LEARNING PROFESSIONAL ETHICAL PRACTICE: THE SPEECH PATHOLOGY EXPERIENCE

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ABSTRACT

An ethics curriculum is an integral part of most health profession courses. This thesis will explore using a qualitative approach to investigate the learning and application of professional ethical practice by Flinders University speech pathology students. This work will identify factors that may influence students' readiness to learn about ethics. The knowledge, skills and attitudes that underpin professional ethical practice which speech pathology students were able to demonstrate at the conclusion of their entry level course will be illustrated. Also described will be the factors, identified by students and academics and field educators, which may influence student learning of this complex area of practice.

To explore this topic, the results of "The Defining Issues Test" (Rest, 1979b) of moral judgement development, independent and scaffolded case studies, as well as group and individual interviews with students, and individual interviews with academic and field educators have been used.

Results from this study suggest that a significant number of the undergraduate speech pathology students involved in this study found learning and applying ethical principles difficult, as their ability to reason morally remained conventional and rule bound. At the point of graduation, the students applied clinical and ethical reasoning skills, whilst emerging, were not yet well developed. The ability of students to demonstrate the integration of ethical theory and practice appeared limited. This lack of integration may be influenced by the fact that few field educators could report being exposed to formal ethical theories and ethical reasoning approaches during their own undergraduate education. Some of the more generic ethical practice skills reported by academics as being embedded throughout the speech pathology course,

such as communication, team work and the seeking of professional support, were more clearly demonstrated by students.

Results of this study suggest that exiting students and newly graduated speech pathologists require ongoing support in the area of professional ethical practice. More explicit embedding of the theoretical underpinnings of the ethics knowledge base throughout the curriculum may be required. To be able to support the integration of professional ethical practice in students and new graduates, speech pathologists currently practising in the field who did not receive formal ethics education during their own degree or since, may require ongoing professional development in the formal knowledge base pertaining to professional ethical practice.

DECLARATION

I certify that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief does not contain any material previously published or written by another person except where due reference is made in the text.

HELEN SMITH

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Last but not least I would like to thank the many participants in this study; students and in particular the core group students; academic and field educators. It is through your time, honesty and willingness to engage with me in this project that I had something to say.

However, I also wish to acknowledge that, despite the above mentioned support and advice, the opinions expressed in this work are uniquely my own as are any errors.

1 INTRODUCTION

This thesis is an exploration of how student speech pathologists learn ethical practice. In the introduction the concept of professional ethical practice and its importance to the practice of health professionals in general and speech pathologists in particular is outlined. The second chapter provides a review of the literature on the teaching and learning of ethical practice in the health professions and how this may relate to speech pathology students. It concludes with the questions posed by this study. Chapter three outlines the research process including the theoretical underpinnings, the study design, and the methods used to obtain and analyse data. Chapter four presents and discusses the student data from a learning readiness perspective. Chapter five presents and discusses the student data from the point of view of learning effectiveness. Chapter six presents and discusses the educators' perspective on their own teaching and students' learning. Chapter seven is the conclusion and draws the implications of the study's findings for the teaching of ethics to health professional students and further research that may extend the topic further.

1.1 What is professional ethical practice?

Discussions about ethics require a common understanding of the term. A standard definition of ethics is "the moral fitness of a decision, course of action" (Wilkes & Krebs, 1982). Ethics can also relate to "moral principles" (Macquarie Australian Encyclopedic Dictionary, 2006). Ethics is not about feelings nor is it confined to "religion" or religious belief (Ethics-Connection, 1995-1998). Ethics and laws do not necessarily equate, as many laws can be unethical for example, Australian laws prior to 1966 which excluded Australian indigenous people from

voting. Finally, ethics is also not simply what society accepts as a consensus view on a key issue, for example, the current Australian federal government refugee policy (UNK, 1999) is considered unethical by many Australian citizens.

Ethics is the consideration of the consequences of human actions. It is also about the values and virtues upheld and the principles on which individuals and groups base decisions (Anderson, Brown, Kilminster, & McAllister, 2000; McAllister, Kilminster, Brown, & Anderson, 2002). As a consequence, ethics in the professional setting can be a tool for establishing and maintaining trust.

Ethical practice is a complex area of professional competency (Mattison, 2000) that requires the development of ethical decision-making skills[1] which are central to professional development (Andrews, 2004). These ethical decision-making skills rely upon:

1. Adequate knowledge, skills and training;

2. Integration and application of knowledge bases;

3. Clinical reasoning skills;

4. Sound personal and professional judgments.

It may also involve the translation of personal morals into an action plan (Mattison, 2000). The translation of ethical knowledge into personal decisions, and then into actual professional practice also involves a range of complex skills including communication, empathy, and conflict resolution (Mattison, 2000;

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[1] Decision-making skills involve the gathering of pertinent information, coming up with possible courses of action, weighing up the pros and cons of each course of action and making a resolution about which course of action to follow.

Triezenberg & Davis, 2000).

1.2 Why is competence in the area of professional ethical practice important?

The knowledge, skills and attitudes embodied in professional ethical practice are utilised by health professionals every day, in all aspects of their practice. High profile ethical issues in health care are frequently debated in the media and some examples are the following: the use of embryonic stem cells in research; the allocation by governments of limited health care dollars amongst competing priorities and high profile cases of negligent practice (Martinez, 2002; Thornton, Callahan, & Nelson, 1993). Less obvious to the community at large is the importance of the day to day ethical decisions made by health professionals. For example, decisions about who receives treatment when waiting lists are full, how to share information about a patient and with whom, and what philosophy is adopted by a treatment centre, may all be required in a health professional's routine practice. These are the kind of ethical decisions and actions for which health professionals are held accountable (Mattison, 2000).

How do health professionals learn to undertake this day to day personal professional accountability? In Australia (and generally outside the USA) formalised systems for addressing clinical ethical issues (for example, hospital clinical ethics committees) rarely exist (Kerridge, Savulescu, & Komesaroff, 2001).[2] Individual health professionals therefore need to be able to work through troubling ethical decisions with few resources to guide them.

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[2] This may be changing. For example in South Australia, in 2003-2004 Flinders Medical Centre commenced a multidisciplinary clinical ethics committee. However at the time of writing this thesis, the author is not aware of any other clinical ethics committee in any of the metropolitan hospitals in her state.

Professional associations such as Speech Pathology Australia[3] and the Australian Medical Association (AMA), along with health professional registration boards and state and territory Regulations acknowledge the importance of ethical practice through their codes of ethics, professional codes of conduct, as well as their review procedures dealing with claims of professional misconduct (ASHA, 2003; Martinez, 2002; Speech Pathology Australia, 2000).

The importance given to competence in professional ethical practice is further highlighted within the entry-level education of health professionals by the provision of compulsory ethics classes and workshops in accredited courses (ASHA, 1993; ATEAM, 2001[4]; Brockett, Geddes, Westmorland, & Salvatori, 1997; Cloonan, Davis, & Bagley-Burnett, 1999; Gillam, 1999; Russell, 1999; Speech Pathology Australia, 2001; Triezenberg & Davis, 2000). Speech Pathology Australia has further recognised the importance of continuing this professional development of its members in ethical practice. The Association recently published an Ethics Education Package designed for use by both students and practicing members of the profession (McAllister, Kilminster, Brown, & Anderson, 2002).

The Speech Pathology Australia (SPA) revised Code of Ethics 2000 consists of aspirational[5] ethics (Anderson et al., 2000). This code includes ethical principals and values that SPA members should use as a guide during decision-making on ethical

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[3] Speech Pathology Australia have requested the contraction SPA is not used by members.

[4] The ATEAM are an expert working group of the Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools. Individual authors are not identified in the article prepared co-operatively in 2001.

[5] Speech Pathology Australia provides the following definition for aspirational ethics: "Aspirational ethics outline the principles and values we aspire to use in our ethical decision making, in contrast to mandatory codes which attempt to tell us what we should and should not do in a specified range of contexts" (McAllister et al., 2002).

approaches to practice (McAllister, Kilminster, Brown, & Anderson, 2002).[6] Speech

Pathology Australia's new aspirational ethics is consistent with Beauchamp and

Childress's six fundamental ethical principles of beneficence, non-malificence, truth,

fairness/justice, autonomy, and professional integrity/fidelity (Beauchamp &

Childress, 1994).[7] The code of ethics is also underpinned by five values:

1. Dignity;

2. Respect for client rights;

3. Non-discrimination;

4. Professional interests out-weighing personal interests;

5. Objectivity.

Finally the most recent Code of Ethics is structured around the duties of the

profession towards its stakeholder groups; clients, community, employers, profession,

and colleagues. Speech Pathology Australia suggests that these principles and values

can be used to guide a speech pathologist's ethical reflection, decision-making and

behaviour across a broad range of professional situations (Speech Pathology

Australia, 2000). However, it does not provide direction as to how to approach

situations where there may be competing values or interests. This dilemma or

challenge is also faced by other professions when seeking to apply Codes of Ethics

(Mattison, 2000).

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[6] This is in contrast to the previous Australian Association of Speech and Hearing Code of Ethics which contained obligations, rules and regulations expressed in terms of "Members shall/ shall not…A member must/ must not…A member should…"(Australian Association of Speech and Hearing, 1987, 1996).

[7] These principles will be further discussed in Chapter 2

1.3 What do we know about professional practice and speech pathology?

The researcher conducted a literature review using major English language databases relevant to medicine, nursing and allied health professions revealing many articles relevant to the ethical issues and dilemmas encountered by the medical profession. Mattison (2000) also reports an extensive body of literature written about ethical issues relevant to nursing and social work practice. However, in other health professional areas such as physiotherapy, occupational therapy, psychology, and dietetics, only a limited number of articles regarding ethics have been published in the last decade.

More specifically, a search in the area of ethical practice and speech pathology produced few articles and left the impression that professional ethics in speech pathology is about large issue dilemmas (Brown, Lamont, & Connell, 1998; Groher, 1990; Hodgson, 1996; Landes, 1999; Lefton-Greif & Arvedson, 1997; Serradura-Russell, 1992; Sharp & Genesen, 1996). Examples of such large issue significant dilemmas are: whether to feed an elderly person with end-stage dementia who is aspirating; the management of an adolescent with cerebral palsy who is fed orally but constantly suffering from bouts of aspiration pneumonia. Ethical reflection and action however is not restricted to considerations of life and death dilemmas encountered by speech pathologists. Ethical practice for speech pathologists involves more than simply following an institution's or professional association's Code of Ethics (Barlotta, 2000; McAllister, 2006; Smith, McCormack, & Scholton, 2000).

Ethical reflection and action is an everyday and ongoing challenge for health professionals (Martinez, 2002; Thornton et al., 1993). For example, questions of

how speech pathologists deal with the day to day decisions of how to approach patients, colleagues, and visitors are central to ethical practice. Ethical decisions that are often required to be made on a daily basis by speech pathologists include deciding which patients and with what disorders receive treatment, and for how long (Barlotta, 2000; Hersh, 1998; Hersh, 2003). Also there is the question of how--when resources are finite--speech pathologists can decide who receives sophisticated and expensive alternative communication systems. Hersh (2003) asks how speech pathologists with their knowledge of communication and its diversity obtain consent from clients with significant communication disorders for the assessments, treatments and research they conduct? How do speech pathologists decide how and with whom patient information is shared, or how a patient is provided information about their condition and the implications for their life? McAllister (2006) also asks whether professional ethical action should also involve the political challenge of ensuring those most marginalised (in our communities and wider world) receive the basic services they require.

1.4 What do we know about the teaching and learning of ethical practice?

In the past two decades there has been a growth in the publication of literature focusing on the teaching and learning of health professionals.[8] Much of this literature has focused on the application of adult learning theories, development of clinical reasoning processes and the efficacy of various teaching approaches and learning styles on student learning. The question of the teaching and learning of complex professional knowledge, and the skills and attitudes that are required by

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[8] See Chapter 2 for a full discussion

health professionals in order to practice ethically, has rarely been addressed. The exception is a small number of seminal texts and articles (Metcalf & Yankou, 2003; Mitchell, Kerridge, & Lovatt, 1996; Purtillo, 1993; Triezenberg & Davis, 2000). The medical literature on the teaching of ethics tends to focus on ethics curricula content and learning goals (Asai, Kishino, Fukui, & Masano, 1998; ATEAM, 2001; Thornton et al., 1993). This does not address issues such as engaging students in learning in this area or how competency can be achieved. In relation to the way in which nursing and allied health professionals learn ethical practice, some notable works advocate interdisciplinary and multidisciplinary approaches to ethics education (Cloonan et al., 1999; Metcalf & Yankou, 2003; Purtillo, 1993; Triezenberg & Davis, 2000; Triezenberg & McGrath, 2001).

1.5 Why is this research project necessary?

During the 1990s and 2000s there have been discussions in the literature and within the speech pathology profession about the importance of ethics education for speech pathology students (Best & Rose, 1996; Brown & McAllister, 2000; King, 2003; Lincoln, Carmody, & Maloney, 1997; Pannbacker, Lass, & Middleton, 1993; Pannbacker, Middleton, & Lass, 1994; Pannbacker, Middleton, & Vekovius, 1996; Phillips, 2006; Smith et al., 2000). Speech Pathology Australia's most recent Competency Based Occupational Standards (CBOS) Entry Level document (SPA 2001) highlights the need for new graduate speech pathologists to "uphold" the SPA Code of Ethics. Whilst the speech pathology profession in Australia recognises the important shift from a legalistic application of rules to an aspirational use of principles and values in their most recent Code of Ethics, the challenge for the profession is how to teach this and ensure ethical competency. How do educators positively influence speech pathology student development in the area of ethical

practice? It is not clear how and by what means the profession should measure the competence in professional ethical practice of speech pathology students. For as Joseph Helmick suggests,

> The value of professional codes of conduct is not so much that they exist but rather that they are practiced. It is in the daily practice of the profession (in the fullest sense of the phrase) that one must find the vitality of ethical conduct (cited in Pannbacker et al., 1996).

This is the challenge that the profession must now confront; how do we personally apply and teach our students to apply aspirational ethics in our everyday practice? This thesis attempts to address gaps in the profession's knowledge about student learning of professional ethical practice.

1.6 Conclusion

In this chapter the generic reasons why professional ethical practice is an important and topical consideration for educators of health professionals was discussed. The dearth of current literature pertaining specifically to the teaching and learning of ethical practice generally across the health professions and particularly in speech pathology was highlighted suggesting a place for the current study.

2 LITERATURE REVIEW

2.1 Introduction

2.1.1 A story from clinical practice

The catalyst for considering how students learn professional ethical practice was an experience the researcher had when working as a speech pathologist and field educator in a large city hospital. The experience is described in some detail to provide insights into the researcher's motivation for commencing and continuing her investigation into the topic through both the literature and research.

> *A very competent final placement fourth year student is*
> *working in an acute care hospital. Towards the end of her*
> *placement a man is admitted from a nursing home with a*
> *massive left cerebrovascular accident (stroke). The man*
> *had been in a nursing home due to a previous stroke.*
> *Initially unconscious, on the fifth day following the CVA he*
> *begins to wake up.*
>
> *The student is asked to assess the man and identifies a*
> *severe receptive and expressive dysphasia (communication*
> *difficulties) and severe dysphagia (swallowing problems)*
> *with clear signs of aspiration (food and drink going down*
> *the airway and into the lungs) when eating and drinking*
> *anything. She recommends that he remain nil by mouth and*
> *that a feeding tube should be considered. Daily reviews are*
> *conducted. On day ten still no feeding tube has been placed.*
> *The patient is starting to talk and expresses both verbally*
> *and non-verbally that he is hungry, grabbing at the food*
> *and drink presented at each swallow trial.*

The treating team says the family has said no to the

feeding tube as he would not want to be kept alive in "this

state". Death is no longer imminent and a palliative care

order has not been documented. The student is distressed as

the patient is now awake, alert, and expressing a desire for

food. This cannot be provided safely with oral intake and

so she believes a trial of a feeding tube is indicated. Her

anxiety is overwhelming as she feels powerless in the

situation. She is unsure what her choices of action are and

how to proceed. She is unable to identify either the ethical

dilemmas, discuss them with the team and family or

facilitate a discussion of the current situation and come up

with an ethical management plan. She is overheard

commenting to a fellow student "This is why I would never

work with adults".

Why doesn't this student have the knowledge and skills to begin to identify and even begin to address this dilemma? What if she encountered the situation three weeks later when she has graduated? What knowledge, skills and attitudes could we expect her to have developed in the area of ethical practice? As an educator, the researcher asked, how could I maximise learning for this student in this situation and throughout her professional education? My first step in finding answers to my questions was to examine literature relevant to the teaching and learning of ethical practice.

2.1.2 Introduction to the literature review

In the Introductory chapter of this thesis the generic reasons why professional ethical practice is an important and topical consideration for educators of health

professionals was discussed. In this chapter medical, nursing and allied health discourses are reviewed in order to understand the following: What is meant by professional ethical practice and what may health professions in general want students to learn and master with regards to professional ethical practice. The literature on the teaching and learning of professional ethics will be reviewed from two perspectives: a student learning readiness perspective, and a teaching theories perspective. This literature review will attempt to make explicit the key factors influencing student learning of professional ethical practice.

2.2 What do we want health professional students to learn about professional ethical practice?

2.2.1 What is professional ethical practice?

Ethics is a branch of moral philosophy of which bioethics is a subset. The ethical practice of health professionals is a practical branch of bioethics and could be further specified as clinical ethics, or even, when thinking about speech pathologists in particular as speech pathology ethics (Mitchell, Kerridge, & Lovatt, 1996).

Professional ethical practice is the ability to recognise, think about, analyse, understand, make decisions about and act, often in conjunction with others, on moral issues encountered as part of one's employment as an expert health worker. Ethical practice may be required in all aspects of a health professional's life, in the provision of client care, research, management, or teaching.

2.2.2 Key curriculum goals in the area of ethical practice

Across medical, nursing, and allied health disciplines in recent years a number of authors have outlined and discussed key curriculum goals in the area of health professional ethical practice education. Goals identified from the literature (ATEAM, 2001; Cloonan, Davis, & Bagley-Burnett, 1999; Pannbacker, Lass, & Middleton,

1993; Pannbacker, Middleton, & Lass, 1994; Roff & Preece, 2004; Thornton, Callahan, & Nelson, 1993; Triezenberg & Davis, 2000) are summarised in Table 1 below:

Table 1 Key Curriculum Goals in Ethical Practice

2.3 Personal	**2.5 Promoting and developing moral behaviour in**
2.4 Behaviours/Values	
	2.6 students
	2.8 Understanding personal and professional
	2.9 behaviours and how these influence on decision
	2.10 making
	2.12 Understanding personal and professional values
	2.13 may differ between individuals
2.14 Knowledge	**2.15 Developing an ethics knowledge base**
	2.17 Understanding basic ethical principles as they
	2.18 relate to health

care

2.20   Understanding ethical theories as they relate to

2.21   health care

2.22   Professional Skills

2.23   Ethical awareness

2.25   Ability to participate in dialogues and

2.26   discussions about ethical issues and decisions

2.28   Ability in individual and collaborative ethical

2.29   decision making and ethical dilemma resolution

McNeally and Singer (2001) suggest that the ultimate curriculum goal is to improve students' ability to provide ethical care for clients and their families, communities, and the world in which they live.

The next section of the literature review describes core knowledge, skills and attitudes or values that appear relevant to speech pathology practice based on three major sources. These are the Speech Pathology Australia's (2000) Code of Ethics document and 2002 Ethics education package (McAllister, Kilminster, Brown, &

Anderson, 2002) and an article prepared in 2001 by an expert working group on behalf of the Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools (ATEAM, 2001). This group proposed a core curriculum for Australasian Medical Schools of which much appears relevant to speech pathology education. These sources expand more traditional approaches to ethical practice based on regulations approaches to codes of ethics. They also provide alternatives to biomedical ethics education articulated through topical debates. They expand the horizons for teaching professional ethical practice in the new millennium.

2.29.1.1   Core knowledge underpinning professional ethical practice

As in any area of professional practice, ethical practice requires the development of a rigorous theoretical knowledge base to underpin real life professional application (ATEAM, 2001). Foundational knowledge relevant to ethical practice includes a basic understanding of some of the philosophical approaches to thinking about ethics as well as knowledge of specific topics and concepts. This section provides simple explanations of various common philosophical approaches to ethical thinking. These include a principles approach to biomedical ethics, an ethic of care, virtue ethics, and narrative ethics. Whilst this is not an all inclusive list, all four of these philosophies are relevant to later discussions. They are also approaches relevant to discussions of current health profession ethical practice (ATEAM, 2001).

