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Ethics Education in Health and Social Care:

A Framework for Foundation Degrees

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Abstract

Ethics Education in Health and Social Care: A Framework for Foundation Degrees

Foundation Degrees are still a relatively new qualification. Health and social care employers are being encouraged by Government to develop new roles for unregistered staff, using Foundation Degrees as the required qualification. This inquiry seeks to discover how best to provide a sound education in ethics to students of such programmes, in order to prepare them for complex practice environments.

Theoretical and empirical bodies of work provide a basis for interviewing students about to graduate. Theoretical perspectives differ greatly, providing a range of options to educators who need skill and confidence in discussing ethical issues. Diverse and creative techniques for teaching ethics are evident in the literature, although it is clear that many curricula lack a coherent approach. Research evidence reveals consistent influences from dominant schools of thought, with little use of more recent developments.

Following a series of in-depth interviews with students, Content and Discourse Analysis are used to derive themes and meaning from the data. Themes developed from Content Analysis suggest students discuss ethical practice most confidently when relating concepts to their work. Discourse Analysis reveals the importance of relationships in their construction of moral identity, particularly with people using services and with colleagues in the work place.

Recommendations are made for providers of Health and Social Care Foundation Degrees, notably to ensure a coherent philosophical approach underpins engaging and creative learning opportunities. Ethics education which is embedded through curricula provides a model which reflects and support work-based learning. Dialogue and openness rehearsed in classroom-based learning provides preparation for practice. Examination and critical reflection on work place policies enable students to relate their learning to practice and become active participants in the workplace. Finally employers are encouraged to work with educators to provide guidance to students given the new roles being created for graduates.

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Chapter 1. Introduction

In recent years, health and social care has been dogged by scandals involving poor treatment or the abuse of vulnerable people. Numerous reports recite the same kinds of problem: a lack of communication, inadequate responses to risk, failure to act on concerns, an absence of personal responsibility-taking and so on. At the same time, working in the sector has become increasingly stressful as society's expectations, life-extending treatments and an ageing population create new moral problems. Along with other workforce changes, this has been blamed for professionals leaving their jobs or suffering 'burn-out' (Nordam et al, 2005). Unqualified, unregistered support workers make up a large proportion of the health and social care workforce; over one million Support Workers provide social care alone (DH, 2008). These workers carry out a range of interventions and techniques previously undertaken by nurses, social workers and therapists.

This study is concerned with the education and development of Support Workers, in light of their contribution to ethically-demanding practice. The work-based educational programmes designed with employers, known as Foundation Degrees, are of particular interest. In order to 'upskill' this section of the workforce and reward their extended roles, Foundation Degrees were introduced as a necessary qualification for progression within the National Health Service (DH, 2004a). Although well established in Europe and the United States, intermediate level degrees were new to the United Kingdom (Robertson, 2002). The qualification was heralded as a driver to widen access to Higher Education (HE) and achieve the target 50% participation amongst the 19 – 30 year old age group. It was also intended to meet the need for 'higher level technical skills and knowledge' in many sectors of industry (DfES, 2000).

A considerable amount of government money has since been injected into the development of the new qualification, prompting some critics to question its rapid expansion (Rowley, 2006). The extended roles for Support Workers have also been contentious. Both are considerably cheaper than traditional professional education for nurses and therapists. Reticence among registered staff to cede responsibility to a generic Support Worker has been accompanied by ambivalence from employers. [Both of these responses were predicted almost a decade ago by Ranade (1997)]. Nonetheless, new roles have been steadily developed. The NHS careers

website is a testament to the changing profile of the workforce. Research is underway to discover the impact of Foundation Degrees upon the skills agenda set by Leitch (HM Treasury, 2006) and universities continue to expand the range offered. The Foundation Degree benchmark statement has successfully directed providers to focus on the *employability* of graduates by prioritising transferable skills (QAA, 2004).

Ethical competency is *not* included in the Foundation Degree benchmark statement, although Robinson (Higher Education Academy, 2005) has described it as a key component of employability. Education programmes for registered practitioners are obliged to include ethics and are audited on this basis (QAA, 2003). It is an important, established part of health and social work education and ethical codes of practice are in place for all registered professions. A vast body of knowledge developed throughout the Twentieth Century offers a wide range of perspectives and strategies with which to improve ethics education. Yet very few, if any, mention Support Workers. What research exists comes from a partisan, nursing perspective and is generally critical of the standard of education and training available (Kelly, 2004).

Vocational qualifications promote caring skills and respectful practice, but do not normally introduce ethical concepts. Nor do they provide scope to explore the unique perspective of the generalist Support Worker working in complex hierarchies. Even the people educating Foundation Degree students, in the classroom and in the workplace, tend to belong to traditional disciplines. Their moral identity has been developed against a backdrop of certain professional ideologies; the majority of texts locate ethics within disciplines, commonly referring to 'medical ethics' or 'nursing ethics'.

It would be easy to conclude that only registered professionals experience moral challenges in their practice or require skills in ethical awareness and sensitivity. Whilst it may not be the case that those in supportive roles make life and death decisions, they may well be close to the people involved. They may have worked with them longer than anyone else or be the person with whom decisions or fears are discussed. They are likely to be carrying out the decisions of others and may regularly undertake such activities as supporting people through painful treatment regimes; contributing to physical restraint; giving personal care or carrying out close observations. In most settings, Support Workers will experience the same range and type of ethical issues as professionals, without as much information, influence or education.

If health and social care is morally stressful for nurses, it is likely to be equally so for Support Workers. Yet the expectation that this group will continue to take on extended roles underpins workforce change. The ethical issues generated by people living longer and receiving care at home, are the ongoing kind encountered in everyday practice, rather than headline-grabbing life and death issues. Sherwin (1992) considered the low status of this kind of moral problem to reflect its subordinate, non-medical status.

This inquiry begins with the premise that support workers have, and should have, a legitimate interest in ethics, and that they have a contribution to make towards good practice. Their moral education and development should be an area of concern for employers and for those providing their education. Based upon the level of expectation described in the Foundation Degree benchmark statement (QAA, 2004), it is important that graduates are equipped to recognise ethical issues and to respond sensitively and skilfully. Equally, in order to lay a foundation for academic and career progression, a critical understanding of ethical concepts is essential. The overarching goal of this study is to improve how this aspect of the curriculum is developed and delivered, given the unique breadth of demand – and possible sense of professional isolation - likely to face such graduates upon entering employment. It is important that their learning and achievement is appropriate to their work roles and future careers. The research question is therefore; given the importance of ethics in health and social care, how can curricula most effectively support and prepare Foundation Degree students for practice?

The thesis begins with an extensive inter-disciplinary review of literature, considering both the theoretical origins of different schools of thought and the empirical evidence base. The subjective experience of students is also sought: how they describe real events; their reasoning in situations; and the learning they consider formative.

The objectives are to:

- Identify key themes in ethics education through an inter-disciplinary review of the literature

- Discover through in-depth interviews, what students understand to be ethical issues and ethical practice in work settings, and identify those considered to be morally challenging
- Learn from them how they cope with or resolve such issues, or whether on occasion they do not, also how they reason and articulate their thinking and decision-making processes
- Seek their reflections on their own learning experiences
- Formulate a framework for ethics education suited to the students, the programme and the intended outcomes.

Both aspects of the study are discussed and compared in order to develop both a strategic approach to developing the curriculum and to identify specific learning techniques likely to engage and stretch this particular group of students.

Chapter 2 introduces the place of ethics in health and social care and the approaches to education and training in academia and the workplace. Workforce information and examples from practice are provided to set the context of the inquiry.

Chapter 3 examines theoretical perspectives from a range of disciplines, establishing the major schools of thought and their place and importance in education and practice. Their relationship to research carried out over the past half-century is also established.

Chapter 4 draws together selected pieces of research from Europe and North America, examining and critiquing their contribution to current challenges in health and social care education and practice.

Chapter 5 outlines the nature of this research, with a focussed discussion on the particular ethical issues inherent in primary data collection when seeking to interview individuals about their practice. The role of the researcher as an involved interventionist is discussed and critiqued.

Chapter 6 details the process of inquiry, debating alternative methodological approaches appropriate to the research objectives. A description of the theoretical framework informing social constructionism is given.

Chapter 7 presents the first of two series of findings, arrived at through Content Analysis. Themes are outlined and discussed.

Chapter 8 presents the second series of findings, arrived at through Discourse Analysis. Different issues are highlighted and debated in the light of the Content Analysis and earlier themes from the literature review.

Chapters 9 and 10 discuss findings and offer conclusions and recommendations for developing the curriculum through a framework applicable to health and social care Foundation Degrees.

Chapter 2: Literature Review - Issues from Practice

Introduction

In this chapter, issues from practice are identified. Workforce initiatives and policy changes which have impacted directly upon the duties and responsibilities of those working in health and social care, following the drive to redistribute work from highly qualified to lesser qualified groups, are considered. Ways of preparing staff for dealing with ethical issues in practice, are described and an overview given of the two dominant philosophical perspectives influencing traditional educational and practice-based approaches to health care ethics. A workforce initiative to develop the value base and moral competency of an entire specialist workforce is evaluated. Finally, the implications for the least qualified Support Worker group (to which most Foundation Degree students belong) are discussed in light of their educational and vocational experiences.

Educating the Workforce

The importance placed upon students' moral development by different professions varies greatly; the emergence of nursing, medical and psychology students as the most studied groups over the past forty years will become evident in subsequent chapters. The development, moral or otherwise, of Support Worker education has not attracted the same degree of research interest despite their status as core members of health and social care teams. One of the few comprehensive studies of Support Worker education and training did not mention moral or ethical development specifically, but looked generally at standards. The report was highly critical, concluding that the absence of any national mandatory educational programmes for Support Workers 'threatens public safety' (McKenna et al, 2004: 455).

This has not hindered Government plans however. The role of non-professionally qualified staff and their contribution to care and treatment is set to grow, as financial sustainability necessitates increasing levels of responsibility to be taken across all sections of the workforce. Writing to the Chancellor of the Exchequer in his wide ranging analysis of the NHS, Wanless (2002: letter to Chancellor) stated:

'The (financial) estimates ....illustrate how workload might be shifted away from doctors to nurse practitioners and from nurse practitioners to Health Care Assistants (HCAs). That will need to be a significant part of the solution.' Wanless, 2002.

Wanless went on to suggest that 12.5% of nurse workload could shift to Health Care Assistants, freeing nurses for 'higher order work' (ibid: 91). The controversial report supported the changes proposed in the radical overhaul of NHS pay and reward structures called *'Agenda for Change'* (DH, 2004a). The new framework for all healthcare workers (except doctors and dentists) introduced a new grading and title, of 'Associate Practitioner', an intermediate grade designed specifically to bridge the responsibility and pay gap between degree-educated professionals and unqualified or vocationally-educated Support Workers.

A workforce clustered at the extreme ends of the skills and qualifications continuum was not considered sustainable by the Sector Skills Council (SSC) for health, *'Skills for Health'* (Skills for Health, 2006). The Department of Health promoted the new grade through role redesign and workforce development initiatives (DH, 2002). The Modernisation Agency, which was created specifically to drive the workforce changes, anticipated that Associate Practitioners would challenge 'outdated demarcations' by taking on new responsibilities and progressing up the career ladder (DH, 2003). Skills for Health led on defining suitable qualifications for the new roles, citing the Foundation Degree as one route to the new grade and reiterating the transfer of responsibility as follows:

'Some of their remit will involve them in delivering protocol-based care that had previously been in the remit of registered professionals' Skills for Health, 2005: Career Framework.

Despite this drive from Government, workforce change has been slow. Ambivalence towards a 'flexible, cheap care worker' likely to encroach upon professional territory was described a decade ago by Ranade (1997: 37) and may, at least in part, explain the reluctance of managers to replace a known commodity with an unknown, unregistered one.

Attempts were made to redesign the workforce throughout the 1990's, following the 1990 NHS and Community Care Act (Office of Public Sector Information, 1990) and its drive for care in the community, although success was limited. Øvretveit (1993:108) challenged the dominance of traditional professional roles, concluding from research that the 'core

profession-specific work' constituted only 20% of an individual's workload; the other 80% being equally divided between direct care tasks shared with other professionals, and general care coordination and liaison. Øvretveit's work was highly influential, but it is still generally the specialist skills which are accorded high status.

Alongside the government's agenda to separate managerial and clinical power, and even to shift the balance of power from clinicians to managers and reduce dependency on traditional and often strongly unionised disciplines, increasing professionalisation of the health and social care workforce has continued apace (DHSS, 1983). Many of the features identified amongst established professions over twenty years ago (based on work carried out during the 1960s and 1970s) became easy to identify even in emerging professions: tight control over membership and title, self-regulation and a strictly demarcated work domain (Mintzberg, 1983). Other features, such as the lengthy (5 – 8 year) training and narrow entry gate based on very high qualifications, remain peculiar to medicine, dentistry and psychology.

Self-regulation for all professions was confirmed as the way forward by The Health Act (OPSI, 1999) which, after much debate, introduced new regulatory bodies like the Nursing and Midwifery Council (NMC), the Health Professions' Council (HPC) and the General Social Care Council (GSCC), whose primary purpose was to protect the public from unscrupulous or incompetent practitioners. Students registering with these bodies subscribe to a certain ethical code or set of principles denoting values and behaviours, which is intended, in part, to socialise them into the profession's culture. Subsequent learning about ethics is therefore likely to be focused upon applying those principles to practice. Continued membership of the profession – normally a requirement for employment - depends upon evidence of professional development and continued registration. Absence of professional affiliation and registration results in an individual being prevented from practising and employers generally are therefore reluctant to give greater responsibility to Associate Practitioners. This is an issue of concern for care providers generally, given that high numbers of direct care workers frequently deal with the most vulnerable and isolated members of society, often on a one-to-one basis in a person's own home. The General Social Care Council (GSCC) has finally completed a register of qualified Social Workers, but has not yet begun its planned registration of all workers in the sector. The number is expected to exceed 1.5 million (Kendall & Lissauer, 2003).

Although far from infallible, professional registration provides a measure of protection for the public and important information for employers. Following the Soham murder inquiry, Sir Michael Bichard discussed at length the flaws in the then current system for screening out those with criminal convictions or cautions, asking how the balance should be struck 'between the rights of the individual and the need to protect the vulnerable' (Bichard, 2004:150). He concluded that a single central, national register spanning education, care and the range of voluntary or leisure providers should be established, capable of accessing and updating online the entire range of information gathered on individuals.

It has long been recognised as a key responsibility of education providers and health care commissioners to assess the character of students entering programmes - candidates are interviewed and Criminal Records Bureau screening is a pre-requisite for entry - and thereafter to consider all aspects of their development and not simply skill acquisition. Professional programmes define aspects of character through 'fitness for practice' criteria, but no similar stipulation is applied to health-related National Vocational Qualifications (NVQs) and none was made in the 2004 benchmark for Foundation Degrees, though in both health and social care studies, students have access to the same vulnerable populations (QAA, 2004).

As part of students' development, education in ethics has become an established component of education in medicine, nursing, psychology, social work programmes and (more recently) Allied Health Professions (AHPs) like physiotherapy and radiography. Research confirms that the teaching of ethics remains a largely profession-specific endeavour, despite Dearing's and Kennedy's recommendations (NCIHE, 1997; Bristol Inquiry Unit, 2001). An exception is the newly established Inter-Disciplinary Ethics Applied Centre of Excellence in Teaching and Learning (IDEA CETL) at Leeds University in which 14 subject areas (spanning law, humanities, engineering and physics) benefit from the established teaching and learning excellence within medical ethics (Athanassoulis, 2006). Research findings on the efficacy of the IDEA CETL initiatives are not available as yet, although issues identified as important by the Ethics Special Interest Group of the Higher Education Academy (HEA) are emerging around whether ethics should be taught in discrete modules or integrated into 'other' learning, and whether a uni-professional or interprofessional focus is most effective (HEA, 2007). For the lead to be taken by medicine across such diverse professions is not unusual; the teaching of ethics in medicine is well-established and thoroughly researched. The history of medicine provides many rich and complex examples, not only of far-sighted, principled decision-

making but also of abuse of power. Most notably, the Nazi regime's inhumane medical experimentation upon the mentally ill, twins and other groups horrified the world when it was exposed during the Nuremburg trials. Despite the inhumanity of the experiments, the doctors involved held that they were acting in accordance with ethical principles, stating in their defence that as their victims were already sentenced to death, their actions made no difference. They also asserted that they were conducting the experiments for the betterment of mankind and for the greater good, and that their actions were within the law of the land (Lifton, 2000). The trials eventually led to the Declaration of Geneva (1948) and several revisions of the Declaration of Helsinki (1964); the various amendments and improvements made to these declarations since still encapsulate a 'respect for the person' above the 'needs' of society (World Medical Association, 2004), though Gawande (2006) has found in a recent study of US medical practitioners that many of these assist in executions by lethal injection despite this being banned by the American Medical Association. When questioned, some reasoned that, as the prisoners were condemned to death their expert assistance only improved the situation for the condemned person. However, unlike the Nazi doctors, those involved cited the reduction of harm or pain *to the person* as a motivation (Gawande, 2006).

The shocked reaction of society to health professionals who abuse, maim or kill actually *reinforces* the special regard in which they are held; the unique status accorded to (and the degree of trust invested in) them. Cases of abuse, harm and even murder are unfortunately fairly numerous; high profile examples include Harold Shipman and Beverley Allitt, both of whom continued to harm (and murder) their patients undetected for a long period of time (The Shipman Inquiry, 2005; DH, 1994). As a profession medicine is now examined more regularly and is more hotly criticised for being reactive, protective of its own interests, inward-looking and having a self-interested, detached 'club culture' characterised by a disinterest in communicating with other disciplines or patients (Irvine, 2004; Bristol Inquiry Unit, 2001:2; The Royal Liverpool Children's Inquiry, 2001). Seen as high status leaders and representatives of health care generally, doctors have remained in the eye of the storm through years of scandal and inquiry only to share the unwelcome limelight with others when, for example, a young girl died after prolonged abuse early in the new millennium (Laming, 2003). When Health, Social Services and Police were collectively described as allowing 'a gross failure of the system' (ibid, 2003:3) which led to the death of a child known to be at risk, a sense of urgency entered professional health care education. Interprofessional education, initiated following Dearing's report (NCIHE, 1997), rapidly became established

across health and social care educational provision. Quality Assurance of all health and social care professions now incorporates assessment of interprofessional learning as a core requirement (QAA, 2003). Although most modules focus on collaborative and team working, a minority look at ethical issues in practice, generally at post-graduate level (Glen, 1999; Cloonan et al, 1999; Aveyard et al, 2005). Neither NVQs nor Foundations degrees are routinely included in interprofessional education or have their quality measured against such standards (QAA, 2004).

Ethical perspectives

Ethics education, across most health care undergraduate and postgraduate programmes, has traditionally been based on either deontological principles or the relativist perspective of consequentialism. Deontological approaches are based on immutable rules or principles, considered absolute and universally applicable across time and place. In health care ethics, deontology takes the form of key principles, which are mostly enshrined in law (such as keeping personal information confidential). Conceptually, rights-based approaches, such as those legislated for in the Human Rights Act (2000) sit comfortably within deontology. However, health and social care *practice* must reflect the pluralism of British society by accommodating a wide range of beliefs whilst at the same time upholding the law. This can present conflicts in situations where individuals or groups consider religious law to have primacy. Principles and rights are frequently in conflict; for example, the right to privacy of someone being discharged from a Psychiatric Hospital may compete with another's right to information about the whereabouts of the person should they be at risk of harm. In such situations, debate must include the *consequences* of decisions. Consequentialism, the ideological opposite of deontology, is concerned only with the consequences of decisions or acts, but in practice, both are likely to be drawn upon by a health and social care team planning an intervention or discharge.

Traditionally, medical ethics has been dominated by a principlist approach. Gillon (1985: 2) describes the 'thoughtful and intellectually rigorous' examination of doctors' decision-making as an attempt to construct universal moral principles upon which to base the actions of health care professionals. Building on the work of ethicists Beauchamp & Childress (1983), Gillon (1985) espouses the *'Four Principles'* doctrine, embedding this approach to medical and other health care education. These are:

- Beneficence – doing good
- Non-maleficence – avoiding harm
- Respect for autonomy
- Justice

Criticising his approach, Warnock (1994) points out that the generality of the principles means they might just as easily be applied to law or teaching; *in themselves* the principles contribute little to ethical debate, the first two being an everyday balancing of risk and the latter two being largely outside the scope of individual doctors. The concept of 'scope' - to interpret when certain principles are of a higher order, or 'trump' other principles – was offered by Gillon as a means of practically applying what are essentially abstract concepts (Gillon, 1985). So, despite life-saving surgery inevitably doing some harm, the principle of doing good 'trumps' the principle of avoiding harm. Despite its critics, this approach remains highly influential in all forms of health and social care education.

Unlike principlists, consequentialists look at the consequences of a particular action in order to decide how to proceed. They assert that there are no principles, only consequences; that this year, in this place, a decision may be correct, but next year in a different place or for a different person or group, a different decision may be proper. They hold that decisions should be defended on the unique consequences of a particular set of circumstances. Consequentialists study a whole range of possible outcomes and use tools like 'decision trees' to project and compare a range of possible outcomes, based on several different sets of circumstances. The best known consequentialist position in health care is Utilitarianism, in which the right moral action is held to be that which promotes the greatest good for the greatest number. Utilitarianism was developed early in the 19th century by Jeremy Bentham and later by his protégé, John Stuart Mill (Stokes, 2002). In different ways their work developed the concept of utility as a moral justification for action and is still highly influential today. Bentham's attempt to quantify happiness and pain through his 'felicific calculus' can be seen today in the 'Quality Adjusted Life Years' (or 'QALY') concept in which a health intervention is measured in terms of the years of quality life likely to ensue (Bowling, 1997:93). Public health decisions, necessary in allocating society's resources for the good of society generally, are frequently based on the concept of the greatest good, but

they may conflict directly with the greatest good for the individual; for example, supplying 'flu vaccine for a thousand people may produce more positive health outcomes for more people than one lifelong course of an anti-cancer drug which saves one person, although both may cost the same. The utilitarian argument (refined by Mill) would suggest that acting *for the moral good* means acting to promote the greater happiness of the thousand by supplying the 'flu vaccine (Stokes, 2002: 115).

Frameworks have been developed to assist in individual decision making, such as the 'Four Quadrant Approach' (Jonsen et al, 1998). This detailed step-by-step process attempts to combine respect for the individual and their rights, with the consequences of actions. The practical guidance offers health care teams an alternative to Gillon's (somewhat abstract) principles. Consisting of a series of questions to be worked through, the framework requires the same, difficult subjective decisions to be made, but the process provokes useful discussion with a range of other professionals, and even relatives and friends. Three of the four questions relate to the person and his or her life and perspective, quality of life and the context in which he or she lives. Only one question asks about the indications and likely outcome for the medical intervention.

Looking at consequences seems an obvious way to reach a decision and reflects the reality of every-day decision making, such as choosing a mortgage or taking a new job. However, critics of consequentialism suggest that when used in health care, it has a tendency to belittle the intrinsic value of life by looking at numbers rather than the individual experience. Campbell & Collinson (1988: 46) say of consequentialists that 'they remind us of the difficulties of trying to envisage what the future might hold and of saying what sort of life is worth living'. Principlists criticise consequentialism by using the 'slippery slope' argument; that is, that without solid principles society edges its way towards a loss of boundaries, rules and parameters (Gillon, 1985). An example is the age at which women should be assisted in conceiving: a consequentialist argument will be based on the fitness and ability of the individual woman and / or her partner to care for the child as opposed to her age alone; a principlist will state that it is always wrong to bring a child into the world beyond the age at which conception can take place naturally, regardless of the partner's age, wealth or other extraneous factors. The 'slippery slope' argument in this case is that in future, healthy, well-off women in their seventies or eighties will be assisted to conceive because age in itself ceases to be a barrier.

Frequently the concept of 'best interest' is used in cases where principles and consequences indicate different actions, such as when the preservation of life is threatened by adequate amounts of pain-relieving medication. Originally a legal term used primarily in cases where adults contested custody of a minor, it is embedded in The Children Acts of 1989 and 2004, it is now increasingly used to inform decisions involving incompetent or vulnerable adults (OPSI, 1989; 2004). From a legal perspective, Harrington (2003:4) summarises the concept as essentially a common-sense perspective; a place from which argument can begin, rather than being itself an abstract principle. Although often cited as a principle, the concept is more correctly located within the philosophical perspective of consequentialism.

Ethicists offer useful insights to practice and provide frameworks within which ethical dilemmas can be studied, however uniquely personal and varied our responses are likely to be. The values, beliefs, hopes, memories and fears of everyone touched by a dilemma lead to different responses, and many will be guided by emotions rather than by clear, reasoned thought. Despite his earlier rationalism, Glover defends 'emotional morality' - or that intuitive (even irrational) response sometimes referred to as 'the yuk factor' - arguing that many atrocities of the 20th Century were possible precisely because people's 'moral emotions' had been switched off (Glover, 1999: 103).

Issues for the Mental Health Workforce

A very specific approach to developing the desired values, attitudes and behaviours of workforces, across all professions, has been taken in Mental Health services, where the number of ethical inquiries has always been high, and stigma and fear endemic. A national survey in 2000 revealed that uninformed beliefs were held by over 70% of members of the general public (Crisp et al, 2000). Since the introduction of the National Institute for Mental Health in England (NIMHE), much has been done in mental health services to develop ethical practice among practitioners. The historical and social context is important in understanding why: mental health legislation provides the only means to remove an individual's liberty when no crime has been committed. Under legislation, enforced psychiatric treatment can restrict travel abroad and prevent employment and many other activities normally taken for granted. The difficult balancing of individual freedom with the protection of society was brought to a head when new mental health legislation was promised in 1997. Though it was held up when major ethical and legal objections were raised to the

proposed changes, changes to the Mental Health Act came into force in 2008 (Office of Public Sector Information, 2007). In preparation for the new legislation, a group of psychiatrists, ethicists and legal experts formed the Mental Health Act Review Expert Group in 1998 (DH, 1999a). The group recommended new legislation should be underpinned by the ethical principles of: non-discrimination, autonomy, user participation, consensual care, least restrictive environment and reciprocity (that is, the duty upon providers to ensure that, having taken away an individual's liberty, care plans are complied with and adequate treatment provided).

This issue is at the heart of a treatment service working with vulnerable individuals whose judgement and mental capacity is impaired by the very disorders for which they need help (Morrall & Hazelton, 2004).The Mental Health National Service Framework, also published in 1999, succeeded in uniting diverse factions in a shared vision of what mental health services should and could look like in the future (DH, 1999b). Unfortunately, in a review of the framework five years later, Appleby (DH 2004b) cited a 'lack of progress', in services towards black and ethnic minority users[1].

Frameworks for Ethical Competency

In 2001, the mental health workforce became the focus of two linked training and standard setting initiatives. The first, *'The Capable Practitioner'*, was described at the time as 'a broad, unifying framework which encompassed the set of skills, knowledge and attitudes required within the workforce' and was the result of a prolonged synthesis of research, review and consultation (Sainsbury Centre, 2001:4). The framework outlines a hierarchy of 'capabilities', incorporating ethical and performance components, reflective practice, effective implementation and lifelong learning. It was not universally welcomed; for example, the use of the term 'capability' implied 'incapability' to critics like Morrall & Hazelton (2004). Nonetheless, it provided the first whole-workforce framework against which to train, educate and appraise individuals. The framework lists and defines the qualities and behaviours required to demonstrate certain capabilities, the first of which is 'ethical practice'. In the hierarchy of the framework, this capability comes first, denoting the fact that

[1] The publication a year earlier of the report into David Bennett's death, which described an 'institutionally racist' mental health workforce (Inquiry Panel, 2003:43), probably left Appleby little choice in his conclusion.

every worker, regardless of grade, should possess it. Incorporating such qualities as honesty, openness, sensitivity and being non-judgemental, the expectation is that workers should be able to modify their approaches in order to respond to different ages, cultures and races, to promote equal opportunities and to facilitate accountability and scrutiny (Sainsbury Centre, 2001).

Following *'The Capable Practitioner'*, the Sainsbury Centre was commissioned by the Department of Health again, this time to map Higher Education health and social care programmes against the defined capabilities. 'Significant omissions' were found, particularly in the teaching of 'values' and 'working with diversity' (DH, 2004c:1), so that ten new 'essential, shared' capabilities were defined (see box 2.1).

Box 2.1: Ten Essential Shared Capabilities

Ten Essential Shared Capabilities:

- practising ethically
- working in partnership
- respecting diversity
- challenging inequality
- promoting recovery
- identifying needs and strengths
- providing user centred care
- 'making a difference'
- promoting safety and positive risk taking
- personal development and learning

Sainsbury Centre, 2004b: 3.

As part of the same project, Woodbridge and Fulford were commissioned to develop a *'Framework of Values'* to accompany the *'Ten Essential Shared Capabilities'* (DH, 2004c:10). They subsequently described 'recognition', 'raising awareness' and 'respect' as the three core underpinning values and explained their inter-relatedness in a special appendix dedicated to relationships and hierarchy, although the need for such an appendix suggests that

the theoretical component is something of an add-on created for training purposes (DH, 2004c:7). Guidance, by its nature, assumes all qualified staff have acquired these capabilities so that the document is 'aimed primarily at influencing education and training provision' (DH 2004c:5). This seems at odds with the findings of the Bennett inquiry, and with Appleby's assessment (Inquiry Panel, 2003: DH 2004b). Whilst it is difficult to argue with the spirit or intention of Woodbridge and Fulford's body of work, the accusation of institutional racism lingers. Possibly the task of charging education providers with responsibility for instilling non-racist values in future practitioners was seen as a more manageable one than attempting to assess or having to 'change' the value-base of a workforce. Nonetheless, the framework can at least be said to have 'grasped a nettle' and set down some defining characteristics of ethical practice (Sainsbury Centre, 2001). The inclusion of the whole workforce also provides Support Workers and Associate Practitioners with a framework within which to locate their own strengths, weaknesses and development needs.

In other areas of health and social care practice, similar grades of worker face challenges and changes in their work, education and training, without an overarching framework of priorities. To develop and successfully embed a new role with greater levels of responsibility – yet with little control – requires providers of training and education programmes to be responsive and flexible to the needs of all staff and employers. The new roles as *described* by *'Agenda for Change'* (DH, 2004a) require practical ability, a broad span of knowledge and understanding, a confident and resourceful approach to problem-solving and the ability to communicate effectively. The tasks associated with, for example, facilitating discharge from hospital after common surgical procedures (like hip replacements) may involve liaising with General Practitioners, District Nurses, Outpatient services, Day Treatment Centres, Social Services (such as Home Care), Meals on Wheels, Day Care, relatives (who may need to take time off work), neighbours and carers. Knowledge and understanding of emotional and physical needs are pivotal to success in such a 'hands-on' role, as are the interpersonal skills to communicate, motivate, support, advise, reassure and educate. Knowledge of who to contact (and when) and the appropriate language to use can be taken for granted, but nonetheless can make the difference between success and failure. Understanding enough about health and illness to know when to seek help, or about social issues to recognise potential abuse, is critical to safe practice. When analysed in this way, it becomes clear that boundary-crossing work is complex. It is therefore inevitable that a greater need for

judgement and decision-making skill is needed, including a knowledge and understanding of ethical concepts.

Implications for Support Workers

That care work in itself has the potential to be stressful is treated as a given in the literature, yet few studies consider the perspective of Support Workers. In a Norwegian study of male nurses working with older people, the ethical challenges presented by such work were identified as the main reason for a high degree of 'moral strain' and 'burn out' (Nordam et al, 2005: 1248). Yet Support Workers working in stressful environments do so without the educational and professional framework supporting nurse development. Sianesi (2003) found that vocational qualifications, while developing the reflective skills of students, concentrate on behaviours and competencies that are unlikely to encourage the introduction of ethical concepts to practice. In her study of Support Workers working in complex end-of-life care settings, Kelly (2004) concluded that their status as 'moral agents' warrants dedicated training in ethics; specifically, to prevent the feelings of helplessness so often associated with burn out.

The pay and reward differential (and career prospects) of qualified and unqualified workers is considerable, despite the opportunities offered by *'Agenda for Change'* (DH, 2004a). Research has shown that vocational qualifications such as NVQs lead to little change in salary or career prospects, unlike first degrees (Sianesi, 2003: 1-2). Staff considering new roles need to think carefully about their own motives for doing so in the light of ambivalence from professional colleagues and the potential for moral strain. In addition, careful consideration of team and organisational culture may be necessary, as despite attempts to move towards a 'task culture', in which teams work together to solve problems, Kennedy's (Bristol Inquiry Unit, 2001) findings suggest that the NHS retains its 'role culture'. In such a climate, 'performance beyond role requirement can be seen as a threat by both colleagues and superiors' (Kakabadse et al, 1987: 230).

To different degrees, it is clear that most nurses, doctors and other registered professionals have been involved in decision making when ethical issues are a factor. Indeed everyday practice necessitates decisions such as who to prioritise when two people need attention or

whether to spend time with a patient or on essential administrative duties. Less clear is how involved or included Support Workers have been; whether there is any inclusion at all is likely to depend upon the philosophy and practice of the whole team and the traditions of the specialisms. However, it is likely in most areas of care that Support Workers undertake routine, time-intensive tasks with people, and often personal caring activities such as washing, feeding, playing, toileting, dressing, cooking and exercise routines. In areas such as learning disability, care of the elderly, mental health services and social care, the involvement of a Support Worker can extend to all aspects of a person's life, and may include long periods of time in supportive activities in work, community and home settings. The physical closeness of such tasks takes on a new relevance when considered in the light of Glover's (1977) 'moral distance' discussion. Referring to the findings of Milgram's (1974) obedience experiments just a few years earlier, Glover agreed with the conclusion that it is easier to obey instructions to administer pain if we cannot see or hear the person (Glover, 1977). He extrapolated from this finding that distance, whether physical or emotional, makes it easier to cope with the pain of others:

> *'We care more if the child down the road gets drowned than if thousands die in a flood in another country'* (Glover, 1977: 288)

Glover termed this concept 'moral distance'. Following his argument, the physical closeness engendered by the kinds of tasks undertaken by Support Workers, often increased by the emotional closeness of knowing the patient well over time, is likely to lead to a state of 'moral closeness'. Indeed, this was explored by Burms (1996:157), who used the expression *'moral proximity'* to describe the greater sympathy felt towards those with whom professionals are close.

In contrast, Malone (2003:2317) critiques the increasing incidence of 'distal nursing' forced on the profession by a lack of time and proximity with patients, suggesting it has 'potentially dangerous implications'. It is possible that regardless of pay or career prospects, Support Workers would welcome a greater level of responsibility and greater involvement to reflect their 'closeness' to patients: in decision-making; in actioning decisions with autonomy; in communicating across agencies; and in receiving higher levels of supervision when higher order work is delegated by a professional colleague.

Summary of issues from practice

- Recent workforce changes mean that non-professionally affiliated, unregistered Support Workers and Associate Practitioners now take on higher levels of responsibility in health care delivery, so that a greater understanding of their educational needs and training requirements will be necessary going forward to ensure they are as well prepared as 'professional' colleagues to undertake their new roles.
- Health and social care roles may cause 'moral strain' on Support Workers and Associate Practitioners which in turn can contribute to 'burn out'. Unqualified staff are likely to have as much need as qualified staff for support and education when working in such environments, though there is very little research in this area.
- Closeness developed through caring tasks, and time spent with people being treated or cared for, may increase the feelings of involvement and subsequent moral distress felt by Support Workers.

Chapter 3: Literature Review - Theoretical perspectives

Perspectives from theoretical work are the focus of this chapter. They provide an overview of the main concepts and ideas to shape the research agenda of the past fifty years across Britain, Europe, the USA and parts of Australasia. Terminology is discussed and its usage clarified. The search strategy is described and the rationale for selecting particular theories, over others, is explained. The moral development theory most influential in health education is critiqued and subsequent theories introduced and appraised.

Terminology

Terminology relating to morality differs across disciplines. Philosophers discuss morality, moral philosophy and the concept of right and wrong. 'Moral development' is the concept most commonly used in education and psychology. In clinical disciplines such as medicine and nursing, 'ethics' and 'ethical practice' are terms commonly used to describe moral issues. Both 'morality' and 'ethics' can be used to mean the same thing, but the words can have different connotations. For clarity, I will describe the ways in which I use them throughout this study.

Morality is considered by Killen & Hart (1995:1) to frame: '(1) the role of judgement, (2) developmental acquisition and transformation, and (3) moral integration and character'. This all-embracing concept will be referred to by the term 'morality'. In contrast 'ethics' describes a rules-based approach to morality, as in a 'code' of ethics; that is, the rules describing behaviours and values accepted as the norm within society, transgression of which can lead to rejection by the group. This concept belongs to 'normative ethics', the study of right and wrong based upon values, attitudes and morés. By 'personal ethic' I am describing a person's own moral code. By 'ethical practice' I mean practice informed by generally accepted and agreed societal standards.

Meta-ethics describes the examination or study of ethics. It is concerned with questions such as whether there is any such thing as right or wrong, how such concepts are examined and upon what basis decisions are made. It is not a process intended to deliver definitive answers or to create rules. Gillon (1985:2) uses the terms 'ethics' and 'moral philosophy'

interchangeably. I will not; in this study the terms 'moral philosophy' or 'meta-ethics' denote the *study* of morality, while 'ethics' refers to the normative concept of a personal or societal moral code.

Rationale for selection of theories

Searching the literature for seminal theories and associated research was daunting, due to the sheer quantity of both. Boundaries were necessary to maintain focus on the most relevant areas and to ensure analysis was manageable. A grasp of philosophical perspectives became critical to understanding theories and arguments. Theories of psychological development are also pivotal, given the amount of empirical research they generate. Those currently influencing educational practice and research are prioritised. Sociological and anthropological perspectives contribute greatly to an understanding of the broader issues however it was impossible to do justice to either discipline in this study, as each generates a wealth of highly specialist theory and research.

Across disciplines and most notably in psychology, theory-building has been taking place for decades. For example, Zimbardo's (2007) best-selling book examining the brutality of soldiers in Abu Ghraib prison in Iraq, revisits his own and others' controversial experiments in the 1960s to support the theory of 'situational ethics'. Throughout most psychological, philosophical and anthropological literature, the very *nature* of morality is examined. The question of whether there are *any* universal moral rules, or *only* contextualised moral codes unique to particular communities or relationships, is fundamental. This chapter therefore focuses on the *theoretical underpinnings* of research being undertaken in health and social care practice and in Higher Education, in order to question and critically examine that research in the following chapter.

In anthropological literature, the case for the existence of universal moral behaviours (even crossing species) is made by Flack & de Waal (2000:1). After studying relationships amongst chimpanzees, they describe the animals' use of food sharing, conflict resolution, mediation and other techniques as 'the very building blocks of moral systems', concluding that the animals show a sense of social responsibility similar to humans living cooperatively. Boehm (1982) also searches for evidence of universal moral codes across species, seeing this as a way of understanding how moral and legal systems develop in human societies and cautions against

under-estimating the social abilities and insights of primates. Their use of sophisticated techniques for stopping conflict is presented as evidence that they understand the value harmonious group relationships. By retaining control, the most powerful effectively eliminate deviant behaviours and succeed in protecting the whole group, using social conformity as a condition for membership. Although he does not go quite as far as calling this behaviour 'moral', he introduces a new term - 'proto-moral' - for this pre-moral state (Boehm, 1982: 142).

In making the case for the universality of morality, both studies draw upon observation and interpretation of group behaviours. Neither attempts to explore individual relationships or contextual factors. As a sociologist, Black (1998, cited in Katz, 2000) offers a very different perspective, from a discipline concerned with the ways in which society is organised and how dynamics influence social structures. He asserts that morality, in simple and complex communities alike, is woven into relationships. Conflicts are dealt with in uniquely different ways, depending upon the context and according to the temperament, personality and relationships of those involved. Morality is seen as a wholly relative concept, developed within cultures, each making their own rules. As such, he contends that moral behaviours may be examined, tested and predicted, just like any other branch of social science that 'obeys sociological principles' (Black, 1998, in Katz, 2000:113).

Although they reach opposing conclusions about the nature of morality, the anthropologists and sociologist cited embody a determinist, positivist world view; that is, they assert that, through examination and experimentation, the rules governing (human or primate) actions will eventually be discovered, which will enable their future behaviour to be predicted. Such complete trust in empirical research has little place within philosophy, from which a wealth of thought and writing on the subject of morality emanates. Baggini & Stangroom (2003:2) call the evidence base of philosophers 'the kind of evidence which is available to all', explaining this as the 'facts' established by 'everyday experience' *or* established science. So our own experiences (and thoughts even) become a kind of 'fact' in philosophical inquiry. Despite this major difference, it is impossible to deny the influence of philosophers upon the traditional, empirically-based scientific disciplines. Some of the sternest critics of psychological research and its conclusions are philosophers, who use rational argument to dispute claims and critique

methods[2]. Other philosophers engage in scientific debate, using research to support a philosophical treatise. For example, the utilitarian Singer (1994), an outspoken advocate of animal rights and Darwinian 'evolutionary psychology', supports the relativist thesis that morals develop within communities; that is, they evolve over time in line with biological, mental and intellectual growth. He cites anthropological studies of societies (animal and human) which thrive, and concludes that their success is due to 'mutuality' and cooperation. Singer's view is that 'an essential feature of ethics – reciprocity – is explained by evolution' (Singer, cited in Baggini & Stangroom, 2003: 17).

Engaging in philosophical debate from a natural sciences perspective, 'sociobiologists' go further. By understanding 'replication' to be the goal of all genes, they consider 'selfish' behaviour to be a 'design-feature' to ensure such replication is biologically determined. This may be a design-feature of individuals, (Dawkins, 1976; 2006) or of communities or groups, (Wilson, 1978). However both Dawkins and Wilson reject 'hard determinism', seeing the environment and heredity as the interesting 'recipe' which makes people unique. Dawkins explains:

> *'If there is a human moral to be drawn, it is that we must teach our children altruism, for we cannot expect it to be part of their biological nature'* (Dawkins, 2006: 139).

The Role of Education

So, the fundamental role of learning to the development of morality, is a thread running through anthropological, sociological, philosophical, sociobiological and (as will be discussed), psychological theories. Much of this is brought together in the discipline of education. Educational theory and research is interesting, in that both philosophical inquiry and empirical research make equal contributions. Dewey, one of education's most influential reformers, was a school teacher who became one of the most eminent philosophers of the pragmatist tradition (Campbell, 1995). Understanding education as a way of 'repairing' society, he developed progressive methods of education. He saw the learner as part of a 'community of learners' with a collective power, engaging in activities to 'learn by doing' in order to develop critical

[2] The philosopher Straughan has been one of Kohlberg's longest-standing critics, using logical argument to dissect and undermine the psychologist's claims to empirical truth (Straughan, 1985, cited in Modgil & Modgil, 1985).

faculties, rather than by memorising facts. 'The hidden curriculum' was a term used by Dewey to describe the learning which takes place through the 'moral atmosphere' of a school (Campbell, 1995). He believed that students learn not (just) through intended means but in many ways; through relationships with teachers and with each other; through 'how' things are done not just 'what' is done; by watching and understanding actions and behaviours; and by acute observation of disparities between what is 'practised' and 'preached'. A debate was begun which is as relevant today.

A firm believer in 'science' as the only way to improve the human state, Dewey sought to embed his educational ideas into practice. However he was not a researcher himself so does not leave a body of empirical research. In contrast, Rogers built on Dewey's progressive ideas, and as a psychologist, routinely researched into both his psychological and educational practice (Rogers & Freiberg, 1994). Bringing to his teaching the values of humanism, developed and refined in his counselling practice, Rogers researched extensively, although he also based many conclusions upon his own experience. He identified three 'core conditions' which he considered to be essential for creative and fruitful learning; those are empathy, congruence and positive regard, in the relationship between student and educator (ibid, 1994). The optimism and mutual regard inherent in Rogers' teaching methods – which he spelled out in great detail – are relevant to today's 'student centred' agenda.

