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# An exploration of how ethics informs physiotherapy and podiatry practice.

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Michael James Concannon

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Doctor of Philosophy

The University of Huddersfield

Submission date: 1<sup>st</sup> May 2016

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## **Abstract**

### **Introduction**

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. This thesis explored how physiotherapists and podiatrists embodied health care ethics in their practice.

### **Methods**

Interpretative Phenomenological Analysis (IPA) as a hermeneutical approach was utilised in order to explore how HCE informs physiotherapy and podiatry practice. Whilst always involving interpretation, this method has the ability to describe the human experience as it is lived. Using a framework embedded in hermeneutic IPA facilitated an inquiry that promotes the participant's own reflections of experiential practice (phenomenology) and then interpreting them (hermeneutical) in the relevant and wider 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 one purposively sampled group interview for discussion which contributed to further interpretation.

### **Findings**

Five themes emerged from the data. The themes indicated that there is a desire by participants to extol ethical practice, but acknowledged various limitations in the reality of achieving this.

The place of empathy has a key role in HCE for clinical reasoning and decision making which may prevent HCPs from passively following performance guidelines and checklists. If empathy and virtue ethics can be taught and utilised by HCPs then guidelines may be considered for individual implementation as an outcome, rather than a prerequisite, of ethical decision making.

### **Conclusion**

Ethical decision making may be enhanced by reconsidering the education of 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 HCPs to act in a caring way, thus making the service user the bearer of an ethical interaction.

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## Table of Definitions

The table below offers a definition of terms related to ethical terminology used in this thesis and is pertinent to the theoretical framework.

Term	Simple meaning	Description
Being	See Dasein	Heidegger's, being-in-the-world of another is explained in the care to achieve Dasein (Heidegger, 1962).
Dasein	'Existing with' or 'being there' (Heidegger, 1962).	To be in the world of another in temporality requires you to exist in their world and care to have it disclosed to you (Heidegger, 1962).
Deontology	The 'good will' only motive is to do its duty for the sake of doing its duty (MacIntyre, 1998).	Concerned with the formulation and justification of moral principles with such terms as 'ought', 'duty', 'good', 'evil', 'right' and 'wrong'. This <i>a priori</i> of ethics may be considered as the metaphysic of morals (Kant, 1785/1948).
Empathy	The intentional act of directing another person's experience and making it present to us (Bornemark, 2014).	A complex awareness of the givenness of the experiences of foreign subjects. This would include the circumstances and environment that may lead to that person's experiences as a temporal concern to enable understanding of the experience of the other person (Stein, 1989).
Lifeworld - given or lived	Where a person expresses their behaviour in the individual context of their social and historical experience (Landes, 2015).	This is understood as prereflective experience without preinterpretations (Dowling, 2007).
Lifeworld - experienced by another	Using empathy with receptivity to understand the experience of others (MacIntyre, 2006).	Apperception through reflexive awareness and reflective interpretation is required to engage with the dynamics of the lifeworld of the participants (Ginev, 2014). Engaging in the hermeneutic circle (double hermeneutic) explicitly engages the historicity and cultural location of the researcher in the lifeworld of the participant experience allowing the inter subjectivity to open up and close down the evolving understandings (Finlay, 2013).
Phronesis	Practical wisdom or prudence (Aristotle, 300 BC/2004).	The ability to deliberate about what is good and advantageous with a substantive determination to seek such outcomes from ones behaviour (Gadamer, 1996).
Sorge	Care (Heidegger, 1962).	Sorge or 'care' is an essential component of our being-in-the-world, and provides the connectedness required to be engaged in-the-world or indeed in another person's lifeworld (Miles et al., 2013).
Utilitarianism	Production of the greatest happiness of the greatest number (MacIntyre, 1998).	The 'good' and 'right' action is achieved if the greatest happiness is distributed to the greatest number (MacIntyre, 1998).
Virtue ethics	Discerned moral conduct resulting in action arising from choice and must be distinguished from desire, temper, wish and opinion (Aristotle, 300 BC/2004).	Virtue ethics continues to rely on Aristotelian concepts relating to moral agency and to human character which requires traits to deliberate and make decisions in accordance with correct reason (Svensson, 2009). To achieve this one must be equipped with prudence (phronesis) (Aristotle, 300BC/2004; Gadamer, 1996; Svensson, 2009).

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## List of abbreviations

ADP	- Advanced Development Programme
BMA	- British Medical Association
CPD	- Continuing Professional Development
CQC	- Care Quality Commission
CSP	- Chartered Society of Physiotherapists
DoH	- Department of Health
EBM	- Evidence Based Medicine
EBP	- Evidence Based Practice
GMC	- General Medical Council
HCE	- Health Care Ethics
HCP	- Health Care Practitioner
HCPC	- Health and Care Professions Council
IPA	- Interpretative Phenomenological Analysis
NHS	- National Health Service
NICE	- The National Institute for Health Care Excellence
NSF	- National Service Framework
SoCaP	- Society of Chiropodists and Podiatrists
SoP	- Standards of Proficiency

## CHAPTER 1: Introduction

This chapter offers a justified explanation as to why the study was initiated. It does this by locating health care ethics pertinent to physiotherapy and podiatry in the context of contemporary practice in the UK.

### 1.1 Reflexive position statement

Diligence was required by me as the researcher when considering what had emerged from the data before attempting a deeper interpretation of the meaning of what was found (Finlay, 2013). To achieve this it was essential that fore-structures, which are inevitable, were explicitly acknowledged and worked reflexively (Finlay, 2013). This awareness is seen as a protection from imposing my assumptions on the study (Laverty, 2003). Fore-structures in this study are those which may be understood or known in advance of interpretation (of the participant findings) and could be considered as an anticipation of meaning or prior awareness of a context dependent experience or knowledge (Mackey, 2005). This research was embedded in the philosophies of Heideggerian and Gadamerian hermeneutic phenomenology where the constructing of 'our' reality from 'our' experience of being-in-the-world, demanded assurance that rigour was applied throughout the analysis (McConnell-Henry et al., 2009). Analysis in this way attempted to ensure that the potential influence from my 'fore structures' did not detract from the data, through hidden bias and prejudice, but permitted entry to the 'things in themselves' (Miles et al., 2013). Gadamer refers to prejudice as 'tradition' where Heidegger uses terms such as 'background', 'co-constitution' and 'preconceptions' (Koch, 1996). Koch (1996), draws on Merleau-Ponty's (1945/2012), analogy that we do not need to see the light, but only what it illuminates, but without the light nothing would be seen. This contextualises how my background in health care provision may draw on experiences offering the participants further background meanings and frames of reference. Prejudices are part of the contribution to the personal horizon from which new horizons are being continuously formed (Annells, 1996). Annells (1996), points out that whilst forming horizons, self-reflection by the interpreter is a vital aspect, but self-understanding is always 'on-the-way' and is a path where the completion is a

clear impossibility. The horizon can never be complete, but is being acknowledged and evolved over time through data analysis at macro and micro levels and ensuring that the analysis does not move beyond the data and out of the hermeneutic circle (Whitehead, 2004). The participants' life events combined with my own perspectives resulted in the co-constituted interpretation and the Gadamerian 'fusion of horizons' (Koch, 1996). It is the process of dwelling with the horizons of meaning that facilitated the phenomenological attitude that opened the intersubjectivity to be engaged, without which only the subjective account of experience would have been reported (Finlay, 2013).

During the reflexive and iterative process of data collection and interpretation I recognised the use of intuition, which permitted flexibility in the decisions to stop, steer in different directions or to probe deeper. Intuition in this way allowed the essential use of 'self' to facilitate emerging data that was be meaningful (Parahoo, 2006). In the pursuit of rigour it was essential to fully explicate any preconceptions and any of my contributions which co-created data from the interview process (Lowe & Prowse, 2001). This was a vital asset of IPA, but a criticism of the method if I did not explicitly recognise the theoretical preconceptions and my role in interpretation (Brocki & Wearden, 2006). If achieved, Brocki and Wearden (2006), claim that this ensures the accessibility and clarity of the findings.

My ongoing self-critique and self-appraisal allowed the unavoidable inclusion of self-interests to be incorporated into the inquiry (Koch & Harrington, 1998). Rather than suspend or attempt to bracket these interests, it may be argued that, through Gestalt psychology, the observable and empirical 'figure' appeared by virtue of the 'ground' that supported it and was only given its form by the necessary context, without which meaningful phenomena could not appear (Murray & Holmes, 2014). The intersubjective context of me, as interviewer, was included in the interpretation of the participant's experiences. The rigour that had been applied in the analysis is evidenced in sections 3.6 and 4.5 and gives credibility and trustworthiness to the data obtained and the process of interpretation of that data.

Interpretative rather than traditional phenomenology alone allowed a broader canvas for me to paint a description of the phenomena reviewed (Caelli, 2000), but

highlighted that reflexivity must therefore have assumed a key role (Dowling, 2007). The rationalisation advocating reflexivity is to develop the human science attempting to embrace the intersubjectivity of both the methods and philosophies involved (Finlay & Gough, 2003). Rigorous reflexivity offered self-awareness and thoughtful analysis of the intersubjective dynamics from the data that allowed me to form conclusions and in turn transformed what was perceived as a problem into an opportunity (Finlay & Gough, 2003). Although there is a diverse understanding surrounding the definition of reflexivity, common agreement involved the examination of my preconceptions and motivations (Finlay & Gough, 2003) and any recognisable influence that was drawn into the interpretative process. Ensuring a reflexive attitude not only allowed me to properly enter the hermeneutic circle, but it also enhanced credibility by offering the reader transparency of the decision making throughout the data collection and interpretation. This trail of decisions is theoretical, philosophical and methodological and has the potential to clarify the research process for the reader, thereby improving the trustworthiness of the process (Austgard, 2012; Koch, 1996).

After the first two interviews a period of reflexivity was utilised, allowing brief analysis of the data captured before continuing with further interviews. This formed part of the iterative process to review and alter the method of interviewing. Using this strategy the initial horizons and prejudices were not eliminated, but acknowledged and accepted to be inextricably linked to the interpretation contributing to the analysis (Whitehead, 2004). This is a defining feature of qualitative research which enabled me to accept my role as a central figure actively sampling participants, gathering data and constructing interpretations from it (Finlay & Gough, 2003). The same reflective and reflexive approach was used throughout the interview process. The changes to the interview method at this stage were subtle alterations to encourage meaningful discussion around HCE. Open ended questions were used with a cautious approach in challenging the participants. After further reviewing of the literature on research methods, the interview technique continued to be modified and following various adaptations, I became more willing to have meaningful discussion with the participants about the experiences they shared.



Reflexivity was an integral part of the epoché adopted throughout this phenomenological approach. Epoché achieved through reflexivity illustrates self-critique and self-appraisal which provided an explanation from the findings of how my own experiences were reflected in the research process and contributed to the rigour of this research (Koch & Harrington, 1998; Murray & Holmes, 2014). Bracketing or Epoché, from the Greek word meaning 'to refrain from', is fundamentally linked to phenomenological research, characterised by Husserl as abstention, dislocation from, unplugging or exclusion from the normal faith given to the reality of what is experienced (Moran, 2000). Effectively it allowed me to ensure awareness of my own prejudices and recognise the influence on the participants at data collection or throughout the analysis. Various phenomenologists have this issue at the heart of their methods (as discussed in the philosophical influences of Heidegger and Gadamer in Chapter 3). Whilst some believe bracketing should take place prior to, during and after data collection, alternatively others believe it ought to be done only during analysis as it is inappropriate during the interviews where the relationship with the other person takes the priority (Dowling, 2007). For this, I followed the Heideggerian philosophy where bracketing is acknowledged in the analysis phase. The questions used throughout the interview process were evolutionary and emerged from the varied perspectives of the participants and their experiences shared (Crist & Tanner, 2003). Contact sheets were used for each interview which allowed the documentation of any temporal and none recorded influences that were recognised. This along with the verbatim transcription allowed a full analysis of all data, recognising the researcher to be a part of the data collection. Offering enhancement through intuition of the research questions contributed to generating meaningful data for interpretation that was faithful to the research methods and added to the trustworthiness of the findings (Hicks 2004).

## 1.2 Reason for Study

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; Millstone, 2014). Morality and health care are inextricably entwined

(Hamilton, 2010) and are inherent to the practice of HCPs (Drolet & Hudon, 2015). Ethical dilemmas have continued to challenge health providers historically and in the modern context (Franzblau, 2010; Williams, 2005; Winkler & Gruen, 2005). As the study and practice of ethics have evolved, the accepted ethical norms have changed through many dimensions, but what remain consistent are the principles underpinning the ethos of health care. Ethics of health has its roots in ancient civilisations evidenced by the Code of Hammurabi 1740 B.C. and the Hippocratic Oath 400 B.C. circa (Ivanov & Oden, 2013). Health Care Ethics (HCE) may have been of interest to philosophers and physicians since the time of Hippocrates, but the rising of medical ethics as an academic discipline has only emerged since the 20<sup>th</sup> Century and perhaps only in the last few decades has this manifested as clinical ethics in the UK (McClimans, Dunn & Slowther, 2011).

Hippocrates, who is often referred to as the father of western medicine, is credited with the (Hippocratic) Oath that, in part, hoped to ensure that the individual person responsible for health care provision was, and always remained, mindful of their duties, as laid down in the swearing of the Oath (Gupta, 2015; Katsambas & Marketos, 2007; Lang, Wyer & Haynes, 2007). Though the Oath is extolled as a paragon and paradigm of medical ethical codes, it should not be treated as though it represents a set of abstract ethical principles pertinent for all ethical dilemmas, but rather should guide the HCP to learn how to act as a moral agent (Sansom, 2013). Taking an oath may be considered as a dynamic form of reflective practice that connects us deeply to our own core values both as human beings and as professionals (Gaufberg & Batalden, 2014). The premise of the original oath assumes the individual clinician will, to the best of their ability and judgment, attempt to do no harm to service users, but also to maintain accepted professional ethical standards. The principles of this oath remain part of the philosophy of care in all medical institutions (Franzblau, 2010; Gupta, 2015; Katsambas & Marketos, 2007; Kumar, 2010).

For the purpose of this study, HCE ethics 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). For HCPs, operating ethically means to treat each other with careful attention, sensitivity and compassion using an integrated set of values, principles and morals that allows systematic and deliberate promotion and protection of human dignity (Weinstein & Nesbitt, 2007). This respect for the inherent worth of the dignity of the individual is fundamental in the principles underlying health care (Dugas, 2005). This form of ethical reasoning and justifiable decision making is contextualised in health care policy and the clinical environment providing health care to individuals (McClimans et al., 2011).

As a HCP and educator, the author has worked in health and social care since 1991 and recognises the challenge for individuals who pro-actively reconcile organisational and individual ethical standards impacting on service delivery. There is potential for internal conflict in decision making, where the HCP may feel torn between the correct behaviour as dictated by a code of ethics and their employer expectations or personal expediency (Weinstein & Nesbitt, 2007). The influence of the health environment on professional integrity and standards of practice is not consistently understood and can be antithetical to the philosophy of client-centred practice espoused by HCPs (Carpenter, 2010). 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 (Jackson, Wood & Zboja, 2013; 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 may

have been evidenced in the 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. One of the recommendations of the Francis report was to make all those who provide care for patients, individuals and organisations, properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service.

Individual HCPs appear to value ethical principles, but do not seem to actually use them directly in the decision making process (Page, 2012). Cognitive dissonance and an agentic shift may explain how a moral compass can be overlooked causing an erosion of agency (Jackson et al., 2013). The conflicting responsibilities challenge the principle of autonomy for a HCP, autonomy being one of the four ethical principles that are widely disseminated and accepted from a pluralist approach to ethics in health care (Duncan, 2010). Autonomy may be considered as the ability, skill or trait of the autonomous person to have the capacity of self-governance over their understanding, reasoning, deliberating and management of independent choices (Beauchamp & Childress, 2013). However, normative ethics in health care may alter the dynamics underpinning ethical autonomy of HCPs and potentially even disenfranchise them (Balch, 1998; Nakayama, 2007; Traynor, Boland & Buus, 2010). By itself, autonomy is a weak foundation for HCE especially if separated from the categorical imperative that Kant expounds (Svenaeus, 2003). Svenaeus (2003), takes this further by suggesting that autonomy can lead to a peculiar form of relativistic nihilism thereby undermining the potential of a HCP to establish good ethics. Yet HCPs are expected to have the capacity and duty to act autonomously in their day to day practice (Health and Care Professions Council [HCPC], 2013a; HCPC, 2013b). The issue of agency and autonomy is complicated by the corporate structure and the effect this has on the decision making of an individual, which can lead to a deterioration of ethics based on the actions of individuals (Jackson et al., 2013). Actual decisions made may seldom be fully rational and may not measure up to the ideal, but fall along an axis that radiate from

the ideal, if, however, the choice appears to respect the autonomy of the service user then it may be justified (Kultgen, 2014).

There is a paucity of evidence available within the field of physiotherapy and podiatry 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). Part of this study will include consideration across the literature from other health care settings and empirical data collected in this study to explore how ethics is interpreted and how it may influence practice amongst physiotherapists and podiatrists. This study explores and delineates these issues within a philosophical framework of hermeneutical phenomenology in the context and theoretical framework of HCE.

### 1.3 Current understanding of ethics in the context of health care

#### 1.3.1 Frameworks and guidelines

Bioethics as a discipline informs health care professionals and enables them to identify and respond to moral dilemmas (Kass, 2001). A set of ethical principles expresses and values underlying rules that can be provided by an analytical framework that represent common morality (Winkler & Gruen, 2005). The limitations of such frameworks, Winkler and Gruen (2005), highlight, are the abstract and universality of the principles in general. They indicate that even where agreement on the principles has been achieved it does not provide a method for resolving the conflicts between them, but that such frameworks help to clarify what is morally at stake and identify the irresolvable aspects of the situation. Furthermore, a rule-governed decision making process can fail if conflict over competing demands remains unresolved (Tyreman, 2000). A health care organisation may be viewed as a trustworthy service provider if it enables the staff who deliver care to be advocates for their patients, part of which may involve the creation, critique and improvement of organisational guidelines (Winkler & Gruen, 2005).

In health care throughout the UK, there are various levels of governance which aim to encourage the achievement of quality assurance. Examples of this are; the National Institute for Health and Care Excellence (NICE) and National Service Frameworks (NSFs) which are funded and advised through the UK's Department of Health (DoH). The NICE guidelines and NSFs are intended for use by the NHS, Local Authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing and are designed to promote good health and prevent ill health (National Health Service [NHS] Choices, 2012). The guidance is produced by the people affected by it, including health and social care professionals, service users and the public. The purpose of guidance that NICE creates is based on the best available evidence and that it will provide a service that represents good value for money, weighing up the cost and benefits of treatments (The National Institute for Health and Care Excellence [NICE], 2012). Guidelines are primarily developed to assist HCP and service user decision making about appropriate care for particular clinical circumstances (Ouimet, Landry, Amara & Belkhodja, 2006). Dichotomously, the use of rules (including guidelines and frameworks) as the essence of critical thinking could cause confusion masking ideals of knowledge and truth, which results in formal rules becoming one resource among several for rational construction (Hoffmaster & Hooker, 2009). Ubiquitous disclaimers inferring that clinicians ought to rely on their professional judgment in applying guidelines, paradoxically encourages HCP heuristics to be developed (McDonnell Norms Group, 2006).

Guideline adherence may be considered a static construct and one opposed to the dynamic requirements that HCPs are expected to be able to use to distinguish between evidences for appropriate decision making, which is the hallmark of critical thinking (Huang, Newman & Schwartzstein, 2014). What is, therefore, required for science, for ethics and for health care is a new and richer conception of rationality that underpins the development of norms including the applied norms of criticality in ethical decision making (Hoffmaster & Hooker, 2009).

### 1.3.2 Obligation and governance

It is incumbent on health care professionals to conduct themselves in accordance with their code of ethical practice (HCPC, 2012b). Primarily this is obligated upon HCPs externally and spans all known generations of medical providers. The Hippocratic Oath described the basic ethics of medical practice and was the initial expression of a moral code of conduct in medicine (Raina, Singh, Chaturvedi, Thakur & Parihar, 2014; Willacy, 2011). There has been a resurgence of professional interest in medical oaths and codes of conduct leading to The British Medical Association in 1997 publishing the first draft of a revised Hippocratic Oath to be considered by the World Medical Association (Hurwitz & Richardson, 1997). The General Medical Council (GMC), whose role it is to protect, promote and maintain the health and safety of the public by making sure that doctors follow proper standards of medical practice (General Medical Council [GMC], 2014), provide the Good Medical Practice Guide (GMC, 2013) which is to be adhered to by all registered medics in the UK. Almost all medical schools in the USA and around half in the UK administer an oath of some kind (Hurwitz & Richardson, 1997). However, what is not well documented is if this is voluntarily adopted or if it influences practice. The BMA have found that when resisting human rights abuses or considering the resolve of doctors' integrity when acting in extreme circumstances, then the oaths affirm a commitment to firm moral parameters (Hurwitz & Richardson, 1997). Consequently, the BMA recommends that medical ethics are incorporated into the core curriculum and that all medical graduates ought to make a commitment by means of affirmation to observe an ethical code (Hurwitz & Richardson, 1997). Affirming a professional oath may not prove that one will act better than others, but it does state a claim that there is the potential to drift away from the highest standards and the oath illustrates the need to reflect and act to resist that drift (Meffert, 2009).

### 1.3.3 Regulation of physiotherapists and podiatrists

The regulation of physiotherapists and podiatrists actions and behaviours has taken various forms over many decades. The British Medical Association set up the Board of Registration of Medical Auxiliaries (BRMA) in 1937 as a non-profit making company (HCPC, 2012a). This included the professions of physiotherapy and

podiatry who both functioned with their own committees within the BRMA. This evolved into the Council for Professions Supplementary to Medicines in the early 1960's and eventually into the Health Professions Council (HPC) from April 2002 (now Health and Care Professions Council (HCPC) since August 2012). Any complaints about the ethical practice of a registrant would be undertaken by the Conduct and Competence Committee. This was a statutory committee and advised the Council on issues related to conduct performance and ethics of all registrants. Currently when a complaint relating to the ethics of a registrant arises, then the HCPC's Fitness to Practise Committee initiates an investigation (HCPC, 2014a).

Ethics maintains a critical relationship with professional codes of conduct and guidelines, but it is a branch of philosophy that cannot be simply reduced to a set of practice rules (Drolet & Hudon, 2015). Ethics are, however an integral part of the demands and expectations placed on all HCPs. The HCPC acts as the regulatory body for physiotherapists and podiatrists in the UK and set the Standards of Proficiency (SoP) which every registrant must meet in order to enter and maintain registration (HCPC, 2013a; HCPC, 2013b). As autonomous professionals, registrants need to make informed and reasoned decisions about their practice to ensure that they meet the Standards (HCPC, 2013a; HCPC, 2013b). The HCPC remind registrants that they are autonomous in their professional role, but need to seek advice from appropriate sources to enable them to justify their decision making process, if called to do so (HCPC, 2013a; HCPC, 2013b). The HCPC also provide registrants with the Standards of Conduct Performance and Ethics. These Standards provide a focus to registrants based on the HCPC's expectations of their behaviour. This can play an important role in helping the HCPC make decisions about the character of the people who apply to the Register and also in cases where judgment is made about whether someone is fit to practise (HCPC, 2012b). They have been written in broad terms in order to take account of changes in best practise, technology, the law and wider society in the future.

Physiotherapists and podiatrists working in NHS settings may also be scrutinised under the Care Quality Commission (CQC). The CQC monitor, inspect and regulate services to ensure they meet fundamental standards of quality and safety (Care Quality Commission [CQC], 2015). The CQC's remit is to answer five questions



about the services they are inspecting relating to: safety, effectiveness, caring, responsiveness and leadership (Brown, 2014). They also publish their findings in order to help people make informed choices about their care (CQC, 2015). This ensures not simply safe, but effective, compassionate and high-quality care (NHS Choices, 2015).

#### 1.4 Introduction to the thesis

This work considers ethical policies and perceived ethical practice in the philosophical framework of hermeneutical phenomenology. This was considered in the conceptual and theoretical framework of dialogical and phronetical ethics.

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 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 lifeworld 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 producing something that superficially follows the application of guideline based care, which could be deployed blindly (Landes, 2015).

## 1.5 The organisation of the thesis

Chapter 2 - explores the extant literature contextualising ethics in health care.

Chapter 3 - discusses the key philosophical paradigms that have influenced the research methods and the underpinning concepts of ethical practice.

Chapter 4 – presents the working methods that were used to progress data collection and analysis.

Chapter 5 – offers an overview of the findings.

Chapter 6 – presents a discussion of the findings of Theme 1 which is the perceived understanding of HCE.

Chapter 7 – presents a discussion of the findings of Theme 2 which is the perceived embodiment of HCE.

Chapter 8 – presents a discussion of the findings of Theme 3 which is how the perceived ideals in health care are challenged.

Chapter 9 – presents a discussion of the findings of Theme 4 which considers the service user as the centre of health care.

Chapter 10 – presents a discussion of the findings of Theme 5 which is the interpretation of the embodiment of HCE.

Chapter 11 – is a discursive conclusion of the key findings of the research, balancing potential outcomes against the recognised limitations of this study.

This introductory chapter has considered governance, guidelines and frameworks as a part of the ethical decision making of physiotherapists and podiatrists. The following chapter explores the extant literature surrounding ethics and the impact towards service provision for physiotherapists and podiatrists.

## CHAPTER 2: Literature Review

This chapter considers the extant literature to contextualise HCE in terms of the theoretical antecedents along with the lived demands of the practical application of ethics.

### 2.1 The Literature Review Method

The literature review has been informed by conducting a series of literature searches using the University of Huddersfield's search facility, Summon. Summon does not draw from databases, although it does contain some data from abstracting & indexing (A&I) services. Instead it predominantly receives article data (usually including the full-text) directly from journal publishers. In most instances, one might expect the same content that is indexed in specific database (e.g. Emerald, Science Direct (Elsevier), Wiley Online Library, Sage Online and Springer Link) to also be indexed in Summon. Summon accesses journal databases directly from the journals themselves. This system will access approx. 80% of the content on CINAHL (Cumulative Index of Nursing and Allied Health Literature).

During the early stages of this research, Medline, Pubmed, PsycINFO, CINAHL and the Cochrane Library were also searched as a method of retrieving published work from the wider systems available. This allowed confidence when comparing these databases with Summon. A summary of search terms are in Table 1 below. There were no limits set by date or content, providing they were available in English and were pertinent to the unfolding themes.

Conducting a literature review prior to commencing data collection may prejudice the research by reliance on background understanding, which influences the data constructing (Finlay, 2011). Engaging in an early literature review may narrow the analytical field of vision leading to specificity in focusing on certain aspects of the data or conversely may enhance analysis by sensitising the reviewer to more subtle features of the data (Braun & Clarke, 2006). Husserl's phenomenological approach negates or limits this concern through bracketing the prior knowledge (McConnell-Henry, Chapman & Francis, 2009). Alternatively, the Heideggerian philosophy of a

hermeneutical enquiry accepts and even encourages prior knowledge which can facilitate meaningful questions being formed throughout the data collection process (McConnell-Henry et al., 2009). Conversely the risk of completing a literature review after data collection may render the participant recruitment unnecessary and therefore unethical if the review in any way invalidates the necessity for such research (Lowes & Prowse, 2001).

Table 1 Terms used for literature searching	
General search terms used	
Main subject area	Methodology
Initial searches	
Ethics in health care	Qualitative research methods
Decision making	Qualitative data collection
Ethical decision making	Interviewing for qualitative research
Ethical decision making in health care	Forming research methodology
Health care ethics	Justifying research methods
Clinical reasoning and ethics	Ontological stance in research methods
Ethics in podiatry	Experimental phenomenology
Ethics in physiotherapy	Template analysis
Ethics for health care practitioners	Interpretative phenomenological analysis
Ethics for AHPs	Action research
Autonomous practice in health care	Grounded theory
Normative principles in health care ethics	Phenomenological methods of research
Minimum standards in health care	Phenomenology and research
Forming judgments in health care decision making	Research methods using phenomenology
Forming reasoning and practical reasoning	Hermeneutical methods of research
Work based morals and morality	Hermeneutics and research
Freedom and decision making	Research methods using hermeneutics
Educational research for social justice	Thematic analysis
Knowledge and epistemology	Content analysis
Evidence based practice/medicine	
Informed consent	
Later search terms following the emerged themes from the initial findings	
Empathy	
Phronesis	
Disenfranchisement	
Cognitive dissonance	
Agency	
Apathy	
Organisational ethics	
Tacit knowledge / Heuristics / Intuition	

The fundamental premise of performing a literature review serves to contextualise key aspects of the new research in relation to the existent literature. It also establishes what gaps may prevail in the general pool of knowledge on a given subject area which in turn allows the selection of an appropriate research question

and study design. At the end of this process one may be considered an expert in the current state of knowledge of that subject area (Davis, Thompson & Panacek, 1995). Despite this suggestion, the author recognised the need to constantly re-review the literature to continue the exploration and interpretation of available published work in the context of HCE. Themes emerged during the process of analysis which illuminated new areas of knowledge that were not anticipated previously and required framing into various contexts (Smith, Flowers & Larkin, 2009). These themes can be seen in Table 1. This reflexive and exploratory continuum remained part of this research throughout the process.

## 2.2 The foundation of ethics

Ethical decision making arises from choice and deliberation in determining voluntary actions that are believed to be modifiable to best reach the end in which one directs one's actions (Aristotle, 300 B.C./2004). In the pre-philosophical writings of the Homeric poems to the Sophists, the Greeks had realised that the meaning of key words involving the framing of a moral question was no longer clear and the concepts defining the moral frameworks were rendered problematic (MacIntyre, 1998). The ancient ethical theories promote reflection of oneself as the moral agent based on a teleological framework and the pursuit of happiness in reaching such ends (Annas, 1995). The concepts expounded during that era were inextricably linked to the social order of the recognised hierarchy and only those who function within that hierarchy would be able to apply those value predicates (MacIntyre, 1998). In current health care systems, ethics are not optional and are inclusive of all stakeholders since they are an integral and essential part of care provision (Limentani, 1998). HCE concerns the moral responsibility, authority and power of all physicians and health care professionals (McCullough, 2000).

The concept of Virtue Ethics that had been retained from the ancients collapsed with the science of the sixteenth and seventeenth centuries, resulting in Aristotelian teleology being rejected for autonomy, secularisation and linking ethics to the natural and observable order, separating it from the lived experience (Goodman & Marcelli, 2010; Schneewind, 1990). During the late 18th century, Kant attempted through his 'categorical imperative' to assist moral decision making, facilitated through universal

principles. A consequence of this shift systematically divorced morality or ethics from reason and human identity leaving an impoverished language from which to understand ethics and morality (Goodman & Marcelli, 2010). During the 20th century the advancing theories of the phenomenologists recaptured ethics in the context of phronesis (practical wisdom). The Gadamerian and Aristotelian concept of phronesis can only be acquired through long experience in concrete and practical matters of life (Svenaeus, 2003). Svenaeus (2003), clarifies Gadamer's thesis, that applied hermeneutics is not the application of universal rules, but the hermeneutics of medicine ought to be grounded in the interaction between the HCP and service user. It is through the relationship and understanding forged out of that interaction that the merging of horizons may arise through interpretation in a dialogical understanding. This involves the lived experience of the service user and the HCPs' professional and technical understanding of the health concern. Horizon is a metaphor for how we perceive and interpret reality (Austgard, 2012) and it is the merger or fusion of horizons through language and dialogical interaction that offers better understanding of another's situation. The dialectical and dialogical understanding, developed more fully through philosophical hermeneutics (Spence, 2001), offers a platform to the understanding and practice of HCE.

### 2.3 Models, theories and modern perspectives influencing health care ethics

Moral theorising influencing HCE in recent decades has been promoted through subsequent publications of Beauchamp & Childress' work (Upton, 2011). The modern concepts of ethics have not, however, emerged out of a vacuum in history, but are a continuation of existing ideas borne out of Greek ideology, Augustinian introspective processes and Christian conceptualisations of the human subject (Goodman & Marcelli, 2010).

#### 2.3.1 Consequentialism

'The greatest happiness for the greatest number' is a common interpretation of the concept most associated with utilitarianism (a common form of consequentialism) (MacIntyre, 1998). The adoption of utilitarian ethical decision making in organisations limits the quality of the decisions by failing to serve the interests of all

parties involved, whereas deontological approaches guide actions on the principle and duty which emphasises the nature of the action rather than the outcomes (Pimentel, Kuntz & Elenkov, 2010). However, critics assert that defining happiness or pleasure is difficult to convert to utility and it is only applicable with any kind of moral legitimacy in a society where non-utilitarian norms of decent behaviour are assumed to be upheld (MacIntyre, 1998). To highlight a problem of using utilitarian ethics, Upton (2011), discusses the short fall between moral theorising and determinacy of decisive action in any given situation. He suggests that to maximise the good, one has to have used the theory in one's deliberations or to have established if the action eventually held true to justify a greater good. Upton (2011), highlights that the failings may be due to a number of causes e.g. not having sufficient time to calculate the necessary action, not informed suitably to perform the calculations and not being free from bias to make the correct judgment. This renders moral theorising difficult to use by busy HCPs despite the fact that they most need it (Upton, 2011).

### 2.3.2 Deontology

Deontological ethics could be considered as being dutiful to actions driven by adherence to rules, regulations, laws and norms (Chakrabarty & Bass, 2015). Deontology is commonly associated with Immanuel Kant, who expounded the categorical imperatives as formula of universal laws, one of which he expressed as: "I ought never to act except in such a way that I can also will that my maxim should become a universal law" (Kant, 1785/1948 Chapter 1:17p67). This places emphasis on the 'good will' only motive as doing its duty for the sake of doing its duty (MacIntyre, 1998). This is difficult to apply in practice where health is hard to define and is not simply the absence of disease. The provision of health care aims to consider the person's individual needs (Department of Health [DoH], 2005b), but is at the same time bound to a system of commissioning and criteria based provision with various guidelines, frameworks and policies possibly dictating which services can be distributed to those seeking care (DoH, 2005c). If a person has a medical need which falls out of the local agreement of commissioned services, the HCPs' response to the patient may influence the health outcome for that person. This may depend on which ethical theory influences their decision making. For this to be

achieved within a deontological framework, the HCP is considered to be both the moral agent and the decision maker. A moral agent is a person who is capable of thinking, deliberating, deciding and acting in accordance with personal and professional moral principles (Carpenter, 2010). Kant fused sensibilities with empirical principles to claim that each person has innate structures affording rationality and agency and giving individuals access to the moral laws which ought to be followed (Goodman & Marcelli, 2010). Kant's duty bound ethics reject the moral significance of consequences (Upton, 2011), but fails to guide the HCP into knowing what is considered 'right or wrong' (Pimentel et al., 2010). Whilst deontology remains a part of ethics education it must be accompanied by the autonomous and rational construction of ethical values centred on critical reflection and appropriation of professional duty and commitment to society (Ramos et al., 2013).

### 2.3.3 Virtue Ethics

Moral reasoning has long served as the foundation for ethical decision making (Levitt & Aligo, 2013). Virtue centred ethics considers the character at the core of morality and supposes that the question is not 'what ought I to do?', but rather, 'what sort of person am I to be?' thereby rendering the primary moral judgment directed towards the character of moral agent (Schneewind, 1990). The purpose of virtue ethics is to recognise that ethics is not merely a matter of what one does, but who one is, thus making it an agent centred theory rather than action centred (Meagher, 2011). In virtue ethics the conditioning of one's actions towards morality is a matter of habit and should be developed (Pimentel et al., 2010). Contemporary virtue ethics continues to rely on Aristotelian concepts pertaining to human character, constituted by well entrenched dispositions or traits to deliberate and make decisions in accordance with correct reason (Svensson, 2009). Svensson (2009), adds that one has to reliably act in appropriate ways whilst being properly affected in desire and feeling. To achieve this, Svensson (2009), comments that one must be equipped with practical intelligence or wisdom (phronesis). This provides an ability to appreciate the salient features determining what would constitute the appropriate thing to do in particular situations. From a phenomenological and hermeneutical perspective, virtue ethicists claim that only by the appropriation of phronesis can medical ethics be both epistemic and phronetic (Svenaeus, 2003). Prominent



theories in Stoicism referred to virtue as a skill or *techné* (Annas, 1995). This infers that virtue ought to be teachable or learnable and thereby developed and embodied by HCPs.

#### 2.4 Ethics in health care

Health is a complex issue partially concerning social, psychological and physical matters which may be morally defined in ways that change for every patient and across time (Landes, 2015). The Hippocratic Oath was originally taken not just by the physician, but also the physicians' assistants and associates, whereas moral challenges affecting different members of the modern day health care team may manifest with conflicting responsibilities and obligations that are bound, not by a single oath, but by different codes of conduct (Hurwitz & Richardson, 1997). Codes of conduct, policies, guidelines and minimum standard are intended to support or enhance clinical excellence, yet they have the potential to disenfranchise autonomous practice and decision making (Nakayama, 2007; Traynor et al., 2010). They offer a replacement for individual accountability and responsibility (Eriksson, Höglund & Helgesson, 2008) and may have resulted in the modern interpretation of ethics now being effectively appropriated to ticking boxes with regulatory and guideline adherence/compliance (Loughlin, Upshur, Goldenberg, Bluhm & Borgerson, 2010).

When attempting to apply ethical practice to clinical situations, the potential benefit of a hermeneutical appropriation of *phronesis* offers alternatives to the conceptualised bioethical models that exist in principle-based theory (Svenaeus, 2003). This suggestion implies that ethics in medical practice should not merely be applied as a medical science, but as a hermeneutical enterprise (Svenaeus, 2003). The hermeneutical enterprise could manifest as a dialogical approach and may be compared to reflective equilibrium which is a process of considering initial moral judgments and integrating them with more general principles and theories placed in the context of the individual stakeholders (Widdershoven et al., 2009). Widdershoven et al. (2009), believe that this process allows the ethical practitioner to change as a partner in this dialogue, the result of which alters the practical and

theoretical perspectives through respect of service user autonomy, through empathy and attentiveness to their individual needs.

Wood (2001), advocates the use of ethical approaches and principles when resolving ethical dilemmas, especially where the choices may involve equally unsatisfactory alternatives. She highlights this using a fictitious case study and guiding the reader through a process. She then applies Curtin's (1979), six step model of ethical decision making, i.e. (1) Perception of the problem, (2) Identification of ethical components, (3) Clarification of persons involved, (4) Exploration of options, (5) Application of ethical theory and (6) Resolution/Evaluation. The conclusions drawn are that clinical expertise and skills in moral judgment are necessary in order to recognise and manage ethical issues involving decision making between equally unsatisfactory alternatives (Wood, 2001). What appears to be overlooked is whether or not someone is able to perceive or recognise the issue at hand as an ethical dilemma. This determines whether or not a decision will be made on the basis of moral or non-moral considerations (Street, Douglas, Geiger & Martinko, 2001). Wood's (2001), paper uses a framework that pre highlights the problems for consideration as 'ethical concerns'. There is, however, a presumption that HCPs will automatically recognise the phenomena presented to them as ethical in nature.

There are few studies that identify ethical issues that physiotherapists or podiatrists face routinely in practice (Delany, Edwards, Jensen & Skinner, 2010a; Delany, Spriggs, Fry & Gillam, 2010b). The recognition of certain events as ethical issues may require a particular skill base that only appears through a philosophical lens. McGrath, Henderson and Holewa (2006), state that bioethics has evolved from its origins in philosophy to the present broad sociological perspective. In forming ethical decision making, McGrath et al. (2006), expounds Gilligan's (1982), theory to suggest that there have been recent advances in bioethics and that prior philosophical thinking in some way inadequately omitted important non-rational factors associated with the social context and relationships. They offer no suggestions as to how prior philosophy has ignored these issues. They also fail to qualify their assertion of how Gilligan's theory has laid the foundation for a more sophisticated understanding of ethical decision making. McGrath et al. (2006),

states that this has consequently begun to pose a sociological challenge of how to explore organisational processes that facilitate a systemic health response to ethical concerns. In McGrath et al.'s (2006), small pilot study (18 participants who were all staff at the same hospital) the participants were drawn from a population working on an acute medical ward. Their findings were not consistent with other studies that found that decision making remains variable, dependent on the organisation and other external factors. Nixon and Aruguete (2010), found that the majority of their participants adopted a utilitarian strategy when allocating limited health care resources.

External factors such as organisational culture play a significant role in affecting the behaviour and actions of its employees (Johnstone et al., 2004; Nelson & Donnellan, 2009). External factors influencing the practice of physiotherapists and podiatrists, for example resource limitations, has the potential to blind them from recognition of the ethical context of decision making that may be embedded in the culture of their environment/employer (Freeman & Sweeney, 2001). Reducing human action to juridical or economic issues are factors that influence ethical thinking (Numminen, Leino-Kilpi, van der Arend & Katajisto 2010). Aware of their professional codes of conduct, HCPs may abandon their ethical principles during their professional careers which can drive a wedge between organisational and personal values (Weinstein & Nesbitt, 2007). This may be attributed to the institutional imperative i.e. a business model of service provision (Weinstein & Nesbitt, 2007).

Leadership in organisations can also influence the ethical conduct of its individual members, but has the potential to become largely procedural and institutionalise what are agreed values (Piementel et al. 2010). One example of this is the institutionalisation of confidentiality where an organisation may create 'processes' to facilitate this concept such as computer protected passwords, policies and protocols (Winkler & Gruen, 2005). According to Winkler and Gruen (2005), this may resolve only one category of problems, that of organisational barriers to enabling ethical practice. Confidentiality, as described by the Hippocratic Oath requires 'discretion'. Where the potential for conflicting values arise, substantive principles in health care organisations are required to guide deliberation about ethical dilemmas and promote understanding of broader moral concerns (Winkler & Gruen, 2005). Recognising the

influence of organisational ethics on service provision, the American College of Health Care Executives [ACHE] produced an ethics self-assessment tool (ACHE, 2013). The voluntary members of this association agree to a code of conduct which recommends that self-assessment is completed with a philosophy of reflection and a view to foster changes within their organisation. The self-assessment tool is comprised of 65 questions which are categorised under four work life headings. Although self-reflection is engendered and thus may challenge the conscientious thinker, the tool may fail with an individual who is less skilled in self-awareness. There is also a potential for cognitive dissonance to disarm honest or true reflection since the questions are targeted to the individual's application of work. This demands judgments on them as a person rather than exploring a hypothetical scenario. It does, however, provide a stimulus to effect individual change for those who are able to engage with its designed intention. The instructions given with the tool propose that it ought to be used as a method to change recognised failings and it also offers advice of how to attempt to effect such change in practical ways.

A fundamental principle of applied ethics is the ability to recognise what constitutes a dilemma requiring ethical decision making (Curtin, 1979; Wood, 2001). Many of the empirical studies that refer to ethical decision making are centred on matters that overtly relate to ethics, such as end of life issues (Cooper, Frank, Hansen & Gouty, 2004; Johnstone et al., 2004). Both Cooper et al., (2004), and Johnstone et al., (2004), have produced empirical data on nurse's experiences of ethical issues; both studies however, use similar methods for data collection, adopting a questionnaire which presupposes an understanding and recognition of ethics. Johnstone et al.'s (2004), research was based on 398 voluntary responses from Australian nurses with an average of 19.8 years of experience and Cooper et al.'s (2004), research was based on 295 American Staff Nurses. Without generalising their findings beyond the limitations of their studies, the samples were sufficient enough to offer a key sense of ethical issues encountered. One of these issues is a critical examination of accredited ethical education programmes at under graduate and post graduate level along with the nature and availability of continuing professional development opportunities.

For physiotherapists and podiatrists, recognising an ethical concern may be less obvious than in nursing due to the differences in exposure to life and death decisions such as euthanasia, abortion and organ transplantation (Williams, 2005). A typical day may seem free from any major ethical dilemmas even though there are many overt and covert ethical challenges (Meffert, 2009). Additionally, ethics education amongst nurses is higher than that undertaken by allied health professionals which may have influenced a Gestalt shift in their moral perceptions (Johnstone et al., 2004).

## 2.5 Health Care Ethics and Person-centred Decision Making

How decision making will be exacted is often inextricably linked to evidence based practice (EBP) and informed consent. In these contexts there is a potential dichotomy for health care providers due to a requirement of integration of the best evidence, patient values, clinical expertise and conflicts with costs (Thornton, 2006).

### 2.5.1 Patient autonomy and informed consent

HCPs routinely make decisions concerning clinical management where the efficacy of the treatment is questionable and thereby raising ethical challenges during service user consent (Freeman & Sweeney, 2001). Where there are no clear gold standard treatments supported by the evidence based paradigm it renders decision making and the process of gaining informed consent precarious, since one of the primary functions of informed consent is to enable autonomous choice (Cohen, 2014). During this process the HCP has to determine what the service user expects from the provider, but also to be aware that there is an expectation that the service user seeks treatment by an expert (Glaser, 1990). With the modern rhetoric of consumer discourse the representation of the service user as reflexive and autonomous regularly fails to recognise the often unconscious and unarticulated dependence that they may have (McIntyre, Mandy & Borthwick, 2015). Careful balance is required with the asymmetric relationship between the service provider, who has expert knowledge and skills, and the service recipient, who may be vulnerable and usually lacks expert knowledge and is therefore reliant on the HCP to act in their best interest (Winkler & Gruen, 2005). Expert knowledge in this context refers to the

medical intervention rather than the experience of the medical condition that would give rise to the acceptance of the patient as the expert.

Empowerment theory in a health care context is not always clearly defined (Tengland, 2008), but is based on the premise of people having the capacity to make choices and own the responsibility for doing so, which may increase their autonomy in decision making (Holmström & Röing, 2010). It may be conceptualised as an educational process seeking to help others develop their knowledge, skills, attitude and degree of self-awareness, to effectively involve them in informed choice making (Feste & Anderson, 1995). For service user empowerment to succeed, it must be firmly rooted in health systems that support and foster its wider adoption (Raina et al., 2014). Empowerment is said to occur when the HCP increases the capacity of service users to think critically and make autonomous, informed decisions (Anderson & Funnell, 2010). It has, however, been suggested that service users may not have the skills or general awareness to successfully gather information and indeed interpret the information when retrieved or they may be happy to trust the HCP, relinquishing the responsibility and therefore remain passive in receiving health care (Henwood, Wyatt, Hart & Smith, 2003; Johnston-Roberts, 1999). More responsibility can also become a burden to service users, thereby requiring the HCP to encourage and support the process with care, in order to prevent any feeling of abandonment (Stiggelbout et al., 2012). This creates a difficulty when deciding how successfully 'empowered' the recipient of health care should be throughout the 'informed – consenting' mechanism.

### 2.5.2 Decision making supported by the use of evidence and guidelines

HCPs are expected to ensure best practice is offered to recipients of their service (HCPC, 2012b). There is an increase in emphasis on evidence to underpin health care practice which has become the dominant paradigm which informs management guidelines worldwide and is taught in all areas of clinical medicine and paramedical disciplines (Duggal & Menkes, 2011). There are, however, barriers that may prevent HCPs from operating with a robust evidence base, for example resource allocation, individual awareness of new concepts in health care, staff development restrictions and market forces (McDonnell Norms Group, 2006). Whether or not this conflicts

with an ethical perspective of care provision is a matter for consideration within this project. Due to a just distribution of finite health services, one may consider good health care to draw upon and harness the aforementioned resource issues to target efficient health care delivery by using business principles to make strategic decisions and focus on value in health care (Scurlock, Raikhelkar & Nierman, 2011). If, however, a service provider is under pressure from financial constraints, time restriction, personality conflicts, complaints and resource issues, this can then place an external influence on decision making (Levy, 2009). External pressures may encourage HCPs to allow their actions to be guided by frameworks with an understanding that they are following EBP (Ouimet et al., 2006). Conversely there is the potential for health care practice to be judged as unethical depending on which guidelines are being used (Eriksson et al., 2008). Explicit guidelines and codes can play a practical role in informing practice, they are, however, reliant on tacit or implicit skills that form the foundation of good judgment and integrates evidence with expertise and values (Thornton, 2006).

Evidence based health care's foundations are formed, in part, from rigorous research methodologies (Biggerstaff & Thompson, 2008). Evidence based epistemology requires objective ethical decision making in the clinical reasoning process, discerned through critical appraisal (Freed, Bonnici, Craddock & Franks, 2012; Freeman & Sweeney, 2001; Hamer & Collinson, 2005; Higgs, Jones, Loftus & Christensen, 2008; Thornton, 2006). Clinical reasoning with critical thinking is required for professional and ethical decisions (Freed et al., 2012) and therefore essential for quality clinical practice (Mitchell, Overman & Forrest, 2014). Whilst this is fundamental to health care, it is difficult to teach and to learn because of its complex, tacit and invisible nature (Delany & Golding, 2014).

The central virtue of health care decision making requires the wisdom acquired through an evidence base, to be applied under the guidance of prudence (ter Meulen, 2005). The practical virtue of prudence (Aquinas' theological interpretation of what Aristotle calls *phronesis*) entails acting in accord within a particular situation to achieve an end goal of optimal balance carefully reasoned among competing commitments in light of making the right decision and resulting action (Henry, 2006). One challenge for HCPs, when faced with ethical decision making, is that instances

of morally “fine and just” conduct involve so much difference and variety that they are widely believed to be such only by convention and not by nature (Aristotle, 300 B.C./2004 Book I:iii 14-17). Thus, ethics and morality existing as something distinct does not yet exist as separate from the wider social context (Fantino & Stolarz-Fantino, 2005; MacIntyre, 2007).

For decision making in health care, simple acquisition of supporting evidence that assuages one from the need to reflect deeply on service provision has the potential to be judged unethical (Eriksson et al., 2008). Following guidelines that are made current and relevant by the funding agents of a service may be acceptable in some measure, but conversely it questions the autonomy, motivation and professionalism of such a practitioner, if appearing as instruction-seeking and guideline-following (Loughlin et al., 2010). Loughlin et al. (2010), take this notion as a threat to autonomous practice suggesting that what has been known as ‘professional’ practice becomes no more than technicians awaiting instructions from others, whose authority to issue them remains unquestioned.

Without recognition of the context and location of the lifeworld of the individual, ethics can be reduced to codes, moral abstractions and punitive injunctions (Murray & Holmes, 2014). This, therefore, means that decisions being made individually by HCPs should be discerned through reasoning skills rather than following a set of norms with an expectation that they offer definitive guidance. It is therefore a challenge for HCPs to adhere to practice guidelines and simultaneously use ethics that are framed at a deeper level based on normative theory. Whilst normative theory offers a framework of principles that support decision making, its limitation lies in the fact that norms would be based on accepted behaviour, which assumes some kind of tested or empirically idyllic system to follow. Guidelines are therefore reductionist abstractions from clinical practice that form unifying theories that offer normative value, but maybe a distance from clinical realities (Henry, 2006).

With respect to ethics and morality, action guided norms may assist individual decision making if applied with critical thinking, but whether or not an action guided norm exists that can claim to be universal is contentious (Hamilton, 2010; Henry, 2006; Kingma, 2007; Kingma, 2010). This highlights the importance of the clinical



reasoning process for appropriate discernment to inform ethical decision making (Freed et al., 2012; Thornton, 2006). Where HCPs precisely understand what the problem is, they should have appropriate problem solving decision making skills to make an informed and timely decision (Muoni, 2012).

HCPs remain in control when deciding the needs of the service user by interpreting current evidence based research and following pathways of care, which has been described as 'locus of authority' (Delany et al., 2010a). A HCP could apply a clinical management or pathway of care that accords with the financial or resource saving philosophy of their organisation and yet assuage their conscience in having found 'suitable' evidence to support their decisions. This may be given in the form of guidelines that have been created to improve outcomes through the use of treatment approaches and to reduce or limit the costs by therapies or procedures (Kosimbei, Hanson & English, 2011). Thus the problem of forming clinical decisions that are truly informed, agreed and ethical remains a key challenge and one that this study intends to explore. During the second century a publication, attributed to Galen, called 'on the best sect' highlighted this concern, where the Empirics and Methodists (both 'sects' who practice medicine) were accused of drawing their decision making from what was purported to be based on reasoning skills (Smith, 1979). Smith (1979), emphasises that in the absence of transparency their practice remained subjective and often unjustified. This issue remains a risk in current health care practice, where evidence can be found and arguments gained, superficially, to support the use of various treatment modalities, but perhaps without integrity to the full and considered critical appraisal of the available evidence.

A demand of modern day health care is for HCPs to develop and utilise skills in interpretation and critique of the available evidence to inform practice (HCPC, 2013a; HCPC, 2013b). Critical thinking is essential for quality clinical practice which requires skills to streamline the acquisition and appraisal of information (Mitchell et al., 2014) and has been described as a key dimension to clinical reasoning (Delany et al., 2010a). The HCP needs to be reflexive and reflective in rationalising ideas inferences, assumptions, principles, arguments and conclusions from experience and best current evidences (Muoni, 2012). Applied to ethical decision making, reflexivity provides a means to increase awareness of one's personal values,

emotional reactions and how this may manifest through clinical practice and therefore affect service user choices (Delany et al., 2010a). This is a systematic and analytical approach emphasising scientific rational thinking which should demonstrate an understanding of clinical ethics (Muoni, 2012). If guided by prudence, acting becomes a reflective experience which is purposeful and contemplated (Vanlaere & Gastmans, 2007). It is therefore highly desirable, but demanding and underdeveloped for HCPs, due to the difficulties in teaching and assessing the attributes required (Tyreman, 2000).

The science of preparing knowledge for use in practice involves and may begin with evidence synthesis of which the Cochrane Collaboration has been a recognised and significant contributor since 1993 (Weeks, 2013). This is not, however, a modern concept since as early as 1700 B.C. (in the Edwin Smith Surgical Papyrus describing wounds and therapies) there is evidence of clinicians recognising the benefit of sharing knowledge (McDonnell Norms Group, 2006). This sharing of knowledge consisted not of scientific principles alone, but clinical observation (Hunter, 1989). Hippocrates in 460 B.C. is purported to have encouraged systematic guidelines for clinical medicine which were based on collaborative experience of others in practice (Smith, 1979). He used the term 'analagia' meaning reasoning from experience. Galen argued that Hippocrates gave 'reason' equal status to 'sense perception' and that he avoided the excesses of empiricism and dogmatism (Smith, 1979). Process driven dogma is an errant view of knowledge and becomes 'scientism' or 'objectivism', which is a modern tendency to reduce knowledge to only that which can be empirically verified (Mitchell, 2005). Contemporary structures of EBP appear to have privileged empirical science as the 'objective' knowledge (Henry, 2006; Landes, 2015). This approach often renders the realm of value based decision making inferior by implication that it is subjective.

Moral norms are to be strictly separated from facts and need to be constructed carefully rather than detected quasi-empirically (Schleidgen, Jungert & Bauer, 2010). In an attempt to clarify these meta-ethical assumptions and due to cognitive and motivational limitations Schleidgen et al. (2010), propose that any normative moral theory has to transfer its basic principles into applicable rules. This, they suggest, should be achieved through empirical data and hence allows collaboration across

the two sciences (of empirical social science along with normative theory). They do, however, conclude that whilst based on deduction, their suggestions to translate basic principles into practice rules (after consideration of cognitive, motivational and external limitations) allow ethics to be context-sensitive, whilst not uncritical. They conclude that empirical-normative collaboration is difficult, but not impossible and considering the logical and methodological framework it should not only be possible, but mandatory. This notion was also supported by Hope (1999), who emphasised the importance of a robust philosophical approach with a secure intellectual base for bringing empiricism to the increasingly complex and sophisticated field of medical ethics. Nevertheless, HCPs are often encouraged to follow guidelines, as a quality assurance mechanism to unify service provision consistent with current trends (targeted through EBP) (Nakayama, 2007). Therefore norms and guidelines are not a prerequisite of the ethical solution of practical dilemmas, but rather the outcome of the decision-making process itself (Spranzi, 2013).

The use of action guided norms requires a process of reasoning considered in the context of the circumstances given. MacIntyre (2007), refers to Homeric references to knowledge being what to do and how to judge a situation making the point that morality as something distinct does not yet exist and that it cannot be separated from the wider social context. Subsuming facts under rules as a method of using empirical constructs for ethics is fundamentally flawed (Hoffmaster & Hooker, 2009) and may therefore limit ethical decision making. This, for a HCP, may be the local policies, guidelines or widely accepted custom and practice traditions. Aristotle (300 B.C./2004 Book VI: i 17-35), asks “what is the right principle that should regulate conduct?” He then answers his own question with a simple statement “contemplative and calculative intellect”. One difficulty to achieve contemplation and calculation in person-centred care is the time allocation afforded to each service user. In routine practice, a physiotherapist or podiatrist may see 15-20 individual service users per day. Therefore, when faced with the potential to consider the moral basis to an individual decision, or how much to include the service user to achieve informed consent, a HCP may not feel they have sufficient time to fully engage with a process that allows individually considered care.

This perhaps offers explanation and justification to the development, use and possible reliance on formalised care pathways or guidelines for minimum standards that exist in health care. Consequently it may be common for a HCP to approach ethical decision making from a business oriented approach to health care delivery which can seriously detract from quality care (Weinstein & Nesbitt, 2007). It is, however incumbent on physiotherapists and podiatrists to remain autonomous whilst managing the surrounding contexts of empiricism and normative expectations in health care provision (HCPC, 2012b). The HCPC describe physiotherapists and podiatrists as autonomous professionals who are accountable for their informed and reasoned decisions (HCPC, 2012b). This is context based and demands that standards are met which are relevant to practice and are centred through the service user and involve wider consultation with others related to their care. HCPs should, therefore, form their clinical reasoning with freedom to make choices based on consideration of internal and external circumstances (College of Occupational Therapists [COT], 2010) and be able to act on, and justify, the decision if asked to do so (HCPC, 2012b).

With freedom and autonomy of practice, a HCP must seek to form decisions that are grounded on accepted customs and EBP. For HCPs, autonomy may be considered as independence with the freedom to exercise professional judgment within a given scope of practice thus serving as the hallmark for professional status (McIntyre et al., 2015), informing clinical reasoning and ethical decision making. Implicit to moral agency is the autonomous ability to reflect on, and assume responsibility for, the outcome of ones actions (Carpenter, 2010).

The modern concepts of ethics have not emerged out of a vacuum in history, but have evolved (Goodman & Marcelli, 2010). 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.

## 2.6 Aim and Objectives

Therefore, based on the current gap in knowledge, the aim and objectives of this study are 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.

This chapter has explored the extant literature and contextualised health care ethics in relation to the aim and objectives of this research. The following chapter explores and discusses the methodological and philosophical influences that were applied to this study.

## **CHAPTER 3: Methodology/Philosophical Influences**

This chapter discusses the method determined and how it facilitates the exploration of HCPs' understanding and application of HCE. The adopted approach was influenced by ontological and epistemological concerns requiring theory to be embedded throughout the process and establishing inter-connectedness with the research (Johnston, 2014). Ontological and epistemological concerns require reflection before selecting a methodological approach when the purpose of the research is to understand a phenomenon from health care (Charalambous, Papadopoulos & Beadsmoore, 2008). Structural and philosophical ideals that are formed this way offer continuity and coherence, which in turn provide appropriateness to the methodological and analytical process (Mackey, 2005).

### **3.1 Theoretical Framework - ethical decision making in health care**

Ethics in health care is a complex process which involves clinical reasoning, balance of conflicts, decision making and reflexivity (Campbell et al., 2005; Edwards, 2009; Gallagher & Hodge, 2012). A HCP may find the widely published construct of the four basic principles (Beauchamp & Childress, 2009), difficult to use as a guide for clinical decision making (Devlin & Magill, 2006; Thornton, 2006). Frameworks of particular moralities are not finished products and periodically need adjustment by further specification and the search for reflective equilibrium (Beauchamp, 2003). Reflective equilibrium entails deliberative reflection and revision of beliefs in an inquiry, moral or non-moral (Daniels, 2013). Similarly the four principles are also in need of interpretation and further analysis (Macklin, 2003). Macklin (2003), emphasises this by offering polemic criticism of the four principles suggesting that they constitute a deductive system and therefore presumably a rigid method for arriving at solutions to complex ethical dilemmas. Macklin (2003) argues that they are deficient because they do not offer guidance or clear answers to troubling moral issues. The four principles approach to Health Care Ethics (HCE) can seem to promise an algorithmic model of ethical competence despite Beauchamp and Childress stressing the need for judgment during application (Thornton, 2006). Macklin (2003), indicates that moral agents have to come to their own resolutions using their preferred moral theories. The subjective convictions of those involved

highlight the gap between bioethical theory and clinical practice and thus illuminates the need for rethinking the concept of ethical knowledge as well as the role of education in clinical ethics (Carpenter, 2010; Morgenstern & Richter, 2013; Rozmus & Carlin, 2013). Empirical ethics may be understood as an interactive dialogical learning process which helps the HCP integrate theory and practice in a radical way (Widdershoven et al., 2009).

To explore how a HCP experiences and applies a dialogical learning process, this study required an explorative method which allows the individual HCP to share their understanding of moral agency, reflection and decision making within their interpreted ethical framework. To achieve this, a hermeneutic phenomenological approach was utilised to explore and gain understanding of any key elements and ethical dimensions that contribute to perceived effective decision making in health care. Also to identify any barriers to ethical decision making and explore how an individual HCP may reconcile any tension that exists between their service provision, the service user and the employer (NHS or Private Practice). The researcher sought to establish how this was achieved praxeologically (HCP conduct using decision making to achieve a desired end by a group of chosen means – utility based decision making). The decision making may be consciously or unconsciously considered, self-determined (autonomous agency), or more superficially arrived at by following a set of guidelines or policies. In this context, ethics is the 'object' of the inquiry and how the HCP (as the 'subject') views or experiences this 'object' in their relationship with the service user or service offered to the service user.

Langdrige (2007), refers to phenomenological approaches in considering how objects enter our world only when we perceive them and when they are presented to our consciousness. He explains how the variables that can influence our perception of an object may differ depending on; the context, the mood of the perceiver and the position of the perceiver in relation to the object. It suggests that there is a co-constitutive relationship between 'us' and the phenomena 'we' encounter in 'our' engagement with the world, therefore to understand this, one needs to reveal how they co-constitute each other and draw on each other for their ongoing meaning and sense (Introna, 2011; Sokolowski, 2000). Inter-relationality implies that any experience of the object effects a correspondent change in the subject (Ihde, 2011).