<u>A principles approach to biomedical ethics</u>

Over the past decade a principles-based approach to teaching health professional ethics has dominated curricula (Jones, 1999). The Speech Pathology Australia Code of Ethics (2000) states that it is based on the five principles of beneficence and non-malificence, truth (veracity), fairness (justice), autonomy and professional integrity (fidelity). Four of these principles, namely autonomy, non-malificence, beneficence,

and justice have been described by Beauchamp and Childress as the prima facie principles of biomedical ethics (Beauchamp & Childress, 1994; Mitchell et al., 1996). The fifth Speech Pathology Australia principle professional integrity will be addressed further.

What do these principles imply? Beneficence is about doing good, of benefiting others. An example might be providing effective and proven treatments to people. Non-malificence is about preventing harm and ensuring that harm is not knowingly caused; for example, not giving someone food which they are at high risk of either inhaling, or choking upon. Veracity is to do with being honest, clear and truthful. As an ethical principle justice is about the fairness of actions. It is also about weighing up competing claims for service according to need, that is, (to say) the greatest access for those with greatest need (Gillon, 1994). It may also mean the greatest good for the greatest number; in which case not everyone will be treated identically (Mitchell et al., 1996). Autonomy is about respecting the right of people to their self-determination regarding decisions which affect them. This is the principle that underpins issues such as consent, refusal of treatment, and confidentiality.

Speech Pathology Australia's Code of Ethics (2000) describes a fifth principle, namely professional integrity. It defines this principle as combining fidelity (honesty), respect and loyalty to clients, colleagues, communities and professional organisations. It also includes ensuring that members can provide best practice within the constraints of the environments in which they work.

These principles, it has been suggested, cover many of the ethical issues encountered by health professionals in providing services to clients (ATEAM, 2001;

McAllister et al., 2002). In any scenario several principles may be relevant for consideration and prioritisation by those involved in making the decision.

Ethic of care

The theory of an ethic of care was proposed by Gilligan in 1982. She proposed that caring, by those personally close to those in need was the highest ethical priority (Gilligan, 1982, 1988; Gilligan & Pollak, 1988). According to Gilligan's ethic of care, detached, abstract and impersonal ethical reasoning is viewed as morally problematic. An ethic of care is often perceived as a feminist approach to ethical practice (Mitchell et al., 1996).[9]

Recently, an Ethic of Care has been expanded away from a focus on the private domain, and of close interpersonal relationships, to include more public concerns. Catchpoole (2001:pp133) proposes a less narrow ethic of care "…which can be extended to global others as well as close others" (Catchpoole, 2001). This approach of an extended ethic of care suggests that it is through being connected with people either personally or privately, and seeking to provide the care they require, that a minimum ethical standard can be attained. A consequence of following this approach is that the interpersonal context in which the ethical decision is to be made is fundamental to providing "…ethically sensitive and morally supportive care" (ATEAM, 2001). This care needs to be balanced across a person's interconnected relationships (Catchpoole, 2001). This understanding of an extended ethic of care which embraces all interconnected relationships, including those encountered professionally, will be utilised in this thesis.

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[9] Gilligan's theory was initially proposed in contrast to the more traditional justice-based approaches proposed in the 1960s and 1970s and was based on developmental research with young women.

<u>Virtue ethics</u>

Virtue ethics derives from the philosophy of Aristotle (Mitchell et al., 1996). It considers virtues rather than rules to be of the highest ethical order. Examples of these virtues include honesty, gentleness, integrity, wisdom, discernment, and kindness (ATEAM, 2001). In virtue ethics the intent of an action or the motivation for an action is the over-riding concern in determining whether behaviour is ethical or not, rather than the consideration of concepts or rules (ATEAM, 2001; Mitchell et al., 1996).

Competency in virtue ethics is dependent upon the development of personal or professional values. Speech Pathology Australia in their code of ethics (Speech Pathology Australia, 2000) highlight five key values:

1. Respect for the dignity of individuals;

2. Respect for the rights of clients;

3. Avoidance of discrimination;

4. Professional service is more important than personal interest;

5. Objective and disciplined behaviour is expected when providing services.

It could be interpreted therefore that the Speech Pathology Australia code of ethics includes both ethical principles and virtues.

Other writers discuss these and similar values as attitudes. The ATEAM (2001) for example, highlight eight core attitudes for ethical medical practice. These include; honesty, integrity, empathy, compassion, trustworthiness, respect and commitment to critical self-appraisal, competence, life long learning, and self-care.

Virtue ethics provides a way to reflect on the intention of actions, and to integrate

professional - and one would hope, the personal - in ethical professional actions and interactions.

<u>Narrative ethics</u>

Narrative ethics provides a theoretical framework that suggests that ethical decision-making occurs in a personal, cultural and social context. The personal, social, economic and cultural perspective of the individuals involved and the meaning of the situation to them are central to ethical interpretation and decision-making in narrative ethics (ATEAM, 2001; Mattison, 2000). In other words, to make ethical decisions those who are making the decision have to understand what those decisions may mean for the individual patient, their family and community and the health professionals concerned. Narrative ethics also requires that those involved in decision-making understand the influence of their personal experiences and power in the exercise of interpreting and understanding both the client's, and their own situation or story (ATEAM, 2001; Nicholas & Gillett, 1997). Jones (1999) goes on to say that ideally, narrative ethics is relational that is contemplating the impact of decisions not only on the person themselves but also those who surround them. Ultimately, the multiple voices and multiple stories of all involved need to be heard and empathised with, in order for respectful ethical decisions to be made (Jones, 1999). Both aspects of narrative ethics, namely the consideration of environmental context and the importance of the meaning of the personal story are used in this thesis.

Clearly the theoretical approaches to practical professional ethics outlined thus far are only a few of those available. They are presented however as being based on current work by health professions in Australia. Many professional organisations may still propose more rules, regulations and legislation approaches to ethical

practice (Pannbacker et al., 1994). This more black and white approach to ethical

practice on the surface may appear more straight forward but application of rules can

become murky when faced with the grey of real life practice.

Consideration of the same ethical issue through the lens of each of the theories

presented may lead to different reasons for and approaches to the resolution of an

ethical dilemma or an ethical decision. It is hoped that by means of the curriculum

presenting students with a sample of theoretical approaches they may begin to gain

insight into the diversity of viewpoints that may still be considered "ethical". This

knowledge of diversity may further inform and strengthen the ability of students to

provide the basis and reasoning behind their own ethical decision making and

practice whilst acknowledging that others may act differently yet also from a

legitimate ethical framework.

2.29.1.2   *Core skills underpinning professional ethical practice*

In the previous section 2.2.2.1 a core knowledge base underpinning professional

ethical practice was outlined. There are also core skills that will enable health

professionals to identify, consider, implement and reflect upon ethical practice

decisions (ATEAM, 2001). Many of these skills are consistent with skills used by

health professionals in other aspects of their professional practice, for example

professional communication, shared decision making and collaborative action skills

(ATEAM, 2001; Speech Pathology Australia, 2001, 2006). In the new COMPASS™

assessment for Australian Speech Pathology students these skills would fall into the

generic competencies of reasoning, communication and professionalism (Speech

Pathology Australia, 2006)[10].

Some ethical practice skills are however specifically related to translating knowledge of theoretical ethics into actual ethical practice for example, ethical awareness and moral reasoning. The Speech Pathology Australia Ethics Education Package (2002) is not explicit in identifying core skills for ethical practice, nor does the 2001 Competency-Based Occupational Standards for entry level Speech Pathologists differentiate core skills. However, some key ethical practice skills are identified by a number of authors (ATEAM, 2001; Mitchell et al., 1996) working in the Australian context, and they are briefly outlined in the following section.

Ethical awareness

The recognition by students or practitioners that an issue, decision, or action inherently involves ethical components is part of ethical awareness. In a sense, ethical awareness is about health professionals developing a sensitivity around ethical issues pertaining to their practice (Corey, Schneider-Corey, & Callanan, 1988). Purtillo would suggest that part of ethical awareness is also knowing the difference between ethical distress, when the health professional knows the correct course of action but there are barriers to its completion, and ethical dilemmas, where there are two or more ethically correct courses of action but the health professional can not do both (Purtillo, 1993). Without ethical awareness it is very difficult for health professionals to make conscious ethical decisions or to debrief situations which may have caused ethical distress.

Moral reasoning

Edwards (2000) proposes that moral reasoning is a critical subset of a health

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[10] See Section 2.3.4 later in this chapter for further discussion of COMPASS™.

professional's clinical reasoning about which much has been written in the past decade (Higgs, 1992,1997; Higgs & Jones, 1995,2000; Higgs & Terry, 1993). Moral reasoning involves the ability to analyse, understand and interpret the ethical propositions of others. It also involves the ability to construct and defend or justify a particular ethical decision (ATEAM, 2001).

Ethical practice skills

The ATEAM and others suggest communication, shared decision making, and collaborative action skills as being core ethical practice skills (ATEAM, 2001; Mitchell et al., 1996). Again these skills are vital in other areas of practice but with regards to ethical practice they relate to a health professional's ability:

> …to communicate about ethical issues with clients, families, team members etc; to facilitate decision making, with all key stakeholders; and to implement, ethical decisions, particularly when challenged by team and institutional constraints (ATEAM, 2001).

In the context of ethical practice these skills require the integration of high level generic clinical practice and interpersonal skills, and an awareness of the particular client and family, in addition to the ethical issues and the workplace or institution views and values.

Summary of core skills

The three areas outlined above (ethical awareness, moral reasoning and ethical practice skills) are all fundamental to ethical practice (ATEAM, 2001). Whilst the latter two, can perhaps be viewed as the refinement or specialist advancement of other professional practice skills there are specific competencies that are required when using ethical practice skills in the delivery of ethical health care services. These include an ability to use them with empathy and in a context of care.

2.29.1.3   Core ethical attitudes and values

Just as there can be considered core knowledge bases and skills for ethical practice there are also some fundamental attitudes and values which contribute to professional ethical practice (ATEAM, 2001; McAllister et al., 2002; Speech Pathology Australia, 2000). Ethical attitudes and values should be an integral component of a health worker's professional identity (Speech Pathology Australia, 2000). The ethical values and attitudes incorporate honesty, integrity, trustworthiness, courtesy as well as the following.

Empathy or compassion

The ability to feel for other people and to imagine being in their circumstances and to understand what that may mean to them are fundamental aspects of empathy and compassion (Wilkes & Krebs, 1982). At a deeper level, it may mean developing greater socio-political and cultural awareness. Then, as a consequence of utilising this awareness one can begin to understand a particular client's life and circumstance, or the situation of a particular client group and then to modify one's expectations, or services in light of this understanding.

Respect

A standard definition of respect is polite or kind regard and/or an attitude of deference (Wilkes & Krebs, 1982). This attitude includes respect for self (for example a commitment to self-care), for clients and for the dignity of people and other professionals in the health care team and their role in client care. The Speech Pathology Australia's Code of Ethics (2000) incorporates this attitude in a number of sections including confidentiality and client relationships. A very important aspect of respect is knowing about the personal/professional boundaries we need to keep between ourselves and our clients, students, employees and colleagues so that their

interests rather than our own are served by our professional involvement with them (ATEAM, 2001; Speech Pathology Australia, 2000). This is aimed at preventing the personal exploitation of vulnerable others by the professionals they encounter.

<u>Responsibility</u>

An approach that leads to responsible practice includes a commitment to critical self appraisal, reflective practice, professional competence and lifelong learning (ATEAM, 2001; Speech Pathology Australia, 2006). This is because health professionals have a responsibility for providing current and appropriate best practice assessment and management to clients. In the Speech Pathology Australia Code of Ethics (2000) many aspects of this attitude of responsibility are discussed. These include, amongst others, a duty to provide accurate information, be professionally competent and use best practice standards, meet our responsibilities to our employers and maintain and advance professional standards. Responsibility also comprises being professionally reliable (ATEAM, 2001) which incorporates providing consistent services, turning up for meetings with colleagues and clients when agreed and so on.

Professional responsibility also encompasses a responsibility to the broader community, including the global community (ATEAM, 2001). Speech Pathology Australia use the term advocacy to highlight this aspect of broader responsibility in their Code of Ethics (2000). This attitude of ethical responsibility incorporates a sense both of moral obligation and professional responsibility to act (Hay & Foley, 1998).

<u>Summary of core attitudes</u>

Professional ethical attitudes may seem difficult to define and teach. This section

has attempted to clarify and make explicit some of the approaches and behaviours that may reflect appropriate professional ethical attitudes. By providing specific examples of behaviours reflecting ethical attitudes potential teaching points, points of reflection, discussion and reinforcement for students have been highlighted.

2.29.2 The need to explicitly teach professional ethical practice.

In the previous section the breadth of theoretical knowledge and high level practice skills and attitudes for professional ethical practice as discussed by Speech Pathology Australia (2001,2006, the ATEAM (2001) and Mitchell et al (1996), have been outlined. This outline is by no means exhaustive. It provides however a contemporary illustration of the significant content and complexity implied by the term professional ethical practice currently held by a number of health professions in Australia and thus contextually relevant when considering the teaching and learning of ethical practice to Australian speech pathology students. This section now discusses why there is a need to explicitly teach this area of practice in health profession courses. As the American Association of Speech and Hearing (1994a) stated

> …principles of ethics can and must be taught with the very same rigor that
> we would use to teach scientific methods…(p.18) cited in Pannbacker,
> Middleton & Vekovius, 1996 (p. xii)

Personal morality is concerned with an individual's values and beliefs, that is what the person believes is right or wrong. Professional ethics, by comparison is concerned with how a group of professionals and the clients or communities can find an answer to the question of "what ought we do? " (St James Ethics Centre, 2007). Our professional ethics may be informed and influenced by our personal morality.

Professional ethical practice however requires the ability to think, discuss and act beyond the personal.

This level of knowledge integration and complex practice can not simply happen by osmosis, assimilation or "professional socialisation" if by these terms it is implied that learning is through the so called "Hidden Curricula" (Ewan, C. 1988). Just as we do not expect students to learn professional counselling through professional socialisation such as observing an empathetic clinician, nor can we expect them to learn how to become an ethical practitioner through an accidental or poorly defined ad hoc teaching regime or opportunities for observation. Lincoln, Carmody and Maloney (1997) suggest that professional socialisation as they understand it, is about the development of a professional persona. According to these authors the development of a professional persona includes explicit teaching around professionally relevant technical competence (knowledge and skills), interpersonal skills, standards of conduct and ethical competence relevant to the occupational role. It is not a simple cloning process, but rather an intentional development, an induction into a professional role (Harper-Simpson, 1979). The risk with professional socialisation even as described above is its tendency to maintain the professional status quo.

Some authors contend that the experiences students and new graduates face in the work environment can actually lead to ethical erosion or a negative change in ethical views and values, if those in positions of power are observed modelling unethical values, attitudes and behaviours (Feudtner et al., 1994; Feudtner & Christakis, 1994; Satterwhite, Satterwhite, & Enarson, 2000). McAllister and Lincoln (2004) go as far as suggesting that when students observe professionals operating in an unethical

manner, students risk becoming cynical and disillusioned. The observations of these authors may be considered signs of the hidden curricula at work. The very real risk of students being exposed to the hidden curricula highlights the need for both rigorous and explicit teaching in the area of ethical practice. The reality of the existence of the hidden curricula also lends itself to the provision of opportunities for students to reflect on their observations of unethical behaviour with a mentor, teacher and/or peers. Examples of these opportunities may include student ethical forums or formal mentoring arrangements to explicitly identify unethical practice and discuss ways of managing situations of current practice differently in the future.

2.30 How does the literature inform our understanding of the teaching and learning of professional ethical practice?

In the previous section (2.2) some of the core knowledge, skills and attitudes fundamental to professional ethical practice by health professionals were identified. This section considers how these fundamentals may actually be taught to health professional students through their professional education program.

Academic staff are responsible for designing and implementing the curriculum in a health profession course. The design and implementation of the curriculum may be completed in consultation and conjunction with their professional peers. To produce qualified speech pathologists in Australia, the curriculum must be accredited by Speech Pathology Australia. To be accredited, a course must show how the curriculum will produce graduates who meet the competency based occupational standards of an entry level speech pathologist (Speech Pathology Australia, 2001). This section examines the teaching and learning literature to identify what factors need to be considered when designing an education program with the goal of producing ethically competent health professional graduates.

2.30.1 Three considerations when thinking about teaching and learning in professional ethical practice.

When designing curricula to achieve the goal of competent professional ethical practice which incorporates the core knowledge skills and attitudes, as outlined earlier in this chapter, three major things need to be considered. Firstly, who are the target learners? Secondly what is their personal social, emotional, and intellectual development and how does it contribute to or detract from their learning? Thirdly what do they bring to the learning situation that may help them engage in learning? For the purpose of this thesis, the target learners are speech pathology students. The second and third deliberations are explored from the viewpoints of a learning readiness model or a pedagological model approach to student learning.

Another consideration of this literature review is how teachers can create opportunities to facilitate the deep learning and knowledge integration which will ultimately result in actual competent professional ethical practice. This consideration is explored from the perspective of methodological approaches to student learning.

Finally the question of how we measure competence in professional ethical practice is considered through the literature. What role does assessment play in the motivation and application of learning by students? This final question is examined through literature considering the role of assessment in academic learning.

2.30.2 Learning readiness approaches to understanding learning

Pedagogical and andragogical[11] approaches to student learning incorporate both consideration of an individual's cognitive, emotional and social learning readiness and the more generic adult learning considerations of how students engage in the

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[11] Adragogy was defined by Knowles (1970) as the art and science of helping adults learn (Knowles, 1970; McAllister et al., 1997)

learning process(McAllister, 1997; McAllister et al., 1997). Learning readiness is a

student's preparedness for learning of a given topic in a particular context at a

particular time (Best & Rose, 1996). It is a key consideration in many adult learning

theories. It is a multifaceted concept which involves the inter-relation of factors such

as the student's cognitive development, learner task maturity, and the student's

motivations for learning (Higgs, 1991; Higgs, 1992; McAllister et al., 1997). In

health profession programs such as speech pathology, students often have little or no

influence over the structure, timing or key content of their learning because their

courses are highly structured and the content and timing prescribed by University

faculties to meet the readiness to practice requirements. Thus learning readiness may

have a significant influence in determining ultimately how much mastery of a

particular topic area is achieved and when and how a topic should be introduced in a

course in order to maximise student engagement in learning.

2.30.2.1   Cognitive readiness for ethical practice

The developmental psychology literature suggests that there are cognitive

developmental factors that may influence ethical decision making in children, young

people and adults (Kohlberg, 1984; Lickona, 1980; Piaget, 1932, 1948). Lickona

(1980) suggests that the underlying premise of cognitive developmental theorists

such as Piaget and Kohlberg is that ethical thinking develops in structured stages

(Callahan & Bok, 1980; Callahan & Sissela, 1980). The movement from one

developmental stage to the next is determined by both internal cognitive growth and

stimulation from the external environment (Duska & Whelan, 1977). The

implication of this is that cognitive developmental factors may affect an adult's

ability to learn, understand, and utilise particular approaches to ethical decision-

making and thus professional ethical practice. Professional ethical decision-making

may require cognitive development beyond an individuals current stage particularly

if considering decision-making of young adult professionals.

Kohlberg and his stages of moral judgement development

Whilst Plato may have been the first[12] to suggest that moral understanding

progresses through a series of stages most contemporary work in this area is based on

Kohlberg's model (Kohlberg, 1984; Kohlberg, Colby, & Abrahami, 1987) which is

an expansion of earlier work by Piaget (Piaget, 1932, 1948). The underlying premise

of Kohlberg's work is that thinking in the area of the moral domain develops and

changes according to a universal set sequence (Kohlberg et al., 1987)[13]. The name

and key features of Kohlberg's six stages of moral reasoning development are

outlined in the Table 2 below:

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[12] Some might argue that Eastern schools of thought may predate Plato.

[13] Perhaps considered a somewhat modernist and mechanistic approach to thinking about development.

