# A review of ethics education in healthcare literature and the case for a dialogical pedagogy

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***Abstract***

*In the United Kingdom, as in other countries, the increasing need for care has led to a shift in the dynamics of the workforce. Higher levels of responsibility across all types and grades of worker are now evident. The acquisition of 'skills' and a need for increased bureaucratic efficiency are the solutions of policy makers, however insufficient attention has been given to the - arguably more important – new moral responsibilities incumbent on workers who hitherto have not required such a thorough understanding of what informs their ethical judgments and care provision. That this is in a context of reported disengagement, moral strain and a 'task-focused' approach, further demonstrates the importance of ethics education that is relevant and appropriate.*

*In this article I shall argue that a dialogical pedagogy is required. In enabling students to critically understand the, often contradictory, emotional, intellectual and practical demands which assert themselves in such complex work, skills-based approaches fall short. The enormous gap between moral theories and the students' own experiences can lead to confusion, disaffection or more likely the abandonment of theoretical insights altogether. I propose that educators need to embrace the ethical dimensions of their topics in all teaching and learning activities.*

## Introduction

> *'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).

Governments worldwide face an unprecedented increase in the need for health and social care provision, as treatment possibilities increase in line with our expectations, needs and life expectancy. Britain saw a 90-fold increase in the number of people celebrating their one hundredth birthday during the last century, while babies born as early as 23 weeks gestation are surviving (OfNS, 2008; Greisen, 2004). At all points between, new treatment possibilities and life-prolonging technologies not only create new moral problems but mean many more of us use – and work in - health and care services than ever before.

As part of the financial solution to this increasing demand, workforce changes were heralded by a government-commissioned report which envisaged 'how workload might be shifted away from doctors to nurse practitioners and from nurse practitioners to Health Care Assistants' (HM Treasury: 2002). The significant gap between degree-educated professionals and the minimally-trained support workforce was recognised in two important mandates during 2006. The first admitted that despite £5 billion of investment in healthcare education, only a 'small fraction' was targeted at staff working in support roles (DH, 2006a). The second stated the moral dimension as well as the financial and was categorical: 'There are no good reasons why such learning should be limited only to senior staff, clinicians and professional staff in healthcare' (DH, 2006b).

The same report placed emphasis on practical, occupational skills rather than thinking skills or judgement (DH, 2006b). Yet, greater responsibility requires more knowledge and skill to make difficult decisions or live with unsettling compromises, in all areas of care. As well as 'life and death' decisions, commonplace everyday situations can be stressful and just as often have no clear 'right' course of action. Sherwin (1992) considered the low status of this kind of moral problem to reflect its subordinate, non-medical status. The more junior, less qualified the worker, the more likely they are to encounter the everyday ethical issues as promotion traditionally denotes a move into managerial or supervisory roles.

Most such occurrences probably remain private between cared-for and carer although some become public and examined. Inquiries into deaths or cases of abuse analyse the detail of

individual actions, reasoning, knowledge and skill of those involved. Every such analysis reveals small, seemingly inconsequential decisions - each no doubt felt to be quite ordinary at the time – which only later assume importance when seen as part of an inevitable sequence of events. Nonetheless it is relatively easy to identify with someone who makes a wrong decision and to sympathise when inexperience or poor supervision is evident. It is less easy to relate to the seemingly uncaring or callous treatment of people revealed through covert documentaries and reports (such as the recent one by the Patients' Association, 2009).

Is this simply an inevitable by-product of working in imperfect, busy, often inadequately-staffed environments, or ought we to care more about our carers' ability to care and their own well-being? Both 'life-and-death' and 'everyday' decisions, whether examined or not, can cause a particular type of stress – termed 'moral strain' by Milgram (1974:66) - when one's own sense of what is right or wrong is at odds with how those in authority are directing us to act. Even in the absence of explicit directives, a lack of time, knowledge or resources could be seen to cause internal conflict leading to such strain. Those in the most junior or casual roles are likely to face the daily impact upon people using services, such as the home-carers with brief time slots for each visit.