A current philosopher, Nussbaum, draws on Dewey's work and that of Indian pragmatist philosopher, Tagore. She sees education as the only way to achieve personal and communal 'freedom from oppression', and advocates a 'capability' approach to education which focuses on 'critical thinking, world citizenship and imaginative understanding' (Nussbaum, 2006:385). Although she distinguishes capabilities from 'rights', the distinction is a fine one; capabilities are a 'basic human entitlement' based on outcomes, rather than procedure (Nussbaum, 2004:13). Arguing against Rawls' 'social contract' theory, Nussbaum offers an alternative, extensive global structure in which, among other things, institutions take more responsibility for developing capabilities in individuals, wealth is redistributed from wealthy countries and caring for the ill, elderly and disabled is made a priority (ibid:17). Educational strategies to develop capabilities include creative and dramatic activities, in which participants experiment with stories, local history, traditions and learn different values and perspectives (Nussbaum, 2006). Although her examples come from oppressed groups, the relationship with Dewey's 'learning by doing' approach is clear (Campbell, 1995). The importance of facilitating ethical awareness among groups who hold very different perspectives is at once obvious, yet

neglected, in all the current research. She states: 'An adequate education for living in a pluralistic democracy must be a multicultural education' (Nussbaum, 2006:390).

Perry was an educator and educational researcher who developed a framework of 'intellectual and ethical development' from research on 313 'freshmen' at Harvard during the 1950s and 1960s (Perry, 1968). Students were surveyed, interviewed and a minority followed longitudinally over the four years of their education. Open ended questions elicited from students their views on education and its influence on their development. The concept of moral development was not made explicit. The stated goal of the study was to investigate students' responses to 'intellectual and moral relativism' within their education (Perry, 1968:7). Again the ability to embrace pluralism emerges as critical to the future of society:

> *'The growing person's response to pluralism in thought and values, and indeed his capacity to generate pluralism himself, are therefore critical to the destiny of a democracy'* (Perry, 1968: 6).

From his findings, Perry developed a lengthy and complex framework. This incorporates nine 'positions' from which the student views the world. Each is grouped within four categories, which might overlap and through which students might pass, retreat from or seek to escape (ibid, 1968). The four broad categories are described in Box 3.1.

Box 3.1. Perry's Scheme of Intellectual and Ethical Development in the College Years

- **Simple Dualism**. Right and wrong answers are sought and ideology is largely unquestioned. Students are classically looking for simple answers.
- **Complex dualism**. Students begin to acknowledge that not everything is known, but suspect answers are being withheld. Authority may be fallible. Still trust in an 'ideal'.
- **Relativism. S**tudents experience uncertainty and confusion, realising 'facts' may be interpreted differently. A negative stage for some. Questioning of values. Education seen as 'the way they want us to think', although commitment is beginning to be made to accept differences and recognise that others may hold 'absolute' values.
- **Commitment in relativism**. Now skilled in critical thinking, students use rational processes to draw upon learning and experience, and commit to a sustainable position. Accepting multiple interpretations, balance between reflection and action is achieved.

Adapted from Perry (1968: appendix).

Perry rejected the concept of 'hard stages' as described in developmental psychology. He understood the learner to approach learning from different cultural, social and intellectual vantage points and to draw from each at different times, consciously rejecting certain positions at various developmental points (ibid, 1968). Although he published swiftly and is often mentioned in education literature, his framework is used in only a minority of research studies. This may be because he was very open in acknowledging the limitations of his work, only ever describing his findings as a 'description'. Perry never tried to generalise his findings from the intellectually gifted, mostly male sample of Harvard graduates. Unfortunately his work does not appear to have been built upon in any significant way or his methods repeated. This is in contrast to the work of his peer, Kohlberg, a psychologist who was also building a theory of moral development during the 1960s.

The work and influence of Lawrence Kohlberg

Kohlberg developed, refined and tested a theoretical model from the early sixties through to his death in the late 1980s. It is still used, in an adapted form, in psychological and educational research (Rest, 2000; Lind, 2006). His interest was in 'moral judgement competence', which he defined as 'the capacity to make decisions which are moral (i.e. based on internal principles) and to act in accordance with such judgements' (Kohlberg, 1964: 425; cited by Lind, 2006). Piaget's cognitive-developmental 'hard stage' approach to human development was Kohlberg's starting point. Stages are defined by: qualitative distinctness, stages as structured wholes, invariant sequential progression and hierarchical integration (Hersh et al, 1979:52; Kohlberg, 1976; Piaget & Inhelder, 1969).

Kohlberg's hierarchical model of six moral stages (Box 3.2), developed during his doctoral thesis in 1958, became his life's work, but he never published the original research. He studied the responses of 72 young men from the age of ten through to 16 and followed this with a longitudinal study, over the next 12 years, of 50 men from the original group (Hersh et al, 1979). His findings supported his personal belief in absolute moral principles and universal forms of reasoning, the highest of which is that governed by an unwavering commitment to a set of internal principles based on the concept of universal justice. These govern actions and behaviours with no regard for consequences. Such principles can be religious in nature but equally well may stem from a political perspective or similar abstract concept. Kohlberg tested his theory on different groups, in different countries, over 20 years,

never swaying from his original claim to a universal theory of moral development. However the fact that his theory relied on unpublished original work with a relatively small group of males, attracted criticism over the ensuing years (Modgil & Modgil, 1985). Kohlberg defended his model to the end, believing it to be absolute and universally applicable, across genders, cultures and time (Kohlberg, cited in Modgil & Modgil, 1985).

Box 3.2. Kohlberg's Six Moral Stages

LEVEL 1 – PRECONVENTIONAL

Stage 1 – Heteronomous Morality: Avoidance of punishment and the superior power of authorities.

Stage 2 – Instrumentalism, individualism, exchange: To serve one's own needs or interests, recognising others have needs too.

LEVEL 2 – CONVENTIONAL

Stage 3 – Mutual interpersonal expectations, relationships, interpersonal conformity: The need to be a good person in own eyes and those of others, caring for others, desire to maintain rules and authority which support stereotypical good behaviour.

Stage 4 – Social system and conscience: To keep institution going as a whole, avoid breakdown of system 'if everyone did it', imperative of conscience to meet one's own obligations.

LEVEL 3 – POST-CONVENTIONAL OR PRINCIPLED

Stage 5 – Social contract or utility, individual rights: A sense of obligation to law because of one's social contract to make and abide by laws for welfare of all and for protection of rights; feeling of contractual commitment, freely entered upon, to family, friends, work; greatest good for greatest number.

Stage 6 – Universal ethical principles: Belief as a rational person in the validity of just, universal moral principles, and a sense of personal commitment to them.

Abbreviated. Source Kohlberg (1976, 1984).

Critics sought answers to the many methodological and conceptual problems which dogged studies. These were helpfully summed up retrospectively by Kohlberg's (somewhat partisan) colleagues, Hersh et al (1979), who acknowledged and accepted the following problems:

- A complete omission of girls or young women from the early studies
- Data collection only beginning at 10 years old
- A paucity of data on stages five and six

- A poor publication record
- The inherent assumption that moral reasoning leads to moral action.

Although these serious issues weaken the authority of the theory, they appear not to have limited its influence, even to the present day. Because of its importance it will be considered in some depth in order to better appraise more recent health and social care research studies in Chapter 4.

The moral development framework consists of six stages grouped into three broader categories; preconventional, conventional and post conventional or principled (see Box 3.2). From an early point, analysis of research findings was based on the model; that is to say, responses from participants were grouped into one or other of the six stages. Participants were presented with three dilemmas and questioned about their responses. Replies were assessed against the six stages, with key words and phrases used to identify at which level of moral reasoning the individual was (mostly) operating. Dilemmas were developed to ensure that two or more values conflicted, as Kohlberg posited that by having to *think* about one's values and prioritise, a new 'order' of values emerges. This can be compared with Piaget's concept of knowledge as a process, in which 'to *know* something is to *act* on that thing' (Thomas, 1985:262). Their methodologies can also be compared, as Piaget engaged children's physical and mental faculties in play or discussion, eliciting from them just *how* they were ordering or deciding upon action (ibid, 1985). Kohlberg engaged participants in moral thinking and then questioned them on *how they were thinking* and ordering their responses. He was satisfied that the ability to *reason* at a given level equips us to *act* morally, as we are then able to draw upon a greater range of resources and options.

Many studies by other research teams were set up to test this relationship, but seem only to prove that no such correlation is reproducible. One such study of adolescents (already allocated to one of Kohlberg's six stages) was designed to see who would cheat in a school test (Hersh et al, 1979). Although 45% of students at Stage 4 did not cheat, 55% did. This proportion is only slightly smaller than the proportion (64%) of cheating students assessed at Stage 2, 36% of whom did not cheat. Kohlberg conceded that we are more likely to *say* the things we know to be right rather than *act consistently* upon them, but maintained that those who reason at a higher level 'are less likely to be influenced by situational factors and more likely to act consistently on their values' (Kohlberg, ibid, 1979:95).

Hersh et al (1979) present a helpful, if somewhat esoteric, critique of this perspective. Kohlberg offers direct quotes throughout and was the author of the preface, so it can be assumed that he was a significant influence in the writing of the critique. They describe a slightly more robust study of University students, tested for moral development one year after a 'sit-in' protest, which they may or may not have participated in. The premise of the study is that a greater proportion of students operating from a higher moral level would have participated in the protest, than of those operating at lower moral levels. Of the 214 students who accepted the invitation to be tested, a greater proportion of those subsequently assessed at Level 6 had chosen to participate in the sit-in (75% of men and 86% of women), appearing to prove the hypothesis. However 60% of the men assessed at Level 2 also took part, confounding the hypothesis that a *significantly* greater proportion were acting directly from higher moral principles. There is also an implicit assumption that those operating at higher levels would choose to demonstrate, although those choosing not to protest in this way may still have been acting on higher principles. Whilst the authors include some of the most interesting original data, they appear to have no real answers to this finding or others, other than to make a distinction between 'behavioural' motives and 'justice' motives. This seriously undermines the credibility of the critique and suggests research findings were interpreted to 'fit the theory', rather than in a rigorous and open-minded way. In support of this criticism, one of Kohlberg's closest and most loyal colleagues, Rest, also appears to criticise his response to 'disconfirming' data; in that he describes him simply revising again and again the interview scoring system, rather than revisiting the basic concept of hard stages (Rest, in Modgil & Modgil, 1985: 461).

Kohlberg's findings were not being duplicated by others researching the same topic in Britain. Durkin, reported by Kay (1968:173), found it disquieting that many of his 17 year old research participants were making moral judgements in very similar ways to those used by infants. Morris, also reported by Kay (1968:176), found in an extensive study of over 300 British adolescent schoolchildren, that, although apparently very mature moral judgements were being reported by many boys, closer questioning revealed a purely anti-authoritarian stance. This prompted him to conclude that while it is possible to under-estimate a child's morality, it is *as easy* to over-estimate it. Both were using Piagetian-influenced concepts, during the same social period, albeit in a different part of the world.

Despite the criticisms, Kohlberg continued to seek 'universal moral principles' which were 'the product of mature, rational judgement' and equally relevant across genders, cultures and

belief systems (Hersh et al, 1979: 44). He generated a list of ten 'Universal Moral Issues', including such things as the value of life and truth, which he contended would be found in all societies (ibid 1979:84). It is useful to understand the context of his life when considering these goals, and his strong rejection of relativism. He rejected psychological theories which explained morality as a product of upbringing or early childhood experiences; that is, those stemming from a Freudian perspective (ibid, 1979: 44). Such theories were, to him, a way of diminishing personal responsibility by locating morality alongside culture or personality. In the aftermath of the Second World War, during the war in Vietnam and the Watergate scandal, he heard relativist moral arguments used to support what he considered *immoral actions.* To criticise such actions (or claims to relativist morality) he considered it necessary to adhere to some greater, universal principle:

> *'A person who rejects these claims must explain on what basis he is criticising other people's morality. He must assume the existence of some moral principles whose validity is not limited to any given society'.* Kohlberg cited in Hersh et al 1979: 44

This statement describes Kohlberg's personal stance which may have pre-dated or been born of his interest in philosophy. The work of Immanuel Kant was to influence his work greatly and so is important to understand. Kant's most important contribution to moral philosophy is his contention that mankind will only move forward and thrive if doing one's duty, as opposed to being motivated by personal desires or happiness, is the objective; that duty can only be known if moral laws (absolutes) are established and adhered to, for the moral good of all humanity (Singer, 1994).

Such 'moral laws' needed to meet three criteria: they should be r*eversible* (should be upheld if applied to oneself in that situation); *consistent* (would be administered in the same way even in different times, places or cultures); and *universalisable* (may be generalised and applicable to all). Kant is credited with having worked through every detail of his theory. Having established the three conditions necessary for a moral law, which he called the 'categorical moral "ought"', or the categorical imperative, he stipulated the kind of reasoning necessary to arrive at the right moral laws (Kant, 1788, cited in Singer, 1994). He contended that by thought alone is it possible to reach moral decisions. All everyday urges and personal desires need to be set aside so that the thinking process is unhampered by personal interest, fears or prejudices. He described a perfect, detached type of reasoning:

'..which connects him with an order of things which only the understanding can think and which has under it the entire world of sense, including the empirically determinable existence of man in time, and the whole system of all ends which is alone suitable to such unconditional practical laws as the moral'. Kant (1788 cited in Singer, 1994: 39).

Singer (1994:20) located this concept of the 'pure moral law', (distinct from feelings and arrived at only through reasoning), as the *furthest endpoint* of the Darwinian evolutionary theory. It is possible to Kant's principles reflected in the legal system and all other formal systems for inquiries or complaints; in that personal interest is accepted to be incompatible with good reasoning.

To live life by obeying moral laws, when to do so flies in the face of personal interests, is a tall order. Imagine deciding upon one's moral duty every day in this way: for example, deciding how to respond when passing a homeless person asking for money in the street. Yet for many years Kohlberg claimed to have derived his six stages empirically, from research on boys, still only aged between 22 and 28 at the end of the 12 year follow up. Hersh et al (1979:77) come closest to tackling this issue however. Explaining Kohlberg's theory to teachers, they describe stages five and six as 'derived philosophically', quoting Kohlberg's later contention that only two 'practising philosophers' were able to meet the criteria for either. This effectively refutes the claim that Stage 6 was derived empirically. Nonetheless Kohlberg defended the empirical evidence for this stage in his final contribution before his death, though not vigorously. He grouped stage 5 and 6 together and even went as far as to say 'I have backed off from some claims about the nature and adequacy of Stage 6', (Modgil & Modgil, 1985:512). In later years Kohlberg became very affected by Rawls' 'Theory of Justice', as he developed his idea of the 'just community' (Richardson & Weithman, 1999; Hersh et al, 1979).

Criticisms of Kohlberg

Spiecker & Straughan (1988) made the point that, in Kohlberg's model, effective teaching can only take place when the educator has reached the later stages, as only from this perspective is it possible to understand each stage. How a student is able to appreciate the perspective from the next or later stages, before he or she is actually there, is also a puzzle.

Kohlberg's explained the necessity of 'cognitive conflict', aroused in students by discussion of dilemmas which provoke them to order their values (Hersh et al, 1979). However the criticism that this is still an intellectual exercise remains a valid one as it is possible to learn the theory and devise answers to correspond with the highest stages. This debate has implications for educators with a remit to engage students in abstract moral principles, such as Gillon's 4 Principles (Gillon, 1985) or those embodied in the '10 Essential Shared Capabilities' (DH, 2004c).

Philosophers and educators criticised Kohlberg's lack of attention to moral action. Straughan compared Kohlberg's position to Socrates' claim that 'to know the Good is to do it' (Straughan, in Modgil and Modgil, 1985:151). He contends that the interview methodology proves only an individual's ability (or lack of) to engage in hypothetical ethical debate, saying nothing about their true morality. This is an important criticism of all interview-based research methods.

Another critic questioned how a theory developed from empirical study could ever be seen to give rise to universal, moral truths (Carter, ibid, 1985:15). This is known as moving from 'is' to 'ought'. He questioned why empirical study was thought to provide answers to philosophical questions, wondering if this was a more 'tempting route' than more rigorous, philosophical inquiry.

Wilson makes the point that every person is different in how they learn, assimilate, remember and rehearse actions (Wilson, ibid, 1985). He found developmental psychologists' attempts to identify stages of development 'entirely baffling', arguing for a more straightforward understanding of morality as following 'the rules', against a backdrop of basic principles (ibid, 1985:230). He considered these principles to be things like 'doing what's best for people', or 'treating people equally', positing that children would probably prefer and use 'reasons most salient in the regime that controls them at that age / stage' (ibid, 1985:230). Unless indoctrinated in a particular method likely to *prevent* independent thought, he argues, children will build on those basic rules and eventually assimilate them. They will never need to prove their morality by engaging in elaborate, esoteric, hypothetical conversations (such as the Heinz dilemma) which have *hidden rules* all of their own (ibid, 1985: 230).

The critics offer important perspectives. Certainly, engendering the drive to *act* morally is the business of classroom-based educators, who generally use thinking, reflection and discussion to influence future actions. However in the work-place, it is behaviour (not thoughts or

motives) that is observed and measured. A health care worker can belong to a pro-euthanasia lobby group, or a radical political party or religious cult, as long as they adhere to law and policy at work. Whether someone is behaving in a self-interested way by following the rules, or whether those rules become assimilated and internalised over time, is difficult if not impossible to assess. Whether it even matters to patients is debatable, as long as the behaviour shown to them meets an acceptable standard.

Developments following Kohlberg

One of Kohlberg's original team, Rest, built on their early work to develop his own 'Four Components' model of moral development (Rest & Narvaez, 1994, cited in Lewin et al, 2004). His linked 'Defining Issues Test' (DIT) is based on Kohlberg's dilemmas. It is used a great deal in health and social care research. His work is called the 'neo-Kohlbergian' approach (Rest et al, 2000) and is based on the central inquiry: 'What must we suppose happens psychologically for moral behaviour to take place?' (Rest & Narvaez, 1994: 26). He concentrated his research on 'processes' (rather than stages) which integrated thinking, feeling and behaviour, as he considered their separation to be 'artificial' (Kurtines & Gerwitz, 1991:138-139). His 'Four Components' framework described necessary conditions for moral behaviour to take place (see Box 3.3), (Rest & Narvaez, 1994: 1 - 26). This approach has been used in health professionals' education on many occasions (Bebeau, 2002).

Box 3.3. Rest's Four Components Framework

1. **Moral sensitivity.** Understanding the professional's role, being capable of empathy and skill in interpreting social interactions.
2. **Moral judgement.** Once aware of a moral issue, judgement requires the ability to identify different courses of action, to imagine how different people would be affected by each, and then to select a justifiable response.
3. **Moral motivation.** When a moral judgement is made, the motivation to pursue the moral choice is prioritised over other choices such as self interest, convenience or self preservation.
4. **Moral action.** The interpersonal and problem solving skills needed to carry through the moral choice, combined with perseverance and strength of character, are necessary for moral action.

Abbreviated from Rest & Narvaez, 1994: 1 - 26

Unlike Kohlberg, Rest embraces the challenge of moral action, and even breaks down his fourth component into the necessary aspects of action-taking. He does not insist that moral judgement leads to moral action. He also differs from Kohlberg in moving away from what he calls the 'hard stage concept' (Rest, in Modgil & Modgil, 1985: 461). Rest's DIT is probably the most commonly used measurement tool in contemporary research (see Chapter 4).

Also derived from Kohlberg's work, the 'Moral Judgement Test' (MJT) seeks to measure moral competency. Its author, Lind (2006) contends that this test has advantages over the DIT as it is able to actually measure competence, requiring a task to be completed (unlike Rest's DIT which measures only the preferred mode of reasoning). However Lind is clearly committed to the concepts Kohlberg and Rest pioneered. His MJT test only appears in one recent research study found as part of this inquiry. This may be due to much of his work only being available in German.

A humanist theory of moral development is offered by Hoffman (2000). His work on empathy, located within psychological theories of motivation and emotion, describes five types of moral dilemmas: the 'innocent bystander', who has to choose whether or not to help a stranger; the 'transgressor', who accidentally harms someone; the 'virtual transgressor', who is innocent but believes he has harmed someone; 'multiple moral claimants', in which a choice has to be made about who to help; and finally 'caring versus justice', in which the needs of individuals conflict with issues of justice (Hoffman, 2000:4). He uses 'types' to examine human behaviours and feelings of guilt, most interestingly in situations where fear of harm or punishment to oneself overrides the empathic desire to help another in distress. Hoffman considers Kohlberg's work to be of immense importance and acknowledges the importance and relevance of the cognitive theories already discussed, given that 'moral judgement' is one aspect of moral development. However he asserts: 'empathy is the spark of human concern for others, the glue that makes social life possible' (2000:3). He draws on the treatment of Jews in Nazi Germany to examine the feelings of those who placed self-preservation before their own moral judgement. While applauding Kohlberg's rejection of relativism following the Holocaust, he nonetheless places as high a value on 'caring' as on justice and notes that the two may well conflict in some situations (2000: 273). An example which summarises this tension is offered in the following example. The renewal of the tenure of a faculty colleague who is underperforming is being voted on. If voting colleagues know the person's child is very ill or that the family will suffer greatly by the person losing his job,

the caring principle may win. If, however, the unfairness of a person being paid for a less that adequate performance is the deciding issue, the justice principle may take priority (Hoffman, cited in Kurtines & Gerwitz, 1991: 290).

On cultural relativism, Hoffman defends the role of empathy as a universal driver. Whilst he acknowledges the Western emphasis on individualism, he asserts that even in more collectivist societies, individuals are acting from a sense of self – and of others - and self preservation in conforming to societal norms (Hoffman, 2000: 280). Using 'normal distribution' to explain why some people are highly motivated to act on empathic feelings, whilst others appear to have no sense of empathy and are called 'psychopaths', he advocates 'socialisation' techniques. These include experiencing a range of emotions, modelling empathic responses and 'role-taking' play, to increase children's moral responses and reduce their 'empathic anger' (Hoffman: 2000: 287 – 290). Like Wilson, Hoffman considers embedded 'principles' to come to the fore during adolescence, when decisions have to be made and alternative courses of action compared and given weight (Hoffman, in Kurtines & Gerwitz, 1991: 293). When principles and empathic feelings 'match', a 'hot cognition' takes place, activating coolly-acquired, thought-through principles with emotionally-charged, empathic arousal (Hoffman, in Kurtines & Gerwitz, 1991: 294).

This theory, although referring to children's and adolescents' moral development, is relevant to Higher Education; in that it suggests that acquisition of abstract moral principles is important as they can be *re-activated* in an immediate, emotional moral encounter. It also suggests empathy can be increased through contact with others - as Allport (1954) asserted in his 'contact theory' - through structured interventions such as role play. The universality of empathy as a human attribute is well defended by Hoffman, although he admits to considering it to be fragile, and does not consider it to lead to reciprocity and justice (Hoffman, 2000: 283).

Another humanist psychologist working in Britain through the 1980's responded to Kohlberg's body of work, providing a balanced critique. His particular interest is in the 'gap' between judgement and action – or, knowing the right thing to do but for a variety of reasons not actually doing it – which leads him to examine the small, everyday actions unlikely to be influenced by conscious thought (for example, wiping a child's runny nose - or failing to do so). This has relevance to practice, given that many small, important acts or omissions are at this level of automatic responsiveness and are unlikely to be considered as

'ethical practice' by most practitioners. As a humanist, he does not share the Kantian view of duty. He proposes that in dilemmas, most people talk with friends or relatives, rather than sitting contemplating the 'just' solution in isolation (Kitwood, 1990: 149).

Kitwood (1990) admires Kohlberg's contribution to the subject of moral development (and cites research which confirms a relationship between moral reasoning and action: McNamee, 1978; Blasi, 1980, cited in Kitwood, 1990). However he highlights philosophical and methodological contradictions. On the one hand Kohlberg looked for correlations between 'scores' and future behaviours; on the other, he sought, through interview, to understand subjective experiences. The two techniques are inherently at odds with each other (ibid, 1990: 147). His most important criticism, however, is of the Westernised attitudes permeating Kohlberg's, and his followers', work. Even when the studies were replicated across very different cultures, the same dilemmas (such as the Heinz dilemma) were used. This shows to Kitwood a startling lack of insight into the different life experiences and values of people living, say, in small, rural villages in China or religious communities in India to those of people in New York or Berlin (ibid, 1990: 139). Advocating a 'richer conception of the person' than the cognitive developmentalists employed (ibid, 1990: 151), he asserted:

> *'..a moral standpoint cannot be taught according to the pedagogic model of putting water into the bucket, and far less can it be imposed by authority; it is something that each person must be allowed to construct on his or her own behalf'.* Kitwood (1990: 102).

Carol Gilligan and the Ethic of Care

One person, however, will forever be thought of as Kohlberg's strongest and most influential critic. A member of his research team for many years, Gilligan developed an alternative, feminist theory of moral reasoning and action which is well known as the 'ethic of care' (Gilligan, 1982 / 1993: 62). Questioning why women never progressed beyond Kohlberg's 3rd stage of moral development, Gilligan refused to accept the explanation that women only progressed in their moral development when they left the traditional caring role and entered male domains such as the workplace. She blames the bias within Kohlberg's original all-male

sample and suggests that his commitment to universal justice principles reduced the interpersonal, caring perspective to a lesser form of morality (ibid, 1982).

Initially using the same methodology as Kohlberg, Gilligan began to find that reasoning through the famous three dilemmas produced very different answers and insights from women participants. At first she did not attack his methods, only his generalisations and conclusions. In her own research she used hypothetical and real life moral dilemmas, including in depth interviews with women going through the process of deciding whether or not to have an abortion (ibid, 1982). Her theory of moral development is still a stage theory, but stages are considered to be transitions rather than 'hard' stages, and are 'interconnected' rather than hierarchical. She uses the analogy of a 'web' of connections, rather than a pyramid within which only a few reach the top (ibid, 1982 / 1993: 62). Using Kohlberg's same terminology, Gilligan identifies different goals for women:

- *Preconventional* – the goal is individual survival. The transition from selfishness to feelings of responsibility for others leads to
- *Conventional* – in which the goal is self sacrifice. The transition from goodness to a sense of personal integrity and personhood leads to
- *Postconventional* – and the principle of non-violence, or not hurting oneself or others (Gilligan, 1993: 72 – 78).

Importantly, she does not agree with Kohlberg that greater 'cognitive capability' is the factor leading to higher stages. Rather, she concludes that it is changes in women's *sense of themselves,* which drive them on to the next stage. She says of the final stage:

> *'Once obligation extends to include the self as well as others, the disparity between selfishness and responsibility dissolves'* (Gilligan, 1993: 94).

Like Black (1998, cited in Katz, 2000) she proposes that morality is intertwined with relationships; that ethical reasoning, decision-making and actions are always located within real, immediate and personal relationships (Gilligan, 1982). Gilligan uses Perry's concepts to explain the move from 'absolutism' to the 'acceptance of relativism' by her own research participants, extending this process well beyond the college years into adulthood and middle years (Perry, 1968; Gillgan: 1993: 166). Her 'ethic of care' theory spawned many theoretical and empirical studies, becoming influential within the nursing discipline (Morrall, 2001).

Criticism centres upon both methods and content though, which largely involved women's subjective experiences. Nonetheless, one of her many supporters, Hekman, (1995:23) defends the 'interpretative' nature of the inquiry, rejecting the positivist assumptions underlying the accusation that the work is 'ideology' rather than 'science'. Larrabee (1993:52) similarly distinguishes Gilligan's ethic of 'appropriate response' from the universal, Kohlbergian concept of 'right action'.

For educators, all these theories have implications for how to support students in their ethics education. In Kohlbergian-influenced educational frameworks, students will be 'assessed' and their stage of development measured, possibly pre- and post- an educational intervention, in a quasi-experimental process. Exercises in moral reasoning – classically verbal description and debate of dilemmas stemming from the three 'problems of justice' (Kohlberg, 1984) - will be set, discussed and explored further to help them progress their thinking to the next stage. Intermittent re-testing will show whether their learning has been successful. The theory suggests their actions will follow their abstract reasoning abilities and be as morally good as the student's reasoning ability enables them to be. Cochrane & Manley-Casimir (1980) helpfully developed a large volume of texts and practical exercises dedicated to this approach. They explicitly applied their 'role exchange test' (a version of Kant's 'categorical imperative') to assess the internalisation of universal moral principles in young people.

If Gilligan's, Hoffman's or Kitwood's theories are the influential, learning will be drawn from students' own lives and relationships. Practice experience is seen as key to understanding and exploring personal morality. Only by fostering and nurturing relationships and discussing issues and dilemmas, is the 'ethic of care' likely to be instilled or constructed, and accorded status.

Alternative Theories

So far all the theories discussed locate morality within the individual. Not apparent in current health or social care research are the ideas of Zimbardo (2007), who challenges theories based on individual development and offers instead an alternative view, in which systems and situations take a share of responsibility for individual moral actions. He rejects the traditional concept of a 'rotten apple', introducing instead the 'rotten barrel'. This theory is not new.

Indeed Zimbardo was a peer of Milgram, who became famous for his highly controversial obedience experiments during 1961. Both worked in the USA during the 1960s and 1970s on 'situational' theories of morality. These will be outlined given their important implications for ethical practice in health and social care.

In Milgram's experiments, ordinary citizens believed they were administering life-threatening electric shocks to others yet many continued to obey instructions (Milgram, 1974). Conditions in which people would refuse to administer pain were identified (when in physical proximity with or having to touch the other person to administer the shock), and those in which they would continue, even to the point where they believed the person had died (usually when administering the pain through a third party), (ibid, 1974:122). Women generally obeyed or refused in exactly the same numbers as men, although reported greater anguish afterwards (ibid, 1974: 63). Milgram concluded that:

> *'it is not so much the kind of person a man is as the kind of situation he finds himself in that determines how he will act'* (ibid: 1974: 205).

The findings created a very hostile reaction in the American press and public and Milgram's career was all but wrecked (Zimbardo, 2007). However an earlier study of obedience in nurses showed 21 out of 22 nurses obeyed an unknown doctor's telephone order to give a dangerous amount of medication to a patient (Hofling et al, 1966). The nurses later explained that they obeyed because doctors became annoyed if their orders were not followed (ibid, 1966). [3]

Ten years after Milgram's experiments, in 1971, Zimbardo and colleagues created a similar experimental situation. This time, 24 male volunteers (students who were paid $15 a day), were randomly assigned to role play either guards or prisoners in what was called the Stanford Prison Experiment (SPE). The experiment had to be stopped after six days, following extremes of abuse and humiliation from the guards towards an increasingly passive, submissive and sullen group of prisoners. Several suffered emotional breakdowns during the experiment (Zimbardo, 2007:178).

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[3] In studies attempting to replicate Hofling's et al experiment participants were given access to advice from colleagues and superiors; none agreed to obey the instruction (Rank & Jacobson, 1977). More contemporary studies also acknowledge contextual factors, such as the presence of colleagues, as integral to the nurses' decision-making (Bucknall, 2003).

The behaviours of USA soldiers towards Iraqi inmates in Abu Ghraib prison resembled the dehumanising treatment of the SPE (Zimbardo, 2007). Whilst politicians and senior members of the armed forces blamed a 'few bad apples', it soon became clear that systemic problems existed (ibid, 2007: 430). Becoming interested in those who resist involvement in such situations, Zimbardo developed a *'10-step programme to resist unwanted influences'*. This consists of:

- admitting our mistakes
- mindfulness (or taking a critical approach to situations)
- taking personal responsibility
- asserting ourselves
- rebelling against unjust authority
- valuing our independence
- being 'frame-vigilant' (or remembering the big picture)
- maintaining a sense of the past and future rather than operating only in the present
- refusing to sacrifice freedom in the name of security
- and opposing unjust systems (ibid, 2007:451).

This aspect of his work has been criticised as the weakest. One critic thought the 10 step programme 'just too American for cynical British stomachs' (Bywater, 2007). Nonetheless systemic issues arise regularly in NHS inquiries, such as the 'institutional racism' accusation (Inquiry Panel, 2003) or the multiple systems failure identified in the Climbié report (Laming, 2003). Situational theories are clearly important, as is the way in which we prepare students to understand and work within diverse settings.

One final theory, drawn from neuro-psychological research, is that of the 'ethical brain' (Gazzaniga, 2005) or the 'moral mind' (Hauser, 2006). Both neurological scientists are engaged in researching the mental processes involved in moral judgement. Both posit that, far from making decisions based on cognitive reasoning, our intuitive responses occur very swiftly and are *followed* by the conscious reasoning process. This reasoning may or may not conclude in the same way as the intuitive response. Differences can lead to internal conflict, a familiar experience when one's immediate response may lead to feelings of guilt or even shock, when reflected upon later (Hauser, 2006). Hauser is carrying out international web-

based research into our responses to dilemmas and has found, so far, that those responses (but not the actual reasoning processes) are similar (ibid, 2006: 127). He calls this shared, innate sense of right and wrong a 'universal moral grammar' which, like language, is learned and understood *within a local context*, which provides our customs and laws (ibid, 2006: 43). When one set of customs is 'fixed', another set can be as difficult to understand as a foreign language (Hauser, 2006). Unlike Kohlberg, Hauser does not consider there to be universal moral laws, only a shared tendency *within people* towards right and wrong. The differences in reasoning – or 'cultural stories' – is explained by Gazzaniga as the work of the left brain, or what he calls 'the interpreter':

> *'... because it seeks explanations for internal and external events and expands on the actual facts we experience to make sense of, or interpret, the events of our life'.*
> Gazzaniga (2005: 147)

Although a radical departure from the Kantian concept of a thoughtful, reasoning approach to ethics, as the pinnacle of human moral achievement, the new neuro-psychological theories offer new ways to explore the reasoning processes of students. Neither researcher is saying that shared moral tendencies lead to pre-determined or fixed value systems. Rather, that (across and within cultures) we share more similarities than differences. However we have difficulty *understanding* each other's stories or interpretations.

This theory has important implications for educators. Learning, in which the students' initial intuitive response is captured and revisited, may well allow exploration of feelings otherwise suppressed. 'Unpacking' how they have interpreted their responses can only be helpful and will possibly lead to a more open and honest debate. It is also possible to see how Nussbaum's goal of learning from others' differing perspectives may be achieved by creating a situation in which immediate, unfiltered responses are shared in an open and trusting manner, rather than more self conscious rehearsed responses (Nussbaum, 2006).

Summary of theoretical perspectives:

- Many disciplines build theories and many conduct empirical research in the field of moral development. Dominant throughout the latter part of the 20th century is the psychological cognitive-developmental theory of Kohlberg, continued today by Rest and Lind.

- Humanist and relational theories offer an alternative paradigm. They continue to be studied and utilised in health and social care teaching. Educational philosophers contribute greatly to the debate, offering a broader political and societal view of educational strategies.
- Situational theories, researched during the 1960's are gaining ground again through the work of Zimbardo although there is no reporting of current research in this field. Newer work from neuro-psychology suggests that evolution plays a part in morality. The role of intuition is of particular interest.

Chapter 4: Literature Review - Research Findings

Research into ethics education in health and social care comes mainly from nursing, medicine and psychology. There are many different ideologies and classroom methods within each, all offering valuable and transferable approaches and techniques. To capture and compare the different approaches, this chapter will critique the main bodies of research by discipline. This is necessary because this is generally how research has been conducted. Research from the education of the workforce will also be included where relevant, along with research on undergraduates. Studies from interdisciplinary education and smaller professions will be critiqued towards the end of the chapter, which will conclude with a summary of themes generated.

Search Strategy

The search strategy required clear boundaries given the amount of related published research. Health, social care and related education research provided the primary focus. No specific search was made of sociological, theological or anthropological literature. Educational and psychological studies of childhood were informative, however due to the sheer volume of work in this area only they were excluded. Much of the earlier work, based on feminist theories, was excluded for the same reason. Many descriptions of curricula were sacrificed in favour of more analytical pieces. Very limited, specialist studies (for example, 'paediatric critical care nursing ethics') were excluded, as the findings were often not transferable. Finally, other than seminal work, research articles more than twenty years old were generally excluded. Full text articles in English were largely available electronically although a very small number were available as abstracts only. Several of those were found in paper collections. Boundaries were set at the beginning of the search, but new ones became necessary during the process.

A very open approach to reading was taken early on, followed by a gradual 'funnelling'. Educational, health and social care databases were searched using two separate terms due to their differing terminologies. 'Moral development' and 'education and ethics' resulted in a total of 527 'hits' using the OVID database. Many more came to light through following links

in reference lists. As boundaries were imposed, by reading many abstracts, a final number of 68 articles were selected for fuller reading and analysis. Research from medical education made up the largest proportion, with nursing a close second. Within both fields, a good deal was highly specific, partisan or limited in scope they were rejected. Psychological studies were fewer in number, but often of high quality. Smaller professions were hardly represented and quality was often disappointing, however some useful methodologies were found and so towards the end of the chapter, these are discussed and critiqued. Studies with relevance across disciplines or specifically to this project were prioritised for detailed critique.

Research from Medical Education

Contemporary studies come mainly from the USA and the Netherlands. A review of all USA studies from 1974 – 2004 provided a useful starting point (Eckles et al, 2005). Concentrating on empirical studies of ethics teaching in medical education, the authors note the absence of research considering students' religious, cultural or socioeconomic backgrounds. They conclude there are four areas of deficit, each showing a lack of:

- stated goals
- stated outcomes for students
- study into types of teaching methods
- evaluation of the effectiveness of teaching methods (ibid, 2005).

A dichotomy is found between studies which consider ethics education as a way of producing 'virtuous physicians', and those which see it as a way to produce skilful 'problem-solvers', (Eckles et al, 2005:154).

In a study from the Netherlands, Leget (2004:492) points out how easily medicine accords with consequentialism, as a practical, results-orientated profession highly influenced by the hidden curriculum. He considers this, along with students' young age and liberal culture, to be responsible for their detachment and low level of engagement in ethics (ibid, 2004). Satterwhite et al (2000) found amongst students in the USA, an increasing proportion negatively affected by observation of, and participation in, unethical practice. As many as 55% of fourth year students (of a cohort of 462) stated that derogatory comments to patients were 'sometimes or often appropriate' (ibid, 2000:462). The same study elicited students'

views of changes in their ethical orientation. Despite the greater tolerance of unethical behaviour, most participants (70%) said it had stayed the same. The authors point out the paradox in the two responses. This finding is reinforced by the proposition made by Kenny et al (2003), in a Canadian study, that 'role modelling' is a major factor in character formation. They argue that the 'acculturation' of values and attitudes cannot be taught, only demonstrated and rehearsed in practice. Both studies support the theory of acculturation by role models, albeit in the wrong direction for Satterwhite's participants (2000). Leget (2003: 493) also considers the effect of role models ('their stories, jokes, anecdotes, and the messages about their science') to be an important component of the hidden curriculum. Lack of engagement was considered by Kenny et al (2003:1208) to stem from the reliance on 'solving problems', meaning that 'the ethics of character' have been lost. They propose a greater valuing of the virtuous professional and a return to virtue ethics.

Another study suggests ways to improve students' interest in ethics. Musick (2000) cites Bisonette's (1995), urging for greater attention to be paid to issues students identify as ethical dilemmas; that is, the issues which cross the 'student boundaries'. When Huijer et al (2000: 834) conducted a large, four year study of ethical issues identified by 522 students in Amsterdam, four main areas of concern were identified: seeking patients' consent; end of life decisions; medical failures; and problems in referring patients to other clinicians, including poor communications between staff. A minority of students (5%) even questioned whether they really wanted to become a physician. Others expressed feeling powerless in the face of more senior colleagues. Patients identified as causing the most dilemmas were those who were noncompliant with treatment, followed by those in whom the student had an emotional interest. Like Musick (2000), the authors urge educators to listen to students and encourage greater sharing of opinions, moral values, uncertainties and failure of treatment interventions (Huijer et al, 2000).

With this goal in mind, UK educators Roff and Preece (2004) describe a teaching methodology in which students teach each other, having studied in depth a case from practice. Other disciplines also take this approach. For example, Candela et al (2003), describe nursing students in the USA exploring a topical issue in depth then presenting it back to peers for debate. Candela et al (2003) use Perry's developmental model to understand the students' progress, suggesting that research and debate is helpful in developing a number of skills, not least the confidence to articulate and defend their views.

Rest's Defining Issues Test 2 (DIT2) is used by Hren et al (2006) to explore Croatian medical students' moral reasoning. They also administered is the 'Machiavellianism and Paulhus Socially Desirable Responding (SDR)' tests. Findings suggest that far from being independent of personality traits, their moral reasoning scores are closely associated with the Machiavellian 'flattery and amorality' subscales. Without knowing more about these tests and their reliability, it is difficult to assess the worth of this conclusion. Nonetheless this study introduces the possibility that participants who are capable of a high standard of moral reasoning – thought by Kohlberg and still considered by Rest to be a sound indication of moral action – also score highly for *amorality*. The DIT2 may therefore be vulnerable to clever and manipulative use (despite its author's inclusion of several 'in-built checks' to avoid such misuse) (Rest, 1990; cited in Duckett et al, 1997: 223).

Other studies offer an analysis of medical curricula. Two from the USA sent questionnaires to medical schools with the aim of analysing progress in teaching ethics (Swick et al, 1999: 830). This study comprised a 2 stage survey of 116 medical schools, 41 of which participated in the qualitative second stage. Their conclusion is that, although 89.7% of respondents said they offered 'formal instruction' in ethics, few explicitly assess behaviour and only a minority (41 of the 116) provide learning materials (ibid, 1999). Of those who did so, the wide variance and inadequacy of learning strategies described gives the authors cause for concern. A more recent, smaller study by Lewin et al (2004) uses 'adult educational principles' (see Box 4.1) to appraise the ethics teaching of the 15 participating schools. The four 'basic' principles closely resemble the aligned learning described by Biggs (2003).

Box 4.1: Lewin's Adult Educational Principles

1) clear and observable learning goals and objectives
2) active learning activities stressing application of principles to real situations
3) problem orientated and relevant content with immediate practical application
4) performance based evaluation with provisions for individualized student feedback and program evaluation and improvement

Lewin et al, 2004: 37

As well as these principles, Rest's 4-stage component model (Box 3.3) was used to appraise the curricula (Rest & Narvaez, 1994: cited in Lewin et al, 2004). The authors conclude that,

while some curricula include learning activities to promote both moral sensitivity and judgement, less include moral motivation and action. Creative learning activities, such as panel discussions with service users and use of critical incident technique to evaluate preceptors' approaches, are highlighted as particularly innovative. Like earlier studies, the authors note that a proportion of students 'observed role models exhibiting undesirable behaviours' (Lewin et al, 2004: 40). They suggest a seven-point approach to teaching ethics, which includes a model of moral development and creative and innovative learning activities. They also suggest all learning be underpinned by the features of Biggs' aligned learning approach to allow constant measurement, evaluation and improvement (Biggs, 2003). The straightforward approach advocated is based on ethical *skills* being learned, rehearsed and measured.

In a commentary on the assessment of moral development, Huddle (2005: 885) asserts that such a skills-based approach 'will not suffice'. This is because, unlike clinical skills, students already bring a personal moral viewpoint. New learning has to take this into account, not simply add new ideas and then 'measure' the degree to which they have been acquired. Sustained change will only be fostered by creating a 'virtuous faculty' which invites imitation, and assessment should be personal and narrative. Huddle also criticises assessment methods, asserting this should be carried out during stressful, real experiences over a period of time (Huddle 2005: 886).

Both Biggs' (2003) and Huddle's (2005) different educational approaches are challenged by Leget (2004), who describes, retrospectively, an unusual methodology informed by emotion theory. A group of 3rd year undergraduate medical students from Nijmegen were prepared, by reading many arguments for and against euthanasia, to watch a documentary following a woman diagnosed with a terminal illness through to her death by voluntary euthanasia. The author describes the students' unstructured sharing of emotions, immediately following the documentary. Leget calls this stage 'sharing of emotions' (Leget, 2004: 491). Later, in groups of 15, the students were asked to judge the doctor's role, in accordance with Dutch law, and examine the ethical arguments used in the documentary. The approach reflects Hauser's (2006) description of examining intuitive responses through a later reflective process.

