An exploration of how ethics informs health care practice

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Abstract

Background
Moral complexities exist in every day health care practice creating conflicting responsibilities in providing care. Health care ethics (HCE) enable an applied practical linkage of theory and practice to create professional behaviour that focuses on service user benefit.

Research Question/Aim
This study explored how health care practitioners located in the UK embodied health care ethics in their practice. The study focussed on participants from the professions of physiotherapy and podiatry currently practising in the UK.

Research Design
Interpretative Phenomenological Analysis as a hermeneutical approach was utilised. Whilst always involving interpretation, this method has the ability to describe the human experience as it is lived.

Participants and research context
Purposively sampled individual interviews were carried out (n=21) in an attempt to interpret the participants' lifeworld of embodied HCE. The preliminary findings were taken to a purposively sampled group interview for discussion which contributed to further interpretation.

Findings
Five themes emerged from the data indicating a desire by participants to extol ethical practice, but acknowledged various limitations in the reality of achieving this.

Discussion/Conclusion
Ethical decision making may be enhanced by character virtues including empathy. Empathy is a basic condition and source of morality. As a central component of phronesis, empathy may enable understanding of a service user's needs and increase motivation for Health Care Practitioners to act accordingly.

Key words
Ethics; Empathy; Phronesis; Virtue; Hermeneutics; Healthcare; Guidelines; Phenomenology

Introduction

Ethics may be considered as the summation of morals, values and codified laws of professional behaviour (Meffert, 2009). For Health Care Practitioners (HCPs), ethics embodies an applied practical linkage of theory and practice in an amalgam of character building professionalism and organisational skills (Kulju, Suhonen & Leino-Kilpi, 2013; Milllstone, 2014). Ethical morality and health care are inextricably entwined and are inherent to the practice of HCPs (Drolet & Hudon, 2015) due to the dilemmas that challenge health providers in the modern context, as they have historically (Winkler & Gruen, 2005).

As the study and practice of ethics have evolved, accepted ethical norms have changed through many dimensions, but what remain consistent are the principles underpinning the ethos of health care. For the purpose of this study, HCE are considered as those that focus on patients' best interests and rely on interventions of proven benefit and acceptable risk (Beauchamp & Childress, 2013). HCE is an applied branch of ethics or moral philosophy that attempts to decipher the rights and wrongs of practice in the light of philosophical analysis (Campbell, Gillett & Jones, 2005). Ethical decisions are the final analysis of the individual, but ethical/unethical decisions are not made in a vacuum and the organisational culture and context serve to influence the individual decision making process (Kulju et al., 2013). HCPs frequently have to make both explicit and implicit choices that extend beyond the objective and practical and into the contested and ethical, and yet they receive little training and guidance on how to reach an ethical decision (Schröder-Bäck, Duncan, Sherlaw, Brall & Czabanowska, 2014). The principles of clinical ethics are often discussed when considering clinicians' obligations to patients, but there are no comparable and agreed set of ethical principles to guide individual decision making (Winkler & Gruen, 2005). Moral complexity exists in every day practice, creating conflicting responsibilities in providing health care due to the refashioning and restructuring of provision to contain costs, for example redefining the inclusion and exclusion criteria for service provision (Hurwitz & Richardson, 1997). Cost containment may have caused the basic values of health care to be forgotten, namely charity and caring (Balch, 1998). This was evidenced in the UK Mid Staffordshire scandal where the Francis report illustrated failures to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). This failure, according to Francis, was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care.

Ethics in health care is complex and is morally defined in ways that change for every patient and across time (Landes, 2015). A foundation of principles can be used to offer choice and deliberation in determining voluntary actions (Aristotle, 300 B.C./2004), which may be facilitated by using a variety of recognised models and theories of HCE. There is, however, a paucity of evidence available within the field of allied health practitioners to facilitate explication of these issues. Of the available research, it appears that ethical knowledge is rarely used to analyse the issues raised in practice and that gaps exist in the theoretical frameworks currently used for ethical analysis (Drolet & Hudon, 2015).