When one considers clinical decision making and the process as it appears through perception, there are many variables influencing practitioners, which may involve implicit moral theories, intuitions and emotions (Curzer, Sattler, DuPree, & Smith-Genthôs, 2014; Weinstein & Nesbitt, 2007). This highlights the subjective process by which one engages with perceived ethical dilemmas. An ethical dilemma may only be brought to one's consciousness through key priorities related to governance or when emotive issues are expressed by the service user. If one's attention is not alerted to this process, then it may not be perceived as 'needing' consideration. Hence the act of decision making may be observed objectively, but experienced subjectively. This subjective experience requires choices to be made from the practitioner's knowledge. This knowledge is informed by the environment, empiricism and of oneself.

Part of critical thinking/reasoning is to formalise reflectively the tacit and personal knowledge, which is not arbitrary if it results from sincere, responsible attempts to make sense of the world around us (Henry, 2006). Reasoning is said to have truth as its object and the human will is the rational appetite which drives the potential to reconcile the two (Stein, 1989). The perception and consciousness of establishing 'truth' are issues that are considered using the hermeneutical and phenomenological method adopted. This research explored and attempted to illuminate how ethics is understood in terms of health care delivery.

### 3.2 Empathy achieved through hermeneutics

To understand the lifeworld of the participant the researcher reflected the methodological process using empathy through hermeneutical phenomenology. This underpinned the theoretical framework of the phenomena being explored in the HCP-Service user relationship. In order to achieve an empathic response through hermeneutical phenomenology, a HCP must first be aware of the 'need' to appreciate this process. Thereafter they would also need to recognise and understand how their relationship with the service user can influence the outcome of the dialogue that exists between the two. Schleiermacher's early work covered various interrelated aspects of ethics including hermeneutics and translation, making clear links with understanding through interpretation, but first being grounded in the



context of the cultural influence of the author (Forster, 2008). Forster (2008), interprets Schleiermacher's argument plausibly suggesting that cultural developments, through language and intellectual concepts are only explicable if the developments offered by individuals are adopted by the broader culture and thus become part of its common stock. For HCPs' interpretation of ethics, Schleiermacher's argument emphasises the essential nature of the historical context of HCE for relevance to its understanding. This notion sets the scene to consider what ethics means from the social, personal, academic and organisational perspectives of HCPs.

Schleiermacher's hermeneutics generalised the philosophy in an attempt to move away from interpretation of the written language, but rather to interpret human dialogue, written or verbal (Forster, 2008). It was Schleiermacher's hermeneutics that influenced Wilhelm Dilthey to take this concept forward (Svenaeus, 2003). In Dilthey's essay 'The Rise of Hermeneutics' he describes a realisation about reflexive awareness that considers the possibility of empathy.

The inner experience through which I attain reflexive awareness of my own condition can never by itself bring me to a consciousness of my own individuality. I experience the latter only through a comparison of myself with others, at that point alone I become aware of what distinguishes me from others (Dilthey, 1996, p.236).

Empathy is most crucial of all our experiences and is one of the most difficult for us to achieve (Dilthey, 1996). Empathy is commonly accepted as an important component of professionalism and mutually beneficial attribute of the HCP-service user relationship across health care (Fields et al., 2011). A HCP is currently challenged to achieve empathy through 're-creation' of the facts available via one's senses from outside and only through re-creating these gestures, sounds and actions can inner experiences be complete and thus have a better understanding of the other person's perspectives (Dilthey, 1996). Husserl (1925), acknowledges the importance of Dilthey's notion of the 'inner unity' stating that Dilthey's writings on the inner unity of phenomenology and descriptive-analytic psychology contain a gifted

preview and preliminary level of phenomenology and remain rich in the most valuable suggestions for work in phenomenology. Empathy is an important component in professional encounters and is of particular importance for HCPs to develop empathic skills in order to provide fair and professional treatments (Rasoal, Jungert, Hau, Stiwne & Andersson, 2009). It is also related to clinical performance and improved patient outcomes (Fields et al., 2011; Hojat, 2014; Hojat, Louis, Maio & Gonnella, 2013; Williams, Brown & McKenna, 2013).

Empathy is a pillar of the patient-practitioner relationship, but remains an inherently ambiguous concept (Berg, Majdan, Berg, Veloski & Hojat, 2011; Fields et al., 2011; Hojat et al., 2009). It is a multi-dimensional phenomenon which is a complex concept to understand, experience and practice and is also difficult to teach and assess (Fields et al., 2011; Ouzouni & Nakakis, 2012; Price & Archbold, 1997; Williams & Stickley, 2010; Williams et al., 2013). Empathy can be described as a predominantly 'cognitive' attribute involving an understanding of service users' experiences, concerns and perspectives rather than an 'affective' attribute which would involve feeling (feeling being related to sympathy) (Berg et al., 2011; Hojat et al., 2013). Empathy should be understood as a demanding form of cognitive or imaginative perspective-shifting (Slaby, 2014) which allows us to consider the perspective of the other person i.e. the service user. It is not only a basic human emotion, but also an important and learnable skill for HCPs of which a basic amount is essential in both patient care and in clinical ethics consultation (Bruns & Frewer, 2011). Bruns and Frewer (2011), highlight that little is known about the role of empathy in clinical ethics and that there is a paucity of literature available to inform ethical networks about the core competencies required, concluding that it appears elusive in written protocols.

Empathy does not guarantee the HCP will develop an adequate understanding of the service users' problems, but without it failure to understand the needs of the person is more likely (Svenaesus, 2014). What empathy offers is an understanding of 'others' by relating their words to the world around them which can only be achieved by triangulating this with one's own pattern of interaction with the world (Ramberg & Gjesdal, 2013). What must be avoided is empathic deception which is the misapplying of what is assumed as givenness of the other which is distorted by one's

life-long habits of intuiting and thinking (Stein, 1989). In order for self-knowledge to facilitate an empathic approach there must be evidence of one's moral motives that can be trusted, lest the duty of self-knowledge be impossible to fulfil (O'Hagan, 2009). O'Hagan (2009), explicates Kant's concern that in self-observation one is prone to discover a self which has been invented for one's own appraisal and assessment of one's own goodness. Using one's own frame of reference perhaps based on life experiences will shape and define empathic understanding emphasising the criticality of empathy education (Williams & Stickley, 2010). Caution may be required to avoid excess projection of one's own consideration which may be moderated with the use of 'reiterated empathy' and to cease using one's own zero point of orientation as 'the' zero point, but as a spatial point among many (Stein, 1989).

According to Stein (1989), empathically considering the world view of the other person whilst retaining one's own world view allows a shift of one's zero point and thus potentiate the intersubjective experience of the fusion of these horizons, giving a new perspective. Similarly, Gadamer's philosophy seeks to achieve an 'authentic shared experience' with the use of the word 'Truth' to inform the need for openness to the third party, in their world and not only to one's own world (Svenaesus, 2003). (Authenticity and adequacy of understanding of another is a source of contention and is discussed throughout this research in context of the phenomenological endeavour). Svenaesus (2003), emphasises that for the fusion of horizons to be achieved, through a dialogic hermeneutical relationship, it is essential to recognise the asymmetry between the HCP and service user. A failure to respect and separate the locus of experience and agency may arise through a deep tendency to project our own template of experience onto others (Carse, 2005). The avoidance of empathic deception is necessary on the part of the HCP which, through a modified orientation in reiterated empathy, allows a fusion of horizons and a productive understanding between both the service user and HCP. If achieved, this fusion of horizons, through dialogical phronesis, is one that is shared and at the same time independent (Stein, 1989).

Health care has a natural tendency towards Heideggerian philosophy due to the proximity of the being-with-others, thereby allowing the HCP to share more fully in

the human experience of the service user, engaging in a 'shared humanity' due to an understanding, as possibility and as careful concern (Dowling, 2007). Empathy is a key instrument to improve the therapeutic effectiveness of the clinician-service user relationship which is why the importance of empathy cannot be overemphasised (Kluszcz, Nowicka-Sauer, Treciak, Nowak & Sadowska, 2006). By nature some people are more empathic than others, but acquired empathy can be taught as a skill and developed with practice and experience (Ouzouni & Nakakis, 2012).

### 3.3 Phronesis with a dialogical approach

As with Stein's consideration of empathy, Aristotle's concept of practical wisdom or phronesis, and its relevance for medical ethics, has been much debated and is a central part of Gadamerian hermeneutics (Svenaeus, 2003). Aristotle refers to phronesis as 'prudence or practical wisdom' and states that we grasp the nature of prudence if we consider what sort of people we call prudent (Aristotle, 300 B.C./2004). This implies that the virtues are found in the individual character of the HCP. If one embraces the virtues in order to seek and enter dialogue with the service user, it enables a better understanding of their needs. Gadamer believed that understanding is attained only through dialogue and what he termed the fusion of horizons (McConnell-Henry et al., 2009; Widdershoven et al., 2009). This fusion of horizons must not, however, be misunderstood to mean a 'reaching of the same understanding' or of a 'better understanding' (Koch, 1996). Rather, one will gain an understanding that will be different for both parties, but richer and more enlightened if achieved through interpretation resembling Aristotelian phronesis, which can neither be deduced theoretically or fully articulated (Ramberg & Gjesdal, 2013; Widdershoven et al., 2009).

Gadamer's 'fusion of horizons' is embedded in the Heideggerian position of participation through the, unavoidable, hermeneutic circle where new data is formed by the co-constitution of the contextualised life events of the researcher and the researched (Koch, 1995). Or as stated above, as a fusion of horizons through dialogical phronesis, which is shared and at the same time independent (Stein, 1989). Caution is required to ensure that the research remains firmly within the hermeneutic circle so not to decontextualise the interpretation (Whitehead, 2004).

The potential of a merged horizon offers a new understanding in clinical practice where a HCP practising phronesis with dialogue and empathy may balance the resource options available and open a new and agreed strategy to manage ill health (Svenaesus, 2003).

Since the widely practised principle based theory of HCE cannot be relied upon, virtue, phenomenological and hermeneutical ethics are potential alternatives when applied to clinical situations (Svenaesus, 2003). Gadamer (1975), refers to 'moral knowledge' being precisely 'phronesis' and that this Aristotelian virtue is the basic hermeneutic virtue itself, and accordingly that phronesis is the mark of a good medical hermeneut (Svenaesus 2003).

Phronesis is a moral and intellectual ability which informs moral virtues and allows the possessor to make moral judgments (Svenaesus, 2003). In these judgments exists a challenge for HCPs to bring about an objective understanding that can then be considered as 'true' knowledge. This enables application of appropriate and agreed care. This is, however, a complex process that requires reflexivity and hermeneutic praxis. With respect to practising hermeneutics, Gadamer (1975), indicates that the hermeneut sits between two tensions i.e. strangeness and familiarity and that the work of the hermeneut is not to develop a procedure of understanding, but to clarify the conditions in which understanding takes place. For HCPs this may be accomplished by developing a professional standard of proficiency that demands skills in virtue ethics and empathy to be developed as an essential outcome through education (Berg et al., 2011). To avoid solipsistic practice one must be self-aware and skilled in discernment to acknowledge one's prejudices which governs the understanding of the service user's expression of their understanding (Gadamer, 1975). This is something which Gadamer believed difficult to achieve since "we find that by following the criterion of intelligibility, the other presents himself so much in terms of our own selves, that there is no longer a question of self and other" (Gadamer, 1975 p268). To avoid this failure Gadamer encourages the need to regain and re-create the historical consciousness itself and therefore to recognise those presuppositions governing the approach to understanding.

To succeed in the dialogical relationship, the HCP must stand outside of the normal assessment process and consider the two horizons, firstly of self and secondly of the service user. The hermeneutic virtue that Gadamer is applying is one that Aristotle proposed as a sense of 'good understanding' rather than 'true understanding' where a medical hermeneut who is phronetically active, will, through dialogue, treat the person for the agreed good of the person, rather than purely for the treatment of diseases (Svenaeus, 2003). In answering the question on how doctors should morally relate to their service users, Parker (2007), explicates the complications in Boyd's (2005), hermeneutic approach which provides the conversational vehicle for moral resolution. Parker (2007), concludes that once agreement is found in a given situation the moral question may not be over and that this is an ongoing process.

This approach opposes certain medicalised pathways of care which may be led by financial or outcome based criteria. It does, however, have the potential to fully engage with a more modernised view of the service user being a genuine, integral and essential part of the medical team (DoH, 2012). This notion has been engendered in modern and ancient health care and politics. The Aristotelian concept of phronesis was more likely applied to politics than medicine in the sense that the Aristotelian, Hippocratic and Platonic concept of health inferred that health is not something the physician can bring about to the service user, but the physician can only help by attempting to restore the balance of health equilibrium with them (Svenaeus, 2003). For this to arise the lifeworlds of the two parties need to come together and be narrowed-down and in this process, through dialogue, the fusion of horizons is enabled (Gadamer, 1975; Stein, 1989; Svenaeus, 2003).

#### 3.4 Methodological approach/Philosophical Influences: Heidegger/Stein/Gadamer

The philosophical influence of the chosen methodological approach was derived from Heidegger, Stein and Gadamer with a direct emphasis on the dialogical relationship first opening a new horizon through empathy. This approach invited participants to an ongoing conversation, but offered little direction and suggested that understanding arose through a fusion of horizons (Austgard, 2012; Koch 1995). Part of Heidegger's phenomenology is concerned with examining something which may be latent or disguised as it emerges into the light and is exposed through

interpretation (Smith et al., 2009). Gadamer tends to emphasise the effect of context in the interpretative process along with echoing Heidegger's acknowledgment of the interpreter and the interpreted (Smith et al., 2009). According to Koch (1995), this is a dialectic between the pre-understandings of the research process, the interpretive framework and the sources of information. Stein's (1989), 'Problem of Empathy' was used to explicate the complex notion of understanding others and oneself through others and their given experience in order to enlighten and facilitate the practice of ethics in health care. This concept therefore underpins both the method of phenomenological research and the phenomena under exploration.

### 3.4.1 Phenomenology

Qualitative methods are especially useful when a research question is complex or dilemmatic (Brocki & Wearden, 2006). When planning a qualitative research method, the approach selected needs to be applied in a manner congruent with the philosophical paradigm underpinning the study (Annells, 2006; Davidsen, 2013; Mackey, 2005). To take a critical stance towards the intersubjectivity of knowledge and how it is influenced by history and culture, phenomenology uses language to focus on rich aspects of experience (Davidsen, 2013). By its modern application, phenomenology is more concerned with understanding rather than objective examination and description, which serves to 'illustrate' rather than 'act' as a 'critical examination' of phenomena (Caelli, 2000). For health care research Caelli (2000), presents the argument that rather than using participants' lived experiences merely as a tool to access phenomena, the interpretative approach allows a fuller investigation of the experience itself. This therefore allows one to understand the meaning of the lived experiences and importantly the perspectives of the people who experience it. This in turn serves to potentiate holistic care through fostering an understanding of other people's experiences and their life events which are contextualised in the culture they are embedded (Svenaeus, 2003).

Originally phenomenology was developed as a philosophy and now is frequently applied as a research method in qualitative research (Clarke & Iphofen, 2008; Dowling, 2007; Mackey, 2005). Phenomenology is one of the most commonly used single approaches to qualitative research in health care (Annells, 2006). As a

branch of phenomenology, the methodological rigour that Interpretative Phenomenological Analysis (IPA) can offer as a research tool can help understand health care concerns (Biggerstaff & Thompson, 2008). Conversely several authors have contended that phenomenology can be used erroneously and that its misinterpretation of Husserlian and Heideggerian phenomenological approaches requires a necessary re-examining in the way it is being used in health research (Austgard, 2012; Caelli, 2000; Murray & Holmes, 2014).

There are as many styles of phenomenology as there are phenomenologists, but perhaps only a number with their own distinct features (Dowling, 2007). These different perspectives of phenomenology locate their various forms through the paradigms proposed via their champions, for example; Husserl, Heidegger and Gadamer, positivist, interpretivist and constructivist respectively (Dowling, 2007). Phenomenological researchers aim for rich, fresh, complex descriptions of the phenomena, as concretely lived (Finlay, 2013). Finlay (2013), proposes that the essence of this approach encompasses five mutually dependant and dynamically iterative processes which may lead the researcher to go beyond subjectivity and into the broader realm of the lifeworld experience. These are: 1) To embrace the phenomenological attitude; 2) To enter the lifeworld, through description of experience; 3) Dwelling with horizons of implicit meanings; 4) Explicating the phenomenon holistically and 5) Integrating frames of reference.

Heideggerian phenomenology in particular recognises the understanding of human experience, which can be developed through the interpretation of language, history and culture, with an emphasis on where the person sees them self within the world (Clarke & Iphofen, 2008). Phenomenology, as a research approach, does not categorise or explain behaviour, but it allows understanding of how a person's world is lived and experienced (Finlay, 2011). Phenomenological analysis offers an illuminating account of human and moral action because it occurs in subjective experience (Bristow, 2009). The exploration of a person's actions related to ethics means that it is embedded in the individual's interpretations of this construct and is therefore an experiential phenomenon. Wojtyla (1979), according to Bristow (2009), was opposed to separating an act from experience on the premise that 'being' and therefore 'truth' is experienced in 'act' and therefore ignoring this gave rise to the



Kantian errors of the purely formal ethical principles. The formality of normative HCE (frameworks, guidelines and minimum standards) are considered in this study in order to establish if there is a separation of ethics, in the Kantian method from that of other models incorporating alternate ethical dimensions such as Virtue Ethics.

Hermeneutic phenomenological philosophy is based on the concept of being-in-the-world which relates to a person being and relating to the whole context of that persons world. Heidegger expresses how 'being' (or *dasein*) exists by coming to know 'our' world through 'our' relationships with other people and the things around 'us' and that by entering 'another's' world one can uncover the meaning that they give to their experiences and how they interpret that experience (Miles, Francis, Chapman & Taylor, 2013).

#### 3.4.2 Hermeneutics

Hermeneutics has become a philosophy in wider use for health care research allowing a focus on meaning and understanding in context (Charalambous et al. 2008; Crist & Tanner, 2003; Finlay, 2011; McConnell-Henry et al., 2009; Miles et al., 2013; Moran, 2000). Annells (1996), agreeing with Osborne (1994), suggests that the modern hermeneutic inquiry has arisen from phenomenological meta-theory. It is not only a modern research method, but indeed an ancient philosophy that is often used to fortify contemporary qualitative research (Fleming, 2003). The term hermeneutics is a Latinized version of the Greek word *hermeneutice / hermeneuein / hermeneia* meaning to interpret or decipher (Miles et al., 2013) (or *hermeneusin*, a verb meaning to understand or interpret McConnell-Henry, 2009). It enables understanding of that which is interpreted through language, whether through texts or experiences and thus unfolds our orientations to the world (Annells, 1996). Hermeneutics has been evolving in the scientific endeavour to explore and articulate the various, sometimes conflicting perspectives on a situation (Widdershoven et al., 2009). Using methods of interpretivism as a line of inquiry required deeper understanding than was available through the natural and physical sciences (Miles & Huberman, 1994). Miles and Huberman (1994), draw attention to Dilthey's thesis that such a depth of understanding requires empathy or indwelling with the subject of the phenomena in question. It was Dilthey's focused search for the legitimisation of

the human sciences that led his argument on the 'lived experience' and how the world is given to us through symbolically mediated practices. Essentially this requires the self to understand itself through the interaction with the symbols mediated. Dilthey believed that this must be the aim of the philosophy of humanities if we are to legitimise the essence of hermeneutics (Ramberg & Gjesdal, 2013).

Martin Heidegger, who is considered the prime investigator of modern hermeneutics, initiated a major shift in phenomenology with the evolution of hermeneutic phenomenology (Annells, 1996). Heidegger's work arose from that of Edmund Husserl and retained the maxim 'to the things themselves', but sought to illuminate the question of 'Being' by the 'phenomenological attitude' (Annells, 1996). This refined consideration of understanding as a mode of 'Being' rather than 'knowing' moved from the epistemological emphasis of Husserl's objectivism to understand 'being-in-the-world' as a more ontological position, which he phrased 'dasein' (Annells, 1996; Mackey, 2005). Phenomenology could be argued to be a higher order than ontology if one observes with caution that they are not two different things, instead they designate the same thing whose essence is appearing and which is constituted exclusively by it (Ginev, 2014; Henry, Rivera & Faithful, 2015). Heidegger considered the actuality of any description without interpretation as impossible in the; telling, recording or re-telling (Mackey, 2005). This was re-emphasised in Gadamer's hermeneutics whose core tenet was that understanding and interpretation are indissolubly bound up together, rendering a definitive interpretation impossible, since interpretation remains dynamic and is always 'on-the-way' (Annells, 1996). The dynamic intersubjectivity highlights that the horizon perceived is not what one thinks, but what one lives (Merleau-Ponty & Landes, 1945/2012). Merleau-Ponty and Landes (1945/2012), state that one can be open to the world and unquestionably communicate with it, but that one does not possess it, as it is inexhaustible. Therefore the world of lived experience cannot theoretically represent a present reality, but its embodied values are disclosed and pertinent to the context and purpose of the disclosure (Ginev, 2014).

Beyond the critique of Husserlian idealism one must recognise that phenomenology remains the indispensable presupposition of hermeneutics (Ricoeur, 1975). Ricoeur (1975), argues that the most fundamental phenomenological presupposition is in the

philosophy of interpretation suggesting that every question about any kind of 'being' is a question about the 'meaning of being'. By Gadamer's self-revelation, his seminal work, *Truth and Method*, is most accurately read as an extension of the phenomenological hermeneutics of Heidegger's *Being and Time*, therefore inextricably woven into the evolving philosophy (Svenaeus, 2003). For Gadamer (1975 p258), the hermeneutical rule of "understanding the whole in terms of the detail and the detail in terms of the whole" stems from ancient rhetoric and has been applied to the art of understanding. This developed concept of understanding, through the practise of hermeneutics, facilitates an attempt to establish agreement where previously it had failed to come about or had been disturbed in some way (Gadamer, 1975). Gadamer describes the circle of understanding not as a methodological, but an ontological structural element in understanding (Koch & Harrington, 1998).

#### 3.4.3 Critical justification of IPA

This research is therefore embedded in dialogical hermeneutical phenomenology and is ontologically, epistemologically and methodologically contextualised in the paradigm of constructivist-interpretive or constructivism (Annells, 2006; Dowling 2007; Lowes & Prowse, 2001). Due to the value it places on human experience, phenomenology can be defined as a science of essential 'being' (Clarke & Iphofen, 2008). IPA increases the sensitivity to humans when considering their 'being in the world' rather than offering analysis of pre-existing theoretical preconceptions (Smith & Osborn, 2015). Smith and Osborn (2015), posit that this interpretative endeavour is appropriate for humans who are sense making organisms. In the context of IPA research, this gives added value which is likely to be a product of systematic and detailed analysis of the text, the context that is considered and from dialogue with the theoretical frameworks surrounding the emerging and expanded data set (Smith et al., 2009). IPA is concerned with understanding what the participant thinks or believes about the phenomenon and therefore focuses on the thoughts and beliefs, cognition and mentation of what is captured in the interview process (Murray & Holmes, 2014). The findings are, however understood to be an amalgam of experiences that are merged through interpretation in the context of the lifeworld of both the participant and the researcher. This has been referred to as a double hermeneutic as it is the researcher trying to make sense of the participant trying to

make sense of their experience (Smith, 2011). This apperception renders the dynamics of the lifeworld of the participants as ontologically inscrutable, without the reflexive awareness and reflective interpretation, which play a crucial role in the methodological aspects of the double hermeneutics (Ginev, 2014).

### 3.4.4 Alternative methodological approaches considered

Table 2 Alternative methodological approaches

Method	Brief Description of attraction	Basis for rejection
<b>Grounded Theory</b> Originally formulated by Glaser and Strauss (1967), this approach is inductive and seeks to construct theories and hypothesis to emerge out of the data	With particular reference to constructivist grounded theory - this was appealing in the pluralistic approach to constructing theory out of the researcher's interpretation of data gained (Mills, Bonner & Francis, 2006)	The relativistic ontological position, however, could negatively influence an exploration by a concern that the gestalt effect could restrict the findings. (This was considered in the context of the theoretical framework adopted).
<b>Action Research</b> This approach attempts to describe, interpret and explain a given research question and then seek to execute a change or intervention aimed at improvement and involvement of the participants (Walsh, Grant, & Coleman, (2008).	It is typically identified with research in which the researchers work explicitly with and for people with a focus to generate solutions to practical problems (Meyer, 2000).	If forming an action plan to guide HCPs to ethical decision making this method may have been considered further. On its own, it would be too restrictive based on the subjectivity and lack of available knowledge of the current understanding of HCE in physiotherapy and podiatry.
<b>Ethnography</b> An approach reliant on data collection in the natural environment, influencing or mediating the behaviour of the individuals in that culture (Parahoo, 2006). This approach enables an understanding of the participants' world by the researcher gathering data from the cultural context of the participants (Bamkin, Maynard, & Goulding, 2016).	This method was attractive as health care practitioners may be considered as a culture and thereby making it possible to collect observed empirical data from this group. It would provide a nuanced understanding of the comparison of what people say and what they do (Savage, 2000).	However, through any meaningful observations the researcher considered a restriction on deeper exploration with respect to the 'why' or 'how' behaviour arises from the actions (not ethical decisions) observed. It also requires lengthy entrenchment of the researcher in the cultural setting to enable them to become such a common feature of the participants' world that they revert to their usual behaviours (Bamkin, Maynard, & Goulding, 2016).
<b>Template Analysis</b> The development of a coding template which summarises themes identified by the researcher as important (Brooks & King, 2014).	It encourages the analyst to develop themes more extensively facilitating a richness in the data pertinent to the research question (Brooks, McCluskey, Turley, & King, (2015).	Recognition that the researcher's own inclinations and prejudice could restrict the codification process and risk missing some of the richness in the data that was not previously considered and thereby potentially lost.

### 3.5 Sample

The sampling process tracked the statistical demographics of the population of physiotherapists and podiatrists across; males, females, pay grade bands or levels of seniority and numbers of years' experience. This was done for both the private

and public sectors. A spread sheet was created in order to match the demographics and allow a purposive sample to be drawn against this information. The established population and target sample can be seen in Chapter 4, Working Methods. The sample gained can be seen and compared against these figures in the demographics section of Chapter 5.

The sample was carefully selected and soundly justified, since it is the data source of research. Whilst recognising that it is not the claim of qualitative research to be able to generalise the findings to alternative settings, it remains essential for the reader to be able to judge if the sample and sampling method offers usefulness for other settings (Parahoo, 2006). Purposive sampling is commonly adopted for phenomenological inquiry due to the ability to select individuals based on their knowledge or exposure to a particular problem (Lavery, 2003; Speziale & Carpenter, 2007). Purposive sampling is theoretically consistent with the qualitative paradigm adopted i.e. IPA, rather than through probability methods (Smith et al., 2009). It was broadly homogeneous with the knowledge that a small sample size can provide sufficient perspectives, given adequate contextualisation (Brocki & Wearden, 2006). Sampling methods are generally adopted to gain some representativeness of the population in question (Englander, 2012). However it is not the aim of phenomenology to achieve a representative sample in terms of either population or probability. IPA helps illuminate a particular research question and develop a full and interesting interpretation of the data with any conclusions drawn being specific to that particular group and generalisations should be approached with caution (Brocki & Wearden, 2006). The advantage of this sampling method lies in the information-rich potential of the individuals to allow a great deal to be learned, which is of central importance to the purpose of the research (Speziale & Carpenter, 2007). Therefore the purposive sample for this research was aimed at participants who have the experience of the phenomena explored (Englander, 2012; Endacott & Botti, 2007).

### 3.5.1 Sample Size

For qualitative research, sample size is not the starting point, but must be taken into consideration with the richness of data to ensure it fulfils the purpose of the research (Parahoo, 2006). Data collection continued until 'adequacy' was satisfied and

therefore predetermination of a given number of participants was not possible at the planning stage (Speziale & Carpenter, 2007). The aim was to achieve an end sample size that may be termed 'adequate', although this is commonly thought of as 'saturation' (Endacott & Botti, 2007). Saturation is a problematic concept in the context of IPA since the analysis continues iteratively and repeatedly in the light of insights obtained from other sources and therefore could theoretically continue ad infinitum (Brocki & Wearden, 2006). 'Saturation' has been referred to as a myth, since the data can only be given as true, during a given period of time, by a given number of participants, which may alter in time for those or other participants (Speziale & Carpenter, 2007). The compromise between the traditional notions of saturation along with realistic resource limitations requires good strategising with transparency in order to demonstrate the principles of the sample obtained in relation to the purpose of the inquiry (Speziale & Carpenter, 2007).

The goal of representativeness in qualitative research demands conscientious decision making in order to attain data that is meaningful (O'Leary, 2005). To fulfil a phenomenological role, the researcher attempted to take enough data from a wide enough sample of a population to maximise the likelihood of discovering the essences of a phenomena (Speziale & Carpenter, 2007). Since ethics committees may require an idea of the intended sample size prior to the study being allowed to commence, Endacott and Botti (2007), suggest that for a homogeneous sample as few as 5-8 participants may be required and for a heterogeneous sample maybe 12-20, but these figures are inconsistent across the literature. There is consensus to suggest that a definite number is not the aim of phenomenological research, but rather, if the phenomena has been illuminated or not, although an increase in sample size, most likely means the researcher could achieve a better appreciation of the variation of the phenomenon (Englander, 2012). The primary concern with IPA is to obtain a detailed account of the individual experience and given the complex nature of experience in human phenomena, IPA usually benefit from concentrated focus on a smaller number of cases (Smith, 2011; Smith et al., 2009). A consensus towards the use of smaller sample sizes seems to be emerging and indeed is the norm for the potential of IPA to be realised (Smith, 2011). The small sample size enables the micro-level reading of the participants' accounts thereby offering a possibility of some access into the understanding of the elusive phenomena (Smith & Osborn,

2015). The analysis of large data sets may also result in the loss of potentially subtle inflections of meaning (Brocki & Wearden, 2006).

This research was ideographic using phenomenological analysis for which a small sample size was acceptable as the work is not making claims about generalised or larger populations (Brocki & Wearden, 2006; Finlay, 2011; Langdrige, 2007; O'Leary, 2005; Rodriguez & Smith, 2014; Smith & Osborn, 2015).

### 3.5.2 Data collection - Interviews

Language helps express the way the world presents itself and may also reveal, in a different way, the speaker who is using the language as a responsible agent (Sokolowski, 2000). In terms of data collection IPA requires intensive qualitative analysis which is derived from a rich detailed account of participant's experiences (Smith, 2011; Smith et al., 2009). Semi-structured interviews were used which allows the 'conversation with a purpose' to provide a comfortable interaction with the participant enabling a detailed account of the experience under investigation to be gained (Laverty, 2003; Smith et al., 2009). IPA offers particular attention to enabling the participant to recall as full an account as possible of their experience which requires high level of skill on the part of the interviewer to have a strong empathic engagement and highly attuned antennae ready to probe further into interesting and important aspects (Smith & Osborn, 2015).

A dialogical approach was adopted seeking a holistic interpretation of various perspectives and values of as many participants as possible in the process of interviewing (Parahoo, 2006; Widdershoven et al., 2009). This exemplary method of IPA research allows contextualisation of the phenomena being explored which permits the social, cultural and historical aspects of their experience to be explicated rather than solely seen through the researchers' interpretive lens (Brocki & Wearden, 2006; Parahoo, 2006). Consistent with the Heideggerian and Gadamerian philosophical influence, this style of open dialogue allows co-creation of data by both interviewer and participant (Lowe & Prowse, 2001). This may be described as a meaningful conversation with a non-directive approach so that the participant is able

to tell their story in which ever way they wish and thus take the interviewer with them in their narration (Biggerstaff & Thompson, 2008; Koch, 1996; Smith et al., 2009).

A dialogical approach to empirical ethics focuses on the practical experience of the participants and thereby requires the interviewer to avoid ethical theory in the body of the questions (which may take a more central position throughout the analysis phase) (Widdershoven et al., 2009). Any probes used were determined by the course of the conversation rather than pre-determined, since in a phenomenological interview only one initial question may be necessary as the interview process will generate data with no further guidance (Lowe & Prowse, 2001). In phenomenological interviews based on Heideggerian philosophy, whether any data generated can be viewed as irrelevant is contentious (Lowe & Prowse, 2001). Interviews, however, need a degree of structure to ensure that the data gathered are relevant to the research question (Brocki & Wearden, 2006). Brocki and Wearden (2006), critically appraised 52 IPA research articles and found that 46 used semi-structured interviews, with a further 3 using focus groups along with interviews. The open ended and non-directive style of interview facilitates the participants' ability to tell their own story in their own words which is a central premise of IPA (Brocki & Wearden, 2006; Lavery, 2003). For IPA, an interview is an event which facilitates the discussion of relevant topics which allows the research question to be answered subsequently, via analysis (Smith et al., 2009).

Prior to each interview, the exploratory nature of the research was reiterated to reassure the participants that judgment was not being made about their individual practice. This was intended to contribute to the trust which may be built between the interviewer and participants in order to gain honesty and openness, which in turn may potentiate credible knowledge from the data (O'Leary, 2005). The interviews were opened with the same invitation to each participant to share something of their level of work and experience to date, and to indicate if they worked in the private or NHS sector. After this, the only question pre-prepared for all participants was to ask what HCE means to them. The method of interviewing remained inductive and allowed the data to follow the direction of the participant, with a focus on the phenomenon being researched (Englander, 2012). Using this inductive method essentially facilitates the production of knowledge at an early stage by collecting,



recording and interpreting the data in context and then formulating explanations of the observed phenomena (Johnson, 1990).

This research was influenced by Heideggerian and Gadamerian phenomenological methods, which are more interested in interpretation than description and thus rejected the need for bracketing during the interview stage. Gadamer (1975 p398), opposed the notion of bracketing by stating: “to try to escape from one’s own concepts in interpretation is not only impossible, but manifestly absurd.” From Gadamer’s perspective, in a hermeneutical situation, it appears to be an advantage not to be freed from prejudice (Annells, 1996). This permits the augmentation of interpretation through acceptance of prior understanding or ‘fore-structure’. Heidegger recognised the importance of the researcher’s relationship with the participants and of their interpretations, which imposed a freedom, without which the historical constraints prevent (Racher & Robinson, 2003). This approach permitted the acceptance and value of the descriptions given by the participants, but demanded more from the researcher than simply taking the role of recorder (Mackey, 2005). Since the researcher was inextricably placed in the contexts of the participant’s experiences, the input is accepted as an integral component to interpretation and understanding (Miles et al., 2013). Gadamer argued that the values that the researcher brings to the research are unavoidable because all research contains a pre-understanding, originating in the researcher’s historical context, making it meaningful to the consumers/readers (Koch, 1996; McConnell-Henry et al., 2009 (from Koch, 1995)). Koch argues that Gadamer rehabilitates the notion of prejudice (Koch, 1994), which therefore allowed the interviews to become purposeful data-generating activities (Lowes & Prowse 2001).

Heidegger referred to fore-structure (pre-understanding, prior awareness and anticipation of meaning) as acknowledgement that interpretation already exists fully formed, but in need of expression (Mackey, 2005). If achieved, this reflective and reflexive practice provides opportunities to glimpse insights into the lived world, from the lived experiences that are taken for granted and can go unnoticed (Miles et al., 2013) and allow what is already understood to be revealed (Mackey, 2005).

### 3.6 Trustworthiness of data collection

Phenomenological research has a primary aim to understand and reconstruct the experience and knowledge of phenomena, demanding that issues of reliability, credibility and the quality of it are to be examined in the context of rigour, trustworthiness and authenticity (Laverty, 2003). It is essential to attain credibility when making any claims about knowledge derived from research (O'Leary, 2005) which has also been referred to as 'truth value' (Miles & Huberman, 1994). The philosophical influences and assumptions underpinning this research requires congruence between the philosophical approach and the establishment of rigour (Koch, 1996). Koch (1996), holds that the ontology and epistemology inform the interpretation of the research question and, if achieved, are tied to the rigour and legitimacy of the research. For trustworthiness of any research, auditability and transparency of the whole decision making process is essential (Koch, 1996; Miles & Huberman, 1994; Robson, 1993). This allows the reader to consider the justification of the methods chosen in the context of the targeted population and thus the meaningfulness in any given context (Finlay, 2011).

There has been a reconceptualising of the notion of rigour with a shift over the last couple of decades from a conventional empirical-analytical paradigm to alternative paradigms (Koch, 1996). Referring to qualitative trustworthiness there seems to be a lack of consensus with respect to what had traditionally been referred to as reliability and validity (Koch, 1996). Others have suggested that this legitimacy can be achieved through good practice evidencing the transferability, dependability and confirmability of the research (Endacott & Botti, 2007; Robson, 1993). The transferability is less easy to define, since phenomenological research does not necessarily aim to achieve this in the same way as quantitative research. Here one must attempt to offer the reader adequate description in order to allow the judgment of similarity between alternative contexts (Koch, 1996). Whilst Koch makes this point in reference to Guba and Lincoln (1989), Denzin and Lincoln, (2005), go further to say that quantitative studies offer very little information about context where qualitative methods addressing issues of context, meaning, power and complexity can enhance the transferability of a clinical trial into clinical practice (Denzin & Lincoln, 2005).

Issues of rigour in qualitative research persist as a legacy of the scientific method and continue to challenge new researchers as they shift from conventional to alternative paradigms (Koch & Harrington, 1998). The theoretical framework and methodological approach must be made clear because it carries with it a number of assumptions about the nature of the data and the process of analysis (Braun & Clarke, 2006). For IPA analysis, interview transcription retains the central place in terms of data, but the emerging themes will grow substantially through the comprehensive exploratory commenting during analysis (Smith et al., 2009). It is important to allow the coding to remain inductive without trying to fit the data into a pre-existing coding frame, whilst acknowledging the researcher cannot code the data in an epistemological vacuum (Braun & Clarke, 2006; Smith et al., 2009).

Two central issues for hermeneutic research are the legitimation (rigour) and the representations (whose voice is being heard) (Koch, 1996). A rigorous and reflexive approach, characterised by ongoing self-critique and self-appraisal, enables quality assurance, which in turn defines the data as more than anecdotal evidence, but gives credibility to the findings (Koch & Harrington, 1998; O'Leary, 2005). Part of the rigor to achieve trustworthiness was to employ various strategies that help authenticate the robust methodology and thereby the findings through: a) Triangulation of the processes, b) Perform member checking from insiders and c) Refer to others to assess one's ability to recognise one's own world view (Miles & Huberman, 1994; O'Leary, 2005; Robson, 1993). (The details of the strategies utilised are discussed in the Working Methods, Chapter 4)

### 3.7 Pilot Interview

A pilot interview was carried out in order to ensure adequate preparation and assessment of the proposed method (Finlay, 2011; O'Leary, 2005). Subsequently, this allowed the researcher to make any changes which were perceived to benefit the structure of the interviews (Robson, 1993) (this is discussed further in the Working Methods in Chapter 4).

### 3.8 Data analysis

IPA is concerned with meaning and how this meaning arises in experience (Langdrige, 2007). It provides detailed examinations of personal lived experiences producing accounts of each case in turn rather than a more generalised approach and is therefore explicitly ideographic (Smith & Osborn, 2015). Since experience cannot be extracted straightforwardly from the participants, a process of engagement and interpretation by the researcher is required, which ties IPA to a hermeneutic perspective (Smith, 2011). Hermeneutic phenomenology is an inquiry arm of the philosophical paradigm which has strongly emerged for researching existential issues and is proving popular in the field of health (Annells, 1996; Finlay, 2011).

The researcher was required to have cognisance of the disciplinary context and the philosophical basis of the tradition of the paradigmatic inquiry in order to ensure they were appropriately applied (Annells, 1996; Austgard, 2012). This method guided the interpretation by advocating that analysis should move beyond description, but interpretation should not move beyond the data and out of the hermeneutic circle (Whitehead, 2004). IPA is espoused to the Husserlian philosophy that gives primacy to understanding people's everyday experiences in detail in order to understand the phenomenon in question (Biggerstaff & Thompson, 2008; Braun & Clarke, 2006). Heideggerian and Gadamerian IPA acknowledge the researcher as an active participant during the formation of emerging themes, which are interpreted through one's own thinking and from the fused horizon which includes everything that can be seen from different vantage points (Charalambous et al. 2008; Koch, 1996; Stein, 1989). This is engagement of double hermeneutics where the researcher is trying to make sense of the participant trying to make sense of their experience (Smith et al., 2009). Thus, the interrelations between reflexive awareness and reflective interpretation play a crucial role in designing the methodological, epistemological and ontological aspects of the human sciences' double hermeneutics (Ginev, 2014; Murray & Holmes, 2014).

Hermeneutic phenomenological analysis is iterative, inductive, fluid and emergent (Finlay, 2011), but requires a systematic and strategic approach. Consistent with other qualitative approaches, phenomenological research offers no recipe of analysis, but relies on adaptation to the specific topic and consideration of the

lifeworlds of the phenomena being investigated (Davidsen, 2013). Since there are no rules or methods to guide the inquiry, the analysis remains a challenging aspect of this methodological approach (Austgard, 2012). There is a basic need to work in a cyclical manner whereby the findings from one participant form the input for the next participant and research phase, implying that the data are continuously interpreted and analysed (Widdershoven et al., 2009).

Gadamer (1975 p261), highlights Heidegger's concept of the hermeneutic circle which expounds that "understanding of an object remains permanently determined by the anticipatory movement of the fore understanding". This recursive process is necessary throughout the phases of analysis and develops understanding over time (Braun & Clarke, 2006; Finlay, 2013; Mackey, 2005). The movement from part to the whole allows the emerging data to remain open to divergent interpretations whilst recognising the temporality of the truth in the horizon of both the participant's experience and the researcher as analyst (Whitehead, 2004). Engaging in the hermeneutic circle explicitly engages the historicity and cultural location of the researcher in the lifeworld of the participant experience allowing the intersubjectivity to open up and close down the evolving understandings (Finlay, 2013). Whilst seeking to elucidate the essences of the structures as they appear in consciousness the interpretation is understood in the context of the presuppositions that are motivated by the individuals who make the interpretations (Lavery, 2003). This final analysis may therefore be understood to represent a subjective conclusion to the understanding of the phenomena being explored.

This chapter has offered justification for the elected use of a hermeneutical phenomenological approach to explore how HCE informs physiotherapy and podiatry practice. This method has the ability to describe the human experience as it is lived and allows the exploration of the phenomenon (Biggerstaff & Thompson, 2008; Charalambous et al., 2008; Murray & Holmes, 2014; Rodriguez & Smith, 2014; Smith & Osborn, 2015). The next chapter explicates the process of applying the adopted method.

## CHAPTER 4: Working Methods

This chapter makes explicit the rigorous and reasoned process of methodological decisions reflecting the philosophical influence and theoretical framework that was described in the previous chapter (Charalambous et al., 2008; Englander, 2012). A simple flow chart of the design process can be seen in **Figure 1** below.

**Figure 1** – flow chart of the working methods process



## 4.1 Population

The target population for this study were physiotherapists and podiatrists, two of the professions regulated by the Health and Care Professions Council (HCPC).

Physiotherapists and podiatrists were selected as the author is a practising podiatrist working alongside physiotherapists. The research question emerged through experiential recognition of the challenge for HCPs who pro-actively reconcile organisational and individual ethical standards impacting on service delivery. At the time of sampling there were 219162 HCPC registrants in the UK (HCPC, 2014d) of which 46516 were physiotherapists and 13005 podiatrists.

An NHS workforce census was carried out during 2002-2012 (NHS Information Centre for Health and Social Care, 2013), which found that there were 22043 (47%) Physiotherapists (18606 Full Time Equivalent) working in the NHS. From the 46516 HCPC registered physiotherapists this indicates that approximately 24473 (53%) would be working in the private sector. The Chartered Society of Physiotherapy (CSP) recorded the number of CSP member physiotherapists working in the NHS as 21809, with 12802 in private practice, which accounted for 34611 of the 46516 HCPC registrants (Chartered Society of Physiotherapists [CSP], 2014). The CSP members completed the data collection themselves directly onto the CSP website. This only includes CSP members however, and is not the full population of HCPC registered physiotherapists. There may minimal be adjustments to the figures to allow for non-practising HCPs, but in order to maintain HCPC registration, a level of practice and continued professional development must be evidenced (HCPC, 2014b). This would suggest that the figures should be reasonably accurate. It may be the case however, that a number of the 22043 NHS physiotherapists could be working in the private sector concomitantly to their NHS contracts (this data is not available with the HCPC, NHS or CSP).

The NHS (2013), census offered no data for podiatrists as an individually identified profession. It defined and included podiatrists as AHPs involved in 'direct patient care' who are not a nurse or GP. The professional body for podiatrists (The Society for Chiropodists and Podiatrists) commissioned a report on 'Developing a Sustainable Podiatry Workforce for the UK Towards 2030' and concluded that based

on the HCPC figures from 2011 for England, there were approximately 9599 podiatrists, of which 3870 were working in the NHS and 5729 assumed to be working in the private sector (Townson, 2014)

#### 4.1.1 Sampling Strategy

When data collection for phenomenological research is planned, inclusion criteria is established for various reasons, one of which is to ensure a homogeneous sample is obtained in order to explore how a phenomenon is experienced by a particular group (Crist & Tanner, 2003) and thus be meaningful to the research question (Thompson, Panacek & Davis, 1995). In this study, the chosen group was physiotherapists and podiatrists. The inclusion criteria were established in order to sample:

- Health Professions Council (HCPC) registered physiotherapists or podiatrists who are currently involved in health care provision.

To ascertain the population of physiotherapists and podiatrists in the U.K. workforce, information was gathered using the most current and accurate data available from the HCPC (HCPC, 2012d), the Information Census (NHS, 2013) and a report commissioned by the Society of Chiropodists and Podiatrists on the sustainability of the podiatry workforce (Townson, 2014) which is summarised in table 3 below.

	<b>Physiotherapy</b>	<b>Source</b>	<b>Date</b>		<b>Podiatry</b>	<b>Source</b>	<b>Date</b>
<b>HCPC Registrants</b>	46125	HCPC – freedom of information (FOI) gender	2012		12662	HCPC - FOI gender	2012
<b>HCPC Registrants</b>	46516	HCPC register	2012		13005	HCPC register	2012
<b>Female</b>	36054 (78%)	HCPC - FOI gender	2012		9165 (70%)	HCPC - FOI gender	2012
<b>Male</b>	10071 (22%)	HCPC - FOI gender	2012		3439 (26%)	HCPC - FOI gender	2012
<b>NHS</b>	22043	NHS workforce census	2012		3870	SoCaP - Townson	2014
<b>Private Practice</b>	24082	assumed figure by deductive calculation			5729	SoCaP - Townson	2014

From the data presented in Table 3 the sample strategy was formed to gain representation from the whole workforce based on:

- The proportion of physiotherapists compared to podiatrists. There were more than three times the number of registered physiotherapists compared to podiatrists (See figure 4) (HCPC, 2012d).



- A mixture of private and NHS employed physiotherapists and podiatrists with proportionally more having experience of private sector work in order to reflect the population trend (CSP, 2014; NHS, 2013; Townson, 2014). The figures were supplied via the respective professional bodies. The HCPC do not hold registrant information about which sector individuals practice (HCPC, 2009a).
- The proportion of females compared to males. Physiotherapists and podiatrists are represented by 78% and 70% females respectively compared to 22% and 26% male representation respectively (note 4% or n = 58 unknown data for the gender of podiatrists) (HCPC, 2012d)

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.

An internationally trained HCP was also targeted in order to reflect the whole population of registered HCPC physiotherapists and podiatrists. This was more pertinent in the physiotherapy sample since there were 13.4% of HCPC registered physiotherapists in the UK who have been internationally trained compared to only 1.2% of podiatrists (HCPC, 2009b)

A purposive sample was also utilised for a group interview. Participants were recruited with the intention to balance the discussion equally between previously interviewed participants, service users and new participants. 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). The reason for inclusion of a group interview is discussed in detail in section 4.5.

## 4.2 Ethics

Approval and peer review for this study was gained from the School Research Ethics Panel (SREP) at the University of Huddersfield. Permissions were also gained from

relevant R&D departments of any participating NHS Trusts, in order to comply with NHS Research Governance arrangements (DoH, 2005a) and to establish if the research activities would require vicarious liability insurance (see appendix 1).

To inform the participants of the nature of the research and the expectations placed on them, the information sheet (see appendix 3) was provided at least one month prior to participation. This included an explanation of voluntary participation and terms of withdrawal. All participants had the capacity to sign their own consent, as they were registered HCPs.

#### 4.2.1 Access

After ethical approval was gained (see section 4.2) participant recruitment was sought. Local NHS Trust managers or private practice associates were written to in order to seek permission to contact potential participants at their work address (see appendix 1). Once permissions were granted, individuals were contacted and given a copy of the consent form (see appendix 2) and the information sheet (see appendix 3). The HCP participation was voluntary. If they agreed, then interview arrangements were made for a time and place that was mutually convenient. The same access and ethical considerations were given to all the individual and group participants. The service users were not active recipients of service currently receiving care from the NHS or private sector. They were both known to the researcher and through purposive sampling offered their time to contribute to this research question by agreeing to participate in the group interview.

#### 4.2.2 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 which is discussed in section 4.5.

#### 4.2.3 Confidentiality

Confidentiality of the participants was assured by the researcher. This ethical and legal issue is of paramount importance to ensure the appropriate use and protection of participant data (DoH, 2005a). The protection of confidentiality however may reach a boundary or limitation (Butts, 2014). There was the potential for unexpected disclosure of information for example a public interest disclosure, such as safeguarding issues or health care practice that breaches the HCPC 'Standards of Conduct, Performance and Ethics' (HCPC, 2012b). The participants were informed in advance that if a disclosure were to occur, 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. This proposed action was made clear in the participant information sheet (see appendix 3). At the start of the group interview, a brief introduction was given and then ground rules were established highlighting issues of confidentiality and respect for all members within the group (see appendix 7).

All interviews were recorded with permission of the participants, who were informed that the audio recordings will be transcribed and that only the research team will have access to this data. All data was retained in a password protected computer and was stored in a secure office in the researcher's institution and would be held for a period of five years after the study has been published. It is the researcher's responsibility to destroy the data at that time. The personal data associated with individuals was kept secure and separate from the main body of the written research.

#### 4.2.4 Anonymity

As stated above, unless explicitly agreed in advance then any information obtained about a participant during research is confidential and is governed under the Data Protection Act (Finlay, 2011). However, it is often difficult to guarantee anonymity in qualitative research due to the level of personal details offered in narratives (Finlay, 2011). The individual interview participants were all assured of their anonymity by the chosen method of data reporting. The data collected was sensitively managed in order to protect any individuals being identified prior to dissemination. 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. The pseudonym will also be used in any publications, conferences or presentations that may result from this research. Any information that could identify a participant or their employer (NHS Trust or private practice) will not be used in any publications or conference presentations. This explanation and information was given during the consent process.

#### 4.2.5 Psychological support for participants

Since research can involve an element of risk, there must be consideration of the potential benefits of return from the research against the safety and wellbeing of the participants. For all research, the primary consideration must be the dignity, rights, safety and wellbeing of participants (DoH, 2005a). The interviews had the potential to raise sensitive issues from the participants' knowledge and experience of ethical practice. Any participant could have become distressed by exposure to previously unconsidered or unresolved issues. In the event of this happening during the interviews, the individual(s) would be supported to ensure they knew that they were free to pause for a while, move away from the particular line of questions that may have caused the distress, or to establish if they are happy or not to continue at that time. Similarly their right to withdraw from the study would also have been reiterated. Participants were advised prior to the interviews that if this became evident, they should seek support from their Occupational Health Department or their GP. At the start of each interview, the voluntary participation was reaffirmed and that the choice to continue or withdraw from the study remained theirs.

#### 4.2.6 Researcher safety / support

Lone working by the researcher during interviews was a potential risk. The University of Huddersfield's guidance on lone working was followed. A nominated person was aware of the interview schedule and approximate timing. Contact was made with this person when each interview had been completed in order to report personal safety. A well charged mobile phone and appropriate identification was carried at all times.

#### 4.2.7 Dissemination of data from the findings

There is both an interest and a responsibility for a researcher to get their work published (Robson, 1993). After due diligence with respect to confidentiality and anonymity, it is intended that this research will be placed in the University of Huddersfield Research Repository. Subsequently, the findings of this research may also be published in appropriate peer reviewed journals and at conferences. All participants were informed of this intention, prior to consent. All participants were invited to member check the data prior to it being disseminated.

### 4.3 Data Collection

#### 4.3.1 Pilot Interview

The pilot interview consisted of one interview with a podiatrist which lasted for 25 minutes. The purpose of the pilot interview was to allow an opportunity to assess the practical aspects of carrying out the interviews including participant understanding of the information sheet and consent form. It also allowed the researcher to test the recording equipment, the use of the interview prompts and consider the timing of the process. The pilot interview facilitated a period of reflection and adjustment of the semi-structured interview method which was adopted for the main data collection. 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). Transparency of the drafting process is essential in order for the reader to judge the quality of the interview and the impact this may have had on the subsequent data

(Brocki & Wearden, 2006). The original draft of the interview schedule and prompts followed by the modified version can be seen in Appendix 5. For the pilot interview schedule, the *a priori* themes that were acknowledged in pre-understanding of the phenomenon were recorded. This was based on experience of the custom, practice and policy that surround HCPs (see figure 2 below).

Figure 2 – *a priori* themes considered for the formation of the pilot interview



One facet of IPA interviewing is the acknowledgment that analysis begins during data generation which leads one to accept the importance of the researcher deciding how much movement there is away from a schedule, recognising the potential value that some movement away may enlighten the research question (Brocki & Wearden, 2006; Widdershoven et al., 2009). To ensure transparency and clarity for the reader, verbatim extracts are offered in the findings chapters along with supporting narrative to give context to the discussion. This facilitates the embodied understanding by making it habitable for the reader evoking a lived experience through the engaged communication which offers a sense of bodily being-there (Finlay, 2013).

### 4.3.2 Interviews

Participants were invited to take part in an individual interview which was scheduled to last around 60 minutes and would be conducted by the sole researcher. To reduce the inconvenience to each interviewee, the interviews were offered at the participant's normal place of work. This was sanctioned by the NHS Trust Research and Development Departments, the NHS Trust's line manager or the private practice manager. The interviews took place from May 2012 to June 2013. The organisation of each interview followed a similar structure with respect to the research ethics (discussed above), but 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).

### 4.4 Data 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 (Langdrige, 2007). The inductive nature of IPA allows the discussion of analysis in the light of varied existing theories or approaches, but may not strive for generalisability (Brocki & Wearden, 2006).

Until analysis of data is undertaken the often lengthy descriptions of participant information may appear similar. Coding the data however was extraordinarily revealing and led to a deeper and broader understanding (Caelli, 2000). One important feature of this process was to ensure that the method of coding could be verified or replicated by others (Miles & Huberman, 1994). (Examples of the codification and thematisation can be seen in appendix 9). This begins with highlighting anything in the textual data which appears relevant and potentially

contributing to the understanding of the research question (Brooks & King, 2014). The method used for coding and thematisation was sensitive to the emergent and iterative methodology. Thematic analysis is compatible with constructionist paradigms of research and is a flexible research tool which can potentially provide a rich and detailed account of the data (Braun & Clarke, 2006). 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). Charalambous et al. (2008), describe Ricoeur's four principles of 'distancing', which address the difference between the text (verbatim interview scripts) and the discourse (the interview conversation). This considers the transcription itself and the meaning of the written word, the relationship between what has been written and the intent of the person, the meaning of the text beyond its intent as well as the author's intent and the new interpreted meaning of the written word and the audience. Following this process allows the meaning of what has been interpreted to be shared rather than one person's experience being revealed and directly becoming another person's experience (Charalambous et al., 2008).

The phenomena of ethics in health care was being explored and it was through refraction of a variety of lenses (philosophical, theoretical, literary and reflexive) that enabled interpretation of the participants' lived experiences (Finlay, 2011). In order to remain faithful to the hermeneutic phenomenological method, the number of *a priori* ideas (see figure 2) that were built into the original interview schedule were reduced prior to the participant interviews. This allowed reliance on the data offered by the participants and thus rendered the emerging data as inductive.

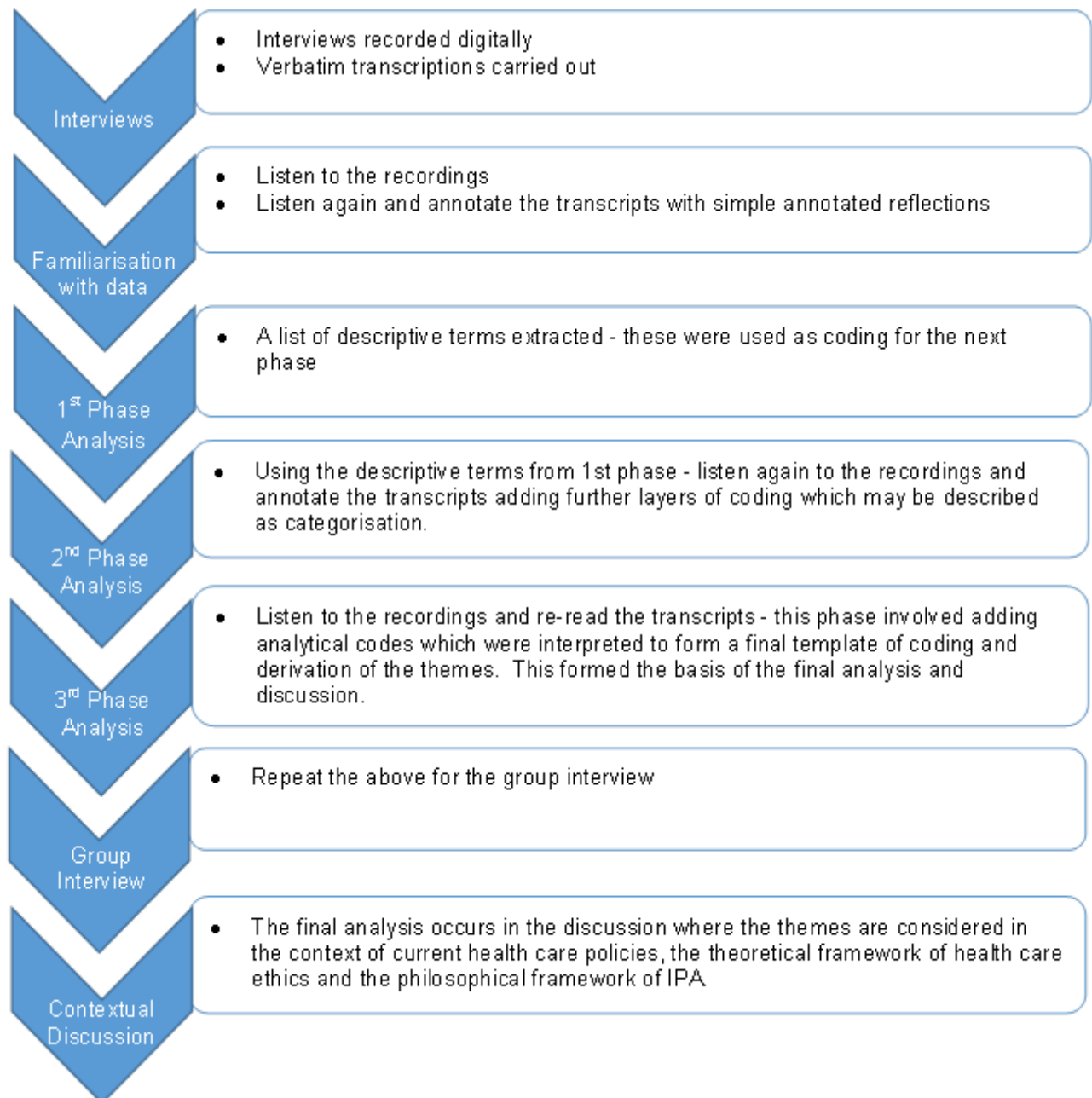


Initially the emergent themes were identified and reconstructed descriptively prior to interpreting the data (Finlay, 2011). Finlay (2011), expresses caution here to remain aware of one's potential to impose 'favourite theories' over the data rather than allowing the data to invite appropriate theories in the interpretative process. From this data one may attempt to derive themes which are basic patterns, opening a deeper understanding of the participant's experiences (Austgard, 2012). It was important to recognise that the more material available to interrogate demands more rigorous selection during analysis, which requires caution that the more frequent a theme may arise does not necessarily mean it should be ordained as more important than other themes (Biggerstaff & Thompson, 2008). The process of thematisation can be seen in the Findings Overview, Chapter 5, with examples given in appendix 9. The transparency of this process offers accessibility to the reader and thus trustworthiness of the analytical process (Austgard, 2012).

The transcription process was initiated after two interviews in order to ensure that the data captured was meaningful to the research question and that the remaining interviews could benefit from further informed reflexivity. IPA has been developed with a specific commitment to idiographic inquiry, allowing each individual's account to be examined in detail as an entity in its own right (Rodriguez & Smith, 2014; Smith, 2011). Typically IPA aims at detailed analytic treatment of each participant followed by the search for patterns across the sample, which also assesses the balance of convergence and divergence (Smith, 2011). The process for data analysis began by listening to the interview recordings individually. This was followed by a second process of listening to the recordings whilst reading the transcripts. During this process a simple method of circling and short annotation on the scripts was carried out. This permits familiarisation and checking for accuracy of the transcribed data (Biggerstaff & Thompson, 2008; Braun & Clarke, 2006). The first phase coding from the annotated transcripts resulted in the formation of a list of descriptive terms directly extracted from the data. The second phase of coding involved listening to the recordings and re-reading the transcripts using the descriptive codes to allow further layers of coding to be annotated to the transcripts. This phase may be described as categorisation (requiring interpretation). Each category was codified distinctly. The third phase of coding added analytical themes (interpretative - not using participant language) to form the final template of coded

analysis. The emerging themes were derived from interpretation following the interrogation and interconnections in and between the annotated transcripts. This formed the basis of the final analysis. The group interview was analysed using the same process. Examples of the coding process in context of the verbatim transcripts along with the hand written reflections and can be seen in appendix 9. A simple flow chart of the process of analysis can be seen in figure 3 below.