The study has the potential to be very useful. However the author seems to rail against the students at times, asserting that each response is actually an 'avoidance' of ethical debate. He categorises their avoidances into four types:

- Students promote individual liberalism, considering euthanasia to be a legal choice, not an ethical one.
- Students consider the matter to be wholly a matter of medical consequences, concluding that the doctor has no choice but to minimise suffering and offer euthanasia.
- Students respond emotionally, locating the decision within individual choice based on personal history and circumstance.
- Students respond from firm religious convictions and are supported by non-religious students who refuse to challenge another's religious belief. (Leget, 2004: 492).

All four types are seen by Leget as ways of avoiding scrutiny of the ethical issues. The fact that each can be supported by an ethical theory explains why, to so many of the students, the study of ethics is 'futile' (Leget, 2004: 492). Their avoidance is explained using Nussbaum's 'emotion theory', in which emotions are attached to the conflicting aspects of a dilemma:

> *'Emotions are not just the fuel that powers the psychological mechanism of a reasoning creature; they are parts, highly complex and messy parts, of this creature's reasoning itself'* (Nussbaum, 2001: 3).

Emotion theory proposes we begin with the emotions provoked in students. We explore and analyse them to understand what is causing feelings such as sadness, helplessness or fear. We then relate them to students' presuppositions about, or hopes for, society. Finally by asking them to identify with the doctor in the documentary, they are able to orientate (or re-orientate) their reasoning around their own identity and perception of self as a good doctor promoting the good of society (Leget, 2004).

The study, despite its lack of clarity as research, provides an interesting and practical alternative to the more traditional cognitive approach. Similarities to Gilligan's 'ethic of care' and communitarian ethics can be found (Gilligan, 1982; 1993). The approach also has a parallel in the biological theories of Gazzaniga (2005) and Hauser (2006), who describe the intuitive response taking place first of all, followed by reasoning (possibly unconsciously) tailored to fit the intuitive response. Both suggest there is scope to intervene before the reasoning becomes *immutable truth* to the individual, by harnessing and exploring all aspects of the immediate response and its emotional antecedents. In this way it may be possible to

identify reasoning which may simply be rationalisation or denial of less socially desirable aspects of our own responses.

Research from Nurse Education

Nursing studies will be considered next and the different methodologies discussed. Many personal journal-type, discussion or opinion-based papers were available in nursing journals, along with a high number of descriptions of programmes and courses. The overwhelming amount of such literature meant many had to be discounted in order to critically appraise studies offering empirical evidence. Unlike medicine, some research included practising nurses and was included because educational recommendations were made. Those selected emanate from England, Wales, the USA, Korea, Sweden, Finland, Holland and Norway. In general, the methodologies were grouped around: Kohlberg's stages and Rest's DIT; surveys developed by the researchers; individual interviews; and programme evaluations. The findings of surveys will be considered first of all, as these tend to present a 'big picture'. Studies using the DIT will be considered next followed by more detailed, smaller scale ones.

A literature review of USA-based research into nurses' experiences of 'moral distress' provided a useful introduction, identifying important features that would emerge in many of the studies. An important contrast to medical education research was the importance, to nurses, of the power differential in their relationship with doctors (Corley, 2002). Redman and Fry (2000, cited in Corley, 2002: 641) and Baggs and Schmidt (1997, cited in Corley, 2002: 641) both found that nurses reported experiencing conflict with doctors regarding treatment decisions, which at times felt 'impossible' to resolve. Other morally distressing factors identified in a wide range of research were listed by Corley (2002: 641) and are presented in Box 4.2.

Box 4.2: Morally Distressing Factors within Nursing

- 'harm to patients in the form of pain and suffering
- the treatment of patients as objects when meeting institutional requirements
- health policy constraints
- medical prolongation of dying without letting the patient or family know about choices concerning care

- the definition of brain death
- inadequate staffing
- the effects of cost containment'

Corley (2002: 641)

A very different set of factors were identified by a large, national survey of nurses and nursing assistants in Holland. Over 1500 respondents from 91 health care institutions completed a postal survey. The survey questionnaire was developed from themes in nursing research, which were refined through qualitative interviews and a panel discussion by experts, followed by a pilot study (van der Arend & Remmers-van den Hurk, 1999).

The very detailed description of methods, combined with rigorous statistical analysis, give the study credibility. However the complex survey design – incorporating demographic data, general satisfaction ratings, scales / subscales of main categories – along with the large amount of data presented, makes it difficult to prioritise the key findings. The different cultures and health care systems may account for the very differences to Corley's (2002) study. The authors are careful to stress that the categories described within the survey are worded to reflect the *very words, phrases and ideas* communicated to them by practising experts and nurses themselves. Five categories (see Box 4.3) enabled respondents to identify situations they had experienced and then to rate whether and how strongly they experienced each item as a 'problem' (van der Arend & Remmers-van den Hurk, 1999).

Box 4.3: Five Categories Identified by Dutch Nurses as Causes of Moral Distress.

- organisational problems
- moral problems, including actions of colleagues, actions of physicians diagnoses or treatments
- collaboration problems with colleagues
- collaboration problems with other disciplines
- problems with patients or families

van der Arend & Remmers-van den Hurk, 1999

The issue causing most 'moral distress' was that of 'organisational problems', with 'moral problems' coming second. However, individual perceptions varied greatly. For example, although 100% 'recognised' the moral problem of 'verbal aggression towards patients' under the subscale of 'actions of nursing colleagues', only 62.4% found this to be 'morally problematic' (ibid, 1999: 477). In the same category of 'moral problems' (on the subscale of 'actions of physicians') 83.1% found carrying out treatments 'with which they disagreed', to be a problem. Similarly 71.4% found 'carrying out painful treatments' to be a problem and 64.5% felt the same way when physicians failed to attend a patient in need.

On both subscales, respondents who had completed additional educational courses in health care ethics scored higher; that is, they found the situations to be *problematic more often*, than those without additional education (although the authors consider the differences to be minimal) (ibid, 1999: 477).

Data presented as a table show some further interesting results, almost certainly reflecting cultural attitudes towards death. In the subscale 'actions of patients / family' only 33% of the 506 respondents working in General Hospitals reported finding the suicide of a patient morally problematic, although 63.1% of those working in Psychiatric Hospitals did so (ibid, 1999: 479). Given the efforts to reduce suicide in the UK over the past twenty years, both seem surprisingly low, however no similar studies could be found to make a direct comparison. Only 33% found 'active euthanasia' morally problematic (ibid, 1999: 479), another finding unlikely to be duplicated in the UK, but again no direct comparator is available.

In common with other nursing studies, 83.1% of respondents in Academic Hospitals and 78.3% of those from General Hospitals experienced as morally problematic (in 'actions of other disciplines'), the 'continuation of treatment instead of allowing patients to die in peace'. Taken together, the findings suggest that amongst Dutch nurses, a morally consistent position towards death is held. The extensive amount of data presented in table form could be discussed at even greater length, however the conclusions of the authors are most relevant. They discuss the fact that whilst most respondents are aware of moral problems, surprisingly few find such issues to be a problem *to them personally*. The interviews and observations gave the authors reason to conclude that nurses feel 'powerless' to influence or change things. The questionnaire supported this by the high ranking of 'organisational problems', interpreted by the authors as the location of problems outside themselves or their span of

control (ibid, 1999: 480). They speculate upon the incongruity of the high numbers *recognising* moral issues in practice, with the few 'sometimes' *experiencing* these as personally problematic. They consider the possibility that nurses see the development and resolution of moral issues as part of the everyday process of nursing, towards which they have limited responsibility:

> *'This does not imply that they accept such a situation. Rather, they seem to place it in its specific context, see themselves as outsiders, experience it as something to which they can stay passive, and, as a kind of end result, be inclined not to mention it at all or at least not to make mention of it'.* (van der Arend and Remmers-van den Hurk, 1999: 482).

Although carefully worded, it is difficult not to infer that many of the respondents felt that important moral problems were simply none of their business. Their feelings of powerlessness and stance of passivity is commented upon by the authors as an important area for future change, citing education as one way in which a greater sense of moral agency might be imbued (ibid, 1999).

A smaller survey of 231 nurses in the USA, 96% of which were female, found five ethical issues with which nurses were most often involved, and five most disturbing dilemmas (Plunkett, 1999). The five ethical issues with which they were most involved were:

- respect for rights and dignity
- respecting informed consent to treatment
- staffing patterns limiting care
- treatments with risk to nurses' health
- use of physical / chemical restraint (Plunkett, 1999: 3).

Issues causing them to feel most disturbed were:

- staffing patterns limiting care
- prolonging the dying process with inappropriate measures (as in other studies)
- implementing policies that reduce quality of life
- treatments with a risk to nurses' health
- working with unethical / impaired colleagues' (again a category to emerge in other studies) (Plunkett, 1999: 3).

This time the survey was developed by a nursing network, the 'Nursing Ethics Network'. The authors support respondents' beliefs that they had inadequate resources with which to deal with such moral problems. A majority, 87%, feel that more education is the answer and indeed the research team recommend this strongly (ibid, 1999).

Four studies found, used the DIT to assess nursing students' moral development over the course of their education. A fifth used a very similar type of measure developed on the same principles (Duckett et al, 1997; Krawczyk, 1997; Nolan & Markert, 2002; Kim et al, 2004; Auvinen et al, 2004). All of them found that moral development scores increased over the three or four years of a programme of study, in keeping with Rest's studies since the 1970's (Rest, 1979, 1986, 1990; cited in Duckett et al, 1997: 228).

Duckett et al (1997: 225) recruited all 348 new students in four cohorts, from 1989 – 1992 (stating there was 'no penalty' for not participating), to the longitudinal study. Students completed the full version of the DIT on their first day, and then repeated it near the end of their studies (213 successfully completing both tests). The researchers assessed students' scores and discuss whether increases in relation to particular characteristics. Throughout the study, Kohlberg's model is referred to almost as a 'fact' of students' development. No discussion or criticism of the model is offered. In the same way, Rest's DIT is treated uncritically with no limitations discussed. The principle author cites her own previous work with Rest's team. Questionnaires were sent to Rest's research facility for analysis, suggesting that this study is virtually 'in-house'.

At one point a swipe is taken at critics of Kohlberg's model; the female participants' scores are consistently higher than the smaller proportion (n=45) of male participants' scores. Male participants average 39.8 on exit, female 44.5; average college students 42.3 and graduates 53.3 (Rest, 1986; cited in Duckett et al, 1997). This is used by the authors to support the principle author's previous contention that Gilligan was incorrect in saying that the model 'disadvantages women' (Duckett et al, 1992; cited in Duckett et al, 1997). Nonetheless key findings are presented and support the well established hypothesis that education increases moral development scores, and in addition that:

- even very low scoring students improve their scores over time
- age is not a factor

- women and those with higher previous education grades have higher scores on entry and exit
- that on entry, nursing students collectively score lower than the expected score for students in general, but score higher at exit (Duckett et al, 1997).

Although an unspecified number of students score lower on exit the authors remain loyal to the theory. The reader is told this is probably due to 'measurement error', said to be common when retesting is done 'too soon' (ibid, 1997: 228). Whilst the authors lament the lack of research into other aspects of ethical development, they offer no new or interesting avenues for future research, suggesting only that educational variables might be better understood by further research (ibid, 1997: 229).

A similar, smaller longitudinal study by Kim et al (2004) uses the DIT to measure the moral development of a group of 37 Korean student nurses. This time, the Korean version of the DIT is used, (Moon, 1994; cited in Kim et al, 2004) over four years of practical and academic study. The study also finds an improvement in the collective score, but a 'dip' in third year scores is difficult to explain. The authors suggest:

> *'Rather than simply concluding that moral cognition dropped to a lower level because P(%) declined in the third year, we postulate that the student nurses' moral judgement was being affected by ethical conflicts that they had never experienced before, as they were faced with novel medical and nursing situations, so it became difficult for them to make moral judgements while they were coping with real, multidimensional circumstances'.* (Kim et al, 2004: 262)

This justification for lower scores, with its similarities to Satterwhite's et al (2000) study, deserves exploration. Like Duckett's et al (1997), it simply fails to address the question: if the Korean students really had achieved given stages, then surely they would have approached their 'novel medical and nursing situations' with a 'Level 5B' set of reasoning skills? As it is, the reader is asked to believe that this level of reasoning ability only operates in the classroom, abandoning the student in practice when 'action' is needed. This finding, and Kim's (2004) explanation appears to fly in the face of two important aspects of the theory; that is, that stages are sequential and unidirectional, and that moral reasoning is the precursor to moral action. Even Rest's softer transition theory does not offer an explanation. Nonetheless, the study offers some interesting comments on cultural variation and student characteristics. The dilemmas most often found to face the Korean nursing students include:

- coping with conflicts between graduates of three year courses and four year courses (not mentioned in any other studies)
- whether or not nurses should be subordinate to doctors
- nurse shortages
- aggressive treatments of the terminally ill (Kim et al, 2004: 255).

In the only study found so far to do so, the authors explain findings in relation to student characteristics as culturally bound. For example, a weak correlation between students with lower scores and higher monthly incomes is considered to be due to an 'egocentric approach' to one's own goals (ibid, 2004: 262). Similarly, a weak correlation between higher scores and middle children is thought to be due to the upbringing of middle children, who should respect younger and older people (ibid, 2004: 262). Although interesting in itself, it is difficult to see the potential to apply such findings. The authors acknowledge the lack of statistical significance and make no attempt to generalise the findings. Their interest in finding better ways to embed ethics in curricula raises the question of whether this long and detailed study was the best suited, methodologically, to their aim of developing nurses with a greater sense of moral agency (ibid, 2004).

Krawczyk (1997) uses the same tool, with 180 student nurses, in a cross-sectional study from the USA. First year and senior student nurses from three different educational establishments, each of which approached ethics education differently, completed the DIT once. Findings showed that the programme in which dedicated, small group teaching over a prolonged period, from an expert health care ethicist, produced senior students with a higher DIT score than the course which embedded ethics in other units, or the one which did not teach it at all (and which achieved the lowest scores). This time the DIT is used to measure and compare different groups, as the important variable in this study is considered to be the ethics teaching component of the curriculum. Once again, the theory of moral development is neither critically appraised nor challenged.

Unfortunately important variables are not discussed. For example, the first two establishments, in which the DIT scores are highest and second highest, are both religious establishments, the third being a non-religious state school. It is not possible to know whether (only) students with a religious conviction apply to such schools but it is fair to assume that religious education forms part of the curriculum. This could be seen as an important variable in itself. Similarly the teacher qualifications vary from the 'Doctorate in Sacred Theology' in

the first school, to a PhD in the second school, and finally a Masters degree in Science at the third. Again this important difference is presented in a table of programme characteristics but not discussed as a variable (ibid, 1997: 60). Comparison of the three senior groups is made on the basis that they are, by this point, at the same educational level, although no mention is made of prior education or grades necessary to gain a place on the respective programmes (ibid, 1997).

The largest collective gain is made in the third establishment. This is not mentioned though, despite the difference in first and third years' P score being 10.24, compared with a difference of 9.67 in the highest scoring school and only 2.9 in the second (Krawczyk, 1997: 63). It would be interesting to know just what is working so well in the state nursing school, in the absence of any formal teaching, to improve the scores so dramatically from first to senior years. The cross sectional nature means that comparison of first years and third years is open to the criticism in that the two groups may have very different characteristics (not mentioned in the study) or have experienced a change in earlier school curricula. Unless all three programmes have remained unchanged for the past three years, seniors may have experienced different types of learning to that described in the study. Whilst some interesting recommendations are made regarding the importance of student engagement in learning, the study leaves many questions unanswered and raises important others. For example, how does a religious nursing establishment differ in its handling of life and death questions to a non-religious state-run nursing school?

Finally, in these DIT based studies, the emphasis is on classroom teaching of ethics. Other than as a reason for reduced third year scores (Kim et al, 1997), none refer to practice-based learning. This is despite such learning being an integral part of nurse education.

The final DIT study of student nurses is an exception. Auvinen et al (2004) conclude from a cross-sectional study of 52 first years and 54 fourth years studying at four polytechnics in Finland, that the DIT scores are improved in third years as a *direct result* of having to deal with ethical dilemmas in their practice. (P% was 40.6 in first years, 47.1 for the third years). Despite a high rate of DIT questionnaires failing the 'internal reliability' checks[4] the study adds a useful new dimension, by asking the fourth year group how they learned about ethics

[4] 'Internal reliability' checks exclude any questionnaires with inconsistencies between answers or in which meaningless items have been added, essentially to 'trick' respondents not thinking deeply enough about responses

and whether they dealt with ethical problems in practice (ibid, 2004: 541). No correlation between any method of teaching and DIT scores is apparent, however all those who recorded personal experiences of dealing with ethical issues achieved higher scores. Unfortunately, despite presenting a wide range of statistical analysis, this one finding is only discussed in the text, with no statistical evidence presented. Overall, the Finnish students' collective P% scores are lower than those in the many USA study conducted by Duckett et al (1997). No reasons are offered for this difference. The authors conclude with the observation:

> *'To make choices between statements and rank order them in a test situation is not the same thing as making decisions in ethically problematic situations. The measurement of moral judgement yields information about the respondents' thought construction in ethical decision-making but says nothing about the way that person acts'.*
>
> (Auvinen et al, 2004).

A longitudinal study from the UK, in which five ethical dilemmas were presented to students as part of a questionnaire, appears to have sought more from respondents than the DIT (Nolan and Markert, 2002). In addition, this study offers very useful insights from other research. The authors consider the need for students to have experience in *resolving* – not simply identifying – moral dilemmas (Cameron, Schaffer and Park, 2001, cited in Nolan and Markert, 2002). They highlight the importance of being able to fully integrate theory into practice, in order to retain new ethical knowledge and skill (Turner and Bechtel, 1998, cited in Nolan and Markert, 2002). They also discuss the importance of the student – teacher relationship, considered by Glazer-Waldman et al (1990, cited in Nolan and Markert, 2002). Norberg et al (1994; cited in Nolan and Markert, 2002) posited that some nurses prefer to approach their work as a 'task' to be completed rather than to engage with highly complex ethical issues. This is similar to the conclusion of van der Arend and Remmers-van den Hurk (1999) discussed earlier.

They brought each of these themes into their own questionnaire, which asked students to rank issues from vignettes. They were able to compare responses from (the same) 15 student nurses at the beginning and end of their four year nurse education (Nolan and Markert, 2002). Unlike all the DIT studies, the students' reasoning had not simply 'progressed', but had changed in many ways. Many more were *uncertain* of issues they had previously been certain about. Some selected the same answers but based their reasons on very different factors such as the principle of patient choice and autonomy. Many (sometimes as many as nine of the 15)

held to *exactly the same views* on particular issues as they had expressed four years earlier (ibid, 2002: 255). All 15 students identified 'parents' and then 'education' as the most important influences on their moral development in both pre and post degree questionnaires, and clinical education as the least. Seemingly in contradiction to this, of all their *educational* experiences, clinical experience was rated by them all as the most important learning experience, with few regarding formal education in moral philosophy to have been helpful (ibid, 2002: 256).

This study, although small, is very detailed and picks up something not apparent in the DIT studies yet which feels intuitively right; that is, that greater uncertainty is an inevitable consequence of deeper thinking and exposure to real problems and dilemmas. This is just as Perry described in his latter two stages, 'relativism' and 'commitment to relativism' (Perry, 1968). The DIT *may* have picked these changes up as higher scores, but it is not possible to know. Alternatively, as Kim et al (1997) found, the uncertainty following practice may have caused scores to drop. Others in the study described 'holding back' from committing to courses of action due to fear of litigation (for example, when telling the truth to a child). Although understandable this does suggest (in Kohlbergian terms) a 'lower' stage of reasoning, as knowledge of consequences develops (Nolan and Markert, 2002).

Other studies use interviews and written narrative to elicit an understanding of the experience of learning about, or dealing with, ethical problems. Blake & Guare (1997) used three 'depth' interviews with 11 nurses to explore how they experienced ethical problems in practice. Their findings centre upon the tensions experienced by nurses in balancing 'ideal actions' and 'realistic actions' (ibid, 1997: 14). How nurses reached decisions depended upon: their experience, their ethnic group, the authority and sense of collegiality each possessed, their education and whether or not they had feelings of powerlessness (ibid, 1997: 14). Again, as in earlier studies, issues causing most concern included: institutional policies, pain management, continuing life support measures and physical restraint (ibid, 1997: 14). A Korean study using a phenomenological approach and involving 73 student nurses, found that 44% experienced problems with other health professionals, most focussing on conflict resolution (Cameron, 2001). Lemonidou et al (2004) used students' own written narratives to explore ethical conflicts. Empathising with patients was identified as the first stage in a process leading to taking a moral stand and becoming aware of personal values. A different focus is

offered by Durgahee (1997), in a British study of students taking a palliative care course, over a period of five years. By storytelling, students were encouraged to 'relive' clinical experiences and explore their own reasoning processes. The authors conclude that this technique is cathartic, helping to increase insights and improve self-perception, by allowing reflection upon action to take place (ibid, 1997: 145). None of these studies attempt to 'measure' ability or development. They all offer some new and different perspectives and reinforce other familiar themes.

Articles describing teaching techniques or programmes similarly reinforce themes, so only those offering new approaches will be considered here. Holland (1999: 435) reflected upon the use of Case Study, concluding that within UK nurse education they are the 'mainstay' of teaching methods. He concluded that the way in which case studies are used should be the subject of further study, given concerns around confidentiality. Begley (2006: 257) advocated for Aristotelian virtue ethics, given the need to develop nurse 'exemplars', who embody 'practical wisdom and excellence of character'. He suggests teaching includes: formal theoretical ethics; 'virtue' taught as knowledge or skill; practical experience; and exposure to good role models. Also proposing the use of formal theoretical philosophy, Webb & Warwick (1999) suggest nurses need to be able to *philosophically* construct complex issues. They suggest this should be done by concentrating on the process of decision making. The approach based on 'rights and duties', they suggest, leads to a standardised nursing approach. Instead, appreciation of the many different types of possible outcomes for a patient enables nurses to have a greater influence over final decisions, as they will have an appreciation of the complex decisions made in the course of treatment.

The three latter positions are taken by British nurse educators. All are scholarly works based on experience and examination of a topic, so it is not possible to assess the effectiveness of such approaches in practice. Nolan and Markert (2002) found 'formal' moral philosophy to be the least valued by students, raising the question of whether student preference should or should not be taken into consideration when developing curricula. Difficult subjects, even if not popular, surely have a place in learning about complex moral issues. The surveys of qualified nurses suggest a sense of powerlessness and even of detachment is widespread. A grasp of moral concepts may increase confidence in multi disciplinary debate and hence increase engagement and influence.

Jaeger (2001: 131), an academic philosopher teaching ethics to 'practical-minded' nurses, offers a possible answer. She asserts that moral philosophy not only *fails to equip* nurses for the range of contradictory demands they face, but at times *militates against deep understanding* and appreciation of a situation. It achieves this by providing a plethora of equally justifiable responses based on different ethical stances. (This is similar to the argument against formal theory made by Leget, 2004). The author offers as an example a story of how lack of time and a narrow job description, prevented a nurse attending to the self-evident physical and mental health needs of an abused young woman seeking birth control. She cites Kymlicka (1996, cited in Jaeger, 2001) and Gilligan (1977, cited in Jaeger, 2001) to explore how an abstract, depersonalised approach to moral theory risks neglecting the real, concrete, personal 'other'. By embracing relativism and rejecting the concept of empathy, Jaeger proposes dialogue (with patients, colleagues and even within communities), as a way to develop moral sensitivity and engage in 'communicative ethics' (ibid, 2001: 136). One of the few authors to address the diverse cultural, religious and social make-up of nurses and patients, Jaeger posits that sensitivity to the differences is more than just putting oneself in another's place:

> *'It requires openness to the possibility that one does not share a moral framework with the other person and that a new framework must be dialogically created for a particular decision'.* Jaeger, 2001:140

Jaeger shares with Webb & Warwick (1999) the aim of instilling in nurse graduates the ability to challenge and influence the institutional policies which seem to leave so many feeling powerless (Jaeger, 2001).

Turner (2003) recommends analysis of the key documents generated by organisational leaders of health care organisations, in order to compare their espoused and actual values, and find any contradictions. She considers this kind of learning to be useful in empowering staff and students to challenge and review policies which cause conflicts in practice. Another strategy to generate engagement and confidence amongst student nurses is suggested by Candela et al (2003), who uses small group debate of a current ethical issue from their practice placement. She believes the following techniques produce more thoughtful, articulate individuals: the use of real problems, informed by institutional policy and guidance; preparation in the form of workshops; debates in which students take the opposite to their preferred argument; and lectures and time to research their own issue. In evaluating her

course, students reported the most useful learning was that which enabled them to see 'many sides' of an issue (ibid, 2003). The author compared this to Perry's 'relativism' stage (Perry, 1968). It is also possible to see how such learning relates to Jaeger's 'dialogical ethics', as first of all students would need to recognise and be sensitive to the ethical implications of a routine situation in their practice, then explore it from many perspectives within a given context (Jaeger, 2001).

Overall the research from nursing contributes to the debate greatly, particularly when compared with the apparent dearth of research from other professions in health and social care. Unfortunately many of the empirical studies rely heavily and uncritically on the stage development concept and standardised testing. Smaller qualitative studies are interesting and offer new insights, and are often accompanied by scholarly debate.

Research from Clinical Psychology Education

The final major contributor to the empirical evidence base is psychology. Psychology students differ from other health and social care professions as a first, non-clinical degree has to be completed before doctoral programmes (normally in specialist areas such as educational or clinical psychology) can be undertaken. Most studies focus on practising psychologists, typically in the USA or Canada, and several cite the 'Competency Training in Ethics Education and Practice' statement (de las Fuentes et al, 2005). This paper was developed by experts and members of the profession, working in small and large groups, at a dedicated conference. A 'competency based' approach to ethical practice led to the identification of four core abilities concerning:

- one's own ethical decision-making model
- recognition of ethical dilemmas
- recognition and reconciliation of conflicts among codes and laws and
- raising issues appropriately (de las Fuentes et al, 2005: 362).

'Courage' was discussed as an ethical ability but not included. A useful overview of learning and assessment priorities, which would be applicable to any discipline, includes: the importance of role modelling within facilitative learning environments; personal and interpersonal skill and awareness, in particular of cultural needs and differences; knowledge

and critical faculties regarding rules, laws and policies; and finally openness and a non-defensive approach to feedback (ibid, 2005: 365).

Unlike the dichotomy in medical education expressed by Eckles et al (2005), the statement clearly prioritises becoming 'virtuous' practitioners, followed by knowledge and skill acquisition in decision-making within complex contexts (de las Fuentes et al, 2005). A new learning technique is also described. The 'morality genogram' uses critical incident technique to help students explore events in their lives that have shaped their moral orientation, values and beliefs, (ibid, 2005: 364). Suggested assessments are also novel, including 360° assessments by peers and educators. The emphasis placed on academic integrity and clear boundaries in relationships is greater than elsewhere and is identified as integral to developing virtuous professionals (ibid, 2005: 365).

For the first time, Rest's 'four stage model of decision-making' is discussed (Rest, 1983; cited in de las Fuentes et al, 2005). This is the only non-medical framework for ethical decision-making to be referred to in research. It was also cited by Eberlein (1987) in an earlier, comprehensive, overview of ethics teaching in psychology. Eberlein uses the model to challenge what he sees as the prevailing view, that moral philosophy has no place in education (ibid, 1987). He discusses several other problem solving approaches, including a dialogical one involving consultation and involvement (Sinclair et al, 1987; cited in Eberlein, 1987), although essentially all are based on Rest's basic model (see Box 4.4).

Box 4.4. Rest's Four Stage Model of Decision Making

Rest's four stage model of ethical decision-making:

Component 1: interpreting the situation – being sensitised to a moral problem, imagining courses of action possible, consequences of each action and its effect on the welfare of each party involved

Component 2: formulating the morally right or ideal response – choosing between possible courses of action and deciding which is more ethical

Component 3: deciding what one actually intends to do – deciding between moral values and other competing factors such as friendship, financial reward, self interest

Component 4: ego-strength or character – implementing the plan of action, indicating to what extent the ideal can or will be implemented, sacrificing self interest or risking being different.

Rest, 1984; cited in Eberlein, 1987: 356; Fly et al, 1997; and de las Fuentes et al, 2005

Two other discursive papers offer useful contributions, again relevant to all professions. Handelsman et al (2005) presents an approach to education based on Berry's 'model of acculturation' (Berry, 1980, 2003; cited in Handelsman et al, 2005). This model understands the educative process to be a journey, from one set of values and preferences to a new set, which over time must come to be held and owned as dearly as the original ones. Hall (1987) looks specifically at gender related ethical issues, in particular the problem of sexual relationships between male psychologists and female clients. The study provides an exemplary use of case studies to explore the many responses to dilemmas (Hall, 1987: 573).

Empirical research includes a study by Haas et al (1988), in which a questionnaire was completed by 294 practising psychologists. Using dilemmas to seek reasoning and likely actions from respondents, the aim was to explore the link between moral reasoning and moral action, of which the authors were unconvinced. Although it is a detailed and rigorous study, their findings fail to provide any further insight into this link. Characteristics of respondents are linked to 'preferred actions' and prove that most respondents think alike, with minor and usually statistically insignificant differences between gender and age (ibid, 1988). The authors conclude that the variety of reasons given for choosing the same actions, and the many different actions following from a similar reason, disprove Kohlberg's contention that moral action follows moral reasoning (ibid, 1988). It is difficult to see how this is so, however, as the reasoning may still be 'moral' and the actions reported certainly appear to be so. The format of their questionnaire is strangely close to Kohlberg's own methodology, showing his influence even within a study purporting to disprove his thesis.

In a more recent study of students' ability to integrate their knowledge, feelings and actions (Betan & Stanton, 1999), a more persuasive link is made. Again in questionnaire format, 258 respondents were asked to consider a scenario (a colleague drinking alcohol to the detriment of clients' treatment) then score actions they know they *should* take (in line with their professional body requirements) and actions they *would* actually take (ibid, 1999). Additional items including 'feelings of anxiety' were scored and open ended questions asked about

feelings and emotions. The study proved that whilst 47% knew they *should* report the colleague's behaviour and 41% would do so after warning the colleague, only 37% actually *would do so* in the first instance (ibid, 1999). This was taken by the authors as proof that the issue for educators is not instilling knowledge – as in total 95% knew what they should do to adhere to their professional code – but motivating students to overcome emotional concerns such as friendship and loyalty (ibid, 1999).

In the final psychology study, a questionnaire sent to Programme Directors of 243 educational establishments in Canada and the USA sought to discover the nature of three ethical incidents involving students experienced in the past five years (Fly et al, 1997). A response rate of 31% elicited 89 incidents. These were grouped into eight categories: confidentiality (25%), sexual and non sexual professional boundaries (20%), plagiarism / falsification of data (15%), 'welfare' (eg questionable judgement, incomplete paperwork) (10%), procedural breaches (10%), competency (9%), integrity / dishonesty (8%) and misrepresentation of credentials (3%). The authors stress that this does not represent *numbers* of incidents, only proportions returned by Programme Directors asked to think of three incidents. However the high incidence of boundary violation, also mentioned in other studies (de las Fuentes et al, 2005; Eberlein, 1987; Handelsman et al, 2005; Haas et al, 1988), is interesting given that this has not featured in any of the medical or nursing research examined so far. Fly et al (1997) use Rest's four stage model (Box 4.4) to describe teaching strategies for each stage, providing a very useful, complete framework for curricula development. Additionally, in common with medicine and nursing, the authors comment on the importance of role modelling and the ethical treatment of students by all Faculty members, given the power of the hidden curriculum (Fly et al, 1997).

These studies add yet more dimensions and offer much to other educators. Psychology is not unique in experiencing problems of relationship boundary violation or falsification of data yet it is the only discipline to acknowledge its presence in ethics education. It is also interesting that so many of a small sample of studies chose to use Rest's four stage model of decision making, as this has not been used elsewhere despite frequent use of his four components framework (Rest, 1983).

Research from Smaller Disciplines

Of the remaining research from other professions, one study concerns practising counsellors, another includes counselling, social work and youth work students, and five look at students and graduates of occupational therapy, physiotherapy, dental nursing students and pharmacy students. Each has been selected because something new is added to the debate although it is apparent that their contribution is nothing like the extensive bodies of knowledge developed in the other three professions.

In a Scottish study, Brown (2006: 100) interviewed 20 counsellors to discover how each experienced 'ethical and legal challenges'. The biggest single issue for this group is confidentiality, and how to remain within the law whilst encouraging disclosure. Limitations of the study are its small size and necessarily private subject matter. Nonetheless, Brown (2006) is the first to highlight high levels of uncertainty amongst practitioners despite a superficial awareness of in-house policies, procedures and laws. As a relatively small group, counsellors may be unique in this, indeed the study cannot even be generalised to other counsellors. However the issues are complex - for example, being asked for client information by the police, or judging whether more harm will be done by voicing suspicions or keeping quiet – so it is more than likely that other professions will be affected by similar uncertainty (ibid, 2006).

By contrast, the following researchers used experimental methods, dividing students into intervention and control groups. Gawthrop & Uhleman's (1992: 39) Canadian study measured the effectiveness of an ethics training programme by using mixed groups of counselling, social work and youth work students, selected into 'treatment' and control groups. Finding that the group with ethics training scored more highly on a standardised ethical decision-making scale, the authors concluded that this intervention was successful. In another experimental study from Thailand, pharmacy and dental technicians were measured using Lind's Moral Judgement Test (Lind, 2006) before and six months after a structured discussion of dilemmas (Lerkiabundit et al, 2006). Again the groups with training improved their scores, leading to further confirmation that ethics training improves reasoning for at least six months (Lerkiabundit et al, 2006). Glazer-Waldman et al (1990) found the same after controlling groups in a school of 'allied health' students; once again, improvement in scores followed discussion of ethical dilemmas.

The only study found to refute this trend was carried out in New Mexico, in which 98 Occupational Therapy and Physiotherapy students were followed longitudinally over a two year training programme and tested on entry and exit using the DIT (Dieruf, 2004). No significant differences in scores were found on exit, despite rigorous methodology and extensive statistical analysis, although the students fell within the average student range of scores (ibid, 2004). The author concludes that the educators of these groups of students 'must take the responsibility for evaluating students and implementing curricula that facilitate ethical decision-making', (ibid, 2004: 24). Their exit P% score of 45 – 46 is not dissimilar, though, to the nursing students in studies by Duckett et al (1997) (in which the highest P% exit score was 44.5) and by Auvinen (2004) (P% exit scores of 47.1). This suggests that the students in this study *entered* their education with at least as high P% scores as other students exited with, despite the researcher's criticism of the educators. Findings could also be seen to raise questions about the quantitative methodology and even of its reliability.

A retrospective study of 30 years' worth of physiotherapy literature found the majority of peer-reviewed journal articles were philosophical in nature and based on principlism, with a small number of empirical studies based on moral judgement theory (Swisher, 2002: 692). Again a strong recommendation was made that more research be conducted into the 'unique ethical problems' of physiotherapists to address gaps in knowledge (ibid, 2002: 692). A qualitative study, involving only eight practising Canadian physiotherapists (Finch et al, 2005), sought to explore in depth the ways in which practitioners integrated ethical issues into clinical practice decisions. They concluded that whilst participants 'readily described clinical situations involving ethical issues', they 'rarely' identified the conflicts and resolved more confidently those without complex implications (ibid, 2005; 147). Again they recommend students develop a clear professional ethos and understanding of the ethical issues found in practice, given expanding clinical roles and increasing responsibilities (ibid, 2005). A final study of a similar scale involved ten practising Occupational Therapists in Australia (Atwal & Caldwell, 2003). This time the method used Case Study design, Critical Incident Analysis and observation, and involved users of the service. The authors conclude that ethical principles were violated, along with the professional code of conduct. A strong recommendation is made that further research is carried out into practitioners' ethics and that educators attend to this aspect of learning and development (Atwal & Caldwell, 2003). The small numbers involved in these few studies means no broader or international generalisations can be made. However the recurrence of the recommendation that more is

done to improve allied health professions' education in ethics is undeniably interesting if not somewhat concerning. Possibly the lack of research is itself indicative of a very different culture within these groups, many of which originated as 'technical' in nature. If so, the point made by Finch et al (2005) is timely.

Interdisciplinary Research

In the UK, interdisciplinary education in health and social care became established in the early part of this decade, although many single initiatives began in the 1990s and earlier. The relative newness of interdisciplinary education in health and social care means that there is only a small amount of literature specifically on learning or teaching ethics. The following articles were found through the original search or through links from other articles. Of the published articles found in the original search, descriptions of programmes are most common, empirical studies least common. The UK and USA based articles describing features of interdisciplinary education - usually meaning doctors and nurses although increasingly including other disciplines - invariably cite the benefits of:

- understanding the other professions' perspectives
- learning to have dialogue with each other
- sharing and appreciating the differences between professions, individuals, clients and patients in ethnically diverse communities
- learning to collaborate
- reflecting together on difficult ethical issues
- listening to each other
- sharing of self-conceptions and conceptions of each other
- development of mutual respect

(Browne et al, 1995; Weisberg & Duffin, 1995; Bowles & Jones, 1999; Cloonan et al, 1999; Glen, 1999; Tschudin, 2000; Hagger & Woods, 2005).

Whilst acknowledging the benefits of all the above features, Aveyard et al (2005) set out to discover the views of educators in one UK University, through Nominal Group Technique carried out in small mixed groups. They concluded that whilst many subjects were shared by all disciplines, case studies used should be specific to the clinical settings students experienced in practice. Further, they suggested that, ideally, learning about ethical issues

should be facilitated in those practice areas where each student had a reason to be involved in real situations (ibid, 2005). The educators in this study are side-stepping a difficult issue. Educators designing programmes have a responsibility to integrate theoretical and practice-based learning, particularly when other studies suggest practice creates the most confusion and distress amongst learners.

Learning in practice presents particular challenges. It can be difficult to structure learning when by their very nature, ethical problems may be unforeseen or not arise at all during a clinical placement. The everyday issues with an ethical component provide good learning but needs to be very consciously shared and discussed across disciplines. They may well be within the domain of just one or two groups or only reviewed periodically. Time not normally spent on discussion and exploration has to be dedicated to the students. Finally, many ethical issues will be private and discussed in confidence between senior team members, or even be subject to potential litigation. Many life and death issues or decisions to treat or withhold treatment may exclude students. Such barriers may be overcome in teams committed to interdisciplinary working, however considering the ongoing investment in uni-disciplinary ethics teaching and research, ought not to be underestimated. Meanwhile academic educators are well positioned to ensure that students have space, time and expertise to help them reflect and explore experiences from practice.

A wide range of interesting and useful teaching techniques and strategies also emerged from the studies, some closely aligned with philosophical perspectives, others more generic in nature. They include:

- **Hypothetical dilemmas** debated within small groups, intended to stimulate thinking and develop higher order reasoning skills.
- **Case studies from life** (real, known from media or 'made-up' from a combination) which were researched and analysed from differing perspectives, often debated (from a perspective other than one's own) and sometimes presented to peers. Usually intended to stimulate thinking and develop skills in articulating reasoning.
- **Peer group teaching** on a theme, intended to give scope to students to identify issues, thereby increasing understanding and ability to articulate issues.
- **Watching documentary** of real life situation or films, or reading, followed by small group discussion in which immediate thoughts and feelings are shared. This is

intended to create and then capture emotional responses which can then be explored and related to students' personal values.

- **Listening to students' ethical issues** in practice, including incidents which transgressed their personal boundaries; this is specifically connected to student – teacher relationships particularly positive role modelling and is intended to orientate learning around the issues with which students struggle.
- **Learning in and from ethical issues in practice placements**, working environments and life generally. This may be combined with classroom-based analysis and discussion. It is intended to sensitise students to ethical issues of an everyday nature and increase awareness, also to facilitate future debate with colleagues and other team members in practice settings.
- **Role playing,** taking different perspectives. This is intended both to develop empathy and begin to develop skills in creating dialogue with groups or individuals who have a different perspective or value-base.
- **Using narrative techniques,** re-living experiences from practice, story-telling, primarily intended to connect students to their own feelings, to encourage a deep level of reflection and develop listening skills.
- **Critical Incident Technique,** analysis of events. This is particularly intended to develop reflective, observational and analytical skills, to increase understanding of the environmental, social, cultural, behavioural influences upon an incident and to encourage reflection upon the range and complexity of ethical issues.
- **Panel discussions with service users**, intended to create dialogue, understanding, appreciation of different perspectives.
- **Formal moral philosophy**, theory. Intended to underpin decisions and actions so that individuals can articulate clearly their rationale for advocating a certain decision and also gain confidence in having discussions with colleagues formally trained in such concepts.
- **Analysis of organisational policies**, guidance, rules, comparison with practice, identification of conflicts; this is intended to increase understanding of the espoused ethical stance of leaders and be well placed to influence or challenge, also to reduce detachment from organisation and subsequent cynicism.
- **Use of decision making models** in combination with real or hypothetical case studies, which may be combined with specific teaching activities linked to each stage

of the process; for example, exploring options may lead to series of related exploratory activities and discussions. This is intended to develop students' abilities in using models and arriving at well reasoned decisions.

- **The 'morality genogram'** – an exploration with students of critical life events, influences shaping students' moral outlooks up to this point in their lives. This is intended to link students' own background, values, beliefs and experiences with their current / future responsibilities as practitioners and enable convergence. If done as a group the activity may increase understanding and appreciation of differences.

In summary

Dialogical and communitarian ethics, based on relationships and appreciation of differences, offer much of practical value to educators despite appearing less often in the research studies. The stage-development models appear still dominate, despite many using outdated methodologies rather than the newer and more complete assessment tools. Studies using qualitative techniques frequently limit themselves to evaluative appraisals of programmes or retrospective surveys, when opportunities exist to explore in much more dynamic ways the current experiences and views of learners. Anonymous, questionnaire and telephone surveys offer a good deal to the debate, not surprisingly given the importance of being able to share views anonymously in such a fraught area of professional practice. The very best of the research studied seeks to answer the eternal question of how best to develop virtuous practitioners and equip them with knowledge and skill to help others tackle the issues pertinent to them and their patients. At the other end of the spectrum, studies appear to be established merely to prove the 'truth' of particular theories, or add further ammunition to an ongoing academic argument. In the next chapter, some of the methodological difficulties encountered in this study may explain why some tried and tested methods are so often used and also why so many studies are small scale. The following overarching themes have emerged from the studies discussed:

- Uncertainties in educational philosophy exist, in particular whether one or other approach to ethics education is superior.

- The overwhelming majority of studies did not consider whether religious, cultural, social or economic backgrounds of students had any impact at all upon their moral orientation or decision making.
- In almost all studies the perception of education as vehicle of change was a given, although in most this was taken to mean inevitably a positive change for the better. A minority identified or explored negative change following exposure to and acceptance of poor practice.
- Despite the many debates on gender, results from studies were by no means conclusive. Some showed women scored higher than men on the DIT (Duckett et al (1997), others showed men to be more ethically aware (van der Arend & Remmers-van den Hurk, 1999). Most simply did not mention gender issues.

Specific themes emerged with regard to particular types of practitioner, in particular:

- Nursing research highlighted recurrent themes in particular feelings of powerlessness and detachment, a 'task oriented' approach, issues of unethical behaviour by colleagues, feelings of subordination to doctors and specific clinical dilemmas.
- A clear focus on producing virtuous practitioners emerged from psychology research, in which (uniquely) dilemmas created by relationships with clients were examined and specific issues around confidentiality and accountability discussed.
- For allied health disciplines, a limited evidence base suggests that as professions there is some way to go in ethical development within education, practice and research, in order that practitioners are equipped to embrace extended roles and increased responsibility.

Chapter 5: Introduction to methodology and ethical concerns

The overarching aim of the study is to understand how to effectively introduce ethical practice into the curriculum of a partly work-based health and social care programme, given the increasing importance of ethical reasoning and action in complex settings (Johnson et al, 2004). Unfortunately it is not uncommon for the subject of ethics to be poorly rated by students on health care programmes, so there was an incentive to improve students' learning experiences and competence (Leget, 2004). The inquiry took place in two parts. First of all a detailed analysis of secondary data was made, followed by primary data collection from student volunteers. The review of research (Chapter 4) included studies from several established professions, ranging in type from small-scale exploratory to longitudinal and experimental, from which overarching themes were identified. These were useful in identifying issues for the second part of the inquiry, which sought to discover how a group of students construct an identity as ethical practitioners.