Consideration across the literature from various health care settings and empirical data collected in this study were used to explore how ethics is interpreted and how it may influence practice amongst HCPs. This study explores and delineates these issues within a philosophical framework of hermeneutical phenomenology in the context and theoretical framework of HCE.

Aim and Objectives
Therefore, based on the current gap in knowledge, the aim and objectives of this study were to explore how HCPs engage with HCE to determine their actions.

Principal Aim:
- To explore how ethics informs physiotherapy and podiatry practice

Objectives:
- Explore the understanding of ethics for individual physiotherapists and podiatrists.
- Ascertain how individual physiotherapists and podiatrists perceive the embodiment of ethics and how this informs their practice.
- Explore perceived barriers to ethical practice for physiotherapists and podiatrists.

Methods

Population

The target population for this study were physiotherapists and podiatrists. At the time of sampling there were 46516 physiotherapists and 13005 podiatrists registered in the UK (HCPC, 2012b). Of these there were 47% of the Physiotherapists and 30% of the podiatrists working in the NHS and 53% and 70% respectively working in the private sector (NHS Information Centre for Health and Social Care, 2013; Townson, 2014).

Sampling Strategy

The inclusion criteria were established in order to sample: Health and Care Professions Council (HCPC) registered physiotherapists or podiatrists who are currently involved in health care provision. From the data presented in table 1 the sample strategy was formed based on:
- The proportion of physiotherapists compared to podiatrists.
- A mixture of private and NHS employed physiotherapists and podiatrists.
- The proportion of females compared to males.

Additionally the target sample sought to gain representation from:
- All NHS pay grade bandings 5-8 and include HCPs who are currently in management bands.
- HCPs from within the private sector with notation given to the breadth of experience by the numbers of years worked post qualification.

	Physiotherapy	Source	Date		Podiatry	Source	Date
HCPC Registrants	46516	HCPC register	2012		13005	HCPC register	2012
F	36054 (78%)	HCPC - FOI gender	2012		9165 (70%)	HCPC - FOI gender	2012
M	10071 (22%)	HCPC - FOI gender	2012		3439 (26%)	HCPC - FOI gender	2012
NHS	22043	NHS workforce census	2012		3870	SoCaP - Townson	2014
Private Practice	24473	assumed figure by deductive calculation			5729	SoCaP - Townson	2014

Table 1 Target population from HCPC, NHS and professional body data

A purposive sample was also utilised for a group interview. The number and type of sample was carefully considered to ensure the data was able to meet the aim of the research and at the same time facilitating an interactive and meaningful discussion (King & Horrocks, 2010).

Access

Following ethical approval, participant recruitment was sought by writing to local NHS Trust managers or private practice associates in order to seek permission to contact potential

participants. Once permissions were granted, individuals were contacted and given a copy of the consent form and the information sheet. If they agreed to voluntary participation, then interview arrangements were made for a time and place that was mutually convenient.

Interview procedures
After consent was obtained, all interviews were digitally recorded and later transcribed verbatim. During the consenting procedure each participant was informed that once the transcripts were completed, they could request to check the transcripts for accuracy. This is part of the member checking process and contributed to the strategy striving for transparency and trustworthiness.

Confidentiality
This ethical and legal issue is of paramount importance to ensure the appropriate use and protection of participant data (DoH, 2005). The protection of confidentiality however may reach a boundary or limitation (Butts, 2014). In the event of an disclosure of information such as safeguarding issues or health care practice that breaches the HCPC 'Standards of Conduct, Performance and Ethics' (HCPC, 2012a), the participants were informed in advance that the researcher would have a duty of responsibility to inform the line manager or the HCPC, where the matter would be dealt with in line with appropriate policies.

Anonymity
It is often difficult to guarantee anonymity in qualitative research due to the level of personal details offered in narratives (Finlay, 2011). The data collected was sensitively managed in order to protect any individuals being identified. A greater challenge in qualitative research is to protect the anonymity of the participants in group interviews since they are each exposed openly within the group. This matter was discussed during the opening section of the group interview where all participants agreed a ground rule to respect and protect anonymity by not discussing any findings outside of the group. Despite confidentiality and anonymity being assured, it is necessary to have a strategy for traceability of data. The purpose of this is to enable the potential withdrawal of participant information at their request. This was achieved using pseudonyms.