Figure 3 Flow chart of the process of analysis



Phenomenological and hermeneutical approaches were utilised in a three tier analysis framework. Firstly each interview was analysed using thematic coding that best captured the essential qualities of each interview transcript followed by

identification of connected themes from each interview and finally interrogation of the same themes between interviews (Biggerstaff & Thompson, 2008; Smith, 2011). Secondly the findings were then discussed and further developed at the group interview. Finally the findings were all contextualised through the philosophical framework and the theoretical context located in the extant literature surrounding HCE. This process offered justification to the essence of what each individual account contributed to the overall research question before more general claims could be drawn through narrative analysis (Rodriguez & Smith, 2014).

Hermeneutically the intention was to capture not just the phenomenological analysis (i.e. how the participants offer their experience of the phenomena they are presented with), but also how the researcher made sense of their sense making (Finlay, 2011; Murray & Holmes, 2014; Smith, 2011). During this process the subjectivity of bias and researcher assumptions were not bracketed or set aside, but were embedded in the interpretive process (Laverty, 2003). This was not a linear process of analysis, but was recursive allowing active searching for patterns and meanings by interrogating the data and making connections between the themes by the reading and re-reading of the transcripts throughout the research process (Biggerstaff & Thompson, 2008; Braun & Clarke, 2006; Rodriguez & Smith, 2014). This method allows emergent characteristics to be enhanced with the development of voice, inclusion and dialogue contributing to responsive evaluation in analysing the transcripts (Widdershoven et al., 2009).

#### 4.5 Trustworthiness of the research

There is a clear imperative for rigour to be pursued in order to offer conviction and strength to the findings (Long & Johnson, 2000). 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; Lincoln & Guba, 1985; Miles & Huberman, 1994; Robson, 1993; Smith et al., 2009).

#### 4.5.1 The Group Interview

One strategy to achieve trustworthiness in authenticating the data interpretation was to present and discuss the emerging findings in a group interview. The findings obtained from the individual interviews were analysed and emerging themes identified from the data. These themes were then presented at the 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).

The individual interviews offered one source of data, researcher interpretation then added to the data set. The purpose of the group interview was threefold. Firstly, to act as a strategy of establishing trustworthiness of the data collection and interpretation. Secondly, to further develop the themes from the individual interviews, by discussing any key issues that might inform the development of ethical constructs. Thirdly, to explore or explicate any further contextual understanding offered by the purposive sample of group participants, which may potentially influence the emerging themes. 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; Robson, 1993).

Emerging themes in a given phenomenon can be gradually illuminated through conversations with associated stakeholder groups, who will have a variety of interests, values and perspectives (Widdershoven et al., 2009). In hermeneutical research active engagement of as many stakeholders as possible may minimise bias and domination of any individual perspective for which the facilitator should be alert to, and ensure the process is open to all parties (Widdershoven et al., 2009). Triangulation in this way supports theoretical arguments to improve completeness, holistic understanding and increase scientific rigour (Jones & Bugge, 2006; Long & Johnson, 2000). The group interview was conducted with physiotherapists, podiatrists and service users. An external facilitator was selected, who is recognised to be an essential member of the group and whose role is core to the success,

allowing others to be put at ease and also acknowledging the researcher's place in the group (Brewis & Leith, 2014). The researcher met with the facilitator in advance of the interview in order to ensure informed understanding of the aim and objectives of the research and how the group interview fits into the working methods to support the data collection (Brewis & Leith, 2014). An interview guide and schedule was agreed, which also offered clarity of roles within the group (see appendix 6).

Of the seven purposively sampled participants, two were services users, two from the individual interviews and three were new HCP participants. For the triangulation process, the inclusion of service users and of participants from the individual interviews allows contextualisation of any convergent and unique findings to be discussed and challenged (Jones & Bugge, 2006). This encourages the researcher to explain aspects of the research that may be taken from granted and thereby improve transparency (Jones & Bugge, 2006).

The inclusion of two participants from the individual interviews was one of two methods of adopting member checking of the data (Finlay, 2011; Robson, 1993). 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). Therefore careful and conscious awareness of these issues demands a guarded approach to using member checking, but some researchers consider this process to be a method of strengthening the trustworthiness of the interpreted findings (Finlay, 2011; Koch & Harrington, 1998). The purposive selection of the group participants and rigorous reflexivity were key in assuring a balanced approach to member checking in this way. As a further method of member checking, the participants were offered the chance to review their transcripts and to offer them an executive summary of the findings once the interpretation of the data had been completed.

#### 4.5.2 Further strategies to authenticate trustworthiness of the findings.

Various strategies to authenticate trustworthiness of the findings were adopted and can be summarised below.

- Triangulation involving checking the data that was emerging against the extant literature (which was also integrated to the group interview).
- Use peer debriefing (Robson, 1993) by talking about the design and analysis with other post graduate researchers applying similar methodologies.
- Giving a presentation as a key note speaker at an undergraduate research conference during the data collection phase, thereby exposing the developing themes to peers who had the opportunity to question and challenge them.
- To check with 'insiders'. To help achieve this, the researcher communicated with an ethics special interest group to check any consensus from that population about what empirical findings are extant in the field of HCE. This allowed contextualisation and comparison of the findings.
- Having others scrutinise the analysis also ensures credibility (Brocki & Wearden, 2006). To help achieve this the researcher completed the coding analysis of three interviews and asked two, more experienced, qualitative researchers to do the same, allowing comparison of the themes that appeared in their interpretation of the interviews. This critical evaluative process seeks assurance that the themes identified are clearly evidenced in the participants' accounts and serves to assess the researchers' ability to recognise their own interpretation in the findings (Rodriguez & Smith, 2014).
- Reflective field notes were created throughout the interviews and data analysis. This aided reflexivity at each stage of the process with respect to the researcher's thoughts, feelings and observations.

Exploring alternate ways to validate the data is part of proactive reflexivity following the recognition of the limitations and difficulties in examining ones preconceptions (Parahoo, 2006). For credibility, authenticity or internal validity of qualitative research, it is important to recognise that the process of checking is not intended to create a rule based strategy, but a strategy for critical questioning before theorising (Miles & Huberman, 1994; O'Leary, 2005). It is essential to be aware when

interpreting incorrigibles, such as individual lived experiences, that there is no conceivable way of judging the accuracy of the perceived experience (Gomm, 2004).

This chapter discussed the research method and underpinning philosophical framework which enabled the use of interpretation of the participants shared experiences to better understand the phenomenon explored. The design and methods were influenced through a Gadamerian and Heideggerian based hermeneutic phenomenology. The contextual analysis and findings of the interviews are explicated in the next chapter.

## CHAPTER 5: Findings Overview

This chapter offers a brief overview of the core findings with respect to the demographics of the sample population of participants. It also explains the process of analysis offering transparency to how the themes emerged out of the data offered by the participants.

### 5.1 Demographics

Individual interviews of between 20-90 minutes were carried out over a one year period from May 2012 to June 2013. Table 4 below gives a summary of the characteristics of each participant.

Table 4 Participant demographics										
	Podiatry	Physio- therapy	Band	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



All participants were given an information sheet and consent form in advance and on the day of the interviews consent was obtained (see the previous chapter, Working Methods). Although the participants were informed that they could have a transcript of their verbatim interview, only one participant elected to do this.

There was one group interview with 7 participants, a facilitator, an observer and the researcher. This took place at the University of Huddersfield and was 90 minutes in length. The group were presented with the preliminary findings from the individual interviews for open discussion. This acted as a means to assure trustworthiness of the initial analysis through participant validation and member checking (as discussed in the Working Methods, section 4.5). This served to increase the credibility and trustworthiness, but also generated new data by focusing on aggregation of 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.

## 5.2 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.

In the Husserlian method, the rigour of applying the phenomenological reduction allows objectivity to describe things as they appear in human consciousness through the analysis and stripping of tacit knowledge and thereby permitting the temporal course of experience to be apperceived (Watson, 2006). Heidegger's 'dasein' sheds light on the embodied experiences of the participants and how the tacit intelligibility of ethics is formed through pre-understanding and pre-reflection. This focus allowed the embodied experiences that are contextualised in the lifeworld of the participants

to be explored. Heidegger's undertaking was to find the right questions that will reveal the hidden meaning of experience. The being-in-the-world that Heidegger champions is hyphenated to illustrate the inseparableness of the context (Miles et al., 2013). This interpretative process captures the lived experience and it is this ontological view that illustrates the main divergence from Husserl's more descriptive analysis of the 'things' under review. The findings are an interpretation of the shared experiences by the participants in the field and phenomena of ethics. It places their experiences in their world, explicated through the interview with the relationship of the participant and interviewer that is inextricably woven into the findings.

### 5.3 Individual Interviews

There were twenty-one individual interviews. The participants were purposively selected from the overall population (HCPC registrants) using the strategy discussed in the Working Methods, Chapter 4. The sample represented gender, breadth of experience levels, years qualified and the workplace sector, NHS or private practice (see table 4). The following graphs illustrate how the sample compares to the population of HCPC registrants at the time of data collection (HCPC, 2012d).

Figure 4 illustrates a comparison of the number of physiotherapists and podiatrists from within all the other professions under the regulation of the HCPC.

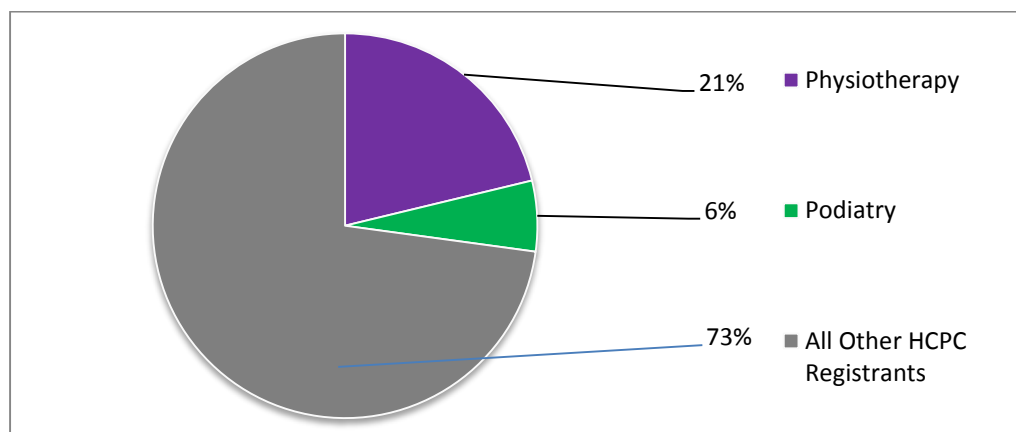


Figure 4 – HCPC registrant statistics

Figures 5 and 6 represent the percentages of HCPC registrant physiotherapists and podiatrists compared to the participant sample of physiotherapists and podiatrists.

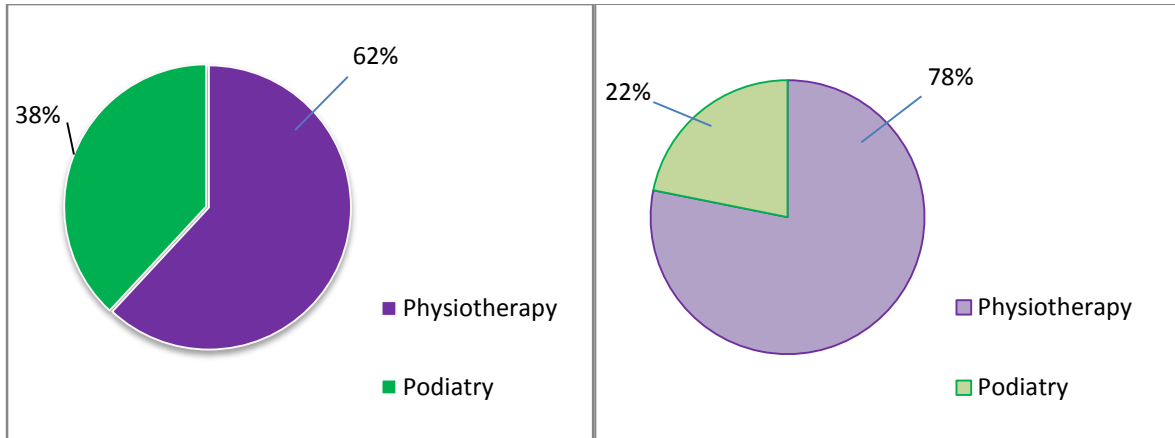


Figure 5 – HCPC registered Physiotherapists and Podiatrists

Figure 6 – Sample of participant Physiotherapists and Podiatrist

The balance of both professions in the sample is not substantively different than that seen in the underlying population of registered physiotherapists and podiatrists

Figure 7 represents the gender comparatives between HCPC registered professionals compared to the sample of participants. The gender balance of both professions in the sample is not substantively different than that seen in the underlying population of registered physiotherapists and podiatrists.

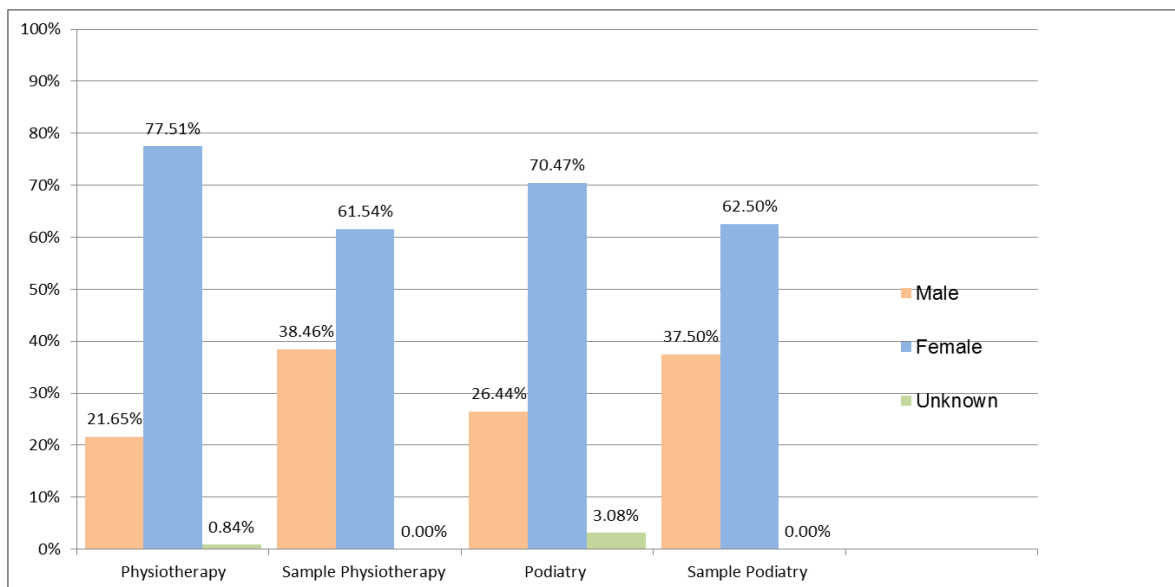


Figure 7 – Gender analysis, comparing HCPC registered physiotherapists and podiatrists with the sample

Figure 8 shows the number of years the participants have worked within their registered profession, comparing physiotherapists to podiatrists.

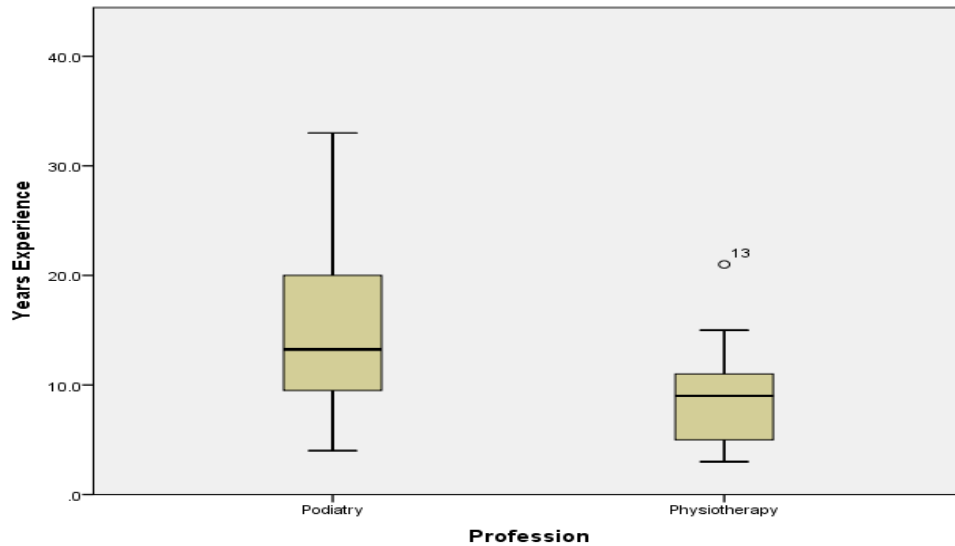


Figure 8 – Experience post qualified in number of years

Figure 9 shows how the workplace statistics compare between the participant physiotherapists and podiatrists with available data registered by the NHS workforce census and the professional body workforce analysis. The figures illustrate that the sample achieved within a 2% match for the physiotherapy workplace and within 5% for podiatry.

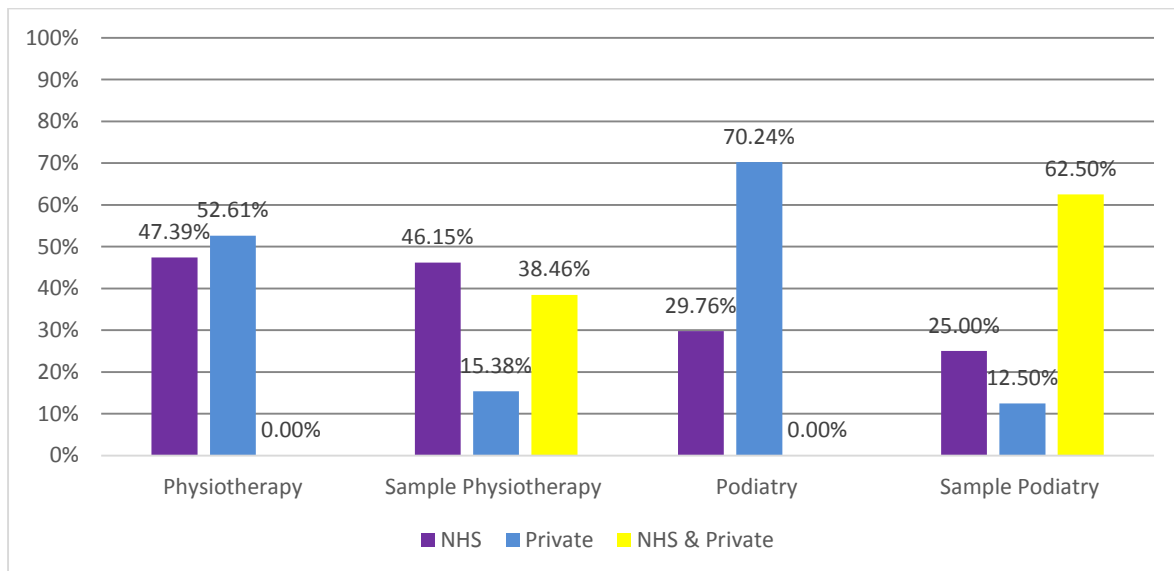


Figure 9 – Work place analysis, comparing HCPC registrant data to the sample

Figure 10 shows the pay grade banding of the participant physiotherapists and podiatrists illustrating the spread of experience across the sample.

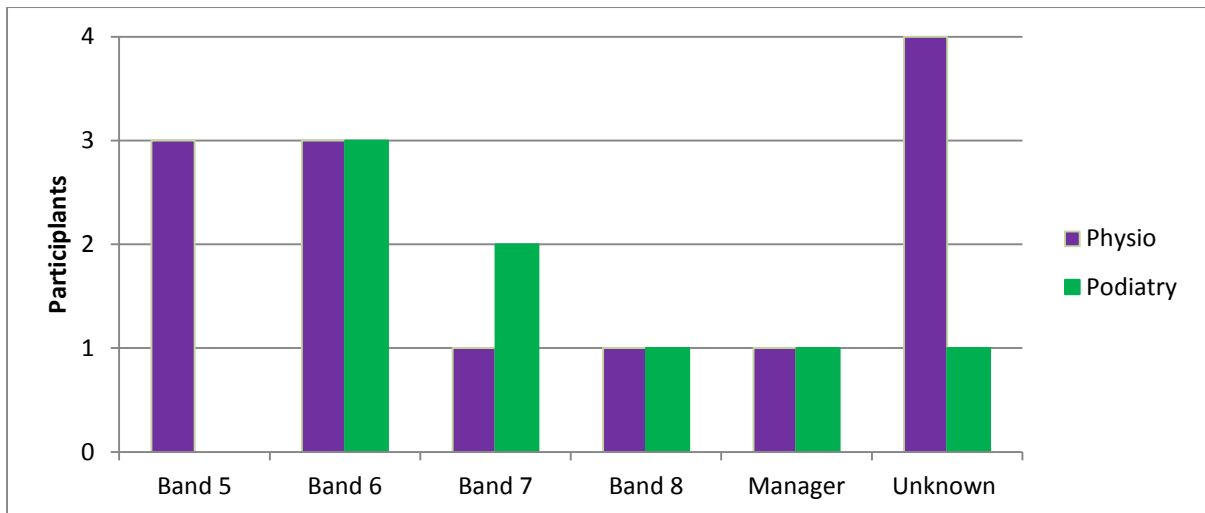


Figure 10 – Pay grade banding of the sample participants

#### 5.4 Preliminary findings

Emerging out of the early interviews, was the concept that ethics are regarded as desirable but the explanation and justification of how they are embodied is not clearly understood. There was a common perception that ethics seemed to imply good or bad practice. This, therefore, may have affected the willingness of participants to admit to practice that could not be clearly justified. Reflexively, the interview style was modified to offer encouragement to participants appearing somewhat hesitant to share their experience of HCE. This encouraged a freer discussion and permitted more meaningful experiences to be shared.

#### 5.5 Group interview

There was 1 group interview. As discussed in section 4.5, the primary reason for the group interview was to offer a level of trustworthiness in the data analysis. The secondary reason was to enrich the data by further discussion and critical consideration around the extrapolated themes. It provided new data along with corroborative data, enhancing the findings from the individual interviews and contributed to a wider frame of analysis and a second method of data forming. The group interview accepted and developed accessions to the findings of the individual interviews. The group interview generated several ideas to consider as possible resolutions to engage HCPs in ethical decision making (see table 6 in appendix 11).

5.6 The process of analysis is illustrated below in table 5.

Table 5 Analytical processing of findings		
<b>Phase 1 analysis - Description</b> <i>Descriptive terms taken from the raw data</i>		
<b>Phase 1</b>	101 descriptive terms were extrapolated from the raw data (see appendix 9)	
<b>Phase 2 analysis - Categorisation</b> (8 categories were derived from the 101 descriptive terms found in phase 1 analysis)		
<b>Phase 2</b>	<b>Category description</b>	
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	
<b>Phase 3 analysis - Thematisation</b> (5 themes were derived from interpretation of the 8 categories formed in phase 2 analysis)		
<b>Phase 3</b>	<b>Theme description</b>	<b>Previous Categories from phase 2</b>
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



Examples of the transcripts, with evidence of interrogation to codify and theme the texts, can be seen in appendix 10.

This chapter has offered a brief overview of the findings. The following five chapters represent the findings by theme. Each theme is presented in conjunction with a discussion locating the theory, policy and research literature and as such constitutes combined findings and discussion chapters. Each of the themes are discussed with verbatim examples from the interviews. At the end of each extract there is a pseudonym and line reference which offered traceability to the researcher for reflexive re-reading and re-interpretation to view the quote in the wider context of the incorporated discussion.

## **CHAPTER 6: Findings - Theme 1**

### **The Perceived Understanding of Health Care Ethics (HCE).**

This chapter discusses Theme 1 which is the perceived understanding of HCE. This includes the participants' difficulties in understanding HCE and their experience of the meaning, formation or derivation of HCE.

#### 6.1 Difficulties in the understanding of HCE.

A prevalent idea amongst clinicians is that ethics is simply a matter of common sense and experience (Hope, 1999). The question that was asked of all participants was "what does health care ethics mean to you?" This question seemed not to have been anticipated by several of the interviewees. Although participation only took place after reading the information sheet and completing the consent form, participants struggled to demonstrate a personal working understanding of HCE. This open question was designed to initiate the freedom to share their thoughts from any starting point. An example of this was illustrated by Chris.

"I don't know to be honest... I don't know ....I don't know....I don't know"  
(Chris - lines 438, 471, 472, and 768)

"ethics is one of them words you sort of just accept you know. If a five year old kid asked you to tell them what ethics is, I wouldn't actually know" (Chris - line 514)

"it's more, it's almost like that that sort of er, it's the good buzz word cos you know if something's ethical it's good" (Chris - line 820)

His and other participants' reluctance to answer could be associated with the commonly reported perception that ethics involves judgment of good and bad practice and therefore may create a level of caution when answering the question. This has been recognised in other professions, where psychiatrists and nurses sometimes felt insecure in talking about their work and did not want to engage in critical conversation about their practice, based on a misplaced feeling of pride (Widdershoven et al., 2009). Chris adopted a tentative style of answering throughout the interview and he continually claimed to be unsure about his understanding of ethics. He stated that something non-ethical is bad and so made a distinction between good and bad. He contextualised ethics as a "buzz word" in the work place

which may infer a more ephemeral or in vogue term of reference rather than one of personal ownership. Ethics ought to be a lifelong part of practice invoked every day and at every encounter in health care, which requires consideration of this fundamental issue from all HCPs (Baykara, Demir & Yaman, 2015; Duncan, 2010). Chris stated that ethics is “one of them words you sort of just accept you know” and yet, throughout the interview he admitted that he does not know what it means. This was further evidenced by Cal who offered no answer to the question of what HCE means to her.

“I don’t know really, I don’t know what you really want? Erm (pause) (Laughs) I don’t know...”

(Michael: what would you say if I asked you if your practice was ethical)

Well I’d say - yes! (laughs)...

(Michael: it might be uncomfortable to say no, but how do you explain how your practice is therefore ethical?)

... well I don’t know, I suppose ethics is working like fairly across lots of different people lots of different patients... offering like an even service accessible service I guess. I don’t know if that’s more like your equality and diversity though” (Cal - line 69).

Cal offered elements of what HCE means to her and then alluded to the potential that these aspects may relate more to equality and diversity inferring that these issues may not be what she understands as HCE. Fran used generalist descriptors to try and place HCE in the context of respecting people’s beliefs, but by her own admission, she struggled to answer the question of what HCE means to her.

“oh my God. Er... gosh..... Oh I don’t know..... Ethics, erm, now I’m on the spot a little bit there. Erm..... Ethics, well I suppose.... It is but how do you actually use it in practice. Well to be ethical, so erm, I suppose erm, treating patients erm.... hmmm, this this is difficult this is an ethical way... so erm... hmmm. To be politically correct... it’s a big thing but erm... ooh I can’t think of that word now, either... not to be, prejudiced... is the biggest thing I think. Ethical, Erm...to work within good practice, good boundaries...not go against erm...I suppose people’s, is it not right, not to go against peoples beliefs...erm... (sighs..) I suppose I’m thinking like, I suppose if you go back, ethics, there’s also like the ethnicity it was thinking something that side I suppose... I’m sorry, I’m not help...quite helpful” (Fran - line 78).

As Fran struggled to answer the question she was invited to elaborate on the term ‘boundaries’ that she believes give her the ‘ethical framework’ to complete her work.

“Erm...(long pause).....”

(Michael: So, who sets the boundaries?)



“Well er, erm...the CSP I suppose, work within them guidelines erm, so I suppose it's (sighs), I suppose those are the boundaries erm...I'm not sure really how else to, to answer that.” (Fran - line 168).

After stating that HCE is offering a 'fair treatment' Luke also struggled (after a long pause) to elaborate any further.

“I'd say it was in, in, involving a fair treatment for a patient erm... [sighs] (pause of 27 seconds), I wouldn't actually know Michael, erm... I can't ask you for a hand either can I?” (Luke - line 44)

Whilst always reflecting on what the participant experienced through the analysis of their spoken words it is also important to look for what is not said or said 'between the lines' or indeed paying attention to the silence and the absence of speaking (Laverty, 2003). Also the indications of pauses the mis-hearings, apparent mistakes and any remarkable speech dynamics that occur (Biggerstaff & Thompson, 2008). This offers further 'authenticity' of interpretation (Murray & Holmes, 2014). These difficult exchanges with Cal, Fran and Luke relate to lack of insight of HCE and highlight how this concept may not be engendered in the daily cognisance of HCPs. This was found in some of the literature suggesting that HCPs offer assurance of their ethical knowledge, yet few can demonstrate the ability to identify and to analyse ethical and professional issues (Rozmus & Carlin, 2013). Delivering health care in the modern context brings ethical challenges for professionals involved (Atwal & Caldwell, 2003). These challenges sometimes require dialogical ethics to be used to explore the various and sometimes conflicting perspectives on a morally complex situation (Widdershoven et al., 2009). Widdershoven et al. (2009), comment that to seek resolution to these problems, through dialogue, presupposes that the HCP must already have insight into the matter. The failure to recognise ethical issues, thus preventing ethical action, will be discussed in later chapters.

## 6.2 Generalised principles of ethics

Consideration of the best interest of the service user and upkeep of professional standards were commonly described by participants as their understanding of HCE. The Health and Care Professions Council (HCPC) is the regulatory body for physiotherapists and podiatrists and provide The Standards of Conduct Performance and Ethics. The HCPC emphasise that the standards are in keeping with “your

duties as a registrant” (HCPC, 2012b p3) and that they are “standards that you must keep to” (HCPC, 2012b p3). The first of which is “you must act in the best interests of service users” (HCPC, 2012b p3). HCP decision making is therefore based on objective and justifiable values which results in receipt of appropriate treatment and is presumed to be in the best interest of the service user (Devlin & Magill, 2006). Devlin and Magill (2006), state that this is only a presumption and not a certainty due to the fact that few HCPs are skilled enough to know how to undertake or challenge clinical decision making with regards to ethics. In the following examples these ‘standards’ are acknowledged as a part of how HCE are understood. The first is given by Alex who associated ethics with issues related to protection.

“I would say treating a patient in an ethical manner would be not to do any harm to them, that would be the main thing” (Alex - line 119)

Mary spoke of communication as a key to her understanding of HCE, but had a sense of including ‘protection’ as the underlying requirement for ethical practice.

“ethics means, basically it’s a protection of the patient, so within the treatments...you are basically entering a professional relationship with a patient...so you take on their thoughts, and their opinions and basically it’s more, it’s a communication, to both come to an agreement before any treatment progresses...so they are fully informed...and then it’s also about protecting the patient, the information that they divulge and give to you, that that’s all kept confidential.” (Mary - line 18).

The notion of ‘protection’ first, that Alex and Mary alluded to, is consistent with the tradition of the Hippocratic Oath which has been summarised as; beneficence (to do good or avoid evil) and non-maleficence (to do no harm) (Willacy, 2011).

Kumar (2010), suggests that the oath speaks about earliest codes of ethics denouncing that a physician should ceremoniously recite it, but states that it laid down the criteria for a perfect physician as; observant, humane, learned, orderly, thoughtful, pure of mind and an ability to gain more applicable knowledge. Kumar (2010), indicates that the oath was based on a sense of responsibility towards patients and to keep professional, self-holy and upright whilst also retaining professional confidentiality along with human dignity and religious responsibility. This engenders a greater demand on the HCP than Alex and other participants had considered. It advocates a move away from mere recognition of simply not doing

harm and attempting to do good, but to strive for something more personal in one's own character development that involves personal and potential virtues. Kumar (2010), comments on the noteworthy aspect of the oath being marked out primarily as a series of negatives whereby it is possible to summarise the statutes of the oath today without the virtues that Hippocrates had based it on. This will be discussed in Chapter 10, in relation to passivity with devolved responsibility. Kumar (2010), recognises that decision making is difficult, but that if the medical profession simply promotes knowledge without humanity, then it generates monsters, which can be avoided if one practices medicine by following the oath as indicated by Hippocrates.

Whilst Mike interpreted HCE as doing the best for individuals he also underpinned his description with the proviso that one mustn't do anything wrong.

"I guess to me it means that you are trying to do what is right for the patient on an individual basis. It's not a blanket approach that should be applied to everyone, round peg square hole sorta thing. I think it is, ethics are to me doing the right thing for each patient based on their circumstances and their condition and obviously not, mistreating them in any way" (Mike - line 81).

The following are further examples by Ruth, Conner and Pat of generalised terms to describe their understanding of HCE, with various connotations of protection.

"I think it's to me I think one, confidentiality and then just sort of treating your patients equally, how they want to be treated making sure you get informed consent (pause) and you sort of doing your duty of care you're not... if you think something needs flagging up you flag it up (pause) just not being discriminatory like (pause)... so you're not like you're depriving anyone, anybody of anything." (Ruth - line 73).

"Yeah, I suppose what it means is having a duty of care to the patient then, to put it into those terms... within that you're keeping records safe, you're not taking notes outside of the workplace and things like that... you're not breaching confidentiality." (Connor - line 64).

"Ethics to me is about equal opportunities type o'thing, health and safety would come into it, that kind of thing, about being ethical as in not hurting people. That's what I think about being ethical in practice." (Pat - line 24).

Terry understood HCE primarily as being safe, up to date with evidence based practice and respecting the confidentiality of the service user.

“I would say it's making sure that every patient that you ever treat, you provide 'em with a (sighs) safe treatment and you're being professional throughout and part of that will entail the confidentiality... obviously I mentioned safety into that and you're keeping yourself up to date with any new treatments, that again that you should be providing as an evidence based. But main thing I would say is safety and that you're not disclosing stuff to other people. They should feel confident when they're coming in.” (Terry - line 29).

Sue considered HCE in terms of professionalism, but was perfunctory in her explanation and offered no examples of how this approach is achieved.

“Erm, your professionalism, how you deal with your clients and the way you go about your business. Providing the care and the service to the clients that you see.” (Sue - line 20)

To James, HCE meant the difference between right and wrong and a professional duty of care.

“erm...well yeah the term ethics is just the difference between right and wrong I'd say...(pause) and in a health care setting...obviously the difference between right and wrong in terms of your profession really, confidentiality is probably one of the big things I think about when ethics is used ...and duty of care I guess” (James - line 126).

Pete and Dannie also referred to HCE in terms of doing the 'right thing'.

“it's to be making sure you do the right thing, not disadvantaging anybody by means of convenience or whatever - it's the right thing” (Pete - line 54).

“I would say that means doing the right thing for the right person, not treating everybody the same because you can't do that, but treating everybody with the same level of respect and care.” (Dannie - line 48).

Dannie was invited to try and explain what is meant by doing the right thing.

“I think for me I, if I'm trying to do the right thing for somebody, I'm trying to do the things in their best interest, what they want and something that I can deliver to them. But the right thing for one person is not necessarily the right thing for another. So its exploring what that person actually wants because that will influence the decision of what's the right thing.” (Dannie - line 68).

Dannie recognised the importance of exploring what an individual wants and that this ought to influence the decision of what is the 'right thing'. This is discussed further in Chapter 9, Person-Centred Care.

Jane included individual responsibility, adherence to codes of conduct and service user best interest in her understanding of HCE.

“erm, (sighs) I think it means about taking responsibility for your work and abiding by, appropriate code of conduct and making the right decisions for the patient with their interest at heart, I guess so code of conduct stuff.” (Jane - line 33).

Doing the 'right thing' that James, Pete, Dannie and Jane spoke about is in accord with the Hippocratic Oath (as summarised by Willacy, 2011 above) and has governed the medical professions for over 2000 years. This was primarily a list of negative cautions or minimum standards. These participants refer to the concept of doing the right thing with examples of adherence to the minimum standards or codes of conduct, but ethics is the study of human action with particular interest in the moral character of voluntary action (Kumar, 2010). This places a weight of importance to the concept of 'doing the right thing' beyond the minimum standards. Marie described ethics as a belief that you are doing the right thing, and links this with an evidence base.

“blimey that's difficult, doing the best interest of the patient doing the right thing for them really and making sure you can back up, it's quite hard in physio probably because there's not much science, you know, a lot of what you do is through you believing it's the right thing to do” (Marie - line 73).

Marie described believing you are doing the right thing, even in the absence of supporting evidence. This may be described as 'intuiting' which is widely used in clinical decision making, albeit underestimated compared to scientific decision making methods such as evidence based practice (EBP) (Nordenstam, 2013; Pearson, 2013). Despite the rise of the EBP paradigm, the use of tacit judgments that are associated with intuition based decision making (heuristics) have been shown to be valid and enriching when balanced with personal experience offering final arbitration in the decision making process (Banning, 2008; Cioffi, 1997; Traynor et al., 2010). Ethical judgments are not simply rule or principle driven, but will draw

from deduction by the HCP and context of the service user to inform the right action (Thornton, 2006). Liz offered an example of how HCE relates to a wider concern than standards or guidelines.

“it means how we treat our patients, what our thought processes are when we go into someone's home or they come into our clinic you know things like, I would've thought it was to do with like, privacy and dignity and all that kinda stuff...making sure we're giving 'em the right information and they understand it and they understand what we're doing to them and why we're doing it. And we're not harming them. It covers everything we do.” (Liz - line 45).

Liz was asked what she means by "thought processes" in the context of HCE.

“is it the right treatment, is it suitable for this person, is there anything else that I need to do, do I need to refer onto another member of a team, specialist GP, if that's in the best interest for the patient, ethically am I doing the right thing for the patient...I'm thinking about you holistically... if the person not got (laughs) er doesn't understand properly is there somebody there that can help them understand?” (Liz - line 100).

Liz described ethics as a holistic approach in ensuring that she considers all aspects of the service users' needs by referring to their personhood. Sarah also identified with personhood in describing ethics as practising equality to deliver patient choice.

“erm (sighs), I suppose it's something that kind of sticks with you that you don't really think about a lot and that you just kind of do naturally I guess and just making sure that the patients have the right to kind of, choose what they want, that regardless of whatever their kind of background or whatever their thoughts of whatever their beliefs” (Sarah - line 105).

Mark offered a confident and comprehensive description of what HCE means to him.

“very simple terms, to me ethics encompasses, professionalisation, caring, openness and honesty and being extremely careful that you don't cause harm to the patients in your care and that would encompass things like evidence-based practice, following the clinical governance arrangements et cetera.” (Mark - line 18).

Mark included personal virtues and the concept of caring along with the generic professional references that other participants use. The majority of the examples given are classified as “intellectual virtues” by Aristotle (300 B.C./2004 Book II:i 15).

Aristotle argues that there are two kinds of virtue; intellectual and moral. He proposes that 'intellectual' owes its inception and growth chiefly to instruction. 'Moral', on the other hand, arises out of habit which is where the word was derived (as a modification on the word ethos – ēthos being 'character' and ethos being 'custom'). This understanding is pertinent to HCE. A list of minimum standards can remain intellectual virtues and therefore a 'potential', but to achieve 'actualisation' habituation is required (Aristotle, 300 B.C./2004). Horgan and Timmons (2008), consider this in context of a 'frame problem' and conclude that fully systematisable general principles (such as minimum standards) cannot offer moral normativity due to the complex and nuanced nature of humans. This notion will be explicated in Theme 5 when considering how a HCP might be disenfranchised or become passive in consideration of HCE.

### 6.3 Formation and evolution of HCE

In 6.2 above, various participants describe HCE in terms of adherence to minimum standards of professionalism. These were summarised as intellectual virtues for which Horgan and Timmons (2008), suggest are inadequate to offer moral normativity. Normative ethics may be defined as a code of conduct that applies to all who can understand it and can govern their behaviour by it (Gert, 2015). Various participants allude to 'doing the right thing' and ensuring respect for service users which demands moral virtue to be applied. One cannot function without moral virtues in understanding the context of the service user's situations, which is a form of practical knowledge (Widdershoven et al., 2009). Widdershoven et al. (2009), claim that fostering a dialogue with service users requires specific expertise including knowledge of ethical theories, which can help to deepen the experiences and views of practitioners. HCPs are faced with difficult situations in which they have to make decisions with explicitly moral dimensions and yet they receive little training in the area of ethics (Schröder-Bäck et al., 2014).

#### 6.3.1 Ethics education - undergraduate, post graduate or vicarious learning

In order to improve quality of care, practical moral sensitivity and knowledge is required, which is developed through training and experience (Widdershoven et al.,

2009). When asked where individual ethics are formed, Chris had no recollection that his employers or education providers have ever inputted into this subject for him and didn't recall the subject being discussed.

“I don't know... health care ethics is a term...I don't think it is a term I've heard that often (pause)... yeah I've never really known ethics to be discussed... I don't remember it being (discussed) at degree level education... or at higher degree at MSc, no I don't remember. Yeah I can't think of when I've come across ethics before other than in research I suppose, where you go through ethics committees” (Chris - line 2375)

As with Chris, Alex stated that other than not harming a patient, for her there has been no formal education contributing to HCE. She used a phrase to suggest that “you just pick the rest up as you go along”. This alludes to a concept of tacit knowledge which may be vicariously adopted or acquired by allowing sense-making in the workplace to be gained by learning and unlearning through experience of knowledge in motion (Cox III, Hill & Pyakuryal, 2008).

“the whole undergraduate training is about the how to treat, do the treatment isn't it and with that comes the ethics, you don't do something if you know its gonna cause them harm... you shouldn't hurt someone... so that's all in your training isn't it... and then you just pick the rest up as you go along. I've not been on any particular course about ethics... or, I mean we've been on stuff about changing behaviour, now that's, 'cos that's a massive problem in health care, so skills that can persuade people to change their behaviour is really good” (Alex - line 456).

Alex confused ethics with behaviour change which may arise from the institutional and paternalistic medical model, from which health care empowerment has tried to move away (Piper, 2010). Alex went on to describe that vicarious learning takes place from experienced to junior staff by "picking it up".

“I think in a profession you share your ethical consideration probably with fellow professionals most of the time I don't think I've come across much where I will do something drastically different to someone else, you might do a different treatment, but what you thought ethically would be similar I would think and I think that's probably people passing on their knowledge, you would be working as a junior podiatrist with older people with more experience and you would pick stuff up from them and then we all pass stuff down to the students now and younger members of staff so it's probably a learning thing within the profession a lot of it... Yeah, you pick it up... or multidisciplinary clinics, you pick stuff up from other professionals, doctors, nurses, as well, and how they would work ethically. (Alex - line 519).



The importance of the learning process with the indispensable role of practical reason (prudence) allows people to become virtuous by acting virtuously and reflecting on their acts, thereby making the virtuousness purposeful and contemplated (Vanlaere & Gastmans, 2007). Consistent with Alex's model of clinical vicarious learning, Vanlaere and Gastmans' (2007), claim that the most effective and intelligent way to teach ethics is to locate the HCP in a clinical setting under the direction of a mentor. They do not offer any data or evidence that led them to their conclusions and thereby leaving this claim void of further critique, but in isolation this statement holds true for the acquisition of bad habits and cultural behaviours as it would for good ones (Jackson et al., 2013) (This issue is discussed in more detail in Chapter 8, Theme 3).

Contemporary HCPs provide care in highly organised and complex surroundings where other professionals and service users do not necessarily hold the same values as their own (Verkerk & Lindemann, 2012). The majority of podiatrists and physiotherapists work in private practice (52.61% physiotherapists (NHS, 2013) and 70.24% podiatrists (Townson, 2014)), many of whom may work in single staffed buildings. Therefore Alex's notion of "picking it up" when working in teams cannot account for physiotherapists and podiatrists practising in the current workforce. Neither does it explain how the mechanism of learning is reflected on or checked (for those who do work in teams). For vicarious learning of ethics to be effective one might also expect that the experienced staff ought to have an authentic knowledge and practice of ethics supported by official mentoring competence, perhaps recognised objectively. This raises a concern professionally and pedagogically about the notion of learning ethics. Ethics education and training must provide HCPs with the tools to accomplish critical reflection in a pedagogical context that allows good care to be taught and cultivated (Vanlaere, Coucke & Gastmans, 2010). Experience alone may not enable a HCP to teach something that has become ingrained in their way of thinking and being for them (Delany & Golding, 2014). Alex's example therefore relegates the learning experience to be a personal and informal condition, which remains unchecked. There is the possibility to never observe or learn ethics formally and also the possibility to observe and develop poor practice which is devoid of ethics. This was experienced and shared by some

participants as the cultural acceptance of non-ethical practice (Cultural influence on ethical behaviour is discussed in more detail in Chapter 8, Theme 3).

Alex also related ethics to how the clinician communicates with the service user, adding that she was not taught 'communication' at college either. As with training for ethics, she expects this is just something that you "pick up as you go along".

"I don't think we were particularly taught how to treat them from the communication side, they probably are now but we weren't, you just pick that up as you go along..." (Alex – line 392).

This presupposes that there is ethical expertise which according to Morgenstern and Richter (2013), raises two important questions; 1 – What is ethical expertise and 2 – how does one learn it? Conversely, using a model of team discussion around ethical issues (during case load management) has shown to assist HCPs to learn a way through ethical problems in service user care (Svantesson, Lofmark, Thorsen, Kallenberg & Ahlstrom, 2008). The model that Svantesson et al. (2008), discusses, however, was a study based on a ward round structure in dialysis care and was led by a philosopher-ethicist. This is unlikely to be a model that would be used in physiotherapy and podiatry as evidenced in section 6.1 above, where there are participants with an abundance of clinical experience and yet cannot articulate what ethics means to them. What follows in Theme 3 is a compounding issue where resource restrictions present limitations to service provision creating potential ethical dilemmas that are not recognised by various participants as an individual concern.

Continuous ethics education of clinicians aiming at early recognition of ethical issues may provide part of a proposal to resolve the concerns above (Morgenstern & Richter, 2013). Ethics education should not be limited to introducing the principles of right action, but the curriculum should include a pedagogical means of teaching and cultivating a caring attitude, which is precisely the approach of virtue ethics (Vanlaere & Gastmans, 2007). Cal claimed that her ethics have changed from what she learned at University. She did not, however, indicate any direct ethical training which informed the changes.

“it’s got to have changed from uni... like you see it just by working with people and because we’re a team we work with lots of different people all the time so you’re picking up loads from each other all the time” (Cal - line 652).

Cal and Alex both considered vicarious learning from others which has been discussed above. The culture of learning in this environment appears to be one of custom and practice of clinical facilitation rather than consideration of ethics. For moral sensitivity and moral reasoning to improve, it is necessary to have a planned content of ethics education in the curricula (Park, Kjervik, Crandell & Oermann, 2012). Ruth thought she had developed a better understanding of ethics by exposure through experience. She struggled to articulate what ethics is, aside from using key descriptors of professional standards such as; confidentiality, equality, informed consent and duty of care (reported in 6.2 above) and yet denied that it has ever changed or evolved.

“I’ve probably got a better understanding of it and like I come across it - well you come across ethics like every day don’t you?... so I’ve probably got a better understanding. I wouldn’t say that my - that it’s changed but (paused) probably more aware of it” (Ruth - line 390).

James contextualised his ethics formation through post graduate research and did not consider ethics to be something he thinks about on a day to day basis.

“it’s developed yeah and in the post graduate diploma there was ways you had to analyse research from an ethical point of view... (pause) do I think about it now... obviously well no, not on a day to day basis... I just hope that I work in a way that is just kind of ingrained and quite ethical really it’s probably how you’d live your life really...you don’t (pause) break the law, but you don’t think about it...you just think you do what’s right...

... I guess as well as maybe the way you’ve been brought up or the way that I guess the two are; what you do in society and what you do in your job...I don’t really need to think of how I work ethically (pause) because you know the kind of person you are and you know you live your life in that way and you’ve been brought up that way really so that’s probably why for me personally I don’t think about ethics really...so I guess I - I don’t know, I probably do what I feels right as a personal point of view.” (James - line 768).

James related upbringing to individual ethical morality in one’s actions. He appears to be disengaged from reflection on ethical matters by his claim not to think about ethics and is assured that his upbringing creates an ingrained decision making to do

what is right. After stating that ethics are not formally taught, Terry claimed that it is his personality that allows him to know right from wrong.

“where have I had it from? Erm... (phee...laugh) well we don't get taught it after university...I mean, we must have had (blows) a three hour lecture, if that? I can't even...we had an Ethics Law and Management module, one module which were more really about law and it were so brief, I mean, I can't remember anything of it, that says it all, and then I've done my Masters and I can honestly say I've had nothing, and we done a 30 credit research module and there was not a great deal discussed about it, I mean we had a little bit about setting up a protocol... research ethics.. but NOTHING on NHS ethics so there was diddly-squat really...

(Michael: So where do you derive yours from? Where do you get your ethics from? What makes you ethical?)

...Well I think it comes, personally I think it's your, how your personality is generally, I mean, knowing right from wrong and treat people as you'd want treating yourself.” (Terry - line 148)

Terry and James alluded to knowledge of right and wrong in the treatment of others which may be considered as a tacit awareness. Since organisational and cultural contexts are factors that influence a HCPs' ability to provide quality care, having tacit knowledge may not always be successfully drawn upon for caring (Kontos & Naglie, 2009). Doing what you think is right, therefore, brings a human and ethical demand for self-discipline and self-criticism (Gadamer, 1996).

In a like manner to James and Terry, Fran and Dannie considered upbringing as the source of their ethical formation.

“I think it's your own... teachings or learnings that we've come... and then obviously as you grow and mature you develop your own, I suppose feelings or opinions and... I feel like I had a good... upbringing, background yeah...” (Fran - line 238).

“I think, you know, it's like your moral compass isn't it to start with and you have a lot of ideals and ethically, doing the right thing

(Michael: Where did you get your moral compass from?)

...(laughs) I wonder that, that's off, that's a growing up thing isn't it really, that's how you're brought up and your experiences where I went to school, people you're around, your education. All over the place.” (Dannie - line 632).

Another example of the lack of training and development in ethics was given in Jane's answer to how her HCE have been formed.

“I don’t remember doing much at college... I think certainly not necessarily the learning of ethics... I don’t think an awful lot of it has ever been taught. I’ve never been on an ethics update or training session or anything like that.” (Jane - line 297).

Mark also stated that ethics was not taught formally in any professionally related training other than for research, which he understands to be a different context.

“I was never taught anything about ethics through my podiatry training... a lot of it are my own personal beliefs... things I’ve picked up over the years and also I’ve learned about ethics through research, but that’s in a different context.” (Mark - line 26).

Sue also identified that she had not been taught ethics, but that it is part of your personality and believes it can be self-taught.

“...I don’t think I was taught at University, I think it’s kinda been self-taught, I think it’s within you and it’s experience from dealing with clients and the type o’ clients that you, you’re exposed to.” (Sue - line 29).

Sue referred to experience and self-teaching of ethics so was asked if she thinks her ethics has changed or evolved. Sue was convinced it has developed and gives a definite and affirming response, but when asked for more details about how her ethics were formed, she replied in terms of general awareness of patient care.

“I’ve been picking up on it over the years and it has evolved. Definitely. I suppose I were just [sighs] more aware of the gold standard and best practice where the newly qualified practitioner, you’re just getting the job done and you can’t think outside o’ the box, where now you understand the components...” (Sue - line 339).

Mike was the only participant to acknowledge or remember any undergraduate education relating to ethics. He did, however, explain that it was not summatively assessed and was not taken seriously by the students. It is a point of interest to note that this participant was trained abroad and so whilst he is the only participant to recognise HCE being taught, it was not in the UK.

“we did a module at undergraduate education, I think we did moral issues of today...You were certainly taught about sort of cultural understandings and backgrounds and different people that may present to you in various ways, shapes, forms. We probably didn't take it very seriously at the time 'cos I remember us doing a skit where we did...we were tryna (laughs) disseminate the differences between various cultures that might come through the door...and then I think we got a fail.. (laughs) so we (laughs), we didn't take it too seriously, but I think, as I say, I was given a grounding in it in University and I don't think it was a pass/fail subject...it wasn't a module...but I think my own ethics and morals in terms of what I do is just about doing what's right for that person...” (Mike - line 26).

In the group interview Joan had stated, with a rhetorical question, that it is not good enough that ethics appears to be a matter of personal integrity rather than a formal and professional requirement. Despite the fact that HCPs have access to a well drafted code of ethics and professional conduct, when confronted with an ethical dilemma it often appears to be unique and not found in the existing ethics literature and so find themselves having to rely on their own resources, problem solving ability and reflective thought (Barnitt, Warbey & Rawlins, 1998). Hence why the Socratic method of teaching ethics is said to be highly suited as it is not the teaching of ethical knowledge, but the training of the capacity to attain ethical knowledge by one's own efforts of problem identification, deliberation, problem-solving and reflective clarification (Birnbacher, 1999). In response to Joan's comments, the group were asked how moral or ethical development is nurtured or checked for HCPs and if Continuing Professional Development (CPD) profiles are known to include ethics.

“Dave: Well, it's like all of these things, they're all minimum standards aren't they...now the patient may not want minimum standards, they may want the best care possible, so straightaway we've got a conflict 'aven't we...'cos we're working to minimum standards. So what actually is measured in CPD is the minimum standard that's expected of a podiatrist, a physiotherapist, an occupational therapist.

Chris: But is morality ever measured? Within the minimum standards. It's a sticky wicket to touch on 'cos unless you're confident, you question that you're morally right, 'cos it can come down to opinion, difference of opinion can't it, so you can't tell somebody their opinion's wrong.”  
(Dave and Chris - group interview line 1142)

Chris spoke about the difficulties that decision making invokes in the absence of moral certitude. As it is not possible to construct a moral theory that can, in all

circumstances, satisfy all the facets of moral judgment, this means that when facing a moral dilemma part of you is going to be dissatisfied (Cushman & Young, 2009). There is, however a moral demand placed on HCPs to engage in practical reasoning. The practice of trading off between competing moral demands requires reconciliation amidst conflicting axioms for which there is some evidence for reflective equilibrium at the level of individual moral judgments (Cushman & Young, 2009). Reflective equilibrium is the end-point of a deliberative process in which we reflect on and revise our beliefs, seeking an acceptable coherence between them (Daniels, 2013). Dave impugns that all HCPs strive for this, but instead they are working towards minimum standards and the HCPC only seek evidence to this effect. No one in the group interview opposed this. Reliance on standards and principles alone may detract from the importance of the HCPs' personal qualities to achieve ethical significance (British Association of Counselling and Psychotherapy [BACP], 2009). The Ethical Framework for Good Practice produced by the British Association for Counselling and Psychotherapy (BACP, 2009) identify that a course of action does not necessarily become unethical merely because it is contentious or that other practitioners may reach different conclusions. Rather the BACP (2009), conclude that the challenge of working ethically means that when compelling obligations are faced, it is a practitioner's obligation to consider all the relevant circumstances and be appropriately accountable for decisions made. Only Joan seemed to be particularly resolute at voicing these issues whilst the other members of the group seemed to acknowledge them, but did not attempt to discuss possible resolutions to these concerns.

### 6.3.2 Personal ethics contributing to virtue ethics

Codes of ethics may be considered to be ineffective, little understood or used and not nearly as influential as one's own personal values (Sansom, 2013). Virtue ethics may be considered from a bottom-up approach, rather than introducing principles or theoretical concepts (Annas, 2015). Annas (2015), postulates that in most of its forms, virtue ethics is a theory about how one can live better, and so must start from how we live and the dispositions one has. This notion encourages HCPs to use personal ethics to challenge and make demands of oneself, which leads to revision (sometimes radical revision) in how we think ethically (Annas, 2015). For this to be

fulfilled one has to be cognisant of, and versed in, the concepts and practices of ethics.

The participants in the group interview demonstrated acceptance that HCE for physiotherapists and podiatrists seems to be reliant on personal virtue. Aristotle (300 B.C./2004), asking the question 'what is the right principle that should regulate conduct', refers to the contemplative and calculative intellect. He purports that since moral virtue is a state involving choice, one must have rationality and desire, but the desire must pursue that which the reasoning asserts. Thus the calculative faculty aims towards truth as rightly desired by exercising choice. Contextualised as phronesis (practical wisdom) which is not a moral virtue itself, it offers an ability to judge the right action in a particular situation, therefore assisting one to make wise choices (Svnaeus, 2003; Waring, 2000). For practical wisdom to be engaged one requires the development of moral virtues. Chris believes ethics may be related to morals and is a personal matter, but delineated HCE as a different issue which is dictated by the employer and not individualised or personal.

"Are we just talking ethics here or health care ethics? cos (pause) I suppose with the idea of conscience it's down to an individual's belief system but then if it comes into health - this is going back to my point...I suppose that it comes into health care ethics" (Chris - line 841)

"ethical decisions are based on belief but health care ethics are not what the individual thinks but the organisational body" (Chris - line 455)

"health care ethics seems to me a strange term because to me ethics is down to an individual person" (Chris - line 1261)

What Chris described was also a predominant view that McGrath et al. (2006), found in their study highlighting that ethical values were professionally based which almost always took precedence over personal values. McGrath et al.'s (2006), study included one physiotherapist, four other HCPs, eight nurses and five doctors. It is difficult to discern how these conclusions were drawn since there was no interview prompts or other transparent data which evidences how the interviews contributed to this finding. Chris, however, demonstrated a similar deference to what he termed HCE as distinct from his personal ethics. Pete stated that his ethics, although personally derived, are applied within the organisational process.



“I think I am pretty pragmatic... I just think I've understood more I've learned more and applied it to my own understanding of where I sit in the organisation” (Pete - line 970).

Pete shared a similar example given by Terry and James (described earlier) demonstrating confidence in their ethical formation to a point that dismisses the need for reflection of their own competence. HCE in this context demands that the clinician uses method and methodology which are the hallmark of science, but requires human self-discipline to keep to a method and therefore against those inclinations, assumptions, prejudices and subjective interests which tempt all of us into believing to be true only what suits us (Gadamer, 1996). Neither of the three participant examples demonstrated the application of any methodology in ethical decision making. Jane, Fran and Terry also described ethics as personally developed conduct stemming from parental upbringing with a societal influence aiding recognition of right and wrong.

“I don't know, I just think it's the way we just conduct ourselves, I think it's partly through what you are taught as what's the right thing to do, but I think it's...a humanity thing almost isn't it? It's who we are and what we do by each other really. Who teaches that? I don't know. I think it's, maybe it's the parental thing, maybe it goes right back to that... I don't know who taught you that, I guess, it's part of, it is your upbringing, but it's partly a society thing as well isn't it, just what's right and what's wrong.” (Jane - line 64).

“...I suppose when you think about boundaries...I always think of what you've learnt from your parents...about treating other people wi' respect, giving people common courtesy, it's those type o'things.” (Fran - line 209)

“I think it stems from your personality of how you are, I would think that most who work in health care have got a slight caring side anyway 'cos you wouldn't do that job but not everybody does... So you're hoping that you're doing everything appropriate but you might not. Exactly, it's up to you, there's no guidance, yeah so it's individual definitely.” (Terry - line 527).

This may illuminate an aspect of virtue that is essential to achieve ethics, but it is hard to understand how one can do good HCE without relying, explicitly or implicitly on ethical principles to justify decisions and actions (Macklin, 2015). Mary was clear that ethics/morals is a personal development from religion and home upbringing with taught examples from others, but she conceded that professional ethics should be formalised through education.

“I would say... from religion, from my upbringing and what I’ve been taught by examples, seeing how people act and emulating that and... innate as well, just the general knowledge that you don’t want to give anyone a bad service or a disservice. I always kinda treat people as I’d want to be tret... ethics can come into your daily life every minute of every day. But professional ethics... it’s something that possibly does need to be taught...  
(Michael: Have you, since qualifying, formally gone through any ethical training as a part of your CPD?)  
... No, it’s not formally been part of my CPD.” (Mary - line 321).

Mark confirmed that his ethics have evolved and like Mary believes that it started with his upbringing in church and was absent from formal professional teaching.

“I was brought up in the Church...and that dictated my starting point and that...sort of helped in the absence I think of any strong tuition on that at college so that’s the personal belief thing..” (Mark line 274)

Several of the participants account for HCE as a personal matter involving morals, which is integral to their individual clinical role. They arrive at this through their upbringing, parents, religion/church and society. In the group interview Becky answered a question about individual ethics by stating that her ethics were formed at home and in church and this gives her a conscience to act from a personal level and motivates her to do the right thing. Two other participants affirmed this without elaborating, but Mark agreed with Becky and shared what he had previously discussed in his individual interview.

“Becky: I mean Michael’s talked about what’s your motivation to do the right thing isn’t it, well for me it was my background, my upbringing...as a child in a kinda Christian household and it was about doing good, not doing harm, being kind to one another and that’s what drives me to do the right thing, be professional and have good ethics if you like.  
Mark: It’s kind of interesting...you mention that because, mine came about from my childhood for those very same reasons. What I did at college had very little influence on it...my childhood upbringing had every influence on it.  
Becky: Yeah.” (Becky and Mark - group interview line 961)

If ethical decision making for physiotherapist and podiatrists is therefore a matter of personal virtues then one has to discern where the intention of action arises. Aristotelian ethics refers to virtues as states or dispositions of the soul that allows us to think, feel and act in an appropriate way (Svenaeus, 2003). Normative or principle

based theories of medical ethics do not provide this same intention to act on behalf of the service user, but engender external influences which may include a lack of emphasis on person-centred ethical values and more focus on cost containment, which in turn causes frustration and demotivation for the HCP (Balch, 1998).

Providing all those involved in the decision making process have the service user at the heart of the process then the challenge may not be one of agreeing the ends, but the means (Hurwitz & Richardson, 1997). Decision theory may be considered as a theory of rational preferences satisfying certain intuitively plausible axioms (Pillar, 2009). This could be achieved through a phronetical approach using dialogue with all involved stakeholders.

Phronesis can facilitate right judgments, decisions and actions if cultivated through moral virtues which are mutually reinforcing states necessary for achieving better ends for service users (Svenaeus, 2003). Philosophical ethics may not necessarily be related to applied ethics and may be treated as distinctly different (Loughlin et al., 2010). If phronesis is considered a defining trait of a good HCP then it is not surprising that virtue ethics has been disinterred from the catacombs of ancient philosophy and has attracted new interest in the context of medical ethics (Svenaeus, 2003). Participants of this research, however, do not evidence the prevalence of ethics formation as a distinct part of their professional development.