Moral proximity of this kind has been suggested by Jones (1991) to cause intensity of moral strain for caring individuals, as might be expected. Malone (2003:2317) considers such proximity to be a *positive* feature of such relationships however, warning of the 'potentially dangerous implications' of more distant, proxy techniques motivated, in her view, by a lack of time and resources. Glover (1977:288), following Milgram's findings, summarises: 'We care more if the child down the road gets drowned than if thousands die in a flood in another country' (Glover, 1977: 288).

This article will consider how educators might usefully contribute to the development of practitioners, whatever their place in the hierarchy, who are well prepared and able to engage with the prospect of an increasingly complicated and fraught practice arena. Research evidence from international – largely professional - sources will be used to scope and identify the issues, followed by a discussion of the role of education and a proposed pedagogy for engagement.

## The research evidence

Of all the healthcare professions, the majority of research is from medicine, nursing and psychology. Several nursing studies from the USA into moral distress found 'harm to patients' to be its primary cause, followed by institutional policy directives and financial constraints (Corley, 2002: 641; Plunkett, 1999; Blake & Guare, 1997). In-depth interviews described moral strain, as the participants reported struggling to balance their 'ideal actions' with 'realistic actions' (Blake & Guare, 1997:14). Factors influencing participants' responses included their degree of experience, their education, and a sense (or lack) of authority, collegiality and power.

A different picture emerges from a Dutch study, in which the primary cause of moral distress is described as 'organisational problems', with 'moral problems' coming second (van der Arend & Remmers-van den Hurk, 1999: 477). This complex study seeks to understand how such problems are experienced by nurses, concluding that that whilst most respondents are *aware* of moral problems, surprisingly few find such issues to be a problem *to them personally*. The authors conclude that nurses feel 'powerless' to influence or change things, locating problems outside their span of control. 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).

Disengaging, or locating oneself outside of the problem, may be a symptom of the 'burn-out' described by researchers investigating moral strain amongst mental health nurses (Nordam et al, 2005). Alternatively it may be inculcated through cultural norms or adopted as a coping mechanism.

In medicine studies tended to originate from education, reflecting the longer tradition of medical ethics. Few identified concern with relationships with other professionals, focussing generally on individual development. A good introduction is provided by Eckles et at (205: 154) who conclude from a review of USA research from 1974 to 2004, that a dichotomy

exists; whether to produce ‘virtuous practitioners’ or skilful ‘problem solvers’. A reliance on solving problems is seen by Kenny et al (2003: 1208) as the root cause of disengagement amongst medics, leading to a loss of ‘the ethics of character’. Leget (2004:492) also identifies disengagement in ethical problems as a major threat to good practice, identifying four main ways of avoiding deep engagement:

- The perception of issues as legal in nature, not ethical
- A consequentialist approach (akin to problem-solving)
- Emotional responses based on personal circumstances
- Religious convictions in turn supported by non-religious peers who refuse to challenge such a stance

From a large cohort-study, Satterwhite et al (2000: 462) found over half of fourth-year student-respondents to be influenced by observation of, and participation in, unethical practice; over 200 stated that derogatory comments to patients were ‘sometimes or often appropriate’. Like Kenny et al (2003), the researchers conclude that such values are inculcated through the ‘hidden curriculum’, a term used by Dewey to describe the learning which takes place through the ‘moral atmosphere’ of an organisation (Dewey, 1916). Leget (2004: 493) also considers role models (‘their stories, jokes, anecdotes, and the messages about their science’) to be an important component of the hidden curriculum.

A four-year, longitudinal study in Amsterdam sought to discover what students themselves found to be morally straining (Huijer et al, 2000). Students found most dilemmas to be caused by patients who would not comply with treatment, followed by those created by an emotional interest in a patient. They also reported poor communication and feelings of powerlessness in the face of senior colleagues, alongside failures of treatment and end-of-life decisions, not unlike those reported in nursing studies. Huijer et al (2000) urge educators to listen more carefully to students and encourage sharing of opinions, moral values, uncertainties and perceived failings.

A related discipline, clinical psychology, also offers useful findings from the perspective of an all-graduate, doctoral profession. Many studies use qualitative methods such as detailed case studies, expert panels and open-ended questions within surveys. Unlike medicine, psychologists across North America developed, through a conference and expert panel, a statement for the profession which places as its overarching goal the development of virtuous

practitioners, who are able to use their knowledge and skill to make decisions in complex contexts (de las Fuentes et al, 2005).

