex concerns arise regarding issues such as MAID, it is crucial to prioritize time with learners to engage in discussion and invite them to share their perspectives. There are varying views about MAID as a health care option (Kirby, 2021; Suva et al., 2019), and diverse perspectives about ensuring easy access to MAID across faith-based and secular health care facilities (Kirby, 2021; Shadd & Shadd, 2019; Sumner, 2019). As RNS, some of the group in Ethics in Practice 8-4 may already have professional or personal experience with MAID. Using a trauma-informed approach (Carello & Butler, 2015; Heath et al., 2017) can contribute positively to safety in an educational space such as this one.

Educators should engage in critical conversations with RN learners about accessibility to MAID. The problem of inequitable access to MAID across faith-based and secular health care institutions continues to be a fractious issue in Canada (Kirby, 2021). Thus, it is essential not to make assumptions that every faith-based institution is unable to support MAID.

Supporters of institutional conscientious objection (ICO) claim that the right to conscientious objection (CO) for individuals should also be available to institutions (Kirby, 2021). While ICO is assumed to be based on religious grounds, other reasons, such as self-governance, or lack of professional expertise, are sometimes ignored (Shadd & Shadd, 2019). Opponents argue that ICO interferes with an individual's right to access health care, as well as a health care professional's moral and legal right to provide MAID (Kirby, 2021). Kirby concluded that "nonconditional accommodation on the basis of ICO to MAID is ethically unacceptable in Canadian health care jurisdictions" (p. 1). Kirby proposed a modified version of ICO with several eligibility criteria, one of which is the location of MAID. In the case of MAID in institutions, Kirby indicated that MAID would need to be attached to the primary facility so that there would be minimal disruption and harm when a patient required transfer.

Nurses are well positioned to advocate for clearer MAID policy (Beuthin & Bruce, 2018; Schiller et al., 2019), which will benefit patients, their families, communities, and nurses. While nursing education is an ideal place to foster learners' political activism

(Banner et al., 2019; Buck-McFadyen & MacDonnell, 2017), it requires leadership buy-in and active support at academic, regulatory (Buck-McFadyen & MacDonnell, 2017), and practice levels. Educators and leaders can support learners' critical understanding of MAID, as well as other ethically challenging scenarios. For example, learners could discuss the importance of equitable access to chronic illness care and palliative care so that MAID does not become a default decision at end of life. RN learners should understand the controversies, policies, and legislation that underpin access to care in their practice location. In what follows, we articulate our overall recommendations for nurse educators and leaders regarding ethical practice in nursing education.

Top “Ten Plus One” Tips for Nurse Educators and Leaders

1. Be clear and confident about the theoretical approaches and ethical guidelines that inform your teaching practice.
2. Consider how power and hierarchies play out in nursing education. What is your role and the role of others to mitigate the potentially negative effects of power and hierarchies?
3. Broaden the conceptualization of advocacy beyond the individual patient to include healthcare resourcing and provision, and see systemic change as important as change at the bedside (Scott & Scott, 2021, abstract).
4. Ensure that ethical concerns across levels in education (beyond education about ethical content) are visible and addressed in your practice area.
5. Honour relationships as the core of teaching and learning processes.
6. Support learners to develop and enact their moral agency.
7. Foster the capacity of educators and leaders to practice, teach, and advocate for their ethical obligations.

8. Advocate for educators to be acknowledged and valued as advanced practice nurse leaders in relation to ethical practice.
9. Support each other to be ethical learners, ethical teachers, and ethical leaders.
10. Encourage yourself, learners, and other educators and/or leaders to be politically minded and to acknowledge the responsibility to articulate ethical concerns and advocate for change.
11. Promote and foster scholarship that advances knowledge and ethical practice in nursing education.

Conclusion

Nurse educators, leaders, and learners should be inspired and directed by ethical, theoretical, and philosophical underpinnings that are consistent with their own beliefs and values and are congruent with the values and standards of their profession. We have described theoretical and philosophical perspectives to help guide educators in their ethical teaching in nursing education. Based on our analyses of educational processes, our experiences as educators, and our own beliefs and values about nursing education, we support critical pedagogy, anti-racist curricula, and Indigenization of nursing education, as reflected in the theoretical sources we have cited in this chapter. While these sources provide us with *our* “go-to” guidelines, we acknowledge there are many others. We therefore invite educators, leaders, and learners to reflect on the theories and philosophies that guide their ethical practice.