### 6.3.3 No evidence of formation or consideration to develop ethics

Ethics may be perceived as a matter of common sense and acquired through experience in health care settings (Hope, 1999). This is corroborated by the participants of this study with twenty out of twenty-one claiming to have received no under graduate or post graduate training in ethics and none of the participants have attempted to further their CPD related to HCE. Only one participant acknowledged what he described as a personal interest in the subject. Concernedly several participants suggested that ethics does not play a part in their daily work with Connor stating that he does not think that it enters his consciousness.

“I wouldn't say that ethics comes into my conscious at all or the word ethics, or anything like that.” (Connor - line 264).

Luke also claimed that he has not previously thought about ethics before participating in this study.

“I think this is the first time I’ve thought much about it. I think it’s getting harder in terms of the patients that you can see and this fairness that you can provide because of the constant cuts, the constant scrutiny that we’re under as practitioners, specially within the NHS at the minute.” (Luke - line 241).

Although Luke spoke about the resource limitations that he experiences, he did not acknowledge that this may be an ethical barrier. Alex also acknowledged that this research has made her think about ethics and that she had not previously received any training related to ethics.

“it's made me think about... 'cos I know what my ethics are... as an individual but you don't really express them that often. ...and we do use the word ethics occasionally I would think, but not.. and whether they teach, it's how you would teach that to a podiatrist Undergraduate? cos I think you would, maybe, you just come out with what you need at the beginning and then you pick everything else up... (Alex - line 1772).

Alex reflected on the lack of undergraduate training in ethics and stated, "you just pick the rest up as you go along". This is somewhat contradictory since she indicates that ethics are not expressly considered that often. For clarification, she was asked a direct question to establish if ethics for her has ever been formalised in terms of lectures, in-service training or used as evidence towards regulatory body standards of proficiencies, to which her answer was clearly emphasised as "No". This echoes the issue discussed out of Luke's comments above where only experience can teach you ethics. The dichotomy lies in the circular reasoning that indicates that ethics remains untaught and undeveloped by any formal means yet through experiencing ethics, one can develop it. Neither Luke nor Alex suggested where good ethics may be experienced and learned with appropriate checks and balances in place, especially since both of them highlighted that ethics are neither considered nor expressly discussed routinely. Connor initially contextualised ethics in terms of research rather than a clinical issue, but then stated that he had not come across the word ethics, even in research.

“Hmm, erm...I would say I don't think too much about it to be honest. I mean I recently started doing the masters and that's been kinda heavily research based in fact massively research based, but still I'm not, I don't think has the word ethics around it...” (Connor - line 688).

“erm...I was expecting it to be quite heavily research-based ethics questions like putting proposals and things like that and the ethics re, regarding that rather than your kinda clinical practice” (Connor - line 831).

Pat does not think about ethics at work, although she believed she practices ethically despite not being able to explain what it means.

“I don't think about ethics (laughs) but I know it's always there in the background you'd like to think that if you thought something was unethical you wouldn't practice unethically, I'd like to think I'm sort of ethical in my practice, but I couldn't exactly tell you what ethics means to me, I don't know.” (Pat - line 348).

Sarah concluded that she does not know what ethics means.

“I know when I read the thing, I was a bit like, ethics..... ethi....., it's just something that you kind of, a term that actually when you think about it, do I ACTUALLY know what it means” (Sarah - line 877).

During the group interview, ethics and the apparent lack of ethical awareness was discussed and attributed to the fact that physiotherapists and podiatrists do not face life and death consequences from their actions. It was highlighted that consideration of ethics may be clearer in such circumstances of 'big dilemmas' (Johnson, 1990). It was suggested to the group that ethical concerns arise in less obvious scenarios. An example from one of the individual interviews was shared, where empowered and less empowered service users are treated differently by HCPs.

“Becky: I think it depends how much people want their coffee breaks or, I mean some of us are run ragged, rightly or wrongly and you don't have lunch and you don't do that, and that's not looking after yourself really is it but...  
Dave: I think you're right Michael, I think it's the, the grey areas that are the, the black and white ones are probably easy to make an ethical decision on, it's the grey area that's tricky....” (Becky and Dave - line 1637).

Earlier in the group interview the notion that there are few life and death situations for physiotherapists and podiatrists to deal with was considered a contributing factor

to apathy or disconnection when engaging in ethical decision making. The lack of attention towards HCE for physiotherapists and podiatrists illustrates the need to consider how ethics is currently taught and regulated.

Minimal literature related to ethics was found in connection with physiotherapy or podiatry with only one study considering similar research questions. Praestegaard and Gard (2011), found that all interviewees considered ethics an important aspect of physiotherapeutic professionalism, although most had difficulty explicating their understanding of ethics and uncertainty about what constitutes an ethical issue. If the HCPC included ethics in the mandatory CPD profile, then it should follow that HCPs would potentially embody ethics within practice. Aristotelian ethics considers its application in clinical practice as phronesis or practical wisdom. Practical wisdom may be characterised as knowledge of how to act in situations that cannot be judged by the application of algorithms or rules of actions, but rather by understanding the concrete situation and judging how to act in that case (Svenaeus, 2014). Whilst this would not ensure cessation of misfortunes, accidental wrongdoings or bad relationships, it may engender the reflective practice to examine HCPs' actions in particular situations with respect to their values, commitments, moral outlook and character, in reacting to moral situations (Halwani, 2003). This was raised by a service user in the group discussion and will be discussed in Chapter 10, Theme 5.

This chapter has considered how the participants understood the meaning, formation or derivation of health care ethics. The next chapter illustrates how these concepts are perceived to be embodied by the participants.

## **CHAPTER 7: Findings - Theme 2**

### **The Perceived Embodiment of Health Care Ethics (HCE)**

Theme 2 was constructed through interpretation of how the participants' views of HCE are experienced in action. This includes the perceived accountability, responsibility and ownership of HCE in the context of the health care organisation.

#### 7.1 HCE embodied in; standards, guidelines and evidence based practice (EBP)

Embodiment of HCE can be problematic as a consequence of; the gap between the rules and the practice (that the rules are meant to regulate), the ethical knowledge required (to interpret the theory to practice) and the multiplicity of the demands of differing guidelines (Eriksson et al., 2008). Judgment for ethical decision making is liable to variation, therefore ethical predicates are problematic if one tries to govern them by criteria (MacIntyre, 1998). Chris recognised the paradox on how standards for practice can also create unethical conditions. He spoke about HCE incorporating guidelines and standards of practice, but also demonstrated that the same guidelines can restrict access for service users due to criteria for inclusion/exclusion of provision.

“part of our standards, is your ethics. What's your booklet called I've forgotten what the - HPC booklet's called...  
(Michael – The HCPC Standards of Conduct Performance and...)  
...and ethics yeah. Yeah it's like this idea that NICE produce... guidance and the whole idea that it's not ethically right that it's based on funding (pause)... yeah and that's where ethics would come into it I suppose” (Chris - line 482).

This example demonstrates how a HCPs' practice may become compromised as they encounter conflicts between personal standards and moral codes versus institutional codes which focus more on efficiency as opposed to effectiveness thereby limiting care for service users' best interests (Weinstein & Nesbitt, 2007). Chris demonstrated how he resists acceptance of this by referring to HCE as:

“it's your duty of care really I suppose” (Chris - line 548)

He then tried to explain duty of care, but did not articulate a clear understanding of it.

“Yeah it's what you would deem as a duty of care that you would - cos I hear that bandied around a lot as well... probably more than HCE. (pause)... Mmmm I would think for everybody you've got a duty of care as a national health service which is where I work (pause) you've got a duty of care for everybody because everybody comes under the - And what I'm sort of seeing more and more now is very much like, not a litigious what's the word I'm looking for? So for example duty of care to me would - I would think that you've got a duty of care to everybody because you're a care provider for a national (pause)...body but somebody might say well you've not got a duty of care to that patient because they don't meet the inclusion criteria for example”. (Chris - line 550).

He used the term “bandied around a lot” which suggests a casual or frivolous application of what is considered a duty of care. Chris considers ethics as the duty of care, which he links with consequentialism in avoiding litigation and thereby demonstrating defensive practice. After deliberation he then identified how NHS restrictions for service provision could nullify the duty of care if a person does not meet the inclusion criteria. This causes turbulence for Chris who then illustrated an autonomous narrative concluding that he may still retain a duty of care for the individual service user, despite not meeting the inclusion criteria for NHS care.

“I would see myself as having a duty of care at that point” (Chris - line 642).

Chris retains an element of virtue in his ethical decision making. The basic virtue of medical decision making cannot be avoidance of risks, as exercised in the precautionary principle, but the prudent assessment of benefits, burdens and harms and weighing this ethical assessment against other principles which may include the respect of patient autonomy or, as in this case, a just distribution of scarce resources (ter Meulen, 2005).

Fran was unable to articulate what HCE means to her and concluded that it is political correctness and respecting people's beliefs. She was asked for clarification on what she means by political correctness.

“erm, politically correct. I suppose really it's to keep the boundaries that we.... and the principles and our own ethics for... see ethics again! .... our own principles that we work by, the principles that you know, from the physiotherapy code of conduct ...” (Fran - line 147).



Fran focused on external codes of conduct which set boundaries for HCE. This was echoed by Jane who partly described HCE in relation to doing the right thing, but concluded that this was associated with codes of conduct.

“... abiding appropriate code of conduct and making the right decisions for the patient with their interest at heart I guess, so code of conduct stuff ...” (Jane - line 36)

Jane was asked for clarification on which code of conduct she is referring to.

“we abide by the AHP's code of conduct, the HPC or whatever it is now. Those and I guess the Trust has its own policies as well about the way we should treat our patients and what their vision is and all that sort of global picture plus the NHS's stuff as well. Yeah, the physios got their one but, yeah but all sort of part of the HPC stuff but yeah so the CSP as well ... I suppose, you'd only ever really think that there was an issue if there was a complaint that's where it and that's your fear really that you some, in some way do something and that upsets someone that then has a complaint...but I'd like to think that complaints were misunderstandings rather than somebody being unethical and intending to be (laughs) ...” (Jane - line 107)

Initially Jane's explanation demonstrated ethical accountability which is embedded in frameworks or policies from the HCPC, the CSP and the Trust. Jane then illuminated her opinion that ethics in practice are identified with complaints. She then stated that complaints are “just misunderstandings” rather than unethical matters. This statement appears to admonish any responsibility from the service provider. Consistent with Chris, Fran and Jane above, Pat associates the standards set by the CSP and HCPC as benchmarks to facilitate good ethical practice.

“yeah, they have their own standards set down do the Trust and we obviously then work to the standards set by the CSP and the HPC as well but yeah, I'd like to think if someone was practising unethically it would definitely be picked up. We do have caseload reviews, watched assessment, we have a lot of peer supervision and, so I think if someone was practising unethically then it would be picked up.” (Pat - line 44).

During her interview Pat struggled to identify what ethical practice is, but in this extract she made an inference that unethical practice is not good and it would be “picked up”. She attempts to highlight how good ethical practice might be

maintained through peer supervision. This is also discussed in Chapter 10, Theme 5 where Pat contradicted herself and showed disaffection to this process by commenting that peer supervision restricts her clinical autonomy. As moral agents, HCPs are required to make autonomous clinical and ethical decisions based on policies, other health care team members and also their relationship with the service user (Delany et al., 2010a). Further exploration of how Pat's decision making remains autonomous and accountable reveals additional contradictions.

"I think my autonomy's just in my selection of treatment, in my assessment and then my treatment selection is autonomous although we're very much guided now with the NICE guidelines as well, which I don't agree with a lot of them, I mean some of them I just think from experience, I don't believe the treatments they promote actually are the best for that category of patient... (Michael: so as far as NICE guidelines are concerned and your autonomous choice to ignore them, where and how will you justify your clinical decisions?) ...evidence based practice... and we do sort of keeping up to date, I've done a lot of external courses, a lot of people are doing their masters degrees but...so it is just keeping up to date with the journals, the reading and courses and experience of using skills but all skills we learn are evidence based and so that's how I would justify my treatment choices." (Pat - line 269).

Pat contradicted herself by suggesting that she is autonomous in selecting a treatment regime, but then indicated that this is guided by NICE guidelines and finally stated that she doesn't agree with all the guidance. When moving away from the guidelines her clinical decisions are then justified by EBP. There was no recognition that the NICE guidelines may be evidence based. There is also a tension between the concept of autonomy and being restricted by guidelines and outcome measures with little reference here to practical autonomy in decision making. Dannie also related her ethical decision making to EBP.

"I think you first and foremost want to go with the, what the evidence says." (Dannie - line 531).

There is conflict with Dannie's answer and other participants who refer consistently to the Advanced Development Programme (ADP). This is a self-management philosophy and seems to be the preferred option in the participant's experience of working in the NHS as opposed to an evidence based approach. Here Dannie elevates the paradigm of EBP above that of practical wisdom or experience that allows clinical discernment based on individual needs. One risk of this process could

be the inability to allow practical application of knowledge as a consequence of invoking science far beyond the limits of its competence (Gadamer, 1996). This errant approach to applying the evidence may lead to uncritical health care that could erode good clinical practice (Henry, 2006). Situation and circumstances ought to drive the decision to exercise discretion and thus bind the ethical consideration that action is about doing what is right, not merely doing it the right way (Cox III et al., 2008). Potential barriers to autonomy in practice will be discussed as an ethical concern in Chapter 8, Theme 3.

Accountability and personal responsibility in the decision making process was also shared by Jane. Initially she suggested that experience informs decision making.

“Just experience, yeah, what I know works for people and I guess, what you were taught years ago and what you know is the right treatment for the right problem...” (Jane – line 554)

It was highlighted that experience can inform a variety of valid treatment options and therefore the HCP is required to engage in active decision making. With this, Jane spoke about setting consensus pathways based on evidence to allow less experienced physiotherapists to follow them.

“I think, certainly we have done a lot of work on developing pathways and looking at that and having those exact conversations and ironing out what, having looked at research and look at evidence and really reflecting quite hard on what's out there and coming up with a consensus as a group as to what we feel is most appropriate for patients, now that doesn't mean that it's an absolute bog-standard recipe...but we have clear guidance and that's obviously shared with more junior members of staff who haven't got that experience to pull from.” (Jane - line 589).

The notion of guidelines or procedures directing decision making may contribute to disempowerment or disenfranchisement (Traynor et al., 2010). Although guidelines may be deployed with good intention to increase service user experiences, there remains a question around frameworks obviating the need for decision making. Where an organisation advocates clinicians to follow guidelines or pathways of care, this may restrict autonomous decision making and a create reliance on what appears to be evidenced frameworks. King, Thomas, Martin, Bell and Farrell (2005),

considered practitioners' perspectives on the Gold Standards Framework (GSF) for community palliative care. Their study concluded that the GSF enables practitioners to achieve more consistency of care with a reduced likelihood that service users would 'slip through the net'. The research was conspicuous by the omission of any service user perspectives, but only considered practitioner perspectives. This demonstrates a focus of consideration towards the safety net of minimum standards of care rather than improving services by encouraging autonomous decision making tailored to individual needs. Chris gave an example of how his decision making is influenced by pathways of care.

"there's a care pathway there's a 'Diabetes Foot Pathway', that we are to follow for people with diabetes" (Chris - line 2085).

He then raised concerns about the fact that pathways may be considered as a safety barrier although he feels they are substandard for individual provision.

"I honestly believe (pause) there isn't a support framework there (pause) ... you base it on clinical judgment I don't know how you describe how you get to the point of clinical judgment... I've had this conversation before when we developed the foot screening pathway... I said, but you are trying to set a criteria to diagnose ischemia, you're asking... you're trying to put clinical judgment on to a piece of paper and you can't ..." (Chris - line 2128)

This section illustrates the difficulties HCPs face in justifying ethical practice by the interpretation and application of clinical guidelines. During the last three decades the ancient philosophers' historical view of ethics have been reduced to regulatory mechanisms, comprehensive sets of 'authoritative guidelines' and effectively appropriated to ticking boxes on forms in order to facilitate compliance (Loughlin et al., 2010). Character virtues may be more appropriate and important for guiding ethical principles rather than conformity to a set of guidelines or rules (Beauchamp & Childress, 2013). Even if guidelines are easily understood, implementation often requires new elements of consideration at the point of care, without explicit consideration of the individual context of practice the guidelines may not succeed to fulfil their design (McDonnell Norms Group, 2006). Despite being in full possession of what appear to be scientific evidence, HCPs must still allow for subjectivity,

fallibility of the technology and the uncontrolled uncontrollable variable that is the patient (Hunter, 1989).

## 7.2 Autonomy – Personal, Professional or Clinical

In the previous section Chris alluded to pathways or frameworks for care being potentially inadequate. The human experience of care giving should not be reduced to algorithmic rules or managed by mechanistic laws, but rather, interested in the totality of the human experience (Sansom, 2013). Autonomous agency means that every agent has an authority over oneself that is grounded, not in one's political or social role, nor in any law or custom, but in the simple fact that one alone can initiate one's actions (Buss, 2014). Lucy demonstrated autonomy by considering alternate criteria to judge what is in the best interest of the service user and if necessary, stepping outside of the pathways or frameworks of care.

“for me personally, it's me knowing my job as I do and the experience that I have equating that to what a patient needs and what the NHS can offer and trying to do what's right for that person and what's the right decision... not based on a pathway in particular... I think pathways are good but if that's not right for the person I don't think that's ethical - sometimes when for instance if someone's got hallux valgus, in absolute agony you know they're not going to respond to conservative management I wouldn't think that's ethical to put that person through conservative treatment if they need surgery... so I kind of think something being ethical is sometimes pushing for the right decision for the person rather than what someone says you've got to do” (Lucy - line 242).

“...because I think even if someone has to wait two weeks if they're in mega pain I can at least get them started on something on the day but that will only be for a select number because we only get so long to see somebody so I can't give out insoles to everybody because I'd just... we wouldn't have the time, so for me I've kind of fulfilled what I want now for my patients because I'm going to give a bit extra to those who really need it.” (Lucy - line 644).

Lucy demonstrated her desire to do what she could and which she referred to as a "bit extra". Lucy demonstrated a level of autonomy by making a decision to move away from the regimented pathway of care. Lucy believed that this is providing “a bit extra”. Since the context is a service user in “mega pain” it illustrates a potential concern that a HCP considers basic pain relief as constituting a “bit extra”, especially since it amounted to a simple and inexpensive conservative treatment. This challenges the basic tenet of health provision and may be a contributing factor to

disenfranchisement of health care staff. Ethical understanding involves recognition and acceptance of our responsibility for what we say and think (Pleasants, 2008) and contributes to autonomous decision making. Lucy was asked what affords her the courage to go against commissioners and make her own decisions.

“because I'm a professional and I've got the exp- they employ me. I don't know if its arrogant but I think I've got to this level they're paying me good money to do my job I'm not spending all this time working my arse off to get to this level for me to just follow somebody who doesn't know what I know about what I'm doing so you got people on a commissioning board that are GPs some of them might know about feet but a lot of them don't” (Lucy - line 717).

Lucy referred to the recognition of her experience and how her understanding of the service users' needs is more appropriate than simple adherence to commissioned service expectations. This is an example of how the dasein or 'being-with' creates a better understanding of the needs presented in context rather than a single mode of disclosure (knowledge - episteme) as a possession of truth (Landes, 2015). Landes (2015), claims that this influences the decision making process as a means of phronesis informing the action. HCPs are accountable for their decisions regarding service user care within a given context and professional environment (Verkerk & Lindemann, 2012). Autonomy in contemporary practice is a common expectation as well as an aspiration which challenges the beleaguered HCP by accountability, performance measures, national or local policy guidance, care pathways and both managerial and service user demands (McIntyre et al., 2015). Clinical autonomy and moral agency requires an understanding of the ethical issues balanced with the needs of the service user whilst working within the constraints and opportunities afforded by the health policies and institutional structures (Delany et al., 2010a). Mike demonstrated how autonomous practice can be balanced in the face of adverse decision making. He draws a clear distinction between role responsibility and risk taking based on the potential pressures on fulfilling his role.

“do you get pressure from the coach to play the players....? yeah, I do, and really it's up to me to, it's not up to me to say whether they're fit or not it's up to me to give the coach the balance of probability of whether they'll get through that game and any consequences of playing long term, so I'll often say to the coach, ... I think this player is not a hundred percent fit, he's gotta niggle, he's gotta tight hamstring and I think there's a seventy percent chance of him getting through this game and a thirty percent chance that he will break

down and miss four to six weeks so you make the decision and that's throwing it back on the coach sometimes, but I'm only there to give him my best most measured view." (Mike - line 313).

Lucy illustrated with volition a perceived responsibility for service users in her care.

"I think from the moment the GPs refer them to our service because we're the senior clinicians they're our responsibility, to make that patient journey right for them, so from them coming to see me they're my responsibility until the minute they are in the hands of somebody else... and I'm duty bound to make sure they have got everything informed as possible." (Lucy - line 826).

Lucy was animated in the following extract and illustrated her responsibility, and at the same time frustration, with the culture of her colleagues and organisational flippancy towards the issue of accountability to do the best for the service users.

"I feel duty bound if I refer anyone to a surgeon I've got to have shadowed that surgeon before...I don't make the decisions for the patient, but if a patient asked me anything then at least I can tell them about the surgery so I think if you referring on for a surgical procedure you've got to have seen that procedure done and you've got to see what those surgeons are like ... (Michael: is that your own choice and decision to act this way?) ... yeah because no one else has, like people are listing for surgical procedures have never seen it being done... I've done it on my own days off, other people don't even do it in their work time and I've gone on days annual leave to do it because I just think it's a no-brainer, I think you should have to do it...it should be put in your job, they should allow you to do that as a part of your job but they don't..." (Lucy - line 940).

Here Lucy demonstrated autonomy to attempt to overcome barriers in providing quality care. The organisational culture can affect the quality of HCPs decisions (Carpenter, 2010), although little research is available to support this claim in physiotherapy and podiatry. Lucy gave an example of her action, which for her is above and beyond the contractual role. She was asked if she could influence the organisation to remove this barrier. On line 1013 of her interview she stated that she has mentioned this to her management who "flippantly" agreed that it is a good idea to have seen the procedures that you are enlisting service users for, but she then states that nothing gets done about it. She concluded this exchange by demonstrating ownership of this issue, adopting the responsibility and professional accountability, but at the same time exempting any organisational responsibility.

“it’s just that there are so many balls to juggle and at the level that you’re working at you should be able to independently sort that out yourself” (Lucy - line 1036).

Dave introduced a discussion about personal ethics or morals being part of professionalism. He contextualised this with an expectation of self-reflection.

“Dave: is this all to do with clinical reflection? and how you actually reflect on what happens in practice...and, well I was gonna say, does a moral religious upbringing make you reflect on your actions from an early age anyway so that when you come into practice you reflect on what you’ve done in the day anyway that might make you better at reflecting, and we’ve got other people who haven’t got them reflection skills, maybe (Dave – line 1526).

Dave’s reference to personal ethics being part of professionalism may reflect the lack of thoughtful alternatives for managing ethical dilemmas that are rooted in theoretical ethical principles (Freed et al., 2012). Joan appeared concerned about the burden of ethical decision making being individual and the paucity of clinical supervision for which Becky confirmed by indicating that ethical decisions remain personal and unchecked.

“Becky: the only time anyone’s ever mentioned in practice to me about ethics was as a second year student when I was on an ICU placement... but since I graduated nobody’s ever even mentioned anything about ethics or checked it or asked my opinion or anything. (Becky - line 1544).

Individual assessments and having an awareness of self-limits are two ways to inform the autonomous practice that Mike described when considering how ethical principles are embodied.

“I think for me, if every person that comes in you have to do a thorough examination and get to the route of what their problem is...and then based on that, try and give them the best practice that you have in your locker...  
...there’s no point thinking right this person’ll really benefit from acupuncture but I can’t do it, I’d refer them onto someone else” (Mike - line 112).

Other participants recognised the external pressures, but demonstrated apathy when commenting on opportunities to take individual action to oppose them. Without



having autonomy Mike emphatically stated that he would not want to do the job if he had to concede to decision making based on external pressures.

“there’s times where I just say NO he's not fit.... Like there is a, definitely a line that I will not cross if I don't think they're fit. Do I have the final say? Yeah, I think I do on players fitness... so, do I have the autonomy to make the call? Yeah I do, if that was taken away from me, would I wanna do the job? NO. Because you'd be carrying the can for something you're not making the decisions on...(Mike - line 488)

Recognising the specialist role Mike has and the autonomy that he retains, he was asked to project the same question to his knowledge of private and public sector work and if he has any experience of external pressures that reduce autonomy and create barriers to good clinical and ethical decision making.

...Yeah. Yeah, Absolutely. Absolutely....I think all you can do in those situations, you can't, you are governed and definitely dictated to by the insurance companies as to how many treatments they have because that's in the service level agreements with various companies.” (Mike - line 537).

### 7.3 Organisational influence in accountability and autonomy

As illustrated in section 7.2 above, autonomy has the potential to support individual and ethical decision making in clinical practice. However, decision making can be influenced by the employing organisation and other professional environmental influences, for example work load. This may impact on one's professional autonomy and thus undermine clinical autonomy due to; economic, political and technical facets (McIntyre et al., 2015). Autonomy is a word derived from the Greek 'autos' and 'nomos' translating as 'self' 'rule or governance' which describes personal ruling free from controlling interferences and from personal limitations caused by inadequate understanding (Rodriguez-Osorio & Dominguez-Cherit, 2008). Autonomous agents are self-governing agents, but governing oneself is no guarantee that one will have a greater range of options (Buss, 2014). Contemporary professionalism has been shown in the literature to be reconsidering the value of the long-standing concepts of 'deprofessionalisation' and 'proletarianisation' (McIntyre et al., 2015). According to McIntyre et al. (2015), it is technical autonomy, which may be considered as the use of discretion and judgment in clinical decision making that

is becoming increasingly regulated by standards of practice, accreditation and licensure which are proving erosive to clinical autonomy. Pete evinced this concept by suggesting that decisions can be imposed on you from the organisation. He inferred that the service users' choices and the organisation have diametrically opposed positions on the scale of costs and savings.

“some things are forced upon you now there are some things that are pre-determined ethically...it it's a balancing act I think is ethics it is (pause) it is continually changing depending on the needs of individuals and service users I always imagine with an outpatient service you've got efficiency at one end of the scale and patients right at the other end of the scale.” (Pete - line 63).

The consideration and relevance of factors determining autonomy presents a challenge to HCPs in order to ensure ethical decision making is achieved. Internal institutional policies can instil, cultivate or hamper the development of virtue in HCPs which illustrates that they ought to be considered as mutually serving assurances to determine right action in HCE (Meagher, 2011). For Lucy, HCE is about using the means available in conjunction with experience, to optimise service user outcomes.

“I always give them my advice and they've always come willing to accept the advice so I can pick on one hand how many people have not wanted the advice... (pause)... health care ethics for me personally it's me knowing my job as I do and the experience that I have equating that to what a patient needs and what the NHS can offer and trying to do what's right for that person” (Lucy - line 217).

There are conflicts in Lucy's approach. She offers advice to the service user based on her experience and the resources available. This is scientific reductionism where biology and basic sciences are applied to the problems of disease with no psychosocial context of the service users' lifeworld (Henry, 2006). Immediately before this part of the discussion Lucy had been explaining how she cannot offer meaningful advice when assisting service user choice because there is no objective outcome data available to inform the service user or practitioner. Lucy was frustrated by this along with the criteria that forces service users down certain pathways of care, for example, accepting orthotic therapy when the service user clearly desires surgery. The organisation's resource limitations were a source of conflict for Lucy throughout

her interview. Similarly Chris deliberated about what he feels ought to be achieved for service users, but highlighted the obstacles that confuse his responsibilities.

“but have I done my bit I spoke to the GP and the GP said I can’t get it (the MRI) it needs to go to the consultant. The GPs actually written to the consultant to ask for the appointment to be brought forwards but nothing more’s been done and I’ve accepted that instead of actually investigating it myself or enquiring myself because I know where the consultant is I’ve not got a contact number but I’m sure it would be quite easy to find out... I don’t know (pause) I suppose it would be (my role) it’s down to this duty of care isn’t it if it came to it, where the sort of line of law with regards to negligence would be, have I done everything reasonably possible” (Chris - line 1906).

Chris showed that he was concerned about the consequences of various potential outcomes in this scenario, which seem to overpower his autonomy. He did not identify with the service users’ clinical need as the primary outcome, but rather he was more concerned with roles and the consequence of culpability with negligence. In the previous section, Lucy demonstrated autonomy by going outside of the organisation’s minimum frameworks to provide a better service where she believes it necessary. In the following exchange she illustrated disassociation from service user empathy and a lack of autonomy.

“I kind of try to then come out of that role and think well I’m here to work for that service, they won’t pay for it, I’ve not got any choice, I just try and show compassion and show the patient that you understand but just more or less say- put it across that its kind of out of my hands really...  
(Michael: Does that trouble you?)  
... yeah it does yeah I hate it (pause) ...it only takes for one to totally go off the rails and have an awful quality of life and die early because of it and it could happen and I don’t think that’s right I don’t agree with it!” (Lucy - line 1278).

The frameworks and pathways that govern her choices create conflict for Lucy, but she relinquishes autonomy and allows the organisation to affect her decision making, despite the fact that she clearly does not like it. She recognised that it is a matter of commissioning which leaves her without choice and so is disaffected from the organisation. The culture or corporate decision making structure may lead to a deterioration of ethics within an organisation, but in the final analysis this is based on the decisions and actions of the individuals (Jackson et al., 2013). Without value driven decision making within organisations, chaos can ensue in the form of lack of leadership, loss of direction, inconsistency, poor decision making and errors (Levitt-

Rosenthal, 2013). Connor spoke about the distribution of services that is directly influenced by funding and fed down through the organisation.

“I suppose that we, we're hearing quite a lot that no-one gets anymore and no-one gets any less, everyone should be getting the same...I think it's fed down by our managers I would've thought and they are then going off both, I suppose funding...that has a major part to play” (Connor - line 117).

A resource limitation appears to force challenges on ethical decision making for health care teams (Maynard, 2001). The rules of ethics in the health care profession are rarely explicit, but the economical perspective is clear, that is to maximise benefits from limited resources (Maynard, 2001). Whilst there may be no literature currently indicating how physiotherapy or podiatry services are engaging with these difficult decisions, the HCPC standards of proficiency demands that the autonomy of service users be upheld. The HCPC states that HCPs should “understand the need to respect, and so far as possible uphold, the rights, dignity, values and autonomy of every service user including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing” (HCPC, 2013a; HCPC 2013b). The term “and so far as possible uphold” assuages the need to adhere to this principle when balanced against resource limitations. The Code of Ethics and Professional Conduct for Occupational Therapists, however, indicates that the autonomy of clients must be respected and upheld (Atwal & Caldwell, 2003). The code itself states: “You have a continuing duty to respect and uphold the autonomy of service users, encouraging and enabling choice and partnership-working in the occupational therapy process” (COT, 2010). The College of Occupational Therapists include ‘encouraging and enabling choice and partnership-working’ which elevates the importance of service user autonomy rather than a paternalistic ‘lip service’ to upholding the autonomy of service users, ‘so far as possible to uphold’. Atwal and Caldwell (2003), conclude that there may be an extended role for ethics committees and ethics consultants to assist practitioners to overcome such ethical challenges.

The NHS Constitution’s second guiding principle states that service users should have access to NHS services which are based on clinical need, not an individual’s ability to pay (DoH, 2015). This constitutional principle underwent a subtle alteration from its original form in the Patient Charter (1995). It now undermines the certainty

of access for all with the pronouncement that 'NHS services are free of charge, except in limited circumstances sanctioned by Parliament'. This raises a question about what level or quality of health service is to be received (Barnitt et al., 1998). Barnitt et al. (1998), speak about the duty to provide a service in the framework of utilitarian ethics and suggest that it may be necessary to accept referrals even though it is recognised that the resources cannot offer clients a complete treatment. In utilitarian terms, this would be better than refusing to accept new referrals and preventing any kind of service to a number of clients in order that another number of clients get a full service. This challenges the NHS commissioners with issues related to distributive justice and providing equality of services (Beauchamp & Childress, 2013). Ethics in this context appears not to be considered at a practical level when HCPs deliver services that are formed within organisations (Page, 2012). Mike conceded that one has to work within the boundaries of the employers' resources, indicating that this may come down to self-preservation.

"I think you have to toe the line at times in terms of, there is a pathway often for these patients to go down and I don't think you can just jump the pathways here and there or slot people in ahead of others for various tests or scans or whatever else, so I think you need to follow a procedure that someone's obviously spent a bit of time thinking about and go down it. I think if you sign up to be a member of an organisation and get paid by that organisation to do the role they want you to do then you have to be a little bit conforming to what and how they want you to do things or else you run the risk of not being paid and not having a job there anymore, so there is an element of self-preservation in that, definitely." (Mike - line 694).

Where the decision may be solely dependent upon the perception and human values of the clinician, a failure to appreciate the strengths and limitations of each option or the temptation for the clinician to include self-preservation can provide a flaw in the decision making process (Barnitt et al., 1998). Where constraints or barriers to act in a person's best interests affect the decision making process, this may be termed 'constrained moral agency' (Delany et al., 2010a). Mike previously stated that he would not remain in a job where he is not able to do the best for the patient. Here he conceded that you would run the risk of not getting paid if you don't conform to the expectations of the employer. These issues are raised again in Chapter 10, Theme 5 where a level of compromise for cognitive consonance arises.

Mark believes that ethics was not taught in a professional context and that training in ethics does not exist, but alluded to the influence on HCEs arising through direct line management.

“they would get it from... my philosophies if you like as Head of Service, so my beliefs would cascade down through the service with people picking up that this is the right thing to do and also through things like the governance frameworks which I’ve described as for the ethically blind, they don’t really appreciate it so we’re gonna put a framework of governance in place, we’re gonna put the Health and Care Professional Council framework in place, we’re gonna have disciplinary frameworks for those who don’t quite get it so...you can recognise those and work with it.” (Mark - line 35).

Courage and dedication to serve service users in the face of bureaucratic obstacles are virtues of leadership which are most often admired (Millstone, 2014). Mark was aware that, as Head of Service, his own beliefs and philosophies are cascaded down and adopted by those under his authority. Leaders who are ethical in times of change may be more credible in the eyes of their subordinates which in turn can induce positive attitudes and behaviours (Sharif & Scandura, 2014). Mark recognised the vicarious, cultural and organisational influence that leads to adoption of ethics in the workforce. And for those who “don’t get it” then the frameworks have to be followed or else a disciplinary action will ensue. These managerial responses to ethical decisions are in turn influenced by the ethical stance of the organisation (Pimentel et al., 2010). Pimentel et al. (2010), state the importance of integrating leadership behaviours with organisational values and vision in order to create a consistent, coherent and effective ethical climate within the organisation.

#### 7.4 Consequentialism

A key finding from the individual interviews was the influence of legal consequences and other environmental factors affecting decision making in health care practice. Arguably, it was legal claims against adverse consequences of treatment that led to the recognition of ‘informed consent’ as a concept of information disclosure rather than a concern with service user choice (Braddock III, Edwards, Hasenberg, Laidley & Levinson, 1999; Whiteman, 2013). Marie acknowledged that for her, ethics had

been a background issue, but she is more aware of it now due to the consequences of the 'claims culture' and budgetary pressures of physiotherapy.

“(ethics) I think it is just something that’s there in the background, but I think it’s something we’re more aware of now, certainly of doing the right thing... as much in safety and the kind of culture that we’re in...of claim of claiming and of making sure that you really explaining yourself all the time and you’re really saying why you’re doing things and that people understand what you’re asking of them. I think I am more aware of that now than when I started. I don’t know if that’s ethics particularly but I’m certainly much more aware of that, I think ethics at Uni were, probably was I thought a bit more around my dissertation and more around consent for research, more of that than patients at first, we always had to just...are we okay to treat you – tick!” (Marie - line 590).

Marie suggested that at University ethics was related to consent for research or a lip service approach to gaining consent for treatment. Now she thinks it is being understood in her organisation as an issue to do with legal defence. Perhaps it may be necessary to develop a reconciliation of the awareness of the legal environment with the provision of ethically and clinically sound service user care (Kapp, Turner & Baker, 2012). Teaching of ethics to undergraduates could be improved to create ethical awareness and better moral decision making skills, whereby students can live ethics instead of merely learning about it (Park et al., 2012; Solberg, Strong & McGuire, 1995). Luke referred to ethics education in relation to following guidelines and policies and believes it is something that is “instilled” in you.

“I think it starts as soon as you’re training, it’s instilled into yer from the beginning and then once you get out into practice you’re following your own Trust ethics, Society ethics, the HPC, but we’re all working to guidelines in order to provide a fair and potentially suitable treatment for the patient...I think it boils down to just being professional and I think being professional is instilled into yer from the beginning.” (Luke - line 187).

Luke associated ethics with professionalism and working within guideline frameworks. Professionalism may lead to carrying out duties that are unethical if the required action demands following resource limitations rather than service user benefit (Eriksson et al., 2008). Institutionalised professionalism is considered further in Chapter 8, Theme 3. Luke previously referred to ethics as being ‘fair with patients’ for which he was asked if he had received any training to develop his faculty of judgment to facilitate ‘fairness’ in decision making.

“the professionalism’s probably what is, instilled into you in terms of how you conduct yourself professionally but...in terms of, in answer to that question I think only experience can get you that” (Luke - line 214).

He claimed that experience is the only thing that can teach the faculty of judgment. This creates a dichotomy by the presupposition that experience is derived from the clinical environment which may be represented by organisational or institutional practice based on utilitarian ethics or impoverished ethics. Gadamer (1996), describes how the issue of institutionalisation is contextualised into economic and social environments and how it has consequences at the individual level of work. He describes how an individual with their own assignment is fitted into a larger business like whole. At the same time the individual can function to complete their role without any orientation to the whole. Gadamer (1996), suggests that the individual rationalises their virtues to accommodate and adjust to the organisation and the autonomy and the formation of one’s own judgment leading to action is correspondingly neglected. For Alex, this may be evidenced in her risk aware notion of patient safety which is the stimulation for consequence driven accountability.

“because of everything's so risk-aware now, we always have to look at... why're you're doing that... would it pass the front page of the Sun test, you're doing something that if it was hung up in the paper (laughs), it would be dodgy so we're always aware of what we're doing from a safety point of view and a risk point of view, treatment-wise” (Alex - line 392).

For risk management Alex refers to policies and guidelines that constrain practice.

“but a lot of places are constrained by policies and guidelines and I mean a lot of podiatry, the evidence-base is a bit dodgy for quite, not dodgy, but it’s not really there for a lot of what we do, but we know it works and people come back... If it was something like heel pain, we have a protocol for heel pain... and it'll be evidence-based... so if someone questioned what we were doing I would say this is what we do here, these are the reasons why and it is evidence-based.” (Alex - line 1381).

Alex contradicted herself by first stating the lack of good evidence available and then claiming the use EBP as a method of giving assurance for how guidelines are formulated. She did however say that it is rare for a patient to ask about outcomes. The discussion then moved to the PASSCOM data that is available in podiatric



surgery and how this clinical database currently offers a transparency of outcomes. When Alex was asked why she thought the PASSCOM data was innovatively collated within her profession, she immediately stated that it was related to "risk".

“podiatric surgery was really good ‘cos right from the beginning, they knew they gotta prove it and make sure it was safe. Hence PASSCOM... very forward thinking really, compared to some areas of podiatry I think... (Michael: What d’you think’s created that forward thinking in that area?) ...Risk.” (Alex - line 1517).

This illustrates that patient outcomes and transparency may benefit the service user, but the first premise of such a project is to avoid litigation and attempt to evidence that it is a low risk intervention. This is a consequentialistic approach to the reasoning for gathering outcome data rather than the potential benefits to improving service user choice. Referring to accountability in negative terms related to litigation and defensive practice, Alex offered a perspective about the difference between NHS and private sector HCPs based on continuity of service user contact.

“some of my friends are private practitioners and they over-compensate because they worry even more about litigation and things because, we, in the NHS would see one patient, you probably wouldn’t see them again even if you work in a routine clinic for months and months, someone else would see them so it’s never really your individual responsibility whereas in a private practice if you’re working on it, it’s your responsibility” (Alex - line 604).

Alex highlighted that overcompensation of care arises due to fear of litigation which is amongst the greatest deterrents to unethical behaviour (Weinstein & Nesbitt, 2007). Chris also reduces elements of his ethical practice to following codes of conduct and culpability.

“it’s like this idea of the health profession code of conduct stuff that if somebody’s referred to you and you just ignore the referral, I’m thinking cos in the NHS if I just ignore a referral and didn’t do anything I’m culpable if something happens” (Chris - line 700).

For Chris, culpability from his employer only seems to become an issue if something goes wrong. This is consequentialism rather than concern or care for what one thinks is good ethics is for proactive patient benefit. He gave a further example of a service user who may not have received “gold standards of care”.

“So ethically is that right (pause) ...I can just see it, something going wrong with it all and then when you actually look at the process it’s not good in terms of- she’s- Because she’s relatively young really she’s only- she might be late forties (pause) she might even be younger she’s probably younger she’s probably early to mid-forties...

(Michael: And does that make a difference - the age?)

...(laughs) No. Well the idea is if this went wrong and she decided to sue and that’s where I think it would be looked, it’s like a scoping type thing what would lead to somebody actually investigating what’s going on and it would trigger litigation, if it is reported if a complaint is made”. (Chris - line 1826).

He discussed how the potential to get sued concerns him. He raised several issues that allude to the notion of ethics being framed in consequences that seem unethical because of the weight of fear placed on HCPs. Her young age, her suing him and how things may look, are the primary concerns rather than doing the best for the service user and thereby being defensible as a secondary outcome. Chris demonstrated the concept of ethics being embedded in consequentialism. When asked if his ethics have evolved through experience Chris reverted to discussing research ethics.

“I don’t know if I’ve been aware of it having evolved. But then again (laughs) it’s all ethics - when I’ve come across ethics it’s almost a ridiculous that (pause) all I want to do is a questionnaire for example ... from that point of view even when you do an audit even when you do a patient satisfaction questionnaire, or you’ve got to go through it when we produce leaflets, it’s got to go through a patient information group...

(Michael: why do you think the ethical processes are in place)...

...I don’t know to be honest, if I was being honest I’d say I don’t know... I understand they’ve got to be there because (pause) they have. I don’t know whether they have to be seen to be doing or because the concern is that you’ll upset somebody, the complaint and this is where the punitive thing comes in.

(Michael: What do you mean by punitive?)

...punishment! In terms of someone will bring you to task about it.” (Chris - line 2454).

The only experience Chris has of ethics is related to research mechanisms and is sceptically motivated, but he was honest enough to say he doesn’t know why they (ethics) are in place. He understands ethics to exist for punitive reasons to highlight culpability following complaints. Discussing barriers that may prevent ethical decision making Liz also demonstrated defensive practice as a means of avoiding litigation.

"I just document it all and I speak to the boss and I document my reasons why so it's in that patients notes..."

(Michael: what does the documentation serve to prove?)

...that what I felt was needed, but I didn't have access to it, or I had to refer on because I don't have that authorisation...

(Michael: what good are those notes? so you document it, why?)

...so then if anyone then says to me why, or say an ulcer deteriorated or something and then we were then having to justify why this ulcer deteriorated, I've shown that I've done everything under my...because that's what's happening to us all at the moment." (Liz - line 510)

Liz used documentation of notes as a focus which was defensively driven to serve to protect against litigation or employer investigation in her practice. There was no consideration to use the documented notes to create an impact on improving care or service provision, which she considered to be falling below standards. The adopted approach serves to ensure the shortfall in care is documented in clinical records so that the responsibility belongs to someone else, if later questioned. This excerpt is also discussed in Chapter 10, Theme 5. Similarly Jane responded to the question about her personal ethics evolving by indicating anxiety about consequences of service user complaints.

"I think my response to things has changed, I'm more anxious about the consequences of things and the thought of a complaint or you know, you're sort of a bit wary of people that you think are likely candidates to make a stink, and there are those people around and not just myself, but within our department I think we're all very cautious with people who we think might complain and desperate to get it right for them." (Jane - line 320).

Jane was asked a direct question to establish if the focus of her care is centred for patient outcomes or consequentialistic defence.

"it is DEFINITELY BOTH, it's definitely both, I can't, I could never say it's all, it's only that I'm concerned about the patients' outcome. It's definitely how that...what process I would end up in." (Jane - line 457)

Consequentialism has the potential to re-orientate services towards those that 'shout the loudest' rather than those prioritised as needing it the most (Barnitt et al., 1998). Jane added that she does not remember this being part of her early career. She also projected this to other HCPs to say that it was a fear for everyone. Jane was

asked a closed question to establish if she believes that the defensive and consequentialistic culture could affect decision making and alter treatment.

"Yes" (firm response) "yeah, yeah, no it does... It makes me cautious..."  
(Jane - line 489)

Additionally, Sarah stated that she thought her HCE have changed over the years, which has been attributed to pressure and exposure to service user complaints.

"I think as a student you think you are aware of it (HCE), but I then, I think the more you come across complaints and why patients complain, the more I think there's more pressure." (Sarah - line 761).

Mike recognised that barriers exist which influence his ethical decision making, but he attempts to retain clinical autonomy.

"absolutely. For me, regularly...it's not always a perfect world...do I try and as a result of coach pressure or player pressure being on the end of their contract and wanting to get back and play, do I bow to that and bring them back a fraction earlier than I should?? Yeah, I do sometimes, but rarely, based on being burnt by it in the past because I just think...there are lots of complicating factors to what I do. Ethically... (sighs) sometimes I think you do take the option that you can just know will work in a shorter space of time than doing everything by the book in terms of rehab..." (Mike - line 237).

Mike referred to the experience of "being burnt" in the past which he believes influenced him. Consequentialism for Mike is complex and reflected not just for his own protection, but also for the service user and others responsible, for example a coach or player. The varying degrees of consequences are related to financial issues, contract agreements, team selection, success or failure as well as individual injuries. He offered a scenario where he considered the external pressures that are involved in his decision making to be balanced, autonomous and reflective.

"I'm just there to facilitate the healing process as best as possible... Have you then brought them back into a match situation as fully prepared as you think you can, or have you run outta time based on fixtures, or have you rushed the process, now if you rush the process, I think at times you get burned. Well you get burned as in the player breaks down again" (Mike – line 354).

Whilst Mike shared the reflective nature of his practice, the reflection appears to be defensively contextualised. In order to understand his description of getting “burned”, he was asked for clarification about who would indict blame on him.

“Everyone!.. everyone! Me! It’s my job! It’s my job to get this player back and not have them break down again for me that’s one of the worst case scenarios in sport. And it happens, it happens to everyone because everyone tries to push the boundaries at times, coach’s pressure on you to get your best players back, you’re in a relegation dogfight, you need you know there are external pressures all the time but you know the ‘burning’ is the fact that if the player breaks down again the first place they’re coming is back into your treatment room and you’ve gotta look ‘em in the eye and say, well you know, I don’t quite know what’s happened here, cos I’ve given it my best shot the first time.” (Mike - line 360).

Mike demonstrated a complex balance of ownership of responsibility with potential consequences that are brought into his reasoning, alongside the external pressures that influence his decision making. Conversely, Alex shared a less considered view of how consequentialism negatively affects the HCP.

“I think if something awful had happened to me clinically then that would, I know colleagues who’ve been sued or I think if something like that happened that would probably make the way you work, that would affect you quite dramatically and you’d be extra careful that the patient understood everything and had signed everything or whatever the problem was whereas until that’s happened to you you’re...we’re careful and we tell all our staff to be careful and do it properly and document everything, but you never know do you and the ones that you’re not sure about, the ones that you are sure of, they’re the ones that’ll be the ones that try and sue you.” (Alex - line 1734).

Where Mike illustrated the difficulties and the balance required to make ethical decisions based on all aspects of potential consequences, Alex spoke of the negative emotion a HCP may experience and then highlights defensive, but superficial actions that are adopted in practice. It appears that consequentialism reduces the consideration of ethics to that of procedural practicalities on ticking boxes for consent or clinical documentation which is no more than ‘lip service’ consideration of ethical decision making (Loughlin et al., 2010). The reflective experience focuses on being careful with individuals who may sue you rather than optimising gold standard care in every case which may secondarily serve as practical legal defence. In the group interview Joan commented that the first point of

ethics appears to be self-preservation. This was confirmed as a theme observed in the findings of the individual interviews.

“Joan: Can I sort of make an observation then? is the first point of ethics self-preservation?”

F: That’s an interesting view...

Dave: I was gonna say, it’s not surprising than that prevails in the NHS ‘cos anybody who’s been to the NHS ethic service to get a research project...

All: [Laughs].

Dave: ...will tell you that it’s about ticking boxes as opposed to actually looking at whether you, what you’re doing ethically. It’s very blurred, whether it’s about health and safety, some of it isn’t obviously, they’re obvious ethical things but a lot of the other things that you have to fill in are, seem to be defensive on part of the NHS of what might go wrong.” (Joan and Dave - group interview line 1658).

Dave confirmed what Joan questioned about ethics in the NHS. He related it to research ethics and claimed that it is not about ethics, but ticking boxes, which is matter of defensive practice from the organisation.

## 7.5 Embodying ethics through personal virtue

Cal considered how ethical decision making relates to reflection of oneself in the motivation and action one gives to meet the needs of the service user.

“well I don’t know if I’m on the right lines with what I think ethics is, because with patients that are difficult whether it’s language barriers or cultural difficulties you do have to sit back and think, well like you do with everybody, this is a family member, am I doing them like all that I can? Am I putting myself and the Trust out there to help them? ” (Cal - line 159).

Cal alluded to her own motivation, but also raised the issue about what the ‘Trust’ offer to overcome the difficulties that a service user may face. This concept was also raised by Mike who offered insight into managing ethical conflicts and highlighted that the HCP is the point of contact and key in ethical decision making.

...the NHS I think... at times it’s a little bit about waiting list management. I think they’ve gotta waiting list that they have to try and get down or see them within a sort of period of time that’s stipulated and therefore like you said, they get that one treatment, exercise, empowerment type philosophy and that’s it. Does that get many people better? NO! I don’t think. I think it’s a balance

between empowerment, exercise, hands-on treatment therapy as a passive and an active side of the sorta treatment they're having so, I think again, like realistically you couldn't say that just giving someone a set of exercises is the right thing to do all the time... so I think personally from my experience the right thing to do is to engage that person, find out what their actual problem is, find out what its actually affecting most in their day to day life how can you make their life a bit better, how can you try and alleviate that problem as best you can." (Mike - line 141).

Mike offered a balanced approach to recognising personal ethics that clearly highlighted the service users' needs being considered. Through personal judgment Mike illustrated how ethics can be practised to achieve improved health outcomes and person-centred care. He highlighted that there may be conflicts and barriers inherent in the organisation, but for him they are being managed by personal judgment and autonomy. At variance with this, Dannie used the term "moral compass" to describe her personal ethics, but then explained her belief that she ought to ensure she does not use her own morals in decision making.

"...I'm just very aware of, being able to step back from things... it's that thought of... I want to make the right decision for this person and I need to make sure that I'm not using my own morals, my own judgments in making this decision and I think as long as you can recognise that you don't have to be perfect, but just recognising that you're trying, you can only do your best can't you really, but you are trying to make the right decision and recognising that you know you you're not perfect." (Dannie - line 678).

Dannie seems to have a confused autonomy, stating that she ought not to use her own morals in health care decision making, but speaks of ethics in terms of one's own moral compass, formed in one's upbringing and developed by experience. She concluded this extract by stating that "you can only do your best" and to "recognise that you are not perfect". Dannie offered no reflection on how "doing one's best" is actually achieved or checked. This, through reprieve of cognitive dissonance may be a mechanism of avoiding engaging in conscience, without which, may prevent empathy and phronetical practice. Health care empathy involves an understanding of service users' experiences, concerns and perspectives, but also demands a capacity to communicate the understanding with an intention to help (Berg et al., 2011). Dannie's comments perhaps illustrate the disconnection from accountability to fulfil this.

## 7.6 Person-centred care ethics

There is evidence from nursing research to support the concept that nurses are less concerned by the 'big' issues surrounding bioethics, but what most distresses them is protecting service users' rights, human dignity, autonomy and service user involvement, which are threatened due to an under resourced health service (Johnstone et al., 2004). Mark stated that the service user ought to be at the centre of all ethics and hopes that the NHS would do something about any incidents that did not find this.

"The patient should be absolutely central to it and I think if you look at my sort of simple headline...sort of definitions of what to me constitute ethics they're all about the patient, every single thing. So it's all about recognising what the patient needs and wants in order to get an optimal experience whichever way you look at it... the right to know that they've had the best and most effective treatment they could possibly have...and that's where the expertise, the evidence-based knowledge comes from.

(Michael: that's an extremely laudable definition of how we should see patients coming out of the service. Do you think that is the reality?)

... I think that depends where you go...and I would like to think within our service the majority of practitioners will be taking that approach and we do regular surveys, we follow them up quite carefully and anything we pick up that doesn't fit with that, we try and do something about. But, you know, we've got all these controversies in the NHS at the moment, we had \*\*\*\*\* Hospital on the news yesterday...that's completely failed and crashed. I don't think you'd have to go too far before you found exactly the opposite side of the coin. So I think, the NHS are just so enormous that standards vary widely." (Mark - line 219).

Mark's answer demonstrated a clear conviction about the quality of service that should be offered to patients receiving care. He recognised, however, that the NHS is enormous and therefore acknowledges that standards are widely varied. What was not considered in Mark's response is the organisational barrier where criteria are formed that prevents potential service users being accepted for treatment. His safeguard for ethical checks is the use of surveying. This is only adopted for existing service users in order to check what standard of service they received. Many potential service users are not able to get NHS treatment and therefore are not being surveyed. The concept of restricted access to services was interwoven into Luke's understanding of HCE, for which he used the term 'fairness'. He was asked what is meant by 'fairness' and who defines what is fair.



“I think you make an agreement between yourself and the patient...” (Luke - line 54).

Throughout the interview, Luke perceived no barriers in health care and did not acknowledge any “unfairness”. In Chapter 8, Theme 3, Luke exposes his concept of ‘fairness’ being rooted in utilitarian ethics resulting in a lack of empathy with people who fall outside of criteria to receive a service. Therefore ‘fairness’, for Luke, is a personal definition based on utilitarianism. Health care in general uses a strong utilitarian base of ethics in order to simplify its policies and practices to meet the needs of a large population of service users at the expense of validity for individuals (Lawson, 2011). Applied ethics for HCPs requires integration of ethical dimensions related to the theoretical knowledge and literature which results in the autonomous and moral agent listening to the needs of the service user, thinking reflexively and reasoning critically (Delany et al., 2010a).

In this chapter various approaches to ethics have been found in the data generated by the participants. Embodiment of ethics for use in clinical practice enables formal conceptualisation of what are often complex issues for which the varying approaches provide tools to explain the moral reasoning behind the decision making process (Lawson, 2011). The next chapter will consider the perceived barriers or conflicts in achieving ethical decision making.

## CHAPTER 8: Findings - Theme 3

### The Perceived Challenge of Ideals

This chapter considers Theme 3, which is the perceived challenge of ideals experienced in the context of delivering health care. During the process of ethical decision making, individuals may move through a series of sequentially ordered steps, namely; recognition of the moral issue, making judgments, establishing intent to act morally and finally to engage in moral behaviour (Drolet & Hudon, 2015; Street et al., 2001). For HCPs, recognition of the moral issue is essential in order to progress through the process. This chapter presents the HCPs perceptions of potential barriers that affect ethical decision making. It also considers the organisation and cultural norms accepted by custom and practice.

#### 8.1 Differences between NHS and private sector service

In her consideration of how ethics arise in practice, Alex acknowledged that NHS and private sector staff differ in attitude to service provision.

“...that's what a lot of our staff think... they don't worry about it so much as a private practitioner might do...people are paying you money for a service that they expect. In the NHS, they're not paying so it's free...

(Michael: it's not free, a percentage of one's salary goes towards NHS contributions)

... I mean the patients don't take it so seriously if they're not paying, without a doubt, people don't turn up, they don't tell you, they're not bothered really (verbal emphasis was expressed for “not bothered”)... But I was thinking about ethically because if you're in private practice and you've got a patient with a corn and bad shoes causing the corn and they're coming back to you every 5 or 6 weeks, it would be unethical not to give them the foot care advice but what if you cure the corn and you lose that patient and I couldn't work like that, that's why I don't do any private work, 'cos I think it's, you always want to try and make someone better or keep them well and not ignore something if you know its gonna make you thirty quid every 6 weeks”. (Alex - line 655).

Alex raised ethical concerns about the motivation of private practitioners who may not want to resolve the clinical pathology if it means they lose profit. She confirmed this and indicated it as a reason why she doesn't want to work privately. With this, Alex recognises unethical principles as a fundamental issue in the profession. She believes that the private sector staff are not working in the best interest of the service

users, which is a concern since around 70% of the podiatry workforce is in the private sector. The health care provider must work with the best interests of others in mind rather than their own best interests (HCPC, 2013a; HCPC, 2013b; Ramos et al., 2013). As previously discussed, Alex believes that ethics is not taught formally, but only vicariously within the profession of podiatry. This is therefore a pronounced issue whereby if Alex believes that ethics are taught vicariously, it suggests that unethical practice could be self-perpetuated. Similarly Cal identified differences between her experiences in the private sector compared to NHS in the context of “doing the right thing” for the service user.

“it’s quite different from both clients that we see and I guess the way that you work, and again the demand really, in private practice it’s much more manual therapy because you’ve got the time to do it whereas here you’ve got twenty minutes and you’ve got to work out what’s the most important thing to do and if exercise is, then your manual therapy goes by the by sometimes... (Michael: Are there ever compromises in either of the two service sectors due to resource or service limitations?) ...Definitely! if I had more time with patients in the NHS I would use my manual therapy skills a lot more if I had exercise classes available to my private patients I'd be referring them on so its pros and cons to both.” (Cal - line 271).

This contradicted her apparent belief in the “doing the right thing” for the service user, but rather, demonstrated acceptance of each service limitation without appropriate clinical reasoning. This will be discussed in Chapter 10, Theme 5, where this participant demonstrates apathy towards the restrictions dictating clinical decision making. Connor offered a similar experience and indicated that the private sector offers a more positive service.

“well the differences are that you get more time, or I get more time where I work privately, so you can do more things, more time to do...it means that you can do a lot more through your treatments which is nice basically...

...But I think the major constraint is probably time within the NHS...so I say time constraints are massive.. a major thing really from my point of view.” (Connor - line 514 and 639)

Cal highlighted similar disparities between NHS and the private sector when questioned about autonomy and any restrictions placed on her decision making.

“I guess, guidelines so we're using- there's a tool called the Start-Back at the minute which is a questionnaire that screens people with low back pain and you get a score...and it's something that we're encouraged to use to help us work out, if it's just advice, one off session, they shouldn't see us anymore and it's not, you absolutely have to do this, but is something that's strongly encouraged” (Cal - line 496)

It is noteworthy that Cal linked autonomy to the use of a guideline tool that she refers to as "strongly encouraged". She stated that it is not used in the private sector and consequently, more autonomy is retained due to not being restricted by this practise.

“in private practice we don't really have any restrictions like that because you're self-employed, so it's down to you to make those decisions...you've got to clinical reason and back up everything that you're doing.” (Cal - line 534).

The development and implementation of practice guidelines appears to have restricted the autonomy of both the HCP and service user (Ten Have, 2000). Cal did not recognise this to be negative or conversely that autonomy in the private sector is necessarily positive. This highlights the organisational influence that affects decision making. It appears that this participant does not recognise these influences even though working under both conditions of private and public sector fields. Exercising discretion to demonstrate understanding of a given situation requires context judgment which may not be routine, and one which does not lend itself to guideline based decision making through EBP or commissioning of resources (Cox III et al., 2008). Dannie demonstrated a lack of value for individual and context based decision making by her comments inferring that treatments should be standardised.

“I think as a good physio your treatment should be the same whether you're private or NHS but again there are lots of private physios out there that aren't like that and we get the people that they fail with here (laughs) cos they don't change them.” (Dannie - 148)

This latter statement indicates a negative judgment on "lots of private physios", but she does not offer any suggested methods of resolving the issue or that it ought to be dealt with. Her language use indicates that she sees herself as a good physiotherapist and others as the opposite, evidenced by "we get the people that they fail with". The quality of care divided across the two sectors is called into

question. James offered a different perspective than Dannie, speaking about the duty of care in the NHS being subordinated to budgetary apportionment.

“when I worked in the NHS, was when you get referred for your shoulder, I guess it was all money and budget, if they needed treatment for the knee as well, the back, you couldn’t treat them for that, technically you were told not to”. (James - line 473).

James commented on the resource limitations in the NHS and suggested it is being delivered as a cost effective process which restricts the physiotherapist and reduces the potential to allow freedom to react to the service users’ needs.

“absolutely, it is, no there is a big difference yeah, I think...and what was coming in the end of my kind of role, work as an NHS and probably more so now from speaking to colleagues or people or patients who have been to local physio’s, they don’t do that much manual therapy anymore ...and they’ve been told that they have to justify using manual treatment now ... otherwise it’s just ‘there’s a sheet of exercises’ or send them into a class because it’s more cost effective - I guess your hands are tied a little bit by the NHS, you have 20 minutes for a follow up and that’s all you have, but here you you’ve got a bit more flexibility”. (James - line 536).

Ruth also recognised time limitation as a key difference between the two sectors, which prevents NHS HCPs doing everything that they would want to.

“the one thing is sort of your, the amount of time you get with people so it’s not always possible to do everything you want to do because you’ve not got the time because you’ve got x amount of patients to see” (Ruth - line 114).

Ruth elaborated on the challenges that are faced and how she perceives the differences between the NHS and private sectors.

“I think everybody probably feels like that because you might not have all the equipment you think you’re going to have for example to do a certain job...(pause) ... y-yeah (laughs), I think it’s quite common really. ... some of the physio’s here work privately as well but I think there’s a different ETHOS in private practice...I think one, they probably get a bit more time because they’re not under the pressure of the NHS and your waiting list and things like that...so they probably got a bit more time and if they need to book more time with a patient then they do and its beneficial for them because they get more money for it...and I think that because the patient is paying they maybe listen more to what the patient wants rather than what the patient actually needs

potentially- so if the patient wanted to come even though they feel 100% better they'd say yeah that's fine, maybe not every private practice... but probably most... there is more of an emphasis on doing things a bit quicker in the NHS I think getting people through" (Ruth - line 139).