A very open approach is apparent in a large questionnaire-based study of 243 universities which asked for lists of ethical incidents involving students (Fly et al, 1997). This method revealed falsification of data, dishonesty, misrepresentation of credentials and violation of sexual and non-sexual professional boundaries. Such issues are reflected in the emphasis placed by de las Fuentes et al (2005: 365) upon academic integrity and boundaried relationships.

Another study seeks to understand the link between students' knowledge and actions (Betan & Stanton, 1999). Asked through questionnaire, 258 respondents considered a scenario then scored how they *should* behave and how they *would* behave, alongside descriptions of their accompanying feelings. Although 95% knew the correct course of action, only 37% said they would follow this, leading the authors to conclude students need help in adhering to their professional code when emotional concerns or friendship are features of ethical problems. This study reflects findings of an earlier one, which found that the ability to reason successfully through a dilemma did not necessarily lead to moral actions (Haas et al, 1988).

It is not surprising that scant research has been carried out into either smaller disciplines, or staff in support roles. What little there is indicates gaps in knowledge, an inability to identify or resolve serious ethical problems, violations of professional codes of practice and uncertainties around breaking confidentiality when others are at risk (Swisher, 2002; Finch et al, 2005; Aywal & Caldwell, 2003; Brown, 2006). Of support staff, findings are generally critical. Johnson et al (2004) cite a lack of preparation for complex tasks and ethical reasoning. A more extensive review of training and education concludes that the absence of any national mandatory educational programmes for Support Workers 'threatens public safety' (McKenna et al, 2004: 455).

Only an unpublished PhD study considered the experiences of Support Workers working in complex end-of-life care settings, who were found to have feelings of helplessness associated with burn out. The author concludes that their status as 'moral agents' warrants dedicated training in ethics (Kelly, 2004).

## The role of education

By reviewing a selection of the past decade's research evidence, four main areas of concern from students, practitioners and educators can broadly be summarised as:

- **Treatment / management issues** including risk of harm, pain or end-of-life issues and including such problems as non-compliance with treatment and treatment failures.
- **Organisational constraints** including lack of staff time, resources, knowledge and scarcity, even absence, of appropriate education and training particularly for staff closest to the person and probably furthest from decision-making.
- **Institutional, cultural and interpersonal factors** including the moral atmosphere created by leaders and team members, the influence of role models, ineffective or divisive communication methods and styles between staff because of grade or power differentials, or departmental / disciplinary boundaries.
- **Intrapersonal responses** including disengaging with moral problems, feeling helpless or powerless, not acting in accordance with what one knows to be the right action, failure to translate knowledge into action particularly when emotionally involved, concentrating on the task in hand, basing decisions on emotional factors or conversely, on (intellectually-derived) problem-solving techniques.

It is possible to look again at practitioners much-criticised for not seeing, let alone spending time with or getting to know, child-victims of abuse or elderly, dying people. They may be, to paraphrase van der Arend and Remmers-van den Hurk (1999: 482) *seeing themselves as outsiders, experiencing it as something to which they can stay passive.* They may even be implicitly encouraged to do so, by organisational and cultural practices. The research combines to offer insights which in turn suggest alternatives to educators who are well-placed to influence intrapersonal development and, indirectly, cultures.

Before considering tactics, however, it is necessary to establish the legitimate scope of the educator. Leget (2004) found students to be reticent to challenge each others' religious beliefs or personal values, preferring to defend the individual's right to hold views – of whatever kind. It is likely that educators also feel reticent to challenge espoused values and beliefs, fearing the relativist response that matters of morality are entirely personal and therefore unassailable. Educators in health and social care settings often arrive directly from practice,

not from research or scholarly backgrounds. If their sense of esteem rests on being 'expert', then acknowledging uncertainty or risking disagreement may be uncomfortable.