Overview of methodologies

The most difficult aspect of this study was the balancing of my need for sensitive, even private information about practice experiences, with my duty to respect the trust placed in me by student volunteers, and my responsibility to guide them on *their* duty of confidentiality to others. I will discuss this more fully. However this overview of methodologies is intended to show how fraught this area of investigation is, if high ethical standards and methodological rigour are to be maintained.

Students brought issues for discussion, which they identified as having an ethical component or causing them a dilemma. Semi-structured interviews were used to explore their interpretation of the term 'ethical practice'; to examine with them an ethical issue from their practice; to discuss the ways in which they responded and participated and to reflect upon their influences, including educational ones. Consideration of others' contributions and perspectives formed an important part of discussion and, on occasion, led to reflection upon influences more generally.

It was possible, although at times limiting, to remain within the themes, questions and prompts given approval by the Research Ethics Committee. The conditions of approval are, that no changes are made to the original information / interview schedule, without full resubmission to the committee (see Appendix 1). Whilst acknowledging the importance of giving accurate information to potential recruits as early as possible, it is my experience that as an *educational* piece of research, developments and improvements are made during the period between submission for ethical approval (in this case November 2005) and the administration of interviews (Spring / Summer 2006). This approach to ethical approval conditions risks the student researcher either omitting refinements to their tools and techniques in the light of growing understanding and knowledge, or transgressing the ethical approval rules. In this case, I remained within the interview schedule but offered scope to explore issues more deeply through flexibility on timing and use of supplementary questions.

Issues arising from the literature review informed the methodology of the second part of the study and enabled a realistic assessment to be made of its scope and limitations. Both will be discussed more fully in this chapter. Themes derived from both parts enabled conclusions to be drawn regarding effective learning and its implementation in practice. It also showed just how many different approaches to the study of health and social care ethics have been used in education. Research purposes ranged from exploration or evaluation to theory-testing and prediction. Methods included standardised 'tests' (once-off or at several points in longitudinal studies); observation combined with group discussion; postal questionnaire surveys both small and large scale with open and / or closed questions (some of which incorporated a test/retest element along with open questions); interviews; post-module evaluations and several which used telephone or questionnaire surveys to seek curriculum information from educators.

Critical appraisal of the studies raised many questions concerning both methodology and ethics. For example, test / retest studies frequently achieved high returns without being specific about how students' engagement was sustained over three or even five years. Duckett et al (1997:224) achieved an 85% response rate over four years. She stated there was 'no penalty' for non-completion but said nothing about how such a high return was achieved over such a long period.

Data Protection legislation in the United Kingdom (UK) prevents use of students' addresses for follow-up research unless specific consent is given at the beginning of the study (OPSI,

1998). If similar legislation is in place in those countries in which test / retest methods are used, there is no scope to do remedial work with students who are discovered not to have progressed (or to have regressed) in their moral development. Medical students in one study were found to be much more tolerant of low standards at the *end* of their education, leaving no time for educators to explore or address this (Satterwhite et al, 2000).

Nonetheless, it is easy to defend both types of problem on the grounds that the studies aimed to discover new things in order to improve education for future students. Far better to know of problems from the 'snap-shot' of a one-off survey, or the honest views of graduating students with no more assessments ahead, than not to know at all. Coercion of students into longitudinal studies which probably commenced some five or six years ago (or more) is less likely to be taking place today as ethical approval procedures have improved world-wide. The methodological problems can be seen in context and justified. However this is not the case for all the research reviewed.

A small scale study based on interviews discovered poor knowledge and mistaken assumptions amongst participants (Brown, 2006). Although the researcher discusses this as a dilemma, no actions are described which would disabuse the participants of incorrect practices or give them correct information. The same study included friends and colleagues of the researcher, who noted the difficulty of researching in such a small community of practitioners. The likelihood of such colleagues being completely open and honest in such a situation has to be questioned. Alternatively they may have been overly trusting and shared more than planned.

At the other extreme, a large scale anonymous survey found practitioners, who, aware of colleagues' poor practice, did not perceive this to be personally ethically problematic (van der Arend & Remmers-van den Hurk, 1999). Again no remedial actions are described, other than recommendations made in the published paper. The very anonymity which allowed such honesty from respondents prevents any follow up, raising the question of how the researchers were left feeling. Having made such discoveries they were not in a position to intervene, although change might be effected by impact of the publication itself. Both studies raise questions: just how serious an incident of poor practice would such a researcher have to learn of before feeling a line had been crossed? What responsibilities, if any, does the researcher have in such a situation, given their commitment to confidential handling of data and the fact that they are most probably dealing with anonymous replies?

Milgram's controversial methods are blamed by Denzin and Lincoln (1998:168) for the current ethical codes imposed on researchers. However they also cite Douglas (1979; cited in Denzin and Lincoln, 1998:168) who 'demanded that we deceive the establishment in order to expose it'. Whether the attitudes or actions of nurses constitute the establishment is debatable. The ethical issues raised by intervention in clinical research on grounds of humanity are clear cut, however the rationale for intervention is less so when a nationally-administered questionnaire is the tool. The need to discover views, attitudes and actions of a group or community of practitioners, in order to raise awareness and standards in the longer term, could be said to outweigh any temporary emotional burden upon researchers or the feeling of impotence caused by discovering poor practice or law breaking about which nothing can be done. Presumably it would be taking place anyway and would not be *caused* by the research.

The small scale interview-based study presents another type of dilemma. The immediacy and intimacy of the interview situation (particularly if in-depth) is more likely to elicit sharing, even off-loading, if someone is troubled or uncertain that what they have heard, witnessed or participated in is unethical. The promise of confidentiality and probably of anonymity in published data may provide just the circumstances to share a long-standing concern. Questions may provoke unwitting or accidental disclosure of routines, practices or attitudes considered acceptable by the participant but not by the researcher. The majority of studies in Chapter 4 were conducted by academics, who were also members of the professional communities being researched, as is frequently the case in health and social care. As an 'insider' the researcher may hold a position of high status in the health community and may have considerable expertise, which may differ from participants' expertise as they may bring more up-to-date, applied knowledge of legal or procedural or practical guidance, or hold a pragmatic view of practice norms. Alternatively they may know much less and be vulnerable to exploitation by the researcher who may have an agenda or personal investment. The Feminist movement promotes an engaged, collaborative relationship with participants in which openness and honesty are intrinsic to the research goal, neatly summed up by Denzin and Lincoln (1998:169): 'And you do not rip off your sisters'. Walford (2005: 83) challenged the assumption that anonymity should always be the 'ethical norm' in research, asserting that it is probably impossible in such small scale studies and possibly undesirable. Certainly colleagues of Brown (2006) may be able to identify others in the small community of practitioners to which she refers. More problematic still is the possibility that individuals may

be wrongly identified by peers or even employers or clients, supporting Walford's (2005) contention that, in such small scale work, anonymising may actually be undesirable. The alternative, of naming individual participants, is unlikely to encourage people to participate or to be open and honest. Balancing the tension between seeking open and honest sharing from participants whilst giving full and factual information on the possible implications of doing so, is a reality for this study, as it is for many of those whose work is discussed in the review of literature.

Recruiting to the Study

The research aim, to learn about students' experiences during a programme of study, requires an exploratory methodology, through which views and opinions might be sought as well as detailed experiences. As part of a doctoral programme, the study is constrained by a two year timescale. Practical requirements include the need for students to be geographically accessible and to be near, or at the end of, their programme so that any undue influence from me as researcher and educator is minimised. (Interviews took place after participants' work was submitted and they were awaiting graduation). Relatively low numbers studying Foundation Degrees across the country were reflected in the final year cohort, so it was always anticipated that the study would be of a small scale. An anonymous questionnaire, although likely to generate a higher response, would not allow for the depth of exploration possible in individual interviews. Knowing students were local, to practice environments as well as academic, served another purpose not possible with anonymous questionnaires. Disclosures of poor practice could be resolved more easily by supporting the student. My own dual (triple) role of State Registered practitioner, researcher and educator means that an interventionist approach is inevitable, so this was built upon in information and invitation letters to students (rather than hidden away in small print). Making the implications of any such disclosure explicit probably deterred some potential participants. However volunteers were well informed, and remain so. Combined with students' lack of engagement in ethics already discussed, it was anticipated that uptake would be low. In consideration of the sensitive nature of the subject matter, participants were invited to become actively involved in planning their interview beforehand, in self-editing during the interview and afterwards through member-checking, and by adding to their interview transcript by 'phone, further interview or on the transcript itself. Information given well before the interview invited them

to think about their workplace rules regarding confidentiality in order to remain within work place policies and the law.

Given the risk of my exerting undue influence over a group of students known to me, I considered approaching an alternative group of students from another Foundation Degree in the subject area. However unlike discipline-based programmes, which are all required to meet national benchmarks, Foundation Degrees differ greatly. No other programme, within a manageable distance, offered a comparable curriculum or similar employment goals for graduates. In addition my own dual role continued to present the same issues. Nonetheless it is acknowledged that while certain problems exist wherever and however such research is carried out, others are created by my State Registration and subsequent ethical duties, and have to be dealt with openly.

Because of these issues, I explored the possibility of a historical study, such as a meta-analysis of literature in the field, with no primary data collection. On careful reflection this emerged as the only approach able to avoid all the methodological and ethical problems discussed so far. The extensive body of research into the subject would have made this a worthwhile enterprise which might then have been used to analyse contemporary data on unethical practice leading to deregistration (available through professional bodies). Together this would have provided an up-to-date indication of ethical transgressions in practice. The disadvantage of this approach was the inevitable focus only upon registered practitioners from traditional professions, as the absence of information or research into the unqualified workforce would effectively exclude them from the study. Similarly the new Foundation Degree qualification would be excluded, as graduates are not registered and there is still little research into the qualification as a preparation for practice. As a goal of the study is to improve ethics education for this group, the approach was rejected in favour of balanced secondary and primary data analysis. I decided upon a small scale, exploratory study, in which my own integrity as researcher / registered practitioner / educator is an explicit condition of my agreement with participants and in which they agree to plan, edit and exercise control over their data.

It was my wish to involve students as early and as fully as possible in the recruitment process (given the inherent tensions already described), in order to increase understanding, trust and subsequent participation. However the ethical review procedures made it necessary to describe the study in its totality before any approach could be made to students. The letter of

invitation and information (Appendix 2) was completed in and adapted in minor ways following two stages of ethical review. It was presented to students in the agreed, hard copy format. Straight away it was clear that not only did this fly in the face of any hope to involve participants in the research design, it prevented any changes being made as a result of ideas offered or questions posed by students once the recruitment process had begun. Purposive, convenience sampling was the only option open to me given my wish to establish a collaborative and mutually respectful relationship with participants. Volunteers were therefore sought following distribution of letters. Having decided upon the cohort of students to be included, time parameters were planned and ethical approval processes implemented across two Schools within the University (the one in which I was a student and the one from which students were to be recruited). Originally I had planned that, following ethical approval, students would be informed of the study during their second Level 2 module, which introduces them to the concept of research and to research ethics. I hoped that they would be well placed to understand the study, its rationale and to ask searching questions. The length of time taken for ethical approval (five months in total), despite only three minor changes being necessary, meant that this module was finished and students were approaching final exams. I decided to wait until near the end of this period before disseminating letters, face to face, during a group revision session. Students were reassured that participation would be entirely voluntary and those expressing an interest were invited to attend a dedicated meeting to discuss the process. Not surprisingly, given their busy timetables, there was little enthusiasm for this. The six who ultimately participated returned the enclosed slips to me there and then, booking interview appointments within days. Although four others spoke to me on subsequent occasions or emailed to tell me they intended to participate at a later date, none came to fruition despite several follow-up invitations from me. Others not intending to participate in interviews from the beginning offered to write replies to me using the interview schedule although none of these manifested either.

The issue of timing proved critical. While it felt more comfortable interviewing them once their studies were concluded (although there remained the possibility of failing modules and requiring resits), this was a busy time when their energies were needed elsewhere, such as attending job interviews. Several students commented immediately and over the next few weeks, that the invitation and information letter (appendix 2) was far too detailed to read, deterring them from volunteering. A minority suggested that the whole study looked too much like a 'test'; an unwelcome idea following their final examination period. This response

was disheartening, given the detailed attention given to the tone and content of the information, but was understandable considering my role. I learned a lot from their responses, particularly about the important balance between enough and too much information, and about the tensions of being an 'insider' researcher. However collaborative, open and supportive I intended to be, to the students I was first and foremost the person who had been part of the team assessing them for the past two years. It is not surprising that many would not countenance placing themselves in a potentially vulnerable situation with me now they were on the point of graduating.

Another aspect of the study raised concerns which were expressed by many students and led to an aspect of the study being omitted. My information letter requested students to volunteer, if they were prepared to participate themselves *and* felt able to suggest a work place mentor who might be contacted for a telephone interview about the *curriculum*. Despite (I thought) clearly separating the two interviews, several interpreted this as a linked inquiry designed to 'check' their own account. I was asked about this during the session when I gave letters out and reiterated that conversations with mentors would not refer to student participants at all. However with hindsight, this is a fairly obvious link for students to make and a clear deterrent. I decided to omit this part of the study for this reason and carry it out separately with volunteer mentors at a later date.

The following excerpts from the Ethical Approval Submission (Appendix 1) give details on anonymity, confidentiality, ethical considerations and storage to illustrate the standard and detail required. At no point was my own concern mentioned in feedback from the Ethics Committee; that is, the issue of my educator role and undue influence. It is apparent that the research question and objectives evolved greatly over the study period, though the Ethical Approval requirement to carry out the study as planned meant that no significant changes could be made without resubmitting the entire proposal (such as inclusion of first years or the development of questionnaires as an alternative to interviews). This felt constricting after the pilot interview, when subtle changes of tone or emphasis were needed, highlighting to me the conflict between an evolutionary, learning process and the rigidity of an ethical review process prioritising advance planning.

Other than the postponement of mentor involvement already mentioned, only one further change took place; all interviews over-ran the planned one hour significantly. On one

occasion recording was paused part-way through. The reason for this will be discussed in full. The excerpts give examples of forward planning required for the ethical approval.

Excerpts from Ethical Approval Submission (for whole submission see Appendix 1):

Inclusion criteria: second year students studying and attending Fd in H&SC.

Exclusion criteria: Students from cohort suspended from programme for any reason or currently involved in disciplinary or complaint processes. Although this is not currently the situation for any students, exclusion would be justified in the students' interests given my role as Consortium Manager; that is, I would not wish to place them in a situation where they may reveal or feel obliged to reveal their thought processes in relation to any practice or classroom learning. For the duration of the study, any student participants newly involved in a disciplinary process would be recommended to withdraw in order to avoid unintentional sharing of issues connected to disciplinary. Any complaints would be redirected to the Director, HCIU.

Explain how participant anonymity and / or confidentiality will be maintained?

No participants will be anonymous given the nature of interviews, although mentors need not identify themselves on questionnaires. Data will be treated as confidential in accordance with the Data Protection Act 1998. Names and addresses will never be placed on audio tapes or transcriptions which will only be identified by a code. The key to codes and actual names will be stored separately from the interview data with no identifying information, in a locked drawer in the researcher's own home. Interview data once transcribed will be stored on a memory stick and hard copy in the researchers' own home. Audio tapes will be stored securely in the University, in accordance with Data Protection Act 1998, for a period of 15 years.

What will happen to participants?

Student participants will be asked to take part in an individual, in-depth, semi-structured interview with the researcher, lasting approximately 1 hour, which will be audio-taped. A written narrative is also possible. They will also be asked to recruit a mentor to the study and will have choice in who they approach. Interviews will take place during a day when they would normally be at University but will be at an agreed time outside teaching sessions. This is to minimise travel time and expense. A normal teaching room will be booked by the

researcher and a 'Do not disturb' notice placed outside. See interview schedule and information sheet. Following the interview a transcription will be sent to each participant for corrections, amendments or editing of any section they would not wish to be included in analysis. Once returned, data will be included for analysis and first transcriptions destroyed.

What will the participants be asked to do?

Student participants will be asked to explore in interviews their moral perspective on a critical incident from their practice. There will be scope and time to discuss their understanding, responses, thought processes and reasoning. Their prior, immediate and subsequent actions will be discussed, as will their relationships to those involved and any influential policies or protocols. Any influences upon their thinking and actions will be explored. The broad themes identified in the interview schedule will be influenced and guided by the interviewee's response and will therefore differ in each interview. Participants will have had time to consider incidents for discussion prior to the interview (see students' information sheet) so that they do not share anything they may later regret. They will also have had time to make notes against the interview schedule to which they may refer although at no point will they be asked to share any such preparatory notes. Every effort will be made to ensure participants take and keep control of what and how much they share in the interview setting. This is due to the ease with which an experienced interviewer may create intimacy and lead the interviewee into areas he or she may not have planned to explore, and also in consideration of the unequal power in the relationship between student and educator. A written narrative responding to the interview schedule is an alternative for those unwilling or unable to be interviewed.

Outline the pilot work that will be completed?

Pilot interviews will be conducted; one with a colleague simply to rehearse the semi-structured interview themes which will then be used to improve the order of questions and then discarded. Two pilot interviews will be conducted with participants and then used to refine structure and questioning strategy. Participants' feedback on process will be sought. Unless significant changes are made to the interview schedule, both interviews will be included in analysis.

How will you *attempt to prevent* the provocation of discomfort (eg fatigue, injury, pain) and / or distress in participants?

I will ensure written information is clear, explicit and concise so that individuals may make informed decisions before taking the subsequent steps, such as attending the discussion meeting or arranging an interview. During the discussion/s I will ensure people know they are able to withdraw at any point including stopping mid-interview if necessary.

The interview schedule, or structured interview / questionnaire will be available from the outset and pre-planning will be recommended, to encourage ownership of information shared. It will also be recommended that thought is given to critical incidents described, in case issues are still unresolved or feelings still raw. It will also be suggested that where questions still exist, these are formulated and possible ways of seeking answers or resolutions considered within or following the interview. I will agree and adhere to interview times and venues with participants, including their latest point to finish. In short, at every step the goal, rationale for and process of the study will be made open and explicit to potential and actual participants. Their participation will be on mutually agreeable terms and they will retain control over content and process of their contribution.

How will you *manage* any symptoms or distress arising?

As an experienced mental health professional I will use my knowledge of the interview process to anticipate, recognise and acknowledge distress and will ask participants' preference to continue, pause or stop. I will always be concerned for their well being and will not react in any negative way to any distress they experience. I would seek to communicate acceptance and encouragement for them to pause or explore another aspect until they regain composure or decide not to continue. I am aware that they may wish to stop recording and discuss their distress privately. I would take responsibility for supporting their next step. I would also bring along the University Counselling and SUSU helpline nos. should they recognise deeper personal issues and wish to seek a confidential source of support immediately or in the longer term.

How will data be stored securely during and after the study?

All data will be coded and names / contact details used to set up interviews stored separately. The key to any coding will be stored in a locked, secure cupboard along with interview recordings and transcriptions in my own home rather than on University premises, where all storage has to be accessible to others.

Following checking of transcriptions by researcher and participant, original audiotapes will be destroyed. Transcriptions will be securely stored in accordnace with the Data Protection Act 1998.

Raise any ethical issues not covered elsewhere and how you will deal with them.

It is possible that participants may describe a practice incident in which poor or unethical practice took place. As a State Registered Occupational Therapist I have a responsibility first and foremost to adhere to my Code of Ethics (COT 2005) and protect the public from such practice. This responsibility is explicit in information materials. I would have to make a judgement based on the participant's knowledge of the current practice situation of the present risk to patients, staff or students. I would therefore pause recording and remind the student of my responsibility. I would explore the specific incident and ask for details of time, place, people and outcomes. It would then be for me to make a judgement in consultation with the student regarding any risk still present and take appropriate action, where possible encouraging the student to report or disclose the information to the line manager involved. However should the student not be able to do so or refuse for any reason then I would personally have responsibility for reporting the incident. Students would be informed of this (information letter).

The Interview Process

Despite the offer of anonymous, written answers to the interview schedule questions, all participants who responded opted for a face-to-face, recorded interview. The aim of the interview was to understand individual experiences and the ways in which participants worked to resolve, challenge or accept ethical issues. Fontana and Frey (cited in Denzin and Lincoln, 2000: 646) describe interviews as:

> *'not neutral tools of gathering data but active interactions between two (or more) people leading to negotiated, contextually based results'.* Fontana and Frey (cited in Denzin and Lincoln, 2000: 646)

This concept of the interview method guided the development of the interview schedule (Appendix 3). A loosely-structured format was chosen in favour of structured or unstructured, as it provided themes with which to address the main research question and objectives, and

allowed scope for digression and exploration. Open questions were used throughout to encourage reflection and depth. An important theme from the literature is the importance of students' real practice experiences and their description of their strategies and actions (Huijer et al, 2000). This theme formed the first part of all interviews. Following this, students were asked to reflect in their own words upon the key influences in their own ethical orientation, only finally asked directly about formal learning experiences if these had not been discussed already. The other important concept from the literature is the identification of 'student boundaries' and the importance of giving students scope to identify issues which caused them concern (Huijer et al, 2000; Roff et al, 2004). No judgements were made when students asked whether their issue was 'important enough', only encouragement to explore it. Of course, what is unknown is whether 'safer' issues were selected in preference to more controversial ones, or whether the issues raised were indeed those genuinely experienced as ethical dilemmas.

Stake (1994: 242) considers Case Study design to be compatible with the exploration of 'foreshadowed' issues, as the focus upon a system (or part of) enables knowledge of pertinent issues to be addressed, proactively and legitimately, in data collection. For this group of students, the issue of 'trust' from employers constitutes a foreshadowed issue; in that the new grade to which they aspire is still largely untested. Following the first interview, which was also used as a pilot, minor refinements were made to clarify and to apportion time. In subsequent interviews I printed a reminder to myself of the key research question and objectives, as advised during supervision, so that I could surreptitiously check that my questioning was enabling me to stay focussed on the main research questions. The main variation from the interview plan was the length of time each interview took. Students invariably booked out a morning or afternoon and with the exception of one, all ran over time by negotiation. I booked longer sessions in order to check that recording equipment was working and to create a relaxed atmosphere, however I had not anticipated the extent to which students had planned their answers and researched subjects for the interviews. Most brought written notes or reminders or had scribbled thoughts on the information letter.

The longest interview lasted two and a half hours. Fortunately I had not planned anything immediately afterwards as the *depth* of discussions did indeed require this amount of time. On reflection, the planned one hour was a gross underestimate given the subject matter and did not recognise the investment students would make in the experience. It was necessary to suspend recording on one occasion, as a student began to discuss a colleague. The student

asked if it was 'okay' to discuss another person or whether she would be breaching her own duty of confidentiality to the individual. We discussed the issue in detail. I felt that, as the incident had been dealt with, we could discuss the issues stemming from the incident, as long as we mentioned no names or identifiable features. The student agreed. I felt this was the right course of action as I had committed to this in the information letter. On reflection I feel that this was respectful of the student's own concern and feel able to defend my decision to suspend the recording to discuss the dilemma. Schostak (2006: 122) called this 'the ethics of the double bind', when a 'juicy quote' is tempting to pursue, despite the researcher's own sense of this being outside the contract agreed with an individual.

In summary:

- Ethical issues identified through the review of research positively influence design and methodology and in this study, saved both time and possible mistakes.
- Ethical review procedures, although costly in terms of time, did not identify or offer guidance on some pertinent issues such as the effect of undue influence and the likely interpretation by students of inclusion of mentors, thus reducing the potential for development and learning through the process of peer review.
- A rigid approach to ethical approval which does not reflect the evolutionary process of educational research limits the potential for improvement to the research methodology.
- An interventionist stance was necessary given the role of the researcher and the nature of the research topic, which in itself raises important ethical questions.
- Personal judgement and integrity is necessary within sensitive interviews, in order not to exploit the trust and possible naiveté of participants.

Chapter 6: Methodology - Theoretical Framework

This chapter considers the theoretical and methodological issues informing research design and choice of methods. As an exploratory, inductive study, a normative or positivist methodology would clearly be unsuitable. The study is not intended to disprove a hypothesis or provide predictions about student behaviours, unlike much of the research in this area.

Theoretical Perspectives

The wish to hear and understand students' own voices and perspectives locates the study within the interpretivist paradigm in which my role is to interpret from an involved, learning perspective. Husserl's interpretive phenomenology sought to discover meaning directly from subjective experience (to 'put the world in brackets'), uncluttered by the social, cultural conventions or structures (Cohen et al, 2000:24). Factors external to the research relationship are discordant with such a paradigm, though, and conflict with my responsibility to apply the structures of the ethical approval process and my professional code of conduct. Suspending my judgement in order to explore others' experiences is not an option open to me (even supposing I am capable of such mental discipline).

Awareness of the impossibility of 'bracketing' my previous experiences, values and knowledge caused me to question this concept and favour instead the circular reflexivity of Heidegger (Cohen et al, 2000). A detailed description of the ethical challenge or strain of practice lends itself to in-depth, exploratory conversations. Equally, deep personal reflection upon, and evaluation of, *my* influence in the process would necessitate a rigorous and honest self-examination. I questioned my reluctance to engage in such a process and in doing so, recognised the motivating presence of *hope*. I acknowledged my hope that, whatever the students' experiences, by discovering how they coped, what worked for them or who was helpful in working through conflicts, it would be possible to understand how best to incorporate opportunities to learn into the curriculum. I hoped, not only that such learning might be an end-product of the research, but that participation *in itself* might enable participants to gain insights or make changes in their own lives. I acknowledge that such a goal is incompatible with phenomenology, and more akin to Action Research. Recognising

my motive, gave me reason to examine the philosophy developed by the Critical Theorists, who are, like the phenomenologists, opposed to positivism yet committed to examination of the world as it is *constructed* through personal experience (Denzin and Lincoln, 1998:187).

The political goal of emancipation and transformation inherent in Critical Theory was initially very attractive to me. The temptation to perceive the students as an oppressed group due to their poorly paid, often casual employment is very real. Indeed, the likelihood of them experiencing 'ethical strain', without the support of systematic training (McKenna et al, 2004) lends itself to an Action Research project designed to address the inequity. However, an apparent inequity does not automatically mean individuals *feel* oppressed; caring roles have worth and reward. Even if the students do feel oppressed, *I* have not been asked to liberate them from their oppressed state. As an educator and student researcher I am not active politically or practically in their working worlds. To consider myself in any formal sense their 'advocate' for workplace change could be seen as presumptive and patronising, particularly since it could be argued that they are already engaging in a form of emancipation through education. Gore (1992, cited in Simons & Usher, 2000:70), considers the risk that 'emancipatory' research might 'impose yet another "regime of truth" upon research subjects'. Finally, the political goal of critical theory to *transform* is not only at odds with the research aim to *understand* the students' perspectives but is an over-ambitious goal for such an educational, small scale study. However the paradigm offers useful insights. The rigour of the three-stage approach to gathering data (the 'technical', 'practical' and 'emancipatory' interests) offers much to any research process by according quantitative, qualitative and ideological / sociological concepts equal respect (Cohen and Manion, 2000:29).

Social Constructionism

Considering the research question in relation to these two very different approaches, it is increasingly clear that a Social Constructionist world view underpins the research goal and my interventionist stance as researcher. Social Constructionism offers a sound underpinning theoretical framework from which to explore issues, and strategies with which to develop research methods. The theory reflects the research goal of understanding *how* students make sense of, and use, their learning experiences. To understand the origins of Social Constructionism, though, it is necessary to return to the concept of phenomenology,

described by Benton & Craib (2001: 82) as 'a complex philosophical position....concerned with the way we impose meaning on the world'.

Husserl's work is concerned with 'setting aside' *what* we already know in order to discover *how* we develop that knowledge, belief or value (Cohen et al, 2000:24). Schutz develops this further, by developing his theory of 'ideal types', or constructed 'rational puppets', through which behaviours and responses can be anticipated given their rational goals (Benton & Craib, 2001: 84). Through the 1960s, Garfinkel further develops the concept, studying the 'taken for granted' rules influencing relationships and structures in society and first using the term 'ethnomethodology' (Benton & Craib, 2001: 84). From Garfinkel's work, Gergen refines the concept of 'social construction', a purely theoretical proposition:

> *'in which we treat the real as constructed (not separate from history, culture and relationships, but constitutive of them)'* (Gergen, 1999: 113).

Calling this theory Social Constructionism[5], Gergen defends its contribution as theory, frequently against attacks on its veracity as 'truth'. For example, Williams & Beyers (2001) criticise its ontological basis, asking how people could construct their own reality without some form of *a priori* intelligence or innate knowledge about the world. Brinkman (2006) suggests 'mortality' is a reality, *not* constructed, but nonetheless key to the sense of caring about each other demonstrated in all societies and fundamental to an ethical stance. Gergen answered both, reminding them that as a theory, Social Constructionism does not aspire to be offering an objective truth about the world 'out there' (Gergen, 2006:303). Rather, it is a way of understanding and developing the worlds and communities we inhabit:

> *'...theory is nothing more or less than a form of human discourse. It is a way of talking or writing within a community, a constituent of the meaning-making process by which realities, rationalities and values are constructed'. (Gergen, 2006: 303).*

To discover whether this theory is helpful in exploring the research question, its application to the research question will be tested in Box 5.1. The 'basic belief system' of positivists, critical theorists and social constructionists provide a useful starting point from which to explore any research question, in order to ascertain compatibility of world view, according to

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[5] Social Constructionism is a term sometimes used interchangeably with 'Social Constructivism' however Raskin (2002) describes important differences. Although he considers there to be many more similarities, the importance of an individualistic notion of 'self' underpinning constructivism is not present in constructionism.

Guba and Lincoln, (cited in Denzin & Lincoln, 1998: 195). Differentiating the social sciences from natural science, the authors explore the ontologies, epistemologies and methodologies of the major world views underpinning research inquiry. Social Constructionists' basic beliefs will be explored in greater depth and applied to the research question in Box 5.1 (Columns 1 &2 taken from Denzin & Lincoln, 1998, p203):

Box 5.1: Social Constructionism applied to research question.

Item	**Constructionism**	**Application to research question and objectives: given the importance of ethics in health and social care, how can curricula most effectively support and prepare students for practice? What do students consider to be ethical practice and how do they cope with dilemmas in practice?**
Aim	To distil a consensus construction that is more informed and sophisticated than any of the predecessor constructions. Reconstruction includes the inquirer.	The aim of the study is to begin dialogue with a group not yet researched. Consensus will be looked for in emerging themes but given the very small number of participants differences and unique perspectives will be expected. By beginning with a thorough literature review it is hoped to build on previous constructions and draw informed conclusions.
Ontology	Relativism, local and specific constructed realities 'Constructions'	There will be many different realities (truths) of what constitutes ethical practice. Participants will have individual, or local, or specifically constructed realities, possibly local to a team, or to a geographical patch or to a specialism. Such realities may be developed and sustained by policies and procedures, statements or directives which may then take on the status of

	are not 'more' or 'less' true in an absolute sense, simply more informed and / or sophisticated.	'absolute truth' especially if they are government driven, for a period of time but are likely to change in response to events and changing societal norms.
Epistemology	Transactional / subjectivist; created findings	Ways of knowing will be through own view of the world, own beliefs, experiences, values and developed through relationships, power, directives, dependencies with others
Methodology	Hermeneutical / dialectical	Interviews characterised by cyclical discussion, seeking to understand, accepting understanding, not interpreting as an objective 'other' but as a member of the tribe with a given understanding of own. Rational discussion, putting opposing arguments, trying to resolve through dialogue.

Using this framework, Social Constructionism appears to offer a compatible view of the world, in that the research question assumes participants will play a role in creating ethical practice. It also offers guidance on methodology and ethical considerations.

Denzin and Lincoln (2000:159) suggest that interpreting others' words or actions is so bound up with complex 'ethical and political implications', that the researcher should ask 'How shall I be toward these people I am studying?' when considering the research question, design and methodology. The importance of an open, collaborative approach, which respects both the potential vulnerability of the research participants (in discussing sensitive work experiences and as students) and their unique perspectives, simultaneously as students and workers, is reinforced by this question.

The existence and influence of laws or professional codes of behaviour will be treated within the study as constructions of the community, as opposed to factual 'truths'. This allows exploration, with the students, of their understanding of, and criticality towards, such

phenomena. Similarly the study will be located within the community of practice and thus subject to those same rules and laws, reinforcing the importance of acting upon any risks identified during interviews. Gergen (2006:303) described the role of theoretical inquiry thus:

> *'Practitioners may employ theoretical discourse to coordinate their activities, to unite them as a community, to infuse their actions with intelligibility, to offer alternative metaphors, to reflect upon their activities, and to provide each other with a supporting rationale'. (Gergen, 2006: 303).*

This approach offers a coherent way of designing the study and interpreting data, and enables ethical practice to be explored as a relativist and culturally normative concept. Students' contributions are analysed from this perspective and conclusions drawn.

Case Study Design

The small scale, exploratory nature of the study lends itself to Case Study design. Stake (1995) describes Case Study as 'a choice of object to be studied' rather than a methodological approach. The programme's first intake of students provide the 'object to be studied' (Stake, 1995), during their second and final year. A Case Study approach, unlike fieldwork, requires an 'integrated system', although features of that system may reside both internally and externally (Stake, 1994: 237). A cohort of students may be seen to fulfil this criterion, as they function as a group, access the same internal (University) resources and operate within the same external work environment. It is important for the system to be defined and boundaries to be set, in order that its integrity is not compromised. Only one cohort was included and timescales established to ensure they had all completed assignments. The inclusion of foreshadowed issues from the literature, in interview schedules, was limited due to the need for early submission of the documentation for ethical approval. However the importance of focusing upon real experiences and actions was apparent from the literature review, so formed the basis of interview schedules. It was also possible to plan to spend time considering the various influences upon students, as the literature indicated that the impact of the hidden curriculum within practice environments could easily be underestimated by classroom-based educators.

In summary, the discipline provided by establishing the parameters of a case has distinct benefits, in that wider features of the system can be considered for inclusion and exclusion at

an early stage and energies focused accordingly. A drawback of such discipline is the potential loss of flexibility when, as in this study, participation is low. Broadening the inclusion criteria to include other intakes, cohorts or students of other programmes threatens the integrity of the research, so it was important to do everything possible to maximise inclusion whilst preparing for depth interviews rather than broad coverage.

Analysis

The forms of analysis used in Social Constructionism are usually Conversation Analysis or Discourse Analysis, as both focus on the interview as an event between two people, justifiably of interest in its own right (Silverman, 2006: 128). Although both forms of analysis share this purpose, Conversation Analysis has very strict transcription conventions to assist inter-rater reliability in large studies, making it difficult to read as ordinary text. My lack of experience with this technique, and my wish to share interview data with participants for purposes of member checking, meant that the more flexible, less linguistic approach of Discourse Analysis was better suited to my analysis. Potter (1996: 134 – 5, cited in Silverman, 2006: 224) describes Discourse Analysis as the study of discourse: 'analysis of discourse becomes, then, analysis of what people do'. He emphasises the way people reproduce their realities through talk, tell their stories and construct identities. The researcher seeks to understand all of this by closely analysing and interpreting, all the while being aware of the realities and identities the researcher him or herself brings to the interpretation (Silverman, 2006: 225). The important concepts in Discourse Analysis are:

- 'interpretive repertoires', or words and terms related to metaphors
- the idea of 'stake', or personal investment and responsibility
- the use of 'scripts' or ways of 'invoking the routine character of described events' (Silverman, 2006: 231).

The kind of knowledge sought through Discourse Analysis is very different from positivist or phenomenological approaches, as it focuses upon discovering *how* people describe and organise their contribution to the interview, as well as *what* they choose to share. Analysis of the dialogue is inclusive of the questions or prompts, or even silences, generated by the researcher as well as responses by the interviewee. Unlike Content Analysis, in which interviewees' quotes may be used to *illustrate* the researcher's predetermined hypothesis,

much longer quotes or sections of the two-way discussion are reproduced, in order to *test* the researcher's contentions (Silverman, 2006: 139). This is appropriate to both the in-depth nature of my own interviews with students and the small number, as only limited amounts of data can be handled in such a detailed way. It also recognises the importance of the researcher's contributions.

Rather than seeing the involved and interventionist stance as problematic, as it would be in both positivist and phenomenological approaches, the Social Constructionist view is that the participant will inevitably, and quite properly, respond in ways unique to the interview situation and to their relationship with the interviewer. Information or views described in the interview are understood to be consciously tailored to the listener or to the wider audience. In other words, it is likely that on any other than the most non-contentious subjects, each of us will wish to project a certain image or communicate a particular stance. Silverman (2006: 142) uses Baruch's (1982, cited in Silverman, 2006) research with parents of ill children to examine how parental descriptions of their childcare, at the time of the illness, was exemplary, in the face of poor medical care. Baruch neither seeks to confirm the 'truth' of their experience (as a positivist researcher might), nor does he accept unquestioningly the personal journey they are describing (as a phenomenologist might). He does not 'judge' his interviewees' intentions negatively, but he understands that they are using the interview as an opportunity to describe themselves as adequate parents, thus constructing an identity as 'morally responsible' (Silverman, 2006: 139). The actual words used to achieve this are the subject of Baruch's examination. The detail and meaning of interviewee-interviewer exchanges are analysed using Discourse Analysis, described by Silverman (cited in Denzin & Lincoln, 2000: 826) as focusing upon:

> *'how different versions of the world are produced through the use of interpretive repertoires, claims to 'stakes' in an account (Potter, 1997) and constructions of knowing subjects (Prior, 1997)'.*
>
> Silverman (cited in Denzin & Lincoln, 2000: 826)

Once embarked upon, this route opens up the probability that what is said today, in one context, may be different to what is said tomorrow or next year in a different context, even by the same person about the same incident (Silverman, 2006). This does not mean that any one description is more 'true' than any other, but that *how* accounts of experiences are recalled, assembled and shared is dependent upon the *purpose* of the sharing. For example, an account

of giving birth shared with a close female friend is likely to vary greatly in style and content from the account shared with a male General Practitioner, because the purpose of the sharing and the sense of self (wishing to be communicated) will be very different. Silverman contends this is inevitable, as to ask someone questions about what they would do in any given situation, is actually to ask them something they cannot know. Even if, in the past, they have behaved in a certain way, they may act very differently in the future (Silverman, 2006). This is very relevant to the kinds of questions my interviewees faced from me, as although I was asking for detailed descriptions of practice incidents, I was conscious that I was seeking only one person's perspective. Perspectives, inevitably, are modified by reflection over time and tailored by their expectation of purpose. It may be that students wished to give a good account of themselves as successful practitioners, or envisaged that the qualification itself may be enhanced by favourable reports. Alternatively students could have used the interview as an opportunity to air unresolved grievances or make known problems with the programme or with individuals. It was necessary to accept all these possibilities, at the same time as understanding that what they were sharing – and how they chose to share it with me – was equally valuable, as each one was a 'knowing subject' (Prior, 1997, cited in Denzin & Lincoln, 2000). I chose to draw upon a specialised technique within Discourse Analysis, pioneered by Sacks (Jefferson, 1992; 1995) called Membership Categorisation Analysis. However it is important to note that I was only able to draw upon key principles of this technique given that the interview schedule was not designed with this very specific type of analysis in mind for reasons already discussed.

Membership Categorisation Analysis

Sacks describes individual categories, and collections of individual categories, which form a collective category or 'set'; his example of an individual category is 'mother' and of a group category called 'family' (Jefferson, 1995, 1: 236). He describes the 'apparatus' which generates such categories as a 'culture', explaining how powerfully our shared language and understanding allows instant recognition of a category and its associated characteristics or properties (ibid, 1995, 1: 238):

> *'That's the basic thing I'm interested in, 'membership categorisation device'. And those things are collections of categories for referring to persons, with some rules of application. So there's a collection of categories and there are rules of application,*

where these devices can be applied to populations and members apply them to populations to say things about them, like that's "a baby"'. Sacks, in Jefferson, 1995, 1: 238

Once categories are identified, data can be produced which enables interesting relationships and related activities to be identified and explored, both qualitatively and quantitatively. Following this theme, I identified all the different categories in students' interviews using Sacks' 'consistency rule' (treating everyone called by the same name in the same way), to develop 'sets'. An example of single categories to emerge, easily grouped into one set, was the variety of terms used to describe people called 'patients', 'service users', 'users' and 'clients'. Services tend to use one or other term, depending upon whether they are culturally closer to a medical or social model. However students themselves may use one term consistently regardless of setting, to indicate their personal orientation and relationship with the individual. Some students, working in children's services, also referred to 'the child', 'the toddler', 'the baby' and 'the little boy' to describe 'their' patients, although never referred to this group as 'the patient' or 'the client'. This suggests that these terms are identified with adults who use services. For my purpose, I developed a 'long list' of categories, and a shorter list in which I combined them into one set (including anyone the student described as engaging in activities associated with being in receipt of care or treatment). Such related activities are called by Sacks 'category-bound activities' (Jefferson, 1995: 1: 241). Other categories presented similar issues, for example, the term 'colleague' was sometimes used alongside 'friend' and at other times with 'team member'. Keeping every variation separate resulted in a very long list, often with only one or two entries. I made the decision to keep 'friend' in a category of its own, as the activities recognisable as those that 'friends' participate in are very particular. By contrast, the work-related activities, recognisable as those engaged in by 'colleagues' or 'team members', could be seen as *similar enough* to form a distinct set. References to work-based relationships indicating supervisory, educational or subordinate activities, I kept separate, again because the activities engaged in would be very different from those engaged in with peers.

Making these decisions required careful thought, detailed re-reading and repeated listening to original recordings. Many changes were made and more could have been made, however a point was reached when the sets broadly conformed to Sacks' 'rules of application', explained by Silverman (2006: 184). These are: adequate for *recognition* (the economy rule) and *consistent* in recognising other members of the same category by the same term (the

consistency rule). As the sets of categories emerged from analysis of the data, ideas of how to handle the data began to develop. I considered imposing themes, as in Content Analysis, and had to resist the temptation to do so as I realised such themes were simply reflections of the working hypothesis I had developed throughout interviews, and did not necessarily genuinely reflect what was emerging from the data. An example of this is the concept of reciprocity, to which I had been attracted in one interview. The student spoke passionately about how much she had learned from service users, and how the trust placed in her, by them, in turn made her feel the need to live up to this trust. I found myself scouring other interviews for similar ideas, realising in the middle of this process that this was an attractive idea to which I had prematurely bonded, but which had really not emerged from more than one interview. Fielding and Fielding (1986: 32, cited in Silverman, 2006: 279) identified this tendency to 'select field which are conspicuous because they are exotic, at the expense of less dramatic (but possibly indicative) data'.

The comparatively dispassionate process of developing sets, and then considering ways of handling them, was a helpful antidote to the seductive activity of re-reading transcriptions and listening to students' voices. It meant discipline was necessary as I began to take pride in the rigour I was able to apply to the process. I began to look at the interview data differently. I found myself moving from a feeling of disappointment that I only had six interviews, to a real appreciation of the wealth of possibilities offered by so much text. I also read my own contributions as interviewer differently, wondering why I had moved a student on at certain points – often in the middle of an interesting point – or spent so long on relatively unproductive, fairly abstract discussions. I found myself wishing I could start the interviews all over again, to experiment with some of the strategies described by Sacks (Jefferson, 1995) and Silverman (2006). Two things concerned me as my understanding of Sacks' (Jefferson, 1995) work deepened. Whilst refreshing, the focus upon the interview as the object of study meant that subject or content could be reduced to a mere vehicle for studying the words and exchanges between interviewee and interviewer. I remained very interested in just *what* the students had to say about their experiences, as well as the ways in which they described their participation. I was also concerned that in analysing my own words (and feeling somewhat self-conscious in the process) I would be tempted to exclude anything which showed a lack of interview skill or was obviously leading the student in a certain direction. Straightforward Content Analysis began to seem a good deal more attractive. It was difficult to dissociate from 'my issues' and I had to recognise that I, as well as the student, was intent upon

projecting an image, or multiple images. As a responsible registered professional, open-minded educator and skilful researcher, I wanted to carry out successful and procedurally correct interviews. I was also conscious of the imminent change in our relationship as the students were on the point of graduation and likely to return as mentors to future students. I was concerned, as I learned more, that I had not created enough opportunities to discuss *how* they constructed an identity as ethical practitioners, so was relieved to find discussion of Holstein and Gubrium's work in which they describe 'the active interview' (Holstein and Gubrium, 1997: 27, cited in Silverman, 2006: 132).