Table 2: Kohlberg's Six Stages of Moral Reasoning Development

Level	Stage number and name	Definition	Example
Preconventional	**1.Heteronomous Morality**	**Morality of obedience**	**Do what you are told. Good and bad are absolutes and if you are bad expect to be punished.**
	2. Individualistic, instrumental Morality	**Morality of individual self interest and simple exchange**	**Let's make a deal to satisfy my needs and minimise any negative consequences to me.**
Conventional	**3. Interpersonally normative Morality**	**Morality of mutually trusting relationships**	**Be considerate, nice and kind and you will achieve social approval**
	4. Social System Morality	**Morality of law and duty to society**	**Everyone is obligated to and protected by either society's law or another trusted "authority" (e.g. religious system)**
Post Conventional/ Principled	**5. Human Rights and Social Welfare Morality**	**Morality of universal values and commitment to social change through consensus**	**You are obligated to work within mutually agreed procedures but may attempt to change them through due process if you disagree with them**
	6. Morality of Universal Ethical Principles	**Morality of non-arbitrary social co-operation**	**Equal consideration of all peoples, claims and points of view is given and considered in terms of universal ethical principles.**

Source: From Rest & Narvaez, (1994) cited in Brockett, Geddes, Westmorland, & Salvatori (1997).

Furthermore, whilst Kohlberg contends that one place on the sequence is not

superior to another, the stage in which a person is operating may determine whether or not they understand the reasoning of another person, particularly if the stage at which the other person is operating is at a more abstract (higher) stage (Kohlberg, 1984). The implication of this is that whilst two people may behave in the same way in response to an ethical imperative, their underlying reasons for doing so may be very different, and may be a result of their stage of moral reasoning development.

An example of this could be that two speech pathology students decide to keep information about a client confidential. One student keeps the information confidential because she believes she will be punished by law if she does not, based on State Privacy legislation introduced to her at university. A second student keeps the information confidential based on the principle of autonomy, that involves respect for the client and the client's right to determine who has access to their information. Thus the same action, keeping information confidential, may occur for two very different reasons.

Several caveats are important to note when considering Kohlberg's model of ethical reasoning development. The first caution relates to the fact that an ability to reason at a particular stage does not ensure that actions will be determined by that reasoning (Rosen, 1980). The second is that Rosen (1980) further suggests that transition through all six stages is unlikely for the majority of the population. According to Rosen (1980) the average adult person may only ever demonstrate Stage 4 level reasoning. For example, a study of Canadian Occupational Therapy and Physical Therapy students over several years suggested that up to 50% of any given student cohort were not demonstrating principled ethical reasoning as defined by the Kohlberg model. Their ethical reasoning was consistent with Stage 4 or

below according to the Kohlberg model (Brockett et al., 1997). Finally Kohlberg's

model is based on ethical reasoning relevant to a Kantian[14] or justice (fairness)

philosophical approach to ethics (Gillon, 1979). As discussed earlier in this chapter,

there are many philosophical ways to consider the same ethical dilemma or decision.

Thus Kohlberg's Theory does not, for example inform us about the possible

development of ethical reasoning based on ideas of an ethic of care and responsibility.

See Gilligan for an alternative view of ethical development. (Gilligan, 1982;

Gilligan & Pollak, 1988; UNK, 1994). What is important about Kohlberg's work is

that it highlights another important variable to consider when developing

professional ethical practice.

2.30.2.2   *Learner task maturity*

A learner's readiness for the task at hand has been described by Higgs (1991,

1992c) as "learner task maturity" (p.824). Higgs suggests that the amount of

structure a student needs to learn in any given situation may vary according to

previous experience and familiarity with similar learning tasks, and their readiness

for the demands of the new situation. Thus when low learner task maturity exists, a

high degree of structure and reinforcement needs to be provided by the educator.

When learner task maturity is high then more independence and self direction can be

fostered by educators. When considering learning professional ethical practice,

many undergraduate students may have had limited opportunities to experience and

learn about professional ethical decision-making particularly in the practice setting.

Therefore the majority of students may require highly structured formal and informal

learning environments and experiences in the area of ethics.

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[14] Kant was a proponent of a rule based morality including universal maxims (Mitchell et al., 1996).

Learner task maturity may influence a learner's attitude toward learning about professional ethical practice. If the learning of professional ethical practice is compared to other areas of professional practice which require complex integration of interpersonal and clinical skills such as counselling, then the influence of personal readiness factors may become clearer. Levels of personal maturity, life experiences, personal resources and value systems may all influence a student's receptiveness to learning in this area.

2.30.2.3   Emotional engagement

As part of the emotional and social readiness for learning about professional ethical practice it has been suggested by Hay (1998) that it is through the stimulation and nurturing of moral imaginations that professionals will garner a personal ethical imperative to act and take responsibility for ethical decisions and actions. A strategy to develop this sense of the imperative suggested by Hay is to discuss rights and responsibilities in a way that engenders sympathy and emotional (affective) attachment in the student participants (Hay, 1998). He goes on to suggest that both students' feelings and imaginations must be stimulated (Hay & Foley, 1998). Purtillo (1993) goes further in saying that emotional detachment is a threat to personal integrity and by implication ethical practice. Leget (2004) expands on this to suggest that unlike an emotionally neutral topic such as maths, ethics is a human activity that requires emotional engagement and reflection. Thus emotional engagement appears to be a fundamental prerequisite for learning professional ethical practice. The implication of this is that ethics educators need to create learning situations which engage learners emotionally.

2.30.2.4   Summary

In the section 2.3.2 various factors which may influence the learning readiness of

students have been discussed. Cognitive readiness for ethical practice was considered through examination of Kohlberg's model of moral judgement development (Kohlberg, 1984) and consideration of challenges to his model by Rosen (1980) and Gilligan (1982). Higgs (1991) concept of learner task maturity influencing the amount of structure required for a student to engage in learning any task or topic including ethical practice was considered. Finally the importance of emotional engagement (Hay, 1998) as a prerequisite for learning professional ethical practice was discussed. This review identified many factors that may influence the learning readiness of students in the area of professional ethical practice.

2.30.3 A teaching approaches' view to understanding student learning of professional ethical practice

To achieve the goals of health professional education, educators often talk about the three domains of teaching/learning: knowledge, skills, and attitudes (ATEAM, 2001; Best & Rose, 1996). Higgs and Titchen (2000) (cited in Higgs & Jones, 2000) propose that knowledge is fundamental to both the definition and the practice of a profession. Traditionally, the academic program of a professional course focuses on the development of an explicit professional knowledge base in students, whereas the clinical practice streams may place greater emphasis on the skills and attitudes of a profession. This is the so called tacit knowledge base (Polanyi 1958, 1966). With the recent emphasis on more integrated teaching this academic-clinical divide has become less pronounced; instead the emphasis is on developing deep integrative learning in students across all learning environments. This deep learning results in a greater capacity for students to use, apply, and build on knowledge and skills in novel situations and thus to find personal meaning and understanding of the information. In contrast surface learning is characterised by a student's attempts to simply memorise and reproduce discrete and often unrelated pieces of information

(Best & Rose, 1996; Higgs, 1992; Higgs & Jones, 2000). Whether students take a surface or deep approach to learning may depend on how the information is presented, and how the information is approached and processed by the student.

The challenge of health profession education is encapsulated by Heath (1990) who writes:

> Members of the professions must build and maintain a formidable store of knowledge and skills; they must learn to absorb information through the various senses and to assess its validity, reliability and relevance; and they must acquire the art and culture of their calling. And, most importantly they must learn to use these qualities to solve practical problems. (p. 198 cited in Higgs & Jones, 1995)

Holloway (1995) similarly proposes that professional knowledge involves declarative knowledge (knowing facts, knowing what), procedural knowledge (knowing how) and finally conditional knowledge (knowing when, the use of timing and judgment). Thus the creation of new professional knowledge is a dynamic and personal phenomenon made even more complex by the so called tacit (or unspoken) knowledge of any professional group (Polanyi, 1969).

2.30.3.1   Development of knowledge

The underlying premise of knowledge development is that knowledge is actively constructed and not discovered (Higgs, 1992b). This construction is dependent on cognitive mapping[15], reflection, and meta-cognition (or thinking about thinking).

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[15] Higgs suggests that cognitive mapping is a way of describing the knowledge base unique to an individual that has been constructed to the way they interpret the environment, knowledge of the field and the way they make personal sense of their own and others' experiences in the area (Higgs, 1992b).

Adult learning theories

There has been considerable focus by researchers in higher education over the past decade on adult learning principles and student centred learning approaches. This focus has intensified in recent years particularly with the introduction into many programs of problem based learning methods and post-graduate entry level qualification courses. It is believed that application of adult learning approaches fosters autonomous learners (Higgs, 1992c; McAllister, 1997)

Knowles (1980) describes three main characteristics of adult learners: adult learners are autonomous and self directed; adult learners utilise life experience as a learning resource and adult learners like their learning to be problem centred and applicable (Higgs, 1992c; Knowles, 1980; McAllister, 1997).

Whilst adult learners are described as autonomous this does not mean they do not require structured learning situations. The role of the teacher is to create the environmental and decision making conditions which facilitate adult learning behaviours (Higgs, 1992c).

Other characteristics of adult learning behaviours identified by Higgs (1992) from adult learning literature of the 1980's and early 1990's are summarised and explained in Table 3 below.

Table 3 Adult Learning Behaviours

2.31 Behaviour	2.32 Explanation
2.33 Self Correction	**2.34 Ability to identify errors and**

correct

2.35 them

2.36 Progressive mastery

2.37 Building on earlier skills to produce

2.38 more complex behaviours

2.39 Active seeking of meaning

2.40 Thinking about why the new learning

2.41 is important to topic being considered

2.42 Critical reflection

2.43 Thinking about task or knowledge set

2.44 with regards to positive and negative

2.45 outcomes

2.46 Individual pacing

2.47 Being able to determine the speed of

2.48 new learning

2.49 Active involvement in learning

2.50 Dynamic participation in learning

2.51 processes

2.52 Interaction with teachers and other

2.54 Learning through contact with

2.53	**Learners**	**2.55**	**teachers and peers**
2.56	**Identifying own learning goals in**	**2.59**	**Ability to identify relevant learning**
2.57	**context of community goals and**	**2.60**	**goals**
2.58	**needs**		
2.61	**Reciprocal learning (with teachers**	**2.63**	**Joint learning with experts and peers**
2.62	**and other learners)**		

Based on Higgs (1992, p.823)

MacRae and Hanrahan (1990) also add the importance of reinforcement of learning and active participation is an advantage in the learning process. McAllister (1997) further adds to these lists the importance of interdependence of learning. By this she means that students must contribute to the structures facilitating their learning as well as receiving from them. This interdependence is illustrated well by the influence a students learning style may have on the teaching approach adopted and vice versa.

An important aspect of adult learning theory is the acknowledgement of a variety of student learning styles and the implications of this in the practice of education. (McAllister et al., 1997). Commonly understood learning styles are those discussed by Kolb (1984) and further refined by Honey and Mumford (1986). Honey and Mumford describe five types of learners: pragmatists; activists; theorists; reflectors and all rounders.

Pragmatists, Honey and Mumford suggest, learn best through practical applications and hands on concrete experiences such as preparation for a specific client (versus a client group). Activists, they suggest, learn best through new experiences and opportunities to actively experiment. Activist learners need the freedom to do a task and make mistakes, and then to receive immediate direct feedback. Theorists, they suggest, learn best through observation and then the opportunity to analyse and synthesise those observations into a theory. Theorist learners also need to understand the underlying theoretical framework and rationales for what they are seeing and then asked to do. They need time both before and after a task to reflect and explore relevant issues. Reflectors, they suggest, learn best from opportunities to think about different perspectives before coming to a conclusion. Reflective learners like to utilise opportunities to observe tasks and activities in a directed and structured way. They like opportunities to practice prior to the execution of the task. They benefit from time to self reflect on a task prior to receiving feedback. Honey and Mumford suggest that all rounders are learners who can utilise multiple styles of learning and will vary their learning style depending on both the task and teaching style provided.

Consideration of learning styles theory behoves educators (both academic and field/clinical educators) to construct a variety of learning opportunities that ultimately will engage all types of learners. It is suggested that through understanding the style of learner they are teaching and adapting the learning experiences accordingly, more successful, efficient and deep learning in all domains is more likely to occur (Best & Rose, 1996; McAllister et al., 1997).

Fostering deep learning

As indicated above, one important consideration in establishing a knowledge

base in an area of professional practice is to ensure that the knowledge is deeply established and integrated so that it can be recalled and applied beyond the period of assessment. Several factors are pertinent in the facilitation of deep learning. These include learning that is both problem centred and has personal meaning (Brookfield, 1986). When students have a deep approach to learning they search for personal meaning and understanding of the information. They attempt to understand and integrate pieces of information into a cohesive whole. They relate evidence to their conclusions, new ideas to previous knowledge, and concepts to everyday experiences. Surface learning, by contrast, is characterised by a student's attempts to simply memorise and reproduce discrete and often unrelated pieces of information. The student is often motivated to learn simply to complete externally imposed task requirements (Higgs, 1992).

In the 1950s a group of educators led by Benjamin Bloom described a taxonomy for categorising learning objectives as a basis for the assessment of student learning across cognitive, affective and psychomotor domains. The cognitive domain is described as having six levels of complexity. These levels of abstraction of knowledge, from the lowest level to the highest level are labelled knowledge, comprehension, application, analysis, synthesis and evaluation (Anderson & Sosniak, 1994). Knowledge in the context of the taxonomy is described as the ability to remember the idea, material or phenomenon in a form very close to which it was originally encountered. Comprehension is explained as knowing what is being communicated and being able to utilise and transmit the information in another oral, written, verbal or symbolic form. This may involve translation, interpretation or extrapolation. Application is the ability to apply the appropriate abstraction when presented with a new problem or context. Analysis relates to the ability to break

down the material into its constituent parts including identifying or classifying elements, making explicit the relationship between elements and finally recognising overarching organisational principles. Synthesis involves reconstituting elements and parts to form a whole or new pattern of knowledge. Finally evaluation involves making judgements as to the value of the ideas, materials and phenomena. These evaluations are different from personal opinions since they are based on external standards or criteria.

To apply the concept of Bloom's Taxonomy to the area of learning professional ethical practice suggests Level 1 knowledge may relate to an awareness of the principled approach to ethical analysis. Level 2 comprehension may indicate the student is able to give definitions of the principles. Level 3 application, suggest the student can identify a particular principle in a given scenario. Level 4, analysis, may denote the student can identify conflicting principles and rank them in importance of consideration. Level 5, synthesis, may imply they can use their insights to formulate a solution or way forward. Level 6, evaluation, may mean students can create multiple options for a way forward and weigh up the pros and cons of each based on the particular situation they find themselves in.

When considering the application of Bloom's Taxonomy to the learning of and actual performance of professional ethical practice, Rohwer and Sloane (1994) suggest that actual assessed performance does not necessarily reflect Bloom's taxonomy level of learning (cited in Anderson & Sosniak, 1994). That is depth and integration of learning is not necessarily reflected in actual performance behaviour perhaps due to environmental constraints or models provided. So students may be able theoretically create multiple options for making an ethical decision and weigh

up the pros and cons of each option which would suggest Level 6 mastery but in reality only feel able to follow one option through to completion due to a lack of confidence or interpersonal skills or power as a student or only seeing a teacher using a single approach. Performance behaviours may furthermore not reflect the student's level of mastery if the student is not emotionally engaged in the task. Rohwer and Sloane (1994) describe this as the influence of affective meaning for the performance of behaviours.

According to Rohwer and Sloane (1994) the level of learning integration achieved by students may also be influenced by the way new learning is presented. Traditional chalk and talk lectures and set readings tend to result in lower order learning. Co-operative learning and discussion tends to result in higher order learning. Encountering real world problems which induce learning are most likely to result in the most integrated level of learning. The implications of Rohwer and Sloane's observations for curriculum design include building in time for students to think about and process information, and the importance of practicum learning opportunities for increasing knowledge integration.

2.63.1.1   Skills

The underlying premise of skill development in the area of ethical practice is that there are both generic professional skills such as communication to be learnt as well as specific or critical ethical practice skills. This section focuses on three critical ethical practice skills, ethical awareness, ethical reasoning and reflection on practice.

Learning ethical awareness

Ethical awareness is a fundamental skill in professional ethical practice (Mitchell et al., 1996). Many students may be aware of the issues of public ethical debate such as neo natal stem cell research, human cloning and euthanasia. Increasing

professional ethical awareness is expanding that recognition of generic biomedical

issues to include the day to day ethical issues encountered in professional practice.

These day to day issues may include policy issues, resource allocation issues,

research issues as well as direct client related issues and dilemmmas (Hersh, 1998;

McAllister, 2006; Mitchell et al., 1996).

Little is written in the literature about how this skill of ethical awareness can be

taught to students. McAllister contends that ethical awareness is difficult for

inexperienced professionals to demonstrate due to the competing demands for their

active attention (McAllister, 2006). She further suggests however that teaching

inexperienced practitioners to be consciously aware of their intuition and feelings in

situations was a starting point for reflection. Brown, Lamont and Connell (1998) in a

workshop talked about field educators, supervisors and mentors explicitly flagging

ethical issues as a way of assisting the development of ethical awareness for students

and inexperienced practitioners. The ATEAM (2001) focuses on providing explicit

structured learning experiences utilising traditional structures for clinical teaching

such as ethics ward rounds, ethics grand rounds, ethics journal clubs and highlighting

of ethical issues in clinical seminars as ways of developing ethical awareness (and

practice!). All these approaches are dependent on a pool of experienced

professionals with highly developed ethical practice being available to facilitate

student learning in this area.

Learning ethical reasoning as a facet of clinical reasoning

Through the 1990s there was a tremendous rise in the recognition of the role

clinical reasoning plays in the development of professional practise abilities in the

professions (Edwards, 2000; Elstein, 2000; Higgs, 1992; Higgs & Jones, 2000;

Moses & Shapiro, 1996; Shapiro,D & Shapiro, N., 1989; Terry & Higgs, 1993).

Terry and Higgs (1993) define clinical reasoning as the "…thinking and decision making processes associated with clinical practice" (p.47). Clinical practice encounters are by their very nature complex. They often require high-level management of a plethora of information in real time (Moses & Shapiro, 1996). Clinical reasoning is an intermediary step between knowledge and clinical action. It allows clinicians (and students) to utilise their knowledge base (theoretical, research and personal) as it is developed through a variety of ways (classroom learning, clinical experiences, discussions with others, individual reflection) in real life clinical encounters.

Ethical reasoning can be considered one of many complementary clinical reasoning strategies (Edwards, 2000). Ethical reasoning is an important skill for students and health professionals as they learn "…to cope with the pain, frailty and human endeavour within the clinical situation" (Titchen & Higgs, 1995). Ethical reasoning and analysis are critical to patient care (Myser, Kerridge, & Mitchell, 1995). The ATEAM (2001) describes moral reasoning as

> …the ability to analyse ethical issues…to construct arguments and counter arguments that are valid and sound and to examine and interpret the arguments of others. (p. 206)

Ethical reasoning may engage other forms of clinical reasoning such as narrative reasoning.[16] Flemming (1991) and Robertson (1996 cited in Higgs and Jones 2000) suggest that ethical reasoning and reflection should underpin all aspects of health professional decision-making and thus clinical reasoning. Robertson (1996 cited in

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[16] Narrative reasoning is the consideration of contextual factors and stories of the patients past and present as part of the clinical reasoning process (Edwards et al 1998).

Higgs & Jones, 2000) further suggests that ethical theory "…provides a framework to inform, guide and justify clinical reasoning" (p.70). So for example, student speech pathologists might hypothesise why team members, clients or families find particular treatment decisions challenging using hypothetico-deductive reasoning[17] processes. An example may be the student identifying there is a problem with whether a feeding tube should be placed in a palliative client. The student may then hypothesise that for cultural reasons the treating junior doctor may not believe in offering comfort care only (as opposed to active treatment) and therefore the doctor is arguing for a feeding tube being placed. She may test this hypothesis through gentle questioning. Meanwhile the family may be telling the student they don't want the client's life and suffering prolonged. The student may then ask a senior doctor or clinician to discuss medical futility with the junior doctor. The student's field educator may suggest negotiating comfort oral intake with all parties. Speech pathology students may use pattern recognition[18] when considering decisions about ensuring equitable access to service delivery. So for example after gaining some experience the student may recognise a mild language delay can be managed by improving carers ability to provide everyday language stimulation through a group program for carers whilst early childhood stuttering has excellent outcomes using an individualised intensive intervention. Therefore good outcomes for both children can be achieved through different forms and intensity of service. The speech pathology students' clinical reasoning about end of life decisions may change, as their knowledge of the influence of various interventions on the course and path of the

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[17] Hypothetico-deductive reasoning involves problem recognition, hypothesis testing, heuristic search (guided learning) (Fleming, 1991)

[18] Pattern recognition involves the categorisation information to create and recognise patterns (Higgs and Jones 2000)

dying process increases. They may then engage in more interpretive reasoning such as narrative reasoning or collaborative reasoning[19]. They may also use interpretive reasoning models daily when making decisions around information sharing with the treatment team and client confidentiality.