Dissemination of data from the findings
Prior to consent, all participants were informed of this and the intention to publish in appropriate peer reviewed journals and at conferences.

Data Collection
A pilot interview was carried out with one participant. This allowed an opportunity to assess the practical aspects of carrying out the interviews such as the information sheet, consent form, recording equipment and interview prompts along with the timing of the process. The number of interview questions which had been pre considered was reduced. This is a common strategy for IPA interview drafting (Smith et al., 2009).

Interviews
Each interview followed a unique direction of discussion dependent on the participants understanding of HCE. The researcher reflexively allowed the participant discussion to lead the direction of the conversation in line with the methodological expectations. This emergent and iterative process is closely associated with the hermeneutic and phenomenological method (Finlay, 2011).

Data Analysis
Interpretative Phenomenological Analysis (IPA) was used as a research method which is a dynamic process that attempts to access the participant's personal world as far as is feasible, but access depends on and is complicated by the researcher's own conceptions (Brocki & Wearden, 2006). IPA analysis always involves interpretation (Smith et al., 2009).

Using a framework embedded in hermeneutic IPA facilitated an inquiry that promotes the participant's own reflection of experiential practice (phenomenology) and then interpreting them (hermeneutical) in the relevant and wider context (Langdridge, 2007).

The method used for coding and thematisation was sensitive to the emergent and iterative methodology. Compared to other methodologies, IPA does not seek to claim objectivity through the use of a detailed formulaic procedure, although there is a basic process of moving from the descriptive to the interpretative (Brocki & Wearden, 2006). The decision was made to manually code and analyse emerging themes rather than using software such as NVIVO. This decision was informed by the potential consequence of the systematisation of data, generating a collection of empty categories with limited value in theory generation (Priest, Roberts & Woods, 2002). The manual coding is consistent with the hermeneutical circle of moving forwards and backwards with the data which also facilitated a rigorous interaction and understanding of the phenomenon as it was uncovered (Charalambous et al., 2008).

Trustworthiness of the research
A hallmark of trustworthiness supporting the plausibility and persuasive nature of the research is to have a rigorous, transparent and auditable trail of all documentation and decision making throughout the process from design to analysis (Finlay, 2013; Koch & Harrington, 1998; Smith et al., 2009). One strategy to achieve trustworthiness in authenticating the data interpretation was to present and discuss the emerging findings in a group interview for critical discussion. This may also be considered as a method of triangulation for convergence of data, where knowledge of two points enables the calculation of a third (Endacott & Botti, 2007). This would inform the final analysis and interpretation and thereby contribute to the key findings of the research. This added a layer of credibility to the adopted method by giving detail of the way the evidence was assimilated and member checked prior to conclusive interpretations of any emergent findings (Brocki & Wearden, 2006; Finlay, 2011).

Two participants from the individual interviews were included in the group interview as one of two methods of adopting member checking of the data (Finlay, 2011). This utilises Heideggerian phenomenology within a Gadamerian approach, allowing the hermeneutical circle to be taken a step further in offering opportunity for feedback and considered dialogue to participants (Dowling, 2007). Member checking in this way is a difficult process in phenomenological research due in part to the complexity of acknowledging what may have been true at the time of interview, but subsequently may have altered due to a variety of variables. It is also a difficult task for participants to identify their own contribution when individual statements have been interpreted under various different themes (Koch & Harrington, 1998).

Findings

Twenty-one individual interviews of between 20-90 minutes were carried out. Table 2 gives a summary of the participant characteristics. The sample represented a balance of both professions along with the gender comparatives, work place and levels of experience, which was not substantively different than that seen in the underlying population of registered physiotherapists and podiatrists.

There was one group interview with 7 participants, a facilitator, an observer and the researcher. The group were presented with the preliminary findings from the individual interviews for open discussion. This served to increase the credibility and trustworthiness, but also generated new data with a focus on the aggregated consensus to ratify what the researcher considered as preliminary findings (Huang et al., 2014). The group interview

effectively deepened the interpretations that were presented by offering several new facets of consideration, along with confirmation of what had been presented as thematic interpretations of the data.