Ruth connoted that there is unethical practice in both sectors, but did not demonstrate awareness that anything ought to be done to resolve it. She has frustrations which she claims "everybody feels like that" due to lack of resources in the NHS. She then stated that private practice physiotherapists don't have the problem of limited appointments or appointment time as a restriction, but she implied that they use the appointments unnecessarily. She gave an example of when a patient is maybe 100% better the private practitioner may have a "different ethos" and suggests the motivation is because "they get more money for it" and because the "patient is paying for it" they perhaps "listen more to what the patient wants". She then stated that "it's not every private practice, but probably most" inferring how common she believes it is. Sarah shared some of the difficulties she experiences with respect to restricted resources limiting service user choices.

"To be honest, yeah, (laughs) ...and it's even more difficult I think now with the influences of the NHS and the culture within the NHS changing recently in terms of funding and not that you're ever gonna cut a patients' treatment short but...in terms of kind of where money's now involved that then money now follows the patient, so if you're gonna, a patients say in front of you and they want a, b and c and you're not gonna give them it, they'll go to somebody else.... go back to their GP and say they didn't get that and then it only takes for the GP then to take their money somewhere else and they go. So in terms of GP commissioning it's got massive influence..." (Sarah - line 151)

Where Ruth had accused private practitioners of allowing financial influence to affect clinical decision making, here Sarah explained how this influence also exists in the NHS due to commissioning. For both participants financial influence is the deciding factor in service provision resulting in limitations for clinical decision making. Service users' choice and person-centred care become secondary issues (this will be discussed in Chapter 9, Theme 4). Leading on from this discussion, Sarah justified how she forms her decision making in EBP.

"based on my evidence-base, I feel like I'm probably the best I'm gonna be in my career (laughs) in terms of up on evidence-based... so I think I would say

probably 99% the majority of decisions that I'll make 'll be evidence based...(Sarah – line 428).

It was highlighted that clinicians may disagree with what the evidence actually tells them, as it is often contradictory. Sarah responded by reforming her original claim and indicated that one has to draw on experience, since there is not a great deal of support out there to underpin physiotherapy practice.

“To be honest there's nothing great out there to support everything that we do as physios anyway really, and I think a lot of us draw on experience as well, what works...” (Sarah - line 463).

Sarah initially stated that her decisions are heavily weighted (“99%”) on EBP and then contradicted this by claiming that her decision making arises out of experience rather than EBP. A potential dilemma in drawing on experience arises where a service is dictated by commissioning as this limits the provision of therapy and the field of experience to draw from. Consequently this places a restriction on learning potential and reduces the field of experience available for those working in that environment. The medical model and perceived EBP uses a statistical and scientific basis which does not consider how health care is actually practiced and the kind of knowledge that HCPs actually use (Henry, 2006). Henry (2006), claims that without tacit knowledge contextualised in experience and heuristics being acknowledged then the scientific method cannot distinguish between humans and machines. James and John both highlighted this concern for the profession as a whole suggesting it is contributing to a reduction in the skill base of HCPs.

Mark recognised differences between the NHS and private sector provision. His answer also indicated the variability that exists from within the NHS service (which ought to be considered in the context that podiatry is a small profession with only 3870 podiatrists currently working in the NHS (Townson, 2014)).

“you go into some service and you think what a great service...if I had to be a patient...I would love to come to this service with my problems, they're brilliant. They've got it right. Others, you think, I know they're in the same organisation but I wouldn't wanna go anywhere near you lot. No thanks. So again...lot of variability even within the same organisation.” (Mark - line 345).

Mark commented about the variability of service provision within the NHS and in a similar way, Chris recognised the inequalities in service provision as unethical.

“because the diabetes specialist has set up the clinic for the podiatry bit in the hospital... to hell with PVD, rheumatoid... and so it falls to me then not just me but the podiatry team in the community to manage all these complex cases without medical lead and that’s not ethical - I suppose that I mean in a health care ethics point of view, that I mean that it’s terrible its awful it really bothers me some of these patients I come across” (Chris - line 1598).

Although the organisational and unethical issue “really bothers” him, he continues to work in that environment without demonstrating any ability or effort to raise his concerns about what he terms unethical. Later in the discussion, Chris disclosed further barriers to quality care provision and again rationalised it, demonstrating a cultural acceptance of the financial restraints which oppose the idealism of the service user being at the centre of care.

“it’s all about money it’s all about business models now-a-days rather than patient... they always talk about patient centred and they want to be, I think, but you can’t have an unlimited budget on health services” (Chris - line 2343).

Similar to Chris, Sue highlighted inequalities of care within the NHS provision, based on criteria for funding streams, but also between the public and private sectors.

“[Sighs]. Between the services in the NHS it’s probably down to funding, like rheumatology is like the Cinderella of all the conditions, you know, diabetes-wise there’s money being plugged into it so they do get a very good service, I’m not saying the rheumatoids don’t but I think there’s more frustrations on that...there’s longer waiting lists, we’re not able to respond as quick as we do to the diabetics...that’s in the NHS. Private-wise I would say I pretty much respond as I need to...” (Sue - line 236).

In her answer she stated that funding streams in the NHS create disparity for service users and how people with certain conditions have greater accessibility to the services. This disparity of provision exemplifies the difficulties in the NHS value statement that ‘everyone counts’ and that the NHS is to maximise the resources for the benefit of the whole community ensuring that there are no exclusions or discriminations that leave people behind (DoH, 2015). Sue appears to accept the shortfalls that prevent her from responding to service user needs as she feels she



“needs to”. The next section discusses the potential influences that may contribute to Sue, as a moral agent, accepting frustrations with respect to standards of care.

## 8.2 Utilitarian influence on organisational ethics

An organisation’s ethical compass or method to contrive moral practice is reliant on two paradigms of ethical management; the first being compliance to existing codes of conduct and the second being the individual capacity for adequate moral agency (Pimentel et al., 2010). In the example above, Sue demonstrated how her moral agency is not permitted to act according to her judged assessment for service user need. Alex contextualised a similar concern with respect to discharge policies for non-urgent cases.

"some people came in who'd been discharged by some of my team, and I wouldn't've discharged them. Medically they were young fit and healthy but they had the most horrendous feet and probably didn't have the means to pay, some of them, they're the people that we, I would've kept on so there's...it's not... it is quite individual." (Alex - line 1193)

The discharge policy in itself is reliant on clinicians using and interpreting criteria in order to preserve the resources. This in principle is a utilitarian approach to managing the finite resources within the NHS, but the implications to the public are not actually addressed. The commissioners start the process by deciding who is able to receive service provision, but the service user voice or private sector providers are not being consulted.

“so ethically we don’t get rid of someone who has got bad feet even though they don’t have a medical need, if they've got really nasty painful feet we would see that person and at the moment we still are able to. If they cut our budget by 25%, they’re the healthy people with bad feet...will be the ones that have to go, so ethically I don’t have a problem with that at all 'cos it’s not infinite, that leaves a slot for the poorly person sat at home. And that’s what we say to the other colleagues when we're trying to get them to discharge people that don’t have anything wrong with them...” (Alex - line 954).

Alex demonstrated a utilitarian based ethical process in discharging service users based on a hypothetical discussion around a potential budget cut. This is a form of decision making based in normative models attempting to maximise utility (Averbeck

& Duchaine, 2009). Alex changed the focus of her argument from a defence of people she initially would retain as service users, until the hypothetical consideration of a budget cut, at which point she then reverses that argument. It appears that she demonstrated a change in her moral agency where she initially offered a sympathetic description of those individuals having “really nasty painful feet”, but following her agentic shift she had “no ethical problem” with discharging them on the grounds that someone else may have a greater need. The same service user is now described in contrast by Alex as “people that don’t have anything wrong with them”. This highlights the possibility that the agentic shift can be supported by blaming or dehumanising the victim of ones actions as one downplays the consequences of ones decisions (Jackson et al., 2013). Pete also demonstrated acceptance of perceived unfairness in context of utilitarian ethics.

“a patient can go for the GP, get referred to us, they need an injection, back to \*(anonymised)\*, back to us for more rehab, it’s just really unwieldy I think that’s unfair! I can’t see how (pause)... it really frustrates me that that organisations can’t - hang on a minute, we’ve got the skills in place that we could have just sent them from us to physio and jobs are done!... But it’s business!” (Pete - line 492).

This is a recognised frustration for HCPs who have the skill base to offer services yet service users cannot access that facility in their geographical area, but would be able to in a different clinically led commissioning consortium (Whiteman, 2013).

Additionally Pete explained how commissioning and budget savings in the name of efficiency is a threat to the service provision.

“and the problem is some of the commissioners are linked you know it’s the kind of you see in the newspapers questionable business practice MP’s linked to this business that business that private enterprise and you’re not on a level - I ’m told that they’re a partner they’re a partner they’re a partner but in my head I’m going they’re a threat, they’re looking for my business and they’re not making a secret of it!” (Pete - line 579).

Initially he is referring to the safety of his colleagues jobs from within his team, but he then made an association between job security and service provision.

“we don’t want to get stuck in the habit of managing pain conditions we want to rehab people and send them away to self-manage if they have got a long term condition.” (Pete - line 890).

Pete explained how the service was redefined resulting in reduced provision, which was due to financial savings rather than clinical reasoning. He concluded this stating it is "much more fit for purpose". Pete did not acknowledge the question of who determines what the 'purpose' is. He was asked if clinical decision making and clinical reasoning had been restricted, to which he emphatically stated:

"I don't think we're restricted by funding, no". (Pete - line 764)

Pete further justified the 'fit for purpose' claim emphasising the reduction to the waiting list being lower now than it was 12 months ago. There is no acknowledgement that the service is now organised with a set criteria in order to reduce service user contacts. The efficiency savings are there to drive waiting lists down which results in a short term success, but not a success for service users who could not get the service that they want/need.

By redesigning institutions and reshaping psychology through education, this may allow the reframing of moral conflicts, thus offering the potential to reduce the frequency with which moral dilemmas arise (Cushman & Young, 2009). Health care management has been suspected of promoting the use of quantitative methods and uncritical EBP for controlling the average costs of care under a guise of improving services (Henry, 2006). This level of institutional culture where the business of the system was prioritised over the service users' needs is a culture that trumpets successes and reflects little about failings (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). The financial pressures of an organisation may use utilitarian ethics to assuage commissioning decisions, however this results in the idealism of person-centred care being reduced. Pete accepts that resources are simply not available, thereby forcing restrictions on service users. The justification for this appears to be based on cost containment rather than clinical reasoning and thereby validating the decisions in utilitarian ethics (Barnitt et al., 1998). This seems to be influenced by the culture of the organisation ontologically and represents ethical dissolution. Ethical dissolution arises over time and is affected by a variety of factors which can influence an individual's action if that person does not possess a well-defined internal moral compass (Jackson et al., 2013). Jackson et al. (2013),

add that organisations that do not have an ingrained and well-defined standard of ethics are in effect leading their workforce in unethical behaviour. This may also be seen in Dannie's example about the lack of optionality on what physiotherapy service is available in the NHS compared to private practice. She was comfortable with this issue and showed no empathic concern alluding to the restriction of service provision when comparing service user expectations from the private sector.

"I've had a bit of a conversation with somebody recently about that actually. Just, again, particularly with people who have seen private physio's in the past and they're very used to the process I guess, they go in and they pay for their treatment and they get touched for half an hour and they have as many sessions as they want they feel that that's something that is available on the NHS. And it is not! Basically." (Dannie - line 354).

A cultural perspective on service provision may decrease the homogeneity of behaviour across the organisation and affect attitudes about ethical standards which may go unchallenged if there is little fear of retribution due to the approval of this behaviour in large numbers (Jackson et al., 2013). Pete and Dannie represent those influenced by, and who adopt their organisation's philosophies, but Mark shared a concern about individuals for whom he stated are "ethically blind or non-ethical thinkers". He suggested that organisational or ethical frameworks could be creating a barrier for ethical decision making for those "ethically blind".

"the big barrier is...by the organisation dealing with the, in effect the symptoms of ethics rather than those very simple clear headline... by the fact they don't see those simple headlines and be able to sort of work through those... they're getting it through policies and frameworks and I think the problem there is they're just getting too much of that so rather than...taking the simple headline news and working out what should happen there they're just getting the frameworks and there's too many of them... so you may be getting twenty policies sent through, they're not going to read them." (Mark - line 57).

Several participants in this section have included issues related to funding constraints that create ethical dilemma when making decisions about not offering or ending treatment, which has been referred to as; the 'locus of authority' (Delany et al., 2010a). Delany et al. (2010a), describe how a service user may almost always improve with further intervention and therefore the person responsible for deciding

when the end of treatment occurs may perhaps not always be the HCP, but rather, the decision might be made by alternative criteria.

### 8.3 Consent and communication

For a service user to be autonomous and determine what treatments they will accept or refuse, consent is required. This is a basic tenet of medical morals to afford a measure of protection from any perceived paternalism (White & Ashley, 2015). Mary recognised how informed consent is a key issue in the relationship between the service user and clinician.

“I draw my knowledge from the theory and really from the gold standard protocols that were used at uni and the theory behind the treatment that you're gonna do and their medical conditions and that's kind of filtered and then it's spoken to the patient in a way that they will understand. So, you obviously can't come out with a lot of medical terminology because the patient won't be able to interpret thoroughly what you're saying.” (Mary - line 63).

Conversely Chris did not think that consent is achieved. He gave an example where service users may not be aware of the high risks involved in decision making. He acknowledged that informed consent is good practice, but conceded that where a service user is at high risk of serious morbidity, they are not made aware of the risks.

“it's that whole issue of like around consent isn't it... you can't make an informed decision without all the information... I think (pause) I think we try to do this because I (pause)... No I don't think so” (Chris - line 1671).

In a similar way to Chris, Mike also believes that effort is made to gain service user consent in decision making, but there are restrictions preventing this being achieved.

“fully consenting but with risks, y'know what I mean? You've probably gotta make sure you explain the risks and maybe at times we don't explain the risks enough. We give them a best case scenario or a positive outcome scenario and thinking about it, maybe I should do that more, I should say, here are the contraindications here are the risk factors, this could happen. Unfortunately, giving patients all that information when they've got no medical training, no background, is all a bit too much for them a lotta the time, I think you're paid a lot o'the time to take that decision outta their hands.” (Mike - line 287).

After reflection, Mike concluded that this is something he could pay more attention to, which demonstrates a desire to reflect and improve his ethics. This is something that is not evidenced in the other interviews. Other participants appear to defend and justify their practice rather than take this approach. Mike demonstrates accountability along with an honest approach to the issue of the service user being a passive recipient who trusts the expert rather than giving lip service to the current thinking towards an empowerment model. He is not using a medical model approach, but tending towards paternalism when making assumptions about what the service user might understand. He demonstrated responsibility and accountability as a health professional, who he states gets paid well to absorb and make these technical decisions that the service user may not fully understand. It is an honest appraisal of how he considers informed consent and to what extent this is achievable or if it is being afforded no more than lip-service. Paternalism in this context describes the physiotherapist taking the dominant role in decision making based on their knowledge, experience and professional concern to judge correctly for the service user (Charles, Gafni & Whelan, 1999).

The paternalistic approach described can be further buttressed by a professional code of ethics acting in the best interest of the patient, for which an alternative concept is to recognise the HCP within the 'physician-as-agent' model (Charles et al., 1999). Charles et al. (1999), give consideration to decision making being an iterative process evolving from empirical and developmental aspects of this concept. Alex stated that when getting consent or discussing the service user's future you have to wait for them to be receptive.

“but you've gotta wait for them to be receptive really, I'm not into this, you're telling everyone exactly in the same way every time... It depends on the person and the situation, but I think that comes with experience of being a clinician really and...with students now, some are good at communication and others aren't but they'll learn that as they go along, I think they're skills that you pick up.” (Alex - line 174).

Alex made several references to the notion of developing the nuances of ethics through experiential learning. In this extract she indicated that the awareness and recognition of service users' receptivity to the communication that informs the consenting process also comes through experience.

## 8.4 Resource limitations

### 8.4.1 Criteria based commissioning/care

Mary was the only participant from the private sector that recognised barriers to health care, based on criteria or policies.

“I think another barrier is adhering to the protocols within the practice that you work at as well. Sometimes I don’t always agree with the procedures within the practice...

(Michael: Is there anything you can do about that?)...

...I have verbalised on a few occasions where things could be clinically improved. And depending on which practice I’ve verbalised these observations, at one practice it’s very well received and things are usually changed for the positive and at the other practice it’s gone down like a lead balloon [laughs]” (Mary - line 365).

Resource limitations were reported more commonly by the NHS based participants. An example of this was offered by Chris relating to how a gold standard treatment may be the preferred choice, but cannot always be accessed.

“but it’s not always based on patient need is it... So I suppose from an ethical point of view we’ve got this...all this stuff we need... and in practical terms we can’t get it” (Chris - line 1323).

Furthermore Liz felt that criteria for people accessing services are devised according to financial priorities rather than direct consideration of service user needs.

“we’ve changed the barriers in our Trust because of the money (Liz clearly emphasised the word money). So... not high-risk but we had diabetics they were low-risk so corns, calluses or just nails... but had all the sensation and all the forces, now because of money, and we want to keep, so they would technically have gone onto the, we call it AQP... so we would keep them and it would look like we were doing more patients, so we would keep more of our budget that wouldn’t go to AQP, we have now changed our parameters so any diabetic at all that is physically unable to do their own feet... now becomes an intermediate or a an increased risk diabetic so they come under our block so they don’t go to AQP so we don’t lose them.” (Liz - line 774).

Similar to Liz, Fran believes that the responsibility for inequalities lies with the Directors. The fact that she places this outside of her own responsibility will be discussed further in Chapter 10, Theme 5.

“well I suppose it’s the Directors and those people that... decide what this area should do and what, I don’t know actually, because to me it should be the same service across, but there are little things like that, subtleties... things like acquiring certain equipment for people whereas, again if you live in a certain area you can get...” (Fran - line 381).

Fran and Liz placed these issues outside of their own responsibility, where Lucy illustrated how she tries to advocate for service users in the face of resource limitations.

“when I started this MSK job I used to kind of nearly be on the verge of an argument with people because the commissioners wouldn’t let people be list-sent for bunion surgery so I’d be like no you’ve got to try insoles and they’d be like I don’t want to, but you’ve got to try, whereas now I would not put anyone through that because I don’t think it’s ethically right.” (Lucy - line 690)

Alex explained how commissioning has created an ethical barrier to health care, but illustrated a level of apathy and passivity which is evident in the opening comment about “going with what you have got”, despite the fact that she went on to explain how she has a desire to circumvent the health inequality (This, as an example of disaffection, is discussed in Chapter 10, Theme 5).

“I think you go with what you’ve got don’t you, so like we have a MSK service that don’t treat children, so there’s a problem. If we see a child in the clinic and they need some MSK orthoses, it’s where do you send them? because in fact the whole of the MSK service doesn’t treat children because it wasn’t commissioned to do that. So the ethics of that is this kid would need something, but where do you send them? ethically that is a bit uncomfortable because, especially with children, and you know they need this very specialist care that not many podiatrists or physio’s would be able to do and you aren’t able to offer it in a big city NHS dept. because of the way the health policy is at the moment, so that’s quite hard...” (Alex - line 848)

With her example of an ethical barrier to health equality, Alex explained that this was not based on a clinical need, but fiscal management. Furthermore, the key issues were a lack of understanding by the decision makers. This leads HCPs to question



the wisdom of what appears to be a less than rigorous priority setting process, when they struggle to obtain sufficient resources to do their work and enable an impact to service users (Capp, Savage & Clarke, 2001).

“... just a commissioner, I don't think they really realised loadsa kids had problems you know, it was commissioned by people that didn't really understand the service.” (Alex - line 897).

Previously Alex indicated that you have to accept the resources that are given and reduce service delivery accordingly, but here she acknowledged that this may have been due to an oversight in the commissioning process. Alex offered no explanation of how this avoidable decision can be rectified or reversed. This passivity was apparent in her comment that “you go with what you've got”. This illustrates an acceptance that the service is being provided with a nominal budgetary allowance, rather than a strategic fiscal plan based on service user needs or pathological episodes. The fundamental purpose of a health care organisation is quality service user care and thus when balancing the competing priorities, such as the clinicians, staff and the organisation itself including its financial stability, the population it serves ought to be ranked ahead of them (Nelson, 2005). To mitigate cognitive dissonance, Alex may also be diffusing responsibility by sharing the culpability of her action with those that she feels dictate her responsibilities, i.e. the commissioners, resulting in a lack of accountability (Jackson et al., 2013). Similarly Cal recognised barriers to providing health care, but stated that she is not concerned and is happy to work within the limitations. She did acknowledge an issue with some aspects of commissioning which she refers to as a “kind of frustration”.

“I'm just quite happy all the time (laughs)... but I think it's hard because you get used to it...just silly things like working over at *\*\*anonymisation\*\** we have an MSK injection service...so if any of the patients are looking like they're appropriate for injection, discuss it with a colleague and you can get them their injection within a couple of weeks, they're back in physio and it's done really quickly whereas in *\*\*anonymisation\*\** the GPs aren't wanting to commission that, so our patients have to be sent back to the GP which can be a two three week wait before they get seen, they're not necessarily going to get their injection that appointment so it might be another few weeks before they get their injection and then they come back to us. So in one place it's done and dusted in two weeks and in another place it can take you six weeks to two months to get your patient to have an injection and that's another eight weeks' worth of rehab... with injection it's the same with like the exercise so

we have PALS over here which is like a part-commissioned exercise referral so using things like the local gyms and things for cheap, whereas at another area close by, they kind of got rid of their service... so we don't really have places to refer the patients to afterwards so again it's just another kind of frustration I guess." (Cal - line 331).

In order to limit the barriers, Sue suggested the need to standardise care.

"I suppose I'd standardise it, just make it a standard, gold standard, no matter where you went, you'd get the same treatments, not a treatment by postcode not a treatment by paying for it, it would just be a standard and you would get the best care." (Sue - line 298).

Sue's idea to standardise care suggests that treatment should be offered on an equality of access basis. The NHS Constitution (DoH, 2015) has 7 guiding principles which dictate that these conditions for 'best care' should be in place providing a comprehensive service, available to all and based on clinical need, not an individual's ability to pay. The NHS aspires to put patients at the heart of everything it does and be accountable to the public, communities and the patients that it serves. One of these guiding principles, however, potentially detracts from all the other values. The 6th principle states that the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. This has the potential to become a barrier to gold standard health care as it creates an obstacle to access of services for all. The latter part of the guiding principle refers to a fair and sustainable use of finite resources, which may conceivably be a source of tacit adoption of utilitarian based ethics. What the participants in this section have alluded to is the frustration of the criteria based commissioning not providing what the HCP believes that the service users need. This gives a wide spectrum of opinions associated to the 'choice' agenda related to; cost containment, enhanced quality initiatives, concerns about equality with quantity rather than quality, all of which do not seem to empower the service user with more choice, influence or control (Whiteman, 2013).

#### 8.4.2 Physical resources

Terry and Alex had concerns that time limitations create barriers to good ethical practice and affects decision making.

“well I think the biggest problem from an NHS perspective, I think your biggest problem we have is time... you're just bang, bang, bang, twenty minutes, next, next, next, next. And at times, you almost run like a production line that's how it feels like at times, your brain is just so switched on as soon as you come to work its bang, bang, bang and it, and sometimes you probably do let stuff go over your head...this sounds awful but you probably ignore stuff which you probably should keep, hmmm you know I should probe that a little bit more but sometimes you think you're opening a can o'worms because of purely time constraints...” (Terry - line 220).

“it's the time, time is the main thing” (Alex - line 256).

Jane believed time, along with service provision being “process driven” are barriers to ethical practice.

“access to other services is sometimes difficult you know, that we can't easily get an injection (sighs) get an X-ray, it's all process driven so there's things like that the sort of procedures as to how we do things can make things feel slow but... and time, appointment length is something that you just wish you had more of...” (Jane - line 750).

Sarah referred to the number of patient contacts as a source of concern.

“just the standard ones I think... You've got to get through a certain number of patients 'cos that's what you get paid for. It's more so probably now, but you're on even limited resources, because you might be running low on theraband or you might be coming to the end of the year and your financial mess, you're waiting lists, we're forever looking and especially as band 6 your forever looking at your waiting lists” (Sarah - line 567).

Sarah used the term of reference “just the standard ones” which suggests that this may be accepted as common or normal, whereby Connor referred to similar resource limitations and cutbacks as a threat.

“The biggest threat...I suppose, resources is quite a major one. Recent cutbacks and the fact that we have to be, well, efficiency's a massive word at the moment you have to be as efficient as you can” (Connor - line 299).

In her examples of how resource limitations affect continuity of care, Liz's experience compares with Connor's concerns.

“all the time (emphasised). We don’t have access to a lot of the dressings, footwear, insoles or we have to refer on... we haven’t got the ones that we want or the nurses use a certain kind of dressing but we don’t, so there’s no continuity of care ...the whole pressure relief stuff that we're being asked to do at the moment...using a zero pressure aircast boot, but we can’t order 'em but I'm being told to look out for them and decide if someone needs one but then I physically cannot order it... it’s a money thing I think.” (Liz - line 446).

The participants in this section highlight a recognised problem for HCPs where the criteria based provision affects how much and what type of treatment can be given in conjunction with restrictive access to the service in the first place (Kulju et al., 2013).

#### 8.4.3 No perceived restrictions

Marie, Fran and Sue did not recollect any restrictions on service provision that might infer an ethical concern. Marie admitted to restrictions with appointment allocations as a pressure, but she did not think that it creates conflict in ethical decision making.

“I think we are quite lucky here in that we've got access to lots of things so, no I don’t think, not in terms of resources. There’s that awareness of how many times people are coming, and that's been put on us more and more, there's more and more now on our figures and how many times we are seeing people and we can only see people so many times... so yeah, there is that pressure definitely.” (Marie - line 294).

“(silence)..... (during the silence she was intoning her thoughtfulness)... I ... don’t think there are any barriers, or not that I've met so far... or nothing that I can actually think of.” (Fran - line 300).

“Erm... no not, I don’t, well there... any barriers? I suppose a lack of support that you get from your employer on the NHS basis... ‘cos usually the complaints about how long they’ve had to wait, you know, it’s the interval between treatments.” (Sue - line 73).

Sue had 15 years of experience, from which she had not recognised any barriers to ethical practice. She highlighted that service users complain about the interval times between appointments, but concerns herself with the personal issue related to a lack of support from her employer rather than the recognising a potential issue for the service user. This answer contradicted a point later in the interview when Sue admitted that there are barriers to good practice.

“There shouldn’t but there is [laughs]. Yeah. (Sue - line 313).

Different abilities to recognise issues in practice result in inconsistencies of acknowledged ethical dilemmas and may be related to the lack of ethics education (Kulju et al., 2013). Kulju et al. (2013), surveyed 116 (from 168 = 69%) physiotherapists using a revised Moral Sensitivity Questionnaire to measure the moral sensitivity of their participants. Many of the participants acknowledged financial constraints, equality, good care and respect for the person as some key ethical concerns, but 16% of the participants reported ethical issues to be rare or never arising whereas 12% encountered them daily. There are consistencies in these findings, related to common ethical dilemmas, despite the reduced generalisability of the study as a consequence of the participant recruitment being confined to one public health service in Finland. The survey instrument used by Kulju et al. (2013), predetermined the ethical dilemmas and therefore opposes the free thinking of a phenomenological method to explore what one may understand by the term HCE. The questionnaire had one open ended question which was answered by 79% of those who completed the survey. This question was placed at the end of the survey and after exposure to all the terminology of ethics. One possible comparative drawn for this study is that ethics education is reported as very uncommon amongst physiotherapists.

## 8.5 Unethical practice

### 8.5.1 Direct unethical practice

Ethics almost always causes uncertainty and possibly controversy about what the right thing to do is, but it is almost always easier to say what it is to do ‘bad ethics’ (Macklin, 2015). Mary identified what she considered to be poor service provision. She contextualised her practice akin to virtue ethics and stated that she gets annoyed by unethical or less scrupulous practice.

“I see myself as giving a service to someone...it’s not really about me, it’s more about the patient and what they deserve as a person and, I wouldn’t want to take any, it’s not even really about the money, it’s about the time and

just the information, you just want to keep people fully informed so they can make a decision about the way that they wish to progress.  
(Michael: what are your thoughts about the HCPs who you have suggested are doing less for the patient's informed consent)  
.. It annoys me (laughs).” (Mary - line 192).

Virtue ethics informing character traits has been criticised as being less powerful than external situational factors in influencing behaviour (Levy, 2009). The importance of fostering virtue ethics is advocated in increasingly complex clinical roles and has as much to do with honouring professional requirements as with fulfilling service user interests (Devlin & Magill, 2006). Having a virtuous outlook in providing a transparent process to ensure information and accessibility to treatments would go a long way to offering a reasonable choice of options (Whiteman, 2013). Chris highlighted the need for virtues of personal character in the following example where he admitted that patient treatment can, at times, be influenced by the personality of the service user or the clinicians' energy level.

“it possibly influences my treatment which worries me that I don't give someone the proper treatment because I just want to get out of there.” (Chris - 1540).

From an organisational perspective, Pete highlighted what he deems to be unethical practice based on private practice employers expecting physiotherapists to rebook service users too frequently.

“he was challenged by his private employer in saying you're not seeing enough follow ups, you're not bringing your new patients back enough times. (Pete - line 313).

This issue was also raised by Marie who believed that service users were being booked in unnecessarily. When questioned if she thinks this is unethical she confirmed this to be the case.

“yeah, yeah, I think there is.” (Marie - line 830).

She was asked if her practice would have to change if she worked in the private sector compared to how she was working at present.

“I may change my practice, but I would not book them in for the sake of it”.  
(Marie - line 831)

Marie and Pete highlighted an issue which suggests the NHS and private sector services have a different emphasis, which in their opinion shows one doing ‘the right thing’ and the other being motivated by financial gain. Corruption from self-interested inclination can affect judgment (O’Hagan, 2009) and the culture of putting corporate self-interest and cost control ahead of patients is a failing, attributed to a lack of care, compassion, humanity and leadership in health care (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

### 8.5.2 Indirect unethical practice

Less than professional behaviour by HCPs is widely reported in the literature, although this may be indirect action to a service user and may even be action motivated to deceive or manipulate criteria for resource usage in order to give a net result of improving service user wellbeing (Freed et al., 2012). It may be that some HCPs do not engage fully in practical reasoning to arrive at a good ethical decision, but apply a sophomoric moral theory or that they apply sophisticated moral theories in inept ways (Curzer et al., 2014). Chris used NICE guidelines as an example of how he believes HCE is achieved. In the excerpt below he then demonstrated how this may be a contradiction.

“it’s like this idea that NICE produce guidance and the whole idea that it’s not ethically right that it’s based on funding” (Chris - line 500).

He then spoke about the duty of care that is obligated to his professional role. Clarification was sought with respect to the notion of ‘duty of care’, since duty of care has the potential to create dichotomous demands in favour of the organisation rather than towards the service user.

“I would think for everybody you have a duty of care. I work for the NHS. I would think you have a duty of care to everyone because you are a care provider for a national body.... but someone might say that you've not got a duty of care for that patient...(pause)... they don't have an inclusion criteria” (Chris - line 574).

There were opposing conflicts in this discussion. At first he described 'duty' with respect to all, but then recognised that he may not be duty bound to someone who his service provider has excluded (by their own criteria). He offered a further example of poor practice and again created confusion in his example.

"You'd do an assessment, I wouldn't just (pause) I'm sure some practices would, but - You don't just give insoles out...(laughing quietly)  
(Michael: Why do you say that - with a smile on your face?)  
...Yeah - cos I think people would... (pause)... if somebody turned up at your clinic and asked for a specific insole and they told you the shoe size and everything (pause) I suppose you know in yourself that insoles aren't going to be potentially fatal, they can they can make a problem worse and they can heighten a problem but actually just give it... and you can buy insoles over the counter...so if someone's going to come in and ask for a specific insole and be willing to pay money...pay a lot of money for it...  
(Michael: So what do you think is influencing that decision?)  
...It's the money there, definitely..." (Chris - line 1094).

Initially he gave the example as one of poor practice, based on financial gain, but then seemed to justify it on the grounds that the action may not be "potentially fatal". Chris followed this with a discussion on how referral pathways can change clinical decision making depending on the financial status of the service user. He used an example where someone may need further investigation such as an MRI and could access in the private sector within 48hrs which would not be possible on the NHS.

"You might send too many people for an MRI that don't need it...because - just to get the money off either their insurance or the person..."

...But why is it - why is it fair that he's got to skip the queue because he's got insurance...So money would influence their decision...

...Money influences most of the decisions if not all the decisions" (Chris - lines 2742, 2833 and 2960).

Chris thought that this was wrong for two reasons. Firstly that the private practitioners may abuse the referral in order to make financial gains and secondly that a service user is able to "jump a queue" just because they have insurance. He was advocating the NHS system demonstrating that he accepts the shortcomings of the NHS at the expense of the service users' needs or benefits.



Ethics informed through normative guidelines may originate via a complex and non-transparent scenery of various stakeholders (Schicktanz, Schweda & Wynne, 2012). Schicktanz et al. (2012), argue that such frameworks should be formed in environments with richer argumentative exchange and interpretations that include institutional self-reflection in order to increase the reasonableness and legitimacy of such ethical considerations. Alex used an example to explain how guidelines may provoke unethical practice if motivated to create a discharge policy.

“I mean we've got policies and procedures for people to work to guidelines and I know some NHS services who've had to discharge loadsa people who probably we would see... we had to put them in when we needed to discharge and then that made it easier for some of the podiatrists to say to a patient after they'd reassessed them, you don't need to come anymore because this is your score and it means there's nothing wrong with you.” (Alex - line 1005).

Alex claimed the NHS "had to put guidelines into place" to make it easier for the clinician. The terminology empowered the clinician when discharging service users. Alex explained the strategy that was adopted as a proactive way to use guidelines to save budgets, which opposes the idealism of guidelines that are set for the benefits of service users (Kosimbei et al., 2011). Although this may be understood within utilitarian regimens as a mechanism to protect those who are in most need of the service, it encompasses the risk of regressing away from a service provision for all. Alex was asked about NHS Trusts who set their own guidelines and criteria to include or exclude service users who are then offered treatment in the same trust if they are prepared to pay for it.

“I would fight that if we were told to do that... the ethics of that are dodgy. It's like working in a NHS department and saying you know I can't see you back but this is my private practice card, you can come and see me, you can come every four weeks but it'll cost you thirty pou, I think that's unethical. I don't agree with it at all. Based on ...well its open to...not, fraud's the wrong word but its open to mismanagement isn't it, because you if your department is struggling and you need another senior band 6, and they say oh well if you make this much money, income generation in a year you can have another member of staff that, the podiatrist might think ooh we'll discharge a load more people and get them in the private scheme.” (Alex - line 1105).

Alex highlighted ethical issues associated with this type of discharge and selection criteria and voiced her concern and determination to fight against any such action in

her Trust, despite this happening in various NHS Trusts. Guidelines and care pathways are used by Connor to describe how his ethical decision making is based on evidence. When asked who is responsible for forming the pathways of care and what evidence is used to support the guidelines he could not answer the question.

“I think they'll probably differ from just Trust to Trust to be honest...I think the pathways that are developed here, they're only very recent... they're fairly new pathways that are being developed...they maybe basing it on other Trusts, I'm not so sure, but I think mainly it's been decided with the consultants” (Connor - line 229).

In attempting to clarify how the care pathways are evidence based, Connor demonstrated a lack of understanding with respect to how the pathways were formed and if they are local or nationally recognised. He is unsure if they relate to the CSP, HCPC or Trust guidance. The pathway that Connor was describing determines the direction of patient management, but is determined by a self-completed assessment tool by the service user. Connor offered no critique of the system and had no depth of knowledge of the validity of service users' self-completing the questionnaires, but he blindly follows the pathway as a means to determining the clinical selection process. This is discussed in detail in Chapter 10, Theme 5 where Mark referred to it as “ethical blindness”. Application of a guideline without criticality may be considered as a static construct, which is opposed to the dynamic requirements that HCPs are expected to be able to use to distinguish between evidences for appropriate decision making and is the hallmark of critical thinking (Huang et al., 2014). Whilst discussing pathways of care, Lucy recognised unethical issues, caused by lack of resources.

“they've underestimated how much podiatry was needed, we've got a massive wait and we're supposed to get patients seen within two weeks and they're waiting like two months for the podiatry side of things...the thing that I struggle with is the type of treatment that's given, its one standard bog standard insole and isn't adjusted chair side...look you've got a crappy - the same crappy insole for everybody because I think limiting patient to one specific treatment isn't ethical really because we know there's more out there and we are withholding this from patients...” (Lucy - line 465).

Despite her stating that it is not ethical and that she struggles with it, she continues to practice whilst bound to these principles without considering that it effectively

renders her own practice unethical by the same judgment. This is discussed in more detail in Chapter 10, Theme 5. Using an example of a common pathology, Mary highlighted an inequality in service provision between the NHS and the private sector based on conflicting evidence available.

“there's not an awful lot of research that concludes which is the best treatment to provide for that patient and which is gonna be the most effective, so that is where the patient becomes more involved because you talk about the treatment that you're gonna do, the consequence of having that treatment and the after-care and there may not be one right treatment for a specific patient, the treatments would differ depending on the patients' lifestyle and the communication and the conversation that you have with that person.” (Mary - line 95).

Mary demonstrated good practice using service user involvement to overcome potential conflicts in decision making. She then described what she considered to be unethical practice.

“Because it's difficult to resolve a VP... so from an NHS point of view it'd probably be expensive to offer consecutive treatments and appointments so I think they usually do one treatment of cryo and if that doesn't resolve the problem then I think that you're possibly discharged... so within a private practice you can follow the protocols more thoroughly to give you time to resolve the problem... and I normally say, usually I do probably about nine treatments and if it's not responding by then then, I don't think that they're gonna have any benefits from using that...so ethically there is a discrepancy between patients that can't afford to come to a private practice because they possibly then have to live with their VP and eventually pass it on to other people...” (Mary - line 124).

This shows a limitation for service user benefit due to interpretation of evidence based treatment dictating policies for available treatment. Mary indicated that NHS service providers are guilty of not offering treatments as a consequence of the expense. She then referred to private practitioners who do not make it clear to the service user that there may be no success, despite having as many as 9 treatments. Mary was asked if there is anything that she thinks could be done to improve or change the ethical disparity in service provision.

“...I think it's more education. I think it's about giving them the knowledge but that being said, if someone's not the same moral values that I have, whether they've got the knowledge or not could be irrelevant because they probably

just see the amount of money that's in the till at the end of the day. That's probably their focus...to earn money..." (Mary - line 224).

Mary proposed the need for better education, but highlighted that the ethics "morals" of some HCPs or health providers may be called into question by indicating that benefits to service users appear to be secondary to financial issues. There is evidence to suggest that the best approach to improving professionalism in practice is ethics education, without which HCPs may not advocate for service users during moral conflicts (McLeod-Sordjan, 2014).

"I'm not sure because I'm not NHS, I don't know if they would divulge the information to the patient, in that respect it all comes down to finances doesn't it, unfortunately, and not the benefits of the person." (Mary - line 224).

This chapter has highlighted areas of practice limitations that challenge ethical decision making for HCPs. An engaged and valued workforce is not a 'nice to have', but is a 'necessary condition' for meeting the NHS's unprecedented challenges against a backdrop of growing service pressures and tightening finances (Ham, 2014). There are various aspects that demonstrate how the resource limitations impact on service user care. To achieve a just allocation of scarce resources HCPs may have to embrace the challenge of implementing a coherent multiprinciple framework rather than relying on simple principles or retreating to the status quo (Persad, Wertheimer & Emanuel, 2009). NHS providers exist, first and foremost, to serve patients. Patient-centeredness is a dimension of health care quality that may require some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it (Berwick, 2009). The next chapter represents the findings of how patient centred care was viewed by the participants of this study.

## **CHAPTER 9: Findings - Theme 4 Person-centred Care.**

This chapter discusses the service user as a 'person'. The service user ought to be at the centre of consideration of service delivery in health care by obtaining intelligence, focus on improving organisational systems and nurturing caring cultures (Dixon-Woods et al., 2014). Deontological ethics offers one of Kant's categorical imperatives stating that rational humanity should always be treated as an end in itself and never merely as a means to an end, stressing the independent moral worth of a person (Lawson, 2011; Kant, 1785/1948). Theme 4 was formed by the participants' perception of this issue. Person-centeredness is related to a consumer-empowered health care which can achieve an empathic and respectful therapeutic alliance between the HCP and service user (Burks & Kobus, 2012). This theme considers service user autonomy, empowerment and what is found to be 'lip service' in facilitating dialogue that achieves these ethical ideals.

### **9.1 Empowerment**

Service user autonomy is key in resolving concerns about medical paternalism, which in turn can help counteract the power inequalities inherent in medical practice (Meagher, 2011). Empowerment has been acknowledged as an alternative to compliance in order to guide the relationship between the provider and service user rather than the service user remaining a passive recipient of medical decisions (Aujoulat, d'Hoore & Deccache, 2007; Charles et al., 1999; Raina et al., 2014). The 'practitioner-service user' relationship may have shifted from a medical discourse into a counselling discourse thereby contributing to a reduction in power asymmetries as a consequence of policy initiatives such as 'Department of Health Partnerships' (McIntyre et al., 2015). Mary referred to patient education as a means of influencing change to redress some of the disparities that she identified.

"I inform patients, some patients that have been to see me have been to the NHS for treatment and I will inform them regardless, tell them the information... and by educating the patient, if they then go back to the NHS well they've got the knowledge to dispute basically what could be potentially being told to them." (Mary – line 243).

Mary felt that service user empowerment is the one thing she can do to help address health inequalities. She had previously discussed the issue of service user empowerment as one which is driven by moral virtue, but here she discussed this in the context of health inequalities to say that some clinicians don't operate with the same scruples, which she considers unethical. Respect for autonomy is a preeminent value governing the actions of health care providers and is fundamental to the ethical provider-patient relationship (Joffe et al. 2003). Some would argue that respect for autonomy is the first principle of morality (Kultgen, 2014). Promotion of the value of human dignity, well-being and respect are examples of values that can be affirmed by virtuous habits (Dugas, 2005). Sue thought the best way to affect change and address health inequalities would not be by any direct action on her part, but to empower the service user to voice their complaints appropriately.

“Probably an impossibility...

(Michael: Have you ever found yourself trying...?)

... I have...I have tried to persuade people to complain Yeah... yeah [laughs]. Yeah [laughs]. Yeah. [laughs] whether it gets 'em anywhere I'm not sure but I have tried to get them to be the voice and that's...I put it back onto them...as I won't feel my voice would make a difference... Yeah. I would say that's how it is and that's how it's going to be and let's work with it and this is the best we can go for at the moment.” (Sue - line 180)

Sue accepted that she can't initiate improvement within her organisation, but in a similar way to Mary, thinks that empowering the service user to complain may allow their voice to be heard where hers won't be. Unless the decision making process is supported and reinforced by the HCPs' attitudes, values and behaviours it may fail to be reconciled with that of the organisation that has a mantra of 'best practice' (Cox III et al., 2008). Conversely, at the decision making level of care, Terry described how service users seem to be less inclined to use their voice in the decision making process compared to his experience in the past.

“You'll often get patients that, not as many as we used to do, I don't know why but I'd say, three or four years ago, we were getting challenged by patients, I want this treatment. I want acupuncture; I want ten sessions of acupuncture. Now we're not a maintaining service for anybody and again it's as autonomous practitioners we decide, but in consultation with a patient this may benefit you. Now if someone says to me, I want that, and I don't think it's useful, I won't do it and I'll justify it with them, but you got that a lot more three or four years, you don't seem to get this as much...

(Michael: how much do you think the patient is involved in the decision making process?).

...we're pathway driven now so we've got protocols in place now...we have pathways that's based on, most of us have done masters or continually keep updating, so it's all as up to date as we can... I always will talk to a patient and offer, this is what we do, this is what's best and then see what they want to do." (Terry line 335).

Terry acknowledged that service users were more inclined to make requests of physiotherapists three or four years ago, which has now become far less common. He stated this twice although did not know why it may be the case. He seemed blind to the prospect that the reason for service users having less say in their own management could be related to the service redefinition which has become more inclined towards service user self-management or the adherence to pathway driven care. This highlights the dilemmas with the mismatch between language and practice that HCPs face (Whiteman, 2013). Whiteman (2013), argues that the variance in interpretation and lack of consistency for the individual requires a semantic change that obviates the use of 'choice', focussing instead on the options for treatment and thus does not raise false expectations. Terry highlighted that the service is pathway driven and that protocols are in place to dictate management plans. His use of the term 'autonomous practitioners', in the context of his discussion, opposes the essence of empowerment, but rather justifies why the professional makes the decisions. He speaks about higher education which appears to be used to validate the asymmetry in knowledge and therefore decision making potential. This becomes a method of disempowerment from what the patient (in his example) feels they need.

Consistent with other participants, Terry demonstrated how lip service is given to the notion of joint decision making. He states that he always talks to a service user and offers what he can do. He tells them that his offer is the best solution before asking them what they want to do. This behaviour appears to be cultural and one which may be caused by reliance on tighter methods of professional regulation, stricter performance management and greater reliance on administrative protocols to deliver good professional practice (Owens, 2015). Owens (2015), considers how this may encourage professionals to passively follow performance guidelines and check lists in a way which disengages them with the process of care. To balance this, there

may be a benefit in seeking cultural renewal to aim for a collectively defined organisational ethic that can guide practice and thus the exercise of discretion (Cox III et al., 2008).

## 9.2 Joint decision making

Under the widely accepted 'four principles' it is an ethical imperative that shared decision making should be the norm (Stiggelbout et al., 2012) and that there is considerable restorative power in the physician-patient alliance (Raina et al., 2014). Within the centrality of the decision making process, however, there may be conflict rather than congruence between the HCPs need for autonomy in balance with the service users right to it (McIntyre et al., 2015). For joint decision making to be possible it is essential that the service user has access to and an understanding of adequate health information related to their condition (Murray, Pollack, White & Los, 2007). Murray et al. (2007), had found 40% of their 3299 participants hardly ever or never had enough information to achieve shared decision making (even though 62% of the participants had stated that they would prefer shared decision making). This requires clinical pragmatism which views the HCP Service user relationship neither from the traditional paternalistic perspective nor in terms of the opposing autonomous model of consumer sovereignty, but instead embraces a model of shared decision making which requires equal respect for all parties involved (Morgenstern & Richter, 2013). Lucy illustrated an empathic approach as a mechanism to achieve joint decision making.

“what would I think if it was me, and I kind of now think...what I think with patient choice? I kind of go with what the patient wants rather than that what...even if I think it's not going to work or it's going to work, I'll tell them honestly what I think will and won't work and what the chances I think of it working but everyone's human so it might surprise us, but I'll still ultimately go with what they want whereas when I started this MSK job I used to kind of nearly be on the verge of an argument with people because the commissioners wouldn't let people be list- sent for bunion surgery so I'd be like no you've got to try insoles and they'd be like I don't want to, but you've got to try whereas now I would not put anyone through that because I don't think it's ethically right.” (Lucy - line 690).



Lucy attempts to include service user choice in decision making and believes she is there to help inform this process. However, she struggles with this notion due to her belief that there is no outcome based evidence that supports informed decisions.

“but there's no right or wrong answer so sometimes you feel that you you're condemning somebody to a decision when... it isn't really informed consent so the NHS is focused on informed consent and patient choice, but what factors are they based on? are they based on good outcomes? are they based on post op infection rates? y'know there's no facts, so patients make choices depending on car parking, or the one the other day on the alphabet...” (Lucy - line 96).

The issues Lucy raised are consistent with the findings of the King's Fund Collaboration (Dixon et al., 2010) on how patients choose a provider. Regardless of the apparent lack of informed decision making is the concept that choice involvement has an intrinsic value to people (Whiteman, 2013). Lucy applies her personal values to the decision making process with an attempt to gather more information by trying to listen and understand the service users' motivation for the decision in question.

“I like to know why they want to make that choice so if they want to have surgery I won't just say ok you can have surgery...Is there any reason why you want to have surgery is there any reason why you don't want to try insoles and physio....” (Lucy - line 768).

Lucy then described how experience has taught her to try and negotiate with service users in order to achieve better decision making.

“if you've got somebody who on the basis of where the best mates had foot surgery and it's the best thing they've ever done, then it's my responsibility to highlight that everybody's got different problems and y'know the success rate of this and it may be different for you, so I'll inform them, but what I've found from experience if you try and really change someone's mind they won't let you change it and it causes upset for them, it causes a negative image for the patients and it doesn't do me any favours. It doesn't make my working day any easier and I don't feel happy with myself. I don't feel like I've won a battle. I don't feel like improved the patients prospects so I don't go with what they want, but based on what they're telling me I'll know how sensible they are about the decision and if it's a decision where I think they're being irrational then I will make sure the consultant knows.” (Lucy - line 781)

In this exchange Lucy demonstrated her responsibility in attempting to understand the background to the service user choice and then after the dialogue she will then make a decision with them. Lucy's introduction to this extract suggests that decision making is based on newly ascertained understanding between the service user and clinician borne out of dialogue. Although Lucy appears to work with the service user to help them make a good rational decision, it remains unclear about what new understanding or fusion of horizons has entered or influenced the decision making process. Conversely there seems to be a forced merger of the clinician's medical model view imposed on the service user as the discussion concluded with Lucy repeating that she is "duty bound" and it is her "responsibility" inferring that she must make the final decision or the service user must make the 'right' decision. She added that, if she thinks the service user is making an "irrational" decision, then she "will make sure the consultant knows" implying that the decision would be influenced by her professional relationship with the consultant. This struggle represents conflict between ethical principles. Where a service user expresses choice and the HCP considers this in the balance of autonomy and beneficence, it may be concluded that contravening autonomy offers better judgment, thereby justifying paternalism in the professional opinion of the HCP (Hoffmaster, 1994). Mary claimed that service user involvement is core to her service provision.

"I see myself as giving a service to someone, it's not really about me, it's more about the patient and what they deserve as a person and... you want to keep people fully informed so they can make a decision about the way that they wish to progress..." (Mary – line 192).

Mary embodies the concept of patient-centred care with her focus on the centrality of service users. Improvements in patient-centred care are taken to require improvements in the information, choices and control patients have regarding their health, which are concepts offered as an exemplar in the Darzi report (DoH, 2008; McClimans et al., 2011).

### 9.3 'Lip service' to joint decision making in service user involvement

For shared decision making to occur partnerships should be built that go beyond rapport, but involve sharing responsibility (Stiggelbout et al., 2012). For this to be

achieved there needs to be a paradigm shift away from the traditional approach to care which is embedded in the training and socialisation of most HCPs (Anderson & Funnell, 2010). Initially, Alex seemed to advocate service user empowerment by stating that they are “responsible for their own health” and “they are allowed to do what they like”. However, she appeared to adopt an opposing model demonstrated by her use of language to “persuade them” and “if they can’t be bothered to care for themselves that’s up to them really”.

“that person is responsible for their own health and they are allowed to do what they like and I’m quite happy to give people the advice and persuade them, but if someone’s saying I’m not gonna do this and this is the reason why, then I would respect that person’s opinion you know, and I struggle with chasing all the patients that don’t turn up and because I just think unless there’s a reason why they’re not there, because they’re confused or forgetful or frightened, but if people can’t be bothered to care for themselves and I think that’s up to them really...” (Alex - line 341).

Patient-centred care and shared decision making is gaining ground as a leading ideology of modern medicine and health-care (Sandman & Munthe, 2010), but Alex demonstrated a lack of engagement with this. Service users may give away some autonomy to a health care expert in order to benefit from their expertise, but this will happen only if those who act for them do so with due appreciation of the autonomy which remains for them (Kultgen, 2014). Alex continued to frame her care in a paternalistic model demonstrating frustration with service users.

“I think that’s a time thing. When you’ve got twenty minutes you’re probably happier to spend time with people who will listen to you and people that obviously aren’t bothered then you know, you’ll tell them what they need to know, but if they’re not gonna take it on board. But I think if you see someone regularly that’s when you can persuade someone to maybe change their behaviour...” (Alex - line 363).

What appears to be lip service to the notion of service user involvement is potentially a result of the difficulties related to resource limitations, for Alex this is stated as a “time thing”. Alex adopts an expert led behaviour change model, rather than a dialogical or empowering model. This is a fundamental misunderstanding of the empowerment approach which does not involve; convincing, persuading or changing service users (or getting them to change) and it does not involve doing something to patients (Anderson & Funnell, 2010). Ruth demonstrated a similar and superficial

understanding of service user involvement in decision making, whilst retaining a paternalistic response.

“yeah, because they'll read stuff up on the internet, they'll look on YouTube they'll say this is what I think I need (laughs)... because you, at the end of the day, you are the professional and yes the patient might have their own ideas of what they think might work, but looking on the internet you'll come across everything that could possibly work for a certain condition, but knowing our sort of expertise and like the conditions that you see you'll know what works best generally” (Ruth - line 267).

Paternalism in health care decision making can retain the ideal of the HCP as the caretaker of service users' interest, possibly going against the choices or ignoring the perspectives of the service user, providing they are benefited and not harmed (Rodriguez-Osorio & Dominguez-Cherit, 2008; Sandman & Munthe, 2010). Ruth appeared to adopt the culture of provision that informs the service user what will be available, rather than allowing the joint decision making to inform the process which may be considered as 'hard paternalism' infringing on the freedom of choice (Rodriguez-Osorio & Dominguez-Cherit, 2008). For Ruth to adopt a service user-centred approach she would have to shift the representation of her role from a skilled technician and knower to a person who is a facilitator and accept that she does not know in advance what the outcome of her provision will be (Aujoulat et al., 2007). Confronted with difficult situations HCPs need to answer the central moral question framed as; 'what ought to be done for a particular service user at a particular moment and at a particular location?' (Widdershoven et al., 2009). Widdershoven et al. (2009), suggests this requires practical rationality or wisdom applied to that context through hermeneutical dialogue. In a similar way to Ruth, Sarah demonstrated a paternalistic model of service user engagement/choice.

“you are asking them what they want or what they feel they would like and I don't think a lot of patients mind you being honest and saying well actually we can't offer that at the moment or I don't feel that that's the right thing for you because they're still coming to you with a professional opinion” (Sarah - line 269).

Sarah claimed that service users are always asked what they want from the service. She was asked to elaborate and explain the purpose of this approach since what the service user asks for may not be permitted due to the limitation of resources.

“once they've got their expectation laid out on the table it kind of leads you into their goals as well, what they want to achieve and how you can help them getting them and then you have an end point, you have a discharge point with them as well whereas if you don't ever have that, then you're never gonna be able to discharge them and they're gonna be the patients that come back round, the ones that are not happy on discharge are the patients that you've never had that chat with and never laid out those expectations and cleared that out beforehand so it is important.” (Sarah - line 293).

Sarah believes that asking the service user what they want is important, but she reveals that this is not a question of service user choice, but rather it is an opportunity to pre-empt issues at discharge and ensure their expectations are managed from this early stage.

Alex, Ruth and Sarah enter into the framework of person centeredness, but appear to adapt the purpose to appease the pressures placed on them or the service. One method to avoid moral dilemmas is to change the way that morally relevant situations are psychologically framed (Cushman & Young, 2009). This might be evidenced in the way resource distribution is a focus of morality being confused with service user choice. Cal also indicated that her motivation is directed towards meeting the service demands rather than service user choice.

“we've done the advanced development programme within our Trust, it's like a national thing but it's all about your communication and getting patients on board, so it's not that I'm giving you exercises, its, - this is my role, this is what I can offer you! - is this what you want? so patients are choosing whether they want to do that by engaging in the treatment that we're offering and they have 'choice appointments' so they choose to come back if they want what we have available...

... the advanced development programme definitely made our team a lot better at that and yes if it's appropriate you bargain with your patient and you set up a plan together so that patient's getting what they thinks appropriate but we're getting the exercises which we know long term is going to be more appropriate if it's not appropriate then we don't do it. You've got the understanding and you're the professional, you know why we use it, patients don't always have that.” (Cal - line 187 and 222).

It appears that the organisational philosophy and national drive of the Advanced Development Programme may be being applied as a medical model approach to service user care offering 'lip service' to user empowerment. In the extract above,

Cal's language use illustrated this. There is acceptance of the organisational influence to manage resources at the expense of service user involvement. She spoke of getting the service user on board with what is available and the notional "choice appointments" are only taken up if the service user is prepared to accept what limited choice was dictated to them. This opposes the direction of service user empowerment philosophy where service users are, bedside professionals, experts on their own symptoms and situation rather than the traditional approach that Cal demonstrated by making decisions for the service user based on the belief that the professional knows best (Holmström & Röing, 2010). Jane offered similar examples of how the service user is informed of what limited services are available. She also expressed frustrations with GPs who make referrals based on patient choices.

"And we are really clear about that actually...but obviously if somebody wants acupuncture every week because they think it's gonna help, then we do have to have quite a realistic conversation about what we can offer. We do try and get them on-side with that although I suppose we don't always win that conversation and make that clear and get their understanding on that, but we try and just make it clear what we can offer and sometimes it's a case of if that really helps you maybe it is a case of seeing if it's out there somewhere that we can get long-term, but that isn't something we can offer. There is a limit... I think some people totally get that and understand that. Others, occasionally, it's not often, but occasionally people do get a bit disgruntled that they're not getting say, continuous acupuncture...and we find that they wriggle out of the service and wriggle in again to be honest...but we just have to be clear with them each time that they come but GPs don't always help 'cos they might put 'for course of acupuncture again please' and that doesn't help us... Sometimes we do do it as well as a block of treatment to see if it does help...'cos sometimes it's almost their perception that it's gonna help rather than it actually does..." (Jane - line 213).

Jane did not recognise the validity of both the GP and the service user who value acupuncture as a treatment option. She did concede that sometimes physiotherapists will offer it, but claimed it is only the service user's perception that it helps, rather than it actually helping. This was challenged with the suggestion that this, therefore is a valid therapy, but the comment was lost in the conversation. It shows a lack of empathy towards the service user who may perceive this to be a helpful treatment. It shows disaffection from external evidences and belief systems, outside of Jane's organisation, of what might be clinically efficacious. This is an example of *a priori* judgments and may be informed by an understanding that emerges from the application of specific individual and organisational tacit

knowledge (Cox III et al., 2008). This seems at odds with the rhetoric of patient-choice based on the inherent tension between decisions that may be made by commissioning or contract criteria rather than what is clinically appropriate or evidenced based (Whiteman, 2013). If clinical practice lacks an epistemology that recognises the tacit dimension, service users may remain dissatisfied and the organisation will tend to foster policies that discount and ignore the people they seek to serve (Henry, 2006). For Dannie, service user involvement appeared to be clinician and organisation focused and led.

“...it’s very important to me on my first session that the person in front of me knows exactly what’s gonna be involved in. Later down the line basically so they need a full idea of what’s happening, what’s going on with them and how they’re gonna change it. So while we try and give them as much information as possible, how long they’re gonna be with us, how often their sessions are possibly gonna be, what they’re gonna be doing, the amount of input they’re gonna be, have to put in, the amount of input I’m gonna be putting in and then we send them away, we don’t book them new appointments we send them away to think about it. Should they choose to come back, they should be fully informed and ready for it... not everyone comes back.” (Dannie – line 323).

‘Patient choice’ could be considered to be an overt and transparent process clarifying the understanding of the limits within the NHS, which does not give a service user the power to choose options, but to refuse treatments or at best to express preferences (Whiteman, 2013). In this exchange with Dannie, there seemed to be no dialogue before the service user is being "sent away" to "think about it". If the service user "choose to come back" Dannie believes that they are "fully informed and ready for it". Continuing this discussion in the context of ‘No Decision About Me Without Me’ (DoH, 2012), it was suggested that an empowered service user may present themselves with insight to request a preferred management option, as might be the case in a private practice.

“(laughs) Yeah that’s not really an option sorry! (laughs).” (Dannie – line 352).

Concordance is an open-ended relationship between service user and the HCP where different perspectives and knowledge sources can be shared and challenged, but this requires commitment to the concept and its underpinning values from the HCP (McKinnon, 2014). The exchange with Dannie illustrated how her use of

guidelines may prevent implementation of shared decision making if service user preferences are at odds with guideline recommendations and possibly with clinician preferences, which in turn may overrule service user choice (Stiggelbout et al., 2012). Stiggelbout et al. (2012), highlight that it may be the HCPs' anxieties and thus unwillingness to adopt autonomous responsibility, that leads them not to change this situation. Pat was asked how she thinks the service user is involved in decision making.

“in the discharge process, d'you mean? I'd really like to think that it is a joint decision that they, we don't just tell 'em but we will discuss it, I'll always have a discussion with a patient before I discharge them so that they know and I mean you might think it is a joint decision - it isn't always (voice lowering). It often, it could be me saying look, I don't think we can get any further I think most patients would love to keep just coming and coming and coming...but (sighs) yeah, you say it's a joint decision but... you discuss it with 'em but I don't know if it is...” (Pat – line 232).

Pat recognised that joint decision making is valuable by stating that “I'd like to think that it's a joint decision”, but she then illustrated how this is contradicted in practice admitting that it is not the case. It is a communication exercise to inform the service user about the decisions that are being made unilaterally. More concernedly, Pat's immediate understanding of what is meant by joint decision making is related to discharge issues rather than positive and proactive health care choices. This issue was explored further with Luke, who after discussing the resource limitations commented on service users in the decision making process.

...I think in those situations the patient doesn't have a voice really, the patient just has to do what they're told and just has to accept that that's the way it is. I mean you do, you can try and word it to a patient that they don't need your service because they are well themselves and we're having to take care of people who are ill basically... so you can try and sell it to them that way so that they don't feel as though they're being fobbed off .” (Luke - line 255).

Luke articulated that the service user has no voice and illustrated how service user choice is undermined in the power imbalance on decision making. A client centred perspective involves approaching the service user in an empathic non-judgmental manner surrendering the provider agenda and truly listening to the service users' needs (Potempa, Butterworth, Flaherty-Robb & Gaynor, 2010). Luke did not



demonstrate empathy when he stated that the service user has to accept the decisions that are made for them and that “you can try and sell it” to the service user, that others are worse off and they themselves are not in need. Luke’s argument appears to justify a standard of care problem that is subordinated to a professional obligation without any depth of justification to distributive justice (Mackay, 2014). Similarly Marie demonstrated judgment on service user preferences, adopting a unilateral decision making perspective. She contextualised the differences across the private and public sectors when summarising her understanding of HCE as “doing the right thing”. When asked what she means by this she indicated that it is about trying to establish what the service user wants.