By focussing upon students' descriptions of events in their practice, explored by prompts and questions about how they had responded or what others had done, I had in effect carried out interviews very similar to Holstein and Gubrium's 'active interview' (1997: 27, cited in Silverman, 2006: 132). I was reassured to go back through my data and find many discussions of both the 'what' and the 'how'. Another helpful description of these two strands is Rapley's (2006: 16 cited in Silverman, 2006: 137) distinction between 'identity work' (or, in this study, 'how' a student presents themselves as 'adequate' in relation to ethical practice), and 'cultural stories', (the ways in which students select stories to describe their understanding of ethical practice) and where these stories belong within the culture of caring for others. This distinction helped me decide where, within interviews, students were working to construct an identity as an ethical practitioner, and when they were using stories to describe exactly what they actually understood ethical practice to be. For example, a student offered an account of staying for some time with a terminally ill person, instead of continuing with planned visits, as there was no-one else to be with her and she was fearful of being alone. This was a cultural story which said a good deal about the student's experience of terminal illness and being cared for at home in Britain in 2006. At the same time there were many opportunities for the student to assert his values, priorities and stance when describing a moral decision in this situation.

I decided to construct two frameworks for analysis, the first similar to Baruch's tabulation of membership categories (1982, cited in Silverman, 2006: 138). After categorising the different people discussed in interviews with parents of children in hospital, Baruch 'paired' the Membership Categorisation Devices in terms of 'duty towards another'. He then counted the number of times in interviews such pairings were made by interviewees, enabling him to conclude that parents identified themselves as 'having a duty towards their child' in 51% of all pairings. They paired themselves as having a duty towards professionals in 28% of

pairings, professionals having a duty towards the child in only 16% of pairings and finally professionals having a duty towards themselves in 5% of pairings. From this analysis, he used lengthy parts of interviews and investigation of cases which did not fit this emerging norm (the deviant case) to test his contention that parents *constructed an identity of themselves as good, responsible parents* in reflecting upon their child's illness and treatment (Baruch, 1982, cited in Silverman, 2006: 138).

After developing categories and sets from the data, I was in a position to look for relationships between pairs of sets, in a similar way to Baruch. However there are many different sets, so manageability of data was an issue. As I am most interested in the way students construct a moral identity, I chose to count every instance of a student making a statement about ethical intent, reasoning or behaviour: whether by others, towards others; by themselves towards another; or by others, towards themselves.

Schegloff (cited in Jefferson, 1995:200) criticised Membership Categorisation Analysis, on the basis that such analysis simply led to 'the claimed explication of a bit of commonsense knowledge' (Silverman 1998:128). I therefore sought to apply a rigorous process to the analysis, while keeping an open mind on just how 'common sense' (or alternatively, counter–intuitive), any resulting 'knowledge' was likely to be.

Analytical Triangulation

In order to better understand the 'what' of ethical practice, I also wished to analyse separately the *types* of actions, thoughts or ideas students described as 'ethical practice'. Given the criticism of Content Analysis aired earlier (that is, that such a form of analysis would produce a superficial list to support pre-determined categories), I grounded the data by using *precise words* said by students, thereby developing 'participants' categories' (Silverman, 2006:164). Again a long list was the result. Grouping of similar descriptions produced a shorter list, each part of which could be contextualised in specific sections of interview transcript. This second framework enabled the relational concepts of the first to be checked against students' more abstract descriptions and ideas embodied in the second, providing a form of methodological or analytical triangulation (Janesick, in Denzin & Lincoln, 2000: 391). Although derived differently from the same data, both sections were compatible with Discourse Analysis in that

the words themselves provided the starting point, and meaning was not being changed in order to fit pre-determined categories.

Different perspectives on the analysis of qualitative data and rigour include, at one end of the spectrum, the view that no concepts from positivism are of use and, indeed, that *different* terms and references are needed (Janesick, in Denzin and Lincoln, 2000: 393). Close to the other end of the spectrum is the view that, by rejecting conventional measures of rigour, the status of social science research would be greatly reduced (Silverman, 2006: 273). It is the aim of this analysis, that *enough* detail of the original data is presented and that interpretations are explained. This is intended to provide a believable, authentic account, with a clear audit trail of reasoning and decision-making. Importantly, 'generalisability' is not intended to be an outcome of such a small study. The constructionist perspective is that the exchanges are personal, contextual and a result of the *relationship between* interviewee and interviewer, so as a concept, generalisability is not relevant. Janesick, in Denzin and Lincoln (2000: 394) asserts: 'the value of the Case Study is its uniqueness'.

In this study, the concepts of *trustworthiness* and *authenticity* will underpin the checks and processes, put in place to ensure a thorough and open account, in which the 'explanation fits the description' (Janesick, in Denzin and Lincoln, 2000: 393). Trustworthiness has been sought, by offering a detailed approach to member-checking and a decision audit trail. Authenticity has been achieved by offering significant inclusion of the students' own words. Silverman (2006: 282) identified 'transparency' of process and 'theoretical transparency' as measures of reliability in qualitative research. This ensures links are made to interpretations and underpinning theory. Reliability, when interpreted as 'repeatability' is, like generalisability, a redundant concept in small Case Study research, for the same reasons. Instead, I aim for 'low inference descriptors'; that is, description in which the amount of scope for the reader to make their own inferences about a particular description is reduced to a minimum. Interviews were recorded, transcriptions were made by myself following many hours of careful listening and long extracts used for analysis as recommended by Silverman (2006: 287).

Validity has been described as 'the extent to which an account accurately represents the social phenomena to which it refers', (Hammersley, 1990: 57, cited in Silverman, 2006: 289). This places the responsibility on the researcher to represent accurately, and without distortion or manipulation, the data as offered by the participant. In turn, a rigorous search for meaning

is necessary, along with detailed explanation of the reasoning leading to any conclusions. I have already discussed, and consider during analysis, the likelihood of my own influence upon interviewees. By asking students to read and edit, add to or amend their own transcripts, I sought 'respondent validation' or member-checking (Silverman, 2006: 291). Triangulating data, given the sensitivity of subject and elusive nature of students prepared to discuss the topic, proved a problem. It was not possible to observe practice for reasons of individuals' right to confidentiality in treatment. Even if it had been possible, the types of dilemma described by students were rarely observable. Instead, the concept of reflection – upon local meaning, foreshadowed meaning and consequences – informs analysis (Stake in Denzin and Lincoln, 2000: 445). In this way, decisions made and conclusions drawn are explained and justified. Understanding my own contributions and interpretations as part of a reflexive process will require reflection, openness and a preparedness to look at both helpful and unhelpful interjections as part of the learning process.

The criteria checklist developed by the British Sociological Association Medical Sociology Group in 1996 has been used to examine each aspect of the analysis, (Box 6.1).

Box 6.1: Criteria for the Evaluation of Research

Criteria for the evaluation of research.	
Criteria:	**How addressed in study:**
1. Are the methods of research appropriate to the nature of the question being asked?	Yes: active interviews, semi-structured with open questions.
2. Is the connection to an existing body of knowledge or theory clear?	Yes: see literature review.
3. Are there clear accounts of the criteria used for the selection of cases for study, and of the data collection and analysis?	Yes. See Chapter 5.
4. Does the sensitivity of the methods match the needs of the research question?	Scope to improve and refine interview technique in future. Looking at actual incident in practice matched the 'active

	interview' technique.
5. Were the data collection and record keeping systematic?	Yes, also systematic member checking for authenticity.
6. Is reference made to accepted procedures for analysis?	Yes, Content and Discourse Analysis.
7. How systematic is the analysis?	Key words and phrases sought by 'find' option on Windows XP. Individual assessment of each for inclusion.
8. Is there adequate discussion of how themes, concepts and categories were derived from the data?	Description of analysis. See Chapter 7.
9. Is there adequate discussion of the evidence for and against the researcher's arguments?	Discussion chapter
10. Is a clear distinction made between the data and their interpretation?	Methodology chapters
Three further questions by Silverman:	
How are data extracts presented? Is the detail of the transcription or of the field notes appropriate to the claims being made?	Long sections of interview data reproduced; also numbers of pairings.
Are the data extracts positioned within the local context from which they arose? For instance, in an interview or focus group study, are we given what precedes and / or follows a particular utterance?	Yes, within sections; certain boundaries necessary to focus section.
Is any attempt made to establish that the data extracts selected are representative	Tabulations made; possible deviant case discussed.

of the data as a whole? For example, are simple tabulations made or are deviant cases followed up?	

British Sociological Association Medical Sociology Group, 1996: reproduced and adapted by Silverman (2006: 276). *Additional questions relevant to study posed by Silverman (2006: 276).

In summary

- A theoretical framework is essential to a coherent methodology
- Social Constructionism reflects the study goal of understanding students' experiences while respecting the external forces which contribute to their personal identity formation
- A Case Study method is used to organise and define the cohort being researched
- Content Analysis of the interview transcriptions seeks to discover both *what* students consider the meaning of 'ethical practice' to be, and what it *means* to them in their everyday practice
- Discourse Analysis seeks to discover *how* students construct their identity as ethical practitioners by examining the words and ideas with which they organise their stories and metaphors, the personal stakes they hold in describing their practice and the ways in which they use personal scripts
- Small scale, qualitative research requires the researcher to balance competing and conflicting agendas and to bring to the process personal integrity

Chapter 7 Findings: What Ethical Practice Means to Participants

Two forms of analysis are used to develop findings from interview transcripts. First of all, a form of Content Analysis is used to develop broad categories of ideas and abstract concepts organised around exactly *what* students understand and mean by the term 'ethical practice'. This is discussed in this chapter. Next, Discourse Analysis is used to analyse *how* students construct a moral identity, using longer sections of transcript to test out emerging themes. This is discussed in Chapter 8. The two forms of analysis provide methodological (analytical) triangulation (Silverman, 2006:290) allowing findings to be compared and discussed in the light of each other and most importantly, in relation to the research question, aims and objectives.

Findings from Content Analysis

First of all, a grounded form of Content Analysis is used to ascertain what students understand and mean by the term 'ethical practice'. Interview transcripts are used to identify words, phrases and terms used by participants to describe, discuss and illustrate examples of ethical practice. Whilst not formally using Grounded Theory as an approach to the project structure and data collection, the categories developed from the analysis are grounded in actual phrases from interviews; that is, no pre-formed categories or themes are used to allocate words or phrases (Glaser and Strauss, 1967; cited in Cohen et al, 2000; 23). Instead, key words or sentences used by students are selected and reproduced verbatim from interviews. *Any* words pertaining to ethical concepts are highlighted, along with phrases or sentences discussing an ethical issue. The 'recording unit' is the word, phrase or sentence describing or referring to the *concept* of ethical practice, rather than the individual words (Robson, 1993:276).

A very inclusive approach is taken from the beginning, with no attempt being made to develop categories until all such words and phrases are found and listed. This is a departure from the type of content analysis in which themes are developed before analysis, usually based on the review of literature, followed by grouping of recording units by theme (known as categorising) (Cohen et al, 2000:284). The use of verbatim words and quotes maintains the

use of low inference descriptors, at least in the first stage of analysis (Silverman, 2006:54; Robson, 1993:276). This is particularly important given that I was both interviewer and analyst, so had no independent coder or method of triangulating data to review my interpretations. Once key words were found in one interview, the 'find' function in Windows XP was used to find the same or similar words in subsequent interviews. Close re-reading was found to be necessary to find new, related words and check the meaning and use of those already highlighted. Robson (1993:281) describes the use of 'concordances' (or in computer terms the 'key-word-in-context') in which key words are read in the context of the sentence around them, in order to identify variations in meaning of the same word when used in different contexts. The use of frequently-used terms with many different interpretations (such as 'empowerment' or 'professional') had to be treated in this way. Boxes 7.1 – 7.6 show the recording units developed into lists, using original words and sentences directly taken from transcripts.

Interview 1

It's equality in service provision... treating people equally and being just

you are restricted by resources and by regulations about what types of equipment …it might not be possible to entirely do someone justice. it does end up coming down to finances that are out of my hands as a practitioner

It ties in with the non judgemental bit - all about treating everybody as equals, equal to yourself and to any other person, client

I get round it is by teaching the person coping strategies in order to do the best I can which is where I see ethics being, doing the best I can for the person in the circumstances

I ended up offering to call the doctor for her, going through all that on her behalf so that she could relax a bit more, let her get her head together about it. I do a fair bit of that – acting on the spot – getting something done

I do quite a lot – a fair bit – of advocating.

if it's something like major changes with financial implications I will flag that up

Being with a person – frightened to be alone 'I just said okay I'll phone up and arrange for someone else to do my things' 'although she slept….it was really important to her that there was someone there in the room with her

...one of the nurses who was in the resuss(itation) room, she just stood by the side of the trolley and held my hand for the whole of the procedure

...human contact – human ness - Compassion

Making judgements – taking responsibility for own actions

Bargaining with people

Making it their decision

...all the way I'm thinking about stuff that might happen if he's going to lose it on the way, what is happening and keeping an eye on junctions to tell the ambulance if I have to, checking his registration to tell the police if I need to

I've had three placements in mental health and my outlook has changed completely – it was talking to the clients

Box 7.1

Interview 2

..doing the right thing with some sort of a moral code.

I found myself absolutely shocked, that the mother and the health visitor hadn't done a single thing,

..it was reported as an incident to me by a colleague who didn't know what to do and I advised her that she had to speak to a senior manager

..it was the little boy in danger,

She wasn't taking any responsibility.

I would have preferred to have had it on a more solid basis

...obviously aware that he was here and they must have known he was kicking, you know it would have been in their peripheral vision, you know it was a movement, but there was no addressing that situation, they were just talking about 'how much does she weigh, and how is she looking'.

I was very prepared for him to get quite angry at me, when I said let's go and play in the corner, and I said 'Do you want to come and play in the corner?' – 'Yeah okay' and he put his arms up! For me to carry him – and I thought 'how simple was that? I could have done that before'.

..only this time I would have jumped in quicker

...tell someone that she knew she could trust not to.... be inappropriate with the information

...she really did need to tell our manager about it

I encouraged her to tell the person who needed to know

I did want to try and delay one of my friends from taking her daughter for ..

I just felt I knew something that she deserved to know about

...so much supervision

...remain a human being. Compassionate, incredibly supportive.

Safe Practice actually very much, yes, the whole nature of what can I see potentially happening here. With Health and Safety

...rights of the clients and empowerment

I mean it's what's right and wrong isn't it?

..verbalising it.

...trust your own judgement before anything else really

Box 7.2

Interview 3

...you are in a situation where you're actually, um, responsible for people or a person

...really is it in their best interests,

...is it something that is fair, just

...right, in their eyes, in their life

...responsible for people or a person, and how that person's been treated

...if they have consent for what you're doing to them or for them

...if they understand what they've sort of agreed to

I was sort of looking into why certain children would be using the sensory room and maybe some not and I think it was probably an access thing

..it is proven that use of sensory room for children with learning disabilities is beneficial, so all the children who were there should have access to it,

...some children, they were, not taking them enough times, because of the amount of work involved

I just thought it was a bit of a discriminating issue

Some of their older children are slightly heavier and there was more risk, maybe, of them, there was more risk to manual handling them

It's a manual handling training that they'd need, manual handling and basic health and safety

...and reading – where to find information, that's the important thing now, is exactly what information I'm looking for,

'I too can have that information' it's not 'their' information, it's mine as well..

...they put things in their mouths and they tend to stomp about quite a lot, there's quite a lot of movement so actually it would be an unsuitable area

...they will take children in who they feel comfortable with taking in, or who they feel, maybe would benefit, but maybe with the time plan, they could only, you know if they've got a

whole class of children, and one of those takes a long time to get out of the chair into the, into the area, maybe…

...if I feel that it was part of what I should be doing to find out, I would, you know, obviously, um, carefully and respectfully find out,

– whereas now I'm probably thinking – but why? You know – Why? Why are we really doing that – why are we doing it that way? What's the story behind it?

...told us, taught us, to own what we're doing, to take it on board, to own it

If I felt that something somebody was doing was really wrong – really wrong – I, you know, I'll confront them

If I'm working for somebody, and I'm going into a situation where I'm not in authority in that way I wouldn't um, I would go away, you know I would take that with me, I would have to ponder

I think it's part of being, it's part of the responsibility, I take enormous responsibility to pass that situation on ….

„„communicating with different people across different teams

I could actually investigate the bigger picture to make sure I knew all the reasons why

...as far as I really look at it, it's being given the permission to actually do that; but I'm thinking 'do that then, take it that step further – be bold, don't be afraid, take a step and say, do this, do that, use this information, look at it this way'.

I definitely get in there and get alongside the teachers, and work with the children

Box 7.3

Interview 4

When you see something that isn't right you don't just stand by and say nothing, you do something about it

I had to help her, to empower her

I know what we've done has empowered the children

I was coughing up all that dust, in my mouth, what was it doing to the children?

...because it's the children who wanted to do it, if you start when they're younger and encourage them,

...it was a fire risk, because the fire exit was blocked

I woke up coughing so it must have been the dust that affected my health, which then puts more pressure on the health service because then I'm off ..

...it's health and safety at work isn't it?

I'm hoping I will have the confidence to say 'I think this' rather than 'I think that' and agreeing.

...my own health and safety

...like my health and safety at work and I'll say 'that's why I don't want to do what I'm doing'

I need something to back me up

I could say 'this is what's right and wrong'. I think I need to start believing in myself really.

Box 7.4

Interview 5

...ethics is about what's right and what's wrong

It seems to be about doing the best for the patient or clients I think they call them, irrespective of possibly what is best for the practitioner.

..a clear ethical dilemma because there's a need for the patient to be treated but the health care professional has a need to protect themselves as well

...the need of the professional to protect themselves, to protect their families and yet they have a duty of care to the patient

The duty is clear, so the legal duty is clear, the perceived duty is

If you don't want to stand the heat then get out of the kitchen.

I would be very careful about protecting my family BUT, you know, if that's what your job is then that's what your job is and people, if you go in for the fullest protection you can give yourself

I believe that religion actually forbids operations so there's a clear ethical problem there I would have thought because you have the clinical 'best course' versus their religious beliefs so there are some interesting problems..

... I don't think we can start jumping around saying if you don't do this you will die therefore you must do what I say, because that goes against patient centred care. I think all you can do in that situation is present a reasoned argument

..it has to be done with respect.

...you are supposed to wash your hands between patients and

...you can't help but notice bad practice.

...the best way I can challenge something is to do it properly

...not operating outside your knowledge zone and advocating

...advocate for somebody

...more knowledge therefore power

...more reasoned approach

I prefer to understand other people's actions rather than judge them

I would rather say 'why are you doing that?'

If there was no attempt at infection control and no response to my enquiries into that then I would have had to say 'I'm sorry, I can't work here' and I would have had to explain to my placement coordinator.

You could be expected to go back to your coordinator and say 'look, I don't want to stay at this place, it's filthy dirty, they're not prepared to do anything about it, I've offered to help, they're not interested, find me somewhere else please'.

I have to learn to be professional about it instead of emotional but I also have to learn that they need a response that isn't totally professional – does that make sense?

...but you mustn't patronise them... it's quite a complex relationship really and I learned a lot about relating to people in those weeks.

They trust you to look after them, that's what you are there for and they trust that you're going to do it...

...you can't let them down, that's not what you're there for, you know, you're there to do what they expect you to do...

...there is a professional detachment that people that I need to get – so that I don't go home feeling quite so knackered

...people need more than just being fed and kept clean, they need to feel valued still...

...some people just want to talk, they just want an ear, you know, it's, I think it's an important relationship, being a student you can give something back...

Box 7.5

Interview 6

..professionally acceptable

..boundaries between your relationship

..making decisions that are correct

..breaking their rights to obtain something or denying them from something so it's making the right decision.

..policies and procedures

..statutory bills as well that tell you what is the right thing and what is unacceptable behaviour and actions

..picking up things from your line managers and supervisors, things that are deemed to be correct within that particular organisation.

..the right terms of engagement - as in not using language that's unacceptable in a working environment

..you can be friendly but it's not your friend so there's no blurred between a financial relationship or a sexual relationship or an emotional relationship because you're providing a service and you're there to empower somebody,

..you're not there to take away something that is theirs or their rights

..making sure that you're always impartial

..looking out for them as best you can rather than putting your own feelings first

..before your own, as long as it's safe

..code of practice

You're not allowed to do something outside of your care plan or your plan of action

Occupational therapy's code of practice

Social Services there were codes of their fitness

NHS there were codes of ethics

..continuous training anyway, reminding us what we're supposed to do and not supposed to do

...you could see the reasoning behind it

..build up a rapport

I've accepted that that's the official decision

I still think personally I would have pulled out a while ago

..we're placating the daughter at the expense of alienating our service user

I'm not aware of all of the internal wrangling

..empowerment

But because she is saying it is a medical need it comes under the NHS and the NHS is saying 'don't be ridiculous this is just a painkiller it's not a medical need' but daughter won't accept that and Social Services are probably quite happy to back her up because they don't want to pay either

Because you could be the one person who notices that key thing and you could be that person that makes a difference

They won't be doing it for no reason at all, um, but that reason may be because they want to ensure they have a good relationship with the rest of the family because they know they're going to have input with this lady for a very long time

..that we do the best we can

..they don't think about it as deeply as I have

There's much more emphasis on reflection

..or if we've got an observation that might explain why something's been happening the last few times

..(a team debate) - we would just instigate that ourselves. If I really felt I wanted to but then

they would sort of say 'well what exactly do want to talk about, you know' and we would just have it out there and then

They know that there are certain things I would go through to do that, you know, in making sure I knew that I felt they were safe and that it was the right weather conditions and the right flooring and things like that, they know that I would go through that, that's just accepted that I will do that

..they're promoting their individuality as well because we're supposed to do that, promote independence and individuality in our practice

'..you know I really think this person has depression, I really think this is an issue and that's an issue' and she was quite grumpy with me

..that was an ethical issue because I really felt the I felt everybody was slopey shouldering her

..because she had psychosocial issues and depression but then she's not going to be able to unless she gets treatment for that

I'm very straight down the line, if it's right it's right, if it's wrong it's wrong, there are blurred areas, I'm well aware of that, but I personally have my beliefs and I am not prepared to compromise them, um, you know, to the detriment of other people or myself

..the NHS has sent me on a lot of courses about um, promoting independence and coping with people that are dying

Box 7.6

Refining to develop categories

From this long, verbatim list of ideas or activities, loosely associated with ethical practice, I started to work on categorisation. This was not easy as I felt a great responsibility, being conscious that 'since the categories contain the substance of the investigation, a content analysis can be no better than its system of categories' (Berlson, 1952, quoted in Robson, 1993:277).

At first it appeared that participants' descriptions were simply opinions presented in a fairly random fashion, often anecdotal and unsupported. I found it necessary to take a mental break from the analysis at this point in order to reflect upon the meanings conveyed through the descriptions. I found myself veering between finding great importance in a sentence or idea, only to disregard this for another a few days later. This reflection was useful however, as by resisting the urge to rush into categorisation, and after experimenting with several different categories, I found myself recognising three distinct types of meaning emerging. Participants generally describe either:

- abstract concepts, principles or rules, held dearly by them for some time or imparted to them by others and usually internalised to a greater or lesser degree
- personal qualities, skills or abilities of themselves or others, usually considered to be inseparable from (ethical or unethical) actions or behaviours
- professional and organisational codes of practice, guidance or routines usually cited in support of actions or as a benchmark although rarely described in any depth

Within categories, some components were interchangeable, in which case the words preceding and following were used to decide *where* it actually belonged. For example, 'empowerment of others' sounds like a principle: conversely 'being able to do things to empower people' sounds like a skill or set of skills. Where such overlap is evident, the component is included in both categories. In order to relate the raw statement to the newly developing categories, phrases were abbreviated and at times paraphrased. Inevitably some new meanings are attributed through the interpretation process and others altered or lost, despite my clear intent to retain participants' own words. For example, interviewee 3 began by describing discrimination against a child who was unable to access a certain provision because of his weight, yet later on began to question for herself whether there could ever be 'fairness' of access to all children, when some imposed too great a risk due to their

behaviour. Through the Content Analysis process, simply identifying words and phrases and categorising them, her progressive, reflective thought process was lost.

As recording units were identified by category, the three categories began to contain lists of original words and ideas, as Boxes 7.7 – 7.9 illustrate.

1. Abstract concepts, principles and rules

Fairness and equality; fair and equal access to resources

Not judging others

Promoting rights of others

Avoiding harm to self and others

Informed consent to treatment

Promoting the best interests of service users / patients

Justice

Being person centred

Anti discriminatory practice; respect for diversity of beliefs and values

Doing the best for the whole group rather than the individual

Ethical reasoning and decision making

Empowering others

Prioritising the needs of children over those of their parents

Prioritising the health needs of health care workers

Placing the patients' interests above those of the practitioner's.

Impartiality

Respect for the self interest of professionals and their families

Legal duty; Duty of Care

Challenge others' poor practice, or their avoidance of responsibility; challenge injustice

Repaying trust placed in you by patients

Make mutual 'contract' with patients

Personal choice and autonomy

Acting within knowledge and skills

Role model good practice to others by doing things properly

Advocating for patients / service users

Look at whole person

Look for reasons for others' behaviours; seek to understand before judging

Withdraw labour / leave student placement if unethical practice taking place

Report to supervisor / manager any unethical practice

Uphold personal principles, beliefs and values; stand up for own beliefs

Observe cultural and organisational practices

Use acceptable language

Protect others' property

Maintenance of clear boundaries in relationships

Box 7.7

2. Personal qualities, skill, ability, actions

Giving of own expertise

Taking personal responsibility for actions

Being prepared and able to make a judgement

Skill in negotiation

Knowing and doing the right thing

Reducing risk to self and others, proactive approach by looking ahead and anticipating

Informing senior staff of poor practice, using workplace policies to know when to do so.

Maintaining confidentiality

Being trustworthy

Receiving guidance, seeking instruction; accepting managerial decisions

Using knowledge to make a reasoned argument

Justifying selectivity in treatment, based on evidence

Seeking information

Knowing when to challenge accepted practice

Having ways of challenging practice from a junior position / student role or from outside group / team

Working to promote the law

Speak up against wrongdoing

Maintaining and promoting health and safety regulations

Confidence and ability to assert right and wrong

Recognition of bad practice

Speaking up against bad practice

Relationship building skills

Being able to listen

Using ethical guidance

Doing things that empower other people

Accepting managerial decisions

Acknowledging own deficits, in knowledge, information, ability

Working with inter-agency conflicts

Working with inadequate resources

Observing the small details of a person's well being; observing health changes to explain other events

Deep personal reflection

Personal competency

Having compassion

Maintaining boundaries relationships; not exploiting others; not engaging in dual relationships

Managing the conflicts between choice / autonomy and best interests

Managing the conflicts between patient's interest and practitioner's

Balancing managerial decisions when own view in conflict

Balancing competing needs of carer and service user

Box 7.8

3. Professional / organisational codes or guidance

Professionalism

Professional detachment and self preservation

Adherence to a code of practice

Adherence to a care plan

Professional Body's Code of Practice

Social Services' Code of Practice

NHS Code of Ethics

Workplace training in ethical practice

Team debate / formal team review of ethical dilemmas

Following work place policies and procedures.

Box 7.9

The three categories represent one way of grouping students' words and their meanings. While many other ways of categorising could have been employed, the categories grounded in the students' words reflect approaches in moral development; that is, principlism and rule-based approaches, relational and communitarian ethics and finally systemic, organisational ethics.

Further analysis shows that by separating the abstract ideas (of principles or rules) from descriptions of *actual* actions and behaviours, it is possible to drill down into the second category to look more closely at the personal qualities and actions described. This category is by far the largest, giving a clear indication of personal qualities, insights and skills students identify as part of ethical practice. I decided to treat this category to its own Content Analysis, returning to original data to repeat the immersion phase 'to pick up all the clues', (Cohen et al, 2000:284) and allocating recording units to new sub-categories.

This time, descriptions fell quite easily and naturally into four sub-groups, although I found myself making many more interpretations based on my inferences. It was necessary to treat words and phrases as *indications of meaning* rather than simply accepting the students' meaning. To balance my critical analysis with respect for the student's stated meaning, I strived to frame each sub-category constructively rather than negatively. For example, at times there were contradictory positions described within a single interview, such as, respecting the importance of doing as instructed by a mentor (or, being a good student) yet asserting oneself when such an instruction was felt not to be in the interests of a patient (advocating on another's behalf). I chose not to interpret these drives as contradictory, preferring to see each as the working through of a real dilemma. Some students chose to explore such conflicts openly and insightfully, whilst others appeared unaware of the contradictory statements they were making. On reflection the interview schedule itself might usefully have included a section dedicated to exploring any explicit or implicit contradictions, giving participants time to reflect within the interview. Alternatively, two interviews would allow for early analysis and follow up of such strands in a second interview.

The four sub-categories developed from the second category of personal qualities, skills and abilities are:

- ways of being and qualities
- self knowledge and control

- having and applying knowledge
- 'doing', or actions, skills and ability

Box 7.10 shows the original recording units contributing to each.

Ways of being, qualities

Being prepared and able to make a judgement and / or reach a decision

Doing the right thing (even when this means standing out from the group, challenging a senior person)

Being trustworthy

Having compassion

Being a good listener

Being competent in the basic skills required to do the job.

Knowing self and having control over own behaviour

Engaging in deep personal reflection; thoughtfulness

Maintaining boundaries in relationships, not exploiting others or engaging in dual relationships

Acknowledging / having insight into own deficits; in knowledge, information, ability, skill

Taking personal responsibility for actions

Taking guidance and instruction from others and accepting managerial decisions AND knowing when / how to challenge such decisions (being prepared not to conform to group norms or pressure); even from a position of junior or subordinate (student) status.

Having and being able to apply knowledge

Knowing what is poor practice, how to recognise it and when / how to report it

Knowing work place policies, codes of practice, ethical guidance local and national

Knowing right and wrong; knowing basis for such a judgement (personal values, law, workplace guidance and policy)

Developing expert knowledge and being able to share this

Knowledge of the law – Health and Safety, Data Protection Act and confidentiality and putting them into practice, promoting their use and maintenance

Knowing the evidence base (worth) of an intervention AND how to make a reasoned argument (of which evidence may be a part)

Knowing the evidence base in order to make decisions to select / prioritise some for treatment over others with same need

Knowing how to seek / acquire and use new knowledge

Knowing how to use evidence to challenge accepted practice, poor practice or discrimination

Knowing how health changes explain other events; what to look for (observe) in health status / presentation / self report

Doing - skill / ability:

Managing the conflicts between choice / autonomy and best interests; and between patients' and practitioners' interests

Implementing managerial decisions when own view in conflict; challenging when necessary; negotiating skills

Negotiating with service users, carers, families and other agencies / professionals

Giving / sharing own knowledge and expertise with others

Anticipating and assessing risk; and proactively reducing risks to self / others

Speaking up against bad practice and other forms of wrongdoing

Being assertive – especially in asserting what is right and wrong

Building and maintaining respectful working relationships with patients / service users, carers, colleagues, managers, supervisors, mentors and other people working in other agencies AND being able to do so when interests compete, conflicts arise and resources are inadequate

Empowering other people through knowledge and actions

Box 7.10

Having arrived at three main categories and four sub-categories, I wanted to develop key themes which would successfully communicate both the *meaning* of the participants' words and my own *critical analysis* of them. Reflection upon the process of analysis led me to conclude how easy and unsatisfying it would be to choose either one of two divergent courses. Given the subject matter, it is easy to slip into platitudes which describe a high level of commitment by students to values-based practice, or equally easy to take a highly critical approach of their (often) unquestioning repetition of popular terms and concepts.

However I wished to capture both, and deal with the ambiguities within the theme. I therefore give some a dual aspect to reflect instances where aspiration is not necessarily matched by the ability to explain or illustrate, or where doubt and conflict between what *should* be felt and what was actually *being* felt was apparent. I studied the categories and sub-categories themselves, searching for meaning by reconstructing what had been deconstructed through the process of analysis. I am presenting upon six over-arching emergent themes which combine some categories and include all, incorporating various aspects from different interviews. The final themes reflect *what* students explained 'ethical practice' to mean to them, with all its challenges.

Emergent themes: Content Analysis

Theme 1. Ethical practice is underpinned by familiar principles including fairness, justice, equality, respect for autonomy and by rules such as always acting in the service user's best interests. Considered fundamental to practice, principles can nonetheless be hard for students to explain in the absence of a real life example.

Theme 2. Workplace environments where laws, policies, standards and codes of practice, effectively implemented through line management, training and supervision, enable students to know and understand how to practice ethically within that setting.

Theme 3. A personal value base, from which decisions on what is right and what is wrong can be made, is integral to ethical practice, as are humanity and compassion for others. Complex dilemmas requiring compromise, test students' personal values.

Theme 4. Ethical practice requires relationships with colleagues who share practical tasks and tacit knowledge, become role models and give feedback, thereby increasing students' self awareness and sense of identity and purpose.

Theme 5. Exercising judgement and influence in ethical issues requires students to have some knowledge of law, policy, good practice guidance and research evidence, as well as a tacit knowledge of hierarchical and professional structures and domains.

Theme 6. Ethical practice requires students to engage with the sometimes complex and contradictory emotions involved in relationships with service users.

Box 7.11

Emergent themes illustrated by students' words

The themes draw upon brief quotes from transcriptions to illustrate each one in the students' own words.

Theme 1. Ethical practice is underpinned by familiar principles including fairness, justice, equality, respect for autonomy and by rules such as always acting in the service user's best interests. Considered fundamental to practice, principles can nonetheless be hard for students to explain in the absence of a real life example.

'she was asking – you know, what do you consider ethical practice here – and she was like what, I don't even know what those words mean! And she had to come to me and say, you know, I didn't know what she was talking about, and I said oh you know there are ethics, and morals you know... and she said oh why don't you tell me what you know, and I was like, oh, okay, and I thought I could tell her, thought I could explain to her and then I discovered I couldn't – like when you asked me the question at the beginning, it was like, I couldn't really answer the question, well it's ethics isn't it?'
Interviewee 2.

I did an essay last year which was talking about paternalism, you know, how it's the health professional who imposes their view of what is right on the patient and I don't agree with that, I think that the patient should be involved and that's an ethical situation in its own right because if the patient doesn't agree with the professional then who's right?
Interviewee 5

Interviewer. What do you understand by the idea of ethical practice?
Student: Treating people equally and being just
Interviewer: Tell me more
Student: It ties in with the non judgemental bit - all about treating everybody as equals, equal to yourself and to any other person, client
Interviewee 1

'a situation at work, when you are working with people when you are in a situation where you're actually .... responsible for people or a person, and how that person's been treated, if it is, mm, if they have consent, if they have, um, if they understand what they've sort of agreed to, what they want to do, if they have consent for what you're doing to them or for them, um, really is it in their best interests, is it something that is fair, just, right, in their eyes, in their life..?'
Interviewee 3.

Theme 2. Workplace environments where laws, policies, standards and codes of practice, effectively implemented through line management, training and supervision, enable students to know and understand how to practice ethically within that setting.

'there are policies and procedures in most companies and organisations and there are usually, um, statutory bills as well that tell you what is the right thing and what is unacceptable behaviour and actions and there are also, picking up things from your line managers and supervisors, things that are deemed to be correct within that particular organisation'.
Interviewee 6

'I know that if I go into that team and I come up with something that I think is wrong or that we're not doing it in quite the right way or that there's something not quite right, I know that it will at least be looked into, or that there will at least be a discussion about it or an investigation into it'
Interviewee 6

Interviewer: Do you think you have now changed – if you did see something that you thought was really wrong – would you confront it now?
Student: Um – in a health setting? Yes, yes I think I probably would – it depends upon the situation but I would certainly, not necessarily do it alone –

I would certainly say something to my team leader – and ask her what the next step was to make sure that they felt – how confident they felt in it, even as a team leader, did they see it as a, you know, worth actioning, or did they feel that I was really, you know, don't need to take any steps...
Interviewee 3.

'Our manager is wonderful, I don't know how she does it but she manages to remain a human being. She is very compassionate to me, whenever I've had any issues like this (ethical issue) I've gone straight to her and she's always been incredibly supportive'.
Interviewee 2

Theme 3. A personal value base, from which decisions on what is right and what is wrong can be made, is integral to ethical practice, as are humanity and compassion for others. Complex dilemmas, requiring compromise, test students' personal values.

'I'm very straight down the line, if it's right it's right, if it's wrong it's wrong, there are blurred areas, I'm well aware of that, but I personally have my beliefs and I am not prepared to compromise them, um, you know, to the detriment of other people or myself, I just don't, you know...'
Interviewee 6
'I'm a very black and white person, it's right or it's wrong. I've always been told off for it, I don't really do grey. My husband gets cross about it sometimes, he says "look it's alright to be grey sometimes" '.
Interviewee 5

'I mean there are people who fulfil the contract to the bare minimum level, and you can spot them, because there's no feeling, it's a job and they shouldn't really be doing it. They might be clinically competent, but there's more to it than that, to my way of thinking....'
Interviewee 5

'I used to go home absolutely raging about it, but I've learnt now that it's the way that they are and it's the way that I am and some people will make an old man wait for an hour for a cup of tea because it's not tea time and I just go and make him one and that's the end of it, because I can't see the big deal...'
Interviewee 5

Theme 4. Ethical practice requires relationships with colleagues who share practical tasks and tacit knowledge, become role models and give feedback, thereby increasing students' self awareness and sense of identity and purpose.

'You want to emulate the fabulous people and in a negative way, you learn from the people who are not nice, who are not good as practitioners, so they are very, very formative experiences. I don't see how you can progress morally and ethically with any form of understanding without the contact that you gain through the placements. It's not something that you can just pick up from a book'
interviewee 5

'I'm trying to, you know I'm trying to get this working alongside thing with her (Health Care Support Worker) so that we go to places together – she has been told to help the therapy team, so I say, "right, let's go and see X together and we can do some bench work with her then I'll come and help you with the gastro-feeding" '
Interviewee 3

'I get on well with the teachers, I really enjoy watching them, in the classroom, and learning about their education in the classroom, I don't feel like an outsider completely, because I... I can connect, I feel that I can, you know, it's part of me seeing the child as a whole, it's seeing the classroom, seeing them in their classroom situation and when I'm doing a therapy programme with them, you know, I always communicate with the teacher, you

know, 'how are they today? You know, what are you doing today and is there anything I need to know about this child before I take them?', but I mean my communications with the teachers, are, I think, are you know, open, quite good...'
Interviewee 3

Theme 5. Exercising judgement and influence in ethical issues requires students to have some knowledge of law, policy, good practice guidance and research evidence, as well as a tacit knowledge of hierarchical and professional structures and domains.

'where to find information, that's the important thing now, is exactly what information I'm looking for, I know exactly how to find it, whereas before – I knew the information would exist and I knew vaguely about it, but how can I get hold of it was a debate we had – the rehab department contained information but now I know how'
Interviewee 3

'So that for me would be somewhere for me where you would have to start thinking 'if I stay here then I am condoning these conditions and I can't do that' and you could be expected to go back to your coordinator and say 'look, I don't want to stay at this place, it's filthy dirty, they're not prepared to do anything about it, I've offered to help, they're not interested, find me somewhere else please'.
Interviewee 5

'coming from a therapy angle, working with the teachers, I've been treading really carefully as a therapist, because we come as Child Health into the school, you know, so that's for specific children with specific programmes, and so I see an infringement on the teachers and the Head, if I was to start asking – I'm careful about what questions I ask, or what I find out, in case, of what I've seen in such an ethical area, um, that's the Head, she's the Head, that's her school, and that is her therapy room'

interviewee 3

Theme 6. Ethical practice requires students to engage with the sometimes complex and contradictory emotions involved in relationships with service users.

I personally believe that if she does not want our input then we should not be going in, and we should respect the fact that she does not want us to visit her because it's her home and she has a right to privacy and she has a right to her own independence and dignity and I feel that we're compromising that
Interviewee 6

Interviewee: 'all the preconceptions that I had about mental illness but no actual knowledge, just the sort of, um, tabloid preconceptions of it and that's – well I've had three placements now in mental health and my outlook on that has changed completely
Interviewer: In that you now don't have those same preconceptions?
Interviewee: I think I am still have some of them to a degree and some of them are there for a reason - people have mental health problems and there are ... things attached to that – like there's no getting away from the fact, well, that if it wasn't a problem it wouldn't be called a problem. There are symptoms connected with these things, but it's a matter of the way you use that knowledge and so that you can suspend judgement... '
Interviewee 1

'if you have a Jehovah's Witness who doesn't particularly want to be treated then you have a problem and you have to decide how much you can force on somebody I suppose, for their own good and if that conflicts with what they consider to be their own good then you're still up a gum tree.. '
Interviewee 5

'I suppose maybe out of a sense of 'look I'm not going to do this' – in some ways it is very difficult and my mentor was absolutely brilliant and she never

said to that I had to go in and help this mother – I had no problems because I had done it in my work role but I'd be perfectly honest in saying "whose place is it to do this – is it ours?" '
Interviewee 4

The Research Question and Objectives

Is the research question answered by the six overarching themes or any of the objectives addressed? This analysis does not directly answer the question of how curricula can prepare students for practice, but succeeds in addressing three key objectives:

- In-depth interviews reveal *what* students understand to be ethical issues and ethical practice in work settings, and identify those considered to be morally challenging
- Students share ways in which they cope with or resolve such issues, and whether on occasion they do not. They also share *how* they reason and articulate their thinking and decision-making processes, including feelings of ambivalence and uncertainty
- Students reflect deeply on their learning experiences in the workplace, less so on classroom based learning.

This first analysis seeks to discover what students consider ethical practice *to be*, in order to understand their perspective and capture the essential features of their experience. This provides a starting point from which to appraise the curriculum, so that the broader purpose of introducing effective learning and teaching strategies might be furthered. The emergent themes suggest that students consider ethical practice to be multi-factorial; in their summation, workplace rules and policies, personal values, knowledge, relationships with colleagues, managers and service users all play a part.

Themes also indicate a very clear focus on local practice and immediate relationships, with less confidence in discussion of more abstract concepts (although such ideas were the starting point for some interviewees). The expressed lack of confidence, alongside some very competent and insightful descriptions of ethical practice, suggests a dissonance. Students involved in everyday dilemmas, seem to think deeply about them. They contribute practically and intellectually to finding solutions, but some still express a lack of certainty when

discussing their contributions. This suggests learning may be most effective when *embedded* in their own everyday experiences, from which connections are made to broader principles or societal issues.

The over-riding emphasis on work place experiences, work relationships, policies and supervision is salutary to an educator using traditional classroom based methods. This suggests the richness of experiences, gained amongst people receiving and delivering care, makes the workplace the pivotal learning environment. The classroom can provide or facilitate knowledge production and importantly, a place to engage in reflection and debate. However findings suggest that without the engagement in caring activities, learning will be severely restricted.

All six themes can be recognised in the patient- or user-centred doctrine of Government policy or existing theory and research. Considering the body of research, this is not surprising. Indeed, it is reassuring that the students interviewed, cover so much of the ground explored in the literature review, albeit fleetingly and not in depth. Interestingly, those who discussed personal values asserted their origins in family and life experiences, and as *constant features* rather than aspects of themselves subject to change and influence.

In summary

- A grounded form of Content Analysis, using students' own words to understand what they consider ethical practice to be, allowed six overarching themes to be developed.
- Themes reflected current 'user-centred' doctrine or existing psychological and philosophical theory, reinforcing findings from other studies and theoretical perspectives discussed in the literature review.
- The analysis contributed indirectly to the research question by highlighting the pivotal role of the workplace in learning.
- Themes generated directly address three key objectives of the study.
-

Chapter 8: Findings - How participants construct their moral identity

This chapter will focus on the conversations taking place *within* interviews, using Discourse Analysis (Silverman, 2006). The aim will not be to look for themes crossing all six interviews, but to look to the dialogue to reveal *how* students are uniquely forming and describing their moral identity.