	Podiatry	Physio-theapy	NHS Band/ Level of experience	M	F	NHS only	NHS/ Private Practice	Private Practice only	Private Practice - Previously NHS	Years qualified
1	1		7	1			1			9
2	1		7		1		1			12
3	1		8c		1	1				25
4		1	n/a	1					1	3
5		1	5		1	1				4.5
6		1	7		1		1			10
7		1	Management	1		1				15
8		1	6		1		1			10
9		1	5	1			1			3.5
10		1	5		1		1			5
11	1		6		1		1			14.5
12		1	n/a	1				1		11
13		1	?		1	1				7
14		1	6		1	1				6
15		1	6		1	1				13
16		1	?	1			1			9
17		1	8		1	1				21
18	1		n/a		1			1		4
19	1		Management	1		1				33
20	1		6	1			1			10
21	1		6		1		1			15
Total	8	13		8	13	8	10	2	1	240.5

Table 2 Participant demographics

Findings Overview

Ethics appear to be tacitly intelligible to the physiotherapists and podiatrists who participated in this study. The findings communicated that HCPs believe that they perform their roles ethically, but this seems to be recognised by intuition for the majority who offer minimal understanding about how this can be supported. This research highlights issues surrounding congruency and dissonance between the HCPs desire to work within an ethical framework and the actual lived experience of acting to fulfil this desire for service user benefit. The process of analysis is illustrated below in table 3.

Phase 1 analysis - Description		
Descriptive terms taken from the raw data		
Phase 1	101 descriptive terms were extrapolated from the raw data	
Phase 2 analysis - Categorisation		
(8 categories were derived from the 101 descriptive terms found in phase 1 analysis)		
Phase 2 Categories	Category description	
1	The Meaning of HCE	
2	How it is experienced in practice	
3	Formation of ethics	
4	Imbued accountability/responsibility	
5	Conflicts and Barriers	
6	Context at delivery (Organisation and Culture)	
7	Service user involvement	
8	Interpreted category – disenfranchised ethics	
Phase 3 analysis – Thematisation		
(5 themes were derived from interpretation of the 8 categories formed in phase 2 analysis)		
Phase 3 Themes	Theme description	Previous Categories from phase 2
1	Perceived understanding of HCE	1 & 3 Meaning of HCE and Formation of Ethics
2	Perceived embodiment of HCE	2 & 4 Experience in practice and Accountability
3	The perceived challenge of ideals	5 & 6 Conflicts and Barriers in the Context of Delivery (including organisation and culture)
4	Person-centred care	7 Service user involvement
5	Actuality – the interpretation of the embodiment of HCE	8 The author's interpretation of how ethics are actually experienced

Table 3 Analytical processing of findings

5 Themes

8 Categories

101 Descriptive terms

Conclusion and Discussion of the key findings

Health care practice implicitly or explicitly involves discussion of values, norms and virtues in order to make good choices for which dialogue plays an important role (Widdershoven, Abma & Molewijk, 2009). To safeguard and further develop medical ethics beyond the practice that was expounded by the findings of this study, Svenaeus (2014), points to the Aristotelian concept of phronesis. Since health care practice is complex, it requires HCPs to have abilities over and above knowledge and technical acumen, which can be achieved through phronesis, offering a paradigm for the entire process of clinical reasoning (Tyreman, 2000). Phronesis or practical wisdom, considers the right action for an individual person in a concrete situation and can be enlightened through Gadamer's dialogical approach, since dialogue is the vehicle for understanding another person (Austgard, 2012). From a position of improved understanding lies the art of medicine, which allows the HCP to enter the life world of the service user where they express their behaviour in the individual context of their social and historical experience (Landes, 2015). This allows the existential character of the HCP (practising phronesis) to permit better action towards human needs rather than the consistent theme found in this study where participants superficially followed the application of guideline based care, which could be deployed blindly (Landes, 2015).