It is understandable if questions of morality are deferred to the ethics lecture or dedicated module. Yet Jaeger (2001) considers disengagement and passivity to be made *more* likely if ethics education is located within moral philosophy. She asserts that not only does such an approach fail to equip 'practical-minded' nurses for the range of contradictory demands they face in practice, but at times militates *against* deep understanding and appreciation of ethical issues (Jaeger, 2001: 114). It achieves this, she suggests, by providing a plethora of equally justifiable responses based on different ethical stances. This argument supports Leget's (2004; 492) assertion that students find such study 'futile' for the same reasons.

This argument is supported by Norberg et al (1994) who found that some nurses prefer to approach their work as a 'task' to be completed rather than to engage with highly complex ethical issues. In a small, longitudinal study, Nolan and Markert (2002) found that all the students identified clinical experience the most important learning experience, with few regarding formal education in moral philosophy to have been helpful (Nolan & Markert, 2002: 255 - 256).

Clinical education then, is an important source of learning. Indeed, Aveyard et al (2005) suggest practice-based educators are better placed than those inhabiting the lecture theatre or seminar room, to inculcate values within a contemporary legal and policy context. It is hard to disagree that learning from real situations, amongst people working through difficult decisions, can be anything other than an essential and necessary form of learning. However, research studies suggest that although necessary, it is not sufficient.

Of the research in this area, the overwhelming majority of studies use a derivation of Kohlberg's (1984) 'stage development theory'. Most find that over time, students' moral reasoning scores increase. As professional degrees normally include exposure to a wide range and type of practice experience, it can be inferred that both academic and practice learning contribute to this improved reasoning. However some well-constructed studies appear to refute this trend, so the explanations provided by researchers will now be considered.

Duckett et al (1997: 228) found a minority of nursing graduates reasoned at lower levels at the end of their education that at the beginning, but blamed the method of retesting which they said had been carried out 'too soon'. A similar longitudinal study in New Mexico, in

which 98 Occupational Therapy and Physiotherapy students were followed longitudinally over a two year training programme found no improvement in reasoning, although offered no explanation for the lack of positive change (Dieruf, 2004). In the most interesting response to a 'dip' in third year nurse students' scores, immediately following clinical practice, Kim et al (2004) explain:

> *'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

The explanation 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 well-developed reasoning skills? Instead the reader is asked to believe that this high level of reasoning ability operates well in the classroom but abandons the student in practice when 'action' is needed. Could it be that intelligent students simply learn how to discuss abstract concepts and select the morally-highest answers in tests? One of the theory's sternest critics contends that Kohlberg's interview methodology proves only an individual's ability (or lack of) to engage in hypothetical ethical debate, saying nothing about their true morality. (Straughan, 1985:151).

Using different tools, other longitudinal studies of medical students found practice-based learning to have negative effects. Satterwhite et al (2000), as discussed earlier, found a small majority of medical students to be more tolerant of low standards at the *end* of their education. Another longitudinal study found a minority of medical graduates questioning whether they really wanted to practice medicine at all (Huijer et al, 2000). The small qualitative study of Nolan and Markert (2002) picks up something not apparent in the larger studies yet which is clearly important; that is, that greater *uncertainty* is an inevitable consequence of deeper thinking and exposure to real problems and dilemmas. For example, a participant in the study described 'holding back' from committing to courses of action felt to be morally right, due to fear of litigation (for example, when telling the truth to a child). This much more complex picture of practice experience offers educators a deeper appreciation of

how the journey to disengagement might begin, along with ideas for how time in the classroom might usefully be spent.

## Developing a pedagogy for engagement

The conclusion to be drawn from literature is that we cannot take for granted that our caring workforce is adequately trained or educated for the changing environment of practice, much less to delegate greater responsibility to more junior grades, without at least taking stock of the new accompanying moral responsibilities and their implications. Studies indicate that when asked, significant numbers of people identify moral strain and negative coping mechanisms. Different methodologies, stemming from quite different worldviews, reflect similar themes and concerns across many different countries and healthcare systems. Although most were conducted within the last decade, some are older and of course, may no longer hold true. However many reflect establishments and disciplines in which an academic interest and research expertise in ethics education is well-established, raising the possibility that other, less examined groups would yield even more concerning findings.