How do we teach clinical reasoning including ethical reasoning to students? Tanner (1987) suggests that the starting point may be knowing how clinical reasoning develops and the progression from beginner to expert. This knowledge allows increased explicit teaching of the reasoning process at a level appropriate to the student (Higgs & Jones, 2000). Higgs (1997) also suggests that clinical reasoning models are best taught within both the academic and practicum context. McAllister et al., (1997) agree that clinical reasoning is best developed through both academic and practicum learning. Sheppard and Jenson (2000) suggest clinical reasoning can be taught both implicitly and explicitly. Both forms of teaching, they hypothesise, will direct leaning in students. There are pros and cons to teaching clinical reasoning formally as part of the explicit academic curriculum (Higgs, 1997). By utilising clinical reasoning skills in the classroom students can explore options, make mistakes, and have time to reflect on the process without it impacting negatively on a "real" client. The risk is however that the on-line transfer of these skills is possible only in the practicum. The field educator needs to direct attention, observation and feedback to the learner about his/her reasoning skills if this area of development is to be facilitated in a targeted and efficient manner in the clinical setting (Higgs, 1997; Terry & Higgs, 1993). Use of an adult learning philosophy and framework for the teaching of clinical reasoning is suggested by Higgs (1997). This

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[19] Collaborative reasoning is reasoning done co-operatively with others (Edwards et al 1998 in Higgs and Jones 2000)

is because clinical reasoning and adult learning approaches both stress the relationship between knowledge and the individual's strategies used in developing that knowledge. It allows the teaching of clinical reasoning to be based around the student's own experiences.

It is only through the linking of ethical knowledge and ethical practice that students and health professionals can learn to act ethically. Using ethical reasoning prior to and following action is a fundamental transitional skill that requires development in students. Myser et al. (1995) provide a step by step guide to assist students develop an ethical reasoning process prior to determining an action plan given an ethical dilemma. Myser et al suggest students use this guide when considering or reflecting on the ethical dimensions of a clinical problem. See Table 4 for their 11 step approach.

Table 4 Guide for student consideration of ethical dimensions of clinical decision making.

2.64 Step	2.65 Task
2.66 1	**2.67 Gather patient related information: medical, social and ethical histories; results of assessments (examinations and investigations)**
2.68 2	**2.69 Identify existing and / or anticipated ethical issues**
2.70 3	**2.71 Distinguish between medical, ethical, social and legal issues**
2.72 4	**2.73 Determine which bioethical principles or concepts are relevant (e.g.**

For whom, why and when) to ethical clinical decision making.

2.74	5	**2.75 Identify conflicts between principle based obligations (existing or anticipated)**
2.76	6	**2.77 Explain why there are principle based conflicts**
2.78	7	**2.79 State clinical-ethical decision**
2.80	8	**2.81 Justify clinical-ethical decision-consider how guiding principles are balanced, possible objections to the decision and counter arguments to the objections**
2.82	9	**2.83 Identify relevant laws and how they might guide management**
2.84	10	**2.85 Examine the relationship between clinical-ethical decision and law**
2.86	11	**2.87 Argue which legal and ethical obligations in this case should guide decision making and why.**

Based on Myser et al (1995 p. 30)

Even with guides such as this much practice is required by students to

competently use clinical and ethical reasoning strategies in real time situations.

Learning ethical practice through reflection on practice

The notion of effectiveness of learning being equated to time spent learning

appears to be reinforced in some health profession courses where students are

required to complete a magical number of "clinical hours" in particular areas in order to be eligible for graduation. This was the case when I graduated as a speech pathologist requiring 350 client contact hours with no less than 35 hours in Audiology clinic. It still occurs in courses in Australia and overseas. When there are caseload and time pressures, it would seem easier to students to function at an automatic or impulsive level with limited deep thought (Smith & Cornwall, 2002). During their university education, students are typically confronted with a range of new and often personally challenging situations. Not least, ethical dilemmas often challenge students at a personal as well as professional level and it is only through reflection that they gain a deeper understanding of both themselves and the situation. Corey et al., (1988) propose it is only through reflection on situations that may cause ethical distress that students can learn to be more tolerant of ambiguity in ethical decision making and action.

According to the seminal work by Kolb on learning styles discussed earlier (See Section 2.3.3.1) some students will naturally and automatically reflect on what they have done in the practice situation (Kolb, 1984). Jensen and Denton (1991) suggest however that many students require a framework that facilitates reflective practice. Suggestions for providing a framework for reflection include journaling and group debriefings. If regular journaling tasks or scheduled structured weekly group debriefing are mandatory then students' ability to critically reflect is both valued and given the necessary time to occur (Jensen and Denton, 1991). Whilst not ensuring deep reflection structured reflection tasks certainly flag with students the importance placed on reflection on practice. Structured time also provides pause in clinical "business" to process the experiences students have had during their clinic time. Boud, Keogh, & Walker (1985) provide a highly structured three stage process to

help guide students' reflection which facilitates reflective practice before the experience, during, and after the experience. Their model involves not just the recall of events but also pays attention to the feelings surrounding the experience, and finally an opportunity to re-evaluate the experience in light of previous and current learning. Mattison (2000) provides specific reflection guides to assist social workers to reflect on how current ethical decisions are shaped by previous and future ethical decisions.

Other writers have also provided prompts and starters for reflective journaling by students and debriefing discussions (Holly, 1987; Smith 1987 cited in McAllister et al 1997; Walish, Schuit and Olson 1986 cited in Best and Rose, 1996).

Schön (1987) identified reflection as a critical feature of professional competence.

> Competent practitioners must not only solve technical problems by selecting
> the means appropriate to clear and self-consistent end. They must also
> reconcile, integrate or choose among conflicting appreciations of a situation
> so as to construct a coherent problem worth solving. (p. 6)

Whilst this could be seen to be true of all areas of professional practice, it must certainly be the case when considering professional ethical practice.

Schön (1987) further stresses the importance of reflection in the so called "grey" areas of professional practice of which ethical practice must surely be considered an example. Some of these areas of uncertainty would include allocation of limited time to patients, how to ensure treatment compliance in the most vulnerable groups of patients, and how to prevent the inappropriate use of services (Rogers, 1997). Mattison comments that it is only through reflective self awareness that personal

insights can be gained into the patterns of responses to ethical dilemmas (Mattison, 2000). Thus the importance of students learning reflective practice in the practicum as a way of facilitating ethical practice development should not be overstated.

This section has discussed what the literature has to say about the development of the more specific ethical practice skills of ethical awareness and ethical reasoning in students and beginner practitioners. It also talked about why reflective practice skills are of critical importance in the development of a competent ethical health professional. The next section discusses the development of professional ethical values and attitudes by student health professionals.

2.87.1.1   Attitudes

Often, when thinking about students and ethics, assumptions are made that health professional students arrive at their course with deeply held beliefs having already having begun their ethics education (Andrews, 2004). Whilst this may be so, it ought not be assumed. Also, given the diverse approaches available when considering ethical situations and the diverse populations of people that students will encounter in their professional practice, students require opportunities to explore their own values, attitudes and behaviours, and to consider those of other people (ATEAM, 2001; Purtillo, 1993). They also need to learn professionally related ethical attitudes such as professional self appraisal, self care, commitment to professional competence and the implications of professional relationships.

A number of authors would contend when considering the formation of ethical professionals that the danger is in compartmentalising one's life rather than integrating the personal and professional (May, 1967; May, 1983; McAllister, 2001). McAllister in her thesis uses the metaphors of adding layers to a Russian Doll rather

that changing masks as people develop professional roles and identities. The two critical "inner dolls" of McAllister's model are the dimensions a sense of self and a sense of relationship with others, which are critical features when considering the development of ethical attitudes in professional practice.

Attitudes for professional ethical practice are built onto existing personal attitudes and values held by the student. This section reviews the literature with regards to approaches which have been used to develop ethical attitudes in health professional students.

<u>Liberal arts/humanities approach to teaching ethical attitudes</u>

Many health professional ethics educators use film, literature, plays and other art forms to help students emotionally engage with what it means to be a patient, or to have a disability, or to experience the health or education system (Leget, 2003; Rapport, Wainwright & Elwyn, 2004; ten Have, 1995). That is they use creative arts to help students develop understanding, empathy and compassion for those with whom they will work. This engagement with real or imagined characters provides student's with opportunities to gain insights into the experience of illness and disability outside their own life encounters. The use of stories as teaching tools has been used by societies across the ages (Evans, 2001). On closer examination, this approach to developing ethical attitudes seems particularly suited to those who learn from reflection or as a mode for teaching skills for reflection. For the more concrete or activist learners (as discussed in section 2.3.3.1), explicit links through discussion with their own personal or professional experiences may need to be made or other tangible learning opportunities such as being in a wheel chair for a day may need to be constructed.

The use of the arts to engage students in reflection can also be used as a

springboard for them to reflect on their own society and personal values and attitudes (Nicholas & Gillett, 1997; Coles, 1989). The introduction of the social and political determinants of health and the influence of power and social positioning both on access to, and engagement with, health, welfare, disability and education services may challenge students to develop a bigger-picture view of their professional interactions (Nicholas, 1999).

Sarason (1985) would contend however that a liberal arts education or approach is not enough, but that action, reflecting and discussing, and debriefing real life encounters is essential. Deborah Bowman, lecturer in Law and Ethics at St Georges University London, (personal communication, 2003) further suggests that this reflection and discussion can be extremely powerful when student peers are used with experienced faculty "invited" to provide input as required or requested.

<u>Modelling</u>
Many authors have discussed the role of professional socialisation in the formation of the professional identity of health care workers. Professional socialisation is often seen as a key influence in developing ethical practice in students (McAllister, 2000). The risk with the professional socialisation approach is its tendency to maintain the professional status quo. It does not necessarily assist the individual to be part of a "…liberative process of engagement with oneself, one's role and the values of one's profession and one's community" (Jordan, 2002 p. 3). Similarly we risk students becoming "…cynical and disillusioned…" (McAllister and Lincoln 2004), when they observe professionals operating in an unethical manner. This illustrates the power of the so called hidden curriculum at work. Handelsman (1986) (cited in Corey, Schneider Corey and Callanan 1988) contends that there are real problems with the idea of ethics education by osmosis for example

observations of professionals encountered by students. Rather, students require both knowledge (theory) and discursive opportunities in order to question ethical assumptions, reflect upon and debrief behaviour, as well as attitudes encountered.

Ethics teachers can however play a powerful role in consciously and explicitly modelling what it is to be ethical. For students to learn from this modelling however they need opportunities see their teachers recognising and responding to both ethical and unethical behaviour. The very construction of ethics courses can also provide a model for students. For example, courses that are taught in interdisciplinary fashion and that promote tolerance of multiple perspectives, as well as being supportive and respectful of all participants and their experiences can model the very behaviour being promoted as ethical (ATEAM, 2001; Cloonan et al., 1999; Evans & Macnaughton, 2004; Thornton et al., 1993).

Risk of ethical erosion

When considering student learning of ethical practice it has been contended that much of the behaviour students will adapt is from the so called ''informal curriculum'' that they observe in the actual workplace (Hundert, Douglas-Steele, & Bickel, 1996). In reflecting on why students may not become ethical practitioners it is important to examine students' real life learning experiences. Some authors propose that in fact health professional education experience can increase cynicism and decrease care factors in students and hinder their ethical development (Feudtner et al., 1994; Price, Price, Williams, & Hoffenberg, 1998; Satterwhite et al., 2000; Yamey & Roch, 2001). Woodall, Rickenbach & Smith (2001) further suggest that students may struggle to integrate the models they see around them with what they would previously have viewed as unethical behaviour and attitudes.
Therefore, some authors promote the importance of influencing, explaining and

empowering students to act ethically despite the practice environments they may encounter (Feudner & Christakis, 1994; Osborne & Martin, 1989). The authors contention is that positive and negative role models observed by students during practicum influence students' ethical development as much as academic teaching does.

2.87.1.2   Summary

In section 2.3.3 the way different teaching approaches might influence student learning of the knowledge, skills and attitudes of professional ethical practice were explored. Firstly the development of a functional knowledge base fundamental to professional ethical practice was considered. Ways of facilitating student learning in light of current adult learning theories were discussed. In particular methods of fostering deep learning in students were highlighted. Secondly methods facilitating the development of three key ethical practice skills ethical awareness, ethical reasoning and reflection on practice were explored. Finally some positive and negative ways of influencing the development of ethical attitudes in students were considered.

2.87.2 Assessment of professional ethical practice

The previous sections of this chapter has examined the literature with regards to the influence learning and teaching methodologies have on the development of professional ethical practice competence in students. This section examines the role assessment plays as a driver for both teaching and learning.

Assessment of health professional students' attainment in any curriculum area should ascertain the minimum standards of knowledge, skill and attitude required by that profession. In crowded curricula assessment often provides a focus for student

learning (Myser et al ., 1995) and highlights the importance placed on the area by staff and the profession (Little, Bujack & MacMillan, 1992). Rezler et al., (1992) contend that in many health profession courses limited assessment of ethics teaching has occurred because of difficulties in suitable methods of assessment. Mitchell et al., (1993) further suggest that whilst attempts have been made to assess primarily students ethics knowledge base assessment of the effect of ethics teaching on clinical activity is more challenging. More recent discussions of methods of assessment of ethical practice in the literature have been varied. Methods of written assessment included marking students' responses to ethical vignettes, assessing students' presentation and ethical analysis of a personal case studies of situations containing ethical dilemmas, measuring ethical reasoning development of students before an after formal ethics course-work (Myser et al., 1995; Rest & Narvaez 1994). Some methods of clinical assessments have also been discussed. These included students being marked on aspects of ethical practice displayed in clinical examinations and observed during practicum (Malek, Geller, Sugarman, & Jensen, 2000; McKneally & Singer, 2001; Myser et al., 1995; Roff & Preece, 2004)..

For Australian speech pathologists, the Entry Level Competency Based Occupational Standards (Speech Pathology Australia, 2001) states explicitly the need for both performance criteria and cues relating to adherence to confidentiality, ethical practice and the Speech Pathology Australia Code of Ethics (Speech Pathology Australia, 2000). Until 2006 however the Flinders University Clinical Skills evaluation checklist had a single criterion "2:8 Demonstrates ethical and legal conduct" as a fully present or fully absent criterion. Student performance was graded as simply satisfactory or unsatisfactory. Whilst other criteria in the extensive

checklist may also have reflected ethical practice skills[20] these were not explicitly

labelled or explicitly recognised as ethical practice skills and abilities. It was on this

one limited criterion that the student described in the scenario at the beginning of this

chapter would have her ethical practice assessed. She maintained confidentiality,

was respectful in her approach to patients and staff, so then could her conduct be

labelled as unethical? On the other hand, she was unable to demonstrate the

knowledge and skills of ethical practice that would allow her to navigate the

minefields of human interaction she would encounter in all professional situations in

her future. What assessments of ethical knowledge and skills had been conducted

during her academic course work?

Since the time of the scenario[21] described at the beginning of this chapter the

Speech Pathology Australia Code of Ethics has undergone a radical change, and now

highlights more of the knowledge, skills and values expected of those in the

profession. Also, as of 2006, a new national assessment tool "Competency

assessment in speech pathology students'' (or COMPASS™) has been published by

Speech Pathology Australia (Speech Pathology Australia, 2006) and is now being

implemented at Flinders University. In this assessment, behavioural descriptors of

levels of student competency in four generic professional areas - reasoning,

communication, lifelong learning, and professionalism - are provided. A number of

these criteria implicitly and explicitly pertain to professional ethical practice. The

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[20]Criteria that may be considered as having an ethical practice component include: 1:1 Appraises performance with insight and objectivity; 1:3 Actively extends knowledge base; 1:4 Recognises the impact of personal stress and health etc. on performance; 3:7 Planning accounts for client restrictions; 5:8 Determines management techniques appropriate to the client; 7:6 Recognises the need to refer for specialist behaviour management; 8:1 Demonstrates respect of the client's rights and beliefs.

[21] Which occurred in the late 1990s

assessment also includes seven units of competencies based on the Speech Pathology Australia Competency Based Occupational Standards (CBOS). These include assessment, analysis and interpretation, planning, intervention, maintaining and delivering speech pathology services, professional, group and community education, and professional development. A number of these seven units in their descriptors explicitly refer to ethical guidelines of the profession. Thus when students are being assessed using COMPASS™, through both the four generic professional areas and in the seven CBOS units of assessment there are many more explicit opportunities for students to demonstrate their level of competence in ethical practice.

Of concern however is whether the COMPASS™ expectations for entry level professionals are realistically obtainable particularly for undergraduate students. The results of Brockett et al. s' (1997) study discussed in section 2.3.2 suggested that many health professional students may not be able to reason independently in a principled manner[22], and yet one of the major underlying premises of Speech Pathology Australia's Code of Ethics (2000) is the aspiration to upholding certain ethical principles. Similarly, work on student development of generic clinical reasoning and more specifically ethical reasoning would suggest that in the novice practitioner this is often a limited skill (McAllister, 2006). It is unclear whether the COMPASS™ assessment protocols, based on the use of Speech Pathology Australia's (2000) code of ethics, which in part describes the professions aspiration to use ethical principles, will create impetus for better ethics teaching or simply set unrealistic goals for many entry level practitioners and their educators?

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[22] According to the Kohlberg's model of moral reasoning development up to 50% of Brockett et al., s' students were not demonstrating principled ethical reasoning

This section 2.3.4 has explored the influence that assessment processes and protocols may have on student learning. It has also discussed some of the difficulties in assessing ethical practice in health professional students. Particular challenges with regards to the current assessment of Australian speech pathology students' ethical practice have been highlighted.

2.87.3 Summary

In section 2.3 literature was examined to identify what factors may need to be considered wanting to influence the learning of professional ethical practice. Firstly students readiness to learn was explored from cognitive developmental perspectives, with regards to learner task maturity and learner's emotional engagement with the topic. Secondly, approaches teachers may use to facilitate the development of the knowledge, skills and attitudes of ethical practice were considered. Finally the influence that assessment may bring to bear on both teaching content and student learning was presented. The final section of this chapter considers what questions remain for the researcher having reviewed this literature and presents the questions she wishes to answer through her research.

2.88 Formulation of the question

This literature review has presented examples of the knowledge, skills and attitudes that would appear to present the best practice underpinnings of entry level health professional ethical practice. It has also provided the background literature into how these knowledge, skills and attitudes could be best taught and developed in health professional students. The real case presented at the beginning of this chapter would suggest that speech pathology students and new graduates are not necessarily able to demonstrate independent professional ethical practice but whether this is

really so has not previously been investigated.

In this study I aim to explore how student speech pathologists currently learn professional ethical practice through their university education. I want to investigate what they do learn with regards to professional ethical practice and the factors (developmental, personal, and educational) which may influence their learning. It is hoped that through this exploration and examination ways of maximising student learning of professional ethical practice may be identified, and perhaps highlighted to the profession.

2.88.1 Statement of the Research Question

The literature demonstrated deficiencies exist with regards understanding: What is current practice with regards to speech pathology students' learning in the area of professional ethical practice? Do factors identified in the literature as influencing learning in general, influence student learning of professional ethical practice? What is realistic to expect with regards to student competency in this area of practice? How do speech pathology educators facilitate learning in the area of professional ethical practice? These are the questions raised by the student story given at the beginning of the literature review and they remain unanswered at the end. They are the questions this research will explore.