Ethics is a branch of moral philosophy that, after reflection, informs one of what ought to be done in a given set of circumstances (Lawson, 2011) and can help provide patient-centred care through morally substantive justification (McClimans et al., 2011). Clinical ethics has emerged from a long hibernation and is turning away from the sterile, meta-ethical dormancy of the mid-twentieth century, awakened by various heightening concerns including ethical lapses in several professions and research misconduct (Curzer et al., 2014). The findings of this study highlighted a lack of embodiment of the criteria for judging good ethical practice through any quality ethical analyses and justifications for decisions and actions (Macklin, 2015). Whilst the participants of this study recognise that ethics relates to 'right and wrong' actions, there may be a gap between the knowledge of what may be right and wrong and deciding which action to take (Weinstein & Nesbitt, 2007). It is the experience and perceptions of the participant's awareness of these issues that formed the data, giving rise to the emergent themes. The following discussion arises out of the 5th theme which is the actuality derived from the hermeneutical interpretation of the participants embodiment of HCE.

The place of empathy in HCE

The findings of this study demonstrate how judgments concerning the rightness of actions are vulnerable to corruption from self-interested inclination (O'Hagan, 2009). It appeared that an adherence to guideline based practice took precedence over the needs of the patients being cared for. This appeared to demonstrate a lack of empathy towards patients and their expressed needs. Empathy, therefore plays an important role in HCE as a necessary part of the practical wisdom of phronesis and thus helps resolve the difficulties to interpret and balance ethical principles and how they attain significance in a particular situation (Svenaeus, 2014). This is part of our capacity, through virtue and reason, which allows us to transcend our imperfections through a process that improves our judgments (Annas, 2015). Empathy becomes a core part of clinical understanding which is morally significant because of the professional duty to understand and help (Svenaeus, 2014) and can cultivate altruistic virtues like benevolence (Song, 2015). Without proper empathy the task of reaching wise moral decisions becomes that much harder especially within normatively rich roles where proper empathic connection is itself part of what morality demands (Carse, 2005). Empathy is a central skill and character trait associated with being a good HCP which enables one to feel and understand the needs and wishes of service users in order to help them in the best medical and therefore ethical sense (Svenaeus, 2014). Svenaeus (2014), argues that empathy is a basic condition and source of moral knowledge as a central component of phronesis and is thereby a motivation for acting in a caring way.

The findings of this study showed a lack of awareness that empathy in service user care leads to improved outcomes (Hojat et al., 2013; Williams et al., 2013). However, this complex and demanding mental operation which is supposed to reach to another persons' experiential reality may fail (Slaby, 2014). The findings of this study demonstrated a paucity of apparent empathy in the decision making of participants'. Health organisations and academic institutions, therefore, should target educational programmes to enhance empathic skills developed for clinical and professional encounters (Burks & Kobus, 2012; Hojat et al., 2013).

Empathy as a key component of phronesis may be developed through moral training, which facilitates the HCP to decide upon the right steps to realise the appropriate ends (Waring, 2000). These initiatives will, however, be limited unless more training is offered and accepted by health care students along with a fundamental shift in the culture of medicine to accept empathy and other humanistic concepts (Burks & Kobus, 2012). One of the findings of this study showed that none of the participants acknowledged having received any

undergraduate or post graduate training including any continuing professional development in ethics related education.

The role of ethics in clinical reasoning and decision making

Whilst this study was not designed to arrive at an atemporal causal certainty (Whitehead, 2004) it has shown the essential and inextricable involvement of ethics in health care decision making. For a HCP to be able to perform the fiduciary duties that are conferred on them by the nature of their professional status, they need to be able to objectively discern the morality of their action. This study is consistent with others that illustrate that HCPs have a lack of ethical or moral language by which to identify and act within a framework of HCE literature outside a limited biomedical normative approach (Carpenter, 2010).

The HCP confers a value on the service user that may dictate the progress or outcome of their encounter/meeting/therapeutic session. This value is ascertained by the merging of horizons that comes together through dialogue in a health care consultation which arises from the experiences, knowledge and judgments of both parties. Whilst empathy is therefore essential it appears to be at risk of being prevented or disengaged through negative empathy or empathic deception (Stein, 1989). It seems, therefore that the hermeneutic phenomenological approach to the service user-provider relationship may offer something more than a research method to investigate the phenomenon in question. It may offer a philosophy to enhance the future development in the way HCPs approach their service provision. In reference to Heidegger's famous phrase that 'only as phenomenology, is ontology possible', Murray and Holmes (2014), suggest, more radically, that 'only as phenomenology, is ethics possible'. That is to say that only through an understanding of the existential or the subjectively lived circumstances can a HCP grasp the necessary conditions for ethics and ethical care of a service user, who then becomes the bearer of an ethical claim (Murray & Holmes, 2014). The participants' empathy towards their patients was a secondary or superficial consideration in their decision to act, which was often justified by various extrinsic reasons which were centred in the organisational philosophy of care.