Certain conditions and characteristics which are necessary for ethical practice to take place can be extrapolated with a degree of confidence. If understood as features of individuals however, few would make the grade; most of us subject to the doubts, avoidance tactics, compromised values and standards reported by so many research participants. Yet educators might ask how they can influence so many factors outside their reach, particularly if ethics is not their topic. It is proposed that by developing pedagogy for engagement, it is possible to use the curriculum to embed and mainstream ethical awareness, debate and ability into all learning activities.

The skills and competency-based approaches to education have been criticised as inadequate, given the personal moral viewpoint brought by each student. New learning has to take this into account, rather than simply ‘add’ new ideas (Huddle, 205: 885). In order to take into account different perspectives, it is necessary to tackle the question of relativism. Education based on a relativist perspective begins with the premise that no absolutes exist. Principles are not fixed and at best provide a guide. The learning process (in itself) will include exploration of where boundaries lie - in different contexts, at different times, with different people and in exceptional or rare circumstances. Self examination becomes necessary, as

personal beliefs and values (which may be held as absolutes) are integral to the reasoning process. Genuine acceptance of different perspectives require learners (and educators) 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.

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 later by Gilligan (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.

However without some guiding principles, such an approach risks the avoidance tactics and frustrations described earlier. A useful summary of the principlism versus relativism debate is made by Seedhouse:

> *'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.

Enhancing human judgement, in changing and uncertain contexts, is an admirable goal of education and difficult to rebut. Such an approach allows firmly held principles to be respected whilst insisting they be open to challenge. Blackburn (2001: 132) recommends a cooperative process of reasoning, in which we 'take up the reasons of others' through benevolence rather than procedural rules. In similar vein, Nussbaum (2006: 390) considers: 'An adequate education for living in a pluralistic democracy must be a multicultural education'.

By embracing relativism and rejecting the concept of empathy, Jaeger (2001: 136) proposes dialogue (with patients, colleagues and within communities), as a way to develop moral sensitivity and engage in 'communicative ethics'. 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).

In an attempt to integrate reasoning with rules, Leget (2004: 491) describes encouraging students to share their feelings about a person approaching voluntary euthanasia. Later, they are asked to judge the doctor's role, in accordance with Dutch law, and examine the ethical arguments used for euthanasia. Their emotional responses are revisited and compared (and integrated) with later, cooler reasoning.

The wish, generally, to avoid such deep reflective reasoning is understandable:

*'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.

Using real, emotional triggers is the starting point of emotion theory, which proposes we begin with the feelings provoked. By exploring and analysing them to understand their cause, it is possible to relate them to our more reasoned hopes or plans for self and society. By asking students to identify with the doctor in the documentary, the students 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 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 (and therefore has to be justified), 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.

## Conclusion

Caring work is complicated, often with no clear right action, and is increasingly carried out by junior practitioners who take on increasing levels of responsibility in settings outside institutional bases. Most are motivated by real situations and understand their academic learning to be valuable to their work. By understanding how the process of disengagement begins and becomes routine, educators have an opportunity to create learning opportunities which relate complex ideas to personal experiences and beliefs. By developing philosophically-coherent curricula, which may well be eclectic and pragmatic in nature, they provide a framework within which intellectual and social learning can be located. Abstract ideas can be brought to life by emotionally-engaging activities. Self-awareness and acceptance of one's own and others' feelings - a necessary component of moral growth if reasoning and judgement is to be developed and sustained across a range of settings – can be facilitated within safe settings or through individual activities. Time spent in dialogue which is structured and guided to facilitate a common purpose is preparation for practice situations, in which working through differences towards resolution is the only ethical way forward. Principles and rules are important aspects of such discussion but must withstand challenge and be defendable if they influence actions in practice.

To support such an approach, educators, at the very the least, require an openness and curiosity to explore ethical questions, and respect issues identified by students. They may indeed require support themselves, to move from familiar 'expert' roles to that of facilitator. Only by making ethics a subject which is personal and owned is it possible to engage others in the important process of thinking through situations and reaching decisions in practice. Familiarity and confidence in such reasoning is essential to prepare students for the everyday, enduring type of moral problem, which requires criticality to become habitual. How we *are* towards other people, and the effects and implications of our behaviours, attitudes and actions, are of particular importance, given the personal nature and trusted status of caring work.

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