“I think it comes from both, so before we do anything to that patient, it’s what they’re wanting to get from coming. I think that’s where it changes in private and here because there’s some level of expectation in private practice that they want something doing to them and I think maybe more short term whereas patients here and for me, myself, in both private and here, I’m looking more long-term, what’s the best long term outcome rather than in out, in private practice they often come with more of a short term and they’re happy to just keep coming all the time whereas here we, we don’t want that and they don’t want that.” (Marie – line 103)

In this exchange, Marie illustrated an assumption that service users want to keep returning for treatments. She also made a distinction between the NHS and private sector service users as though there were two different populations with different needs. This asymmetry between service user and practitioner shows a lack of understanding of what service users actually want from therapy. Choice appears to be a simple notion that appeals to the individual, but it becomes a complex concept with potential for flawed understanding especially since the choices are neither available to nor accessible by all in the NHS which is a publicly funded health system (Whiteman, 2013). Marie also superimposes a belief that there is only one method of rehabilitation, which is, in her opinion the long term strategy and it does not include any short term intervention that a service user may benefit from.

“it’s quite hard sometimes if they’re not wanting to come on board...its hard reversing that thought...and it depends on what they’ve had before as well, what physio they’ve had before if they’ve come and they’ve had somebody who’s done lots of stuff to them, hands on before, and they just come with that expectation of that worked before, this is what I want this time, then that, yeah

it is hard, I like my job but that can be hard, it can be draining I suppose saying the same things.” (Marie – line 253).

Marie attempted to describe engagement with the service user, but from a medical model perspective. She did not consider the service user’s view of what works best from their experience, but pertinaciously insisted that the clinician knows best and the service has a specific focus and pathway which is going to be followed. On the question of decision making and clinical reasoning, Marie was asked if she was able to achieve her ethical standpoint of “doing the right thing”.

“it’s changed a lot since I started.. and there’s a lot more based around putting the patient at the centre...that’s come from a lot of this ADP, this training that we’ve been doing and the co-creating health... but the co-creating health have put forward this, the programme that we’re doing and been rolled out to GPs it’s kind of about the way we’re talking to patients really and becoming more patient-centred and putting the onus more on them... the first thing is what do they want to get out of coming, is the first thing so that already you’re working towards what they want...

(Michael: if a patient came in saying they know that ultrasound works for them and so they’d like 6 sessions, what would you do?)

...I had someone in this morning, I said, the research shows that we’re going away from ultrasound, this is why it don’t work... this is what we’ve shown now to work, so that’s what I think we should do is that ok? If they then say, no this is definitely what I want, I just still explain more” (Marie – line 374).

In the first part of this exchange Marie claimed to be putting the service user at the centre of focus. The second part of the discussion reveals that service user involvement for Marie appeared to be “putting the onus more on them”. This seems to be an organisational concept offering lip service towards the service user being involved in their own decision making. The ADP (Advanced Development Programme) that Marie alluded to focuses on the fundamental leadership skills which are deemed essential to be effective in a challenging financial environment and is linked to what is referred to as the new Healthcare Leadership Model (Keele University, 2015). This was evidenced in the discussion about the service user who wanted ultrasound because they believe it works for them. She disagreed with the request and claimed her argument is supported by EBP. In the context of EBP, many decisions are made from data which are often uncertain, ambiguous or hidden which results in effective professional practice relying on both theoretical knowledge and experience (Curran, Campbell & Rugg, 2006). These issues are then

compounded by the availability of time and resources, which can be further complicated by the dynamics of NHS or private service provision (Freeman & Sweeney, 2001). EBP has been developed as a paradigm or an approach to decision making in which the clinician uses the best evidence available, in consultation with the service user, to decide upon the option which suits the service user best (Freeman & Sweeney, 2001; Gray, 1997). This paradigm, however, uses a hierarchy which involves the clinician being led by the paradigm itself and may be based on an assumption of given truths about the rigour of research and how evidence is best formed or suited to the given context. Marie explained that the “difficult” service users are the ones that don’t want to get involved in decision making, but just want you to fix them.

“the difficult ones, ethic-wise in that they’re harder patients are when you say what do you want from coming and they say... well you tell me you’re the physio, I want you to fix, to sort me out...” (Marie - line 493)

Marie presented an interesting paradox here. On one hand she is promoting adherence to service user involvement, but in reality this is superficial with a clear remit of communicating with the service user to get them to accept the preordained management plan. This is evidenced in the discussion with the example where a service user requests ultrasound (which is a valid and evidence based treatment option). Paradoxically if another service user returns the balance of decision making to the clinician then she feels this is the ethically hard service user. Conversely, Terry stated that 95-97% of patients want the clinician to decide on treatments and that most patients do not have the background knowledge to make decisions.

“it's an assumption, but most people always go with a clinician, ‘what do you think?’ I know they're moving away from this! I would still say 95-97% of the patients will, what d'you think? you're the ex, and I get it all the time, they're doing all this communication skills and stuff like that and they will still say, well you're t'specialist. I don't know if its government-led or Trust-led, I think it's probably government fielding it down, patient choice and that they're involved in their care but they don't, they haven't got the, generally sounds awful, but they don't have that background knowledge to decide.” (Terry – line 449).

Terry appeared sceptical of the person-centred approach by indicating that patient involvement is a government led initiative. He questioned the promotion of patient

choice on the premise that he believes the majority of patients desire the HCP to make the decisions. The 'principles for effective interventions' in behaviour change acknowledges several key areas that relate to why concordance may be a challenge (NICE, 2007). The guidelines state that health inequalities are the result of a set of complex interactions, including: the long-term effects of a disadvantaged social position; differences in access to information, services and resources; differences in exposure to risk; lack of control over one's own life circumstances and a health system that may reinforce social and economic inequalities. The NICE (2007), guidance indicate that these factors all affect people's ability to withstand the stressors that can trigger ill health and that they also affect the capacity to change behaviour. It also highlights the need to plan carefully for interventions and programmes aimed at changing behaviour. These programmes should be developed in partnership with recipients and that it should equip practitioners with the necessary competencies and skills to support behaviour change, using evidence-based tools. It advocates the evaluation of all behaviour change interventions and programmes. The ADP that several participants referred to is one of the planned initiatives to improve health inequalities by including the service user in decision making. Several participants appeared to engender the model of the ADP as a method of improving communication when faced with budgetary pressures rather than considering the professional scope of practice and the context of health care in an environment where the private and NHS sectors are dichotomously using their skills. None of the participants that referred to the adoption of the ADP comment on evaluation of their service. Neither did any of them give consideration of how their service may require improvement. The system appears to be promoted as a method of altering the communication that enables a shift in the responsibility of therapy to the service user, rather than choice.

In the group interview, Joan (service user), made it clear that she did not feel engaged by the health service with respect to service user involvement.

“very little really. I had physiotherapy and I went to the hospital and I saw the consultant and the consultant didn't even, when he spoke to me, didn't turn from his computer screen to look at me... I felt more able to sort of discuss things with the physiotherapist who told me what he was doing and why he was doing it, in the end he said we'll do this and this is what's going to happen

over these weeks, but at the end of the day this is not going to change what's wrong with you, so, the physiotherapy sort of petered out..." (Joan – line 185).

Joan recalled different experiences with the consultant and the physiotherapist, but with both she felt that there was no real motivation to improve things for her. Irrespective of what the physiotherapist or consultant actually thought they had done for Joan, the critical reality is that service user engagement and empowerment was not successful because what the service user experienced and recalled remained negative. Although the language of empowerment pervades UK health policy, it is still ill-defined and its meaning remains contested in the wider literature (Piper, 2010). Concordance may only become a reality when its meaning is embedded in policy and documentation as well as practice learning and guidance (McKinnon, 2014). Mark offered some agreement with Joan and then an explanation as a potential reason for this disparity.

"I see a lot of variation in this from consultations where there is absolutely no voice whatsoever. The other extreme, you go and the GP will straightaway start asking you all sorts of things. Well I think there's a saying, to be empowered you need to be ready to be empowered and as a patient you will say, well I don't know, I've come to you, I'm not the doctor. And then when people are getting it right... they will give the patient a voice, but they will help the patient express that voice in the right way which I think you see rarely... (F: Why d'you think that, that might be?) ...I think like all things, the fashion will, oh we must consult patients, we must talk to patients, we must let patients have a voice, sort of comes in as a sound bite without the thinking underneath it being put across, so people just latch onto it, oh we're meant to let them have a voice. Well, what d'you want today, and it just takes people by surprise so I think that's why it happens, you get the headline without the underpinning thinking and without the necessary training." (Mark - group interview line 220).

Mark highlighted that patient-centeredness and empowerment are complementary, but complex concepts, placing a demand on the HCP and the organisation to be aware of those service users who do not wish to be empowered (Holmström & Röing, 2010). Service users should be involved in planning their own health care to the extent that they are able and choose to participate (Dugas, 2005). This confounds further the difficulties arising in the paradox where a service user may choose not to choose (Whiteman, 2013). 'Patient' as 'customer' may also contribute to the erosion of empathy and trust that is believed inherent in the caring profession

where consumerism and rationalisation of process does not appear to fit with the understanding and identity of patient-professional relationships (Owens, 2015). Mark acknowledged these complications and attributes the failing of service user involvement to be a complex issue related to staff training and service user expectations. He summarised this issue by suggesting the ideal situation is to give an informed voice for the service user. To achieve the ideal that facilitates dialogical praxis, then service users (and all stakeholders) should be actively involved with consultation and appropriate training (Widdershoven et al., 2009).

“I think...to me either describing it as putting the patient in an informed position...so when they've got a voice, that voice is based on a certain level of understanding rather than here's a voice and, oh gosh I've never had a voice before what can I do with it.” (Mark - group interview line 263).

Person-centred care which is mindful of and responds to the level of involvement desired by service users is an essential part of the HCP service user relationship and the model of choice for contemporary practice which is understood to deliver better service user outcomes (Piper, 2010). Dave contributed to the discussion on how complex the decision making process is. He referred to the attitudes of the clinician and the service user in discerning what is meant by the service user having a voice, which is not the same thing as having what they want.

“Dave: I think that this is so complex isn't it, it's because you've got the attitudes of the clinician and then the attitudes of the patient and I think from what we've all sort of said, then patients come with different attitudes, some want to be part of it, some don't wanna be part of it, it's the patient 'aving a voice, yeah that's a great thing, but actually that's not, that don't mean they can have what they want...that's not the same thing...so there's a real issue 'ere, that's not being addressed in a wider context in politics 'cos that's a vote winner in't it to say patients can have a lot of choice, but actually in reality they can't 'ave a lot of choice 'cos we can't afford to pay for that choice...so the clinicians then got to make difficult decisions...”

Mick: Yeah you can have anything you want as long as it's from this, this or this.

Dave: List, list, yeah.” (Dave and Mick – group interview line 594).

Mick summarised service user choice as a limited choice from a limited resource pool. Despite the NHS Constitution (DoH, 2015) suggesting otherwise, what Dave and Mick acknowledged, from the individual interview findings, was that the NHS

actually offer (at best) for service users to be able to show their preferences from the limited list of services on offer (Whiteman, 2013). Whiteman (2013), concludes that the NHS is delivering a limited and limiting form of health care under the guise of patient choice. With this suggestion the group were asked to consider where or how the service user has as a voice in the health care funding.

“Mark: It’s back to decision making in context, you might want to change the world but you’re not going to do it instantly... but that’s it, the funding isn’t around, you’re just going to get the best within context.” (Mark - group interview line 1199).

Mark acknowledged the finite resources which dictate health care provision and supported the acceptance of this. This is an example of organisational and utilitarian ethics influencing HCPs expectations of health service delivery. These influences are not directly compatible with patient choice and person-centred care, but offer a lip-service approach masked as paternalism. A paternalistic model of decision making is when HCPs make health care decisions based on what they believe is to be in the best interest of the patients (Murray et al., 2007). The struggle over the service user’s role in medical decision making is often characterised as conflict between patient autonomy and the health values of the HCP who is also trying to balance their ethical duties to serve the patient in their best interest (Raina et al., 2014). It may be argued that the paternalist, who believes with rational thought that their encroaching on service user autonomy may enhance it in the future, may then be justified to do so (Kultgen, 2014).

Traditional perspectives on shared decision making focus on the clinical encounter and treatment decisions, but it may be argued that it will be engendered by the entire encounter including the provider-user relationship (Matthias, Salyers & Frankel, 2013). Due to the political rhetoric reported in ‘The Darzi Report’ (DoH, 2008), the Government White Paper ‘Equity and Excellence Liberating the NHS’ (DoH, 2010) and the ‘NHS Constitution’ (DoH, 2015), it is unsurprising that the public may misinterpret patient choice as having their requests or demands met (Whiteman, 2013). Although shared decision making has gained widespread appeal, there is still confusion about what the concept means (Charles et al., 1999). The term ‘choice’ therefore may be more transparently represented through an engagement and

enablement process that allows the service user to express preferences whilst recognising that there are no treatment access assurances in the public sector (Whiteman, 2013).

This chapter has shown that despite any policies that engender shared decision making, it appears that further data is required on what would be needed to support a more successful process (Stiggelbout et al., 2012). This would then prevent a slippage away from patient driven attitudes in favour of a more business focussed approach (Weinstein & Nesbitt, 2007). The following chapter contextualises the interpretation of how HCE are embodied in practice.



## **CHAPTER 10: Findings - Theme 5 Interpretation of the Embodiment of Health Care Ethics (HCE).**

The findings of the previous themes represent interpretation of how HCPs understood ethics, how challenges and barriers to ethical practice were experienced and how their HCP role conforms to the needs of service users or the needs of the organisation. This chapter discusses Theme 5, which represents the contextual underpinning and potential reasoning emanating from the cogitation of the participants in relation to HCE in practice. Ethics and morality are inextricably linked to the wider social context, therefore ones understanding of ethics may differ from experiencing it in others or oneself in practice, depending on external influences including culture and the organisation for which one is employed (Fantino & Stolarz-Fantino, 2005; MacIntyre, 2007). The findings presented in Theme 5 are an interpretation of how the participants demonstrate embodiment of HCE.

### **10.1 Disaffected health care practitioners - compromise from idealism**

Various participants referred to their understanding of ethics originating during their upbringing and formation of character, which informs the rightness and wrongness of decision making. This is an association in time and space to their culture and history which offers context and informs their understanding, beliefs and perspectives on ethics (Miles et al., 2013). Lucy had highlighted an area of practice which she considered unethical. It was a matter that relates to referring service users and enlisting them for surgical procedures without suitable knowledge of such procedures. These issues represented her understanding of unethical practice. Lucy was asked what could be done to effect change with this.

“the manager did say what I suggest is that - he said it quite flippantly... what I suggest is everybody goes and sees the procedures that they're listing - and then it was just left at that.” (Lucy – line 1013).

In her response she showed disaffection with her management, accusing them of being flippant on the issue and then stated that it was left unresolved. The disparity between managers and staff represents conflict in the organisation for Lucy that is not effectively serving either the staff or the service users and therefore creates a

culture where high levels of engagement are not possible (Dixon-Woods et al., 2014). This discussion developed and Lucy exposed a further issue where an imposed criterion forces her to comply with duties that she thinks are unethical.

“I think is a huge ethical issue... everyone who needs a knee replacement if their BMI is over 35 then they're not able to be listed directly for surgery so I think that's unethical myself but that's a rule I can't ignore... so that's the thing that I don't agree with but I'm actually having to enforce..... (Lucy – line 1128)

This illustrated contrasting dilemmas that HCPs face with respect to concerns about service user autonomy and a chosen course of action by the clinician. Lucy justified why she believes it is unethical.

“it's unethical because we're using statistics on em like co-morbidities and things that are involved in a recovery of a knee, but the commissioners who don't have to be on the receiving end of these people and don't have to live day in and day out with that problem are deciding somebody's future life essentially... I just think it's awful, I just think for me it, I just don't, I've got the strong sense that I really don't believe in it” (Lucy – line 1172).

Lucy used the terms "condemn", "awful", "strong sense", "I really don't believe in it", but despite her convictions she complies with the dictated criteria. Lucy is disaffected in this ethical struggle. It is evidenced in the following exchange where her language use referred to her employer and her organisation in a way that disassociates herself from them. She continues to do what "they" say despite her belief that it is unethical, based on a lack of reasoned criticality.

“I don't know how they've come to this- the decision... I think they should look at everybody as an individual case... I just think it is an awful thing to put somebody through and I think for just for the mental health as well to reject someone on that basis I'd (pause) I don't know, we've not actually been explained I don't think the full reasoning for it.” (Lucy - line 1212).

Earlier in her interview Lucy had shown a degree of personal virtue in resisting the organisational dictates (discussed in Chapter 7, Theme 2). During the following exchange she highlighted the compromises she makes from her idealism, but disassociates the responsibility in order to explain the decision to the service user.

"I kind of try to come out of that role and think well I'm here to work for that service, they won't pay for it I've not got any choice, I just try and show compassion and show the patient that you understand, but just more or less put it across that its out, kind of out of my hands really...  
(Michael: does that concern you?)  
...yeah it does yeah yeah I hate it (pause)...I think it's horrible I don't think it's right...I don't agree with it!" (Lucy - line 1278).

Lucy continues to practice within this compromised position although stated that she "hates it". Managing finite resources requires hard decisions on service provision and during economic change the strain on leaders may result in the compromise of moral principles and could affect the subordinates' perceptions of their leaders' commitment to ethics (Sharif & Scandura, 2014). The NHS has a health trainer service that has the potential to improve health among disadvantaged groups, an approach which may help to reduce health inequalities (Gardner, Cane, Rumsey & Michie, 2012). Although Gardner et al.'s (2012), study is based on quantitative measures embedded in a behaviour change approach, it demonstrates potential to empower clinicians like Lucy in order to overcome some of the emotive inequalities that she shared. Lucy offered no such solutions, but appeared to reluctantly accept the inequalities that she finds herself working with. Cal highlighted disparities in practice, but unlike Lucy, Cal appeared to accept them with the suggestion that they have "pros and cons".

"it's quite different from both clients that we see and that the way that you work and again the demand really, in private practice it's much more manual therapy because you've got the time to do it whereas here you've got twenty minutes and you've got to work out what's the most important thing to do and if exercise is, then your manual therapy goes by the by sometimes.....  
(Michael: are there ever compromises in either of the two sectors due to resource limitations as opposed to clinical decision making?)...  
...DEFINITELY, if I had more time with patients in the NHS I would use my manual therapy skills a lot more if I had exercise classes available to my private patients I'd be referring them on so its pros and cons to both." (Cal - line 271).

The latter part of this discussion contradicts an earlier part of her interview where she had spoken of the apparent belief in the "doing the right thing" for the service user and using the ADP to make the service better for them. This excerpt highlights that her decision making may be forged from a limited resource pool rather than based on clinical judgment. The lack of critical thinking and her apathy towards the

disparities shared, illustrated how this participant did not question her autonomous decision making capability as a clinician. As an attempt to improve this concern, Mick suggested that the HCPC portfolio could include a reflection on ethical decision making.

“your health professions council will check your CPD, well that could be anything couldn't it, that could be an hour on a toe-nail cutting, would it not be better for them to say well part of your allotted hours that you have to do each year to keep your health professionals council, a portion of that be on ethics or professionalism or morals, say... would that not be worthwhile?” (Mick – group interview line 1771).

Mick's suggestion to include governance of ethics practice, through the regulator, appears reasonable. It is an interesting dynamic to observe a service user (Mick) proposing this idea as a possible solution to improve ethical practice and it is one of the HCPs who retorts with an obstacle to Mick's proposal.

“Chris: I think that's a good point, but who then sets about what's ethical...

Mick: Well the governing body of your health professions council...

Chris: No what I mean is if you were to be reading something that somebody might judge you, you think you're covering a point that you think's ethical, in the context of your clinical point of view, if you think it's ethically right, and you think it's morally right, but somebody else might say well no, what you're reading there is actually unethical... so, it's how do you legislate...ethics” (Chris and Mick – group interview line 1771).

Pat had stated that HCPs practise with good ethics since they are guided by the standards set by the HCPC and the CSP, she later inferred that her practice may be affected negatively when following guidance.

“we're free to do, to work autonomously and the only limitations placed on us are really a capacity and demand type thing... well I suppose that's unethical in a sense, in terms of patient quality of care that I don't feel we're allowed to give the kind of treatment we want to or the amount of treatment we want to do that's limited in the Trust whereas private practice you can treat someone for as long as you, as long as they want to keep coming... I don't think that's a Trust standard policy but that's definitely we're encouraged to not keep patients going, that's why we have caseload reviews though, to basically breathe down our necks, but I think that's across the board isn't it, everyone's getting like that now. Is that unethical? I don't know” (Pat - line 91).

Pat negatively referred to case load reviews as a method of control that reduces her autonomy with service users stating that “they basically breathe down our necks”. Pat used the term unethical to describe more than one issue that she referred to. She appears to be disaffected when stating that she is prevented from doing what she “wants to give her patients”, because she accepts it as normal. The acceptance of such dilemmas, which challenge ethics in practice, appears to be normalised by the culture of the organisation as evidenced by her stating; “but I think that’s across the board isn’t it I think, everyone’s getting like that now. Is that unethical? I don’t know”. Learned behaviour as such, can be negative and becomes justified i.e. internalised as tacit knowledge from those in the organisation that have rationalised the behaviour and incorporated it into the organisational customs (Cox III et al., 2008).

This enculturation presents a dichotomy and potential issue since Pat previously indicated that there are safeguards against unethical practice, believing that unethical practices could not happen without being picked up. She credited the case load reviews as the method of safeguarding against unethical practice, but later paradoxically referred to the source of her concern for ethics as the case load reviews. Terry alluded to similar issues and emphasised that he did not have the potential to influence change that would remove barriers affecting service user benefit i.e. time as a limited resource.

“... Not here, no. There's no, there's no, it's black and white now mate, it's so stringent now that we don't, we can't do. No, they say that we're supposed to be going that way, but it hasn't changed one bit.” (Terry - line 276).

When referring to patient empowerment he showed disaffection by referring to his employer as “they” and clearly highlights his certainty about the fact that “they say that we're supposed to be going that way, but it hasn't changed one bit”. Liz could not reconcile the disparity between her knowledge, experience and belief that in certain situations she is able to make a difference for a service user, but the resources do not allow this.

“I just document it all and I speak to the boss and I document my reasons why... so it’s in that patient’s notes.

(Michael: what does the documentation serve to prove?)  
...that what I felt was needed, but I didn't have access to it, or I had to refer on because I don't have that authorisation... so then if anyone then says to me why, or say an ulcer deteriorated or something and then we were then having to justify why this ulcer deteriorated, I've shown that I've done everything under my...because that's what's happening to us all at the moment" (Liz - line 510).

Liz demonstrated disconnection from the needs of the service user and re-focused on a litigious or defensive approach to HCE. She stated that documentation of her clinical judgment was the appropriate course of action to evidence limited resources. Different theories of ethics can lead to conflicting conclusions and interpretations of the appropriate course of ethical action which can be manipulated to reach any given conclusion (Meagher, 2011). The struggle with this conflict was evidenced by Mike who deviates from idealism to accepting the actuality of service provision under organisational influence. He highlighted that there is an obligation on the HCP to remain within the boundaries of the employer's guidance on managing service users. He conceded that you would run the risk of not getting paid if you don't conform to the expectations of the employer. He also showed a level of organisational trust in the pathways of care that have been created.

"I think you have to toe the line at times in terms of, you know, there is a pathway often for these patients to go down... I don't think you can, I think if you sign up to be a member of an organisation and get paid by that organisation to do the role they want you to do then you have to be a little bit conforming to what and how they want you to do things or else you run the risk of not being paid and not having a job there anymore, so there is an element of self-preservation in that, definitely." (Mike - line 694).

Earlier in the interview, Mike had made it clear that he could not work where his autonomy to make the best decision is removed.

"do I have the autonomy to make the call? Yeah I do, if I, if that was taken away from me, would I wanna do the job? No." (Mike - line 505).

Ruth illustrated an acceptance of the conflicts and barriers to providing ethical care.

"yeah y-yeh (laughs), I think it's quite common really I think there's a different *ethos* (Ruth emphasised this word verbally) in private practice...I think they probably get a bit more time because they're not under the pressure of the

NHS and your waiting list and things like that and if they need to book more time with a service user then they do and its beneficial for them because they get more money for it and I think that because the patient is paying they may be listening more to what the patient wants rather than what the patient actually needs potentially, so if the patient wanted to come even though they feel 100% better they'd say yeah that's fine, maybe not every private practice, but probably most . There is more of an emphasis on doing things a bit quicker in the NHS I think getting people through.” (Ruth - line 139)

Concernedly Ruth appeared to be apathetic to both issues raised i.e. that “probably most” private sector physiotherapists may over treat patients and have financial gain as a motivation and that NHS staff have an emphasis on “getting people through”. Fran demonstrated a similar response related to potential barriers to providing ethical standards. Although she had not been able to articulate any concerns about the lack of resources available in the NHS, she recognised that the transition from training to practising is “completely” different, thereby suggesting that the training of physiotherapy may hold ideals that are not kept in practice.

“Hmmmmmmm (laughs) it's COMPLETELY different from when you're actually training... and learn. The biggest thing is sometimes you cannot, you're learning that you cannot treat everybody...” (Fran – line 514).

## 10.2 Disempowered/Disenfranchised

Budgetary pressures in health care delivery has caused an inherent change in values and threatens motivation to deliver quality health care as providers become increasingly disenfranchised with the system (Balch, 1998). These issues are inherent in health care organisations, but despite the awareness and efforts undertaken by HCPs and health care organisations the conflict between clinical and organisational ethics remains a key barrier to the delivery of a quality service (Cooper et al., 2004).

### 10.2.1 Disenfranchised within consequentialistic or Utilitarian ethics

Liz explained her view of ethics which appeared through a defensive and legalistic lens and that she worried more about her own culpability related to the ‘blame culture’ rather than having a primary concern for service users.

“I used to think more about the patient, but in the last 12 months, we're all just worried about ourselves now because so many of us are being brought in, or not being sued but our own Trust, where they're questioning every time an ulcer develops to a 3 or 4 grade 4, we now have to explain why...what could you have done to prevent it... and now it's all about us, and we just write pages and pages of notes now (pronounced with a laboured emphasis) just to cover ourselves and that's unfortunately how it's gone in our Trust. But unfortunately we are more worried about ourselves than the patient at the moment, we've all said that in our Trust” (Liz – line 624).

Liz articulated clear concerns about culpability, illustrating her disaffection and disconnection to a person-centred focus of care. Objectively one might consider the Trust that Liz works in to be proactively encouraging responsible accountability with their procedure of responding to serious incidents in patient care. However, the staff feel that this is a ‘blame game’ and enter a consequentialistic and defensive view of care. Liz continued to speak about her frustrations with the blurring of role responsibility and the anguish that she and her colleagues feel at present. It was linked with the onset of Any Qualified Provider (AQP) and privatisation through commissioning. She was asked if she believes the patient is the focus of care in the AQP process.

“Not any more... No... it's all about the money!” (Liz – line 729).

In the following exchange from the group interview there are two HCPs who described how consequentialism governs decision making. They discussed the term informed consent and service user empowerment and contextualised this in a litigious society of defensive practice rather than person-centred care.

John: I'm gonna suggest a darker side to this I'm afraid, I think that informed consent is one method by which the clinicians cover their back and this is a very litigious (sic) society...and taking your point Chris, if a patient disagrees with you, you will spend time discussing it and yes you want to bring 'em on board but to be honest it's because in a court of law you want to be able to prove that you have done that patient no harm.

Chris: And that's why managers will advise you, I mean, again going back to the Trust I've just been working for, they've said as long as I've covered myself...it's not so much making sure you've done the best for the patients as long as you've covered yourself...

John: Yeah. And to be fair that means that you then survive and you can treat another hundred patients this month and...



Chris: But that's not why you got into health care necessarily is it." (Various - group interview line 642).

Person-centred care and shared decision making ought to move beyond the legalistic obligation of consent, which does not necessarily seek to ensure comprehension of treatment goals and options (Matthias et al., 2013). The group participants appeared to accept that consent was being adopted superficially for legalistic reasons, since no one offered any opposition to the opinions shared. Although Chris claimed that this is not the reason people become HCPs, John demonstrated apathy and lack of empathy towards service users' needs by being accepting of the consequentialistic and particularly defensive practice. John also shows how he redresses his cognitive dissonance by justifying the utilitarian approach with the statement that "at least you survive and are able to see another 100 patients this month". Cognitive dissonance is a theory that provides an explanation for the resolution of disjunction between knowledge, beliefs and behaviours and attempts to maintain coherence or consonance in them (Clark, McCann, Rowe & Lazenbatt, 2004). Here one seeks reflective equilibrium, whereby one draws from both moral and non-moral sources to furnish arguments in favour of particular choices rather than making absolute moral demands (Cushman & Young, 2009). Dannie adopted a utilitarian ethical approach that seemed void of sympathy and may be utilised to restore either cognitive consonance or reflective equilibrium.

"you get 20 minutes and in that 20 minutes you have to assess, treat and again we have a lot of challenging patients and it's not enough time.  
...(Michael: if you believe it necessary to have more time is there anything you, as an individual could do to change that?)....  
...Yes, I wouldn't need to go to my manager either, I'd just make that decision but whatever extra time you give to somebody takes it away from somebody else so it's... I need to give time to people who are ... who want to be there and are compliant rather than giving extra time to people who are not.  
...(Michael : So this requires judgment on your part)...  
...it does." (Dannie - line 242)

Dannie justified her action with a utilitarian lens that requires judgment. The judgment appeared to be concerned with achieving better outcomes from the motivated service users rather than helping remove the obstacle or barrier from those who are less motivated. Dannie suggested that the less motivated patients are themselves the biggest barrier. She did not demonstrate empathy which may be

described as the capacity to participate vicariously and understand the experience and emotions of others (Ouzouni & Nakakis, 2012) or the ability to understand the patient's inner experiences and perspective and to communicate this understanding (Kliszcz et al., 2006). Dannie showed disconnection and disaffection from those in most need of extra motivation and extra time. In the group interview Becky demonstrated a similar attitude towards less motivated service users.

“back to Chris's point about, some people you do your best, you do everything you explain things, try and get informed consent, but some people just don't want to be helped and that is the minority, but sometimes you have to almost be resigned to the fact I think, and that kinda comes with experience... eventually I came to the conclusion unfortunately that sometimes you just have to stop and there's priorities and other people that need seeing and who maybe would be involved in their care more.” (Becky – line 628).

Diverting the limited resources to those who want to be helped is a judgment that Becky believes comes with experience. Neither Becky nor Dannie alluded to how one acquires the skill to judge and know who does or does not “want to be helped”. This important question is an ethical issue and one which requires deep consideration in the HCP role. So many care giving relationships are asymmetrical for which moral theorists focus a commitment to the vital significance of empathy as a crucial antidote to emotionally disengaged judgment (Carse, 2005). The findings of this research indicate that physiotherapists and podiatrists have received no training of a skill base that would empower them to be in a position to judge the complexity of such a decision making process whilst guarding against apathy or incorrect judgment. The organisation itself may adopt policies within health care provision which disempower the HCP from decision making. Some NHS policies, based on choice, are considered to communicate what might be unavailable to people and even less popular, inaccessible (Whiteman, 2013). Exploring how service user choice is compromised, Pete explained how he reconciles this from a management perspective by marketing the service differently.

“patients want something that we can't deliver and that might be on-going as acupuncture... it helps the pain. We can't deliver that, that's perhaps an ethical decision and I think what we have to do then is to decide as a service what do we publicise ourselves as? and we publicise ourselves as a rehabilitation service not a pain relief service.” (Pete - line 158).

Pete felt that successful marketing and communication, achieved and permits what amounts to the re-definition of service provision. The move towards person-centred service provision is designed to counter this culture of a monolithic institutional delivery of a one-size-fits-all to cater for groups or populations that fit around the organisations resources, rather than being responsive to individual requirements (Owens, 2015). Pete's acceptance of resource limitations and hence redefining what services will be provided, illustrated disaffection from desiring to offer a skill based profession to meet service user needs. There is evidence that ethical concerns related to cost containment, efficiency savings and resource allocation will challenge HCPs, however it is crucial that they work constructively with all stakeholders to maximise service user interests, rather than acceding to financial constraints alone (Devlin & Magill, 2006). The Mid-Stafford enquiry created 290 recommendations designed to change the culture of putting corporate self-interest and cost control ahead of patients in order to avoid the failings which found a lack of care, compassion, humanity and leadership (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). Pete dispassionately referred to being confident about decisions when complaints arise. This presumed that complaints will arise because the service is not meeting the demand or needs of the service users.

“one of my jobs as the manager is to help the staff be confident that I will support them...when the complaint arises. Similarly you now give them the skills through training or whatever to be able to (pause) guide patients and communicate with patients so that doesn't become a complaint and patients can understand why we're doing what we're doing...” (Pete – line 172).

The training that is offered to staff is targeted towards acquiring communication skills as a prevention tool to guide service users away from the issue becoming a complaint. This illustrates a lack of empathy of what a service user may actually need or want. It demonstrates a level of organisational and cultural acceptance to the point of blindness to what the vocation of the profession seeks to achieve. This is a contentious point amongst other members of the profession who look at these issues as damaging and consider this as a source of future skill base loss (Discussed by John in the group interview and James in the individual interviews). These egregious failings in the quality and safety of individual HCPs can go undetected and uncorrected due to the organisational degradation which become

systemic, institutional and cultural in character (Cox III et al., 2008; Dixon-Woods et al., 2014).

Considering the influence of policies, frameworks and criteria based care, Mark had previously discussed "ethically blind or non-ethical thinkers" (Chapter 8, Theme 3). In the following extract, he explained how organisational guidelines or frameworks could contribute to being a barrier for ethical practice.

"the big barrier is...by the organisation dealing with the, in effect the symptoms of ethics rather than those very simple clear headline... by the fact they don't see those simple headlines and be able to sort of work through those... they're getting it through policies and frameworks and I think the problem there is they're just getting too much of that so rather than...taking the simple headline news and working out what should happen there they're just getting the frameworks and there's too many of them... so you may be getting twenty policies sent through, they're not going to read them." (Mark - line 57).

Mark asserted that policy makers create too many policies thereby making them unreadable. He made the point that policies/frameworks being created to appease headline or superficial understanding of needs are therefore "a symptom of ethics" and thereby create a barrier to good ethics. He offered an example of this which he has recently experienced in practice where a policy exists, but the policy cannot be adhered to for a simple practical obstruction. He explained how this creates a barrier for individuals to act as decision makers as a consequence of policy or framework guidelines governing the process.

"I think there definitely is and in fact I think I was just about to quote an example we had this week... it's all to do with blades, and what we do with our blades. So we've now got European legislation to say how the blades are meant to be disposed of, it's very clear indeed and we now have these special click-safe disposers so it's a good way of getting rid of the blade without any personal risk whatsoever. So what I picked up on this week was a cleaner became very close to cutting themselves, and didn't fortunately, in one of the clinics. Why? Because there was a pile of blades left on a paper-towel in the window-bottom she was cleaning. Why has this happened? Because there wasn't a safe disposal blade thing in that room. So, "oh I know what I was meant to do but there wasn't one in the room", so it almost stops them thinking for themselves. These frameworks are in place and I think it's stopping people thinking." (Mark - line 96).

Mark's example illustrated a mechanism of how an employee can be disempowered and possibly disengaged from autonomous thinking. Eriksson et al. (2008), discusses this in context of ethics legislation. They conclude that replacing ethical documentation with legal counterparts would deprive the HCPs of reasonable chance to assume responsibility for their actions and thus turn health care into a bureaucratic nightmare. Discretionary judgment in these circumstances is discouraged. Discretionary judgment is not the product of explicit knowledge and cannot be delegated based on explicit criteria, but will emerge from the activities of tacitly defined practices (Cox III et al., 2008). Organisational policies and excessive use of procedures can restrict individual decision making and reduce the subtle nuances that the HCP may draw from in the tacit knowledge that informs their practice (Kontos & Naglie, 2009). Mark affirmed this concept in light of the misapplication of EBP.

“there's a paper come out in, I think it was in America and they've looked at various different approaches of clinicians to evidence based practice and everything from those who just embrace it willy-nilly all the way through to those who reject it because this doesn't work in my practice and then those who will balance the things together, they'll use evidence-based practice appropriately and their own intuition and experience appropriately as well. But you need the knowledge, you need the experience to be able to do that...So it's not about using the evidence blindly, it's about using the evidence intelligently” (Mark - Line 144)

Mark's explanation of how he views evidence based practice is clear "it is not about using the evidence blindly, it's about using the evidence intelligently". He made a reference to 'intuition' which is recognised to be a mode of informing clinical judgment, but reached with little apparent effort and typically without conscious awareness or deliberation, a process that expands and increases with experience (Pretz & Folse, 2011). Pretz and Folse (2011), state that intuition is expected to be most appropriate for highly complex tasks including ethical dilemmas and predictions based on inadequate or ambiguous data as was the case in Mark's argument. Moral behaviour must not merely be defined by prescribed codes of ethics, but may benefit from the intuited action of the individual HCP, determined by their background and situational experience (McLeod-Sordjan, 2014).

## 10.2.2 Organisational influences creating ethical challenges

Poor organisational systems can leave HCPs struggling to deliver care effectively and disempower them from initiating improvement (Dixon-Woods et al., 2014). In the face of public policy disincentives and bureaucratic challenges, health care providers have to be morally sensitive to ethical dilemmas and learn how to make professionally grounded decisions, with all stakeholders, to fulfil ethical values (Millstone, 2014). This requires awareness and the ability to apply ethics in practice. One must first of all recognise the influences that limit decision making and subsequently adopt personal responsibility to check the professional standards of proficiencies in balance with the bureaucratic challenges of the employing institution. When asked about this challenge Chris separated ethics (personal belief) and HCE (soundly judged decision making).

“that comes down to your HCE (pause) you’re not going to do an inappropriate treatment for someone if there’s no sound basis for it. But for me ethics is, comes down to sort of a personal belief. And if we talk about HCE I think HCE sort of throws in, are we doing what’s best for a person based on a health need.” (Chris – line 1221).

This contradicted an example of practice, which he shared, where the local service may not allow orthoses to be given to a service user irrespective of whether the HCP believed they are needed.

“There would be, there could be a difference in decision making in as far as it’ll depend if the NHS offers that service for example. If for example the NHS stops offering podiatry insole treatment, and somebody turned up and asked for insoles you couldn’t just give them because you don’t offer the service...even if you think they needed it”. (Chris – line 1118).

This illustrated the disconnection Chris had between what is believed to be ethics and what is embodied in practice. He is influenced by the organisation, its culture and the subsequent accepted norms which are bound up in what constitutes minimum standards, role description and professional expectations. He shared an example of how a service user may require an MRI, but since he is restricted from referring for one there is little he can do about it. He then contextualised the

discussion as going “over and above” rather than advocacy where the clinical need dictated it.

“should you go over and above for every patient... But the term over and above would imply that it is more than a duty of care it’s doing that extra mile and when you have - when you do the extra mile are you going beyond your scope of practice depending what you're doing it for..” (Chris – line 2664).

Chris justified his apathy which assuaged any cognitive dissonance he experiences claiming that he fulfils his duty of care without going “over and above” accepting the restrictions his role places on him. Chris considers pathways, guidelines and minimum standards as the underpinning factors defining his professional role and did not demonstrate autonomy towards ethical decision making. This is an example where the authority granted to professionals creates the potential for abuse through either a fastidious application of policy or due to a lack of virtue in applying discretion when being guided by policies or frameworks (Meagher, 2011). It may be difficult, but sometimes a decision to act outside of the routine may be necessary or even vital (Cox III et al., 2008). In a similar way to Chris, Lucy shared her experience of how service users are restricted by funding and described how the resource problems can be demoralising.

“I’ve been highlighting the fact that the waiting list is like two months to see this person and if someone comes in with raging foot pain they don’t want to wait two months to get a pair of orthotics... she is one podiatrist on her own and she doesn’t get involved in anything so it’s a bit demoralising, so I’ve highlighted that and it’s been ignored and ignored until we got KPIs to meet and we’re not meeting it with her and not seeing them in time so then that’s eventually when they’ve said can you now do something about it” (Lucy – line 571).

Lucy used language about her management in the third person demonstrating disaffection towards her organisation when related to her beliefs and ethical principles. She also indicated that the KPIs (targets) not being met is the catalyst for management to consider a resolution to her concerns. Failures in Mid-Staffordshire were found in part to be a consequence of focusing on targets and achieving financial balance at the cost of not delivering acceptable standards of care (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). Lucy indicated how the need of the service users was ignored until it affected the KPIs, which may contribute

to the disenfranchisement of the HCPs who acknowledge this frustration. Fran highlighted differences and apparent inequalities in service provision and, similar to Lucy, she placed this outside of her own responsibility and directs the blame towards management.

“well I suppose it’s the Directors and those people that decide what this area should do” (Fran - line 381).

Pat also demonstrated frustrations about lack of patient care and highlighted that this is due to her employer applying pressure related to waiting lists.

“there's patients that are discharged that I'd like to have kept on, but maybe have them come back every few months, but I don't, they wouldn't really promote that kind of treatment here, they want you to really get them seen and out, whereas I'd like to have maybe kept an eye on a patient just to really sort of help keep motivating them especially in rheumatology where they're in a lot of chronic pain so some of them need that bit of support, a bit more support and I don't feel like we're quite able to give that, as I would like. (Michael: what informs the clinical decision making to discharge these patients?)  
...it's really the pressures of the waiting lists and getting your patients seen and out.” (Pat - line 137).

Despite the issue raised in this extract, Pat did not recognise any ethical concerns.

“I do think it can be quite restrictive the way we work... I can understand the politics behind a lot of it, that it can't be helped... I don't think that those patients are suffering as a result, they may be getting well, quality of care isn't as good, I think that there's a lot of over worked physio's, particularly in young juniors that come in who are just crammed with new patients and you often probably feel for some of their patients, I think that's where a lot of complaints come from, those patients who don't feel like they've been given the quality of care, they've been discharged and then I might see a patient the second time around and they'll say things like, well I wasn't told this before, or no one told me this, and you think well you were probably seen by a junior who had about a hundred to see that day and they're working like mad and yeah, there isn't all that support, well there is support systems there but, yeah, that's again that's pressures, I think that's across the board though in't it.” (Pat - line 373).

Throughout her interview, Pat offered no experiences that she considered to be an ethical concern. In this exchange she highlighted some restrictions in service user care, but immediately condoned it and demonstrated more sympathy to the service



than empathy with the service user. She referred to service user complaints, which seem prevalent and suspected that they may arise as a consequence of not having enough time and not getting what was expected from the service. She demonstrated her acceptance of this by saying she understands the "politics behind a lot of it and it can't be helped" adding the implication that it is a widely accepted problem. The lack of empathy and disaffection from service user focussed care seems to be related to 'organisational influence'. The examples given here may be contextualised in arguments of distributive justice, which claim to justify a conclusion to the 'standard-of-care problem' solely by appeal to their professional obligations (Mackay, 2014). Conversely this may be a method to mitigate what could be an acknowledgment that she is powerless or disenfranchised from doing anything different within the organisation. This may also be evidenced in Alex's statement below, related to various barriers to good practice that she claimed is due to a lack of understanding by commissioners.

"I think you go with what you've got don't you" (Alex - line 848).

Pete had a similar attitude to Pat showing a lack of empathy for the needs of the service user and more commitment to the management of health service resources.

"we don't want to get stuck in the habit of managing pain conditions we want to rehab people and send them away to self-manage if they have got a long term condition." (Pete - line 890).

Accordant with Pat, Alex and Pete's actions, Dannie also explained how the service user is informed in advance about what is available to them as a *fait accompli*.

"it's very important to me on my first session that the person in front of me knows exactly what's gonna be involved in...we send them away to think about it...Should they choose to come back, they should be fully informed and ready for it...Not everyone comes back" (Dannie – line 323).

Dannie's paternalistic approach was discussed in Chapter 9, Theme 4. The conversation then developed to expose Dannie's lack of insight in the disparity of her practice across the public and private sectors.

“Yeah. That’s not really an option, I’m sorry [laughs]. I’ve had a bit of a conversation with somebody recently about that actually. Just again, particularly with people who have seen private physio’s in the past...and they’re very used to the process I guess, they go in, they pay for their treatment and they get touched for half-an-hour and they have as many sessions as they want and they feel that that’s something that is available on the NHS. And it’s not...”

“I don’t treat my private patients any different to how I treat my NHS patients, basically. Apart from it’s probably, if I’ve got somebody coming privately it’s more directed by them. If they do come in and they say I want x, y and z then that’s what I give them because that’s, part of I guess somebody coming in and having an expectation and giving you some money to do what they want you to do but from the outset my treatment doesn’t change, I give them the same advice, they get the same information about exercise and how long its gonna take and what they should be doing and what I will be doing but again we have more luxury in the private side of it for them to come as many times as they want to then it’s different but, I think as a good physio your treatment should be the same whether you’re private or NHS.” (Dannie - line 416).

Dannie showed no awareness that she contradicted herself fundamentally in claiming that she (as a “good physio”) does not treat service users any differently irrespective of which sector they attend, but then clearly indicated a key difference in the service user having choices in one sector compared to the other. This appears to be cultural rhetoric that may pervade the NHS and is shown to have an impact on Dannie’s attitude towards service user choices. Shared basic assumptions, norms, values and repeated behaviours of groups, allow new members to be socialised into the same philosophies to an extent to which culture becomes the way things are done (Dixon-Woods et al., 2014). This is something which Francis (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) concluded as insidious negative culture involving a tolerance of poor standards and a disengagement from responsibilities. With respect to accessing treatment and the number of sessions allocated, Cal recognised differences between the NHS and private practice.

“yeah, you know - a lot! Yeah. In the private practice yeah, definitely heard people having supervisions and having meetings to say you’re not seeing people long enough... you’ve only seen them a couple of times and getting rid of them. But at the end of the day you’re self-employed, you make the decisions that you think are appropriate. Some private practitioners might not like it, but it’s not like that where I work so I don’t have to particularly worry about that (laughs)” (Cal - line 582).

It is unclear what Cal meant by stating “you make the decisions that you think are appropriate when you are self-employed”. This statement remained ambiguous and may relate to booking return appointments when deemed unnecessary. Cal accepts the differences between the two sectors and indicated that it causes uneasiness for some colleagues, but personally showed no concern for the profession with respect to any implied lack of integrity. Comparably, Liz highlighted concerns related to the ethics of how fiscal measures appear to be altering the boundaries of service provision in order to retain budget levels, but she continues to practice under the guidelines that dictate this.

“...Now because of money...if you’re a diabetic and as of six months ago you would’ve been a low-risk diabetic you’ve suddenly now become an increased risk diabetic so that we can keep them in our budget. [Laughs]...so it is money is changing it.” (Liz - lines 803, 817 and 870).

Connor identified service limitations, but refused to acknowledge that it causes restriction on his autonomous decision making.

“So I wouldn't say we're strangled in that point of view of being kind of dogmatic and pushed down certain valleys without considering what's going on and as I said before with that Start-Back Tool, that's kind of based heavily on research so the only thing that you are kind of, could be strangled on is they like to say that if you should be seeing a patient for around about three sessions and then you either, you should be figuring out whether they're going to a class, whether they need to self-manage or whether they need more sessions with you but they don't obviously encourage more sessions with you they should be going to somewhere that they can be either self-managed or whether they need a class basically so that's quite- 'cos getting down to that point within three sessions is not a lot, considering your first one's an assessment - so that's quite tight.” (Connor - line 386).

This exchange illustrated how the organisational procedures and philosophies influence Connor to accept resource limitations. There was contradiction evident in his belief that it does not restrict his decision making, yet he revealed that three sessions, which includes the assessment, is “quite tight”. He attributed this restriction to an amorphous third person, disassociating it from his own decision making. This illustrated a lack of clinical autonomy since there seems to be little consideration to his professional assessment and any optionality with respect to the pathway that he described. This is an example of practice that is more akin to

techné which is an application of blind deployment of criteria based care as opposed to phronesis which offers concern following the 'being' (or dasein) itself and reflecting one's practice on the individual needs of the service user (Landes, 2015). Fran also illustrated how the organisation has influenced her consideration of service user empowerment and decision making in the treatment planning process.

"we try not to over treat people we try to encourage them to participate in their own treatment planning which is a big thing," (Fran - line 561).

Similar to Connor, Fran is influenced by the paternalistic culture of the organisation to the extent that she did not recognise the contradictions that exist and how they may be overcome. She spoke of service users being involved in their own treatment planning as a "big thing", but Fran's notion of service user involvement was about being able to self-manage their condition rather than having choices in a treatment plan. She reflects on the fact that this new trend highlighted, that in the past she may have "over treated" service users. A further example of the organisation influencing what is considered acceptable in practice was given by Luke who maintained that there are no barriers influencing his clinical decision making.

"(Michael: Do you ever have to refuse to treat patients because they do not meet the criteria set by the Trust you work for?)...

... yeah, yeah quite often, there's patients coming in literally who they've got no medical history, they're not taking any complex medications yet the simple fact is they can't reach their feet, they can't attend to their own foot care, that alone does not warrant treatment on the NHS...

(Michael: So in that situation a patient can't physically do it...is that fair?)

... I think it is fair because I think... we're an aging population so there's already a strain on the NHS and the amount o' patients that we actually have to treat...and there's a lot o' patients who are waiting long times for treatments who are of a higher risk...and for me, it would be those type o' patients that would require our services more than someone who physically just couldn't reach their feet... then no I wouldn't say that was unfair." (Luke - line 118).

Luke saw no barriers or lack of fairness in the example he gave. Within the auspices of utilitarian ethics and distributive justice Luke lacked recognition of any moral aspects related to the limited service provision. A lack of recognition of moral aspects disengages individuals from ethical decision making (Street et al., 2001) which is evidenced by Luke, pertinaciously claiming that refusal to treat people based on NHS criteria is not unfair. This may represent an example of how cognitive

dissonance requires abatement resulting in the recognition of a short fall in service provision being accepted as fair. This for Luke may manifest through a utilitarian approach to his ethics, where there are inevitably more who seek help than can be served (Cox III et al., 2008). This has the potential to obscure an empathic view of the person's needs based on adherence to the criteria and the culture that surrounds it. Whilst conflicting and competing values must be balanced in organisational ethics, an outcome is only fair if procedural justice is sought by the decision makers taking account of the perceptions and values of those affected by the decision (Nelson, 2005). The reduced standard of care cannot be justified as determinate and reasonable, simply by appeal to professional obligations (Mackay, 2014).

With respect to person-centred care and the ability to maintain this philosophy in her practice, Sarah described this concept in the context of a "massive" push from the co-creating health agenda in her organisation.

"I try, and it's hard, it's been a massive push over the last, I'd say at least the last two years... we've had something, co-creating health, agenda for change, ...because GP commissioning at the minute is massive for us and we want to have jobs at the end of the day so you have to, there's a fine balance between making sure that you've still got a job as well as providing." (Sarah - line 520).

Sarah recounted the conflict in ensuring that the service provision also meets the demands of the commissioners in order to ensure job security. Contradictorily to the philosophy of person-centred care, she gave no reference to the service users' best interest in her focus of care, but rather the struggles of meeting the demands of a top down influence on provision. This is an example of multiple competing pressures which contribute to fragmentation, ambiguity and diffusion of responsibility, which weakens the clear valued goals to achieve the aspiration of best care (Dixon-Woods et al., 2014). Joan sought clarification about the 'valued goals' contributing to best care and suggested that HCE appear to be reliant on the individuals rather than any professional regulation.

"Joan: Can I just say, from your personal perspectives then, is ethics a personal thing rather than something that's set down.

All: [Laughs].

Becky: I mean it probably is for me, because that's what has driven me to this position in my life and becoming a physio I could've done anything else where

I maybe wouldn't have to have bothered so much about ethics [laughs]

Joan: Can I then say, is that good enough?

Mark: yeah again picking up the personal thing, yes... and again it is a personal thing, but I think what you then do is apply your person ethics again in context and so, what aspects your personal ethics apply depends on your working situation.

Dave: And just going back to what Joan said, is that good enough, about your personal ethics, but actually when I worked in the health service what drove me to most conflict with my managers would be trying to do things that I thought were right for the patient.

All: [Laughs].” (various - group interview line 983)

The group participants acknowledged the importance of Joan's question. Dave added a concerning point by indicating how trying to implement one's own ethical conviction can create conflict with management. Virtue ethics offers goals to aspire to, but also makes demands on the individual to perhaps stand up for the unpopular position whether or not the individual desires this (Annas, 2015). This was echoed in several individual interviews (Lucy, Liz, Mary and others) who acknowledged that challenging issues with management fails to gain any effective resolution. This may be contributing to a disenfranchised attitude and could be related to organisational influence affecting the motivation of individual HCPs. Clinicians and service users are ethically fraught by the challenge in the relationship experienced between the health care institution and themselves (Meagher, 2011). The findings from this research indicated that this could be a source of disenfranchisement for NHS staff.

Virtue ethics may provide the character traits that make collective action possible and successful in redressing health inequalities within organisations (Meagher, 2011). Whilst discussing the conflicts arising in the NHS, the group interview illustrated how cultural acceptance of the barriers affecting HCPs' ethical decision making, may be manifested.

“Chris: It'll depend on the team around you as well. 'Cos if, if you stand on your own then you, you stand quietly really.

Mick: I went to my GP not so long ago with two issues. I told him my first issue, he was writing up his notes and as I started to tell him my second issue while I was there he said hang on, we've not got much time. And I thought, what are we on the clock, I'm here to give you my problem and it, to be replied with we've not got much time I thought well is that right?

Chris: You do, as a professional...and you're seeing one patient and they just say could you just have a look at this person while you're there and...

Mick: Oh yeah, I can understand the 'while you're here syndrome'...oh while you're here can you just do that but I've took time out of my...I've took time off work in the morning, afternoon, finished work to go there with two issues to my general practitioner who, who then responds...

Chris: You're not allowed two problems [laughs].

Mick: ...I later find I'm only allowed one ailment [laughs].

Dave: I mean, to my personal ethics, I would say that was unethical.

Becky: It's rude isn't it.

John : There's a few jobsworths...aren't there...but it's very financially driven and, you know, a, course of treatment costs so much and if the patient says oh but could you also look at something else, then I think, well you think well hang on a minute, that's double...

Dave: It's bureaucracy in't it.

John: Bureaucracy gone mad. (various - group interview line 1037)

Two HCPs in the group discussion above referred to the HCP in the service user's example as "rude" and a "jobsworth", another HCP stated that he believes this to be unethical, but two of the HCPs offered a defence to the issue presented. One empathised more with the GP than the service user and another ratified the behaviour on the grounds of financial pressures. The conclusions of the exchange attributed this potentially unethical behaviour as bureaucracy rather than individual responsibility. Organisations need to focus on developing cultures that are person-centred not just task focused in order to avoid problems of quality provision in health care systems (Dixon-Woods et al., 2014). John shared concerns about the culture of the work ethos affecting the integrity of his profession.

John: "...but what I'm concerned about for the new clinicians is that they might just think well this is normal, that I will only see, I mean it kills me as a clinician to think that my students will see a patient once a week or once a fortnight and give 'em advice and exercises and that's acceptable, but I think they think that's normal, they might in their heart-of-hearts wonder whether that's acceptable or whether it's clinically correct but because it's acceptable and normal they don't challenge it. And that's why I think physio as a profession'll die in the next five or ten years, because we're not doing what we were developed and asked to do." (John line - 1317)

John was concerned that the new generation of professionals may consider a minimalistic service as a norm (by custom and practice). This supports a previous discussion, initiated by Alex, relating how ethics is learned vicariously through the experience of others and thereby creating a potential to learn 'poor ethics'.

Health care organisations should be aiming to enable their services to be patient-oriented and thus allow the service providers to be able to do this without conflict (Winkler & Gruen, 2005). In order to achieve this, Winkler and Gruen (2005), recognise the importance of shared decision making being founded on shared understanding of each other's values and clinical ethics especially autonomy and beneficence. Shared decision making has been advocated due to its respect of personhood and should be consistent with patient values and also because it may have a positive impact on health outcomes (Murray et al., 2007). It is, however, a complex intervention and its implementation in health care will need multifaceted strategies coupled with culture change among HCPs, their organisations and patients (Stiggelbout et al., 2012).

Health care providers (at all levels) are being forced to face difficult choices between person-centred care versus budgetary pressures causing them to re-evaluate the nature of their own values (Hurwitz & Richardson, 1997). The budgetary pressures have caused confusion in the mind of the consumer and loss of autonomy for the HCP (Balch, 1998). Although there may be bureaucratic challenges to face, health care organisations can and should empower their employees to become self-actualising in a responsible and ethical climate which engenders a reciprocal accountability in the organisation (Winkler & Gruen, 2005). For ethics processes to be working effectively they need to be able to address issues beyond clinical questions and have the capacity to address questions about resource allocation, organisational strategy and community mission (Nelson & Donnellan, 2009). Maben et al. (2012), found that there was a large variation in the quality of patient care between 8 different areas of the organisation, but also between individual staff within each area. They suggest that this may be due to individual factors such as level of skill, experience, tenure and temporality. Temporality in ethical decision making may therefore be influenced by the organisation or moderated and reconciled through the conscience of the individual practitioner. A Heideggerian and Gadamerian attitude may reconsider the service user through temporality and dialogical pronesis.

The duty of moral self-knowledge implicitly involves seeking moral perfection (O'Hagan, 2009). If the philosophy of the HCP is to adhere to minimum standards or pathways of care, then clinical judgment and HCE may be restricted. The task of



'knowing' requires the HCP to consider, reject and apply appropriate data using skills which are not well recognised or understood, but may be enriched or improved (Hunter, 1989). More systematic research investigating the impact of organisational environments on patient care and professional practice may generate evidence that supports the development of ethical health care environments (Carpenter, 2010).

### 10.2.3 Passivity towards moral agency

The understanding of what ethics means in health care was illustrated through the participants 101 descriptive notions extracted from the data. This demonstrated what is understood as HCE and was intertwined with the perception and experience of the contexts of the HCPs (McConnell-Henry et al., 2009). The findings demonstrated consistency with a belief that ethics is good and that people desire characteristics to achieve ethical practice. When challenged about their ethical practices, however, few participants took ownership of their actions.

Moral agency and any subsequent action are potentially evoked by personal moral dilemmas, but top-down influences may have an effect on what is recognised as 'dilemma' (Levy, 2009). This may influence the recognition of the need (or not) for individual action. A further complicating factor is the level of cognitive expenditure required by the moral agent which in turn may influence the recognition of an issue as moral or non-moral (Street et al., 2001). Lucy shared various examples of service provision that she considered being unethical with the following judgments (reported in Chapter 8, Theme 3): "it's unethical", "it's wrong", "it's horrible", "it's not right", "I don't agree", "I struggle with". Professional and clinical autonomy may be understood as the persons capacity to judge, decide and act on the basis of their own attitudes and reasoning (Blöser; Schöpf & Willaschek, 2010). Moral agency arises from the HCP working with service users and others while maintaining their knowledge, motivation and courage to act autonomously which requires a strong sense of self-awareness and the ability to be critically self-reflective (Delany et al., 2010a). Lucy commented on the limited influence she may have on decision making issues.

“Well we, in our meetings we don’t agree with it so we tell our boss which then he meets with the commissioners every so often, so him and the directorate manager go to these meetings, but if the commissioners have decided, no sorry that isn’t happening they’re paying for our service so there’s only so much you can say...” (Lucy – line 1326).

Lucy shared concerns about commissioning issues that appeared to disempower her and cause her to be disaffected. One of the functions of moral judgment is to guide practical reasoning where it is necessary to choose between competing moral judgments, but such adjudication is more difficult when deontological and consequentialistic mechanisms make opposing moral demands (Cushman & Young, 2009). These opposing demands in Lucy’s example are the duty or professionally bound restrictions that the commissioning creates, but conversely results in service users facing unfavourable consequences. Burnout is a concept that arises when a worker in an organisation experiences conflict between their perceived professional expectations and the ‘work rules’ which may result in a problem of diminished capacity to have the will to act (Cox III et al., 2008). Burnout or avoidance of it may result in passivity arising from cognitive dissonance. This may be seen in Lucy’s example, illustrated by her acceptance of what the commissioners dictate, and may also be understood as an agentic shift diffusing or displacing responsibility to those in authority (Jackson et al., 2013). This was also seen in Pat’s response to the question of how she experiences the opportunities to influence change with respect to the moral issues that she highlighted.

“Hmmm, I can only help sort of my... the people who I supervise... and I’ll do a lot of joint assessments, watched assessments, case reviews and I just try and support ‘em best I can to make sure that patients are not being discharged without all bases being covered, I do think some are discharged prematurely and actually it was something that could’ve been treated and actually there’s a lot we can do but again that is just less experienced physio’s maybe and the pressures that they’re under.” (Pat – line 405)

Her answer demonstrated disconnection with any notion of proactively seeking change, but shows passivity towards these issues. She indicated that people are being discharged that should still be receiving treatment. She pointed out that the pressure to do this is on less experienced physiotherapists. When asked if there was anything she could do to improve the service rather than just supporting junior physiotherapists, she replied, "I don’t think there’s much I can influence up, - no

(laughs)." This statement illustrated her feelings of being disempowered from action and how she is disenfranchised in her role, which could potentially lead to passivity. Without the virtue of acknowledged dependence, then some features of individual autonomy and independent rational agency may be obscured (MacIntyre, 1999). Fran and Connor also comment on a lack of personal accountability to effect change.

"I don't, well (sighs), over the years, I have mentioned these things but nothing's ever changed.... I, me as an individual in the position I am in now, my influence and change, I could suggest, I would say...but how that's actually perceived or received on the other side...and pretty much, sorry but that's how it is! That, I suppose has been my response, you know the answer, so I (sighs) I don't know. I don't know how influential I really am in my little world on my own (laughs)." (Fran – line 484).