How this work informs/influences the use of clinical guidelines

Passive reliance on guidelines and administrative protocols can disengage HCPs from a process of care (Owens, 2015). The findings of this study demonstrate how ethical practice may be challenged if one superficially considers ethics to mean adherence to, or reliance on guidance using given frameworks that advise the course of what is the 'right action'. Science may seek the routinisation of knowledge with normative ethics, by offering frameworks or guidelines, but this can lead to learning rule compliance where discretionary judgment is lost and at times is required (Cox III et al., 2008). This was a consistent theme which emerged for the participants of this study evidenced by claims that what is provided to a patient must be evidenced based and more often found in clinical guidelines. Even when the guidelines are easily understood, the implementation will often require individual elements of consideration at the point of care, without which may not succeed to fulfil their design (McDonnell Norms Group, 2006). Virtue theorists argue that obligation-oriented theories that attempt to replace the virtuous judgment of HCPs with rules, codes or procedures, will not produce better decisions and actions (Beauchamp & Childress, 2013). Duty may, however, be inextricably linked with virtue to provide the stimulus to consider virtuous action on the part of the HCP (Annas, 2015), which helps achieve moral enhancement and a mature moral character (Hughes, 2015). Virtue ethics consider the acquisition of good habits of character which in turn suggests a better ability to regulate emotions and reason rather than adherence to pre-set moral principles or rules, thereby offering a distinction in sensitivity to individual situations (Lawson, 2011). Virtue ethics as a model of professional development may not satisfy all aspects of decision making in health

care, but it invites further investigation of deeper theoretical underpinnings to provide guidance for action (Meagher, 2011).

In order to nurture better decision making and therefore actions, virtue ethicists would argue that the most reliable protection offered to service users is not achieved by reliance on institutional rules or government regulations, but rather on the characteristics of the individual HCPs of being informed, compassionate, conscientious and responsible (Beauchamp & Childress, 2013). The intellectual virtues facilitate clinical reasoning that is embedded in the practice of HCPs following frameworks and guidelines, but phronesis has a connection with the moral virtues which sets it apart from scientific knowledge and technical application (Waring, 2000).

The participants of this study appeared to view guidelines for health, care which are underpinned by evidence based practice, as immutable by the scientific method they are derived. Scientific knowledge (episteme) and practical skills (techné) do not in themselves engender morality nor obviate the need for virtuous deliberation where phronesis has a closer relationship (Waring, 2000). HCPs require both scientific knowledge and practical wisdom in order to facilitate healing, the assimilation of both, results in prudence which may inform best judgment in relation to the context of a given situation (Sansom, 2013). That is to say that the lifeworld and situation produce a mode of subjectivity without which ethics is reduced to codes, moral abstractions and often punitive injunctions (Murray & Holmes, 2014). Virtuous behaviour in decision making is a habit of values that are not laid out in written rules (explicit knowledge), but rather are found in tacit knowledge which requires the capacity for judging (Cox III et al., 2008). The findings presented in this study support this argument through the participants who demonstrated a clear desire and respect for what is ethical and moral and yet could only tacitly evidence how they believe this is defined or lived out in practice (Gascoigne & Thornton, 2014; Praestegaard & Gard, 2011). This challenges clinical educators to address the notion that knowledge and awareness of ethics may not lead to ethical behaviour (Parker et al., 2012). It may be argued that healing cannot be accomplished by episteme, since it is a responsive task to the particular individual situation requiring sensitivity, not to universals, but to an embodied network of ever changing relationships (Landes, 2015).