Analysing the Discourses

Rapley (2004, cited in Silverman, 2006:137) described the 'what' question to pertain to 'cultural stories' and the 'how' question to evoke 'identity work'. The latter - how do students construct their moral identity? - will be the province of this analysis. Like the Content Analysis, findings will be grounded in actual transcripts. All interpretations will be identified as such and their basis explained. Sack's Membership Categorisation Device (MCD) introduced and described in Chapter 6 will be the basis of this analysis (cited in Jefferson, 1995). This will be briefly revisited to describe its application to interview transcripts.

Sacks described Membership Categorisation as the creation of 'collections of categories for referring to persons' (Sacks, in Jefferson, 1995: 1: 238). In order to decide upon categories, the transcripts were read and re-read, with any reference to 'a person' highlighted. A long list of people emerged, many falling into natural categories according to similarity of role. The easiest to categorise included those called by the same name or title, however many descriptions were used to describe people using services, such as 'patient', 'person', 'the individual', 'service user', and 'child'. For the purposes of this analysis, a *category* will refer to the term used for a specific role, for example, mentor.

Grouping together these categories into the broader 'sets', (that is, groups of categories involved in the same or similar activities), required difficult decisions to be made. How many sets should be created? How should those who might, as easily, be placed in two different sets, be placed? In the end, I based my decisions on *similarity* of description in the actual transcripts. For example, most students referred to the individual supervising their University work placement as their 'mentor' but one used the term 'supervisor'. I placed both in one set,

as their *role* (or as Sacks called them, the category-bound activities in which they engaged) was clearly the same (Sacks, in Jefferson, 1995: 1: 24). When a person, clearly acting as a mentor, was referred by profession or job title, I placed that person into the mentor 'set'. I also had to count and use pronouns used by students when referring to self. These included: 'I', 'me','we' and occasionally 'my own'. To a lesser degree, this was necessary with others referred to, but generally students called people by their job role or by relationship (such as 'my friend' or 'our line manager'). This was the first instance of interpretation and judgement being required, which would significantly influence the future direction of the study. However the technique of MCD makes it imperative to make such choices, especially as there is no guidance on such detail in either Sacks' lectures or Silverman's examples (Sacks, in Jefferson, 1995; Silverman, 2006).

Twenty two 'sets' resulted from this first trawl. I was looking for any references between sets, to issues or exchanges of any type of 'ethical' nature, in the broadest possible sense. This included any expression of caring, judgements, disagreement about an action, or any expressions regarding right or wrong, to mention a few. The aim of this search was to establish *who* students talked about when describing such issues, in order to gain a different and less impressionistic perspective on their conversations. After highlighting every such reference in all transcripts, I began to collate the 'pairings' identified in the references. For example, in a long description of an incident, the student might describe what she said to a patient, what her supervisor said to the patient's wife, words exchanged by her and her supervisor following the visit, what she thought was right and what she did to help the patient on returning to the office. I began to count the numbers of such references made between the various sets, to develop a picture of who the student described talking with or acting towards. This resulted in a numerical data set of pairs of sets, with numbers of exchanges made.

By focussing on the people and relationships, I hoped to access the *social world* of the students, as opposed to their inner cognitive or intellectual worlds. The approach also enabled a systematic method of extracting data, which could then be viewed in different ways. The following quotes are examples of the kind of pairing (underlined) identified between 'self' set and 'service user' set:

> *'the trouble for me is that a lot of it does end up coming down to finances that are out of my hands as a practitioner but the way <u>I get round it is by teaching the person</u>*

coping strategies in order to do the best I can which is where I see ethics being' (Interviewee 1).

'so I personally believe that if she does not want our input then we should not be going in, and we should respect the fact that she does not want us to visit her because it's her home and she has a right to privacy and she has a right to her own independence and dignity and I feel that we're compromising that' (interviewee 6)

The next quote is an example of a pairing made between a 'mentor' set and 'service user' set by the student:

'she (mentor) *said "ah yes well I was forging a new relationship with this woman and I didn't want to isolate her from the beginning"' (Interviewee 2)*

From the twenty two sets, twenty seven pairings were made. Table 8.1 shows the outcome of this first tabulation.

Table 8.1: Numbers of times interviewees paired themselves with others, or paired sets with other sets

Membership Categories grouped into sets	**Student 1**	**Student 2**	**Student 3**	**Student 4**	**Student 5**	**Student 6**	**Total**
Student : service user / patient / child	24	17	14	2	26	33	**116**
Student : mentor	0	11	0	14	15	6	**46**
Student : colleagues in multi disciplinary team	5	13	11	0	0	13	**42**
Health care and Social Work professionals : service users	0	4	1	0	16	4	**25**
Student : health care and social work professionals	7	0	3	1	4	7	**22**
Student : other students	1	3	2	11	2	1	**20**
Student : Lecturers / placement coordinators	0	0	1	0	9	6	**16**
Student : own family	0	2	0	0	10	4	**16**
Student : family member of service user	0	3	2	5	2	0	**12**
Health Visitor : mother	0	5	0	6			**11**
Student : own manager	0	3	5	0	0	2	**10**
Health professional : child	0	3	3	7	0	0	**13**
Student : teachers	0	0	10	0	0	0	**10**
Health care and social work professionals : service users' family members	0	0	0	0	3	7	**10**
Student : team on work placement	0	1	0	8	0	0	**9**
Student : Health care assistant	0	0	5	4	0	0	**9**
Student : own friends	1	3	0	0	1	2	**7**

Mother : baby	0	2	0	3	2	0	**7**
Health and social work professionals : other students	0	0	0	0	5	0	**5**
Service user : service user's family member	0	0	0	3	0	1	**4**
Teacher : children / pupils	0	0	4	0	0	0	**4**
Toddler : baby sister	0	4	0	0	0	0	**4**
Multi disciplinary team : health care assistants	0	0	7	0	0	0	**7**
Colleague : manager	0	3	0	0	0	0	**3**
Student : head teacher	0	0	3	0	0	0	**3**
Health care team : teachers	0	0	1	0	0	0	**1**
Student : neighbour	0	0	0	0	0	1	**1**
Totals of all pairings made through interviews	**38**	**77**	**72**	**64**	**95**	**87**	**433**

Refining Data Sets

This first exercise enables the interviews to be viewed from a new perspective. Analysis of one interview resulted in 38 instances of the student pairing self or others to others, whilst analysis of another showed 95 such pairings. Some interviews are longer than others, but are not necessarily the ones which generate the most pairings. It appears that some students simply talk more about people. Others talk more about ideas, in response to the same interview questions. Although interesting, the tabulation was unsatisfactory in that some sets were really only categories (for example, 'mother'), while others were a subset of a bigger set (for example 'health care professionals' was a sub set of 'health and social work professionals'). Sets were revisited, regrouped and recounted. Table 8.2 shows how pairings can be viewed when sets are regrouped by type of relationship to the student or to each other.

Table 8.2: Sets further grouped into larger sets to show where pairings are made.

Membership Category	**Student 1**	**Student 2**	**Student 3**	**Student 4**	**Student 5**	**Student 6**	**Total**
1. Total pairings made by student between self and service users and their families							**128**
Student : service user / patient / child	24	17	14	2	26	33	**116**
Student : family member of service user	0	3	2	5	2	0	**12**
2. Total pairings made by student between self and placement mentor / supervisor							**46**
Student : mentor	0	11	0	14	15	6	**46**
3. Total pairings made by student between self and lecturers and placement coordinators							**16**
Student : Lecturers / placement coordinators	0	0	1	0	9	6	**16**
4. Total pairings made by student between self and others in a workplace setting							**105**
Student : team on work placement	0	1	0	8	0	0	**9**
Student : colleagues in own workplace team	5	13	11	0	0	13	**42**
Student : health care and social work professionals	7	0	3	1	4	7	**22**
Student : own manager	0	3	5	0	0	2	**10**
Student : teachers	0	0	10	0	0	0	**10**
Student : Health care assistants	0	0	5	4	0	0	**9**
Student : head teacher	0	0	3	0	0	0	**3**

5. Total pairings made by student between self and others in personal network							**44**
Student : other students	1	3	2	11	2	1	**20**
Student : own family	0	2	0	0	10	4	**16**
Student : own friends	1	3	0	0	1	2	**7**
Student : neighbour	0	0	0	0	0	1	**1**
6. Total pairings made by student between health and social care workers and those using services							**63**
Health care and Social Work professionals : service users	0	4	1	0	16	4	**25**
Health Visitor : mother	0	5	0	6	0	0	**11**
Health professional : child	0	3	3	7	0	0	**13**
Health care and social work professionals : service users' family members	0	0	0	0	3	7	**10**
Teacher : children / pupils	0	0	4	0	0	0	**4**
7. Total pairings made by student between family sets							**15**
Service user : service user's family member	0	0	0	3	0	1	**4**
Mother : baby	0	2	0	3	2	0	**7**
Toddler : baby sister	0	4	0	0	0	0	**4**
8. Total pairings made by student between other sets of workers within workplace							**16**
Health and social work professionals : other students	0	0	0	0	5	0	**5**
Multi disciplinary team : health care assistants	0	0	7	0	0	0	**7**
Colleague : manager	0	3	0	0	0	0	**3**

Health care team : teachers	0	0	1	0	0	0	**1**
Total linkages made in all sets							**433**

Eliciting meaning from the data

The eight combined sets might easily be divided or grouped in different ways. However this grouping enables a closer look to be taken at the number of times students refer to others in different sets. For example, students make more references to their own interactions or experiences with *service users* and *service users' family members* than with any other set (128 out of a total 433 counted, or 29%). The number of times such links are made in conversation can be compared in Chart 8.1.

The next largest group students linked themselves with, were their *colleagues, managers and supervisors* in both student placement workplaces and their own work places. Over half the total pairings made by students were with service users, their families and with people in the workplace.

Whereas both these sets are made up of many different categories of individuals, one single category was linked to self by students in 11% of references made. This category was that of *student mentor or supervisor*; that is, the person supporting them during their student placement. Of all the people students referred to in relation to themselves, these three sets of people comprise 64% of the total. Only another 14% of personal references are made about others: 10% to informal networks including family and friends, and 4% to university lecturers.

Chart 8.1: Numbers of linkages made within interviews between different sets.

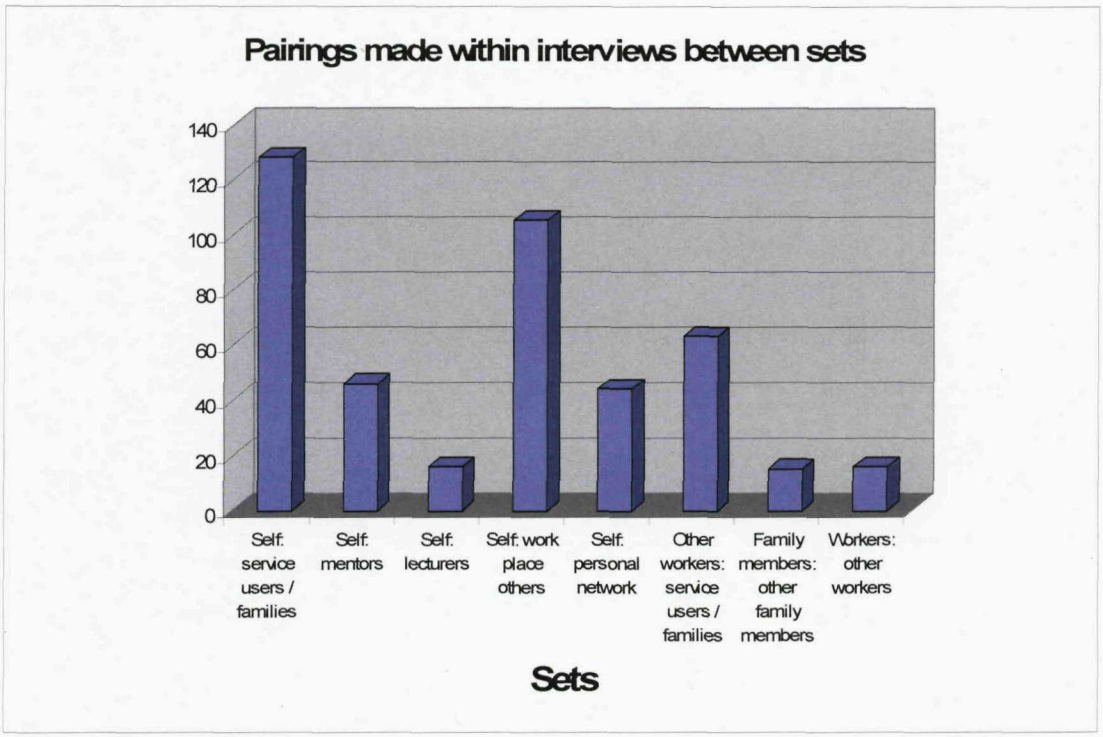
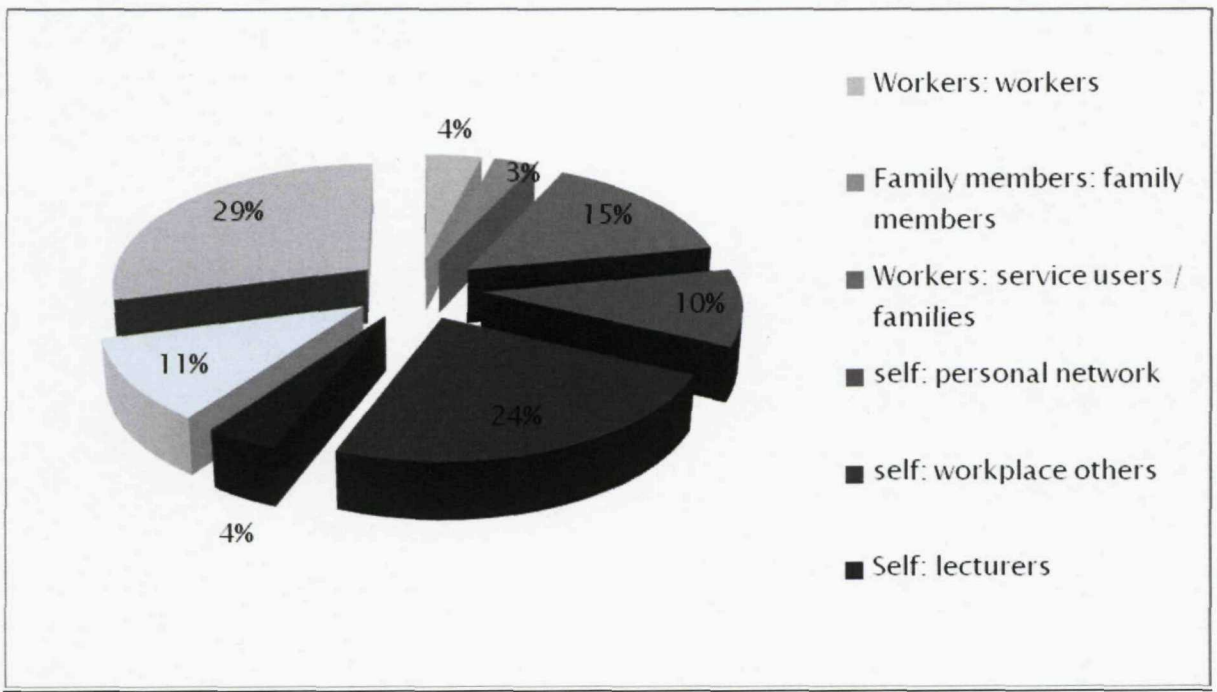


Chart 8.2: Links made presented as % of total.

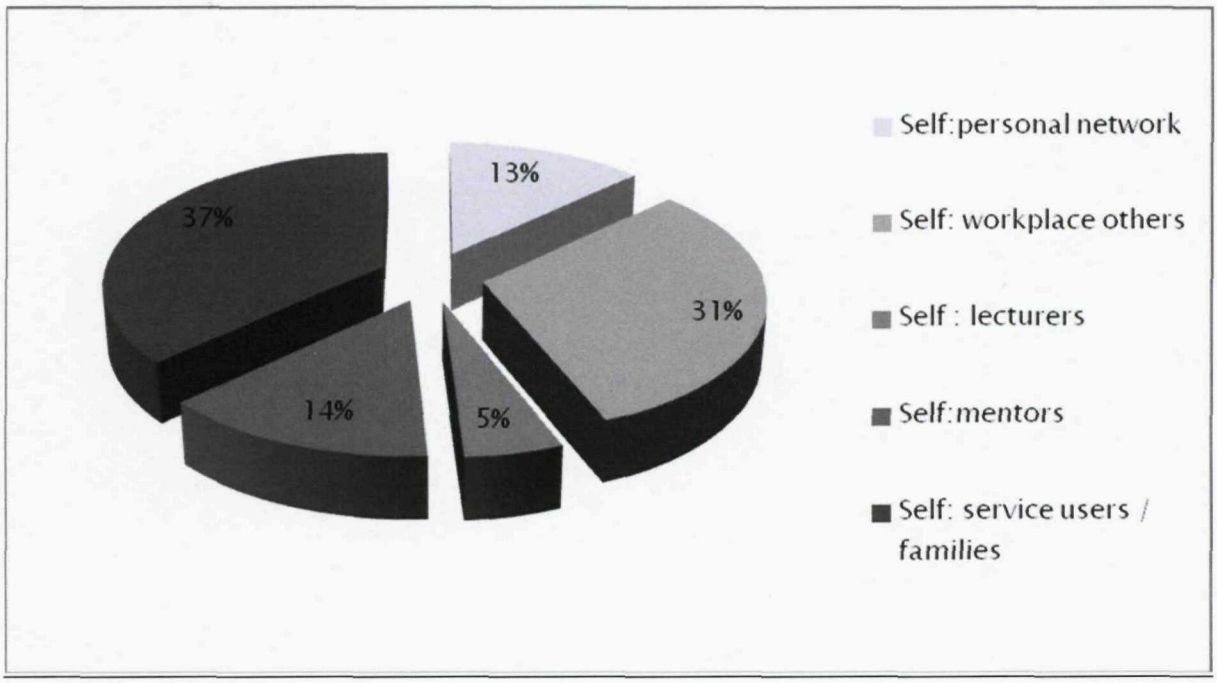


Of the remaining 22%, students discussed sets in relation to other sets. Of this section, most references were made to the relationships or interactions taking place between a 'worker' and

a 'service user or family member' (63 out of a total 433 or 15%). The links made between these two sets may well be relevant to those about to be explored - that is, those between the student and other groups - however they will not be explored in any depth themselves. The two remaining sets, linked with other sets, constitute only 7% of the total combined so will only be referred to if there is relevance to the main exploration.

Students' references to *self* and *other sets* will now be considered in more depth. If only these sets are considered, with 'self' constituting 100% of interactions, the overall proportions look as Chart 8.3 shows:

Chart 8.3: Linkages by % made to self and others



By representing the data this way, it can be seen that over one third of pairings are between service users and families and almost another third with work place colleagues. The remaining 32% of links made, are between the student and mentors, personal friends and families and university lecturers. This is not surprising given that the main subject of interviews is practice, and ethical issues experienced in practice. However all students were asked directly about the influence of their education, so the very small percentage relating to educators could be seen as significant.

The pairings counted are inclusive of all types of discussion and description. Some very clearly refer to an ethical choice or dilemma, such as the decision to remain with a dying woman. Others refer more generally to practice, such as the one cited above, in which a Health Visitor describes trying to build a relationship with a mother. However the data presented, so far, simply *quantifies* how many times students talked about different people in a particular way; that is, by associating them with themselves or others when discussing ethical issues in practice. The discussions could be positive or negative in nature, or refer to unhelpful relationships or poor practice experiences. This quantitative analysis alone is not enough to base any judgements upon, although it suggests a direction worthy of further exploration, given the marked differences in the amount of times specific groups were discussed. The next stage of this analysis will utilise the original transcripts to explore students' descriptions of these interactions, working through each of the five sets with which students paired themselves.

Service Users and Families

Service Users, their families and their impact upon students' construction of identity will be considered first. In all interviews, students linked themselves with Service Users more than once, the smallest number of times being twice and the most being 33 times. Four students also made more than one link to service users' families as well. Table 8.3 shows the range of pairings made in all interviews.

Table 8.3: Total linkages made by students between self and service users / family members.

Membership Category	**Student 1**	**Student 2**	**Student 3**	**Student 4**	**Student 5**	**Student 6**	**Total**
Total pairings made by student between self and service users and their families							**128**
Student : service user / patient / child	24	17	14	2	26	33	**116**
Student : family member of service user	0	3	2	5	2	0	**12**
Totals by student	**24**	**20**	**16**	**7**	**28**	**33**	*128*

Interview transcripts were revisited to ascertain the nature of the pairings made, and to test out the importance of service users and families in students 'identity work' (Rapley, 2004, cited in Silverman, 2006:137). In all except one, students chose to describe situations in which they had taken a firm ethical stand, feeling sure or 'knowing' they were in the right. A typical expression of this was: 'I don't think I was conscious of there being a wrong thing to do – there was only one course of action for me' (Interviewee1). All such discussions related to positive experiences of asserting the right thing to be done and achieving a successful outcome for service users, who again in all but one interview were talked about as people of importance to the student. One said: 'I think the patients themselves are very formative, um, because the people on the placements have such a massive impact, good or bad' (interviewee 5). It is likely that a student being interviewed by an educator will bring stories and anecdotes which provide evidence of their own moral adequacy, not the reverse, so a more detailed examination of a section of two transcripts will be made to further examine such a description. The first will explore an action recalled by a student and the second will consider the importance placed on the relationships developed by students with a family member.

In the first section of discourse, a student is describing what happened in a consulting room between a mother, her toddler and baby, a Health Visitor and the student. As the wellbeing of the children is the primary consideration of such a clinic the toddler and baby are treated as the service users in this example.

Discourse 1: Not watching a documentary

Student: The little brother jumped up before baby was being changed. There must have been a changing mat on there as well, which would explain why he had so little room, a very small amount, maybe that much *(places hands about 1' apart),* and he'd jumped up there, and there was no 'okay you're going to sit up here and sit still', and no, 'why don't you go and see the lady and play with the tractor', and he was fidgeting and it was his foot, twice I put my hand out to actually stop him kicking her head, while she was on the changing mat, and they were both looking at each other, obviously aware that he was here and they must have known he was kicking, you know it would have been in their peripheral vision, you know it was a movement, but there was no addressing that situation, they were just talking about 'how much does she weigh, and how is she looking'

Interviewer: *Both focussing on the baby....?*

Student: ...and on each other, yes, and I thought well maybe they're not focussing on him because I'm here, maybe they think there's another adult in the room who can sort it, and that's partly what gave me the courage to take him off the couch

Interviewer: *So you began to work out then, 'maybe there is an expectation of me to do something'?*

Student: Yes, I'm not the invisible shadow that I thought I was! I think sometimes when I'm observing that I am watching a documentary, I forget people can actually see me and I am a presence in the room and I am just in a uniform

Interviewer: *But then something changed in your day*

Student: Yes, quite, yes, and also because the fact that he hadn't, they hadn't said anything to him, made me think that maybe that was because he wouldn't listen, maybe he had some sort of behavioural thing where, that wouldn't have made a difference, I was very prepared for him to get quite angry at me, when I said let's go and play in the corner, and I said 'Do you want to come and play in the corner?' – 'Yeah okay' and he put his arms up! For me to carry him – and I thought 'how simple was that? I could have done that before'. I was expecting some real ''no I want to sit here' so I picked him up and we played on the farm with his truck, and um, then when they were ready to leave they went off, and I mentioned to the HV that I wasn't happy

Interviewer: *So did you think about yourself differently when you were in your student uniform again – did you have that feeling you just described – this isn't a cinema, this isn't a documentary?*

Student: Yes – for the rest of the afternoon I integrated more with the mums that came in and started to be really interested in them, communicate with them, it just gave me a sense of, that I am part of this and a presence

Student 2

The student, after setting the scene, recalls her reasoning as she assessed what she considered to be a risky situation for a small baby. She describes the absence of a response from the baby's mother and the Health Visitor, who she felt sure were also aware of the danger posed

to the baby, but for some reason unknown to her, had decided to do nothing about it. There is implicit criticism when she describes them focussing 'on each other', suggesting that the baby and toddler should have been the focus of their attention. She then describes thinking that maybe their lack of response was in some way indicative of an expectation that she would act. She remembered this thought giving her the 'courage' to act – the quality considered essential to ethical practice by psychologists in the USA (de las Fuentes et al, 2005:362). Courage may have seemed necessary, as she had begun to think possibly the toddler had a behavioural disorder or similar condition and would react angrily to her overture. Alternatively, it may simply have seemed necessary simply in order to act in the absence of a direct instruction.

Believing this action was expected of her provided a catalyst for action, raising the question: would she have acted differently if she had believed that her intervention was not wanted or required? She describes the *necessity* of a direct intervention, provoking the realisation that she is a responsible adult with the power to act, rather than a passive observer of 'a documentary'. Interestingly she attributes a sense of engagement with other parents later that day, to this successful intervention. In her own words 'it just gave me a sense that I am a part of this'. My own prompt could be seen as leading, as I asked 'But then something changed in your day', introducing the possibility that this was more than simply a moment's awareness. My wish to encourage the student was probably the motivation, however the prompt can be seen on reflection as unnecessarily suggestive. The warm response she received from the child confirmed to her that this was the right thing to do and even that she should have intervened earlier. Again it is interesting to consider whether this experience would have been selected for discussion had the child's response been negative or hostile, or whether such a reaction would have caused her to question the rightness of her own decision.

Considering just this one incident of several recalled by the student, it is possible to identify the importance of a successful response from the child, although none of us, including the student, know the effect of a negative response. She experiences a sense of engagement following an independent act she considered 'right', and for the benefit of that child. Later, she is told by the Health Visitor that her own priority had been engagement with the mother ('she said "ah yes well I was forging a new relationship with this woman and I didn't want to isolate her from the beginning'). Nonetheless for the student the priority is clear: 'it was something to me that was very black and white which obviously to her was shades of grey'.

This tension between the *immediate need* of the service user (both children and adults) and the *longer term needs of family members* came up in three other interviews. In all, the students prioritised the service users' immediate needs while describing more experienced team members' prioritisation of families' needs. The rejection of 'grey' was also a feature of other interviews. Perry (1968) identified this 'black and white' stage as the first stage of development, in which a right answer is considered to exist, unlike later stages when the 'crisis of relativism' is experienced as learners recognise there may be no single right answer, only different choices.

In the second section of transcript to be analysed, a different perspective is taken of the role of the patient and their carer. This time, the student describes learning – about others and herself – from the interaction with the patient's wife, offering advice to myself as educator on ways to support students to engage more actively during work placements.

Discourse 2: Who are you to them?

Interviewer: *Is there something else we can do?*

Student: I think it would be worth, maybe telling the first years - this is maybe what happens, so that they are aware, that there are people they will go and see when they put that uniform on who will look at them as professionals, so that they know, because maybe not everybody realises it and there's all sorts of things, you know, particularly in the first year you go along, you're very much in an observational role, you stand in the background and you feel like a complete, you know, like rain on a washday, no use whatsoever, and you think, I can't, nobody's getting anything out of me being here, but they are, and the opportunities are huge, for people to actually understand what's going on and the way people look at them, and how they're perceived. There's lots to learn, it's not just about watching what the district nurse is doing, watching someone give an injection or something like that, it's not just about that, it's about your interactions with people, with patients as well.

Interviewer: *Some will be more receptive and others less, but there may be some mileage in raising a student's consciousness of that sense of investment in them- ?*

Student: Particularly if they haven't worked in a health care setting, yes, if they already do then they're probably aware at some level but people that come into it thinking they may

want to go on and do something that they haven't before then yes I would think it was worth it actually.

Interviewer: *You could do that in all sorts of ways, Codes of Conduct don't exactly hit the emotional bit*

Student: But if you were to say to a student 'you know, if you go into somebody's room, they've got cancer and the nurse is with them – how do you think they are looking at you? What do they think of you, what do they think you are there for and who are you to them? I went to see one person with the District Nurse who had cancer and the District Nurse went to see the patient and I stayed out in the kitchen with his wife and I had never set eyes on her before, it's my first day and she wanted to know all about going into hospices and whether she could get any help with the medication and you know was there going to be a new bed and did I think it was all going to be alright nurse? And that was my first visit, first day and I was completely clueless….and some people just want to talk, they just want an ear, you know, it's, I think it's an important relationship, being a student you can give something back

Student 5

In describing her own feelings, the student echoes the earlier sentiments regarding worth. Until discovering that important learning can take place about oneself, and about relationships and interactions, her sense of worth appears to have been based on 'usefulness' to those using the service (or even clinical expertise and skill). When asked her view of students' awareness of the investment others make in them, she differentiates between those with some experience who appreciate such an investment and 'people that come into it thinking they may want to go on and do something that they haven't before'. The latter suggests a more self-centred approach to placement.

By inviting students to see themselves through the eyes of a service user, the interviewee could be seen to be appealing for empathy rather than the undermining self-consciousness she herself experienced. By asking 'who are you to them?', she invites students to engage in a process of meta-cognition, in which they not only imagine being someone else, but then look through that other person's eyes at themselves. Such a process forces an interesting and contradictory series of emotions, through which a useful sense of perspective may be gained.

In describing her interaction with a (probably dying) person's wife, the student reflects upon both her sense of 'cluelessness' and of the wife's need for a sympathetic listening ear. Although the wife will no doubt require answers to all these questions in time, the student is able to see her own contribution in perspective instead of disparaging herself for not knowing the answers. This example does not show the student in a glowing light or a negative one, in fact she talks little about what she said or did but describes instead how she felt. Her reasonableness and mature approach to learning may reflect a desire to appear this way in the interview situation. It is highly probable that such qualities would be valued by someone expressing such views. Nonetheless the reflections she shares show a good deal of thought about how she herself used those early, uncomfortable feelings of not being 'useful' to good effect over the longer term.

Both students deal differently with the sense of being peripheral to the lives of those with whom they were intending to dedicate future careers. One has learned that action helps her to become engaged and the other describes a thoughtful and reflective approach. Both discussions support the importance of the service user and their family, whether children or adults, in the student's construction of a moral identity. The child in the first discourse, by giving immediate, positive feedback, reinforces the student's decision to act, leading to develop a sense of engagement. In the second, the wife's concerns provoke reflection and self examination, leading to a different perspective on the kinds of relationship students are able to develop.

Unlike these discourses, Student 4 does not talk very much at all about the service user, pairing her with herself only twice. This transcript will be considered next, to test whether this person was formative in the student's moral identity construction or whether this interview constitutes a 'deviant case', (Baruch, 1982, in Silverman 2006:142). In this interview, the student recalled a situation in which she participated, with her mentor, in a task she would have refused to carry out in her normal job. On reflection, she decides she was wrong to participate and blames this on her own lack of assertiveness when in the student role. The intervention proved nonetheless to be very beneficial to the service user's two young daughters in the longer term, leaving the student with a dilemma. This short excerpt from the transcript is a reflection upon this dilemma.

Discourse 3: No one really loves housework

Interviewer: *Were there any ...she wasn't for example taking drugs?*

Student: I don't think she was – not that I know of, I think her mother was – I think, I wouldn't like to say – I think her mother was a drinker – and that her mother was not in control of her life, so it affected her daughter, her mother was just totally .... And when her daughter grew up she adopted that, she wasn't drinking then but had had bad relationships

Interviewer: *Do you think what you were doing would achieve the desired outcome?*

Student: I really am doubtful – her attitude wasn't 'oh how lovely they're coming to help me' – there wasn't the enthusiasm there, and I don't think she finds – no one really loves housework but like I say it does make you feel better when you've done something but she didn't seem to get anything from it at all, more like 'Oh I'm not wasting my time' – really trying to get her to tidy up, so that she could have friends around, because we said 'friends don't want to come into this mess, if you make it nice you may have a better social life' but she couldn't quite grasp the concept of what we were talking about so I don't know whether it will change – I think the situation will more than likely stay the same until the girls, possibly, maybe as they get older they'll just get wiser and be 'I don't want to live like this'.

Student 4

The description of the service user's mother, suggests the student considers behaviour patterns to repeat themselves through the generations. Even when considering the children's possible rejection of such behaviour in the future, there is clearly doubt: 'I think the situation will more than likely stay the same until the girls, possibly, maybe...'. There appears to be little empathy from the student, who compares the service user's lack of enthusiasm for housework with her own feelings, using the incentive of friends and a social life (which may not even be a feature of the other woman's life). The sentence 'her attitude wasn't "oh how lovely they're coming to help me" ', suggests her own response might have been such, or that a grateful or enthusiastic response may have provided her (the student) with an incentive to help. Again it shows a possible projection from the student of her own values and feelings, leading to a judgemental approach despite her own assessment of the person's limitations: 'she couldn't quite grasp the concept of what we were talking about'.

From this short piece of discourse, it would seem that the lack of pairing of self with service user really does reflect an absence of the kind of formative identification with an individual, present in the other interviews. The dilemma presented to the student by the longer term benefit of the intervention to the children, suggests that these two may provide the student with the touchstone their mother does not. Indeed, there are five instances of her pairing herself with the children through the interview. In summary, this interview would seem to meet Baruch's definition of a deviant case, in that it does not conform to the emerging finding that service users are an important group of people through and with whom students construct a (positive) moral identity. However the fact that it is the only scenario offered in which a student chose to discuss an unresolved dilemma, in which she did not feel certain that she was 'right' but was still engaged in a struggle, militates against this view. By describing work with someone with whom it was difficult to identify or empathise, this student contributes a different perspective on 'identity work' in which the service user and family are actually every bit as important to this student, as to those students who choose to report positive interactions.

Others in the workplace

Next, the influence of others in the workplace is considered. All students talk about someone else in the workplace, whether a colleague, a fellow student, manager or professionals. Some talk about student work placements and others about their own work place.

Table 8.4. Pairings made by student between self and others in a workplace setting

Membership Category	**Student 1**	**Student 2**	**Student 3**	**Student 4**	**Student 5**	**Student 6**	**Total**
Total linkages made by student between self and others in a workplace setting							**105**
Student : team on work placement	0	1	0	8	0	0	**9**
Student : colleagues in own workplace team	5	13	11	0	0	13	**42**
Student : health care and social work professionals	7	0	3	1	4	7	**22**
Student : own manager	0	3	5	0	0	2	**10**

Student : teachers	0	0	10	0	0	0	**10**
Student : Health care assistants	0	0	5	4	0	0	**9**
Student : head teacher	0	0	3	0	0	0	**3**
Totals by student	**12**	**17**	**37**	**13**	**4**	**22**	*105*

All students pair themselves with some or many colleagues. Student 3 pairs 'self' most often with a range of others, and Student 5 (who spoke a great deal about service users) the least. Unlike discussions relating to service users, students relate many varied experiences of teams and colleagues; some very positive and others less so. An excerpt is examined which strikes a balance, in which a student describes managing frustrations whilst working with team decisions. The particular concern the student refers to is the case of a person who does not wish to receive a service, but due to family members' concerns is being seen twice daily.

Discourse 4: There are reasons why she's doing what she's doing

Interviewer: *What are the kinds of things that you justify to yourself, and accept -?*

Student: I don't know, I mean I am the sort of person that tends to go over and over and over and over the same things

Interviewer: *In your mind?*

Student: Yeah, or even verbally because I get annoyed, and I want action and I can't see why it isn't being done

Interviewer: *So you don't accept easily?*

Student: No, no not really not if I can see something especially if I think it's an ethical issue but I can see that there is another side to this and that, that my experience is limited, whereas the experience of the social worker, I think she has been a social worker for 20 years or so, I can see there's more to it and although I'm not happy with the outcome, I think that there are reasons why she's doing what she's doing and that hopefully, I mean because you can never know, whatever decision you make you can never actually be sure that the outcome will be as you wanted, but I'm hoping that what they're planning, because they have planned it, twice a week we talk about all of our patients, about where we're going, what we need to be doing

next, what problems there have been and there will be a case conference if there are continued issues in which the family will be involved and other members of staff as well so I know it's being handled as best they can. I would probably just be a little bit more hot headed because I am so new to everything in comparison to them that I would just say 'no, that's it, finished, we're not doing it, I don't care'

Interviewer: *So there's something there about trusting your colleagues, who have more experience? That even if at some level you agree to differ, you've got a sense of 'well they may know stuff I don't know'*

Student: Yes. Well almost certainly, they won't be doing it for no reason at all, um, but that reason may be because they want to ensure they have a good relationship with the rest of the family because they know they're going to have input with this lady for a very long time

Interviewer: *And do you feel appreciated and supported in terms of your day-to-day difficulties while you carry on with this, because of these other issues - do you think other people appreciate that is quite tough to do this?*

Student: Oh yes, yes - they are fully aware that she doesn't want us there and they know that we do the best we can and they know that each day that she's going to refuse us, but…

Interviewer: *But the effect on you as well – do you think they appreciate that?*

Student: Probably not. Probably they don't think about it as deeply as I have

Student 5

The student describes, at some length, her impatience and tendency to think over work issues. The team system for regular caseload review provides her with evidence that the more experienced team members plan ahead and respect team members' need to air concerns or address more serious problems through a formal case conference. In describing a system in which all are able to contribute openly, she is describing an institutional approach to ethical practice (Zimbardo, 2007:7). Although her assertions are strong, some doubt appears to have crept in: 'so I know it's being handled as best they can'. This suggests some problems are just a little beyond 'them'. This is probably a realistic assessment of long term, complex situations in which a service user's interests conflict with the wishes and concerns of family

members. This dilemma is referred to in a later statement: 'they want to ensure they have a good relationship with the rest of the family because they know they're going to have input with this lady for a very long time'.

Although the student describes her own unhappiness with having to carry out a daily activity with someone who does not want a service, she continually puts this in the context of her own inexperience and 'hot headedness', suggesting the experience of team colleagues is a mediating influence upon her. Perry's 'developmental scheme' (Perry, 1968) is useful in locating the student's movement, from a straightforward assessment that the situation is wrong, to an appreciation of the complexity of trying to achieve a greater good; that is, of managing a person in their own home over a long period of time, whilst maintaining a relationship with family members. The relationships with both the service user and with trusted colleagues created and tested through such dilemmas also support Gilligan's relational theory, in which she asserts that only by engaging with real issues can morality develop (Gilligan, 1982; 1993).

The student's choice to bring this situation for discussion suggests she sees her deep thinking and wish for action as positive attributes. However she also shows insight into the need for these qualities to be tempered by more experienced colleagues. Before concluding on this note however, one question comes to mind: what if the student *was* right in this situation? Lind et al (1985) cited the urge to conform to the will of the group as the biggest single threat to personal morality, and this could be one such situation. The ideology informing what Zimbardo (2007:234) calls 'system power' is person-centredness, a concept well rehearsed by all interviewees. However it is the student who espouses this, and the team which moderates the ideological, with the practical goal of working with the family. The student's description of her own approach and personality is not that of an unassertive conformist (although this is based on self report). The way she describes open discussion taking place within the team also suggests this is not a closed, ideologically driven organisation (again remembering this is based on one person's description).

Workplace mentors

Relationships with mentors are considered next. In both health and social care professions, this relationship is much studied and researched. Different professions have specific mentor

or supervisor training courses which must be passed before students can be placed with them. All the students interviewed were placed with qualified professionals from a range of professions. Not all students interviewed even mentioned a mentor, however. Others talked about them a good deal and in the following interview, the student paired herself with her mentor more times than with any other person or set.

Table 8.5: Pairings made by student between self and placement mentor / supervisor

Membership Category	**Student 1**	**Student 2**	**Student 3**	**Student 4**	**Student 5**	**Student 6**	**Total**
Total pairings made by student between self and placement mentor / supervisor							**46**
Student : mentor	0	11	0	14	15	6	**46**

The following discourse is part of the transcript of Student 2's interview, already discussed as a possible deviant case. Although a different part of the discussion, the theme is similar in that the student is describing the housework task with which she helped the service user. This time, discussion of her mentor's role will be examined.

Discourse 5: Somebody who is going to educate

Interviewer: *And did the mum get involved with it?*

Student: A very, very small amount, she sort of stood and looked, picked up a couple of things, 'oh I'm tired, family have been around', excuses, but apparently the, the week after that, I wasn't there because I was ill with this chest infection, half term and the health visitor came back and said 'oh it's slightly cleaner' so whether she had made an effort, but apparently they're trying to encourage the children as well to clean up

Interviewer: *Were the children there when you were cleaning?*

Student: When I was there, no, although the little one, the youngest girl was there, the following time they were there because it was half term and the children loved it, tidying up, the Health Visitor, this is what made her think it was all worthwhile, that whole thing, teaching the children to keep it clean and tidy. Mum doesn't do it - at least you're not passing down from generation to generation a habit that isn't going to change. And her mother didn't ever clean up so she will teach her children not to clean up and it's a pattern

Interviewer: *So, can you see a difference between just cleaning up and working alongside mum?*

Student: I think it's more beneficial to the children, by the sound of things, because they actually got involved, and they wanted to do that, and because mum's excuse is 'oh I haven't got time, I've got to pick the children up from school, I can't do that' But then apparently I was told by the health visitor that mum was saying 'oh we've got to go, we've got to go' and the health visitor was saying to the children 'will you do it?' and they were saying 'yes' – the children wanted to do it but the mum was stopping them, she wasn't encouraging them, so possibly by encouraging them

Interviewer: *So that week you could see the therapeutic value?*

Student: Yes ....now that we've empowered the children, if someone went in there with a hoover and their plastic gloves um, then they would just go in and do the job and wouldn't... so someone between, who could help that family to actually realise, it's a health risk, with children especially, I mean I was only in there a few hours and ended up with a chest infection, and couldn't breathe even that night, I thought, I was coughing up all that dust, in my mouth, what was it doing to the children? So somebody who is going to educate, again with the children, not so much the parents, because it's the children who wanted to do it, if you start when they're younger and encourage them, if mum's not going to do it, perhaps they would want to do it.

Student 4

Throughout, the student recalls and restates her mentor's values and goals, beginning to assume and own them as her own ('now that we've empowered the children'). This is despite the fact that she had not wanted to be involved and was not there during the critical visit when change began to take place. Initially thinking that a cleaning firm or similar should complete the housework, rather than a health professional, the student begins to shift her position in the statement: 'I think it's more beneficial to the children'. She describes the Health Visitor's tactic of engaging directly with the children and helping them to tidy up, acknowledging that someone 'with a hoover and their plastic gloves' would presumably be focussed solely on the task in hand and not on the children's interests. This gradual shift –

evident during the interview itself – from struggling with the rights and wrongs of whether she should have refused to participate in the task, to a measured reflection upon the pros and cons of directly engaging in tasks alongside service users, again suggests movement and progression.

The certainty of 'rightness' is gradually replaced by a more confusing struggle with several possible ways forward, each with advantages and drawbacks. The mentor appears to have influenced the student by continuing with her own plan of intervention, in which the student was free to participate or not. The explanations offered by the student for its success, suggest this tactic was effective in provoking her to reflect upon the incident and to think more deeply about just what *can* be achieved in such situations. This could simply be referred to as role modelling. Certainly the student's reports imply that her mentor provided a positive role model. However there is more than simply behavioural modelling going on here, as the student genuinely appears to be thinking about her mentor's choice to work alongside the service user. This is an unattractive and anything but 'evidence-based' intervention (helping with housework), with a very long term and uncertain objective of positively influencing the children's future behaviour. Her choice to bring this particular dilemma to the interview is interesting, in that it is an issue with which she is still struggling to come to terms. Having blamed the cleaning task for her own ill health, ('I was only in there a few hours and ended up with a chest infection'), she moves on to consider the effects upon the children, concluding that the situation requires someone who will educate them in self-care for the future. This particular discourse was chosen to examine the student-mentor relationship because it describes a subtle influence, not wholly acknowledged by the student yet powerful in provoking personal identity work in a way unlikely to result from direct instruction or pressure to conform.