3 RESEARCH PROCESS

3.1 Theoretical underpinnings for the research process

In the opening chapters of this thesis the relevance of learning professional ethical practice for speech pathology students was introduced. A number of concepts relevant to ethical practice were described. A review of the literature provided definitions, explanations, and descriptions of terms relevant to the consideration of the knowledge, skills and attitudes required for health professional ethical practice. It also served to highlight relevant existing teaching and learning principles and approaches related to health professional ethical practice. The literature demonstrated deficiencies exist with regards to understanding students' learning of professional ethical practice. Questions were therefore formulated for research by the investigator. This chapter details the journey the researcher took to create and implement a plan to explore the research questions in a meaningful way.

An epistemological[23] approach to explicating the questions and potential sources of bias is presented in the first section of this chapter. It is important to understand bias, epistemology and research methods in order to evaluate the legitimacy of the research and understand the influence context has on its questions and findings. Firstly potential areas of bias during the research phase of this work are described. A detailed description of the researcher's background and how it influenced the theoretical approach taken to investigating the questions posed by this study is provided.

Next the means of establishing the methodological credibility and quality

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[23] Epistemology is an approach that explores the nature of ''truth'' in human and social science research questions (Denzin & Lincoln, 2000; Kemmis & McTaggart, 2000)

(Janesick, 2000; Lincoln & Guba, 1985) of the study are discussed. These are, firstly, the extensive triangulation of data types and sources. Secondly, the recording of an explicit, systematic audit trail of the actual research methods employed in data collection and analysis methods used to conduct the study are described. Thirdly, the study participants were invited to review transcripts. Fourthly, research supervisors examined narrative analysis and thematic coding for credibility and reproducibility. Finally, difficulties with the methods used are reported and discussed. Thus this chapter hopes to demonstrate that the results of this study are credible and a quality research process was used. Later chapters will illustrate why the results are important to the speech pathology profession and may have implications for other health professional groups.

3.2 Deciding on the research approach to take

When initially starting this project I assumed a quantative approach to research would be required. Ultimately, a qualitative research approach was selected to open up the area of student learning of ethical practice for further examination.

3.2.1 Dealing with bias

In qualitative research, bias is difficult to control and is often hidden (Greenhalgh & Taylor, 1997). Detailed background information relevant to the researcher and how bias was challenged are provided (Hay, 1999). In research the questions asked, and the themes identified may be biased by the researcher's educational, professional, and personal background as well as their theoretical viewpoint. Thus this section provides insight into these factors so readers may be more aware of background factors which may have influenced my perspective.

3.2.2 My background

3.2.2.1 My educational background

I entered the Bachelor of Applied Science (Speech Pathology) at Sturt College of Advanced Education in South Australia in 1984 and graduated in 1987. At that time the predominant research methodology taught related to the quantitative paradigm. However, my research group and I as part of the undergraduate degree requirements undertook a study based on structured interviews. This was an early attempt at qualitative research without having been formally taught the theoretical bases of a qualitative research approach. Interviews and results from the interviews were analysed to give quantifiable results with other information gained "adding colour" to the results. Even at that time I felt that facts and figures were unable to give the human face to the questions being answered. These results were presented in a minor thesis (Quattucio, Martin, & Smith, 1987). This early attempt made me more open to a qualitative study.

When recommencing formal education as a post-graduate student I set three personal learning goals. The goals were to learn more about ethical practice, student learning and qualitative research techniques.

3.2.2.2 My professional experiences

After graduation, I worked in a number of diverse clinical settings within Australia and overseas in developed and developing countries. I also worked extensively as a mentor to new graduate clinicians and as a field educator. I was also employed by a number of universities and a training college to provide academic teaching and field education experiences for speech pathology students, occupational and physiotherapy students and rehabilitation technician students. At the time this study commenced, I was part of the Flinders University clinical education team

responsible for providing training and development and mentoring support to field educators across South Australia.

Several issues around ethical decision making became apparent during this time. These included the lack of ethical decision making resources available to speech pathologists and students and the increased stress levels, induced by ethical dilemmas and conflicts, for clinicians operating within, an often already stressful clinical situation (See the student story in section 2.1 for a case in point). It appeared to me that direct or indirect disempowerment of students or recently qualified graduate speech pathologists occurred when they were faced with a dilemma or treatment conflict that was ethical in nature. Disempowerment appeared to occur as a result of their lack of an underpinning theoretical model decreasing their confidence in identifying and communicating the reason for their ethical discomfit with the situation with other participants. This in turn contributed to their lack of participation in the resolution of the dilemma often leading to further discomfort. Ultimately this appeared to result in some students and clinicians avoiding clinical situations, which may have resulted in the need to resolve ethical dilemmas, as in the student story which begins chapter two. In that situation the student wished to avoid working with adults in future so as to circumvent similar uncomfortable situations.[24]

These issues motivated me to design a project which would help me understand current issues around the teaching and learning of professional ethical practice in the hope of improving my own and perhaps others teaching in this fundamental area of practice.

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[24] A previous study has found that these type of sequelae contribute to "burnout", the avoidance of certain clinical groups and / or the erosion of ethical values in the individual clinician (Brown, Lamont, & Connell, 1998). Burnout is a phenomenon where people who have been highly committed enter a state of fatigue (physical, mental and/ or emotional), or frustration due to the emotionally demanding situation, or a situation that doesn't bring the expected reward (Tools, 2006).

In turn it was hoped that improved teaching and resourcing might empower students and new graduates to have the knowledge, skills and attitudes to work through, rather than avoid, situations requiring ethical practice and ethical decisions.

3.2.3 Formulation of the research design

3.2.3.1 Formulation of the research questions

After reflecting on the ethical practice of students I had observed I was left with a number of questions. These questions included why do some speech pathology students appear to deal more easily with ethical issues than others; what kind of experience or background helped some speech pathology students work through ethical decisions more competently than their peers and finally how do speech pathologists teach the knowledge skills and attitudes necessary for professional ethical action to students in academic or practicum programmes? These initial questions were refined following a review of the literature pertaining to the teaching and learning of ethical practice (See section 2.4.1 for the statement of the research questions). The questions incorporated two components relevant to my own learning goals namely ethics and student learning.

3.2.3.2   Formulation of the research methodology

The following section explains how a quantitative approach was explored and rejected in favour of a qualitative methodology. It was hoped a qualitative approach would allow the questions it raised to be explored more deeply.

3.2.3.3 Personal experiences of ethics teaching

My own recall of learning in the area of professional ethical practice as an undergraduate was limited to talks on the importance of client confidentiality and informed consent in the context of recruiting research subjects. These are undoubtedly important issues of ethical practice but are severely limited in their

exposure to such a crucial part of professional practice.

In 1998 whilst attending a Speech Pathology Australia conference workshop (Brown et al., 1998) I was introduced to a principles based approach (Beauchamp & Childress, 1994), to the consideration and resolution of ethical dilemmas in speech pathology. In the workshop the application of these principles was further assisted by the provision of an ethical decision making framework. This information was a revelation and I considered that students, if taught these principles and how to apply them through the use of the ethical decision making framework, might be able to deal with ethical dilemmas more systematically and with greater confidence. I started to consider tentative research hypotheses for further formal study. The hypotheses were:

1. "Student speech pathologists can learn to apply an ethical decision making framework in order to resolve ethical problems experienced in their professional practice";

2. The effectiveness of the application of the framework in real life professional practice could be measured and empirically assessed.

3.2.3.4 Formulation of the research method

At the time of the workshop I felt that these questions could be examined through scientific deduction, that is, whether x but not y had occurred using a quantitative or positivist experimental research approach (Bailey, 1996). The quantitative research design methodology was conceptualised. Firstly, a speech pathology student's ability to make professional ethical decisions before any formal teaching would be measured. This baseline group would be split in two. One group of students would have their ability to make ethical decisions measured after being taught Beauchamp

and Childress's ethical principles along with an ethical decision making framework, and again after having their final clinical placement. A second group of students would not be taught to use the principles and framework and would have their ability to make ethical decisions measured simply after their final clinical placement. In this way, it was believed that the level of student learning about ethical decision making and the influence of various teaching interventions (principles and framework, principles and framework and final practicum, and final practicum alone) could be measured.

This approach to the question however would not have taken into account how the students were currently being taught and learning about professional ethical practice in their course. It failed to recognise that there were perhaps already multiple influences on the students' learning of professional ethical practice. Early discussions with research supervisors in fact confirmed that teaching around ethical principles already occurred in the course at Flinders University and ethically it would be difficult to withhold this teaching from a group of students. The extent and effectiveness of teaching around ethical practice was less clear and would be interesting to explore. I was challenged to consider how qualitative research methods may allow a more exploratory approach to the topic under consideration.

Using qualitative methods, a constructivist approach[25] to the research question had the potential to offer new insights into student learning of professional ethical practice, including issues such as individual student perceptions about learning

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[25] The constructivist approach assumes no single reality of experience of student learning of ethical practice exists; rather, there are multiple and sometimes conflicting realities (Denzin & Lincoln, 1994; Greenhalgh & Taylor, 1997). From a constructivist perspective each piece of 'knowledge' is made rather than discovered. New knowledge is described and modified by the individual after being processed through the individual's own conceptual frameworks. The conceptual frameworks have been themselves have been constructed against a background of shared understandings, social practices, language, history and so on (Schwandt, 2000).

professional ethical practice, individually identified influences on learning, student reported experiences of learning and what their ethics education meant to them. Of relevance to consider was the teaching educators reported providing in the area and somehow measuring the effectiveness of this teaching. It was believed that through exploration and comprehension of these realities, a reconstruction of students' ethics learning could be mapped and presented in this thesis.

3.2.3.5 Potential implications of the research

This research is significant in that it illuminates ways to improve speech pathologists' professional ethical practice. The study indicates where changes need to be made to improve how students learn and how professional ethical practice is taught and facilitated through their undergraduate course.

3.3 Study Design

3.3.1 Ensuring credibility and quality

3.3.1.1 The use of triangulation

This research project uses extensive triangulation to add rigor, breadth, depth and complexity to the acquisition and analysis of data and thus gain a rich picture from multiple sources of knowledge about student learning of ethical practice.[26] Three applications of triangulation were used in this study. Methodological triangulation was used in the acquisition of data including the use of student focus groups, individual interviews and case studies. Triangulation of data sources was also employed. Data were collected from course outlines, participant observation of workshops, students, academic educators, and field educators. Theoretical

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[26] Triangulation of data is where more than one method is used to collect and / or analyse data and more that one source or type of data is considered (Denzin & Lincoln, 1994; Greenhalgh & Taylor, 1997). Triangulation is an alternative to validity techniques in quantitative research. (Flick, 1998)

triangulation was also used for data analysis. This allowed propositional content analysis to occur for example coding responses according to different ethical theories, student learning theories and teaching theories. It also allowed data in the form of student stories to be analysed using narrative analysis[27] approach. (See Section 3.4.4 in this chapter for a more details).

3.3.1.2 Ensuring a quality research process

The quality of this study was enhanced by making the research process (formulation of the research questions, collection and analysis and interpretation of data) credible, transferable and dependable (Bailey, 1996; Denzin & Lincoln, 1994; Greenhalgh & Taylor, 1997). All interviews were carried out by the researcher, according to accepted guidelines of the research genre (Hay, 1999; Hurworth, 1996; Krueger, 1994; The Centre for Programme Evaluation, 1999)[28] Participant members were given opportunities to review their interview data and allow its inclusion prior to the analysis. Data analysis was conducted following the principles of a number of authors for qualitative data management and analysis which will be discussed in more detail later in this chapter (Bailey, 1996; Daily, 1999; Dey, 1993; Hay, 1999; Miles & Huberman, 1994). Analysis results and interpretations were reviewed by research supervisors as a kind of outsider member check (Janesick, 2000; Lincoln & Guba, 1985). A detailed audit trail has been provided (Lincoln & Guba, 1985).

3.3.2 Justification of the methodology

The published literature on ethics education for health professionals has had very little to say on how students (or qualified professionals) report their learning about

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[27] Propositional content analysis is an analysis not dependent on context, whilst narrative analysis is focused on the individual in a given context (Triezenberg & McGrath, 2001).

[28] The Centre for Program Evaluation is a Melbourne University based centre.

ethical decision making. In recent years there has been an attempt by health professional educators to quantify and assess the existence of ethical sensitivity in students (Brockett, Geddes, Westmorland, & Salvatori, 1997; Delaney & Kean, 1988;). Narrative analysis was used to document ethics content in student stories including ethical sensitivities and values (Triezenberg & Davis, 2000; Triezenberg & McGrath, 2001). Qualitative research strategies have been used to understand the influence of the informal curriculum on student ethical sensitivity (Hundert, Douglas-Steele, & Bickel, 1996). Strategies to quantify ethical sensitivity include the use of presentations, modified essay questions, the use of created case studies and vignettes (Roff & Preece, 2004; Mitchell et al 1993; Hebert, Meslin, Dunn, Byrne,& RossReid, 1990). Mitchell et al., were concerned that they might be assessing knowledge rather than the application of knowledge in a clinical context. Hebert et al., were concerned however that it was difficult to work out exactly what aspects of ethical sensitivity were being measured. Rezler et al., (1992) developed and tested a professional decisions and values test. However they felt the reliability and stability of results in the area of values were not reliable over time. Leget (2004) described a process of showing a film and analysing the post video discussion of students. The author stressed that ethics can not be measured in an emotionally neutral fashion such as mathematics and thus many students evaded ethical discussions.

There have also been recent attempts to elicit the application of taught ethical decision making processes using structured case review discussions (Mitchell, Myser, & Kerridge, 1993; Myser, Kerridge, & Mitchell, 1995; Mattison, 2000). These processes use cases encountered by students (or professionals) to stimulate a case discussion informed not only by themselves but also others involved in the case. Unfortunately this was found to be an extremely time consuming and students

required greater guidance in identifying appropriate cases.

Analysis of the literature identifies a variety of potential factors having direct and indirect influence on the development of a student's actual ethical practice skills. Mitchell et al, 1993 discuss the limited exploration of what students actually ''do''. Detailed investigation of these influences has not yet been explored in the literature.

3.3.2.1 Summary – the advantage of qualitative approach

The advantage of a qualitative approach to this project is that it allows the exploration of influences that students of speech pathology encounter and those that facilitate their learning, academically and practically. The data collected and analysed should "illuminate, explain and interpret" (Garman, 1998) the process of learning professional ethical practice for students. The data may then be compared to theories from the literature on moral reasoning development and clinical skill development, thus facilitating theoretical triangulation of the data.

This study was designed to encompass a broad examination of student learning of ethical practice in an attempt to identify which if any factors facilitate learning. Facets of student learning of ethical practice are to be examined from the student, academic and field educator perspective.

Through using triangulation of data sources it is hoped that effective strategies for teaching and learning ethical practice may be illuminated for all parties and the examination of them provide and explanation for why particular strategies or approaches may be effective and in which contexts.

3.4 Method

3.4.1 Population sampling

All sampling in the study was designed to be purposeful, with particular groups of informants being targeted by the researcher, that is, subjects were selected specifically for their relevance to the topic under examination (Denzin & Lincoln, 2000; Hay, 1999). This facilitated the selection of "information rich" (Patton, 1990) cases which provided relevant in-depth information about the topic under consideration.

The criteria for selection of each group are detailed in this section. All chosen informants had the ability and experience to provide detailed and rich information (Patton, 1990) on the topic of what influences speech pathology students' learning of professional ethical practice

3.4.1.1 Student participants

The student sample could be considered an essentially homogeneous sample with regards to the academic and probable field education curriculum inputs they had received. Their backgrounds and personal experiences were unable to be controlled and these were considered important factors for this study to explore, particularly with regard to how they may have influenced their learning of ethical practice.

All fourth year students within the Bachelor of Speech Pathology program at Flinders University participating in the subject Issues in Professional Practice 4 were invited to participate in the research that would be conducted during IPP4 sessions following their final practicum placement. As exiting students who had completed all course requirements other than two final days of course work in IPP4 it was believed that they would have the knowledge, experience and ability to participate in

discussion and reflection on their learning. Thus as a group they are likely to provide instances of the learning process under examination (Morse, 1994; Denzin & Lincoln, 2000). Primary selection (Morse, 1994) was via direct inquiry, that is students were asked by the researcher whether they would be willing to contribute data gathered through their participation in the Issues in Professional Practice 4 (IPP 4) workshop tasks and further volunteer for individual interviews.

With the student sample population there was no attempt to identify or target extremes of experience. The group was selected on the basis of; their generic experience of the learning of professional ethical practice as part of their degree program, their attendance and participation in the IPP 4 workshop and their voluntary response to the invitation to participate. Morse (1994) suggests this will make them a good informant.

Students as a research group may feel vulnerable and obligated to participate. It is hypothesised that students may feel uncomfortable having their participation observed by the researcher, senior clinician who may have supervised them on clinical placement or may be perceived as a future employer or colleague. With the group of students invited to participate, there was no dependency upon the researcher for ongoing student assessments[29], reports or work opportunities at that time or in the immediate foreseeable future. It was stressed at all stages of data collection that they were in no sense obliged to consent to their data from the class activities being included or in participating in group or individual interviews with the researcher. Where practical other university staff also facilitated discussions and sessions. Thus

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[29] The students had completed all degree requirements or were not students on placement with the researcher. The researcher was not at that time in a management position, that is responsible for employment decisions.

it was hoped that students had no sense of obligation to participate to earn "good will".[30]

3.4.1.2 Academic educator participants

Academic staff were invited to participate according to criterion sampling methods (Patton, 1990). Criterion sampling is a purposeful sampling method which selects and approaches participants on the basis that they meet criteria which may imply that they will exemplify the characteristics or processes of interest and thus be a rich source of information (Morse, 1994). Staff were invited to participate in the research based on their employment teaching in the academic program at Flinders University in the undergraduate degree and that their course outline documents explicitly stated the teaching of ethical issues to speech pathology students (Patton, 1990). The eligible academic staff could be viewed as explicitly contributing to the topic of interest - an exploration of student speech pathologists' learning of professional ethical practice. All the academic staff shared a collegial relationship with the researcher.[31]

3.4.1.3 Field educator participants

Field educators were eligible for involvement in the study if they had provided field education experiences to one or more of the student participants in their final practicum.[32] Field educators from the eligible group were approached by the researcher to participate according to maximum variation sampling as defined in Morse (1994) and Patton (1990). Maximum variation sampling intentionally seeks a

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[30] The researchers relationship to the group is articulated to reveal any potential bias in both participation and responses by students (Woolcott, 1990).

[31] As in footnote 3 above.

[32] The terms "practicum" and "field education placement" are used interchangeably throughout this thesis.

heterogeneous sample in an attempt to identify whether there are common experiences despite perceived variations. The variation factor for the field educator participants was there workplace. The researcher thought that different workplace settings might provide different opportunities for students to be exposed to different examples of professional ethical practice. Thus a heterogeneous sample of field educators was determined by the researcher covering six major areas of speech pathology practice in South Australia were students participated in field placements. Six main areas of practice identified were:

- Health, including adult and paediatric acute care and rehabilitation hospitals;

- Community Health, including community services to adults and children and health promotion activities;

- Education, involving services to preschool and school aged children and young people in the public and private sectors;

- Specialist services, not for profit and government services to populations with intellectual/ physical disability, autism or mental health issues;

- Rural services, for adult and paediatric populations through country hospitals&/community health centres;

- Private practice, in private hospitals or the community.

Representatives of these areas of practice would incorporate a range of management settings and philosophies students may typically encounter during their field placements.

A list of the final fourth year placements offered to the student group by field educators was obtained from Flinders University. One Field Educator from each of the six speech pathology practice areas was selected at random (except for the private practitioner as there was only one listed) and approached by the researcher by phone to participate in the study. Five out of the six approached responded and agreed to participate in an interview. Unfortunately the single representative of the private practice group selected to participate was unable to be part of the study. There was no other eligible field educator working in the private sector who could be approached. Further heterogeneity of the field educator participants was ensured by virtue of their varied experience in the provision of student field education, their years and type of professional practice. Field educator participant backgrounds are further discussed further in the field educator profiles in Chapter 6.

All the field educators had a collegial relationship with the researcher. It is necessary to note the researcher's employment with Flinders University's Department of Speech Pathology and Audiology. This employment may have influenced the view field educators presented of the students' competence in ethical practice, but it none-the-less perhaps also facilitated the willingness of participants to explain their educational practice in detail.