"I think this is where we are at the moment, kind of with cost savings that everyone's having to make, basically trying to be as efficient as possible that's why I think I would assume that a lot of places are coming under that kind of threat if they haven't already been doing it for however long now... (Michael: do you think this is the same in private practice?). ... er, I work privately... so that's a whole different world I would say, so that's more about the patient experience...in a private fashion... I think it's a kind of a strongly held perspective that's been around for a long time that you know if you go privately you get better care." (Connor – line 453).

Both Fran and Connor revealed a disaffected attitude towards their accountability in the concerns they shared about service provision. Connor has experience in both sectors and recognises the difference in quality of care, but concluded with passive acceptance of what he (reluctantly) acknowledged as widespread cost savings that might restrict his therapy in the NHS. Cal disclosed similar passivity in her acceptance of the barriers to ethical health care.

"well yeah, there's stuff like that all the time but I think it's hard because you get used to it" (Cal – line 325).

Apathy was apparent in Cal's acceptance that you get used to barriers that prevent good quality care. This incuriosity consists in an inappropriately disengaged or remote stance toward others, manifested in forms of indifference and disconnection (Carse, 2005). Similarly, Fran also evinced a lack of empathy and passivity in accepting the shortfall in "essential" resources at the expense of service user needs.

“if that piece of equipment is essential, if I thought that it was really essential all I could say would be to suggest to the family that maybe they would purchase one themselves. I'd just have to tell them, I'll tell 'em straight, sorry we do not issue this piece of equipment... I wouldn't probably say, oh if you lived in such an area you'd get one, I wouldn't say that to them but I would have to just say we don't supply it I'm sorry but you may benefit from it... (Michael: why would you not try to empower the patient and take proactive steps to redress the inequality?)  
... I suppose it's causing up the, that hassle, that trouble for 'em because they've gone through a lot themselves so I don't think they need extra hassle. I suppose that sounds wrong that but I suppose if I could find other ways around it... I'd certainly try to do that, but I have mentioned it in the past but it doesn't, it just, that it's clear-cut pretty much.” (Fran - line 419).

A HCP has to choose to be a virtuous professional and disseminate information about necessary treatment, even when one has to explain it is not available, or to let utility prevail and the service user no longer be told about the treatments they cannot choose (Whiteman, 2013). Lucy's apparent disconnection from service user advocacy may be due to the belief that nothing can be done to improve this situation, leading to passive acceptance of the problems and no longer recognising them as an issue. Where available resources are insufficient compared to human needs and desires, this can lead to stress, apathy and burnout (Pantouvakis & Mpogiatzidis, 2013). Burnout is a prolonged psychological response characterised by emotional exhaustion and depersonalisation with one's career and has been associated with reduced quality of clinical care, empathy, altruism and career satisfaction (Burks & Kobus, 2012). Where these factors are part of one's organisation, passivity may be a method used to avoid the associated burnout or stress.

Individuals tend to be more satisfied with their jobs and more committed to their organisation when working in an ethical environment characterised by, honesty, concern for others, and interpersonal fairness which is exhibited through management and ethical leadership (Neubert, Carlson, Kacmar, Roberts & Chonko, 2009). These issues are important determinants of employees' health and welfare, affecting job satisfaction, which, for HCPs, are directly related to the quality of services provided by them and subsequently reflects on both individual service users and the health care system overall (Pantouvakis & Mpogiatzidis, 2013). Relationship and organisational investment to support individual staff improves their wellbeing and can improve the quality of the patient experience (Maben et al., 2012). Considering

the inequalities he recognised, James demonstrated a disenfranchised and disengaged attitude leading to passivity.

“I’m probably one of those really that I wouldn’t... (pause) I wouldn’t think I would make a difference really so I wouldn’t... (pause), I don’t know maybe I didn’t feel so much about it that I needed to raise that question really... (pause) again probably think who am I? it’s not going to make any difference.” (James – line 593).

He concluded this exchange with a self-effacing rhetorical question "who am I" before saying it wouldn’t make any difference. Sue also acknowledged that the shortfalls in service provision are not something she can influence, and passively accepted the need to arrange clinical treatments in her own time.

“Just kind of [sighs] sympathise with them, trying to work around the problem if it is an interval, trying to fit them, I don’t know, quite often you’ll see them in your own time” (Sue - line 151).

Marie stated that she gives little consideration to ethics, but justified this by undermining its necessity in her practice, illustrating a lack of understanding of applied ethics in decision making.

“No I don’t think so, I didn’t really know what to expect and I’ll probably have to go away now and look at more ethics and things...I think it’s different pressure for us as, because, not like surgery or, with us we’re not gonna, we can get people better quicker or slower but we’re not, it’s not life or death...” (Marie – line 969).

This was echoed in the group interview with a discussion between Dave, John, Chris and Mark who had disagreement in their exchange about the perceived seriousness of the decision making for physiotherapists and podiatrists.

“Dave: I just wanted to go back to Mark’s point about what we’re saying about, patients are dying in front of yer and actually the patients we see, none of ‘em are gonna die from what we do... (laughs), mostly. The majority of podiatry and physio patients are probably not, so it comes back to the patients’ expectations as well doesn’t it. Now they’re in pain and from what John and Chris have outlined is we’re gonna treat them as much as we can to cover our own backs...Well I actually think that is partly how the NHS functions in one respect, I think it does come down to, you’ve done everything you can, but to a point where they can’t sue you, so let ‘em move on.

John: It might be interesting to see how long these people have been qualified for, I mean in the twenty-five years that I've been qualified, where I went from a very strict medical model and the consultant said jump you ask, how high?, to now we're supposedly in patient involvement but it might be where we came from in that journey has focused our minds, but I would say in the last five, ten years it's become a very litigious (sic) society.

Chris: Definitely." (various - group Interview line 683).

Dave believed that because physiotherapists and podiatrists do not carry the weight of life and death decision making, it undermines ethical consideration. John highlighted two further issues related to an altered understanding of ethics. The first issue was associated with the hierarchical medical model for which John questioned how far practitioners have been expected to change towards a person-centred model. Secondly, that society has become litigious and thereby this contributes further to clinicians' defensive and consequentialistic approach. This supports the findings from the individual interviewees illustrating that HCE are not taught, but are perceived to be bound up in frameworks, guidelines, standards and litigious defence.

#### 10.2.4 Passivity due to a lack of HCE education

Moral reasoning develops through experience and increases with exposure to ethics education (McLeod-Sordjan, 2014). The group concluded that the teaching of ethics may be embedded in professionalism.

"Dave: I'm not sure, I think it's always been there and it's, but it was always called professional issues, that's where ethics come into it and it gets sort of lost in... like I say, what's called professional issues, being professional, it was maybe not highlighted as being ethics as such...

Chris: Yeah, when you give it the new, not the new badge but when you give it that badge of ethics you don't, 'cos your professional attitude was always, had to be spot on in clinic, otherwise you'd be pulled up about it." (Dave and Chris - Group interview line 814).

Ethics education in allied health workers is recognised to be less than that offered to nurses resulting in a lack of moral knowledge and skills with ethical issues not being identified (Johnstone et al., 2004). For education in HCE to succeed it ought to link theory with practice to develop character-building, professionalism and organisational skills which prepare individuals to embody and apply these values in

practice (Millstone, 2014). The group discussion demonstrated a lack of understanding that HCE education may not have succeeded with its intentions.

“John: See we know it’s in the curriculum ‘cos we write the curriculum...

All: [Laughs].

John: ...and we write the learning outcomes but...and therefore we recognise those words exist but it might be that someone hasn’t actually in class... perceived it I don’t think...

Dave: It’s maybe not explicit enough.

Chris: yeah, that’s probably it.

John: ...yeah, you probably need to use those words.

Becky: I label my class, ethics, in year one so it should be quite clear [laughs]

All: [Laughs].

Becky: ...what it’s about really, but I mean it’s quite concerning isn’t it that one of your participants or only one recognised anything to do with that, and some were fairly recent graduates by the looks of it...weren’t they...

John: Well I, I’ve just done something to first year...about the difference between morals and ethics, this is outside and different from research ethics, so we, we’re talking about it now, but as I said, going back ten years maybe it wasn’t as explicit ten years ago...and to be honest, how can anyone remember every lecture in a three year course, if you ask them what they did last week they might not remember...

All: [Laughs].

John: if you ask me what I studied twenty years ago I couldn’t remember. I’ve imbibed it somewhere and I’d recognise my professional values but I don’t know whether I was actually taught about ethics, I can’t remember.” (various - group interview line 814).

The group responded to this issue in a similar way to the individual interviewees. There was apathy towards the findings, which suggested that they may not have embodied the need to integrate ethics with clinical practice. One group participant exclaimed that she is concerned that HCPs are not aware about ethics because she knows it is taught, since she teaches it and “labels the class ethics”. The same participant had previously stated that her only clinical exposure to HCE was as a student on placement and since graduating she stated that “nobody’s ever even mentioned anything about ethics or checked it or asked my opinion or anything.” (Becky - line 1544). Despite Becky and John’s expressions of surprise, the individual participants, of all ranging experiences stated that they have never received any training in ethics.

The goal of ethics education is the development of professional virtues and skills that manifest in a HCP as thoughtful and reflective ethical practitioners (Parker, Watts &

Scicluna, 2012). The extant literature on how ethics education contributes to the goals set out by ethics education are scarce (Cannaerts, Gastmans & Casterlé, 2014). Becky and John's comments suggested that what is being taught is not being learned. This issue did not instigate concern within the group, but they reconciled and assuaged this by suggesting that ethics is covered by the term professionalism. There was no acknowledgement that the education they have received may have failed the students in arriving at a more critical understanding of ethics. Ethics appears to be subsumed by the learning of professionalism, which is a 'hidden curriculum' and one which is comprised of the attitudes and expectations that the educators tacitly and unknowingly inculcate in the formal learning process (Freed et al., 2012). The teaching of ethics is complicated and the terminology used in the philosophy of morality can seem strange and of little practical value especially amongst students who may not have sufficient basic training to follow such complex theories (Verdú, Francès & Castelló, 2012). This may also be complicated by the lack of formal ethics education for educators of ethics (Park et al., 2012; Salminen, Metsämäki, Numminen & Leino-Kilpi, 2013). There is a paucity of formal qualifications for educators with no objective assessment of their competence to teach ethics (Numminen et al., 2010; Park et al., 2012). John concluded this exchange offering an excuse for the participants suggesting that their comments about the lack of HCE education may be due to failing memory. He stated that he couldn't remember if ethics was taught because he couldn't remember exactly what was on the curriculum. Ethics education and its application in health care is a subject that requires, not memory, but in part should develop moral sensitivity, which is a life-long cognitive ability (Baykara et al., 2015; Duncan 2010). It is required on a daily basis during any service user contact and therefore should not be reduced to memory of modular content in curriculum (Kulju et al., 2013). Although formal ethics education may exist along with the professional codes, the participant HCPs are not relying on that training in actual practice, but tend to rely on inner values systems they had incorporated from their childhood (Weinstein & Nesbitt, 2007).

The group participants responded with an overarching feeling that ethics was perhaps not recognised, but that the concept of ethics is considered synonymous with professionalism. This raised a question about who defines what being



professional is. The group attempted to clarify what the term professionalism may mean and where it aligns to, or parts from their understanding of ethics.

“John: Well that’s why I discuss morals and ethics ‘cos ethics is the framework by which we might work, so my icebreaker question was, who in the audience would say that they had morals? and of course they all put their hand up, who has ethics? well they’re not quite sure what that term means so half of them put their hand up...

Mark: Hmm. I think professionalism is much wider, it encompasses ethics...but professional groups, their allegiance is to the profession and professions will have codes of ethics as part of what they do. And I think that’s why it was lost in Dave’s day and even further back, my day, they just called it professional studies...and I think we were looking at professionalism and yes we probably did touch on ethics but it made such a massive impact I’m not aware of it...

Chris: It’s never actually pinned down to one thing as well is it ethic, like you say, code of ethics, it’s very ambiguous within the sort of HPC guidelines and things like that...

Dave: Well it, I could be cynical about it and say that you could say that a professional is what we do as podiatrists, so that if you see what podiatrists are doing around you, you could follow that rather than, you can sort of disassociate yourself from it...I’m just doing what other podiatrists do...as opposed to actually being about your own, whether you think it’s right or wrong.” (various - group interview line 389)

This extract from the group discussion suggested that professional studies or professionalism is what is considered to be taught for ethics education. John’s example illustrated the lack of understanding of ethics and morals amongst undergraduate students, but he failed to relate this to the findings of this study, where professionals with a range of experience all state they have never received any training at any level on ethics. Chris attempted to justify why HCPs may not have understood ethics education by commenting about the HCPC’s Standards of Conduct Performance and Ethics being both a vague and ambiguous document. This comment highlights that ethics demands interpretation and application. Dave raised a new concern to say that whilst remaining professional one can disassociate oneself from individual ethical responsibility, thereby inferring that professionalism can fall short of ethical practice. Mark also alluded to the notion that there is a culture within professional groups to follow custom and practice along with the ethos of the organisation. Dave suggested that the disassociation of one’s individual responsibility can prevent decisions based on what is right or wrong. For moral action to occur, moral thoughts must be accompanied by emotions since there is a

huge gap between knowing what is good and right and doing it (Weinstein & Nesbitt, 2007). Weinstein and Nesbitt (2007), argue that moral character and the requisite personal characteristics including courage are necessary to act on moral decisions rather than the taught elements of moral sensitivity and moral judgment in isolation. This issue resonates throughout the findings of this research, where participants recognise the barriers that prevent ethical decision making, but do not demonstrate actions that overcome the obstacles. Dave and Becky alluded to the need for personal or virtue ethics in order to fulfil what they feel professionalism lacks.

“Becky: I was just gonna pick up on that point there, I think, some people see things as ethics being differently or professionalism being differently and you’re sort of saying there you could maybe just watch what everyone else was doing and follow that crowd, but what if that crowd isn’t doing things right, so what’s gonna drive you to, to do better or make that change...

Dave: Well yeah, that’s the true view of ethics...but what I’m actually saying is that what people do though...’cos I think we’ve...

Becky: Well some people...probably do.

Dave: we’ve all been in practice ‘aven’t we and seen colleagues who’ve done things who you’ve thought, I would never do that, but ‘ow many have actually have we said that’s against the HCPC standards of proficiency and reported ‘em for it? ‘ow many times have we done that?

Chris: Yeah.

Becky: Yeah.” (various - group interview line 934)

Moral virtue could be defined as a dispositional trait of character that is socially and morally valuable and reliably present in a person (Beauchamp & Childress, 2013). The language of obligation may be interpreted by virtue ethicists as derived from the more basic moral language of virtue, thereby disposing the virtuous character to be motivated by respective action (Beauchamp & Childress, 2013). HCPs may not have the ethical or moral language to identify and assess the situation (Carpenter, 2010; Devlin & Magill, 2006). Dave was the only HCP participant who alluded to advocacy for service users’ needs in challenging the dissatisfaction of the barriers in service delivery. Mark supplemented the discussion by describing the role of management to influence change.

“Mark: well ...only Dave said it, I mean, it’s part and parcel of my job to argue about it every day and I’ve had sixteen year arguments and you don’t stop and eventually you will win the context of change, something will happen, and you win. I think the obligation’s just to keep going with it, if you believe it’s right, you know it’s right, you’re certain it’s right, you’ve got the evidence, you

just don't stop and you keep bringing it up and bringing it up, and bringing it up." (Mark - group interview line 1232)

Mark stressed the need for perseverance uses the term "obligation" in relation to fighting for what you feel is right. Although participants referred to person-centred care and patient choice, there was a lack of obligation towards advocacy of service users who may be disempowered. This passive neglect of advocacy during moral conflicts may be associated with the lack of ethics curricula (McLeod-Sordjan, 2014). The participants who spoke about this felt they cannot influence change, where Mark is in a senior position to effect change. Personal virtue along with individual motivation for perseverance to defend service user autonomy may be required. The individual participants appear to be disenfranchised and perhaps this contributes to apathy. Service user advocacy also seems to be undermined by the enculturation of the organisational challenges which take precedence in influencing the HCPs. This may be permitted in a conscientious HCP by actively mitigating cognitive dissonance. Cognitive dissonance has been defined as discomfort experienced by persons either engaging in activities in conflict with their beliefs or in trying to meet two or more conflicting demands at the same time (Fontenot, Hawkins & Weiss, 2012). Joan highlighted this, and suggests that if the HCPs on the coal face are disenfranchised, disconnected and passive to organisational limitations, then this will be infectious to the patient population thereby disengaging them.

“Joan: is it a description of a clinician or is it a description of the patient, ‘cos it could equally apply to both maybe. Because if that’s the attitude of the clinician it therefore then becomes the attitude of the patient because...they think if they’re not interested in me, this is how I feel and they’re the ones who are in control therefore what can I do about it?”

All: [laughs] (various - group interview line 1256)

John raised the issue of passivity in allowing services to be shaped according to the limitations that the organisation imposes upon them. Job satisfaction of health care employees affects health service quality and reflects on patients (Pantouvakis & Mpogiatzidis, 2013). In response to this and Joan’s comments about the question of “is it good enough?”, the group considered what Becky and Mark highlighted with respect to personal moral obligations, and discussed where this is supported, developed or checked.

“Mark: I think the personal morals it’s essential to anchor them to the real world, I mean, if you got into Adolf Hitler’s head he would say adverse morals, he just...spiralled in on himself and lost those anchors completely...so you’ve gotta just keep those checks going all the time...and again it’s within the context that you’re working, so, regularly check the HCPC information, remind yourself what’s there, remind yourself of the rules, make sure you stick to them. (Mark - group interview line 1381)

Mark embedded this discussion firmly in "context" suggesting that personal morals are essential, but must be anchored in the real world in order to check those individual motivations against a set of rules. He places the responsibility of this on the individual and does not allude to any external mechanism of checking. This view of morality is identified not only from a theoretical perspective, but situated in institutional, structural, social and cultural contexts (Hoffmaster, 1994). This context dependant phenomena places a further challenge to HCPs, which may also present secondary outcomes that were previously unforeseen (Pimentel et al., 2010). Dave and Chris substantiate this by illuminating concerns about contextualising personal morals and the regulation of ethical practice for physiotherapists and podiatrists.

Dave: I’ll go back to what I said about it being minimum standards and if you look at the Staffordshire Inquiry... a lot of the people who have been, had problems with their regulatory body are nurses, because they weren’t following a sort of personal sort of care, what does care mean? and it’s come across as being uncaring. So I think there is a personal aspect to the minimum standards that we follow and we have to keep to them because actually the other thing is as well is that the HCPC pays lip-service to checking of, how do they check ‘em, they get us to fill in what we’ve done...  
Chris: And they check, they don’t even check a hundred percent of practitioners doing the job.

Dave: No. They check, we fill in the sheet to say what we’ve done...and if that looks okay on paper, that’s fine.” (Dave and Chris - group interview line 1400).

Dave reintroduced the notion that current application of ethics appears to be little more than checking against a list of minimum standards. Participant members of the group were concerned by the fact that only 2% of the profession is audited by the health professions regulator every 2 years and that this is achieved by paper based self-reporting of one’s practice. Dave emphasised that this checking mechanism is only paying "lip service" to the process. Mark offered a different perspective to

Dave's beliefs by indicating that the most important checks are not made by the regulator, but by the service users and also professional peers.

Mark: I think there are a number of checks and the most important checks I think are coming from the patients themselves, they perceive what's happening to them, they've got the internet and they know what should be happening and they will complain if they believe something's gone wrong. And then I think it cascades out from there, it then may be your peers, I mean we have peer review, so it's your peer-reviewers who pick up aspects of your practice and whether those are sort of ethically up to standards and whatever, then it becomes the senior managers and, all the way through to the HCPC that do something once every few years from a distance." (Mark – group interview line 1422)

Dave reiterated his belief that regulation obtained from service users or peers is inadequate and continues to use the Mid Staffordshire scandal as an example of how this can cascade to severe unethical practice.

“Dave: But, they're all in place, I know that and then what happens when you get a thing like Staffordshire, it's that all the patients have, or unfortunately lots of patients have died, and then it realises that those things weren't happening. So what happens, it's alright when you've got a good manager who's looking at those things, it's what happens when those things disappear. What happens then? That's the issue I think for all our professions...  
Chris: It's only questioned when something goes wrong in't it essentially.  
Joan: Yeah, all I was going to say was, at that point isn't it too late.  
Chris: Yeah.  
Dave: It is for those patients, but it won't be for the next patients unfortunately.  
Joan: Oh right, that's alright [laughs]. (various - group interview line 1434).

Mark claimed that one of the best checks of ethics comes from the service users who he believes will let it be known if it is going wrong. This was not found in the variety of individual participants who alluded to service users' complaints not being validly received. Neither did Mark give any recognition in his argument to the ethical dilemma of prevented access for many people who cannot gain NHS physiotherapy and podiatry services (and that the majority of physiotherapists and podiatrists are now working in the private sector). This illustrates that a service user has no voice in what services are offered, but only that they have an idea of what may be expected if they are to benefit from accessing a service that has been preordained. Mark's feedback mechanism relies on service users knowing what 'could' and perhaps 'should' be available as a service provision. Mark offered assurance to say that the

events in Staffordshire could not happen where he works because of the safeguards that are in place.

“Mark: I think Staffordshire happened because they lost those anchors of the outside world and I spend time reviewing services and the services where that happened they cut those anchors out, one of them we saw they took people straight from college who didn't know any different. In effect brainwashed them into their way of thinking, they didn't know, it's all they knew. So if you keep the contextual things there you've built in the safeguards. That's what they didn't do in Staffordshire. They isolated themselves and then it imploded.” (Mark - group interview line 1454)

Mark suggested that the problems at Staffordshire existed as a consequence of staff being brought in that adopted the culture of those around them without awareness of it being wrong. Participants in this research corroborate that this is how HCE are currently adopted i.e. informal post qualification experiential learning. This contradicts Mark's belief that safeguards are therefore in place to prevent permission of poor practice. Rather, it appears that HCPs seem to be influenced by the norms and the culture of practice around them and thereby accepting of the service limitations. The serious and systematic failings in the NHS at Mid Staffordshire were recognised as appalling and able to flourish undetected, despite the safeguards that pervade health care (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). This was clearly highlighted by Francis who also included health care regulators and the educational organisations who failed to uncover the lack of professionalism, thereby not taking any action to protect patients. The participants in this study seem to be enculturated within their organisation with a passive or disenfranchised attitude towards quality of service provision. The notion of enculturation and passivity amongst autonomous professionals is a contradiction when considering the extant literature on moral agency. The moral agent is afforded the choice to either engage or not, in a particular course of action which is an individual level phenomenon (Pimentel et al., 2010). To develop moral agency may therefore be a reasonable alternative rather than to continue with a strategy of guideline based resolution, which may mean that the ethics will retain infinite regression away from its goal (Eriksson et al., 2008). Rather than continuing to seek general principles that provide guidance for action, professional development should concentrate on encouraging virtue characteristics in the HCP such as fidelity to trust,

fortitude, compassion and justice, which provides the foundation of moral decision makers (Meagher, 2011).

Ethical dilemmas are context dependant phenomena (Pimentel et al., 2010) for which there are no quick fixes. To achieve proficient ethical practice, sustained ethics education and ongoing development are required to strengthen the ethical competence of HCPs (Eriksson et al., 2008). The findings of this study demonstrate that none of the participants recognised having received any post graduate training or development contributing to ethical practice, which may contribute to unchallenged passivity from the participants. The three main ethical theories used in current medical practice are Deontological, Utilitarian and Virtue ethics (Annas, 2015). Whilst moral philosophy has played a dominant role in defining what is taught as the method for reasoning about ethical dilemmas, most educators rely on an amalgam of theories (Truog et al., 2015). These ought to provide appropriate underpinning to avoid enculturation of poor norms in health care practices. Currently there may not be agreement on which moral philosophy or theoretical models to use to determine right action, but this does not invalidate the need to search for a solution to given moral problems.

Participants in this study illustrated a paucity of ethical reasoning, but a reliance on guidelines for practice. Guidelines and frameworks may at best serve as inspiration to ethical decision making, if however, education and training was offered to interpret the guidelines in light of ethical theories, then this may provoke inspired ethical decision making in a new and unexplored area for HCPs rather than a place where ethical thinking had previously ended (Eriksson et al., 2008). To be professionally autonomous, an agent should be able to reflect on the guidelines, distance themselves from the guidelines and then consider various aspects from normative and evaluative perspectives in order to critically reflect and shape their attitude and actions accordingly (Blöser et al., 2010). This may permit discretionary judgment based on individual needs. Exercising discretion rather than simply implementing routine, presumes that the need for judgment and the capacity to exercise it are part of the HCPs character and practice (Cox III et al., 2008).

Virtue ethics use an 'inside out' approach (problem based approach) rather than an 'outside in' (rote learning of ethical principles), which may engender the development of a moral capacity on the part of the HCP (Schröder-Bäck et al., 2014). This encourages them (along Aristotelian lines) to engage in examination and reflection of their own self, in order to live ethically and inhabit an ethical persona (Schröder-Bäck et al., 2014). Moral development, however, manifests unevenly in people aspiring to deal with moral challenges resulting in a lack of unity of virtue (Curzer et al., 2014). Without assurance of such unity the HCP could extol the virtues of justice, but not of courage resulting in dissonance permitting passivity to allow unjust service delivery, an example of disunity of virtue (Penner, 1973).

### 10.3 Empathy

Morally contoured empathy is a complex virtue contributing to wise and judicious judgment which informs appropriate moral responses to others (Carse, 2005). Empathy is an essential component of clinical practice with evidence to suggest it improves treatment effectiveness through enhancing communication and trust (Bruns & Frewer, 2011). The intrinsic moral worth of ethical decision making is reliant on good will, grounds for moral significance and autonomous capacity to reason, which leaves Kant's Deontological theory and therefore normative ethics with inadequacies (Upton, 2011). HCPs may add depth to their professional 'duty' and improve ethical reasoning by use of empathy, however human agency becomes empathy's blind spot and fails the HCP in achieving true understanding of the other (Slaby, 2014). Human agency and social systems may be conceived as mutually constitutive in a form of double hermeneutic (Ginev, 2014). The blind spot can arise as a consequence of our life-long habits of intuiting and thinking which, therefore places a demand on us to shift our centre of orientation or 'zero point perspective' as a spatial point amongst many possibilities (Stein, 1989). Stein's (1989), thesis explicates the use of reiterated empathy which then affords us the opportunity of enriching our own world image through the other person's image of us, without which we are at risk of gross 'empathic deception'. Through individual and vicarious attempts to achieve this, Alex acknowledged how empathy influences individual change in attitude.



“I think I've... what's the word, got nicer as I've got older from a.... You know, when I was younger I was quite, I wasn't ever mean to anyone but I was very, this is the way it's gonna be and I think the older you get the more I think you understand peop, you'll be there one day, you'll be that old person who struggles to get their tights off and can't remember what you've told them...

...I think as you get older you get a bit wiser and then you also see people, good and bad colleagues and think, well I'm not gonna do that, or other people and think well that's such a good way of explaining something... but I think if people think you're bothered about them as well, from an ethical point of view if you're bothered... I think if they think you care....” (Alex – line 1626).

Alex referred to the way empathy, through experience, age and wisdom all inform her ethics. She claimed that some of this is developed following experience of positive and negative learning, not only from oneself, but from working alongside other professional colleagues. This contradicted a previous assertion that Alex made stating that podiatrists often work in isolation, thereby restricting the opportunities for vicarious reflections. Isolative practice may be problematic or detrimental to ethical decision making (Cooper, 2009). Although Cooper (2009), found a paucity of empirical research in this area he contextualised ethical decision making in the theories of Habermas, Mead and Gadamer, drawing from community pharmacists to support the theoretical claims. He concluded that there is an urgent need to undertake research to enhance an understanding of this area of practice.

Pete demonstrated an example of empathic deception when answering a question about potential frustrations with respect to limitations governing his practice.

“sometimes...frustrated... feel under pressure to discharge somebody but I would say if they still need us we should never discharge them. Not if they need us for pain relief, then they don't need us! They need pain relief and I think they do sometimes...(pause) ethically I can think of two instances where a patient said to me I've been to see a private practitioner he does so much more for me than you do, but he's looking for pain relief and as soon as I articulated yeah you can go in and ask him to give you a massage and he'll take your money off you as long as you giving him your money but I am not a massage service, we're a rehab service so our job's to get you to be as good as you can be, teach you to stay there and then wave goodbye to you...

...yeah frankly we want to deliver getting to that point in as few sessions as we possibly can because the fewer sessions they spend with that patient they can actually provide care to another patient... and there's plenty of patients out there to see.” (Pete – line 213).

Pete demonstrated disconnectedness from service user needs or expectations. He claimed that if a patient needs the service then they should not be discharged. His lack of empathy is insufficient for understanding the actual needs of the person which may be due to the distorted philosophy of his organisational belief of what a person may need (Song, 2015). One of the examples Pete gave is about pain relief for which he showed a lack of empathy for the service user. He is opposed to providing a service that the patient feels is necessary and that could provide a resolution, which he dismissed as a 'massage service'. He stated that this is being provided from the private sector. He also indicates in his answer that the private sector physiotherapist will take the money off the service user with inference that this practice is not good. It illustrated disaffection from service user choice and his opinion also raised a concern about clinical reasoning and service provision in the private sector. Pete is delivering the service from a utilitarian and budgetary framework rather than through service user consultation. It also showed disconnectedness from four of the seven founding principles of the NHS Constitution (DoH, 2015) which relate to access and clinical needs in consultation with the service users. Marie also demonstrated a lack of empathy and understanding of the service user's motivation and needs. She gave an example suggesting that service users 'like' and would 'want to continue' with return appointments.

“you'd have a lot of patients wanna come and get sorted and that's it. And some kind of quite like coming and would like to keep coming some people want you to come and do something, I think maybe more in private, to do something to them that's gonna mean they don't have to come back, whereas often it's them going away and doing something and that's often easier to sell here than in private practice.” (Marie – line 128).

Marie demonstrated a misunderstanding of what constitutes service user choice and a lack of empathy in considering their needs. This short excerpt also highlighted recognition of the concept of having to 'sell' 'self-management' to service users, which she believed is easier in the NHS than in the private sector. This notion indicates a paternalistic rather than dialogic approach to decision making. Similarly Luke referred to communicating with service users in terms of 'selling' techniques to explain how this may result in reduced complaints. He placed it in the context of informing the service user that they have no choice in what to expect from a service.

“you can try and sell it to them that way, so that they don’t feel as though they’re, they’re being fobbed off I suppose...  
(Michael: and do you ever get any complaints?)  
...Never...I’ve not in ten years, I’ve not had one complaint, no...it’s the way you communicate with your patient isn’t it...I suppose it’s letting them know that you understand the situation isn’t fair but this is what we have to do because this is the way it is.” (Luke - line 287)

Luke had maintained throughout his interview that there are no conflicts and no barriers to ethical service delivery. During this exchange Luke explained that there are other service users with a greater need based on risk (criteria set by the NHS). Although he conceded that this constitutes a level of unfairness, he assuaged it by claiming the higher need to deliver what is expected in your professional role. For Luke, ethics is professionalism. This raises a question about professionalism in a global sense and questions where service user advocacy exists within this. In order to justify the argument of professionalism, as the mechanism to ethical decision making, Luke drew on experience of being a service user himself.

“you’re looking at it from a professional angle and then you’re looking at it from, when you’re a patient yourself you go to see your own GP, you know what it’s like to be a patient so, you have family... and they go to see a podiatrist and the same thing happens...” (Luke - line 314)

Luke subordinates the empathic consciousness and allows organisational influence to assuage his own concept of fairness in service limitation. He normalised the poor service he experiences and used this as justification for what he recognises as unfair. For Luke, the universality of unfairness makes everything fair. This is an example of human agents intuiting an empathic blind spot, thus creating empathic deception (Slaby, 2014; Song, 2015; Stein, 1989). Mark gave an example of how he attempts to apply empathic reflection through experiences of being a service user which results in a more positive understanding.

“doing work like the Chartermark work in course of my Service Excellence Work... that sort of forces you to step out of the environment you’re in and look back in through a patient’s eyes and I think that’s really helped and another one, I remember when I was a patient myself, I had podiatric surgery and I remember when they were wheeling me in, thinking gosh if somebody was to ask me, if you were to talk to the surgeon now, what would his CPD

needs be and it'd be very personally driven I think, 'cos I know the surgeon involved and what he'd say is oh there's this new porcelain implant they've developed in the States, fantastic new toy for me to get and use, that would get some terrific outcomes won't I. If they'd stopped me and said what should his CPD needs be, I would've said, I don't wanna be in pain in there, I want his pain control to be fantastic. I'm actually a little bit worried about it, I don't want to die, I want his life-support techniques to be the best in the world. I'm also a bit worried anyway so I want him or a member of his team to be absolutely brilliant at putting me at ease. Entirely different list. So I think as you start seeing it through the patient's eyes that's an important driving force as well." (Mark – line 274).

For Mark virtue and personal ethics were formed at home and in the church. He also acknowledged two important events that contribute to the formation of his own ethics. The first was when he stepped outside of service provision to fulfil a role in consultation with service users about the quality of service offered. Secondly, when he became a service user himself and attempted to see things through that perspective. Both of these events triggered an empathic response to inform his ethics. One method of enhancing empathic care is to engage in virtue ethics which engenders moral perception and illuminates human suffering and perception of human vulnerability which in turn serves public health professionals towards a vision or sensitivity that others may lack (Meagher, 2011). It is also necessary for HCPs to be aware of any barriers to empathy (Bruns & Frewer, 2011). Mark concluded his interview by emphasising that empathy is a key influence to considering the service user perspective and therefore improving ethics in health care. He also raised a point about human virtues getting lost in academic standards, something that Mitchell (2005), describes as objectivism or scientism. The domain of the scientific method can neither reduce or reproduce what Gadamer seeks to experience as truth through dialogical phronesis (Landes, 2015).

"I think if everybody had a chance of being a patient that would give them, hopefully, different insights, more empathy into what it's really about and what you really want... I think it's so difficult to feel, and I think that's where the medical profession went wrong, I think we've all experienced the very intelligent doctors who couldn't care less and I think that's where they've whacked up the academic standards and forgot they were needing those human elements to be brought in. I think it's come back now but there was a definite old school that's, you're still getting the tail end of them, did I tell you how important I am, did I tell you how clever... couldn't really care less about their patients...or their colleagues or anything else and I would argue that aspects of those people are quite unethical." (Mark – line 381).

Speaking about personal participation, Mitchell (2005), explicates the lack of virtue in a modern culture where knowledge is reduced to only that which can be scientifically demonstrated and proposes that in order to oppose this we must recover an awareness of human participation. Health care knowledge is essentially and unavoidably clinical, where practical and applied knowledge are formed phronetically and cannot be a matter of scientific principles alone (Hunter, 1989). The clinical environment itself has become increasingly dependent on knowledge and skills for high technical requirements at the loss of compassion and emotional aspects of care in medical education (Williams & Stickley, 2010). The traditionally favoured scientific curriculum has left little room for humanistic concepts which are not seen as essential, but elective (Burks & Kobus, 2012; Schröder-Bäck et al., 2014). In order to ameliorate the apparent trend that empathy and ethical values are being eroded, more needs to be done at undergraduate education to develop practical skills in clinical ethics (Fields et al., 2011; Hojat et al., 2009; Parker et al., 2012).

### 10.3.1 How empathy affects the motivation to act

Sue recognised service user frustration in circumstances where commissioning prevents appropriate treatment. She acknowledged the need to sympathise, but showed no empathic reflection and appeared demotivated or disenfranchised from seeking alternative resolutions to meet the agreed needs of the service user.

“you’re the first point o’ contact and you have to deal with it but there’s nowt that you can do about it, you just have to kinda sympathise...Yeah ‘cos you identify that they need a treatment plan with x, y and z and then you can’t always deliver it to them so you know, you agree that with them and they get frustrated when you can’t actually deliver it because of time.” (Sue – line 119).

Fulfilment of achieving empathy with people does not guarantee appropriate moral responses (Song, 2015). Moral self-development requires that one starts with an accurate assessment of one’s motives for action (O’Hagan, 2009). Despite the highlighted and agreed needs of the service user, Sue concluded that nothing can be done if commissioned time will not allow fulfilment of the management plan. Similar

to Sue, James appeared to offer no self-reflection on his disaffection from some service users.

“if a patient wasn’t getting any better and you're you're trying your best and you can feel, palpation wise, that there's movement there, and they're still struggling with stiffness, but they've come in with these ‘x’ amount of sessions, that’s probably the difficulty of the job... to say do I need to really think about this and reassess or are they, I guess you should never think like this but, swinging the lead a little bit, and that you shouldn’t beat yourself up about it because on the 8th session when they've been allocated... surprise surprise, they'll be better! so there’s difficulty in that really” (James – line 277).

This exchange is an example of how motivation can affect the clinician. James stated his concern about the honesty of the service user being a key challenge in his work, but referred to the duty of care to treat all the service users the same. He failed to consider that his clinical assessment, which appears to contradict the service user’s behaviour, may be an ethical challenge. He ratified this by explaining that some of the legal cases are just ‘tick box’ reports and it is difficult to prove or disprove what the service user tells you about their original pain and any secondary pains or injuries whether you think it is for a claim or not. His conclusion was to ignore the concern and “not beat himself up” about the outcome. He did not acknowledge any duty of care anchored in professional integrity to challenge or expose any false claims. Mike also described how his motivation is affected when service users are not as equally motivated as him, or if he sceptical about their intentions.

“when I get insurance based patients, there's patients you know that don't wanna get better so you go down that route as well. You're like, well I'll tick the box, I'll treat you six times, I'll charge you £30 a session and we'll all scratch each other’s back. You don't wanna get better 'cos you want a compensation pay-out in my view, I'll treat you all six times 'cos you're not better so I've got every right within the terms of our contract to treat you six times and then I'll send you back to the clinician and I may or may not say in some way, shape or form, I'm unsure about this patient’s motivations for being here and their attendance has been sporadic, their application to do their exercises has been poor. Other times I will just say, oh can I be arsed with this? I can't be bothered because you're wasting my time, and I wouldn't do that for long, I just wouldn't, I know I wouldn't survive in a clinic where that went off for long.” (Mike - line 624).

Mike expressed a struggle with this ethical controversy resulting in various potential outcomes. Firstly, he acknowledged collusion for financial recompense. Secondly he suggested exposure of the issue to the insurer. Thirdly he indicated the demotivating factors involved in this behaviour and finally he implied that he would not want to work in a clinic for long where this was taking place. At no point did Mike advocate the need for direct ethical reflection to conclude the best course of action. As with James and Mike, Dannie appeared to be disenfranchised by the resource limitations which she felt restricts health service staff, but directs her frustration towards demotivated service users.

“(laughs) I mean at the moment there really is I think we all feel a little bit like we've got our hands tied is that there's lots of cuts, so there's really no room for improvements in terms of the equipment, the time that you know we're all being very much squeezed, but I guess in terms of changing things... you're trying to get across to people about the compliance, that's certainly changeable you know, you sometimes get to the point where you just throw your hands in the air and just go I don't care anymore, if you don't wanna do it, then I don't (laughs) care, but there could be more effort spent tapping into what will make people more compliant.” (Dannie – line 202).

Dannie did not show empathy in trying to understand potential reasons why the service user may not be able to change (or in Dannie's words comply). This may be a moral motivational indifference that encourages what Cholbi (2009), refers to as epistemic self-defeat which may bring about a reduced rationality in moral judgment due to a lack of motivation. Evidence based decision making combined with motivational interviewing experience has been shown to improve health outcomes for service users (Mitchell et al., 2014). Problems with empathy abound as we are naturally biased in empathising with those who are more similar to us and sometimes fail to include sufficient information about the person or project incorrect information about them, both of which may result in a reduction in moral action (Song, 2015). Dannie concluded this exchange by indicting that the best way forwards is to explore what would make the service users change, in order to "make people more compliant". Dannie directed blame towards the service user rather than any reflective and inward searching for improvements in her own care strategy. A failure to realise and accept challenges to professionalism in relation to accountability, fiscal constraints, transparency and openness along with the growth of service user empowerment, may lead to dissatisfaction in the workplace and possibly lead to

occupational stress (McIntyre et al., 2015). Empathy is complex and having an empathic ability may be linked to the susceptibility of compassion fatigue, to which HCPs are particularly vulnerable (Raab, 2014). Conversely others suggest that empathy may protect HCPs from burnout and has the potential to influence well-being (Kliszcz et al., 2006) and that medical professionals can experience increased meaning and professional satisfaction in their careers when they engage in empathy (Burks & Kobus, 2012). Kliszcz et al.'s (2006), justification is based in empirical data that indicates links between empathy and improved patient outcomes which subsequently reduces medico-legal risks and thereby increasing the satisfaction of physicians and service users. Dannie stated that she capitulates if the service user does not appear to care about complying with her self-management programme. She reconciled this by highlighting that other people are waiting for appointments who are "keen to take the opportunity".

"we're in that difficult position of being under pressure and you do feel as though you're sort of, not writing people off, you have to give them the opportunity to thrive or to, do what you'd like them to do, but if they don't take that opportunity then I have plenty of people on my caseload who are keen to take that opportunity and plenty more on the waiting list who also want to take that opportunity and actually because physio is, because we're not a medical profession I can't give you a drug that will cure you and I can't give you an operation that will cure you, all I can say is if you do x, y and z, I hope that will make you better but I'm not responsible for making you do x, y and z, no that's up to you." (Dannie – line 287).

Any barriers to achieving concordance or compliance were not considered by Dannie. Dannie's example is consistent with a medical model and paternalistic approach to health care. It appeared to be void of reflection or understanding to consider why the current service provision may fail to address the health care issues in her example. There was a lack of empathy and no discernable attempt to try to understand any possible reasoning behind the reduced motivation of the service user. Dannie also dissociates from individual responsibility, but defers this to the service user without exploring the consequences of her action for the service user who must live with the treatment decisions (Matthias et al., 2013). In the pursuit of health care and the endeavour to achieve better health, the responsibility to empower the service user is incumbent on the HCP. The duty of care to pursue health in a wider context is not considered who stated that if the service user does



not want to comply with her proposed management, then she feels like “throwing her hands up... I don't care anymore, if you don't wanna do it, then I don't (laughs) care”. To care for service users is a basic tenet of the role of a HCP. This was illustrated by Martin Heidegger in the interrelatedness of being-with and caring for, in the existential philosophical concept of *dasein* (Wheeler, 2014). Heidegger's *dasein* emerges and reveals existence through being present to another and oneself, through what he termed 'Authenticity' (Svenaeus, 2003). Physiotherapists and podiatrists, as HCPs have the opportunity to aspire to this by uncovering and dismantling authentic interpretation, which for Heidegger, leads to self-understanding through being with others. The importance of 'authenticity' for ethics is that although it cannot necessarily be the goal of medical practice, it sets a higher standard than health and is clearly related to the ethical pursuit of health (Svenaeus, 2003).

*Dasein* and phenomenological theory have a direct implication for health care ethics since a phenomenological analysis may offer attention to the relational dimensions of a service users experience as they unfold in an ethical and intersubjective scene (Murray & Holmes, 2014). This requires reflectivity and awareness of oneself and the knowingness of the impact one may have on others (Miles et al., 2013). Miles claims that it is through 'knowingness' that partnerships with others can be formed based on honesty, trust and respect. She quotes Heidegger (1962), from 'Being and Time' who states that it is only through the act of reciprocity that those relationships will have meaning and understanding. Dannie failed to engage in 'authenticity' or 'reciprocity' in recognising barriers to health care delivery, but directed blame towards the service user being non-compliant rather than considering the failing resources as a potential issue.

“okay, there are probably, there's person specific barriers achieving the right thing. There's somebody's motivation, their compliance with, 'cos physio's very, particularly in the NHS, is very exercise based so that person needs to actually wanna do it and actually achieve it, so that tends to be our biggest barrier to getting people better is they don't do what you tell them to (laughs) but that's okay 'cos that's their choice I guess. That's quite a big barrier and a frustrating barrier, 'cos it's something that you think, oh I really, I can help you but you're not doing what I tell you to do so that's frustrating...

...And then there's the NHS as a barrier, is that we don't get long enough with that patient so we don't get enough time, we don't have enough resources, we

don't have enough equipment so although you know you can change them, and you're in a very difficult position in terms of time." (Dannie - line 136).

The first barrier considered by Dannie pointed blame towards the service users. The phraseology she used emphasised this; "don't do what you tell them" so their "motivation and compliance" is the "biggest barrier" and "that's frustrating" because "you're not doing what I tell you to do". Dannie demonstrated disaffection and lack of empathy by saying "but that's okay 'cos that's their choice I guess". Dannie's misunderstanding of the service user relationship that engenders service user choice is without either empathy or understanding. There is a shift in responsibility from the HCP and organisational philosophy of care, that engenders the service user being empowered to self-management (evidenced by Dannie's comment that the "NHS is particularly very exercise based"). There is no reflection of the reduced efficacy of the NHS's philosophy/strategy and no reflexive consideration of how this may lead to failing the service user. Dannie made no connection with these issues. In the following extract Marie discussed how return appointments are motivated differently between service providers and users.

"it's telling 'em what we can, being honest about what we can offer, what we can't offer and working together, I'll do this here, whether it be some manual thing some acupuncture, but you need to go and do this at home otherwise you are gonna keep coming back and its different here because we can't have 'em keep coming we can't have patients coming forever whereas in private, some patients are happy and they'd like to keep coming forever." (Marie – line 161).

Marie's language use illustrated the power asymmetry that exists. Value judgment as an ethical concern is fundamental in health care, but also requires reflection to recognise the importance of caregiving, not only as a mediator of values, but also between the various effects of power (Ramos et al., 2013). In this exchange Marie did not demonstrate empathy and highlighted the unilateral decision making about appointments. This appeared to be motivated by fiscal measures, which is in itself an ethical issue. She also divided the service sectors into two distinct and different entities. She described how the NHS is a limited service where "we can't have 'em keep coming back", but that the private sector differs and that "some patients are happy and they'd like to keep coming for ever". The motivation for patient

appointments is not rationalised on medical need or on professional scope of practice, but rather what appears to be financially motivated.

Mark considered how empathy shapes his ethics and engaging in the perspective of the service user helps to focus on their needs, but acknowledged that this will not be the same for all HCPs.

“probably very few... I think you could draw a nice bell-shaped curve, we’ve got some members of staff who go along that wholeheartedly and even lead me in some respects, you’ve got the others that go along with it pretty well and then some who couldn’t care less, who don’t see it that way, won’t and I don’t think anything you can do will make them see it that way, and that’s where the frameworks come in to make sure they comply even though they don’t understand why they’re doing it.” (Mark – line 316).

Mark suggested that where personal or virtue ethics are not engaged, the presence of a framework may at least force a level of compliance towards ethics, despite an absence of care or understanding. Upton (2011), opposes this notion by suggesting that moral decisions bound by responsibility are taken autonomously with an understanding and acceptance of their supporting reason, but that it is not possible to act ethically if using guiding principles detached from a theoretical base which are expected to be applied on trust alone. Connor demonstrated how these two notions are manifested differently in practice. He failed to consider his autonomous capacity and neither does he work from a framework of ethics. In responding to a question about limitations in service delivery, Connor passively accepted that service users are likely to receive a poorer standard of service due to cost savings, for which he does not consider as an ethical concern.

“this is where we are at the moment, kind of with cost savings that everyone's having to make and basically trying to be as efficient as possible that's why I think I would assume that a lot of places are coming under that kind of threat if they haven't already been doing it for however long now. (Connor – line 453)

During this chapter issues have been raised about disengagement, passivity and lack of empathy amongst HCPs. This may be related to motivation of staff which could conceivably have an impact on their practice. Connor described how he is

being employed to do higher level work, but at a lower cost and this may contribute to feeling less motivated.

“Well, I’m a band 5 but cheap band 6 you could call it” (Connor – line 196).

Organisations with a disengaged workforce are more likely to deliver care that falls short of acceptable standards (Ham, 2014). The failures of care in NHS organisations that result in shortcomings in quality, safety and compassion can be attributed to poor leadership and a disengaged and demoralised workforce (Ham, 2014). The importance of supporting and nurturing staff to build a strong climate for patient care has been found evident with local leaders having a critical role in setting expectations of values, behaviours and attitudes to support the delivery of patient-centred care (Maben et al., 2012). Improving NHS care through engaging staff and devolving decision-making has never been more important and may be achieved by; developing high staff engagement within NHS organisations, creating a stronger role for staff in governance and ownership structures and providing support by regulators and the wider system (Dixon-Woods et al., 2014; Ham, 2014).

End of themes summary

The five themes presented and discussed in this section have, within the methodological framework, provided a perspective of experiences on how ethics are interpreted and applied by the participant HCPs. The next chapter will draw discursive conclusions from the presented themes and locate the findings within the context of contemporary health care practice and ethical theory.

## CHAPTER 11: Conclusion

This chapter reviews the achievement of the research aims and states the contribution to knowledge with particular reference to the place of empathy in HCE, the role of ethics in clinical reasoning and decision making, how this work influences/informs the use of clinical guidelines and considers the role of HCE education.

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). Clinical ethics can help provide patient-centred care through morally substantive justification (McClimans et al., 2011). More recently ethics is emerging 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 criteria for judging good ethical practice are the quality of ethical analyses and ethical justifications for decisions and actions (Macklin, 2015). The principal aim of this study was to explore how ethics informs physiotherapy and podiatry practice. 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).

### 11.1 Unique contribution

Through the phenomenological method of investigation one attempts to clarify and thus to find the ultimate basis of knowledge (Stein, 1989). Edith Stein justifies how using this method cannot use any previous results of science which is self-evident because in the primary intention stated above, one cannot find the ultimate basis of knowledge if the enquiry is based on an extant science. Stein (1989), proposes that new knowledge must therefore be grounded in itself. 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.

#### 11.1.1 The place of empathy in HCE

Empathy has an important role to play in HCE as a necessary part of the practical wisdom of phronesis and thus helps resolve the difficulties to interpret and balance the ethical principles and how they attain significance in a particular situation (Svenaeus, 2014). Judgments concerning the rightness of actions are vulnerable to corruption from self-interested inclination (O'Hagan, 2009). It is, however, through our capacity in virtue and reason that, within our finite resources, we can transcend our imperfections through a process that improves our judgments (Annas, 2015; Hoffmaster & Hooker, 2009).

Empathy is 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). 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).

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 comparison between empathy and phronesis in this way makes it easier to discern the place and function of empathy in HCE.

Empathy in service user care leads to improved service user outcomes (Hojat et al., 2013; Williams et al., 2013). Empathy and the problem of empathy have been highlighted as a contributing factor for motivation of HCPs to engage with ethical decision making (Bruns & Frewer, 2011; Song, 2015). 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' in their experiences of ethics. A potential reason for failure in empathy is where human agency assumes greater similarities between people than there in fact are (Slaby, 2014). This is, according to Slaby (2014), an egocentric bias which is a pervasive psychological trait in humans which does not recognise the deep seated differences between individuals. 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). Phronesis may also be developed through the acquired experience of moral training, which along with empathy and technical skills of the professional role 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). The Association of American Medical Colleges advocated the enrichment of empathic skills as one of their educational objectives along with the American Board of Internal Medicine who recommended that humanistic values, including empathy, be cultivated and assessed as an essential outcome in graduate medical education (Berg et al., 2011).

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, but deeper still from the experiences, knowledge and judgments of both parties on how the other empathises and intends to partake in the clinical management. 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).

#### 11.1.2 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. The ethical dimensions that are contextualised in the HCPs' reflective practice first need to be identified in order to allow analysis to follow (Drolet & Hudon, 2015). 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 critical goal of ethics education is to develop the necessary skills for moral sensitivity and reasoning to inform ethical decision making (Park et al., 2012). Reflective critical thinking tools and strategies are an essential component in understanding ethical dimensions of professional practice (Kalaitzidis & Schmitz, 2012). HCE education should target the recognition of ethical issues for HCPs to begin to think critically about them in order to facilitate grounded and justifiable decisions (Carlin et al., 2011; Kahlke & White, 2013). Health care students require critical thinking skills to analyse professional and ethical dilemmas just as much as they do for clinical problems (Freed et al., 2012). 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; Park et al., 2012). 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). 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. 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). It may be possible to incorporate such skills development and assessment as a part of the undergraduate training for physiotherapists and podiatrists and furthermore, this could also be part of the HCPC portfolio of evidence of practice.

### 11.1.3 How this work informs/influences the use of clinical guidelines

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 only learning rule compliance where discretionary judgment is lost and at times is required (Cox III et al., 2008). 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 theory argues 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). 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). In their moral theories, the ancient philosophers relied on virtue and the virtues, happiness (*eudaimonia*), and the soul (Parry, 2014). These ancient

theories remain an integral part of the extant literature and require the moral agent to internalise the virtues in order to achieve their desired 'ends' which demands that a person reasons morally and not in terms of their own interests (Annas, 1995). 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). This is not a claim made exclusively for all health care issues and therefore one looks to corresponding ethical frameworks such as deontological and teleological ethics which can mutually complement each other, with deontology deserving normative priority and teleology deserving evaluative priority (Schwicker, 2005). A teleological account of human agency proposes that autonomous human action is explained not by the impulses that present themselves to an agent when reasoning, but by the ends for which action is decided (Cuneo, 2011). Moreover, if these are combined with a dialogical approach, then a shared understanding between all stakeholders may improve the moral quality of care (Widdershoven et al., 2009). To achieve moral enhancement one may re-engage with virtue ethics and consider multiple virtues which temper and inform one another in the development of a mature moral character (Hughes, 2015).

Passive reliance on guidelines and administrative protocols can disengage HCPs from a process of care (Owens, 2015). If, however, training in ethical theory was given to interpret guidelines then it may invoke inspired ethical decision making that HCPs have not been engaged with (Eriksson, 2008).

#### 11.1.4 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; Park et al., 2012). There appears to be a paucity of formal ethics education for physiotherapists and podiatrists. This could be addressed by the educative schools of the relevant disciplines, the professional bodies' Standards of Practice and the HCPC's regulative expectations through the Standards of Proficiencies. Curricula may be needed at post graduate (advanced practice) and continuing professional development as well as undergraduate courses (Dugas, 2005; Fields et al., 2011). Ethics education ought to 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; Vanlaere & Gastmans, 2007). The curricula need to ensure the students have the opportunity to practice these more complex skills (Rozmus & Carlin, 2013).

Physiotherapy and podiatry professions could develop a coherent ethics research agenda that reflects the realities of practice and potentially inform the ethical content of taught curricula in academic programmes (Carpenter, 2010). Little is known about the effectiveness of ethics education on health professional courses (Park et al., 2012; Rozmus & Carlin, 2013). A number of studies have found a strong and positive correlation between formal education in ethics and subsequent ethical behaviour, with others only making a tenuous connection between them (Jackson et al., 2013). Jackson et al. (2013), offer a possible explanation for the tenuous relationship being in part associated with 'how' ethics are educated. Theorising follows on from understanding and although it may be hidden from our consciousness, our fore-structure (pre understanding) always forms the background to our meaning of things (Miles et al., 2013). This suggests that the personal ethics of physiotherapists and podiatrists could require deconstructing and reconstructing if understanding in the context of their professional role and being-in-the-world with service users can make sense. This deconstructing and reconstructing requires a self-awareness that goes beyond the superficiality of criteria based medical assessment during a routine health care appointment. Any model of human behaviour that excludes tacit knowledge in this process is at risk of promoting mechanical behaviour without creative and purposeful action (Henry, 2006).

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).

In discussing the relationship between knowledge and virtue, MacIntyre (1998), expounds a debate between Socrates and Plato where Socrates believed that the knowledge that constitutes virtue involves not only beliefs, but also a capacity for recognising relevant distinctions and an ability to act on them. Of this Aristotle summarises the Socratic stance as a belief that all the moral virtues were forms of knowledge; in such a way that when we knew what justice was, it followed that we would be just. Aristotle insisted that where moral virtue is concerned the most important thing is not to know what it is, but how it arises; indicating that we do not wish to know what courage is, we wish to be courageous (MacIntyre, 1998).

Just as it is that by virtue of the sun's light, we see everything else, but if we look into the sun itself we are dazzled. So it is that, in the intellectual light given out by the form of the Good, we grasp the other forms, but we cannot contemplate the Form of the Good itself. (MacIntyre, 1998 p41)

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; Watson, 2006). Clinical educators are therefore challenged 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).

The findings of this research appear to indicate that ethics knowledge is tacitly understood by HCPs. For a truly person-centred theory of health care epistemology requires the incorporation of tacit knowledge as a foundation (Henry, 2006). Health care organisations can influence HCPs both positively and negatively, therefore tacit knowledge has implications for person-centred care which remains an important direction of future concern for health policy and education (Kontos & Naglie, 2009). Emerging literature in health care suggests there are gaps between knowledge of ethical theory and its clinical application (Delany et al., 2010a). One way of overcoming any shortcomings from an ethical perspective is to educate clinicians 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). 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). A barrier to the development and refinement of ethics education is the lack of an agreed instrument to assess it (Carlin et al., 2011). Curzer et al. (2014), found that ethics classes significantly improved the overall theorising and reasoning scores of the participants. Curzer et al. (2014), had developed an assessment tool to establish if ethics can be taught. The participants were recruited from four universities and from classes including, 'Logic', 'Beginning Philosophy' and 'Introduction to Ethics'. Whilst their findings seem to demonstrate that moral thinking can be taught, they have not established if virtue can be taught since their results did not show that ethics classes improve moral passions, perceptions or behaviour. The sample participants of their study represented a further source of limitation since they were all likely to be sensitive to the subject of moral philosophy as they were a

self-selected population who had chosen to study subjects related to moral philosophy.

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). Acting virtuously can be learned, taught and practised, with role models perhaps playing an important part in this process (Vanlaere & Gastmans, 2007). Annas (2015), adds caution to this principle to say that habits form both ways and therefore all the environmental and personal cultures surrounding an individual may have created habituation. Teaching the habits of ethical caring for HCPs does not develop through theoretical learning alone, but is assimilated as bodily knowing that becomes an extension of the learner (Kontos & Naglie, 2009).

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, does point 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). Phronetic knowledge describes an inwards state of professionalism demonstrating what HCPs are rather than measuring what they do which comes about through critical self-reflection of their strengths, limitations and professional motivation (Tyreman, 2000). Svenaeus (2003), indicates that phronesis can also be used to criticise other ethical theories. Phronesis may not obviate the doubt and uncertainty that pervade moral discussion and decision making, but it has a unique relationship to the moral virtues which allows the concept to be used as a moral prosthetic (Waring, 2000). In current trends of health care practice the patient remains at the centre of their own decision making (DoH, 2012), and through phronetical praxis the HCP is challenged to support this concept by always striving to dialogue with the service user in exploring the right thing to do at this particular time for this particular service user.

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. Acting virtuously in dialogical and phronetical practice will include one's own reflections following on from discussion with the service user and at times other members of the organisation, which facilitates systematic reasoning and allows the drawing of conclusions that may lead to ethical decisions (Brännmark, 2009). This envelops the notion of criticality in health care decision making which embodies practical and theoretical knowledge where praxis pursues criticality in order to achieve phronesis (Tyreman, 2000). 'Sorge' or 'care' is an essential component of our being-in-the-world, and provides the connectedness required to be engaged in-the-world or indeed in another person's lifeworld (Miles et al., 2013). This suggests that the HCP and Service user relationship ought to be underpinned with advocacy that is incumbent on the HCP, through concern and duty, to meet the needs of the service user. 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).

## 11.2 The findings contextualised in the theoretical and philosophical frameworks

Phenomenological research begins with the researcher's curiosity or passion which is formed into a research question where intersubjectivity is embraced rather than the aim being scientific detachment (Finlay, 2013). The process of conducting research, guided in part by Heidegger's phenomenology, required engagement in both descriptive and interpretive activities (Mackey, 2005). The descriptive understanding of ethics, that the participants offered initially, was an eidetic process where the researcher attempted to meet the phenomenon as it presented itself without prejudice (Dowling, 2007). This was recorded as the first phase of coding offering fidelity and transparency of the verbatim transcriptions. The meticulous accuracy of the transcription offers authenticity of interpretation (Murray & Holmes, 2014). To achieve something with the data that is phenomenologically coherent, it was essential that the researcher did not simply use a mechanical application of coding, but to discern the meanings hermeneutically and recognise the important role of the researcher as the analyst in the construction of meaning (Langdrige, 2007). However, in response to the first question to every participant, 'what does

health care ethics mean to you?' It was considered essential for the reader to have the initial capture of responses clearly and transparently reproduced as a descriptive list of notions, in order to illustrate the starting point for analysis (see appendix 9).

As described in earlier chapters, IPA and the double hermeneutic process does not rely on the eidetic and reductionist influence of Husserl's phenomenology, but acknowledges the participation of the co-creation of the data with the researcher. The result of this process offers multiple realities through the self-interpreted construction of each participant's experiences in conjunction with the researchers (Laverty, 2003).

The analytical process was initiated prior to and including the first question asked at each interview, which allows recognition of the starting point of the researcher's and the participant's merging perspectives. The opening question may lead the participant by inference that HCE 'ought' to mean something to them. As would be expected with an observer effect, this may have created various influences on the participants. For hermeneutical phenomenology this effect is part of the valid co-constitution of findings. Heidegger considered the object and the subject inseparable (Mackey, 2005) and interpreted *dasein* as a structure which is *a priori* which he claimed is not pieced together, but is primordially and consistently a whole (Heidegger, 1962). Heidegger insists that whilst the being-in-the-world remains a whole, it affords us variety in the ways we view items which are constitutive. For Heidegger the whole of the structure always comes first, but if one keeps this in one's view then the objects for analysis, the phenomena, will stand out and one shall see the world in its worldhood.