Personal networks

Next, a discourse describing the importance of the students' personal networks is analysed. All students pair themselves with someone outside of a formal work or education relationship, although some make very few references (Student 1) and others make several (Student 5). The nature of pairings varies, from references to *parents* as the source of values and attitudes, to more casual references to *fellow students'* actions, as influences upon behaviour. Although, at only 13% of all pairings with self one this is one of the least

mentioned sets, the influences discussed by students form part of the fabric of their everyday lives. No specific interview question was targeted at this group. Had the research question focussed upon an aspect of their ethical development other than practice, this set may have been mentioned much more frequently so its presence alone warrants attention.

Table 8.6: Pairings made by student between self and others in a personal network

Membership Category	**Student 1**	**Student 2**	**Student 3**	**Student 4**	**Student 5**	**Student 6**	**Total**
Total pairings made by student between self and others in personal network							**44**
Student : other students	1	3	2	11	2	1	**20**
Student : own family	0	2	0	0	10	4	**16**
Student : own friends	1	3	0	0	1	2	**7**
Student : neighbour	0	0	0	0	0	1	**1**
Totals	**2**	**8**	**2**	**11**	**13**	**8**	*44*

The discourse selected for discussion concerns a student's reflection upon living opposite a person with multiple disabilities, and the ways in which she considers herself to be a neighbour, alongside other neighbours. The question which provokes this discussion is not related to neighbours, but to work placements. It is the student's own interest in how communities respond to people with disabilities which directs the conversation.

Discourse 6: the more you help her, the more she wants

Interviewer: *In terms of the work placements – how did that contribute, if it did, and it may seriously not have, I'm not pushing you to say it did – to that aspect of your development?*

Student: My ethical aspect? My first placement in year 2 was only three days, but it was in Adult Learning Disabilities. That really sparked an interest in what I've never had an interest in before, and that made me really think about how people are in the community, and how they fit in and how they've been treated in the past, you know at *(Learning Disability institution now closed)* and appalling conditions and treatment that they were subjected to, and how that's affected the way they respond now, and how it's affected the way they are because they've had no role models or they've had no constant affection, or that's really made me think ethically about how we should be developing things for the future and how

people should be integrated into society because it's such a difficult thing to do, because the majority of people are unwilling actually to help them

Interviewer: *What makes you think that?*

Student: What that they're unwilling? Just comments I get, people, we have a lady with physical and learning disabilities across the road from us, and my neighbour is – rude, just downright rude – and he's a lovely man, but, he feels that she brings it all on herself, all her problems, and, because she shouts, she can't talk properly and she looks physically deformed, her legs, and she screams and shouts and swears at the children and gets hysterically upset, but he can't, my neighbour can't see that that's because she doesn't have the capacity to understand she's doing it, and what implications that has, he just sees her as being 'shouldn't be here' which in some respects part of me feels that no, maybe she shouldn't, purely because why are you putting somebody that's already vulnerable in a flat in the middle of ..... Hill, with all the nasty children who like to hang around and throw things

Interviewer: *And yet your placement – did you look at her differently following your three day placement?*

Student: No, no I've always been fairly, kind of, protective of her in a way, I mean, it's difficult because the more you help her, the more she wants, but I couldn't let her, just, I mean, I've seen her being physically attacked before and I wouldn't let that happen

Student 6

Although only three days long, the student identified her work placement as pivotal in causing her to think about aspects of care in the community she had not considered before. This is despite the experience of living opposite someone with multiple disabilities for some time, and being a student of health and social care. Although she has obviously thought deeply since the placement, it is interesting that this learning provoked a level of interest and concern in a subject she had 'never had an interest in before'. Discovering the recent history of the segregation of people with learning disabilities – and being on placement with people who experienced such regimes - appears to have stirred a sense of injustice and concern for the future. Her experience supports Allport's (1954) contact theory; that is, that personal contact with people from segregated and stigmatised groups reduces ignorance and prejudice.

However, the parallel experiences of discovering the negative aspects of segregation, and of living opposite someone experiencing problems integrating into a hostile community, are difficult for the student to reconcile. While she readily admits identifying with the feelings of another neighbour, although for different and more complex reasons, it would seem that she is struggling with just what to do with or for someone who attracts so much unwelcome attention and aggression and yet is very difficult to help: 'the more you help her, the more she wants'. This sentence suggests the student has tried to help in the past and has had to withdraw or limit her input, possibly experiencing feelings of guilt or inadequacy. It is perfectly understandable for the needs of a vulnerable neighbour to become wearing over time and even resented, however this may be difficult for a student to share in such an interview. When asked directly 'did you look at her differently following your three day placement?' the student said not, which is surprising given her new knowledge and interest. Possibly the personal past of the familiar neighbour was not connected by the student with the difficult past of which she had recently learned.

The student's experience of hostility and aggression from school children accords with Jackman's work (2001, cited in Dovidio et al, 2005: 94), in which he found that 'much violence against subordinates in unequal social relations is carried out by subordinates themselves'. Living in a community and grappling with such difficult societal issues, is much more difficult than simply compartmentalising University-work-placement learning, in which it is easy and tempting to romanticise the past and vilify institutional care. This discourse highlights for me just how knowledge and understanding of a very local and recent aspect of history can combine with a current, everyday experience of living in a diverse community, to produce a real internal dialogue regarding the rights and wrongs of past, current and future political direction. Whilst simply being a 'neighbour', the student was not provoked into thinking deeply about the government policy of care in the community. Following a short work placement, in which she develops relationships and learns about the recent past, the student reports feeling strongly about future policy and the dilemmas thrown up by both segregation and by integration, played out in her own street.

Educators – University and Work-placement based

Finally, the relationship between the student and University teaching and placement staff is explored through a discourse. Of all the sets related directly to self, this one was mentioned

least and then only by three students. This may be because the questions were specifically about ethical *practice*, although every student was asked directly about the influence of their education upon their practice. It may simply be that educators are not associated by students with practice issues or dilemmas, or that classroom based teaching about ethical issues is just not memorable in the same way as practice experiences and relationships. Another explanation may be that students engage with concepts and theories rather than individual educators. Whatever the answer, there is a clear message in the figures below and in the transcript excerpts themselves. Even in abstract terms, the experiences with educators or in classroom settings could either *not be remembered* by students or were *not linked* to practice dilemmas or problems. Some talked of complex terms they could not remember, or of theories which confirmed what they already knew. None described the subtle or transformative experiences practice relationships offered. All were generally warm and positive about the classroom learning, but the message from this group of students was clear: moral identity work takes place in work and practice settings.

Table 8.7: Pairings made by student between self and lecturers / placement coordinators

Membership Category	**Student 1**	**Student 2**	**Student 3**	**Student 4**	**Student 5**	**Student 6**	**Total**
Total pairings made by student between self and lecturers and placement coordinators							**16**
Student : Lecturers / placement coordinators	0	0	1	0	9	6	**16**

Three excerpts of transcripts are examined, in order to understand how the experience impacts upon their sense of moral identity. The three discourses are presented then discussed.

Discourse 7: I feel I've been given permission

Interviewer: *So you have become a critical thinker?*

Student: Only because I feel I've been given permission to do so – I mean, there are certain sort of steps that I feel I can now take towards things like that – now, whereas before I wouldn't dare, because it wasn't..

Interviewer: *Who gave you permission?*

Student: Um, the lecturers, the course, the structure of the course, the way you have, um, told us, taught us, to own what we're doing, to take it on board, to own it, to do it, not just to talk about it in class, not just sit and listen to you know, 'this is what – look at this situation – let's talk about that situation' – but actually – 'off you go, go and do it' and you've got to go and do it

Student 3

Discourse 8: It's not 'their' information, it's mine as well

Interviewer: *Do you feel conscious of feeling more confident now?*

Student: Yes – more confident in my field – but that's because I've now got – I consider myself now having formal training – I needed a formal training – I was confident, I mean I'm the type of person who's always been confident, with children, in any area, and knowing my own capabilities and my own area, you know, self learning, things that I know I'm good at, and can apply, but I had no formal training, I wasn't recognised by anybody, if I wanted to go, you know, to actually officially work with children in a health care setting, I didn't really have that connection there

Interviewer: *And you didn't know about an 'evidence base' at that point?*

Student: Well I probably knew they existed but I really didn't have any passing experience of an evidence base…

Interviewer: *So the journals you would access now – you would know now what you wanted to access?*

Student: Yes, yes, yes, and reading – where to find information, that's the important thing now, is exactly what information I'm looking for, I know exactly how to find it, whereas before – I knew the information would exist and I knew vaguely about it, but how can I get hold of it was a debate we had – the rehab department contained information but now I know how

……and having it at home at midnight, putting your Athens password into the website, is the main thing – I've found it amazing – being able to be a part of the health and social care team

because once you are a member of that team you are given permission, you know, from, just by signing up and being there and doing, you know, being a student – that's what it opens up to you and suddenly you think 'I too can have that information' it's not 'their' information, it's mine as well..

Student 3

Discourse 9: I couldn't put my finger on exactly what I've got out of it

Interviewer: *In terms of your education and the Foundation Degree, has anything helped you make sense of the rights and wrongs of dilemmas you faced?*

Student: Umm..a lot of the theories we looked at at the start of first year and we talked about - Freud and all that - and then we read a bit and most of the sociology stuff and, yeah, that's the sort of stuff that I connect with. I found it fun, relating that stuff to real life…

Interviewer: *What has it done - because it has obviously not given you your values – what has it done?*

Student: Don't know if I can answer that without doing it an injustice - I don't think it's tangible. I know that sounds strange - makes it sounds as though it wasn't worth bothering – it's been really good… The weird thing is I couldn't put my finger on exactly what I've got out of it – it's confirmed a lot of things I was maybe a bit unsure about and it's made me think about things I was unsure about and… I tell you the weirdest thing that happened – the beliefs and things that I had, my outlook… but I had never really read up on anything theoretically before and it's been really strange to read all the stuff and find things *I've* said to people was originally said and written down by someone a hundred years ago about these things – do you remember I said about the humanism and basic goodness of people …? …and there was loads of things, something I was reading today – what was the social theory? I think it was Foucault – no it wasn't - it was action theory and the interpretive theories of society and just going on about how no one can give a definitive answer to anything and it's all subjective and we all create our own subjective reality in that situation and that will be different to everyone else in that situation.. Habermas was one of them …And the number of times I've been over a beer and someone's said that's not true mate and I've said it's true as far as they're concerned…

Student 1

In all three discourses, students recall learning which was enjoyable or meaningful. The first two highlight the instrumental nature of a qualification or access to privileged information. Both appear to have changed the student's view of him or herself, rights to knowledge and rights to 'membership' of the team. One saw herself as capable and confident before, but lacking the necessary recognition which (she assumes) a qualification offers. In the third discourse, the student is less certain about just what has changed but knows something has. This time it is a connection with ideas which is liberating, confirming personal perspectives and opening up a new 'store' of literary perspectives to read and understand. It might be said that opening up such possibilities to students is exactly what the educator is there to do, rather than becoming a social being in the student's work life. Being able to apply complex theoretical ideas ('relating that stuff to real life') indicates that teaching was effective in connecting theory with practice. Both students report feeling confident and able to take ideas and skills into their lives, suggesting teaching was facilitative and empowering. So although there is very little to go on, for these students at least it is evident that their moral identity work has been influenced not only by the people acting as conduits to ideas and information (the educators) but also by the originators of the ideas and theories themselves.

In summary

- Discourse Analysis accesses a different data set than that accessed by Content Analysis. Social encounters are revealed through description and multiple references
- Students talk of a wide range of influences and relationships, illustrating ways in which interactions with others help them to form their sense of moral identity
- The largest group discussed most is made up of people using services. The least discussed is that made up of educators and placement coordinators
- Most expressed a clear sense of moral identity although analysis revealed doubt and uncertainty, alongside a much greater sense of personal development as knowledge and experience increased.
- A 'black and white' view of right and wrong was described by a minority

Chapter 9: Discussion

This discussion considers the implications for educators of the various perspectives examined so far. Its purpose is to address the research question: given the importance of ethics in health and social care, how can curricula most effectively support and prepare students for practice? The final objective, to formulate a framework for ethics education, is also addressed. The research question has been explored through theoretical perspectives, empirical research and primary data from student volunteers. It is clear that before deciding upon specific curriculum models or teaching techniques, educators in ethics require familiarity with the various perspectives on the nature of morality, in order to develop a coherent approach to curriculum, learning outcomes and activities.

The nature of morality

Morality is understood in many different ways. Some believe it to be determined by the environment or genetic inheritance, to others it is a matter of personal choice exercised through free will. To many, morality is seen as universal, across time and place. To others it is a relative concept. Whether constructed by people or revealed through religious doctrine or scriptures, there is agreement that one's perspective on such questions is fundamental to how learning is conceived, developed and appraised. It is clear from considering all these perspectives that practical, applied ethics is a mixture of: guiding principles, rules and laws, and of people, with duties and concerns, thinking through a unique, contextualised set of issues and possible consequences. However, in much of the literature, one view is taken as the correct one, then argued for as the *only* way to educate students. Examples include the principlist approach (Gillon, 1986), Kolbergian and Neo-Kohlbergian approaches (Kohlberg, 1976; Rest, 2000) and consequentialism (Harris, 1985).

For the purpose of this discussion, the major polarisations will be discussed in the light of the broader evidence base and the findings of this study, in order to agree the implications for educators in health and social care. More recent perspectives will also be discussed, including the neuropsychological, situational and dialogical ethics in the light of findings.

The perspective educators hold on the origin of morality is important, as much is assumed in existing research. Throughout this study, morality has been seen as a wholly positive feature of human nature in which caring for and about the ill, weak, elderly and young is seen as a virtue, reflecting the dominant religious traditions of all the major faiths. In most societies, individuals considered to be devoid of morality are generally seen as deviant, even pathological. However there are other views. Nietzsche considered morality to have no value in itself. He asserted that making a virtue of caring and self-sacrifice was merely a way of perpetuating weakness within a declining society (Nietzsche, 1889). Eugenic theories, based on socially-engineering society to rid itself of its weakest members, became very popular throughout Europe (including Britain) prior to the Second World War (Thomson, 1996). At the other extreme, many religious groups such as Creationists and Evangelical Christians support a pro-life objective, in which research on embryos, abortion and any form of assisted dying is considered to be murder.

Whether human beings choose to be moral and exert free will over their thoughts and behaviours (Kant, cited in Singer, 1994), or whether biology determines our responses, is much debated. It is posited by some that cooperative tendencies such as altruism and empathy are biologically determined (Hauser, 2006), and by others, that the selfish goal of replication means 'morality' is simply *not* a design feature (Dawkins, 2006). Most agree we are a mixture of the biological, psychological and social. The broadly scientific communities within health and social care generally coalesce around this 'soft determinism', or the slightly more complex concept of compatibilism.

However, Kohlberg's (1976) influential work is based on the ability of humans to exert free will; that is, consciously, purposefully, wilfully detaching themselves from desire or vested interest by thought alone, in order to engage in selfless, rational reasoning. Duty is placed above consequences or self interest. Described as the most highly evolved mental state by Singer (1994), such reasoning was acknowledged by Kant not to be easily accessible, driven as we are by everyday concerns, responsibilities and insecurities. Nonetheless, an educational approach based on belief in the free will of every student to choose right over wrong, suggests all that is needed is to use reasoned debate to persuade students of the rightness of certain duties or overarching principles. Students are free to choose whether to act well or badly by reference to their duty or principles. Transgressions are understood as an aberration, requiring acknowledgement of one's mistake and probably remorse and penance in order to get back on to the right track. The way in which Harold Shipman was treated by

the General Medical Council following his first offence for drug abuse is an example of this viewpoint[6]

Learning looks very different if a view is taken that our actions, to a greater or lesser degree, are determined somehow: by our biology, our brain chemistry, our social backgrounds or by a complex mixture including our personalities, circumstances, needs and ambitions. Even Kant acknowledged, though clearly separated, the opposing forces of 'reason' and 'inclination', seeing the latter as the forces of determinism. The more recent position of Dawkins is clear, that even though deterministic forces are at play, humans have control over their actions and the ways in which we are 'trained' – or not - to resist biological urges and impulses (Putnam, 2004; Dawkins, 2006). The compatibilist view places importance upon environmental, situational and social forces, understanding students to bring unique blends of biological drives, experiences and personality traits which continue to interact with new forces throughout their education. Such an understanding necessitates a systemic approach, given that inherent drives will make individuals vulnerable to certain behaviours in certain situations. Zimbardo's (2007) situational analysis of the 'rotten barrel' phenomenon, describes the range of factors necessary to promote morality within organisations and teams.

From this perspective, leadership which sets standards and supports training to embed practice, then carefully monitors adherence to policy, is key to such a system. Rather than *persuading* students of their duty or advocating the principle of autonomy (for example, when seeking a patient's consent to treatment), a clear protocol would be implemented and training given, followed by monitoring. As a result of many inquiry reports, care providers tend to be closer to the latter model. However Mintzberg concluded from research into organisational structures that taking away professional autonomy and imposing monitoring systems in this way undermined a sense of worth, leading to poor attitudes and devious behaviours (Mintzberg, 1983). In practice, appealing to duty and reason is an essential part of developing the virtuous practitioner (Huddle, 2005), while monitoring behaviours is an equally essential part of running safe organisations. Facilitating student analysis of organisational policies with an ethical component (such as a consent to treatment policy) followed by critical debate, may

[6] Harold Shipman was suspended from practice for a short period with restrictions placed upon his practice; however in less than a year he successfully gained a new position, followed by successive promotions with no checks made upon his past, monitoring of his practice or adherence to any form of rehabilitation. His word was believed and others considered he had seen the error of his ways. This omission is cited in the inquiry report as a lost opportunity to interrupt his pattern of killing (The Shipman Inquiry, 2005).

well be one way of appealing to duty and reason while accepting that situations will enable some to be less than moral (Turner, 2003). Those critical of the situational theory, or undermined by the need to be monitored, then have the opportunity to consider how they would develop alternative approaches. Inquiry reports are often used for this purpose, however they can all too easily be seen by as aberrant events, far away in time or place, simply caused by 'bad apples' (Zimbardo, 2007: x). By inviting students to evaluate and improve upon real policies which affect their practice, responsibility for creating an ethical system is brought closer to home, by opening up intellectual debate about right and wrong. Such purposeful reflection may also enable students to explore what Schumacher (1977: 40) called the 'inner space'; that is, the place in which we are able to make use of our own self-awareness to move from a passive to an active state.

The other important polarisation to discuss is that which takes place between principlism and consequentialism. In practice equally important, the two perspectives are often written about as alternatives, as though decisions are made on the basis of either / or. Therefore the implications of a purely principlist stance to learning, rooted in moral absolutism and based on a Kantian belief in universal principles, will be considered first along with the hierarchical model of moral development. Kant's 'categorical imperative' still forms the basis of principlist thinking; that is, that moral laws should be derived from what each of us would agree to, were that law applied equally to us regardless of our age, culture or place in society. It is considered by one modern philosopher to be his single greatest contribution to moral philosophy, clarifying as it does the universality of ethical concerns:

> *'insofar as ethics is concerned with suffering, it is concerned with everyone's suffering, or if it is concerned with positive well-being, it is concerned with* everyone's *positive well-being'* (Putnam, 2004:25).

Developing Curricula

Such education has, as its goal, the acquisition and internalisation of immutable principles, imposed from a higher authority or arrived at through reasoned debate. Complex situations in which two or more principles conflict require judgement, called by Kant 'mother wit', without which moral laws cannot be applied to concrete situations (Putnam, 2004: 4). This is often very difficult terrain, involving competing principles such as respect for autonomy (say,

respecting someone's wish to end their own life) and beneficence (doing good by taking them into hospital to prevent them from taking their life). Intrinsic to hierarchical models of moral development is the role of intellectual (or cognitive) ability. The necessity of intellectual ability to reason at a high moral level suggests that lower intellectual ability inevitably limits the capacity to reason morally. Particular teaching methods support this type of learning, such as retrospective case scenario analysis, group debate based upon structured, defensible argument and thought experiments. Such activities are necessarily devised and delivered by those with higher order reasoning ability than the learners. Emphasis upon resolving the specific problems thrown up by conflicting principles requires an essentially cognitive process described or justified, verbally or in writing, with reference to core principles. Theoretically, the consequences of each decision are not the business of the principlist, so in the example above, the fact that no suitable treatment facilities are available within a 100 mile radius, or the likelihood that the person has only one week left to live due to a terminal illness, should have no bearing (although the latter may be discussed in relation to the rationality of the person's wish and therefore their autonomy). One way of measuring the success of the educational objective is to measure the sophistication of students' reasoning abilities, hence the many tools designed to do just that, such as Rest's DIT (1983) and Lind's MJT (2006). Variations of this approach underpin many programmes in health care education as evidenced by the research studies discussed.

The question arises: is it possible to utilise this approach and the teaching techniques described, without a thorough-going commitment to stated, core principles or an understanding of the meaning of a universal system of such principles? In practice, students are normally taught a range of ethical perspectives, including relativist perspectives, providing a range of ideas with which to approach real-life dilemmas. The consequentialist, utilitarian basis of evidence-based health care simply *contradicts* the concept of immutable principles, demanding instead a method of predicting consequences as accurately as possible and comparing the benefits of each. The hierarchy described by Kohlberg (1976), ceases to fit, as the reasoning required by a consequentialist approach is based on *comparison* of different possible futures for people. For example, whether it is better to end one's own life at the time of choosing but possibly without skill or medical help, or whether it is better to be taken to hospital and supported through the last weeks of life. Such reasoning is no *easier* than balancing principles, but the debate is likely to be on issues we can all imagine to a greater or lesser degree. For this type of reasoning, life experiences, empathy and imagination

are *as important* as intellectual ability. So, whether or not it is right to use a form of measurement developed for one kind of reasoning, to measure a different kind of reasoning, is debatable. Although it will undoubtedly produce a result, in this case a numerical 'level', the excellent consequentialist thinker may score poorly because he or she has not been thinking in the way 'required' by the test. This may also explain why studies show students 'regressing' in their thinking following exposure to practice.

Education based on a relativist perspective begins with the premise that no absolutes exist. Principles are not fixed and at best provide a guide. Taken to its logical extreme, the learning process will include exploration of where boundaries lie - in different contexts, at different times, with different players and in exceptional or rare circumstances. Self examination is necessary, as personal beliefs and values (which may be held as absolutes) are integral to the reasoning process. Genuine acceptance (as opposed to superficial assent) of different perspectives require learners to make strenuous efforts to view situations from different perspectives, which in turn require open and trusting explanation, discussion and personal sharing of doubts and uncertainties. Such learning activities have long been proposed by philosophers, researchers and academics (Nussbaum, 2006; Jaeger, 2001; Huijer et al, 2000). Knowledge of the context, in particular of laws, policies and practices, takes on a different type of importance as all possible decisions require contextualisation and comparison with each other, as opposed to justification. This means educators require knowledge and insight into practice issues, as well as skill in individual and group facilitation.

Such learning has been called 'educating for capability' (Fraser & Greenhalgh, 2001: 799), with its focus on enabling learners to develop the ability to respond to and drive changes in continuously evolving environments. The authors recommend learning should provide skill in the use of learning networks, research evidence, IT and knowledge management and ways of working across professional boundaries (Fraser & Greenhalgh, 2001). Self awareness, preparedness to enter uncharted territory and tolerance of uncertainty are important for educators, as teaching techniques may include such activities as: providing structure for personal accounts, or exposure to others' experiences, supportive probing of feelings or challenging of rigid beliefs. Reasoning is equally important, requiring the ability to assess a multitude of conflicting needs against a bigger picture, to make compromises yet retain a clear 'bottom line', as described by Zimbardo (2007). Successful learning is characterised by movement from black and white thinking to confusion and questioning, before arriving at a balanced personal stance, as described by Perry (1968) and similar to Gilligan's third stage

(1982). 'Dips' in confidence and reasoning ability can be understood as an important part of the journey towards a fuller appreciation of the complexity and challenge of care and treatment, rather than viewed as regression or even as an impossibility in an invariant uni-directional process (Kohlberg, 1976).

Developing and delivering this kind of curriculum requires balancing acts. For example, the exploration of all possible actions and their consequences in a given situation needs to be tempered by ensuring students also understand their personal and work role duties and boundaries. Yet the latter risks bringing the exploration or sharing phase to an abrupt halt, by giving the implicit message that the discussion is not worth having because there is an absolute rule (law) which must be obeyed. Leget (2004) discussed such pitfalls which can result in a lack of engagement as students, feeling bombarded by many ethical frameworks, simply revert to the law, or religion, or freedom of individual choice to avoid any personal engagement with difficult issues. Add to this the challenge of working with mixed groups of students: at different life stages, with different levels of ability, from increasingly diverse geographical and ethnic backgrounds, some with strongly held religious, political or cultural beliefs. It is easy to see why teaching impersonal, absolutist principles might be seen as an easier option.

There is good reason to retain both approaches in the curriculum, though, and teach both from a critical stance. This is because without guiding principles, a consequentialist approach may be reduced to endless comparisons or calculations, and without considering consequences the principlist stance may be completely undeliverable. However, more imaginative methods of judging the success of such learning are needed to reflect this pluralist perspective. A useful summary of the principlism versus relativism debate is made by Seedhouse (1998: 44):

> *'Whatever rule is invented in moral philosophy, sooner or later there will be a case in which it will be better to break it in order to create a better human potential. And because of this it is far better – far more moral – to enhance human judgement in the uncertain field of human action and interaction, rather than to instil imperfect sets of rules in people, as if these rules are inviolable commandments. Rules and principles are useful to the deliberative process, but subjective judgement in context is ultimate.'*
>
> *Seedhouse, 1998: 44.*

The neuropsychological theories themselves are engaging. Health and social care students may identify with the more accessible, familiar concepts of science than the often difficult and elusive philosophical concepts. Methods of teaching informed by this perspective include: use of videos, role play, observation and reflection upon real incidents, all structured to capture immediate responses and feelings as Leget described (2004). Discussion is easier if an emotional experience has been shared by the group, such as a moving event or a traumatic experience. This provides scope to move into cooler reflections, which in turn lead to rational thought and analysis. It is possible that students who struggle with the cognitive demands of the detached reasoning and verbal debating over hypothetical events, may have more confidence in dealing with emotions. Those with little life experience to draw on may find themselves engaging emotionally.

Similarly the situational theories of Milgram (1974) and Zimbardo (2007) offer many useful avenues. Education informed from this view necessarily covers the role of personal values and attributes, such as: the development of high personal standards of right and wrong, the confidence to be assertively nonconformist and stand against the crowd if necessary, respect and understanding of (good) rules and laws and grasp of the 'bigger picture'. It also includes examination and awareness of human failures, locating these within a socio-biological determinist model with an essentially optimistic view of personal change and growth. Finally, learning about organisational behaviour, the importance of leadership and culture, psychological theories of emotional intelligence and anger management would all be of equal importance.

Dialogical and communitarian ethics offers yet more avenues. In both, learning focuses upon: understanding and appreciating differences between groups or cultures, the experience of exclusion and oppression and such concepts as vested interests, shared experiences and political agendas. At a practical level, dialogical ethics requires the ability to communicate with openness and genuineness, a non-judgemental approach and skills in negotiation. To develop ethics of the communitarian type, skills in working with disadvantaged, marginalised groups are necessary, in order to hear and understand unique perspectives. Such abilities and values may be found in abundance amongst those who have selected such work for personal reasons. For example, it is often ex-drug users who work successfully to engage at street level with young homeless people using drugs. However in more mainstream services, such as Accident and Emergency, a great many homeless people may be seen by staff without such backgrounds, values or skills.

Whilst all the approaches offer the educator ideological and practical ways in which to develop an ethics curriculum, it is important to be sure just how much ethics is being 'inflated' (Putnam, 2004: 17). Accusing philosophers of inflation, he defines ethics – regardless of specialist or disciplinary origins – as a system of interrelated concerns, mutually supporting but also in tension. This defines the relationship between the most polarised positions.

The contribution of empirical studies

Despite the usefulness of the theoretical work, much of the empirical evidence fails to include a theoretical framework. Several give the impression a tool had been used in complete isolation from its underpinning theoretical base. Of the others, several appear to simply accept a theoretical perspective without question, failing to subject to thorough examination aspects of the theory not supported by findings or even to excuse findings which contradicted theory.

Nonetheless much of value was found, particularly in some of the mixed method or qualitative investigations. Overarching themes discussed in Chapter 4 include the conflicts emerging in different educational philosophies. Following the above discussion, this can now be seen in a new light; for example, whether or not ethics should be integrated through the curriculum or taught in a dedicated module, or whether classroom-based lecturers or practitioners should teach it, suggests to me that such research is focussed on symptoms of problems rather than causes. If sufficient debate had gone into agreeing the *purpose* of teaching ethics (and therefore the various world views informing the curriculum in its entirety), then some of these questions may have been explored more productively earlier in the process. Four studies commented on precisely this topic. Lewin et al (2004) set out four principles for medical education clearly located within a problem-solving model only (Box 4.1). In a meta-analysis of USA medical ethics teaching Eckles (2005) notes that medicine seems undecided whether the purpose is to create 'virtuous physicians' or problem solvers. From the same continent, psychologists state firmly their goal is to produce virtuous practitioners first, then to equip them with skills and methods to solve problems (de las Fuentes et al, 2005). In a nursing curriculum report, the purpose of teaching virtue ethics to nurses is to develop 'nurse exemplars' (Begley, 2006).

After the gender debates of the 1970s and '80s, this subject is notable only by its absence in all but a minority of studies. None discuss ethical challenges within the research itself or debate associated methodological problems, other than issues of confidentiality. A minority discuss whether or how educators might be responding to the greatly changing mix of students entering health and social care. The competency statement by Canadian / USA psychologists includes 'interpersonal skill and awareness of cultural needs and differences' (de las Fuentes et al, 2005). Eckles also comments on the absence of any such debate within medical teaching (2005). The pressing need for a 'new framework...dialogically created' is also noted by Jaeger (2001: 140) given the broad mix of health care professionals.

In my experience it has long been evident that firmly held positions, such as pro-life beliefs, faith-based or not, require skill from lecturers if balanced, open debate is to take place on life or death issues. Recently I became aware of group hostility towards a student who expressed strong disapproval, from her faith perspective, of sexual norms described in a case scenario. Whilst such occurrences present opportunities to explore different beliefs and value bases, this is really only possible when trust and openness has already been developed in a fairly small group. In a large or unfamiliar group, most students frequently simply 'opt out' of such discussions, possibly for fear of saying the wrong thing. An obvious strategy for educators not wishing to cause offence or show ignorance is simply to avoid such experiences by keeping to a rules-based approach to ethics teaching. Many clearly resist this though, as the research studies highlighted many very interesting teaching techniques. These include such ideas as: panel discussions with service users, analysis of organisational policies intended to embed ethical practice, story-telling and a 'morality genogram' in which students explore critical life events which have shaped their ethical perspectives. Such classroom based activities can support practice, if principles 'kick-in' when an ethical dilemma is actually experienced, called by Hoffman (2000) 'hot cognition'.

Learning from students' voices

So did the experiences of the Foundation Degree students add to the existing body of theory and research evidence? First of all the themes derived from content analysis of their words are revisited.

It is evident that several themes reflect issues brought up by other research, but also that differences exist. Students' attachment to guiding principles is supplemented by their very consequentialist approaches to the actual dilemmas presented, although they do not use such terms. It is clear that to interviewees, ethical practice revolves around appreciating and meeting the sometimes complex and contradictory needs of service users and is embedded in work routines, policies, and relationships with colleagues and managers. It is when these relationships become more complex that personal boundaries are tested. The types of problems brought by students reflect strongly 'persisting ethics' and 'ethics in the general sense' (Seedhouse, 1998: 39); that is, those issues which, though not dramatic and visible, cause ongoing deliberation and require answers to questions such as 'what kind of practitioner am I?' This accurately reflects the nature of their practice involvement and reveals the issues experienced as challenging to them. It is only too easy to belittle the amount of stress felt by having to report poor practice by a colleague or to question the judgement of an experienced Care Manager, or to compare such decisions with the life and death ones being made by a minority of clinicians. It is important, then, to take stock and consider how different these issues are from the many reported by nurses as ethically concerning. Whilst many studies reported nurses' relationship problems with doctors, no such problems were described by students. Instead, relationships described were seen as supportive and an intrinsic part of ethical practice.

As important, are the support mechanisms reported. Rules, policies and an understanding of their own place within their organisation and hierarchy are seen as critical to good practice, again unlike the many reports in nursing research of workplace policies being a source of ethical strain. Relationships, particularly with mentors and colleagues, are positively regarded and, in common with Rank & Jacobson (1977), seen as critical to ethical practice. Like de las Fuentes et al (2005), a personal value base is seen as integral to ethical practice. Unlike any of the professions, however, working alongside others in practical tasks, sharing knowledge, giving feedback and actually becoming aware of oneself as a role model to others, was seen as equally important. Information and access to knowledge is an interesting theme, highlighting how Support Workers are not included routinely in activities which graduates from traditional disciplines take for granted. Nowhere is a sense of challenge evident; that is, challenge *by students* of the existing rules or ways of doing things. Frustrations reported by nurses with policies, and with doctors' decisions at least shows a sense of entitlement to have a view on the bigger issues. It is surprising, if not concerning, that the students express so

little frustration and general acceptance. Yet they do report engagement and interest, with none of the interviewees reporting a casual or detached attitude (as many of the nursing studies did). Possibly their general satisfaction reflects the day to day involvement in a care-giving role rather than a passive attitude, or may simply be a feature of those who volunteered to take part.

The Discourse Analysis raises some different issues and reinforces others, despite the two forms of analysis finding different words and concepts. The Content Analysis elicites 'ideas'. Students used nebulous, descriptive words and phrases, often describing current policy or using familiar phrases and concepts, such as 'client centred practice' and 'empowerment'. (As forms of construction, government policy drivers have been successful in providing a language for systems not always experienced as empowering or client centred!) The second method finds none of these descriptions, highlighting instead words and sentences referring to actions and relationships. The two forms therefore complement each other, showing two different types of recall, one of thoughts and the other of events. The Discourse Analysis is more satisfying in this regard, as the method seems to get beneath the conscious view of self, to another set of stories in which students reveal less self-consciously, just who they relate to in their working lives. With almost two thirds of all the paired references involving service users and carers (29%), work place colleagues (24%) mentors / supervisors (11%), these three groups emerge as important influences in students' lives. The method does not lend itself to such distinct themes however, so this discussion will consider how the findings assist in 'bridging' the concept of 'identity construction' to the development of curricula.

The importance of responses from service users or carers is clear in several of the dialogues. Detailed responses show much of the insecurity felt before a risk is taken or a courageous act contemplated. This immediate and powerful feedback cannot be replicated in a classroom or planned for in practice, but detailed reflection and discussion of such events would help to give the emotionally charged experiences of placement a framework against which to appraise the action and its alternatives. Similarly, the antagonism felt by a student not receiving the gratitude she felt was due (from a service user who obviously had a very different lifestyle and values to the student), might usefully be challenged by others or viewed differently by her following a structured, shared reflection on the event. The student is clearly not engaging in dialogical ethics, neither is she moved by feelings of empathy in this situation. Few students asked themselves 'what might I have done differently?' although several feel their actions to be unquestionably correct, even saying there had been 'no choice'

but to act in a given way. Such certainty is in itself affirming of a type of moral identity. Two use the phrase 'black and white' about themselves, as though this is a virtue. When self doubt is felt, every effort is made to justify actions. Feedback and debate may help students *stay* with the doubt and confusion, long enough to confront the difficult issue of 'what is the right thing to do, in this difficult situation?'

The example of a student wondering how she was viewed, even recommending to future students that they pause (to think how they might appear to others), gives an indication of just how important the opinion of service users and carers was to her in her community placement. While at one level trying to empathise with their situation, her concern with how *she* appeared to *them* was itself helping her to build a sense of self in the role of student. She moves from feeling 'like rain on a washday' to the status of important listener.

Mentors emerge as an important group in identity construction. The experience of the student who moves from a passive to active role, realising she is 'not watching a documentary', says much about the temptation to abdicate responsibility to professionals. Again the realisation that her mentor might be expecting her to act – even if this proved not to be the case – gives her impetus to act, which in turn changes her view of her role. This helps her to engage much more fully with parents, gaining confidence and practicing assertiveness skills. Just as Schumacher (1977: 39) describes, the student is operating 'like a machine', finding freedom to act only when she becomes aware of a possible new direction and consciously chooses an alternative to passivity. The very principled stance of the Health Visitor, who gives practical help to a family, is clearly a formative influence on another student, despite her disagreement with the intervention. The importance of role models comes through in many research studies, so it is not surprising that the actions of this individual were remembered, causing the student to feel uncomfortable about her own stance.

The importance of being able to appropriately assert oneself is loud and clear, albeit in a way and at a time suited to the student. A clear sense of 'position' in the hierarchy says much about the emotional intelligence of students, who describe thinking hard about ways of questioning or influencing others, in order not to damage their relationships or reputations. This does not emerge in any other research studies and may reflect the subordinate position of the students. Alternatively, it may be a feature of the more mature student group, bringing with them interpersonal skills and a longer term view of relationships, given their ambitions for the future. The acknowledgement that others may well be better placed to make

judgements (than oneself) showed a student moving into the 'commitment in relativism' stage and away from a strongly held personal viewpoint (Perry, 1968). It also showed the power of the cohesive team and the urge to conform, remarked upon by Lind et al (1985).

Such justifications and rationalisations say much about how identity is constructed, in order to function within a team and maintain working relationships with colleagues. An internal dialogue may go like this: on the one hand, I have to *see myself* as a 'good person' if I am not to be in a constant state of internal dissonance. On the other, I must take instruction from and maintain my reputation with this person / team in order to be *seen* as a good worker. When instances occur in which *I feel bad* about my intrusions into another person's life, it is important to construct a view of myself in which I am both carrying out my work responsibilities properly (in case my manager / colleagues are correct) *and* being an empathic and sensitive person towards my patient.

One student, describing her concerns about a disabled neighbour, expresses well the difficulty in moving from one role to another. She describes an uneasy reconciliation between her feelings of responsibility and drive to help, with her realistic assessment of the limits to her influence. Seedhouse (1998: 41) describes something similar: 'to know ethics in the general sense is constantly to be aware of the tension between duty and inertia – a tension between doing what one ought to, and going along with things as they are'.

Finally, the fairly minimal mentions of educators and formal ethical education suggest that memorable learning and identity formation really happens elsewhere. Although this could well be justified and tolerated, by seeing practice as the *real* place of learning, I am going to suggest in the next chapter that this is not an adequate response. Exploratory, reflective, sense-making activities away from the emotional intensity of a practice environment are, I propose, intrinsic to the process of ethics education. I will discuss ways to remedy the situation and, for one programme at least, re-energise the approach to embedding ethics within the curriculum.

Chapter 10: Conclusion and recommendations

This conclusion draws on the interdisciplinary perspectives reviewed. Recommendations are made for the education of non-professionally-affiliated Support Workers studying for a Foundation Degree. First of all, the research question will be addressed and conclusions drawn. A system of interconnected actions will be described in the form of recommendations for practice.

So, given the importance of ethics in health and social care, how can curricula most effectively support and prepare students for practice? From my wide ranging inquiries, I suggest that there are many different ways in which curricula contribute to students' preparation for, and support through, the many ethical issues they will face in practice. However four conditions are essential.

A Framework for Ethics Education in Foundation Degrees

The first condition is that a philosophically-coherent framework is in place, which may well be eclectic and pragmatic in nature, but must withstand examination and interrogation. It is my conclusion that the philosophical framework most suited to the Foundation degree learner is that of *pragmatism*, in which reflection upon experience, empirical evidence and context enables the learner to decide on a course of action best suited to the unique set of circumstances with which he or she is confronted. This philosophy lends itself to learning activities which engage and motivate students, accepting that knowledge is impermanent and fallible so must be tested out practically.

A thoughtful selection process is another condition; that is, one that seeks to ensure that students have chosen the course of study for broadly altruistic reasons and have an interest in the wellbeing of others. How such selection is carried out is an area of study in its own right and outside the scope of this study.

The third is that educators, both academic and practice-based, must share the goal of preparing and supporting students for complex and ethically-fraught practice. Even if not all educators engage actively, an openness and curiosity to explore ethical questions, and respect

issues identified by students, is necessary to avoid students mentally 'compartmentalising' ethical debate.

Finally, a work based or similar experiential component to the programme is essential to provide opportunities: for values to be tested in practice, to provoke thinking and reflection; to give and receive feedback; and finally to engage with work-place policies in a critical and informed manner.

Given these four conditions, I contend that curricula should embed an ethical dimension in all practical and theoretical learning, using activities designed to provoke interest, thought and discussion. Such an approach is more likely to prepare students for the everyday, *enduring* type of ethics than the discrete, stand-alone module. Separation from other subjects implies ethics is, in some way, different from other activities. The discrete module is probably taught by a different person and based upon new and unfamiliar concepts. The learning needs to be 'flagged' though, and probably identified through marking criteria to ensure it is not overlooked. Learning outcomes which include an aspect of ethics might usefully be matched by a section in marking criteria requiring specific attention to be paid to it coverage.

There is no substantial evidence to support this contention, as the only study to ask the question concluded the very opposite. The Higher Education Academy Special Interest Group in Ethics (HEA SIG, 2007) throws out the same question but has no answer yet. So upon what am I basing my contention? Well, the nature of practice is such that learning takes place in unpredictable, unplanned, opportunistic ways. Students are required to observe, listen and participate in learning, then to make links *across* and *between* experiences. The students interviewed identify the workplace and those within it as the major source of their learning. To organise academic learning in modularised, discrete blocks works well enough for subjects such as human sciences, but ethics is fundamental to subjects like communication skills, safe practice, work based learning and personal development. An integrated approach enables it to be introduced, tested, adapted and reinforced in a number of different ways over time, by a variety of different people, as it will be in practice.

Ideally this learning should also take place within mixed, inter-disciplinary groups of health and social care students, *as well as* integrated, uni-disciplinary teaching of ethics; this is because of the importance of dialogue with people from different cultures and backgrounds in the workplace. If students have the opportunity to explore issues (and exchange ideas) with others from different professions and work roles, they will be better prepared for the kind of

debates which take place in practice. If education continues to 'silo' a topic which in practice is dealt with by teams, (along with service users, families, managers and many others *normally* embodying different beliefs and cultures), then students will be *less* well prepared than they might otherwise be. I would go further, by suggesting that such learning needs to be difficult; that is, it should confront assumptions, prejudice and ignorance. Conversations should address power differentials and moral issues, again in order to prepare for the world of practice in which the evidence suggests such issues are a major concern to a large, important group of practitioners (nurses).

The Foundation Degree students in this study are remarkably uncritical of peers and colleagues. Such inter-disciplinary debate may challenge complacency or the tendency to conform, which threatens the assertion of a personal moral view. Practicing or rehearsing arguments with student peers may help develop the confidence and courage needed to stand alone in a real situation. The reason I would not entirely *substitute* inter-disciplinary learning for uni-professional, links to my assertion that moral education should be integrated throughout the whole curriculum. There are also issues particular to specific professions which require specialised knowledge or skill, such as giving complex information to help decision making or undertaking intimate procedures.

Foundation Degrees provide an unparalleled opportunity to work with employers to further the agenda. As the key group in providing careers for graduates, employers (working with educators) should be encouraged to define the qualities and behaviours they expect from this group of students. Such guidance would, in turn, become a resource in the classroom as students reflect on their experiences and alternative responses to situations.

Finally, I propose that only by making ethics a subject which is personal and *owned* is it possible to engage all involved in care and treatment, in the important process of thinking through situations carefully. One reference point is one's own values and beliefs. Another is the legal and policy framework. Others include the patient's or family's wishes. Such ownership has to be *located* within this broader context (not seen as an alternative to it). How we *are* towards other people, and the effects and implications of our behaviours, attitudes and actions, are of particular importance to Support Workers, given the personal, often intimate, nature of their responsibilities. As a group, they share similarities with users of services: they are not 'members' of professions; they are often distant from or peripherally involved in decision making; they are relatively powerless, and may well lack the courage and confidence

to assert themselves. Only by beginning with themselves and owning their beliefs and values, is it possible to deconstruct those which no longer fit their developing understanding, knowledge and ambitions. Understanding how views have been shaped or reinforced, and practising personal openness and sharing, in the relatively safe educational setting, is preparation for dialogue with people of radically different beliefs or cultures. The alternative is to 'borrow' the professional perspectives and risk feeling like an imposter.