3.4.2 Choice of data collection methods

3.4.2.1 A test of moral reasoning development

To begin to examine students' learning of ethical practice from a learning readiness approach, a measure of students' cognitive developmental learning readiness in the area of ethics needed to be identified. The Defining Issues Test - an objective test of Moral Judgement Development (DIT) was selected for use (Rest,

1979b).[33] It is based on the theoretical understandings of moral judgement development described by Kohlberg (Kohlberg, 1984). [34] It assesses moral judgement development in terms of Kohlberg's stage theory. (See Chapter 2 page 30 for further description of these stages). The DIT is a moral judgement recognition test rather than a generation test[35] (Rest, 1979a; Rest, 1979b). This meant that student scores were likely to reflect the highest possible conceptual level of moral judgement development in the individual student.

The results of the DIT had been used extensively in other studies of moral reasoning development particularly with other health professionals (Rest, 1979a, 1988; Rest & Narvaez, 1994). Unlike other published measures of moral judgement development considered by the researcher this test was quick and easy to administer to groups. The scoring of responses on the DIT is predetermined and requires no judgements on the part of the administrator and was consequently easy to score with large numbers of students. The DIT could be completed in under an hour and required a reading age of only 13 years and reliable English language skills, both prerequisite skills for student admission into the speech pathology course. It was therefore selected for ease of administration and its accessibility to the researcher.

Students were asked to read the scenarios provided in the test and respond to

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[33] Other moral reasoning tests were considered by the researcher. Tests considered included the: Socio-moral Reflection Measure by Gibbs (A copy of this test was unable to be sourced); the Moral Judgement Interview by Kohlberg. (This is a very difficult test to administer and score without extensive training, and also very time consuming as it involves individual interviews); Real life moral conflict choice by Gilligan (A copy was unable to be sourced); Moral Reasoning/Orientation Interview by Self and Skeel; and The Moral Judgement Test by George Lind. (The underlying theoretical construct for the assessment by Lind was difficult to follow as were the scoring procedures.)

[34] See Chapter 2 page 29-30 for further explanation of Kohlberg's theory.

[35] Kohlberg's Test (The Moral Judgement Interview) for determining stage of moral reasoning development required subjects to generate their own stories or situations involving a moral dilemma that were then analysed by the researcher and assigned a stage of moral reasoning development. By contrast Rest's test provides subjects with stories and responses from which they could select responses. The provided responses are said to reflect different levels of moral reasoning based on Kohlberg's model.

twelve questions following each story. Their response was to rate each question as having great, much, some, little and no importance in making a decision about the course of action they would recommend to solve the social problem or ethical dilemma described in the story. Having rated each of the twelve questions the students were then required to rank the four most important questions they would want to consider when making decisions about the scenario. The final score allocated to each question equates to a stage of moral reasoning. Thus the final score indicates whether the student participant was making moral decisions based on a principled or conventional form of moral reasoning. An example of the DIT form and the scenarios contained in the test is at Appendix 1.

3.4.2.2 Written case study.

Part of the exploration of students learning of ethical practice was to measure their competence in ethical decision making processes and approaches. The case study method was chosen to provide an opportunity to illustrate the students' potential functional level of clinical competence in the application of ethical decision making. The case study is commonly used in teaching (Stake, 1994). The case study method of assessment of clinical reasoning and competence has been used extensively in medicine, nursing and the allied health professions (Mitchell et al, 1993). Case studies have also been used extensively in research as a means of advancing learning about a specific issue (Stake, 1994). For this study an instrumental case study was selected[36]. That is, a particular case was written so students' ability to apply ethical reasoning could be better understood.

A typical clinical case incorporating ethical issues and requiring ethical decisions

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[36] Instrumental cases are those where the case provides insight into another issue or theory (Stake, 1994).

was written by the researcher, a very experienced field educator, and clinician. (See Appendix 2a: Case Discussion.) Students were also invited to provide their own case from their own clinical experience as alternative case for discussion. This invitation was offered as a way of maximising student engagement with the task.

An ethical decision making framework guide was also written by the researcher. This was adapted from guides developed by Purtillo and Myser, Kerridge and Mitchell (Myser, Kerridge, & Mitchell, 1995; Purtillo, 1993). The case and the guide were reviewed by academic peers from speech pathology and physiotherapy.

During data collection students were asked to produce a written response to the case or their own case. Once their independent response was completed the decision making guide was provided to students. They were then asked to reconsider their response to the case and add any additional information prompted by the questions contained in the guide (See Appendix 2b: Guided Case Discussion).

The researcher wrote a best practice answer for the case study based on the decision making guide (See Appendix 2c). A scoring system to analyse student responses in relation to four key content areas based on the best practice answer was then devised. (See Appendix 2d: Rating Guide for Case Study).

The four content areas covered by the scoring guide were:

1. Identification of relevant clinical data;

2. Recognition and prioritization of ethical issues;

3. Communication and involvement of stakeholders;

4. Provision of management plan options.

It was thought theses content areas would provide insight into the level of potential ethical practice knowledge and skills of the students. A students' response in each key content category was then classed by criteria and labelled; unsatisfactory, satisfactory, very satisfactory, and excellent. The criteria for classifying student responses in relation to the four content categories are provided in the tables that follow. The students' independent and prompted (after using the decision making guide) responses to the case study were classified. Tables 5-8 illustrate the classification system utilised. For the student who provided their own case study the four content categories and labels were relevant but this student's response was classified according to the case they described.

Table 5 Criteria for classifying student responses in relation to the provision of clinical information

3.5 Description of response	**3.6** Evidence required for each description
3.7 Unsatisfactory	**3.8 None or minimal evidence that relevant clinical information was identified. Basic patient personal and diagnostic information given. (Less than 3/5 pieces of salient information identified)**
3.9 Satisfactory	**3.10 Basic relevant clinical and personal**

		information was identified. (3/5 salient pieces of information identified)
3.11 Satisfactory	Very	**3.12 Identification of essentially all relevant clinical information provided. (4-5/5pieces of salient information)**
3.13 ent	Excell	**3.14 Identification of all relevant clinical information provided, that is 5/5 pieces and a statement related to relevant additional information required**

Table 6 Criteria for classifying student responses in relation to the recognition and prioritisation of ethical dilemmas

Description of response	Evidence required for each description
Unsatisfactory	No evidence of recognition that there are ethical issues involved in the case or denial that there were any ethical

	dilemmas presented
Satisfactory	Recognition of one ethical dilemma
Very Satisfactory	Recognition of multiple ethical dilemmas
Excellent	Recognition of not only multiple dilemmas but also that the resolution of them may lead to conflict thus an attempt to prioritise the dilemmas for consideration made.

Table 7 Criteria for classifying student responses in relation to communication processes

3.15 Description of response	3.16 Evidence required for each description
3.17 Unsatisfactory	**3.18 No evidence of attempting to include others (patient, family, professional team, field educator/mentor) in the setting of management goals.**
3.19 Satisfactory	**3.20 Setting of management goals involved consultation with at least one other party.**
3.21 Very Satisfactory	**3.22 Setting of management goals involved all parties directly mentioned in the case study.**
3.23 Excellent	**3.24 Setting of management goals involved all parties mentioned in the case study and in addition identified relevant extra parties / resources to be consulted (e.g. hospital ethics committees).**

Table 8 Criteria for classifying student responses in relation to the provision of management plans

3.25 Description of response	3.26 Evidence required for each description
3.27 Unsatisfactory	**3.28 Provision of only one management solution.** **3.29**
3.30 Satisfactory	**3.31 Discussion of two alternative plans of action.** **3.32**
3.33 Very Satisfactory	**3.34 Discussion of more than two plans of action.** **3.35**
3.36 Excellent	**3.37 Extensive discussion of management options and their implications for the parties affected by the plan.** **3.38**

Students were initially provided with the written case study and asked to complete their written response independently. In their response they were asked to discuss what they would do in the situation provided. Once they had completed their response they were provided with the written ethical decision making framework. They were asked to add to their original discussion of the case based on any new

information required or prompted, by the ethical decision making framework. This allowed students to provide evidence of knowledge and application of ethical decision making skills, knowledge and attitudes without them being able to independently analyse the case study[37]. Thus the student's response with the decision making framework could be used to determine whether curriculum knowledge regarding ethical decision making was present but not fully integrated by student participants.

The researcher thought that this prompted knowledge recall needed to be considered because of the need to acknowledge that knowledge integration often requires a larger time frame than allowed for in the task. It was also recognised that foundation knowledge was essential for the accumulation of knowledge integration facilitated through experience and reflection on practice.

3.38.1.1   Group decision making case study

Student participants also took part in a group ethical decision making case study. A case study involving prioritisation of services was written. (See Appendix 3: Group Dilemma Discussion.) Students in small groups were instructed to discuss the prioritisation scenario and to create a solution for managing cuts to service provision.

This task was included as group learning is a key teaching methodology in the speech pathology course (especially for skill development in the area of communication and respect for others' opinions). This task explored, through questions in the individual student interviews, the influence of group processes on the development of ethical practice skills.

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[37] According to Bloom's 1950's taxonomy where there may be knowledge comprehension and application prior to knowledge analysis and synthesis (Anderson & Sosniak, 1994).

3.38.1.2   Student focus group interviews

A focus group interview was designed to examine the influence of life events and experiences on the development of personal and professional ethics. These factors may contribute to students' learning readiness for learning about professional ethical practice. A focus group interview was chosen over a standard group interview as it allowed the collection of increasingly specific information regarding what the students' believed had influenced their learning in the area of personal and professional ethics from a large sample (Hurworth, 1996; Kreuger, 1999). A focus group format allows participants to reflect on questions, interact with other participants, add comments beyond their own initial thoughts and thus possibly provide broader perspectives to the topic under discussion (Janesick, 2000; Patton, 1990). Focus groups also allow comparisons across groups with regards to the responses to the key questions (Patton, 1990). A focus group also assists the identification of false or extreme views (Hurworth, 1996; Kreuger, 1999).

When choosing to run focus groups one must also consider the challenges. The facilitator must have well developed group process skills to ensure all voices are heard, for example to deal with conflict and power struggles within the group (Patton, 1990). Also, the number of questions that can be asked is limited (Kreuger, 1999; Patton, 1990). Particular consideration of issues of confidentiality is required in focus group interviews (Patton, 1990). Recording and transcribing interviews can be challenging because of the multiple voices (Kreuger, 1999).

A focus group interview uses a questioning technique that focuses and leads the groups' responses until the very specific key questions are asked. Standard focus group questions are designed with a broad opening question, 3-4 transitional questions and 1-3 key focus questions. This model was used for this focus group

(See Figure 1 for a diagrammatic display of the technique). The idea is that the results to the key questions can easily be compared and contrasted across groups, enabling the researcher to determine whether the same questions lead to the same responses (See Appendix 4 for the questions posed in the focus group interview).

Figure 1- Focus Group Questioning strategy

The interview focused on factors identified by students as influencing their ethical development both personally and professionally. The intent was to elicit a range of student opinions.

There were sufficient potential student participants to form three groups of six to eight students. Time constraints on data collection meant that focus group interviews could not be conducted in a series two per day. This is suggested best practice in focus group research if the same moderator and assistant moderator are used due to fatigue (Hurworth, 1996; Kreuger, 1999). In this study with the assistance of

research assistants[38] they were conducted simultaneously. Only one group of students however consented to their focus group data being recorded for this project. This group was conducted by the researcher with one assistant to transcribe the interview online (as a back up to the tape recording) and make notes of group dynamics, speaker order and other observations. Each group interview lasted between 45 minutes and an hour. The information from the other focus groups was unable to be analysed as these students did not give consent for this information to be used.

3.38.1.3   *Semi-structured individual student interviews*

An important method of students learning of professional practice skills (including ethical practice skills) is the concept of reflection on practice (Schön, 1983, 1987). An individual semi-structured interview was conducted with student participants discussing their real life clinical encounters involving ethical dilemmas. Information was also collected regarding the processes used by the students to deal with these dilemmas including any perceived impact and influence of their academic and/or field placement educators.

The advantage of the longer interview, as a qualitative method of data collection, is that it allows exploration of the students' own recounting of their experiences in learning ethical practice (McCracken, 1988). (See Appendix 5: Student Interview Guide). As students were asked to recall their own experiences and feelings it was felt an individual interview was a more appropriate format than a group interview. The individual interview also allowed time for reflection if required by the student.

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[38] University staff and post graduate students who volunteered and had been trained as moderators and assistant moderators to ensure quality data was collected.

3.38.1.4 Textual analysis of course outlines

Through examination of the topic outlines (1996-1999) relevant to this particular group of students (Russell, 1999) broad textual analysis was used to identify potentially explicit teaching moments in the area of ethics and ethical practice. Outlines were scanned for references relevant to the development of ethical knowledge, skills and attitudes.

3.38.1.5 Participant observation of Issues in Professional Practice 3 ethics workshops

The third year speech pathology topic, Issues in Professional Practice 3, contains two workshops in ethics. These were observed to identify both the content and method of teaching used in this topic. Unfortunately the fourth year students had completed this topic the year before the research was commenced so their experience may have been somewhat different. The academic lecturer responsible for this topic however felt the style and content of the workshops was essentially the same.

3.38.1.6 Semi-structured interviews with academic staff

Individual semi-structured interviews were used to explore with the three academic staff possible teaching moments for ethical practice both implicit and explicit in their teaching of this group of student participants. From the perspective of a methodological approach to learning, and attitudes and skill development it was deemed to be important to understand the academic staff's approach to teaching ethical practice throughout the course and not just in specific topics. (See Appendix 6: Academic Educators Interview Guide)

3.38.1.7 Semi-structured interviews with field educators

Individual interviews with field educators to discuss students' learning readiness for ethics and ethical teaching moments during field placement were chosen as an appropriate method of eliciting information. (See Appendix 7: Field Educators

Interview Guide)

3.38.1.8 *Summary of all data sources*

The following table, Table 9 summarises all sources of data gathered in this project from students, educators, observations and documents. All student data other than the Individual semi structured interviews were completed in class time as part of class activities.

Table 9 Summary of data sources

Source of Data	Type of Data	Number of Pieces
Students	DIT	19
	Written case study completed independently	18
	Written case study completed with Ethical Decision Making Guide	18
	Focus group interview	8 (Core Group Students only)
	Individual semi-structured interview	8 (Core Group Students only)
Academic Educators	Observations (IPP3 Workshops, IPP4 workshop)	3 Workshops
	Course Outline Documents (1996-1999)	Batchelor of Applied Science (Speech Pathology)
	Semi-structured Interviews	3
Field Educators	Semi-structured Interviews	5

3.4.3 Analysis methodology

3.38.1.9   Defining Issues Test

<u>Administration of the DIT</u>

In the DIT, students were asked to consider stories containing moral dilemmas. They were asked to make a decision about a character in each story and what their next action should be. For each story they are then asked to read a list of twelve points of view and to consider which of these views they determine as critical when considering the character's next action.

Each point of view corresponds to either a particular ethical reasoning style (Kohlberg Stage 2, 3, 4, 5a, 5b, 6[39]), or a response that has no meaning. (These are so called "M" or nonsense responses and simply sound pretentious with no real meaning.) For each story there may be more than one point of view (response selection) corresponding to a particular ethical reasoning style.

Students were asked to rate the importance of each of the twelve points of view in their decision making when considering the character's next action. They were asked to rate each of the twelve issues across a five point scale: no importance, little importance, some importance, much importance, great importance. From their five point ratings of the twelve points of view, they were then asked to rank their four top reasons for their decision about a given story from most important through to the fourth most important. Each point of view reflects a stage of moral reasoning as determined by the test author.

Students appeared to have no difficulty understanding the task requirements. No student required further explanation following the provision of the standard instructions and the students completed the DIT within the allocated time.

<u>Scoring the DIT</u>

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[39] See Chapter 2 section 2.3.2.1 for a description of the type of ethical reasoning reflected by each Stage.

The scorer weights these four rankings. The point of view identified by the student as being most important to consider when making their decision about the character's next action receives four points, down to the least important of the top four issues receiving one point. For each student, these weighted scores for the stage of moral reasoning reflected in each point of view are added together. Each student then has a raw score for each Stage of moral reasoning and M category. Only Stage 2 or greater type issues are provided in the test.[40]

As per the scoring instructions these raw scores are then divided by 0.6 to convert the weighted raw scores to percentages. Note, however, even if students ranked highly only issues corresponding to Stage 5a, 5b and 6 (i.e. Principled moral reasoning) they would still be unable to achieve a weighted score of 100 percent for the test. (The maximum score would be 95.) This is because in three of the six stories there are only three not four Stage 5a, 5b and 6 points of view that can be rated and ranked. Even students operating at the highest level would therefore be forced to rank at least responses at Level 4 or below or rank them as M responses. This was not relevant to any of the participating students as they all had a spread of scores across the stages.

(See Appendix 1 for example of a score sheet. See Appendix 11 for student DIT score distributions.)

Validity and Reliability of DIT Results

For discussion of the validity and reliability of the DIT as instrument see Chapter 3 Research Process. Built into the DIT are four checks for validity and reliability of results. These are the M score, Rate-rank consistency check, Rating variation check

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[40] This is because Stage 1 responses are not possible with participants who have some understanding of right and wrong. A person making decisions at the Stage 1 level of functioning does so based solely on fear of punishment for a "bad" decision and no punishment for a "good" decision and not based on moral reasoning. Certainly participants in this test would not expect "punishment" for any response.

and External reliability.

M Score

As stated previously, M score responses are nonsense answers. They are designed simply to sound pretentious. If a person has an M score of more than eight their results are assumed to be invalid as they appeared not to be selecting answers based on meaning, but rather on the fact that they sound complicated. None of the students had an "M" score of more than three. The range of "M" scores was zero to three.

Rate - Rank Consistency Check

These are used to ensure that the participant responds consistently within each story. When scoring each story, the points of view ranked highly (those considered important for determining the character's action) should be consistent with the points of view rated highly. If points of view considered important were ranked highly then they should also be rated highly, which demonstrates consistent responding by the participant. Only the first two rankings are used for this check. A student's questionnaire should be discarded if there are inconsistencies in rate-rank on more than two stories or there are more than eight inconsistencies within a story. Only one student had a rate - rank inconsistency on the first two ranked items in a story. Therefore all test forms passed the rate-rank consistency check.

One student (Student 27) however failed to complete a question. They made no decision on what action to take and only one out of four rankings was made. This test form was therefore discarded as invalid (incomplete). Therefore only nineteen student results are included for analysis.

Rating Variation

If more than nine items in a story are rated with the same importance the protocol should be discarded. No students did this. The test results for the remaining

nineteen students met the validity and reliability requirements of the DIT and could therefore be used for further analysis.

<u>External reliability</u>

The examiner completed the training scoring examples. Scoring involved simply looking up the score attributed to a particular response. Results from this test were analysed according to the manual's instructions (Rest, 1979b). No judgement or decision making about the raw data was required by the researcher. The test provided a stage level for each of the 12 issues in each of the stories. The scoring transcriptions were checked twice by the examiner.

3.38.1.10   *Case study with and without ethical decision making framework*

The responses to the case study containing ethical dilemmas were analysed. Each student had completed two responses-one independently and one with the prompting of the ethical decision making framework.

<u>Content analysis</u>

The ethical decision making framework as a "Best Practice" approach to ethical decision making was used as the template for scoring responses to the case study. See Section 3.4.2.2 of this chapter for further details.

<u>Narrative analysis</u>

Students' responses to the case study were provided as a narrative. Therefore the students' independent case study responses were also analysed according to the narrative analysis framework described below in section 3.4.3.3 Narrative Analysis.

3.38.1.11   *Interviews-focus group and individual student, academic and field educators*

<u>Assessing qualitative results</u>

An important aspect of ensuring the credibility and quality of qualitative research

is the researcher's ability to describe and monitor the analytical procedures used in a detailed and accurate manner (Patton, 1990). This allows the reader to understand the approach of the researcher and to assess whether the analysis is legitimate.

The following section outlines the methods of qualitative analysis considered and used in this project. Woolcott (Woolcott, 1990), suggests that in qualitative research the researcher him/herself is an "instrument". This implies that data analysis occurs at two levels; subtle and intrusive. "Subtle analysis" occurs even when so called "descriptive" processes are used. The data obtained and presented for analysis is already mediated by the investigator. To address this, a detailed description of potential influences on the researcher has been outlined earlier in this chapter. "Intrusive analysis" occurs when the researcher labels and defines the themes or categories to be identified in the data. The intrusive analysis therefore may be more apparent and transparent to the reader because it can be matched to specific occurrences in the data.