The role of space (physical, psychological, and spiritual) in nursing education is illustrated in the scenarios we presented in this chapter. Safe(r) spaces can be co-created through critical dialogue by those involved in the teaching and learning processes. Trusting relationships between learners and educators are at the core of safe(r) spaces in higher education (Anderson & Riley, 2020). Educators can use trauma-informed education practices (Anderson & Riley, 2020; Carello & Butler, 2015) to enhance those spaces.

The importance of the role of nurse leaders cannot be over-emphasized. Cook-Sather and Felten (2018) encourage academic [and clinical practice] leaders to move from a neoliberal dogma to a pedagogy where partnership, reciprocity, and inclusivity are welcomed and encouraged. Such practices require leaders, educators, and learners to share foundational beliefs and values.

While ethical concerns in nursing education may present themselves at the intrapersonal or interpersonal levels, there are usually complex systemic influences that may or may not be visible. Hartrick Doane and Varcoe (2013) emphasized that “people are contextual beings who exist in relation with others, and with social, cultural, political, and historical processes” (p. 150).

Nurse educators and leaders face challenging contexts, including global pandemics, neoliberal mandates in health care, corporatization of higher education, and nursing shortages. Despite these factors, educators *can* make choices. While some things are beyond our capacity to change—for example, our past experiences—it is never too soon or too late to be an educator, leader, or learner who engages in dialogue and commits to relational practice. This entails acknowledging the importance of socio-political contexts; striving to engage in practice with critical curiosity, humility, and respect; and supporting transformative learning and ethical action in nursing education.

QUESTIONS FOR REFLECTION

1. *What are your thoughts about Fowler and Davis's (2013) view that “the entire domain of ethics in nursing education is, itself, taboo” (p. 129)?*
2. *Throughout the chapter, we have emphasized the importance of context for ethical practice in nursing education. How does context influence your practice as an educator, leader, or learner?*
3. *There is no shortage of ethical concerns in nursing education. Can you identify one issue that requires immediate action? For what reasons would you prioritize this issue rather than one of the many others that pervade nursing education? What role would you be willing to take? How would you decide what is needed, and what to do?*

4. *We have described several theoretical underpinnings that guide practice for nurse educators. What influences your practice each day? Consider this question using a theoretical, ethical, and relational lens.*

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APPENDIX 8-1

Individual Reflective Exercise

IT IS IMPORTANT TO REFLECT ON VALUES about teaching, learning, leadership, and context, and to make connections between values and the theoretical frameworks that guide practice. One tool that readers might find helpful is Pratt and Collins's (2000a, 2000b) Teaching Perspectives Inventory (TPI). Reflecting on the TPI enables a focus on teachers' beliefs, intentions, and actions, and can be an insightful way for educators to learn about themselves as teachers. Below is a reflective exercise that you can use to consider the varying components of your practice.

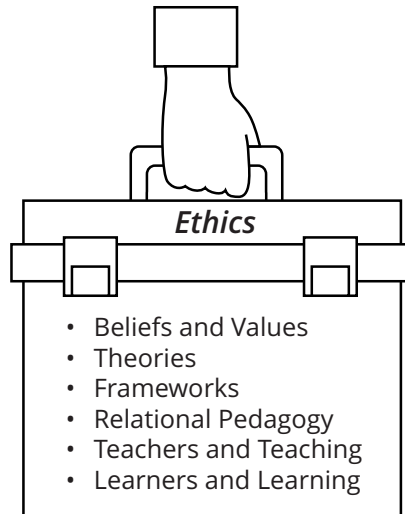
At times, you may find it challenging to name the theoretical underpinnings of your practice. It may be helpful to consider Hartrick Doane and Varcoe's (2015) view that practice is never atheoretical. And even though you may not be conscious of the foundational underpinnings of how you engage in teaching, taking time to think about it will serve you well.

Please take a moment to (1) complete the TPI (<http://www.teachingperspectives.com/tpi/>) and (2) reflect on the values, theories, concepts, and frameworks (pedagogical, ethical, relational) that guide your everyday teaching practice. Once you have identified and analyzed them, note them in your educator

toolbox (refer to Figure 8-1-1). Be as creative as you would like to be—write, draw, paint, doodle.

FIGURE 8-1-1

An Educator Toolbox



REFLECTIVE QUESTIONS

Now that you have completed your reflections and TPI, ask yourself the following questions:

1. *What was the experience like for me?*
2. *What surprised me about either exercise?*
3. *How has the exercise affected my thinking about teaching and learning?*
4. *What does it mean for me as a nursing educator and/or leader now and in the future?*