Emerging literature in health care suggests there are gaps between knowledge of ethical theory and its clinical application (Delany et al., 2010). One way of overcoming any shortcomings is to educate HCPs as ethically competent decision makers (Morgenstern & Richter, 2013). A new focus of medical ethics education ought to consider how to apply ethics into practice in the complexities of contemporary health care (Millstone, 2014).

How to teach HCE

There is agreement that effective teaching of ethics is a requirement in health care (Carlin et al., 2011; Drolet & Hudon, 2015; Meffert, 2009), and that students require critical thinking skills to analyse professional and ethical dilemmas just as much as they do for clinical problems (Freed et al., 2012). This is highlighted by the recognition that the ability to effectively integrate ethical and clinical decision making is predicated on a HCPs' knowledge of ethics and an ability to identify ethical issues in practice (Carpenter, 2010). This study has highlighted the apparent paucity of formal ethics education for HCPs. Therefore a coherent ethics research agenda could be developed that reflects the realities of practice and potentially inform the ethical content of taught curricula in academic programmes (Carpenter, 2010). Since 100% of the participants of this study claimed that they have never received any ethics education at any stage of their training or careers, curricula may be needed at post graduate (advanced practice) and continuing professional development as well as undergraduate courses (Fields et al., 2011). Ethics education might then provide the tools to accomplish critical reflection along with a pedagogical context in which a caring attitude can

be taught and cultivated (Vanlaere et al., 2010). The curricula, however, would need to ensure the students have the opportunity to practice these more complex skills (Rozmus & Carlin, 2013).

The end outcome of ethics education may be directed towards creating a virtuous HCP in terms of behaviour and intention, or to equip them with a set of cognitive skills for analysing and resolving ethical dilemmas (Carlin et al., 2011). Part of the complexity of the education of ethics is the concept that learning moral theory does not necessarily make one more ethical (Lawson, 2011). Teaching of ethical theory as isolated or abstract concepts may not be adequate since some people versed in moral theories may reliably make bad decisions, indicating that developing personal moral theory is only part of the task of developing personal morality (Curzer et al., 2014). This was illustrated by the participants who highlighted conflict between the basic tenets of the four principles, recognising the moral obligation to act in such a way as to benefit the service users, balanced against the context of concern for a fair distribution of finite health resources.

Virtue ethics are said to discourage medical or ethical paternalism by refocussing on a person-centred approach (Drolet & Hudon, 2015). For this to be successful, the HCP must be a good hermeneut with skills in dialogue, phronetically understanding the service user and their own being-in-the-world (Svenaeus, 2003), whose world is also situated in the complex structure of the organisation of health provision. How to become ethical in a way that ethicality is a characteristic of oneself can be found in the teaching of Aristotelian methods where habituation is accessed as a process of learning (Annas, 2015). Immersed in the theories of Aristotle, Heidegger, Stein and Gadamer, what has been explicated in this thesis is that phronesis, without being the way in itself, points the way to HCE and brings virtue ethics forwards as an alternative method to achieve phronetic praxis for paramedical professions such as physiotherapy and podiatry (Svenaeus, 2003).

The findings of this study appear to highlight a block in advocacy due to the moral agency of the individual HCP which may include what Stein's thesis highlights as 'the Problem of Empathy' (Stein, 1989). To foster the importance of empathy as a valuable human quality, profound changes need to be targeted in educational programmes at the undergraduate, graduate and continuing health care courses (Hojat et al., 2009).

Conclusion

This study conducted a phenomenological reduction from existing knowledge related to HCE and returned to the phenomena presented in the findings both to, and with, the researcher. What appears evident in the data is a desire by participants to extol ethical practice, but also to acknowledge the limitations in reality of achieving this. Tacit knowledge and personal character are part of the embodied HCE of the participants along with influence from the provider organisation. The acquisition of ethical knowledge and behaviour appears to be initiated through upbringing and cultural influence, thereby inferring the individual character as the primary source of influence towards HCE. This raises the profile of virtue ethics as a preferential strategy for HCE education.