Narrative analysis

Narrative analysis is a well recognised form of examination in qualitative research (Chamberlain, Stephens, & Lyons, 1997). It allows participants' stories to explain the phenomenon under examination from their own perspective. Literature on qualitative research analysis discusses how analysis of real life stories can be used as a tool to reveal an individual's approach in any given situation (Reissman, 1993).

During the individual student interviews, students related stories of encountering and managing ethical dilemmas. These were analysed according to a narrative analysis framework provided by Reissman (1993) based on previous work of Labov (1972, 1982) and Waletzky (1967). This framework is presented in Table 10.

Table 10 Summary of the narrative analysis framework

3.39 Principle content	3.40 What is included
3.41 Abstract	**3.42 A summary of the overall theme of the story.**
3.43 Orientation	**3.44 A description of the situation: who, what, where and when of the story.**
3.45 Complicating Action	**3.46 Relates to the sequence of events and the protagonist's actions.**
3.47 Evaluation	**3.48 Significance and meaning the story teller gives to the action and attitudes expressed: the why of the story**
3.49 Resolution	**3.50 The last scene: what finally happened**
3.51 Coda	**3.52 Return to the present: how is this story now interpreted, what does it mean to them now**

This form of narrative analysis was used to construct a coherent story of the

student's learning experience (Mattingly, 1991), and through the creation of a coda,

the key message from the story was identified (Mattingly, 1994). In this way, the students' ideas on learning ethics were identified. (See Appendix 10: Narrative Analysis Framework).

Thematic analysis

Thematic data analysis involved the three steps described below. Atlas Ti™ data analysis software facilitated the analysis process (Muhr, 1997). Atlas Ti™ provided a platform which allowed coding of interviews by words, themes, content categories and the linking of the same. The program also allowed identification of the original source material quickly and efficiently.

Open coding is a method to categorise data. This may involve content analysis as described by a number of authors (Denzin & Lincoln, 1994; Strauss & Corbin, 1990) whereby categories are formed through the grouping of concepts. Open coding may also include sorting the data (Woolcott, 1990). Woolcott describes sorting the data as identifying/labelling the broadest categories of data. McCraken (1988) suggests this organisation should occur at multiple levels, the first being utterance/observation called the transcription level. Miles and Huberman propose twelve steps of data analysis of which three are relevant at this stage of analysis; namely, looking for repetition (of events, topics, experiences), noting themes and patterns, and making analogies/metaphors and symbols for what is happening (Miles & Huberman, 1984). For the interview data collected this was done using Atlas Ti™. Examples of open coding included honesty which was later linked with the theme Ethical Attitudes, and communication, which was later linked with Ethical Skills. (See Appendix 12 for examples of codes including open coding.)

Axial coding is the next major step where the original categories are refined and

linked. An utterance or observation is linked with associations within the investigator, the transcript, previous literature or theory, cultural review and so on (McCracken, 1988). For example in this study the category Ethical Attitudes were linked and included honesty, integrity and respect amongst others. Woolcott (1990) suggests this equates to joining and linking the data. At this point data are compared and contrasted. The investigator's intuitions about categories are matched to the literature and similarities and differences are identified. In addition, logical relationships within the data are explained, and oppositions and contradictions are found (Miles & Huberman, 1984, 1988). At this point transcriptions are only used to verify the data and provide examples. Judgement occurs with scrutiny of all previous analysis, looking for inter-theme consistency and contradiction within a data source (i.e., all the data from one student are compared for reliability). Patterns and themes from all sources are considered, resulting in the final analysis (i.e., comparisons across students, comparisons of students versus clinical educators/academics). Overall, the process moves from the particular to the general and from the individual to the group being studied.

Selectively coding, the third step of data analysis is where central categories which tie together all other categories are identified (Chamberlain et al., 1997). In the data set for this project central categories included curriculum influences and personal influences amongst others.

Strauss and Corbin state four important criteria for rigorous analysis: data should fit the phenomenon; they should provide understanding to the participants and those familiar with the area; the theory should be applicable across related areas; and, they should provide information about when the theory could apply (Chamberlain et al.,

1997).

3.4.4 Ensuring rigour

In qualitative research, adequacy of data is ensured by the volume of data collected (Morse, 1994). For the student group of participants, almost 50 pieces of diverse data were collected from 20 students. From the academic educators, the data obtained were rich and relevant although the interview sample size was small. An adequate sample of data was obtained from field educators for the purpose of this study. Due to recording difficulties over the phone with the rural field educator, a summarised version rather than a direct record (transcript) was produced of the interview data. All participants (students, academic educators and field educators) were invited to read and verify or amend transcripts of focus group or individual interviews to ensure the researcher had accurately captured their responses and to provide an opportunity for them to add additional information if they felt their responses were incomplete. It could have been an advantage if negative cases[41] existed as this would have added diversity to the data sets and been useful to confirm the adequacy and appropriateness of the data (Morse, 1986 cited in Morse, 1994).

The audit trail (Morse, 1994) provided in this document and its appendices (e.g., interview schedules, DIT stage scores, scoring guides for the case discussions, examples of codes used for analysis of student interviews, narrative analysis frameworks) shows evidence for reconstruction of the data collection and analysis process. Quotes in this thesis also provide interview number and interview line numbers. This allows readers to understand how the data were collected, processed and interpreted by the researcher.

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[41] The negative case is a way of identifying conflicting or inconsistent evidence that ultimately may challenge or corroborate the evidence (Dey, 1993).

Multiple data coders were not used in this study as this was incompatible with the process of induction for qualitative analysis. The researcher reviewed codes for all four interview types with her primary supervisor who found the use of codes in the random sample reviewed were accurate and the codes use transparent.

Four of the students' case studies (20%) with and without the decision making framework were analysed (See Tables 5-8, pp. 78-80) by a research assistant (a non speech pathologist allied health professional educator) to ensure the ranking system was transparent and able to be applied consistently. Seventy percent agreement in rankings (descriptions of the response) was achieved between the researcher and the other person. Intra-rater reliability across a two year time span with the researcher was also only seventy percent. This can be considered a moderate level of reliability.

Allowing for a +/- 1 rank error then, ninety percent inter-rater agreement and ninety four percent intra- rater agreement was achieved, a high level of reliability. Discussion following the reliability check indicated one ranker recognised and accepted implicit versus information whilst the other only counted explicit information and this may account for the variations.

3.53 Procedure

3.53.1 Participant sample

The study sample consisted of twenty fourth year Flinders University speech pathology students who were enrolled in their eighth and final semester in October 1999. These students were also enrolled in the topic Issues in Professional Practice 4 (SPTH 4304). Student participants consented to have their work used for the purposes of this study. Twenty students participated in the DIT and case study activities. Eight of these twenty students participated in the recorded focus group

and in individual interviews.

The study sample also involved five field educators who had supervised members of this cohort of fourth year students on their final placement and three academic staff involved in their undergraduate education across various years of the speech pathology course.

3.53.2 Ethical Considerations

3.53.2.1   Ethics board approval

Ethics approval was gained from the Flinders Medical Centre Clinical Investigations Ethics Committee.

3.53.2.2   Consent

The researcher provided all student, academic and field educator participants with the applicable information sheet (See Appendix 8 a and b). Participants were provided with the opportunity to ask questions about the research. Assurance was given to all participants that participation was voluntary and confidential. Those who agreed to participate returned the applicable signed consent form (See Appendices 9 a, b and c). For the student group before each task consent was re-requested. From the data collected many students consented to some but not all their data being collected used.

3.53.2.3   Confidentiality

All participants were allocated an identification number which was recorded on their consent form and was the only identifying information on each piece of data they contributed to the study. The researcher maintained a list of names and study numbers so participants could verify interview data.

All data collected were viewed or heard only by the researcher or a research assistant and supervisors. Data were made anonymous prior to any analysis.

Students, Academics and Field Educators were assigned study numbers and these numbers were used on all transcripts and analysis frameworks. Participants in the focus group were formally requested to keep any information they heard confidential. For reporting purposes student participants were assigned study "names" to personalise their responses.

Due to the low numbers and discrete subjects taught complete anonymity of academic staff was difficult to maintain, however at least confidentiality of all interviews was maintained with only the researcher and main supervisor viewing transcripts.

Confidentiality of data from field educator interviews was maintained by a coding system by site. The record of the participant was stored as for students participants outlined above.

At each stage of the study participants were informed of their right to check, withdraw, or limit information, and their right not to answer particular questions or to withdraw from the study itself. All interview participants were sent copies of their transcripts and some participants chose to modify transcripts of their interviews or focus group discussion comments. This was done to ensure that participants felt the data accurately represented their views and the situations they described. The modifications were made and the modified version was used for analysis. For example, one participant wanted an example of an ethical dilemma they had given withdrawn as they felt the people involved could possibly be identified from the story. Thus the richness of the data set available may have changed but ethical integrity was maintained. Participants were also reminded that they could withdraw their information at this stage. None chose to do this.

3.53.3 Data collection

3.53.3.1 Introduction

Data were collected from speech pathology course outlines, Issues in Professional Practice Ethics workshops, student Defining Issues Test results, student case studies, student focus group interviews, and student, academic staff and field educator semi-structured interviews. See Section 3.2.4.2 for the rationale behind data collection strategies selected.

3.53.3.2 Textual analysis of subject outlines

The topic outlines for all courses in the four years of the Bachelor of Speech Pathology course at Flinders University were textually analysed to identify explicit acknowledgement of ethics by lecturers within the formal curriculum outlines.

3.53.3.3 Observation of ethics workshops

Two student workshops in IPP3 were observed and field notes recorded. The workshops focused on ethical issues and included formal teaching on theory underlying health professional ethics.

The IPP4 Ethics workshop was conducted by the researcher and sections of that workshop produced additional student data included in this study. (The Defining Issues Test, written case study responses with and without the decision making framework and one of the Focus Group discussions.) The workshop was jointly designed by the researcher and the academic staff member responsible for delivering the IPP4 topic.

3.53.3.4 Student data collection

Student data collected included the results of the Defining Issues Test, written case study reports completed independently and then modified after being provided

with an ethical decision making framework, a Focus Group Interview, and a semi-structured individual interview. Details about these data and their collection are described below. Data collected for research purposes were not connected to student grades. The workshop session began with an explanation of the aims of the morning - to look at decision-making and at ethical decision making in particular. The project was then introduced, the tasks explained. Whilst all students attending the workshop were required to participate and complete all tasks it was stressed that consent for the use of the results thus produced, for this research project, was voluntary.

The task required in addition to the tasks for IPP4 was the individual interview. It was also highlighted that students could consent to participate in any part or the entire project. They received a badge with their identification number on it to remind themselves of their number if required.

Options for "debriefing" the day's experiences were offered through the student counselling service and year group mentor.[42] It was thought that the recollection of ethical dilemmas could be potentially disturbing for some students due to the heightened emotions around some issues (for example, dilemmas around end of life decisions). Options for obtaining more information about the project were also outlined.

Defining Issues Test

The student participants' developmental stage of moral judgement was assessed through Rest's Defining Issues Test (See DIT form, Appendix 1) (Rest, 1979b). See Section 3.4.2.1 for further explanation of the rationale behind the selection of this tool.

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[42] Year group mentor was assigned to the group in first year as the person they could approach with problems and difficulties throughout their time in the course.

The test was introduced to the students as a decision making task, looking at how they approached decisions about social problems. The test was administered according to the instructions contained in the manual. An hour was allocated for the introduction to and completion of the test.

Case study reports

Students individually completed a written analysis of how they would solve an ethical problem in the workplace based on a case from their own personal clinical experience, or if the preferred, a clinical vignette which was provided (See Appendix 2, Written Case Discussion).

It was stressed that this task was to be completed individually.

Modified case study report (with decision making framework)

Once the students had completed the case study provided or their own case study, they were presented with a copy of the ethical decision making framework. (See Appendix 2b: Guided Case Discussion). The framework was not reviewed verbally with students and they were not provided formal training in its use; rather they were asked to reflect on their case study response already recorded. Then using the decision-making framework as a guide, students were asked, if necessary, to add to or change their initial response based on the framework guidelines and their re-reflection of the case given these new prompts (Students were asked to record additions or changes with a different coloured pen or in a different font). They were encouraged to record a more comprehensive reflection on the issues raised in the scenario and any potential implications for their clinical response. Sixty to ninety minutes were allowed for both tasks to be completed.

Because this study was undertaken with the premise that ethical dilemmas could be emotionally charged, an opportunity to verbally debrief the case study task with

the researcher and the topic lecturer was provided immediately following the task.

Group case study

A group case study was conducted during the workshop. Students were divided into three groups. The same case scenario was given to each group. (See Appendix 3: Group Dilemma Discussion). Students were asked as a group, to arrive at a solution to the dilemma and the reasons why they had come to their decisions. Thirty minutes were allocated to this task, which was followed by a whole class group discussion and debriefing of the process and the decisions made by the groups. No results were recorded at the time of the task but students were asked to comment on this task and the decision making that occurred as part of this task in their individual semi-structured interview.

Focus group interview

Students were divided into three groups that were different in composition from the morning's Group Case Study discussion. Group discussions, utilising a focus group approach were used (Appendix 4). Each group was provided with a facilitator to present the questions and guide the process. Only enough students to form one group consented for their discussion to be recorded for this project. This meant that although the question structure and task was created to use a focus group methodology (Patton, 1990; Kreuger, 1999) the results between focus groups were unable be compared (See Section 3.4.2.4 for more detail regarding focus group methodology). In the focus group interview students were asked to reflect on what had influenced the development of their personal and professional ethical philosophy and ultimately what had influenced their development of professional ethical practice.

The group discussion was recorded using a Sony Mini-disc recorder. A research assistant also manually recorded the responses using student identification numbers

and made field notes. The assistant had professional skills in both running groups and interviewing people. The requirements of her task were explained prior to her being involved in the task. One hour was allocated to the group discussion.

The results of the discussion for the group who agreed to participate in this segment of the study were then transcribed verbatim. Transcripts of responses were then forwarded to participants for verification prior to analysis (See Section 3.5.4.3 for more details regarding analysis of focus group interview data.) The individual student's own responses were highlighted. (Other speakers were only identified via a study number.)

<u>Individual student semi-structured interview</u>

Eight volunteer students from the recorded focus group were then involved in a brief, structured, individual interview scheduled sometime over the next two days. In the interview, they were asked to reflect on their experience of individual and group ethical decision making processes during the workshop. They were also asked to comment on any ethical dilemmas experienced during their field placements and the processes they used to deal with these situations. Finally, they were asked to comment on what in their academic or field experiences they believed had influenced their learning of professional ethical practice. (See Appendix 5: Student Interview Guide)

Individual interviews took 30-40 minutes. Verbatim transcripts were forwarded to the respective students for verification or amendment as required.

3.53.3.5   *Academic educators data collection*

Three academic educators at Flinders University speech pathology course were invited to participate. All were colleagues of the researcher. Data were collected in Semester 2 1999. Semi-structured interviews of 30-45 minute duration were

conducted. These interviews focused on staff members' recall of their teaching of ethical practice throughout their teaching in the undergraduate speech pathology course. They were asked to comment on whether they felt they taught ethics implicitly or explicitly. (See Appendix 6: Academic Educators Interview Guide).

Interviews were recorded on a Sony Mini-disc recorder and then transcribed verbatim. Field notes were also made. Transcripts were forwarded to the respective participants for verification of content and appropriate amendments were made.

3.53.3.6   *Field educators data collection*

Five field educators from a broad range of speech pathology practice sectors agreed to participate. Interviews were conducted at a time and location convenient to the participant during the latter part of 1999. Interviews were of 30-45 minute duration and wherever practical were conducted face to face. The interview was designed to highlight the educator's assessment of students' learning readiness and teaching moments related to professional ethical practice during the field education placement. (See Appendix 7: Field Educators Interview Guide.)

Where possible interviews were recorded using a Sony Mini disc recorder. The recordings were then transcribed verbatim. The interview with the rural clinician was transcribed verbatim during the phone call. The recording system organised failed during the phone call therefore only the transcription was available. Field notes and observations were also made to facilitate later interpretation and analysis. Transcripts were then forwarded to the respective participants for verification and any amendment. Amendments were made prior to data analysis.

3.53.4 Data analysis

3.53.4.1   *Defining Issues Test*

The researcher scored the Defining Issues Test Forms according to the manual's

instructions (Rest, 1979b). There was no scorer judgement required. Reliability of scoring was achieved through:

1. Completing practice items provided in the manual;

2. Following the reliability checks provided in each individual test.

The researcher completed the practice items with a hundred percent accuracy. Scoring required the researcher to locate student responses on a table.

3.53.4.2   Written case study report

Students' work was analysed according to a Analysis Guide for Case Discussion and Rating Guide for Written Case Discussion created by the researcher (Appendix2c, Appendix 2d). The Analysis Guide contained a model of a best practice response based on the ethical decision making framework. The Analysis Guide contained four categories of response allocated according to set content criteria (See Tables 5-8 for details).

The core student group (i.e., the students for whom there was also focus and individual interview data) also had their case studies analysed with and without the decision making framework, analysed as a narrative with the aid of a narrative analysis framework. (See Appendix 10.) The methodology (Section 3.4.3.3 Narrative Analysis) provides an explanation of the narrative analysis system applied. An academic with experience in narrative analysis, read a sample of the student stories and the narrative analysis and confirmed the appropriateness of the application of the narrative analysis framework to the stories provided.

3.53.4.3   Individual semi-structured interviews and focus group interviews

Initially the interview data were analysed for their content (themes, patterns and

categories) from the data and the literature. This information was coded using

ATLAS.ti. a computer software package for managing qualitative data (Muhr, 1997).

This package was selected as a user friendly code-based theory builder able to

record and link text, code, memos and notes[43] (Miles & Huberman, 1984; Weitzman

& Miles, 1995).

Within the student transcripts their stories about the ethical dilemmas they had

encountered were identified and analysed using a narrative analysis framework

(Appendix 10: Narrative Analysis Framework).

3.54 Limitations of the research method

This research was conducted with highly specific groups of speech pathology

students, academic and field educators at the end of the 20th Century. The

experiences and knowledge of these groups at that time may no longer be consistent

with groups that would be found in the course today. For example, many entry level

speech pathology students are now completing post graduate entry level degrees.

Speech Pathology Australia has introduced a new Code of Ethics and an education

package to accompany the code so more speech pathology specific resources exist in

the field.

Sample sizes in this project were small. Ideally focus group methodology

compares the results of multiple group interviews. In this project, only enough

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[43] This software package was selected after attending a workshop run by Eben A Weitzman Qualitative Data Analysis Software: State of the Art, 1999 part of the 1st meeting of the Association for qualitative research, Melbourne, Australia July 6th 1999. This workshop allowed participants to observe different software packages being used to analyse data. For this researcher the Atlas.ti system appeared more intuitive than NUDIST/NVIVO in the way it managed and presented the data and analysis. Conceptually Atlas.ti used "piles" of data rather than the NUDIST/NIVO "files" of data.

students volunteered for the project for the formation of one group. Only three academic staff explicitly identified in their course outlines that they were involved in teaching ethics and were therefore invited to be part of the academic educator sample. Furthermore, the sample group of field educators were drawn from only a small range of the field education placements experienced by students.

Student learning was not measured over time; rather students at the end of their course were asked to demonstrate their current ethical reasoning and knowledge of ethical practice. Whilst the results could be linked to curriculum and practicum learning experiences, this was unable to be proven as there was no pre-course baseline to compare with their exit level knowledge, skills and attitudes.

The use of Rest's Defining Issues Test based on Kohlberg's theory of moral reasoning development could be considered limited as it reflects the development of moral reasoning based on a justice perspective in male subjects.

The classification of student responses in the written case study may have been more reliable with a more detailed description of how the criteria were to be applied to responses, for example, whether only explicit or explicit and implied knowledge was scored as present. The classification system should have been piloted prior to use in the study as it was a new system. These changes could increase the reliability of the labelling of responses as for example, satisfactory.

As all individual interviews were one offs (with participants invited to modify or add when presented with transcripts) more detailed exploration into a number of areas raised was not possible. For example, students were not given the opportunity to elucidate their understanding of what it means to be an ethical practitioner or to explain the meaning of their stories of ethical dilemmas.