Heidegger asserts that *sorge* (care) is a vital structure of *dasein* (being), but the cornerstone of the concept is 'time' (temporality and spatiality) (Miles et al., 2013). This is not considered in a linear fashion of time, but viewed as a connectedness (Annells, 1996). For Heidegger, time and space were not simple memories of events, but the remembering of an experience that reveals more about oneself. This could be understood as seeing the world and the person co-constituting one another, which is the philosophical assumption of indissoluble unity where both individuals are constructing the world, from their own experiences and at the same time being



constructed by the world (Koch, 1995). This allowed the researcher to make sense of the HCPs world from within it rather than as though detached from it (Annells, 1996). This concept offered an important notion of why ethics seemed to be tacitly engendered by the participants of this study (Gascoigne & Thornton, 2014; Watson, 2006). Heidegger asserts that *dasein* is never devoid of mood or disposition, as it is inextricably relative to context (McConnell-Henry et al., 2009). Any adequate account of virtues is impossible if divorced from the context of their social structure (MacIntyre, 2007). This involves the role of tacit knowledge where judgments are made by embodied agents in the face of complex data discerned about care of a person as a whole and their lifeworld which can be only partially guided by ethical codes (Thornton, 2006). Tacit knowledge may be considered as something acquired through experience, but cannot be explicitly articulated and allows action to be decided without deliberation or forethought (Kontos & Naglie, 2009). In this way, tacit knowledge makes possible the conventional and more easily recognised explicit dimensions of human knowledge (Henry, 2006). Explicit human knowledge depends on a wealth of tacit knowledge acquired through experience and is essential for problem solving, which is necessary for clinical judgment and decision making (Henry, 2006).

Tacit knowledge is an important source of knowledge to inform ethical decision making, but its acceptance is limited by the exclusive focus through the evidence based paradigm and thereby neglects the primordial and socio-cultural significance of embodied self-hood (Kontos & Naglie, 2009). Kontos and Naglie (2009), argue that embodied selfhood is what makes tacit knowledge possible both in terms of providing its foundational structure and facilitating its manifestation. Thus, ethics in health care ought to be influenced by the contextual lived experience of the relationship between the service user and the HCP. The awareness of temporality must permeate the interpretation of the phenomenon in order to understand the horizon in which the phenomenon has been presented (Mackey, 2005). Past experiences and current relationships, energy levels, anxieties and external pressures all seemed to influence the HCPs actions. Examples of how this may challenge HCPs were seen throughout the findings where participants illustrated their frustration with service users who they judge as less motivated to comply with them, or that the service may be unavailable due to the NHS criteria of exclusion and

inclusion. This demonstrates a lack of empathy offering limited or no process of understanding towards the service user's lifeworld and their motivation to be involved in the service provision. Motivation is a complex process demanding the recognition that people have different needs, set different goals in order to satisfy needs and undertake various actions for attainment of the goals (Miljković, 2007). It would be wrong to assume that there is one approach of motivation which could be used in any situation (Miljković, 2007). This remains a challenge to the individual service provider, the undergraduate education system, training and development programmes and for the regulation of the role of the HCP.

IPA allowed the examination of the personal lived experiences and was explicitly idiographic by its commitment to examining the detailed experience of each HCP in turn and was a particularly useful methodology for examining HCE, which are complex, ambiguous and emotionally laden (Biggerstaff & Thompson, 2008; Smith & Osborn, 2015). Heideggerian and Gadamerian phenomenological philosophy motivated the researcher to become part of the lifeworld of the participant. Lifeworld is understood as prereflective experience without preinterpretations (Dowling, 2007). It was the lifeworld of participant HCPs applying ethics prereflectively that this research tried to understand. The philosophical framework was directly applied to the interpretation of the participants' experiences with their service users (HCP and service user) and also the research methodology for this study (researcher and participant). This became a triangulated construction between the interviewer, the interviewee and the interviewee's experiences of service provision within the concept of HCE. This approach fostered a more natural relationship between the participants' and the researcher's own experiences, thereby allowing a dialogical fusion of horizons. The horizon that Gadamer conceptualised considered the totality of all that can be seen as a superior breadth of vision (Clark, 2008). This was achieved during the interviews and also during the analysis. The Gadamerian approach encouraged both the participant and the researcher to enter the interview with one horizon and to leave the encounter with a new horizon which extended the field of vision to see better rather than not to see what was previously observed (Clark, 2008). This approach recognised the researcher's centrality and acknowledged not only the articulated interpretations of the participants, but the researcher's ability to reflect and analyse this (Brocki & Wearden, 2006).

### 11.3 Limitations of this study

IPA's theoretical underpinnings originates 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). The researcher therefore acknowledged the subjectivity of the interpreted findings. 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).

#### 11.3.1 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; Clarke & Iphofen, 2008; Crist & Tanner, 2003; Davidsen, 2013; Finlay, 2011; Lavery, 2003; Mackey, 2005; McConnell-Henry et al., 2009; Miles et al., 2013; Moran, 2000; Murray & Holmes, 2014). In order to offer credibility for this research it was essential that the researcher made a particular and concentrated effort to retain awareness of the inextricability of the dasein or 'being with', in the presuppositions made and any influence of the participants (Miles et al., 2013). A criticism of this method is that the analytic methodology is not extant in the literature, with exception to brief descriptions of the analysis or the interpretive processes (Crist & Tanner, 2003). There is also an emerging concern 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 (Lavery, 2003). The researcher adopted caution from Koch (1996), who highlighted three issues concerning legitimization of the hermeneutic research process: 1; the philosophical underpinnings of the methodology, 2; the participation and representation of the researcher in making the data and 3; the establishment of rigour and trustworthiness of the study. These issues were considered throughout the research in order to offer confidence in

negating the impact of each of them. 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 avoid this lack of 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).

In the Husserlian method, the rigour of applying the phenomenological reduction allows objectivity to describe things as they appear in human consciousness and experience (Watson, 2006). By setting aside pre-understanding it helps to eliminate adverse interference with the research process (Miles et al., 2013). This can only be achieved by holding subjective perspectives and theoretical constructs in abeyance which will facilitate the emergence of the essence of the phenomena (Dowling, 2007). The practice of epoché or bracketing has been a source of controversy (Biggerstaff & Thompson, 2008). Epoché puts aside one's preconceived ideas and for Husserl was the main pathway in finding the true essence of the lived experience. The criticisms of Husserl's early work was his contention that knowledge stems from conscious awareness, which thus led him to advocate epoché as essential in remaining objective in his ontological and epistemological end point (McConnell-Henry, 2009). Initially the findings of this research were first presented to the reader with a Husserlian perspective to the participants' understanding of HCE as they emerged from the data (the 101 descriptive terms that were initially extracted and collated into list form). As previously discussed, this was not a true Husserlian approach, since the epoché was not practised during data collection. These descriptions were then developed through the Heideggerian method of analysis bringing about the interpretation of meaning which were then disclosed together in the findings. Careful awareness and reflection was retained in order to acknowledge how any prejudice gives a horizon which can influence the research process (Miles et al., 2013). The eventual phenomenological findings are the researcher's interpretations, rather than the original naïve participant descriptions (Finlay, 2013).

### 11.3.2 Limitations created by data collecting via interview

The author utilised an IPA method which offered knowledge located culturally and historically and may generate often contradictory interpretation of the same phenomena (King & Horrocks, 2010). Interpretation is part of humanity where every encounter involves an interpretation influenced by an individual's background and historicity (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 affecting the reliability of the data arises when interviewers and interviewees may not have a full awareness of themselves, both of which are discussed below (Whitehead, 2004).

Caution was required to remain aware that humans tend to conceal themselves and want to represent themselves in a certain light, thus making themselves artificial and unreliable with respect to the data representing epistemological knowledge (O'Hagan, 2009). Conversely as a hermeneutical researcher one may acknowledge the potential to have explicated a deeper meaning through being-in-their-world which diminishes the focus of the epistemological importance as it is subsumed into the ontological (Annells, 1996). Ontologically, this philosophical 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.

There remains, however, a subsequent paradox where the interpreted findings require trustworthiness and credibility. This is afforded through the rigour that has been adopted throughout this research and may be accepted by proponents of this method (this has been discussed in section 4.5). The aforementioned concerns, however, remain inherent with such methods.

Although the safeguards (discussed in section 4.5) were carefully adopted, the findings remain subjectively reported by the researcher. The acknowledged preconceptions and presuppositions were made clear through reflection and documented transparently in the Working Methods chapter to show any *a priori* thoughts from the early stages of the research. To pursue the fore-structures and thematic meanings held in the data, the researcher had to go beyond the literal meaning of the words used by the participants in order to achieve understanding (Brocki & Wearden, 2006; Finlay, 2013; Mackey, 2005). This therefore encouraged confidence to acknowledge the researcher 'being-in-the-world' of the participant and of this research (McConnell-Henry, 2009) providing that the hermeneutical analysis is always accompanied by critical reflection (Ramberg & Gjesdal, 2013). This helped to safeguard that any prior awareness, attention and anticipation was directed towards the phenomena being explored and ensured the interpretive process continued through immersion of the data i.e. the participant's descriptions of their experience of the phenomenon (Mackey, 2005). The findings were, therefore, presented with verbatim extracts including examples of the interviewer questions and subsequent discussions and were contextualised in the policies, culture and practice of physiotherapy and podiatry. This affords the reader transparency of the process of analysis as it unfolded, discussed and contextualised in the pertinent extant literature.

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 the emphasis of the embodied engagement with the world whilst not 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)

#### 11.4 Potential Outcome:

- Liaise with the HCPC to develop a new assessment metric for ethical reflection built into the Standards of Education and Training and the CPD profile framework for assessing the Standards of Proficiencies of physiotherapists and podiatrists. A key challenge of this may arise in the difficulties of educating and assessing the competency of abstract attributes, hence a common tendency to assess the justifiable measures of knowledge and skills (Park et al., 2012; Tyreman, 2000).

#### 11.5 Recommendations for further research

A key consideration of this study relates to the potential variation of interpretative analysis of the data captured and also what data may have been missed out or overlooked by both the participant and the interviewer (Whitehead, 2004). The trustworthiness of the data in this study is discussed elsewhere, however this remains to be a constraint requiring caution when considering the use of the findings in alternative settings. There are, however, several aspects of HCE that require further research consideration:

- Further studies could 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.
- Further research would be beneficial to establish how key stakeholders may consider the inclusion of ethical decision making into the Standards of Proficiencies for AHPs including physiotherapists and podiatrists.
- If key stakeholders were receptive of such an inclusion then it could be advantageous to carry out an exploration of how similar programmes in other disciplines, which already include such training, achieve these skills. A more coherent and integrated approach to the generation of ethics knowledge might more explicitly respond to the needs of individual practitioners and the profession (Carpenter, 2010).
- Include service users and commissioners in further exploration of possibilities for the development of any new curriculum which may serve to improve ethical decision making at all levels of service provision.

- If appropriate, and in liaison with the regulatory body (HCPC), focus groups (or other suitable methodology) could be used to develop a proposal to communicate a potential change in the HCPC's Standards of Education and Training.
- Further in-depth studies could focus upon the issue of tacit knowledge surrounding ethics and elucidate its potential for integration into practice.
- 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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## **APPENDICES**

**Appendix 1:** Research Ethics Approvals

**Appendix 2:** Consent forms

**Appendix 3:** Information sheet for participants in individual interviews

**Appendix 4:** Information sheets for participants in group interview

**Appendix 5:** Individual interview schedule, themes, and prompts

**Appendix 6:** Group interview agenda

**Appendix 7:** Group ground rules

**Appendix 8:** Group interview schedule, themes, and prompts

**Appendix 9:** Examples of the codification and thematisation

**Appendix 10:** Transcript example(s)

**Appendix 11:** Table 6 – Group interview summaries of potential areas of further consideration to engage HCPs in ethical decision making

## Appendix 1: Research Ethics Approvals

SREP/Appn/Rev1007

**THE UNIVERSITY OF HUDDERSFIELD**  
**School of Human and Health Sciences – School Research Ethics Panel**

**OUTLINE OF PROPOSAL**

Please complete and return via email to:  
 Kirsty Thomson SREP Administrator: [hhs\\_srep@hud.ac.uk](mailto:hhs_srep@hud.ac.uk)

Name of applicant: Michael Concannon

Title of study: An exploration of how ethics informs clinical reasoning and decision making for health care practitioners.

Department: Health Sciences

Date sent: 26<sup>th</sup> April 2012

Issue	Please provide sufficient detail for SREP to assess strategies used to address ethical issues in the research proposal
Researcher(s) details	Michael Concannon - Dept of Health Sciences, School of Human and Health Sciences. 01484 47 3788 <a href="mailto:m.j.concannon@hud.ac.uk">m.j.concannon@hud.ac.uk</a>
Supervisor details	Dr Warren Gillibrand - Dept of Health Sciences, School of Human and Health Sciences
Protocol Version number	<b>2</b>
Aim / objectives	<p><b>Aim of investigation:</b>          To explore the place of ethics in decision making when clinical reasoning takes place in health care.</p> <p><b>Objectives:</b></p> <ol style="list-style-type: none"> <li>1 To explore the processes of clinical reasoning used by health care practitioners.</li> <li>2 To explore the concept of ethics as a part of clinical reasoning processes.</li> <li>3 To consider the potential to develop a framework or guidelines that will support, enable or empower health care providers in their clinical reasoning and decision making based on sound ethical principles.</li> </ol>
Brief overview of research methodology	<p>The method being considered at this stage of the investigation is to interview a number of health care practitioners from Physiotherapy and Podiatry disciplines who are registered with the Health Professions Council (HPC). The participants will be purposively sampled and selected from a breadth of experience levels i.e. newly qualified to experienced staff (stratified and randomly stratified sampling). The decision to include Physiotherapists and Podiatrists exclusively in the interview process is as a consequence of identifying a gap in the literature in relation to health care ethics. These two groups of health care professionals are not represented in the literature in the way that other areas of health care are.</p> <p>This is supported by the method of purposive sampling to recruit to this study.</p>

	<p>From here it is hoped that an understanding of the views, attitudes and practices that are currently being adopted by HCP's will be gained, with respect to how ethics informs clinical reasoning and decision making. I intend to interview until saturation of new information of data has been collected. An estimate of a typical number of participants that might be recruited to achieve this will be around 10-20 people. The findings will be analysed and emerging themes identified from this data. These themes can then be taken to a focus group. The participants to the focus group will also be recruited from the same target population of the interviewees. The researcher intends to use purposive sampling for the focus group in order to achieve a selection of participants who have expressed a particular interest in the subject of ethics in health care. The purpose of the focus group is to enrich the data by further discussion around the extrapolated themes and critical consideration of them. The data that emerges from the focus group can then be analysed by the researcher. This will be used as a basis for the researcher to develop a framework or guidelines that may assist or empower a health care practitioner to inform the process of their clinical reasoning and ethical decision making.</p> <p>An appropriate qualitative method of enquiry will be adopted, using a hermeneutical stance within an interpretative phenomenological analytical (IPA) framework. This method seeks to promote the participants own reflection of experiential practice (phenomenology) and then interpreting them (hermeneutical) in the relevant and wider context. Landridge (2007) supports this by purporting that a phenomenological approach is "a concern with meaning and the way in which meaning arises in experience".</p>
Permissions for study	<p>Permission for this study will be sought from the school research and ethics panel (SREP) at the University of Huddersfield and from any relevant NHS or Private practice managers that may be involved in participation of this study. An application has been prepared for submission to IRAS (see attached) and, where required, the relevant R&amp;D departments will be approached to seek permission to continue with the study.</p>
Access to participants	<p>Participants may be NHS trust staff or private practitioners. Permission will be gained from the appropriate management via the NHS or Private Practice. This will also be pursued via the R&amp;D departments in the relevant trust organisation. Wherever necessary, honorary contracts may be required to ensure appropriate permission is gained for my activities as a researcher ensuring insurance cover for precarious liability.</p> <p>The participants will be written to, with a minimum of month notice, inviting them to take part. The information sheet will be enclosed and consent to take part will also be sought at this stage. A full explanation of voluntary participation and withdrawal</p>

	<p>will also be given.</p> <p>The arrangements for the interviews will be negotiated on an individual basis with respect to making the arrangements as practicable as possible. To avoid inconvenience to the participant, the researcher will attempt to arrange the interviews at the participant's normal place of work. If a suitable room is not available then the University of Huddersfield can be used. The focus group will take place at the University of Huddersfield.</p>
Confidentiality	<p>Confidentiality of the individual participants and their disclosures will be assured. If, however, any disclosure was made that would be of public concern e.g. safeguarding of children and vulnerable adults, whistle blowing issues or a concern about the practice of a health care professional then it would be reported to the local Trust, via the line manager, who would deal with the concern, in line with their Trust Policy. If the concern comes from a private sector worker, the issue may be reported to the Health Professions Council. This proposed action is made clear in the participant information sheet that will be offered prior and as a part of the consent to take part. This information will also be given to the line manager who will be responsible for the initial access permissions for participant recruitment.</p> <p>The personal data associated with individuals will be kept secure and separately from the main body of the written research. This data will be retained for three months after the study has been published. When engaging in the shared environment of the focus group, the researcher will facilitate a brief session to establish ground rules within the group that deal with this issue and ask for respect of it at all times. All interviews and focus group will be recorded with permission of the participants. It will be explained to all involved that audio recordings will be transcribed by the researcher. Only the researcher will have access to this data. The audio data will be locked in a secure office in the researcher's institution. The transcribed data will be retained on a password protected University computer, which will be retained for five years after the study has been published.</p>
Anonymity	<p>Anonymity will be assured for all participants. The individual information and data collection will be kept secure on a pass word protected computer at the University of Huddersfield. There will be traceability of data to enable the potential withdrawal of participant information at their own request. This will be achieved using pseudonyms in the collected data that is associated with the individual participants. As suggested above, the personal data associated with individuals will be kept secure and separately from the main body of the written research. Only the researcher will have access to this data.</p>
Psychological support for participants	<p>The researcher will ensure that each participant will be clearly advised to seek support from their own Occupational Health Dept or their GP should they become distressed as a consequence of this research.</p>

Researcher safety / support (attach complete University Risk Analysis and Management form)	Lone working by the interviewer/researcher during interviews has been highlighted as a potential issue for consideration. The researcher has previous training on management of aggressive behaviour. There will also be a nominated person who will be aware of the researcher's interview schedule and approximate timing. The researcher will make contact with this person when each interview and focus group has been completed in order to report their personal safety. The researcher will also carry a well charged mobile phone. The interviewer will carry appropriate identification with them at all times.  Please see attached risk assessment and management form.
Identify any potential conflicts of interest	None have been identified
<b>Please supply copies of all relevant supporting documentation electronically. If this is not available electronically, please provide explanation and supply hard copy</b>	
Information sheets	For the interviews and the focus groups – both attached
Consent form	Attached – consent will be gained for both forms of intervention (ie interview (s) and focus group).
Letters	Attached
Questionnaire	Attached
Interview schedule	Attached
Dissemination of results	I intend to: <ul style="list-style-type: none"> <li>• Complete a thesis based on the data collected and contextualised in the subject of ethical decision making in clinical reasoning.</li> <li>• Prepare and submit papers in peer reviewed journals</li> <li>• Complete a summary report of the research findings for all participants</li> <li>• Present at local and national conferences</li> </ul>
Other issues	None noted
Where application is to be made to NHS Research Ethics Committee	I have prepared an IRAS application ready for submission (see attached).
All documentation has been read by supervisor (where applicable)	Please confirm. This proposal will not be considered unless the supervisor has submitted a report confirming that (s)he has read all documents and supports their submission to SREP

**All documentation must be submitted to the SREP administrator. All proposals will be reviewed by two members of SREP. If it is considered necessary to discuss the proposal with the full SREP, the applicant (and their supervisor if the applicant is a student) will be invited to attend the next SREP meeting.**

**If you have any queries relating to the completion of this form or any other queries relating to SREP's consideration of this proposal, please do not hesitate to contact either of the co-chairs of SREP: Professor Eric Blyth [e.d.blyth@hud.ac.uk](mailto:e.d.blyth@hud.ac.uk); ☎ [47] 2457 or Professor Nigel King [n.king@hud.ac.uk](mailto:n.king@hud.ac.uk) ; ☎ [47] 2812**

**From:** Kirsty Thomson  
**Sent:** 14 March 2012 11:41  
**To:** Michael Concannon; Michael Concannon U0975790  
**Cc:** Karen Ousey  
**Subject:** Your SREP Application - Michael Concannon - APPROVED - 'An exploration of how ethics informs clinical reasoning and decision making for health care practitioners'

Dear Michael,

Dr Karen Ousey, Deputy Chair of SREP, has asked me to confirm that your SREP application as titled above has now received full ethical approval.

With best wishes for the success of your research.

Regards,

Kirsty  
(on behalf of Dr Karen Ousey, Deputy Chair of SREP)

Kirsty Thomson  
School of Human and Health Sciences Research Office (HHRG/01)  
University of Huddersfield  
Queensgate  
Huddersfield  
HD1 3DH  
Direct Tel: +44(0)1484 471156  
Email: [k.thomson@hud.ac.uk](mailto:k.thomson@hud.ac.uk)

If you're interested in studying at Huddersfield, or have already applied, why not join iHud?  
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NHS Trust



Telephone:  
Fax:  
Email:



30 April 2012



Dear [Redacted]

**ID: 982 An exploration of how ethics informs clinical reasoning and decision making for health care practitioners. PhD**

The Research and Development department has considered the following documents in support of your application for approval to undertake the study on the premises of [Redacted] NHS Foundation Trust:

Document	Version	dated
SREP Proposal NHS R&D Form	2	26-04-12

Your study now has R&D approval on the understanding and provision that you will adhere to the following conditions:

**That the research should:**

- Comply with the requirements of The Research Governance Framework for Health and Social Care (2<sup>nd</sup> DH 2005);
- Comply with regulatory requirements and legislation relating to: Clinical Trials, Data Protection, Health and Safety, Trust Caldicott Guidelines, and the use of Human Tissue for research purposes;
- Be conducted in accordance with: ICH Good Clinical Practice and/or the MRC guidelines for good clinical practice (as appropriate);
- Not commence until it has received written approval from a UKECA recognised Research Ethics Committee (REC) and that any REC imposed conditions of that approval are implemented;

**You must also:**

- Request written approval for any change to the approved protocol/study documents that you or the Chief Investigator wish to implement;
- Ensure that all study personnel, not employed by [Redacted] NHS Foundation Trust, hold either an honorary contract with the Trust or a letter of access issued by the Trust, before they have access to any facilities, patients, staff, their data, tissue or organs;
- Complete the Research Governance interim and final reports as requested;



- Submit monthly recruitment and screening data to R&D (if applicable).
- Comply with our audit and monitoring procedures as required.

**Please note:**

- The use of medicines not in the hospital formulary for the purpose of research is restricted to trust approved trial protocols only. Continued use of them outside or at the end of a clinical trial will require a formal application to and approval from the Medicines Management Committee. Trial participants should be made aware of this situation.

**This approval letter constitutes a favourable Site Specific Assessment (SSA) for this site**

Please be aware that the R&D department has a database containing study related information, and personal information about individual investigators e.g. name address, contact details etc. This information will be managed according to the principles established in The Data Protection Act.

Yours sincerely

[Redacted signature]

[Redacted name]





require to be approved and costed by your directorate and the research support services involved in its delivery, before the research governance process can begin. The documentation linked here ([Directorate Approval Form](#)) will guide you through the process.

**Authorisation by the Research Department**

On receipt of confirmation of approval by your host directorate, research support services and directorate accountant, please forward your *Directorate Approval Form* to your Research Department co-ordinator [XX\\_nhs.uk](#) who will take you through the stages involved in obtaining the agreements and documentation necessary for authorisation - please refer to the [Authorisation Flowchart](#). Hyperlinks to relevant forms and documents are included in the flowchart.

**Help from the Research Department**

Your co-ordinator is available at all times to guide, support and advise. We also have a comprehensive suite of [Standard Operating Procedures](#) to assist you in the good management of your study and in fulfilling your legal obligations.

Please print out this memo and insert it as the first document in your [site file](#), which your co-ordinator will review as the final step in the authorisation process.

If you have any queries, please contact your co-ordinator.

Best wishes,

**XXXXXXXXXXXX**

Senior Research Manager

cc. AXXXXXXXXXXXX

## Appendix 2: Consent forms

### UNIVERSITY OF HUDDERSFIELD

**TITLE OF PROJECT:** An exploration of how ethics informs clinical reasoning and decision making for health care practitioners.

**NAME OF RESEARCHER:** Michael Concannon

#### Interview consent form

I have been fully informed of the nature and aims of this research and consent to taking part in it.

I understand that I have the right to withdraw from the interview at any time without giving any reason and a right to withdraw my data if I wish (up to 12 weeks post interview).

I give my permission for my interview to be digitally recorded.

I give permission to be quoted (by use of pseudonym).

I understand that the recording will be kept in secure conditions at the University of Huddersfield.

I understand that no person other than the interviewer will have access to the recording.

I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.


Name of participant

Signature

Date

Name of researcher: Michael Concannon

Signature:

Date:

*Two copies of this consent form should be completed: One copy to be retained by the participant and one copy to be retained by the researcher*

**UNIVERSITY OF HUDDERSFIELD**

**TITLE OF PROJECT:** An exploration of how ethics informs clinical reasoning and decision making for health care practitioners.

**NAME OF RESEARCHER:** Michael Concannon

**Group Interview consent form**

I have been fully informed of the nature and aims of this research and consent to taking part in it.

I understand that I have the right to withdraw from the interview at any time without giving any reason (up to 4 weeks post interview).

I give my permission for my interview to be digitally recorded.

I give permission to be quoted (by use of pseudonym).

I understand that the recording will be kept in secure conditions at the University of Huddersfield.

I understand that no person other than the research team will have access to the recording.

I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.

Once the group has finished, I will not disclose (outside of the group) any confidential discussion that took place during the group interview and I will not disclose the names of the other members of the group without their prior agreement.


Name of participant

Signature

Date: Tuesday 5<sup>th</sup> November 2013

Name of researcher: Michael Concannon

Signature:

Date: Tuesday 5<sup>th</sup> November 2013

*Two copies of this consent form should be completed: One copy to be retained by the participant and one copy to be retained by the researcher*

## **Appendix 3: Information sheet for participants in individual interviews**

### **An exploration of how ethics informs clinical reasoning and decision making for health care practitioners.**

Researcher: Michael Concannon  
Department of Clinical Sciences  
School of Human and Health Sciences  
University of Huddersfield

Supervisor: Dr Warren Gillibrand  
Department of Clinical Sciences  
School of Human and Health Sciences  
University of Huddersfield

#### **Interview** **Participant Information Sheet**

My name is Michael Concannon. I am a podiatrist working as a Senior Lecturer in Podiatry at the University of Huddersfield. I am currently working towards a PhD and am undertaking a research study which will involve me conducting individual interviews and a focus group. The interviews and focus group will enable me to collect data which I intend to use in part fulfilment of the PhD.

The nature of the research is to consider how ethical issues drive clinical reasoning and decision making in health care practitioners.

#### **Why have I been asked to participate?**

You have been asked to participate because of your involvement in health care practice but before you decide to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and please do not hesitate to ask if there is anything that is not clear or if you would like more information.

#### **What is the research about and what are its potential benefits?**

The research is aimed at exploring the role of ethics in decision making for clinical reasoning in health care. It is hoped that this research may provide guidance that will support, enable or empower health care providers in their clinical reasoning and decision making based on sound ethical principles.

#### **What will I be asked to do?**

After completing a consent form, you will be asked to take part in an individual interview, which will last approximately one hour. I will conduct the interview and will ask you a series of questions on some key issues related to ethics and clinical decision making. The interviews can take place at your work environment (if a suitable room is accessible) or at the University of Huddersfield. With your permission, the interview will be audio recorded and written notes may be taken. Following your interview, you will be invited to review the transcript for accuracy.

#### **Do I have to take part?**

No, participation is entirely voluntary.

If you decide to take part you will be free to withdraw at any time and without giving a reason which can be before the individual interview is held and up to 12 weeks after.

#### **What will you do with the findings from the research?**

The main focus of the research is in part fulfillment of a Doctoral thesis. The findings may be published in academic journals and presented at national and international academic conferences. All the ideas discussed in your interview will be collated along with the information taken from the other interviewees. The data will be analysed and thematically grouped. These themes will then be presented to a focus group (of health care practitioners) for further discussion.

**Will I be personally identified in the research?**

No, all participants will be given a pseudonym and this will be used in any publications, conference or presentations. So that I am able to identify your contribution should you later decide to withdraw it, a list of participants' names and their corresponding pseudonyms will be kept by me on a password-protected computer. Anything that you say in your interview that could identify you personally or the NHS trust you work for, will not be used in any publications or conference presentations.

**Will the information I provide be confidential?**

Before your interview begins, you will be assured that you and your employer's anonymity will be respected. No person outside the research team will have access to the recording or to the transcriptions. The audio recordings will be kept securely. The transcripts will be kept on a password-protected computer.

If you discuss something that represents a breach in professional conduct or a public interest disclosure, then I am under statutory obligation to report it according to local trust policy or HPC guidance.

**Is taking part likely to have any detrimental effect on me?**

This is highly unlikely. However, when taking part in any research there is always a remote possibility that you may become distressed. In case this happens, you should contact your own occupational health department or GP.

**What should I do if I have any questions?**

I will be happy to answer any queries you may have, before during and after taking part in the research.

**Contact details:**

Researcher  
Michael Concannon  
Senior Lecturer  
Dept of Clinical Sciences  
School of Human and Health Sciences  
University of Huddersfield  
Queensgate  
Huddersfield  
UK  
tel : +44 (0)1484 473788  
email: [m.i.concannon@hud.ac.uk](mailto:m.i.concannon@hud.ac.uk)

Supervisor  
Dr. Warren Gillibrand  
Senior Lecturer  
Dept of Clinical Sciences  
School of Human and Health Sciences  
University of Huddersfield  
Queensgate  
Huddersfield  
UK  
tel: 01484 47 3689  
email: [w.p.gillibrand@hud.ac.uk](mailto:w.p.gillibrand@hud.ac.uk)

## Appendix 4: Information sheets for participants in group interview

### **An exploration of how ethics informs clinical reasoning and decision making for health care practitioners.**

Researcher: Michael Concannon  
Department of Clinical Sciences  
School of Human and Health Sciences  
University of Huddersfield

Supervisor: Dr Warren Gillibrand  
Department of Clinical Sciences  
School of Human and Health Sciences  
University of Huddersfield

#### **Group Interview/Discussion Participant Information Sheet**

My name is Michael Concannon. I am a podiatrist working as a Senior Lecturer in Podiatry at the University of Huddersfield. I am currently working towards a PhD and am undertaking a research study which will involve me conducting individual interviews and a focus group. The interviews and focus group will enable me to collect data which I intend to use in part fulfilment of the PhD.

The nature of the research is to consider how ethical issues drive clinical reasoning and decision making in health care practitioners.

#### **Why have I been asked to participate?**

You have been asked to participate because of your involvement in health care practice or as a service user of health care. Before you decide to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and please do not hesitate to ask if there is anything that is not clear or if you would like more information.

#### **What is the research about and what are its potential benefits?**

The research is aimed at exploring the role of ethics in decision making for clinical reasoning in health care. It is hoped that this research may offer information that the researcher could use to develop guidance that will support, enable or empower health care providers in their clinical reasoning and decision making based on sound ethical principles.

#### **What will I be asked to do?**

After completing a consent form, you will be asked to take part in a group discussion/interview with 5 or 6 other people, which will last around 90 mins. The other participants will be recruited from the professions of Podiatry or Physiotherapy of users of these services. The group interview/discussion will take place at the University of Huddersfield in a room appropriate for this activity.

Within the group you will be asked to consider and discuss with each other, some themes constructed from previously organized interviews with other health care practitioners of a similar background.

With your permission, the group will be audio recorded and written notes may be taken. Following the session you will be invited to review the transcript for accuracy.

#### **Do I have to take part?**

No, participation is entirely voluntary.

If you decide to take part you will be free to withdraw and without giving a reason which can be before the group is held and up to 4 weeks after.

#### **What will you do with the findings from the research?**

The main focus of the research is in part fulfilment of a Doctoral thesis. The findings may be published in academic journals and presented at national and international academic conferences.



All the ideas discussed in your focus group will be further analysed and used by the researcher to begin a process of developing themes that could be used to achieve the main aim of this research.

**Will I be personally identified in the research?**

No, all participants will be given a pseudonym and this will be used in any publications, conference or presentations. So that I am able to identify your contribution should you later decide to withdraw it, a list of participants' names and their corresponding pseudonyms will be kept by me on a password-protected computer. Anything that you say in the focus group that could identify you personally or the NHS trust you work for, will not be used in any publications or conference presentations.

**Will the information I provide be confidential?**

Before the focus groups begins, all members will be asked to respect the confidentiality and anonymity of the other members by not revealing to others the names of specific group members or what they have said. No person outside the research team will have access to the recording or to the transcriptions. The audio recordings will be kept securely. The transcripts will be kept on a password-protected computer.

If any member of the group discusses something that represents a public interest disclosure, then I am under statutory obligation to act according to local trust policy or HPC guidance.

**Is taking part likely to have any detrimental effect on me?**

This is highly unlikely. However, when taking part in any research there is always a remote possibility that you may become distressed. In case this happens, you should contact your own occupational health department or GP.

**What should I do if I have any questions?**

I will be happy to answer any queries you may have, before during and after taking part in the research.

**Contact details:**

Researcher  
Michael Concannon  
Senior Lecturer  
Dept of Clinical Sciences  
School of Human and Health Sciences  
University of Huddersfield  
Queensgate  
Huddersfield  
UK  
tel : +44 (0)1484 473788  
email: [m.j.concannon@hud.ac.uk](mailto:m.j.concannon@hud.ac.uk)

Supervisor  
Dr. Warren Gillibrand  
Senior Lecturer  
Dept of Clinical Sciences  
School of Human and Health Sciences  
University of Huddersfield  
Queensgate  
Huddersfield  
UK  
tel: 01484 47 3689  
email: [w.p.gillibrand@hud.ac.uk](mailto:w.p.gillibrand@hud.ac.uk)

## Appendix 5: Individual interview schedule, themes, and prompts

### DRAFT 1

Recording equipment pre tested prior to start of interview

An introduction will be given to explain the purpose of the study. Consent will be taken in verbal and written form – supported by the information sheet and consent form.

Promote a relaxed atmosphere; reiterate that the interview is confidential and will continue voluntarily and that all responses will be anonymised.

### Interview Questions and Prompts

<b>Interview number:</b>		
Question	Prompts	Field Notes or comments to consider
How long you have worked in health care and in what capacity?		
Tell me what the term “health care ethics” means to you.		
Within your practice (podiatry or physio) what aspects of “health care ethics” inform your decisions?		
Do you think that the decisions you make relate to the ethical duties that are documented by the HPC?  Can you give me some examples to illustrate this?	support the participant by offering the HPC document and guide them to the appropriate questions	
How much training have you received in health care ethics?	<ul style="list-style-type: none"> <li>• From undergraduate training?</li> <li>• In post graduate training?</li> <li>• CPD or internal training events?</li> </ul>	
Tell me how your work environment supports the application of an ethical approach to clinical reasoning?  Can you give me an example or some details that help to explain your answer?	policy guidance on patient choices or waiting times or resource provision locally or equipment	
Are there any restrictions placed on you by your work environment that challenges your ethical approach to clinical reasoning?	Perhaps the things mentioned above could help or hinder?	
Tell me some of the things which may challenge the process of ethical decision making in your clinical reasoning.  How do you try to overcome these challenges?	Perhaps consider the ability of the patient to understand and concord with your management planning?	
For each patient you work with do you feel you are able to apply solid ethical principles in your clinical reasoning process?		

Give me a recent example of a decision you have made in clinical practice/provision that have made you think more deeply about the outcome of your clinical reasoning?		
Are you always fully satisfied that the decisions that are made will be ethical? Have there been any times that you recognise a decision that was reached in forming your clinical reasoning that you might not be fully satisfied with? – explain the circumstances for me?	This DOES NOT imply that some decisions made are therefore UNETHICAL but that the process leaves one thinking about possible improvements to the process.	
Are there any suggestions that you might consider that could improve ethical decision making for health care practitioners?	This could be through training Or Institutionally at work? Personally for individuals?	
Routinely, what is the process you go through to gain informed consent with your patients?		
Tell me what you see as the core elements in gaining informed consent?  What about information sharing? Tell me how? How do you ensure patient choice?  If there is a patient where this poses a difficult process, what might you do to overcome this?	prompt – this could be brightness and knowledge or learning disabilities	
Tell me how important you think it is that the patient is informed about the evidence base for treatments?  How would you approach this discussion with your patients?	What might this enable? Why is this important? and indeed What challenge might it give you?	
Tell me about the place of patient trust in your clinical decision making?		
Does your patient interaction change in any way when working with a clearly informed patient when compared to a less informed patient?	This may be in reference to an internet savvy patient who has “read up” or a member of the medical profession – Both compared to a patient who may be struggling to understand.	

When there is a range of modalities for the treatment of a patient – what influences your choice to apply a certain modality?	E.g. non complex pt presentations, complex pt presentations (co morbidities etc).	
On reflection, how do you think your consideration of ethics has evolved/changed over the time you have been involved in health care?	From original understanding of the subject in training at undergraduate level to how practice may have formed your working practices?	
Is there anything that I have not covered that you think may be useful for this study?		

## Final version

- Recording equipment pre tested prior to start of interview
- An introduction will be given to explain the purpose of the study. Consent will be taken in verbal and written form – supported by the information sheet and consent form.
- Promote a relaxed atmosphere; reiterate that the interview is confidential and will continue voluntarily and that all responses will be anonymised.
- Offer an explanation to suggest that the questions may or not be clear and may not illicit clear or known answers but at least to know that there is NO RIGHT OR WRONG answers

## Interview Questions and Prompts

Question	Prompts	Notes or comments to consider
How long you have worked in health care and in what capacity?		
Tell me what the term “health care ethics” means to you.		
Within your practice how do these aspects (of health care ethics) inform your clinical decisions?		
What influence does your work environment have on your clinical reasoning and decision making?	To what extent do you feel able to change or influence this?	
On reflection, how do you think your consideration of ethics has evolved/changed over the time you have been involved in health care?		
Is there anything that I have not covered that you think may be useful for this study?		

## Appendix 6: Group interview agenda

### **Group interview/discussion** **General information about the session**

#### **Your participation on Tuesday November 5<sup>th</sup> 2013:**

There will be an independent facilitator to help coordinate the discussion.

As a part of the group you are being asked to participate in a discussion related to the subject of ethics in health care. This may include consideration of information that will be shared with you, by me on the morning of the group interview/discussion. This information is a summary of how I have interpreted the findings of 20 individual interviews that I have conducted over the last 12 months. No prior knowledge is necessary or expected from you. I am interested in any thoughts or experiences that you may be able to share (or not) with respect to the topics that the group facilitator or I will raise.

My role, on the morning, will be to observe and take any extra notes that may help my analysis of your discussion. I can not pretend to separate myself from the group and therefore am able to join in the discussion as appropriate and may need to join the discussion for clarification where necessary.

#### **My research aim and objectives are:**

Principal Aim: To explore how ethics informs clinical reasoning and decision making in podiatry and physiotherapy practice.

Objectives:

- Identify barriers to ethical decision making in the clinical reasoning process.
- Identify key elements to ethical dimensions that contribute to effective decision making in the clinical reasoning process.

## Appendix 7: Group ground rules

### **Ground Rules for the group interview/discussion**

There will be an independent facilitator to help coordinate the discussion. Before any discussion takes place the group will be reminded that all participants' names and all group conversation, should be treated as confidential and not discussed outside of the group. Any other ground rules that the group feel appropriate can be agreed at this point.

#### **Ground rules:**

- Listen actively and respect others when they are speaking
- Speak from your own experiences
- Don't be afraid to respectfully challenge
- Participate to your fullest ability
- Confidentiality of the discussion after the group discussion

## Appendix 8: Group interview schedule, themes, and prompts

### Group interview/discussion schedule

#### Researcher:

- Welcome and brief introduction by me to introduce the group to the facilitator.
- Consent forms signed and collected and any questions at that stage.

#### Facilitator:

- Group Introductions.
- Ground rules established and agreed
- Michael introduces the findings of the 21 individual interviews:
  1. Phase 1 coding – 101 descriptives
  2. Phase 2 coding – 7 grouped themes
  3. Phase 3 coding – following a theme that ethics appears discordant from the common understanding in practice. This is the main point of discussion from within the group interview.

#### For Discussion:

Theme 1 = Patient at the centre of all decisions

- So first of all in the context of service user satisfaction – can I address a question about how users may feel about how much their voice is heard in patient care, for you or any member of your family?
- Why?
- What are the positives and negatives of the way you feel a part of your own management in the current health care system?

Theme 2 = Staff in health care delivery

- What drives ethical practice?? – can you think about the differences that may arise in the playing out of ethics in practice compared to what might be said on paper or academically by a HCPC?
- Disconnected from personal ethics but looking vicariously to the employer why are staff disenfranchised from “making a difference” against the trend?
- What place in health care is there for Personal ethics? (***If necessary, let us try to define the term “personal ethics”.***)
- What informs the ethics of our workforce? From where have ethics derived? (***Perhaps we could ask the service users where they think the ethics should have been inputted into their clinicians, then ask the manager, then ask the HCP’s***)
- What drives ethics what prevents it? (motivation)?

Summary of discussion

Drawing to a close

- How will the discussion contribute to making changes?
- Where is this information going?





# HICARE ETHICS

- THEMES =
- DEFINE
  - INTERPRET
  - APPLY

CHALLENGED/BARRIERS  
FACILITATED  
INFLUENCE  
AUTONOMY

PHASE 1  
CODES  
= 101

## DEFINITIONS

(27)

- Service Delivery in balance of budgets
- Good buzz word "if it's ethical = it's good"
- If it's unethical then it's putting people at risk
- It's not individual (which is personal belief) but an organisational duty of care
- Thought processes
- Research
- Equal opportunities
- Health + Safety
- Doing the best for the pt's
- Pt's best interest
- A professional relationship
- Equal effort given to all
- Making the time count
- How we Rx our Pt's
- Not harming them
- Rx individually, suitably + holistically
- Not Rx them all the same
- Rx everyone the same
- None discriminatory
- Duty of care
- Doing the right thing
- Honesty in what we can offer
- The environment - who is in the room
  - Dignity
- I Don't know
- ITS DIFFICULT TO DESCRIBE
- RECORD KEEPING (2) ALSO R.H. in accountability + defence against poor care due to resource limits.
- CONFIDENTIALITY

## ETHICS DERIVATION

### TRAINING/EDUCATION

(11)

- None
- You <sup>just</sup> pick it up, experienced colleagues + even other ~~not~~ other professionals
- (1 course) - 1 module but none took it seriously
- Research
- PRIVACY + DIGNITY
- HUMANITY
- PARENTS
- UPBRINGING
- SOCIETY
- MORAL COMPASS
- RELIGION

(11)

## ETHICS IN ACTION

(24)

- WHAT YOU DO MUST BE BACKED UP
- EBP
- DERIVED FROM ASSESSMENT
- BASED ON EXPERIENCE
- IT IS INDIVIDUALLY APPLIED
- FOLLOWING STANDARDS OF CARE
- FOLLOWING PATHWAYS OF CARE
- CHOICE - WHAT WE CAN + CAN'T OFFER
- WORKING TOGETHER
  - ↳ GET THEM ON BOARD
  - ↳ IT'S HARD TO REVERSE THEIR THOUGHTS
- EMPOWERMENT
- ACTING WITH CONSEQUENCES
- AUTONOMY
  - ↳ REFER ON
- EXPERIENCE - AGE RELATED OLDER = BETTER
- ENSURE TRAINING UPDATES AND EXPOSURE TO RELEVANT PRACTICE ISSUES WITHIN YOUR SCOPE OF PRACTICE
- SOUND JUDGEMENTS
- BELIEVE IN WHAT YOU ARE DOING
- BY YOUR JUDGEMENT
- WHAT THE PT WANTS
- LOOK FOR LONG TERM OUTCOMES
- GIVING ADVICE
  - ↳ FOR H'ED
  - ↳ WHEN ASKED DIRECTLY
- EXPLAIN THINGS WELL
- CONSENT
- FULLY INFORMED? WITH ALL RISKS
- ENSURE UNDERSTANDING

## CONFLICTS / BARRIERS (16)

- COMMISSIONING OF - NO KIDS IN MSK IN POST CODE LOTTERY
- POST CODE DIFFERENCES
- MONEY
- Health Policies
- Poor resources
  - ↳ drawings
  - ↳ ISSUES
- No of appointments allowed for certain conditions
- MISUNDERSTANDINGS, COMMUNICATIONS OR EXPECTATIONS
- GETTING TO THE STAGE WHERE NHS STAFF ARE MORE WORRIED ABOUT THEMSELVES (LITIGATION) RATHER THAN CONCERN FOR PT.
- NHS IS NOT PT FOCUSED - IT IS MONEY
- LONG HOURS + MANY PATIENTS
- EFFICIENCY + SAVINGS
- CUT BACKS
- RESOURCE LIMITATIONS
- TIME WITH PATIENTS RESTRICTED
- FUNDING RESTRICTIONS MEANS R<sub>x</sub> IS RESTRICTED TO REFERRAL REQUEST ONLY
- EXTERNAL DEMANDS - PRESSURE & FUNCTIONAL NEED TO 'MOVE ON' (SPORT)

## DIFFERENCES / BARRIERS CREATED IN NHS + PP (11)

- PAYING vs "NOW PAYING"
- NHS STAFF HAVE A DUTY OF CARE "IF" MEETING INCLUSION CRITERIA
- PP - INSURANCE PAYING PTS
- HAVING THINGS DONE 'TO THEM' DIVIDES LONG TERM / SHORT TERM
- EXPECTATIONS of "SERVICE"
- COSTS vs. BENEFITS = "HARD TO SELL EXERCISES"
- NHS "WE CAN'T HAVE THEM COMING BACK FOR EVER"
- NHS STAFF → "PP'S ARE HAPPY TO KEEP GOING BACK"
- NO OF R<sub>x</sub> SESSIONS
- ORGANISATIONAL / CULTURAL INFLUENCES
- PP = BETTER CARE
  - = MORE PERSONAL CARE
  - = MORE TIME

(11)+

## ACCOUNTABILITY (12)

- HCPC - Code of conduct
- AUTONOMOUS
- CASE LOAD REVIEWS
- M<sub>x</sub> OBJECTIVES DIFFER FROM HCPC RESOLUTION + OBJECTIVES
- PT WORKLOAD + COMPLEXITY SHOULD MATCH SKILL BASE
- STANDARDS → FED DOWN FROM MANAGERS
- CONSEQUENTIALISM
- PEOPLE / COLLEAGUES WATCHING YOU
- EMPLOYER PAYING YOU SO YOU ARE CULPABLE BY RESPONSIBILITY.
- WAGE PAYER
- CLAIM CULTURE - BECOMING MORE + MORE AWARE
- SELF = ETHICS IS EVERYTHING WE DO, OUR THINKING + HOLISTIC APPROACH
  - = DOCUMENTATION TO SAFEGUARD OUSELVE
  - = USE UNION (NHS) TO DEFINE ROLE

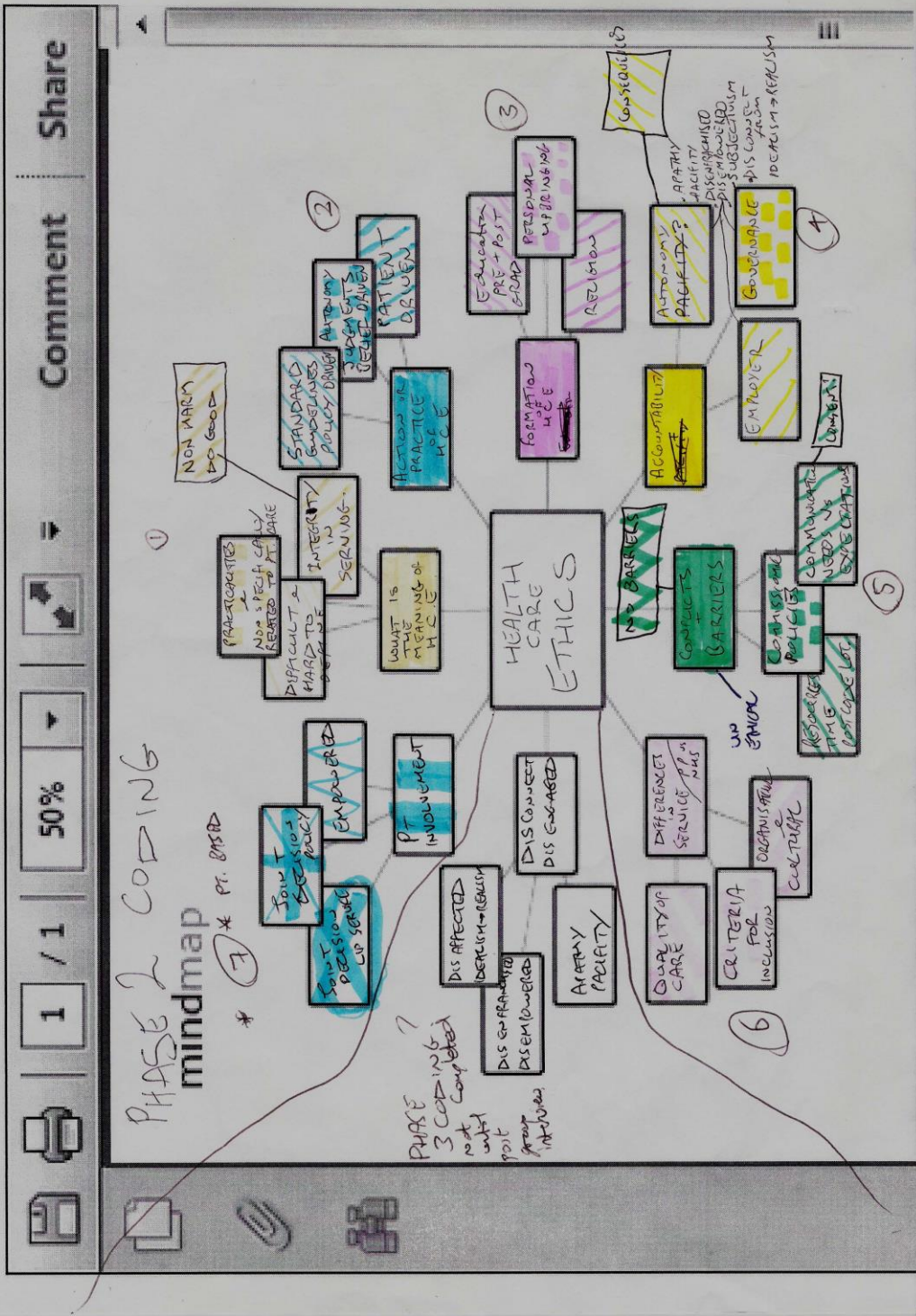
(12)+

Coding Themes (101 themes in the first phase of coding).

<b>Coding Categories (101 descriptive terms highlighted in the first phase of coding).</b>	
<b>Definitions:</b>	
1	Service delivery in balance with budgets
2	Good buzz word "if its ethical – its good"
3	If it's unethical then it is putting people at risk
4	It's not individual (which is personal belief but an organisational duty of care)
5	Thought processes
6	Research
7	Equal opportunities
8	Health and safety
9	Doing the best for the patients
10	Patients best interest
11	A professional relationship
12	Equal effort given to all
13	Making the time count
14	How we treat our patients
15	Not harming them
16	Treating individually, suitably and holistically
17	Not treating them all the same
18	Treating them all the same
19	Non-discriminatory
20	Duty of care
21	Doing the right thing
22	Honesty in what we can offer
23	The environment where you work, e.g. who is in the room = dignity
24	I don't know
25	It's difficult to describe
26	Record keeping for the patient
27	Record keeping for accountability and defence against poor care due to resource limits
28	Confidentiality
<b>Ethics derivation/training or education</b>	
1	None
2	You just pick it up experienced colleagues and even other MDT and other professionals
3	(one person not trained in this country) 1 module at foundation but on-one took it seriously
4	Research
5	Privacy and dignity training
6	Humanity
7	Parents
8	Upbringing

9	Society
10	Moral compass
11	Religion
<b>Application of ethics</b>	
1	What you do must be backed up
2	EBP
3	Based on experience
4	It is individually applied
5	Following standards of care
6	Following pathways of care
7	Choice, what we can and can't offer
8	Working together – to get them on board, it's hard to reverse their thoughts
9	Empowerment
10	Acting with consequences
11	Autonomy (refer on)
12	Experience – age related (older the better and younger the lesser)
13	Ensure training updates and exposure to relevant practice issues within your scope of practice
14	Sound judgments
15	By your judgments
16	Believe in what you are doing
17	What the patient wants
18	Look for long term outcomes
19	Giving advice a) for health education b) when asked directly
20	Explain things well
21	Consent
22	Fully informed consent? With all known risks?
23	Ensure understanding
<b>Conflicts/Barriers</b>	
1	Commissioning e.g. no kids in MSK in what can be a post code lottery
2	Post code differences in provision
3	Money
4	Health policies
5	Poor resources e.g. dressings, insoles
6	Number of appointments allowed for certain conditions
7	Misunderstandings, communications on expectations
8	Getting to the stage where NHS staff are more worried about themselves (litigation) rather than concern for patients.
9	NHS is not patient focussed – it is money!
10	Long hours and many patients
11	Efficiency and savings
12	Cut backs
13	Resource limitations
14	Time with patients restricted

15	Funding restrictions means treatment is restricted to referral request only
16	External demands – pressure and functional need to ‘move on’ (sport related)
<b>Differences/Barriers created in NHS and Private Practice</b>	
1	Paying vs. “non-paying”
2	NHS staff have a duty of care “if” meeting inclusion criteria for the service
3	Private practice – insurance paying patients
4	Having things done “to them” divides long term/short term
5	Expectations of “service”
6	Costs vs. benefits = “hard to sell exercises”
7	NHS staff – “Private practice patients are happy to keep going back”
8	Number of treatments sessions
9	Organisational/cultural influences
10	Private practice = better care, more personal care, more time
<b>Accountability</b>	
1	HCPC – code of conduct
2	Autonomous
3	Case load reviews
4	Management objectives differ from HCPC regulation and objectives
5	Patient workload and complexity should match skill base
6	Standards - fed down from managers
7	Consequentialism
8	People/colleagues watching you
9	Employer paying you so you are culpable by responsibility
10	Wage payer
11	Claim culture – becoming more and more aware
12	Self = ethics is everything we do, our thinking and our holistic approach to patient care
13	Self = documentation to safeguard oneself
14	Self = use union (NHS staff) to define role



Phase 2 = coding in categories – partially interpretive	
Category	
<p>PERCEIVED UNDERSTANDING</p> <p>THEME 1</p> <p>PINK</p>	<p><b>1 What is the meaning of health care ethics</b></p> <p>a - Integrity in services provision</p> <p>b - Including do no harm but do good</p> <p>c - Practicalities not specifically related to patient</p> <p>d - Difficulty in trying to define HCE</p>
	<p><b>2 Application - Action or practice of HCE</b></p> <p>a - Standards, guidelines or policy driven</p> <p>b - Autonomy, judgements, belief driven care principles</p> <p>c - Patient driven, patient centred</p>
	<p><b>3 Formation or Derivation of HCE</b></p> <p>a - Education – formally through pre or post grad or CPD</p> <p>b - Personal upbringing</p> <p>c - Religion</p> <p>d - None</p>
	<p><b>4 Accountability</b></p> <p>a - Autonomy</p> <p>b - Consequences</p> <p>c - Governance</p> <p>d - Employer dictates</p>
	<p><b>5 Conflicts/Barriers</b></p> <p>a - None</p> <p>b - Unethical practice recognised</p> <p>c - Commissioning or policy issues</p> <p>d - Communication of needs and expectations of recipients and providers</p> <p>e - Consent</p> <p>f - Resources, time, post code lottery</p>
<p><b>6 Differences/Barriers created in NHS and Private Practice</b></p> <p>a - Quality of care</p> <p>b - Criteria for inclusion to receive service</p> <p>c - Organisational and cultural philosophy adoption</p>	
<p><b>7 Patient involvement</b></p> <p>a - Empowerment</p> <p>b - Joint decision making</p> <p>c - Joint decision lip service</p>	
<p><b>8 Apathy or pacifistic</b></p> <p>a - Disconnected, disengaged</p> <p>b - Disaffected, idealism – realism</p> <p>c - Disenfranchised, disempowered</p> <p>d - Empathy /lack of Empathy</p>	

PERCEIVED UNDERSTANDING

THEME 1

PINK

PERCEIVED EMBODIMENT

THEME 2

ORANGE

PERCEIVED UNDERSTANDING

THEME 3

PINK

PERCEIVED EMBODIMENT

THEME 4

ORANGE

CHALLENGE of IDEALS

THEME 5

ORANGE

PT AT CENTRE

THEME 7

ORANGE

ACTIVITY

THEME 8

PINK

THIS HIGHLY COMMON USED AS GROUP INTERVIEWS ONLY



## Appendix 10: Transcript examples

CONSEQUENCES R09\_0013

253 as a result of coach pressure or player pressure being on the

254 end of their contract and wanting to get back and play, do I bow

255 to that and bring them back a fraction earlier than I should?

256 Yeah, I do sometimes. But rarely based on being burnt by it in

257 the past because I just think, listen, this maybe important but if

258 they break down again then, and I've seen it happen, then it's

259 worse case scenario for everyone, for me, for them, for the

260 coach, and no-one wants them back in the rehab room for

261 another five or six weeks, for the sake of three days extra. So I

262 am dictated to a little bit by the players, the players responsib,

263 the players expectations, the coaches expectations, players

264 contracts, things like that, that could be up, could be not, you

265 know, they might be on a performance base contract where if

266 they play ten games rather than eleven they get, well if they play

267 eleven games more, rather than ten, sorry, then they get a

268 certain amount of bonus so, there are lots of complicating

269 factors to what I do. Ethically, ... [sighs] sometimes I think you

270 do take the option that you can just know will work in a shorter

271 space of time than doing everything by the book in terms of

272 rehab and stuff like that, so you've got a shoulder impingement

273 that you know with six weeks of proper hands-on therapy, scapular

274 ~~the~~ retraining [12:33], theraband type exercises would

275 generally get better with conservative treatment, but you also

276 know if you send them for er, subacromial space steroid

277 injection it would generally settle within a week, exercises or no,

Conflict  
↓  
EXTERNAL PRESSURES

AUTONOMY  
↓  
PUT WITH CONFLICTS  
+  
\*CONSEQUENCE\*

TO PT      FOR SELF

ACTION OF ETHICS  
↓  
AUTONOMY  
+  
PERSONAL JUDGEMENT  
INC. POS RISK TAKING

12

DECISIONS

278 it might come back but at times you are dictated to by time and  
 279 by expectations on that player and, and things like that so you  
 280 do think right what's the quickest and best fix that's safe for all  
 281 parties and you might go down that route at times.

CONFLICT  
 ↓  
 EXTERNALLY  
 DICTATED  
 PRESSURE  
 ↓  
 ACCOUNTABILITY  
 ↓  
 OUTCOMES +  
 CONSEQUENCES  
 ↓  
 ACTION OR  
 ETHICS  
 ↓  
 AUTONOMY +  
 JUDGEMENT

282 M: You, you are explaining there though something that is clearly  
 283 still patient-focused in the context that they're working and living  
 284 and, and fully consenting...

285 I: Yeah.

286 M: ...in, in all these things...

287 I: Fully consenting but with risks.

CONFLICTS  
 ↓  
 CONSENT  
 ISSUES  
 ↓  
 FULL  
 INFORMATION

288 M: Yeah.

289 I: ...y'know what I mean...

290 M: Yeah.

291 I: ...like you, you've, you've probably gotta make sure you explain  
 292 the risks and maybe at times we don't explain the risks enough.  
 293 We give them a best case scenario or a...

294 M: Right.

*challenged during conversation*  
 \* \* \*

295 I: ...positive outcome scenario and thinking about it maybe I  
 296 should do that more, I should say look here are the  
 297 contraindications here are the, the risk factors, this could  
 298 happen...

299 M: Yeah.

**Appendix 11: Table 6 – Group interview summaries of potential areas of further consideration to engage HCPs in HCE**

Table 6 Group interview summaries of potential areas of further consideration to engage HCPs in HCE		
<b>Summary of the resolutions raised by the group interview members on how ethics could be improved in HCPs.</b>		
<b>Group member</b>	<b>Summary of comments</b>	<b>Line</b>
Mick	Do away with the KPIs	1693
Mark	Do away with checklists and stop trying to do ethics by tick boxes	1693
Dave	To step away from minimum standards, we have got to look to do better than that.	1693
Chris	It should be gold standard not minimum standard	1693
Joan	A supervision framework	1723
Mick	HCP check that a portion of CPD is allotted to ethics or professionalism or morals	1771
Dave	We need to do something about the focus on reflective practice and make sure we give it value, actually questioning what it is you do and are you doing the right thing for the patient	1836
Joan	Do something about the level of accountability	1927
Dave	I think that it comes from ourselves. We've got to be better at being ethical and understanding what that actually means. To be professional doesn't just mean following what you get in a Trust, there's a bigger picture to that. And, and we've got to be better at understanding that we've got an ethical code and we should be following it. I think it is worrying, I find it disturbing that people are apathetic about ethics in practice.	1936
Becky	No matter what kind of intrinsic motivation you've got to follow good practice and have good ethics and morals. All the financial, prioritisation constraints are probably not going to change, and if anything are going to get worse so, this sort of managing of who's going to monitor our ethics I don't know that that will ever really happen because it hasn't yet. But it does concern me. But the main thing that concerns me is that nobody recognised that they'd had any ethical training.	1947
John	The education needs to be meaningful, so I know the students are much more aware of ethical and moral issues once they've been out on clinical placement 'cos they can see real life instance, so it, it questions perhaps whether a classroom discussion of ethics and morals is the right place to do it and if, perhaps it should be in context, within physiotherapy to some extent it is but it could be so much better, and then I think the assessment needs to be meaningful as well, whether that's for students or, or CPD, and personally I think the most meaningful assessment is face-to-face discussion.	1965
Mick	The main point I've think we've picked up on is the, the fact that the professionals don't have time. They're very restricted in who they see, especially in the public sector. I think the only probably way you'd get, get around it is if you took away the financial restraints or the targets you had to meet and then that'd probably make the professionals feel more at ease in treating the patient and not feel like they are stuck to a time limit.	1980
Mark	If we want to get this right it's everybody's responsibility. The educators, the managers, the clinicians the leaders and the patients. I think the patients have an obligation to feedback, problems that they find in practice, despite the fact it's everybody's responsibility I think, if we really wanted to do something about it there needs to be leadership at the very top, you can see it in organisations, the chief executive of the organisation will set the culture of the whole thing and everybody else follows, so get somebody to lead it at the top and it will help them.	1993
Chris	I think there needs to be more proactive switch towards, ethics and morals, whether its individuals or organisations.	2004