The importance of rules and procedures to the interviewees show how effectively new ways of thinking and behaving can be imposed upon, and even internalised by, a group of students. However if such new ways are simply added to an existing, unchallenged set of attitudes then it is easy to see why some situations are so confusing. The proud claim to be 'black and white' thinkers made by some interviewees (who did not come across as such in their interviews) may reveal an earlier construction of self as decisive and clear thinking, which has simply not been revisited since their thinking skills became more sophisticated.

I am therefore recommending that a series of educational strategies be pursued within Health and / or Social Care Foundation Degrees, tailored to the students' diverse needs and backgrounds and informed by the new roles to which many of them aspire. This group appears to be poorly catered for by existing vocational and academic provision, despite increasing responsibility and a high degree of moral proximity to service users. Their lack of affiliation to a particular discipline risks their effective exclusion from the all-important agenda of ethical care and practice.

Recommendations:

It is recommended that those delivering Health and Social Care Foundation Degrees:

1. Develop a coherent approach to ethics education which is integrated through the curriculum, promotes personal reflection and dialogue, and is inter-disciplinary in nature.
2. Embed throughout the curriculum, learning activities most likely to create and support a positive engagement with personal morality, a changing context, rules, codes and laws, increasing in complexity throughout the students' learning.
3. With employers, develop guiding principles for Foundation Degree students – a 'students' ethical code' – to provide a framework within which they are able to further

develop their identity as an ethical practitioner. Such students' codes are already a feature of some HE provision and may cross all schools or disciplines. Employers might include organisational guidance and specific rules. Such an initiative may pave the way for the much-debated voluntary employers' register of Associate Practitioners.

4. Develop students' and educators' cultural awareness and sensitivity, imperative to ethical practice, through dialogue with student peers, educators, workplace colleagues, service users and their networks. Considering the range of religious and cultural backgrounds of students, mentors, service users and educators, consciously using activities which supportively steer staff and students to view the world from different perspectives, is one way to try to reduce the distance caused by fear of saying the wrong thing or giving offence.
5. Establish and reinforce the ethical agenda explicitly, from the beginning of the relationship with the student and throughout their education, thereby creating a culture of openness and integrity. From the application and interview stage, through to formal educational experiences and informal interactions with staff, an explicitly moral agenda might usefully inform everything done by the educators and administrators, including the way policies are implemented and obstacles overcome.
6. Finally, institute regular and creative means of checking whether and how the intended educational outcomes are being achieved, individually and collectively, immediately following sessions and over time, in classroom and practice settings. Assignments, personal logs and mentor testaments are all means of providing clear evidence of the assimilation of ideas or practices over time which could be referred to in marking criteria across all subjects.

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Appendix 1

Actual version sent.

School of Health Professions and Rehabilitation Sciences
Ethics Committee Application Form (2005 Version)

- Only use this form for applications to the School Ethics Committee. Clarify where pilot work remains to be completed; otherwise provide as much detail as possible.
- You are responsible for the accuracy of this form and its contents and agree to conduct the study as outlined, subject to modifications requested by the Ethics Committee.
- Ensure that all documents sent out from the School are properly addressed, well presented and suitably worded. Use headed paper and include the Ethics Number.
- Submit **two complete sets** of the Ethics Form *plus* all of the attachments that the Ethics Committee will need to review, i.e. letters, information sheets, forms, guidelines, questionnaires, interview schedules and assessment protocols.
- The applicant and supervisor (where there is one) **must** sign and date the form.

1. Details of Applicant and Supervisor Responsible for Project

a Please Tick (✓) One — **Undergraduate** ☐ **Masters** ☐ **PhD** ☒ **Staff** ☒

Staff should always tick the 'staff' box.

b Name	Julie Wintrup
c Address	112 Enborne Rd, Newbury, RG14 6AT
	e-mail:jw8@soton.ac.uk **Telephone:**023 80 598834
d Qualifications	DipCOT, MBA, CertEdHE.
e Current Post	Consortium Manager Fd in Health and Social Care, HCIU; Faculty of Medicine, Health and Life Sciences.
f Signature	Julie Wintrup **Date** 18/1/16.

Provide title (e.g. Dr), name, address for correspondence with Ethics Committee and current job title, if applicable, and list relevant qualifications (e.g. previous degrees).

g If project forms part of a course of study, name course *(e.g. PhD in Rehabilitation)*	Doctorate in Education, Southampton University

h Supervisor	**Name:** Prof. Helen Simons	**e-mail:** hrs@soton.ac.uk **Telephone:** 023 80593474
i Current Post	Programme Director Research Degrees; Programme tutor RTP and MPhil; Research Degrees Course Board Chair, School of Education.	
j Signature	Helen Simons **Date** 26/1/16	

Name lead supervisor; provide contact details, job title, department and institution.

Short Title of Study ***(Maximum Six Words)***
Preparing students for ethical practice.

Committee use only:

Ethics Number	*Received*	*Decision*
	Reviewers	

Full Title of Study (for which approval is sought)
Preparing Health and Social Care Foundation degree students for ethical practice: a case study.

2. Background to Project

a Specify Aims and/or Objectives of the Project

Aim: to deepen understanding of how well the Fd in Health and Social Care (Fd in H&SC) prepares students for ethical practice, in order to improve learning and teaching experiences, raise their ethical practice standards and share findings. Objectives include:
1.To learn how students view their preparedness for ethical practice through in-depth, semi structured interviews drawing upon critical incidents within the work place.
2.To learn from other key informants their views on student readiness for ethical practice, using both structured interviews and questionnaires.
3.To identify learning experiences considered influential by students.
4.To review and make improvements to the curriculum in the light of findings, in particular effectiveness of learning and teaching strategies and techniques, and the utility of ethical standards embedded in learning outcomes.

b Background to Study / Summary of Literature

Many Fd in H&SC students wish to become Associate Practitioners (DH, 2002). As a new, unregistered role, it is anticipated that students' preparedness for ethical practice will be a key interest to employers. A long tradition of researching students' moral development exists; Kohlberg's work has influenced much of this, with many curricula based upon his stage development theory (1984). Gilligan (1982) challenged Kohlberg's work, criticising the bias to research only males, then to state universal priciples. Her work influenced nursing curricula, leading to a body of evidence based on the 'ethic of care'; relational and contextualised learning based upon personal experiences might include detailed reflection and analysis of one relationship, understanding each encounter to be unique and to elicit a particular response (Gilligan, 1982). More recently, dialogical theories influenced in part by communitarian ethics take further the concept of contextualised learning, suggesting societal and cultural norms are equally influential and therefore pivotal to understanding individual motives and behaviours (Piper, 2004). Each theory necessitates a thoughtful and particular learning strategy. This study evolved following examination of the literature and appreciation of the importance of moral development in a new group of workers, not included in any existing professional ethical code.

DH,2002.AgendaforChange.http://dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/AgendaForChange/fs/en
Kohlberg, L. (1984). The Psychology of Moral Development:Moral Stages and the Life Cycle, San Francisco: Harper and Row. (continued below)

Summarise the relevant literature and explain how the idea for the study evolved.

c Key Research Question

How well are Foundation degree students studying a Health and Social Care programme prepared for ethical practice?

References continued:
Gilligan, C. (1982). In a Different Voice: Psychological Theory and Women's Development. Cambridge: Harvard University Press.
Piper, D. (2004). Moral Development, Transformative Learning and the Dialogical Self. Westminster Studies in Education: 27: 1: 43 - 55.

Specify the key question that your study is designed to address.

d Study Design *(e.g. cross-sectional observational study).*

Case study design will be used to define the locus of the study and provide guidance on parameters; Stake described it as the study of an 'intergrated system' (1994:237). This system includes people and educational processes, connected by the goal to develop intermediate level practitioners fit for ethical practice. Understanding the complex and interconnectedness of systems enables the role of the researcher to be acknowledged and commented upon within the study.
Stake, R.E.(1994). Case Studies, in Denzin, N.K. & Lincoln, Y.S. (eds) (1994). Handbook of Qualitative Research. London: Sage.

Ensure that the methods chosen will allow you to answer the questions posed.

3. Sample and Setting

a Specify and Justify Study Size (include sample size calculation, if applicable)

The case study design will inform the study size, which is anticipated to be in the region of 8 - 10 in depth interviews with students and 8 - 10 structured interviews or questionnaires inviting narrative, with mentors. As the study is not intended to produce generalisable information, but deepen understanding of the particular, there will be no statistical data produced or statistical supervision.

b	**Statistical Supervision**	**Name:** N/A **Post:**	**e-mail:**

Provide name, job title and contact details of statistical supervisor, if applicable.

c Setting *(specify where the study (data collection) will be conducted).*

HCIU, with students of the FD in Health and Social Care.

d Details of Proposed Sample *(e.g. fellow students, club members).*

Second year students of the Fd in Health and Social Care. From a total cohort of 46, I will be seeking 8 - 10 volunteers to participate in interviews or written narratives. From this group, a similar number of mentors, suggested by participating students, will be asked to complete either a structured questionnaire or structured interview, by telephone or face to face.

e Relationship of Proposed Sample to Researcher

As Consortium Manager I manage the partner relationships and oversee the academic quality of the programme. I have taught approximately one third of the group during their first year and met others - who studied for the first year at FE Colleges - through recruitment and open events.I have marked and cross marked anonymous work from many of the group and continue to both teach on and mark work from selected units. I have the support of the Director, HCIU and can provide this by letter if needed.

Explain how you know of the proposed sample and confirm that you have permission to contact the proposed sample. Provide letters of collaboration, where applicable.

f **Will or may participants come from a vulnerable group? Tick (✓) if Yes.**

Under 16 years old ☐
Cognitively Impaired ☐
Learning Disabled ☐

Other (specify)

Current students

g **Will participants be taking part in other studies and how will you know?**

Along with other health and social care students, they may well participate in the ongoing Common Learning / NGP longitudinal study and I will not know if they have chosen to participate in this as questionnaires are anonymous and I would not infringe their privacy by asking.
At present I know of no other planned study involving this group although I would be consulted in my role as Consortium Manager if any were planned. There may well be other projects in their work places and again I would not know about these unless the students tell me.

h **How will participants be identified, approached and recruited?**

Participants will be identified as students belonging to the second year of the FD in H&SC. Following ethical approval, students would be informed of the study during their second unit, 'Using Evidence in Decision Making'. This unit introduces them to the concept of research and to research ethics, so it is intended that they will be well placed to understand the study, its rationale and to ask searching questions. It is also hoped to engage them as active collaborators by encouraging a critical approach, whilst offering an opportunity to follow through the study and learn from its outcomes. By including work place mentors, it is also hoped that students will begin to discuss their readiness for ethical practice and development needs with others.Study aims, background, rationale and case study design would be explained and information given out along with letters of invitation for themselves and mentors. Details would also be placed on 'blackboard' for those unable to attend.

Participation would be entirely voluntary and interested students would be invited to attend a specific discussion one week later, to discuss in more detail the process, planned outcomes, ethical guidance in place and the nature of the commitment. Potential mentor participants would also be invited to such a discussion three weeks later, or offered a booked 'phone discussion.

Interested students lacking a workplace mentor will be able to take part as long as either a mentor from an educational work placement or personal tutor with relevant practice experience is interested in participating in the structured interview phase. Commitment to participate in the study will be asked for following the consultation by returning the reply slip within two weeks (enclosed). Withdrawal will be acceptable at any point (see information sheet).

Explain how the participants will be identified, approached (e.g. will you contact them directly with information or will someone known to them make the initial approach?) and recruited. If a recruitment poster is to be used, provide a copy and provide evidence that you have permission to display it in the desired (specified) location.

i **Will participants be given written information?** **Yes** ☒ **No** ☐

If no, why?

j **Will participants be given a reply slip to send back?** **Yes** ☒ **No** ☐

If no, why?

Tick 'yes' or explain what alternative means will be used (e.g. e-mail).

k State Inclusion and Exclusion Criteria and Screening Tools, if applicable

Inclusion criteria: second year students studying and attending Fd in H&SC.
Exclusion criteria: Students from cohort suspended from programme for any reason or currently involved in disciplinary or complaint processes. Although this is not currently the situation for any students, exclusion would be justified in the students' interests given my role as Consortium Manager; that is, I would not wish to place them in a situation where they may reveal or feel obliged to reveal their thought processes in relation to any practice or classroom learning. For the duration of the study, any student participants newly involved in a disciplinary process would be recommended to withdraw in order to avoid unintentional sharing of issues connected to disciplinary; any complaints would be redirected to the Director, HCIU.

l Will participants sign a consent form? Yes ☒ No ☐ **If no, why?**

Tick 'yes' or explain why not (e.g. may not be required for distributed questionnaires).

m Explain how participant anonymity and/or confidentiality will be maintained?

No participants will be anonymous given the nature of interviews, although mentors need not identify themselves on questionnaires. Data will be treated as confidential in accordance with the Data Protection Act 1998. Names and addresses will never be placed on audio tapes or transcriptions which will only be identified by a code. The key to codes and actual names will be stored separately from the interview data with no identifying information, in a locked drawer in the researcher's own home. Interview data once transcribed will be stored only on a memory stick and hard copy in the researchers' own home. Audio tapes will be destroyed following transcription.

4. Interventions and Measurements

a What will happen to the participants?

Student participants will be asked to take part in an individual, indepth, semi-structured interview with the researcher, lasting approximately 1 hour, which will be audio-taped; a written narrative is also possible. They will also be asked to recruit a mentor to the study and will have choice in who they approach. Interviews will take place during a day when they would normally be at University but will be at an agreed time outside teaching sessions. This is to minimise travel time and expense. A normal teaching room will be booked by the researcher and a 'Do not disturb' notice placed outside. See interview schedule and information sheet. Following the interview a transcription will be sent to each participant for corrections, amendments or editing of any section they would not wish to be included in analysis. Once returned, data will be included for analysis and first transcriptions destroyed. Mentor participants will be approached by student participants and given the invitation letter, information and reply slip. They will decide to be involved or not, either at that point or following the discussion meeting and will be asked to advise the student directly, enabling them to seek another mentor should they wish. Those wishing to be involved will be asked to return the reply slip indicating their preference for a face to face or telephone interview or questionnaire. Contact will be made directly by the researcher on receipt of the reply slip and arrangements made to speak, meet at an appropriate location of the interviewees' choice or for the questionnaire to be sent. Structured interviews will not be recorded. Brief hand written notes will be made directly onto the interview schedule and read back to interviewees for immediate correction. Both groups will be sent findings

Specify what participants will be asked to do and for how long they will be asked to do it. Ensure that demands on the participants (including time and travel) are reasonable.

b What will the participants be asked to do?

Student participants will be asked to explore in interviews their moral perspective on a critical incident from their practice; there will be scope and time to discuss their understanding, responses, thought processes and reasoning. Their prior, immediate and subsequent actions will be discussed, as will their relationships to those involved and any influential policies or protocols. Any influences upon their thinking and actions will be explored. The broad themes identified in the interview schedule will be influenced and guided by the interviewee's response and will therefore differ in each interview. Participants will have had time to consider incidents for discussion prior to the interview (see students' information sheet) so that they do not share anything they may later regret. They will also have had time to make notes against the interview schedule to which they may refer although at no point will they be asked to share any such preparatory notes. Every effort will be made to ensue participants take and keep control of what and how much they share in the interview setting. This is due to the ease with which an experienced interviewer may create intimacy and lead the interviewee into areas he or she may not have planned to explore, and also in consideration of the unequal power in the relationship between student and educator. A written narrative responding to the interview schedule is an alternative for those unwilling or unable to be interviewed. Mentor participants will be asked to comment upon the programme as preparation for practice (see mentors' information sheet). They will be asked not to name or identify individuals. They will be asked to consider their replies in advance to avoid sharing unnecessary or excessive information.

Explain what participants will be asked to do: detail any protocol that the participants will be asked to follow. Ensure that sufficient but not superfluous data will be collected (e.g. demographics).

c Explain what will be measured and how?

The study will not measure anything; as a exploratory study its aim is to deepen understanding in order to improve educational practice.

See interview schedules and information to students and mentors (attached).

Detail the measurement protocol that will be followed. Provide copies of measures (including questionnaires and interview schedules) and confirm that permission to use them is in place. Ensure that the role of all assistants and/or collaborators is made clear. Comment on the validity and reliability of the proposed measures.

5. Management of the Study

a Outline the pilot work that will be completed *(how and why).*

Pilot interviews will be conducted; one with a colleague simply to rehearse the semi-structured interview themes which will then be used to improve the order of questions and then discarded. Two pilot interviews will be conducted with participants and then used to refine structure and questionning strategy. Participants' feedback on process will be sought. Unless significant changes are made to the interview schedule, both interviews will be included in analysis.
Mentor questionnaires and structured interview schedule will be reviewed by a programme mentor not participating in the study purely for feedback on clarity; changes will be made as a result. Three final questionnaires will be sent to non-participating mentors for their consideration and feedback; again any necessary changes will be made in response.

Specify the decisions to be made before the main study (e.g. procedures to be clarified).

b Outline Project Timetable

See Gant Chart attached.

Indicate when the project, data collection and writing will start and finish.

c Estimated Data Collection Time (minutes)

Time per Participant (min)		Number of Participants		Total (min)
75	X	20	=	1500 ie 25 hours

Record the time in minutes required with each participant (e.g. 30), the number of participants (e.g. 20) and calculate data collection time (30 x 20 = 600, i.e. 10 hours).

d How will you *attempt to prevent* the provocation of discomfort (e.g. fatigue, injury, pain) and/or distress in participants?

I will ensure written information is clear, explicit and concise so that individuals may make informed decisions before taking the subsequent steps, such as attending the discussion meeting or arranging an interview. During the discussion/s I will ensure people know they are able to withdraw at any point including stopping mid-interview if necessary.
The interview schedule, or structured interview / questionnaire will be available from the outset and pre-planning will be recommended, to encourage ownership of information shared. It will also be recommended that thought is given to critical incidents described, in case issues are still unresolved or feelings still raw. It will also be suggested that where questions still exist, these are formulated and possible ways of seeking answers or resolutions considered within or following the interview.
I will agree and adhere to interview times and venues with participants, including their latest point to finish.
In short, at every step the goal, rationale for and process of the study will be made open and explicit to potential and actual participants. Their participation will be on mutually agreeable terms and they will retain control over content and process of their contribution.

Explain the steps taken to prevent any discomfort and/or distress in participants. ***Confirm that a risk assessment has been completed and attached to this application.***

e How will you *manage* any symptoms or distress arising?

As an experienced mental health professional I will use my knowledge of the interview process to anticipate, recognise and acknowledge distress and will ask participants' preference to continue, pause or stop. I will always be concerned for their well being and will not react in any negative way to any distress they experience. I would seek to communicate acceptance and encouragement for them to pause or explore another aspect until they regain composure or decide not to continue. I am aware that they may wish to stop recording and discuss their distress privately. I would take responsibility for supporting their next step. I would also bring along the University Counselling and SUSU helpline nos. should they recognise deeper personal issues and wish to seek a confidential source of support immediately or in the longer term.

Explain the steps taken to manage any discomfort and/or distress (e.g. a helpline telephone number).

f How will data be stored securely during and after the study?

All data will be coded and names / contact details used to set up interviews stored separately. The key to any coding will be stored in a locked, secure cupboard along with interview recordings and transcriptions in my own home rather than on University premises, where all storage has to be accessible to others.
Following checking of transcriptions by researcher and participant, original audiotapes will be destroyed. Transcriptions will be securely stored in accordnace with the Data Protection Act 1998.

Specify how data will be stored, in line with the School's current policy.

g Has the Data Protection Officer been notified about this study? Yes ☒ No ☐

Name:

If no, why not?

Name the Data Protection Officer or explain why one has not been notified.

h Will University insurance cover be sought? Yes ☒ No ☐

If no, who not?

Tick 'yes' or explain why University insurance will not be sought.

i Raise any Ethical Problems not covered elsewhere and how you will deal with them.

It is possible that participants may describe a practice incident in which poor or unethical practice took place. As a State Registered Occupational Therapist I have a responsibility first and foremost to adhere to my Code of Ethics (COT 2005) and protect the public from such practice. This responsibility is explicit in information materials. I would have to make a judgement based on the participant's knowledge of the current practice situation of the present risk to patients, staff or students; I would therefore pause recording and remind the student of my responsibility. I would explore the specific incident and ask for details of time, place, people and outcomes. It would then be for me to make a judgement in consultation with the student regarding any risk still present and take appropriate action, where possible encouraging the student to report or disclose the information to the line manager involved; however should the student not be able to do so or refuse for any reason then I would personally have responsibility for reporting the incident. Students would be informed of this (information letter).

Highlight any additional ethical issues not covered elsewhere on the form (e.g. where the topic of an interview is sensitive or may cause friction between parties).

University of Southampton School of Education
Ethics Review Checklist: Student Research Project

This checklist should be completed by the researcher (with the advice of the research supervisor) for every research project which involves human participants. Before completing this form, please refer to the Ethical Guidelines in the School's Research Student Handbook and the British Educational Research Association guidelines (http://www.bera.ac.uk/guidelines.html).

Project Title:

Preparing Health and Social Care Foundation degree students for ethical practice: a case study.

Researcher(s): ...Julie Wintrup

Supervisor: .....Professor Helen Simons

Part One

	YES	NO
1. Does the study involve participants who are particularly vulnerable or unable to give informed consent? (eg children with special difficulties)		X
2. Will the study require the co-operation of an advocate for initial access to the groups or individuals? (eg children with disabilities; adults with a dementia)		X
3. Could the research induce psychological stress or anxiety, cause harm or have negative consequences for the participants (beyond the risks encountered in their normal lifestyles)?	X	
4. Will deception of participants be necessary during the study? (eg covert observation of people)?		X
5. Will the study involve discussion of topics which the participants would find sensitive (eg sexual activity, drug use)?	X	
6. Will the study involve prolonged or repetitive testing or physical testing? (eg the use of sport equipment such as a treadmill) and will a health questionnaire be needed?		X
7. Will the research involve medical procedures? (eg are drugs, placebos or other substances (eg foods, vitamins) to be administered to the participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?)		X
8. Will financial inducements (other than reasonable expenses or compensation for time) be offered to participants?		X
9. Will you be able to obtain permission to involve children under sixteen from the school or parents? Please also seek children's permission.		NA
10. Are there problems with participants' right to remain anonymous, or to have the information they give not identifiable as theirs?		X
11. Is the right to freely withdraw from the study at any time made explicit?	X	
12. Will the study involve recruitment of patients or staff through the NHS?		X

If you have answered NO to all of the above questions and you have discussed this form with your supervisor and had it signed and dated, you may proceed to develop an ethics protocol. If you have answered YES to any of the questions, please complete PART TWO of this form below and adopt a similar procedure of discussion and signing. Please keep a copy

for your records. Only in exceptional circumstances will cases need to be referred to the School's Research Ethics Committee.

Part Two

For each item answered 'YES' please give a summary of the issue and action to be taken to address it.

Points 3 & 5. Discussing ethical issues or dilemmas may provoke stressful memories if not resolved, or if situations are ongoing. It may also involve discussion of sensitive issues should a participant have witnessed poor practice or unprofessional behaviour, or even taken part in such practice themselves. My response below is taken from the ethical approval submission to School of Health Professions and describes how I anticipate dealing with such possibilities should they arise: I will adopt the following protocols

- ensure written information is clear, explicit and concise so that individuals may make informed decisions before taking the subsequent steps, such as attending the discussion meeting or arranging an interview.
- ensure people know during the discussions that they are able to withdraw at any point including stopping mid-interview if necessary.
- make the interview schedule, or structured interview/questionnaire available from the outset and recommend pre-planning to encourage ownership of information shared. It will also be recommended that thought be given to critical incidents described, in case issues are still unresolved or feelings still raw.
- where questions still exist, possible ways of seeking answers or resolutions to them will be considered within or following the interview.
- Agreement and adherence to interview times (including their latest point to finish.) and venues will be arranged with participants.

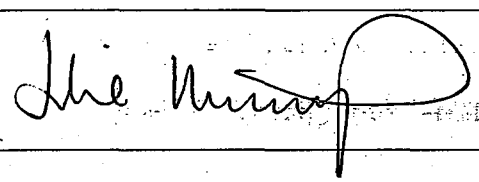
In short, at every step the goal, rationale for and process of the study will be made open and explicit to potential and actual participants. Their participation will be on mutually agreeable terms and they will retain control over the content and process of their contribution.

As a skilled and experienced mental health professional I will use my knowledge of the interview process to provoke intimate sharing in the course of discussing ethical dilemmas. I willanticipate, recognise and acknowledge distress; and ask participants' preference to continue, pause or stop. I will always be concerned for their well being and will not myself react in any negative way to any distress they experience. I do not generally experience discomfort or embarrassment in the presence of another's distress and would seek to communicate acceptance, encourage them to pause or explore another aspect until they regained composure or decided not to continue. I am aware that they may wish to stop recording and discuss their distress privately. I would take responsibility for supporting their next step. I would also bring along the University Counselling and SUSU helpline numbers. should they recognise deeper personal issues and wish to seek a confidential source of support immediately or in the longer term.

It is possible that participants may describe a practice incident in which poor or unethical practice took place. As a State Registered Occupational Therapist I have a responsibility first and foremost to adhere to my Code of Ethics (COT 2005) and protect the public from such practice. This responsibility is explicit in the information materials. I would have to make a judgement based on the participant's knowledge of the current practice situation of the present risk to patients, staff or students. I would therefore pause recording and remind the

student of my responsibility. I would explore the specific incident and ask for details of time, place, people and outcomes. It would then be for me to make a judgement in consultation with the student regarding any risk still present and take appropriate action, where possible encouraging the student to report or disclose the information to the line manager involved. However should the student not be able to do so or refuse for any reason then I would personally have responsibility for reporting the incident. Students would be informed of this in the information letter.

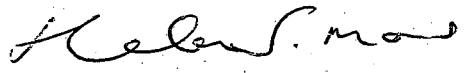
Please continue on a separate sheet if necessary

Signed: (Researcher)  Date: 18/1/06

To be completed by the Supervisor (PLEASE TICK ONE)

☐ Appropriate action taken to maintain ethical standards - no further action necessary
☐ The issues require the guidance of the School of Education's Ethics Committee

COMMENTS:

Signed (supervisor): 

Date: 26/1/06

Appendix 2

Version 2

University of Southampton

Health Care Innovation Unit

Professor Debra Humphris, Director

University of Southampton
B62 Level 1
Boldrewood Campus
Bassett Crescent East
Southampton
SO16 67PX United Kingdom

Tel +44 (0)23 8059 8843
Fax +44 (0)23 8059 8909
Email hciu@soton.ac.uk
Web www.hciu.soton.ac.uk

Ethical Approval number: 506/02-01
Date of ethical approval: 8/3/6

Dear Student

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Thank you for reading this.

Study Title

Preparing Health and Social Care Foundation degree students for ethical practice: a case study.

What is the purpose of the study?

The purpose of the study is to discover how well students taking the Foundation degree in Health and Social Care are prepared for ethical practice, from their own and workplace mentors' perspectives.

The study will seek to explore students' ethical reasoning, judgement and actions through critical work or personal experiences of their own choosing. Responses will be compared with learning outcomes and other key benchmark statements to assess preparedness for practice. Workplace mentors suggested by student participants will also be asked to take part in a shorter structured interview or questionnaire.

Altogether the study will take eighteen months to complete, although the interview stage will last in total approximately two months. The research will also be part of a doctoral thesis in education and as such will be supervised by Professor Helen Simons, School of Education, Faculty of Law, Arts and Social Sciences, Southampton University.

Why have I been asked?

As a second year student of the Foundation degree in Health and Social Care, you will shortly be graduating. You will have experienced several work placements and may well work in a related practice area. You are likely to have

encountered situations or issues with ethical dimensions; it is your perspective on such experiences that is being sought in this research. Only you will be able to describe how prepared you felt to cope with and reflect upon the ethical dilemmas you experienced. You may know what shaped or influenced your response. You will be invited to consider how prepared you feel for future ethical challenges in your practice.

You will also be asked to suggest a workplace mentor (with the exception of NHS employees) to the study, who in turn will be asked to give their perspective. However, unlike your contribution, mentors will be asked to comment only generally on their experience of the programme in preparing students for ethical practice. At no point will they be asked to discuss anything about you or any other individual student. You may wish to read the 'Letter to Mentors' to give you further insight into the mentor role.

Do I have to take part?

No. Participation is entirely voluntary. If you agree to participate you will be given this information sheet to keep and be asked to sign a consent form. Even if you sign the consent form you are still free to withdraw at any time and without giving a reason. Whether or not you choose to take part, or to withdraw at any point, your studies will not be advantaged or disadvantaged in any way.

What will participation involve?

You will be invited to participate in an interview which will last approximately one hour, arranged at a place and time convenient to you. You will also be asked to suggest a workplace mentor who is familiar with the programme, by giving or sending them the mentor information sheet and letter and my contact details. Their role is to provide an informed perspective on students' preparation for ethical practice in general. By involving you in their recruitment, I can be sure they are currently involved with the programme.

Your interview will be recorded and a transcription sent to you within 2 weeks. You may change the transcription to clarify your meaning or experience. Only your final version will be used in the research.

Should you wish to contribute, but not wish to take part in an interview, you may write to me addressing each issue in the interview schedule. Any such communications will be anonymised and treated with the same standard of confidentiality.

Will my contribution to the study be kept confidential?

Yes. It is my responsibility to treat your contribution in the strictest confidence, sharing only emergent themes developed from all contributors and adhering to

the Data Protection Act 1999. The only exception to this would be should you share anything indicating yourself or others are currently at risk (see following section).

During the recruitment phase, names and contact numbers will be stored securely. Once an interview has been arranged, you will be allotted a code and thereafter only the code will be attached to the recording or transcriptions; names and contact details will be stored separately in a secure place ensuring that at no point would your contribution be identified. The key to the code will be stored separately from both and not identified as such. Audio tapes and final transcripts will be stored securely in the University in accordance with the Data Protection Act 1998 following the research . All names and identifying codes will be destroyed following submission of the thesis.

Mentors agreeable to completing a questionnaire or short, structured interview will then be contacted independently by me. Their contributions will either be anonymous (in the case of a questionnaire) or treated in the same way, with a code being attached to each response.

Your privacy will be a priority throughout the study, with all material being handled confidentially and anonymised where appropriate. For example, no quotations would be used which might allow others to recognise a practice area or individual.

Following analysis of the interviews, findings will be sent to you for your interest and your comments on accuracy and fairness. Should you wish to comment on recommendations, opportunities will be made to meet again either individually or as a group to review learning and teaching strategies. This phase will follow the formal research period.

What are the possible disadvantages or risks of taking part?

Preparing for and taking part in the interview will take a couple of hours of your time. Thinking about approaching a workplace mentor, sending them the information and discussing things with them may take another hour or so. It is appreciated that this contribution of time is within the context of a busy student, working and personal life, so is not underestimated.

You may also think and talk about situations which have been disturbing or distressing, and this may be unsettling. There is even a risk that you may have experienced or know of unethical practice and feel confused or unhappy about sharing this with me. My responsibility, as a State Registered Occupational Therapist, is to either advise and support you to act, or to act myself in any situation where users / patients or staff may be at risk due to such practice.

Should you choose to disclose knowledge of any individual being at risk due to unethical practice, which you have not already shared with an appropriate manager / supervisor, I would stop the recording process and explore with you the situation and how best to proceed. It is important that you understand my responsibility in this area both to yourself as a student, and to those using services.

What will happen to the findings of the research study?

The findings will be developed into a chapter of the thesis and submitted for external examination. Findings will also be shared with participants and colleagues in order to discuss potential improvements to the programme. Later it is anticipated that publication will be sought in educaional journals as a way of sharing findings with a wider audience.

Who has reviewed the study?

The Ethics Committee of the School of Health Professions and Rehabilitation Sciences reviewed the study. Contact details are:

Dr. Emma Stack,
Chair,
Ethics Committee of the School of Health Professions and Rehabilitation Sciences
Building 45, Highfield Campus, University of Southampton.

Contact for further information

Julie Wintrup
Tel 023 80 598834
Email: jw8@soton.ac.uk

Thank you very much for reading this information letter and taking time to consider your response. Please do not hesitate to get in touch with any questions or queries.

Your sincerely

Julie Wintrup
Consortium Manager, Foundation Degree in Health and Social Care

Appendix 3

Julie Wintrup jw8@soton.ac.uk

Ethical Approval number: 506/02-01
Date of ethical approval: 8/3/6

Interview Schedule (student)

What do you understand by the term 'ethical practice'?

Do you have any experience of particular ethical issues yourself – as a student or other areas of your work experience? What are the kinds of things?

Is there an example, which has affected you more deeply than others, or in which you have been quite involved?

Can you describe that experience in some detail?

Has anything else happened since the incident / dilemma in intervening weeks / months / years to add to the description? Or give you cause to reflect upon the event?

Looking back, would you have done anything differently?

What do you think about the event / incident with the benefit of hindsight?

What would you say stands out as the single most important ethical issue / dilemma for you?

As a second year student, would you say anything in your education has helped you understand / make sense of / challenge the way in which this incident arose / was handled / could have been avoided / handled better?

What might have helped you understand / deal with / challenge such issues / dilemmas in your practice?

Are there any wider issues this experience brings to mind?

Finally, is there anything you would like to add – on any of the above issues or about your personal experiences, educational and practice?

Thank You.

Appendix 4

Ethical Approval number: 506/02-01

Date of ethical approval: 8/3/6

Student Identification number for this study.

Student Participant Consent Form

Title of Project:

Preparing Health and Social Care Foundation degree students for ethical practice: a case study.

Name of Researcher:

.....Julie Wintrup.....

1. I confirm that I have read and understood the information letter (version 2) and for the above study have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my education or rights as a student being affected. ☐

3. I agree to take part in the study. ☐

Name of Student	Date	Signature
.....	.....	.....

Name of researcher taking consent	Date	Signature
.....	.....	.....

1 copy to student; 1 to researcher.

Appendix 5

University of Southampton

School of Health Professions and Rehabilitation Sciences

Professor Roger Briggs, Head of School

University of Southampton
Highfield
Southampton
SO17 1BJ
United Kingdom

Tel +44 (0)23 8059 2142
Fax +44 (0)23 8059 5301
Web www.sohp.soton.ac.uk/sohp/

8 February 2006

Julie Wintrup
Consortium Manager Fd in Health and Social Care
HCIU
Faculty of Medicine, Health and Life Sciences
Boldrewood

Dear Julie

Submission No: SO6/02-01
Title: Preparing students for ethical practice

The School of Health Professions and Rehabilitation Sciences Ethics Committee has considered your application for the above study at its recent meeting and I am pleased to inform you that **Conditional Approval** was granted. Please see attached sheet for details. Your supervisor will need to sign off the modifications you need to complete.

You can not commence your study until your full approval by the Committee has been confirmed by letter.

Yours sincerely

Dr Emma Stack
Chair, SHPRS Ethics Committee

Enc.

School of Health Professions and Rehabilitation Sciences
Ethics Committee Review Form (2005 Version)

Ethics Number: S06\02-01	**Supervisors: H Simons**
Applicant: J Wintrup	
Project Type (UG/PG/Staff): Staff	**Lead Reviewer: E Stack**
Short Title of Study (six words): **Preparing students for ethical practice**	

Is project appropriate for consideration by SHPRS Ethics Committee? Yes No

Decision of Ethics Committee	
Full Approval	
Conditional Approval: Supervisor to Sign Off Modifications	X
Conditional Approval: Committee to Review Modifications	
Approval Withheld	

Signed: Dr Emma Stack **Dated**

Committee Comments and Modifications Requested

1. **If by 'work place mentors' you mean NHS staff, you will be required to secure permission from an external LREC (plus Trust R & D approval): we cannot give internal approval to use NHS staff time/resources, so please confirm.**
2. Please forward a Risk Assessment Form and a letter of permission to approach the students.
3. Because of the nature of the relationship between the applicant and proposed sample, please ensure that students are told explicitly that taking part or not taking part will not in any way advantage or disadvantage their studies.
4. Remove the section of the Information Sheet suggesting that the participants will benefit from taking part in your study: they may do, they may not.
   We suggest bolding the headings on what is a long document.
5. Please amend the Information Sheet: we are the Ethics Committee of the School of Health Professions and Rehabilitation Sciences and the chair is Dr Emma Stack.
6. Please specify the locations of Mentor Interviews, taking into account your own safety.
7. Audiotapes contain the raw data from your study. We require all raw data to be kept securely at the University for a period of 15 years, so please do not destroy it: store it.

Next Steps towards Full Approval:

- The supervisor should sign a letter to the Chair of Ethics confirming that all **seven** of the requested modifications have been addressed.
- Please enclose a photocopy of this page with the letter signed by the supervisor and any amended paperwork requested.

Appendix 6

University of Southampton

School of Health Professions and Rehabilitation Sciences

Professor Roger Briggs, Head of School

University of Southampton
Highfield
Southampton
SO17 1BJ
United Kingdom

Tel +44 (0)23 8059 2142
Fax +44 (0)23 8059 5301
Web www.sohp.soton.ac.uk/sohp/

8 March 2006

Julie Wintrup
Consortium Manager Fd in Health and Social Care
HCIU
Faculty of Medicine, Health and Life Sciences
Boldrewood

Dear Julie

Submission No: SO6/02-01
Title: Preparing students for ethical practice

I am pleased to confirm **full approval** for your study has now been given. The approval has been granted by the School of Health Professions and Rehabilitation Sciences Ethics Committee

You are required to complete a University Research Governance Form (enclosed) in order to receive insurance clearance before you begin data collection. You need to submit the following documentation in a plastic wallet to Dr Martina Dorward in the Research Support Office (RSO, University of Southampton, Highfield Campus, Bldg. 37, Southampton SO17 1BJ):

- Completed Research Governance form (**signed by both student and supervisor**)
- Copy of your research protocol (final and approved version)
- Copy of participant information sheet
- Copy of SoHPRS Risk Assessment form, **signed by yourself and supervisor** (original should be with Zena Galbraith)
- Copy of your information sheet and consent form
- Copy of this SoHPRS Ethical approval letter

Your project will be registered at the RSO, and then automatically transferred to the Finance Department for insurance cover. **You can not commence data collection until you have received a letter stating that you have received insurance clearance.**

Please note that you have ethics approval only for the project described in your submission. If you want to change any aspect of your project (e.g., recruitment or data collection) you must discuss this with your supervisor and you may need to request permission from the Ethics Committee.

Yours sincerely

Dr Emma Stack
Chair, SHPRS Ethics Committee

Enc.

University of Southampton

Legal Services

University of Southampton
Highfield
Southampton
SO17 1BJ United Kingdom

Tel +44 (0)23 8059 4684
Fax +44 (0)23 8059 5781
Email legalservices@soton.ac.uk

Tel: +44 (0)23 80598848/9

Ref: RSO 4289

REC (if available) SO6/02-01

Ms Julie Wintrup
HCIU
Boldrewood
University of Southampton
Southampton
SO17 1BJ

03 April 2006

Dear Ms Wintrup

Project Title: Preparing students for ethical practice

I am writing to confirm that the University of Southampton is prepared to act as sponsor for this study under the terms of the Department of Health Research Governance Framework for Health and Social Care (2001).

The University of Southampton fulfils the role of research sponsor in ensuring management, monitoring and reporting arrangements for research.

I understand that you will be acting as the Principal Investigator responsible for the daily management for this study, and that you will be providing regular reports on the progress of the study to the School on this basis.

I would like to take this opportunity to remind you of your responsibilities under the terms of the Research Governance Framework for researchers, principal investigators and research sponsors. These are included with this letter for your reference. In this regard if your project involves NHS patients or resources please send us a copy of your NHS REC and Trust approval letters when available.

Please do not hesitate to contact me should you require any additional information or support. May I also take this opportunity to wish you every success with your research.

Yours sincerely

Dr Martina Dorward
Research Governance Manager

cc. File
Ruth McFadyen
Supervisor/s: (if applicable)
Ms Helen Simons

University of Southampton | Finance Department

Memorandum

From:	Ruth McFadyen	**To:**	Julie Winthrup
Ext:	22417	**Dept:**	Health and Life Sciences
E-mail:	hrm@soton.ac.uk	**Date:**	3 April 2006

Reference: HRM/GFT/4289

Professional Indemnity Insurance

Project No: **SO6/02-01**

Preparing Students for Ethical Practice

Thank you for forwarding the completed questionnaire and attached papers.

Having taken note of the information provided, I can confirm that this project will be covered under the terms and conditions of the above policy, subject to written consent being obtained from the participating volunteers.

Ruth McFadyen
Insurance Services Manager

University of Southampton | School of Health Professions and Rehabilitation Sciences | **RISK ASSESSMENT FORM**

To be completed in accordance with the attached guidelines
Ethics number 506/02-01

Activity: Research project involving reading, use of computer, student interviews and mentor interviews or questionnaires. Transcription to be carried out professionally, reducing time spent at computer. Travel related solely to the research project will be limited and in own car, within broadly familiar locations. Travel to see supervisor within campus. Subject of interviews – description and discussion of critical incidents chosen by students to illustrate work place ethical dilemmas and their responses – may elicit disturbing emotions, however by preparing the students to plan what they wish to share and offering support and guidance during and following interviews, it is anticipated that any such distress will be minimal and containable. Should poor practice or risk to others be identified, the researcher's own responsibility as a registered practitioner will guide action in consultation with student and any necessary others.

Location(s): Boldrewood seminar rooms; possibly student's or mentor's workplace.

Significant Hazards: None

Who might be exposed/affected: No significant hazards identified

Existing control measures: Only those described already should student participant become distressed or recall disturbing event – then time will be given, interpersonal skills utilised and support from appropriate body offered.

Risk evaluation: Low **Low / Medium / High**

Can the risk be further reduced: No **Yes / No** (if yes, detail below)

Continued overleaf
Further controls required: None

Date by which further controls will be implemented: N/A

Are the controls satisfactory: Yes **Yes / No**

Date for reassessment:

Completed by:	**Julie Wintrup**	.....	**18/2/6**
	name	signature	date
Supervisor/~~manager~~:	**Prof. Helen Simons**	.....	.....
If applicable	name	signature	date
Reviewed by:	.....	.....	.....
	name	signature	date

University of Southampton Research Governance Form

(For projects requiring ONLY internal Ethics Committee approval)

Project details

Please return to:
HCIU, Boldrewood Campus,
Barnett Crescent East,
Southampton, SO16 7PX
(not SHP28).

1) Name of student: JULIE WINTRUP
Contact number: 023 80 598834
Email: jw8@soton.ac.uk

2) Name of student's supervisor: HELEN SIMONS
Contact number: 023 80 593474
Email: hrs@soton.ac.uk
Note: For undergraduate projects, the supervisor will be designated the study's Principal Investigator

3) Title of Research Project: Preparing students for ethical practice.

3a) Expected start date and duration: 24/4/6 → 6/7

4) Has a risk assessment been completed for this project? ☑ Yes ☐ No
If 'Yes', please attach evidence/documentation.
If 'No', please assess the risks to participants associated with this project.

5) Please indicate the anticipated number of study participants: Adults: 30 Minors (under age 18):

6) Other organisations participating in the study (*e.g. local schools; community centres; private care homes*)
6a) Where are they? (*Please list on separate sheet, if needed*):
none

7) Data protection: Does the project have data protection approval? This will be obtained when possible. ☐ Yes ☐ No

Student's signature: Julie Wintrup Date: 15/3/06

Supervisor's signature: Helen Simons Date: 15/3/06

Please return this form (ALONG WITH A PROJECT OUTLINE/ABSTRACT AND PARTICIPANT INFORMATION SHEET) to:
Dr Martina Dorward, Research Governance Office, Legal Services, University of Southampton, Building 37, Highfield, Southampton SO17 1BJ, Email: par2@soton.ac.uk, Tel: 023 8059 8848, Fax: 023 8059 5781