Limitations of this study

The researcher acknowledged the subjectivity of the interpreted findings which were underpinned by the adopted method of IPA. The theoretical underpinnings of which originate from Husserl's attempt to construct a philosophical science of consciousness. With hermeneutics, this posits that the meaning an individual ascribes to events are of central concern, but are only accessible through an interpretative process (Biggerstaff & Thompson, 2008). . At the same time, the researcher as a phenomenologist, guarded against getting

too self-absorbed in self-indulgent introspection which results in a shift of focus from the phenomenon to the researcher (Finlay, 2013).

Limitation due to the adopted methodological approach

It has become widely accepted in health care research to consider the use of hermeneutic interpretative phenomenology when the method seeks to question the meaning of a phenomenon with the purpose of understanding the human experience (Charalambous et al., 2008; Finlay, 2011; Laverty, 2003; Mackey, 2005; Miles et al., 2013; Murray & Holmes, 2014). There are, however, emerging concerns where the methodological and philosophical foundations are not clarified (Mackey, 2005) along with a lack of sufficient understanding of the rigour necessary to ethically utilise the adopted phenomenological approach (Laverty, 2003). A further concern with IPA is the inability of researchers to give sufficient attention to the interpretive dimensions of their work (Brocki & Wearden, 2006; Murray & Holmes, 2014). This may affect the credibility of the findings especially since the researcher was from a health care background whose training, beliefs and thinking about health may have been forged by a positivist evidence-based perspective (Biggerstaff & Thompson, 2008). As the study is interpretative, the researcher attempted to offer credibility by illuminating the interpretation of the participants' understanding of ethics, and concluded that the process of final reflection and analysis was performed by the researcher rather than formulated by the participants (Widdershoven et al., 2009). The eventual phenomenological findings are the researcher's interpretations, rather than the original participant descriptions (Finlay, 2013).

Limitations created by data collecting via interview

Every human encounter involves an interpretation which is influenced by an individual's background and historicality (Laverty, 2003). Using interviews allowed both the participants and the researcher to engage in a dialogue which facilitated an opportunity to understand the participant's lifeworld perspective of ethics (Smith et al., 2009). An underpinning limitation, however, arises when interviewers and interviewees may not have a full awareness of themselves and thus can affect the reliability of the data (Whitehead, 2004).

The author remained aware that humans tend to conceal themselves in order to be characterised in a certain light, thus making themselves artificial and unreliable with respect to the data representing epistemological knowledge (O'Hagan, 2009). Conversely hermeneutical interpretation allowed the researcher to acknowledge the potential to have explicated a deeper meaning through being-in-their-world, diminishing the focus of the epistemological importance as it is subsumed into the ontological (Annells, 1996). Ontologically, this research method provided a platform from which to understand lived experiences (Miles et al., 2013). It also recognises that the HCPs experience may be corrigible in light of the researcher, through a fused horizon, affected by the interpretative process (MacIntyre, 2006; Stein 1989). Stein (1989), according to MacIntyre (2006), emphasises that this does not invalidate the original experience, which if represented as a true report, remains necessarily incorrigible.

The aforementioned concerns, however, remain inherent with such methods. Whilst acknowledging the theoretical influence and ascribing various levels of trustworthiness to the method, the interpretative nature of the data inherently prevents generalisability for application of the findings into other settings (Parahoo, 2006). It is, however, the key contribution of phenomenology to recognise and emphasise the embodied engagement with the world rather than offering a clear and unambiguous meaning (King & Horrocks, 2010). The findings of this study offer a temporal understanding of the data analysed which gives a temporary coalescence of views about HCE in the context in which this study has explored it (Whitehead, 2004). This suggests subjectivity to the purist, but to the dialogue based hermeneut, it offers structure to the clinical encounter by which the HCP is not primarily a

scientist applying biological knowledge, but rather an interpreter of health and illness (Landes, 2015; Svenaeus, 2003).

Recommendations for further research

- Focus on the service users' experience of ethics from a recipient perspective. Consideration could be given to establishing any differences between the expectations of HCPs and service users and potentially seeking to bridge any gaps between the two.
- To establish how key stakeholders may consider the inclusion of ethical decision making into the Standards of Proficiencies for HCPs.
- An exploration of pedagogical methods of improving education of ethics that have optimum impact on lifelong learning in the health care workplace.

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