For a Masters level thesis it could be contended that too many data sources and analysis methods were used. This made analysis and presentation of methods, data and results very complicated within the limits of a Masters level thesis. Thus, as with all studies this research is a reflection of a particular time in the history of the speech pathology course at Flinders and the speech pathology profession. Since data collection, change has occurred in the teaching of ethics, its assessment and the speech pathology profession's expectations with regards to ethical practice.

3.55 Summary of the research process

This chapter has provided an over view of the research approach taken in this study. The theoretical underpinnings for the data sought, how the data were collected and analysed have been provided. The processes and tools used in the actual collection and analysis of data have been described. Finally limitations of the research method have been identified and discussed.

4 STUDENT READINESS FOR LEARNING PROFESSIONAL ETHICAL PRACTICE

4.1 Introduction to chapter

In the Chapter 3 the variety of data collected from students and analysed was described. This chapter provides the results and discusses findings relevant to data collected on student participants. More particularly it will report on results pertinent to students' readiness to engage in the learning of professional ethical practice. Further it will discuss the results in light of the current literature. The next chapter, Chapter 5 will report and discuss the results on student participants relevant to understanding the effectiveness of student learning in the area of professional ethical practice. Chapter 5 will also report what the students identified as influencing their

learning of professional ethical practice.

The first section of this chapter describes the complete student participant group. More detailed information about the core group students is then provided. This more detailed information provides insights into the students' personal ethical values. It also reports the influences students identified on their personal ethical development.

The second part of this chapter reports and discusses the data pertaining to factors which may influence student learning readiness for professional ethical practice. Factors considered include cognitive development in the area of moral reasoning, and motivations for learning from both a life experiences and emotional engagement perspective. The implications of these findings in relation to student learning will be discussed.

In this study two sources are used to explore students' learning readiness. The first method is the use of The Defining Issues Test, henceforth referred to as the DIT (Rest, 1979a; Rest, 1979b). The second method used analysis of the results from student discussions during the focus group interview (Group Interview). The results of both these explorations of learning readiness will be reported and discussed in this section.

4.2 Introduction to the student participants

Of the students eligible for inclusion in the study 20 students gave permission for the results from their DIT and written Case Study discussions to be used for this research project. Of these 20 students, eight gave consent for their focus group style interview results to be used. These eight also agreed to participate in individual interviews. These eight students are referred to in the project as the core student

group in the remainder of this thesis.

4.2.1 All Student Participants

The average age of all the students who contributed to the study was 24 years with a range of 20-44 years. The average age of the core group of students was also 24 years with a range of 21-36 years. Thus the core group was a similar age to the total student group.

The gender distribution was 84% female for the total student group and 75% female for the core group. Thus slightly more males are represented in the core group sample. This gender distribution for both the total student group and the core student group is slightly different from membership data from Speech Pathology Australia (2007) where 97.7% of practising speech pathologists in Australia are female.

All the students were in the final year of a 4 year undergraduate degree in speech pathology at Flinders University.

4.2.2 Introduction to Core Group Students

The following details about the core group students were compiled in response to questions presented in the focus group discussion. Not all students answered all questions and the following cameos are a composite of each individual student responses. All demographic data collected is provided. Pseudonyms are used.

4.2.2.1 Anthea

Anthea is a 22 year old female student. She has just completed her final placement in a rural community health setting that serviced both adult and paediatric clients. Outside of university, her part-time employment involved working with disabled children and adults.

Anthea reported valuing her family. She felt her guidelines for living an ethically

good life were strongly influenced by

> "…my family and church have been the two major
>
> influences in my life" (Anthea Group Interview Lines 301-
>
> 302)

4.2.2.2 Andrew

Andrew is a 32 year old mature age student. He has a partner who is expecting their first child at the time of data collection. His final placement was in an adult acute care hospital.

Andrew reported valuing security and a feeling of inclusion within the family. He reported that a sense of achievement was an important quality for living a rich and full life. When asked what was important for living an ethically good life Andrew felt that

> "Consideration for others" (Andrew Group Interview
>
> Line 280)

was an important guideline. He went on to further include consideration of the

> "…consequences of our actions." (Andrew Group
>
> Interview Line 281)

Andrew felt his personal ethics were shaped intuitively, that they were not influenced by a particular person or institution.

> "…It's certainly very internal…It may not even be a
>
> reflection it may just be a gut feeling. (as in) Just I can't do
>
> that!" (Andrew Group Interview Line 354-365)

4.2.2.3 Bella

Bella is a 36 year old mature age student with two children. She was the oldest participant in the study. Her final placement was in the education sector with school

aged children. She also has a part-time job.

Bella greatly admires people who can overcome personal challenges and succeed.
She feels people who contribute to life are also to be admired.

> … I really admire people who can contribute…that's in a
> positive way (it) doesn't have to be big…what we think of
> as a really big contribution even a small contribution but a
> contribution none the less. (Bella Group Interview Line
> 246-250)

Bella also values people who accept others in all their broad diversity. She feels
life experience provides guidelines for living an ethically good life.

> I think just experience, a lot of your everyday bad
> experiences change you. Maybe what you thought you
> would never do or you shouldn't do and then you are placed
> in that situation and different factors come in to play. You
> realise maybe your ideas for that situation may not
> necessarily be the right ones [said with emphasis]. (Bella
> Group Interview Line 318-322)

She feels her personal ethical development was shaped by her parents and
observing a sibling getting into scrapes, that is, learning by example of how not to act.

4.2.2.4 Bob

Bob is a 23 year old student who has worked as a child care worker for 6 years.
His final placement was in an adult acute care hospital. He values gentleness, caring
and time for people.

Whilst Bob did not comment on what or who had influenced his personal ethical
development, when discussing how he learnt his professional ethical behaviour Bob

stressed that he brings the personal to the professional. He also commented on the influence of family and friends in professional ethical dilemmas.

> We are people who are professionals. We're not
>
> professionals. We are people that are professionals. And I
>
> think we are applying ourselves to professional speech
>
> pathology just as we are applying our ethics as people to our
>
> knowledge of speech pathology issues…So it's not really,
>
> it's not sort of…I find myself thinking about it as an entity
>
> of its own but it's not really. (Bob Group Interview Line
>
> 518-524)

4.2.2.5 Clara

Clara is a 22 year old student. At the time of interview she was midway through her final student placement. She had recently been doing volunteer work with Timorese refugees. She values work life balance and family.

When discussing where she had learnt her guidelines for an ethically good life she said her school had a major influence which encouraged them to do door knocks and volunteer work. The school motto had been

> "May we grow by serving." (Clara Group Interview Line 303)

4.2.2.6 Donna

Donna is a 22 year old student who lives at home with her parents. Her final placement was working with adult clients at an interstate hospital. She would like to continue working with brain injured adults. She admires hard working people who contribute a lot. Donna reported personal beliefs were important for living an ethically good life but you also had to

> "…go with your feelings." (Donna Group Interview
>
> Line 369)

4.2.2.7 Eliza

Eliza is a 21 year old student who lives at home with her parents. Upon graduating she wants to work with adults. Eliza values honesty and trustworthiness and prioritising family. She believes you only need health and happiness to live a rich and full life.

She believes her friends and family have influenced her understanding of what you need to live an ethically good life.

> I think a lot of it carries over from being taught it from my parents and my school and from my friends and just a general ability to deal with people. You know you've been taught to be courteous and you've been taught to be sympathetic if someone's telling you something, just stressing. It's just those things you've grown up with that you are now applying to people…. That have more problems than my general circle of friends do so…(Eliza Group Interview Line 458-462)

4.2.2.8 Gerry

Gerry is a 22 year old student who lives with her parents, has a part time job, and enjoys many sporting activities. Gerry was yet to complete her final adult placement at the time of data collection although she had completed all the academic requirements of the course.

She admires people who are nice and people who overcome obstacles to achieve their goals and those who care enough to make a difference. She admires the qualities of empathy, compassion, friendliness, and openness. She believes you need determination to live a rich and full life.

When reflecting on where her guidelines for living an ethically good life came

from Gerry responded that it was from parents, school, and reflection on life experiences.

> I just think um lot of my beliefs probably came from my parents…And also from school. Also from observing, as Bella was saying, observing things happening and thinking I don't like that and that…

> So maybe given the knowledge when you were younger but then as you go through life you see, you see those beliefs challenged and that confirms or denies what you already had maybe. (Gerry Group Interview Line 348-353)

During further discussion on the question of where knowledge about how to make decisions for living an ethically good life came from, Gerry was clearly one of the group who felt there was some form of inner intuitive "guide" - the so called gut feeling response.

> Andrew: "It may not even be a reflection it may just be a gut feeling. Just I can't do that." (Andrew Group Interview Line 354-365)

> Gerry: "I think a lot of it has to do with that. I think sometimes you just know that it's wrong. That it feels wrong. I don't know." (Gerry Group Interview Line 365-371)

4.2.3 Conclusion

The core group of student participants represent ranges of age, gender, personal circumstances and life and educational influences. What they perceive as important personal values vary from for example, security to honesty. Their personally

identified influences on their ethical development also vary for example, from family and friends to school and church. Although this group were self selecting, from the larger group of students, by volunteering to participate further in the study, a diversity of voices is still being heard.

4.3 An exploration of the role of learning readiness factors in student learning of professional ethical practice

4.3.1 Review of Key Concepts in the Literature

4.3.1.1 Learning Readiness

Pedagogical approaches to understanding student learning incorporate both consideration of the concepts of individual student learning readiness and more generic adult learning theories. Theories of adult learning or student centred learning are concerned with ways of developing self directed deep learners (Higgs, 1993; Knowles, 1980; McAllister, 1997; McAllister & Lincoln, 2004).

Learning readiness is a student's preparedness for learning a given topic in a particular context. It is a key factor in many adult learning theories. It is a multifaceted concept which involves the inter-relation of factors such as the student's cognitive skill development, learner task maturity, and students' motivations for learning. In the introduction to the core group students each indicated that there were influences prior to or in conjunction with their formal studies in speech pathology that made them open to learning about ethics and ethical practice. In degrees, such as speech pathology, students often have little or no influence over the structure, timing or key content of their learning. Thus learning readiness may have a significant influence in determining ultimately how much mastery of a particular topic area is achieved. Designers of curriculum should consider this element when designing the timing of course offerings in ethics.

4.3.1.2 Cognitive Development

The developmental psychology literature suggests that are cognitive-developmental factors that may influence the nature of a student's ethical practice and their cognitive readiness to learn and utilise particular approaches to it. The underlying premise of the cognitive developmental theorists is that "morality develops" (Lickona cited in (Callahan & Sissela, 1980) pg 104). This development occurs through "challenging interactions with the environment" (pg 110). It may also occur through socialisation (Goldman & Arbuthnot, 1979). Whilst Kohlberg's (Kohlberg, 1984) theory of moral development has been extensively challenged on philosophical grounds (Gilligan, 1982; Gillon, 1979; Nucci, 1987) it is not unreasonable to suppose that just as students may develop different forms of reasoning at different times and rates so they may develop different forms of moral reasoning, and some of these forms for example - more abstract principled moral reasoning - may develop later than more concrete rule governed reasoning. (See the literature review sections 2.3.2.1 for a detailed discussion of Kohlberg's Theory and the challenges to it.) Speech Pathology Australia expects graduate clinicians to be able to apply ethical principles (McAllister, Kilminster, Brown, & Anderson, 2002; Speech Pathology Australia, 2000, 2001) to situations they encounter. Thus the relevance of students' cognitive readiness to be able to learn to use ethical principles may be a factor in their ability to successfully apply them upon graduation.

The DIT's structure and administration is described in some detail later in this section followed by a discussion of results and their interpretation.

4.3.1.3 Motivations for Learning – Contributions of Life Experiences

Adult learning theories are based on the premise that students are ready and motivated to learn. Often the motivation for learning in adult students comes from life experiences or a personal belief or philosophy. As far back as Aristotle it has

been discussed that success in learning ethics is more likely with more mature students as they have probably had more opportunities to experience life in all its complexity (Leget, 2004).

4.3.1.4 Motivations for Learning –Contribution of Emotional engagement

It is suggested that emotions may have a role to play in the learning of ethical practice. The emotions discussed by students in relation to ethical dilemmas they have faced may contribute in some way to their openness to learning about ethical practice. It may also develop what has been labelled the moral imagination (Hay, 1998; Thornton, Callahan, & Nelson, 1993). The emotions stimulated by ethical dilemmas may however also contribute to students avoiding learning about ethical practice as a way of avoiding the emotions it produces in them. McAllister (2006) goes so far as to say

> Mentoring, supervision and professional development
> would therefore have important roles to play in helping less
> experienced professionals utilise feelings and emotions
> about ethical situations to develop ongoing cognitive
> awareness and ethical reasoning. (McAllister, 2006 pp: 79).

It is the role of educators therefore to facilitate the ethical growth of students by engaging both their hearts and their reason (Leget, 2004).

4.3.2 The Defining Issues Test (DIT)

The DIT was used as a formal objective assessment of students' moral reasoning development. (See section 3.4.2.1 for a full description of this test.) Twenty students completed the test but one test was incomplete and deemed invalid and could not be used for analysis.

4.3.2.1 Results of the DIT

<u>Students Preferential Moral Judgment Stage</u>

This score reflects which of the six stages[44] of ethical reasoning, contained within the points of view provided to students for each story, they preferred using. That is, what stage reasoning did they use to assist them to make decisions about the action of the character and hence the resolution of the moral dilemmas presented in the stories? This result is important for determining what stage level of moral reasoning was preferred by each student. It would also indicate how heterogeneous the student sample could be considered with regards to their moral reasoning development.

When identifying the students' most frequently preferred ethical reasoning style the Stage 4 style of reasoning was slightly more frequently observed than Stage 5a. Stage 4 represents the last of the conventional rule based reasoning stages whilst Stage5a indicates a transition into the first of the principled reasoning stages. A greater percentage of the core group of student responses was Stage 5a (Early principled reasoning). Thus it would appear that more of the core group had developed principled ethical reasoning when compared to their class peers (See Table 11). However the statistical significance of this preference can not be determined due to the small sample size.

Table 11 Moral judgement stage used by students on the DIT

	Preferred Moral Judgement Stage (Modal response)	# of Students	# of Core Group Students	% of Students	% of Core Group Students
Preconventional	Stage1	0	0	0	0

---

[44] Remembering Stage 1 options were not provided and that Stage 5a and 5b options are considered as alternative types of Stage 5 responses rather than consecutive stages (Rest, 1979b).

Morality	Stage 2	0	0	0	0
Conventional Morality	Stage 3	1	0	5%	0
	Stage 4	10	3	53%	38%
Principled Morality	Stage 5a	8	5	42%	62%
	Stage 5b	0	0	0	0
	Stage 6	0	0	0	0
Total		19	8	100%	100%

Rest (1979) would suggest that stage preference is not a robust way of presenting DIT data, the P score (discussed next) having more stability over time. As this is a one off assessment it is useful to know for example that 58% of the total student group did not preferentially use principled ethical reasoning whilst only 38% of the core group students did not preferentially use principled ethical reasoning. Thus the core group may show slightly greater learning readiness for a principled approache to ethical reasoning.

Students' Principled or Conventional Moral Judgment Style

The DIT "P" score indicates the overall emphasis students gave "Principled" versus "Conventional" (rule governed approach) (Rest, 1979) reasoning in determining moral judgments during the DIT stories. (See Section 2.3.2.1 for a further explanation of these approaches to moral reasoning.) A "P" score of more than 50 indicates the student preferred a principled approach. The "P" score is, according to Rest (1979), a statistically more robust way of interpreting overall moral judgement development using the DIT. The "P" score is the sum of a student's weighted percentage scores in each of the three Principled Reasoning Stages (Stage 5a, 5b and 6). It is an indication of the overall importance that principled (verus conventional) reasoning played in the student's decision making on the DIT.

From the total group results six students (approximately one third) had a "P" score greater than 50 indicating predominant use of principled ethical reasoning according to the DIT. Thirteen students had a "P" score of less than 50 and the average "P" score was only 43.8 (+/- 9.7) indicating use of conventional or rule governed ethical reasoning (See Jacobs 1977). Of the core group of students four students (that is half the group) had a "P" score greater than 50. Thus we would expect more of the core group to be cognitively ready to learn a principled approach to professional ethical reasoning.

4.3.3 Discussion of the DIT Results

4.3.3.1 Core group DIT results and their implications

<u>Anthea</u>

Anthea's preferred style of moral reasoning was Stage 4 (Social system morality), a conventional, rule governed reasoning style. Her "P" score on the DIT was 35. This score is also consistent with a conventional style of moral reasoning and correlates with her self reports of her management of ethical decisions during her practicum experience

> "…I guess a lot of it the onus is on you to utilise the
>
> organisation's particular guidelines and manuals and that
>
> sort of thing." (Anthea Individual Interview Lines 256-257).

Given that Anthea's "P" score suggests a rule based style of conventional ethical reasoning perhaps it is not surprising that she was looking for an organisation's guidelines and manual to facilitate her ethical decision making. She accepted self-responsibility for a standard of practice expected by her employer and, consistent with a conventional reasoning style felt that protocols established by authorities should give her direction:

> "…I will follow the organisation's policies and guidelines
> and their ethical standards. But there are always going to be
> the grey issues the ones that don't fit neatly into those
> boxes…" (Anthea Group Interview Lines 298-301)

Perhaps her acknowledgement of the "grey issues" shows some developing insight into the limitations of a rule based system of making ethical decisions and a readiness to begin to learn and apply a more principled approach.

Andrew

Andrew preferred Stage 5a (Morality of social contract - Social welfare morality) moral reasoning responses. That is he preferred "Principled" moral reasoning responses, the implication being that he was able to see beyond rules and regulations to examine the particular case before him. His "P" score of 55 is consistent with this preference for principled moral reasoning development. This is interesting from a developmental point of view as Kohlberg (1984) and Rest (1979a, 1994) would suggest that moral reasoning development continues through a person's twenties and Andrew is older than the average student in the group at 32 years old. Others would question too whether his high DIT was also biased due to his gender. Kohlberg's 1984 theory of moral reasoning development is based on a male developmental model. Gilligan (1982) suggests Kohlberg's model is less applicable to women and thus women may appear to have lower DIT scores. (See later in this chapter for a discussion of gender bias in the DIT.)

When reflecting on his own approach to ethical decision making Andrew's response suggested he was comfortable with using a principled approach to ethical decision making.

> "No, I think the easiest for me to come up with the decision

was then really by myself. To really think about the issues

and draw my own conclusions." (Andrew Individual

Interview Line 54-56)

This response seems to fit with his DIT profile as a student who can use
principled moral reasoning to consider a situation. However, a high "P" score does
not necessarily result in confident ethical practice. In his discussion of his course of
action in the case discussion, having formed his own opinion he stated somewhat self
dismissively that the information provided to the treating team was of no real
importance

"….would still be only my opinion put to a team…."
(Andrew Individual Interview Line 58)

Is this an abdication of taking responsibility or ownership for his ethical
decisions? Or does this simply suggest a lack of confidence in his skills in ethical
practice? Or is it to do with being a student during the time of the dilemma?
Answers to these questions are not illuminated by the transcript. Also it is important
to note that the DIT clearly states it is an assessment of the student's ability to
recognise preferred stages of moral reasoning, and not a reflection of the student's
ability actually to use them independently in real life situations. (Rest, 1979)

Bella

Bella's preferred style of moral reasoning was Stage 4 (Social system morality), a
conventional reasoning style. Her "P" score on the DIT was 30. This was the second
lowest score. This score represents a conventional (versus principled) style of moral
reasoning development. Bella however reported struggling with the style and format
of the DIT. She could not understand the intention of the test or the meaning of
some of the choice statements (personal communication). This may have influenced

her scoring.

This style of Bella's ethical reasoning does appear to be reflected in her reported approach to ethical decision making. For example after reconsidering the case study with the ethical decision making guide, Bella identified a need for more information on the hospital's policies on feeding people with swallowing difficulties. Similarly when Bella spoke about learning professional ethics, she first commented on the importance of an organisation's policies and their influence on helping to determine action.

> It's also good to know the rationale behind those policies so
> to learn from their rationale you might be able to
> incorporate their rationale into your, into that grey area and
> see if it fits. (Bella Group Interview Line 403-404)

Whist this fits with Bella's conventional rule governed approach to ethical reasoning perhaps it also indicates a growing awareness that there were grey areas to professional ethical practice that did not necessarily fit rules.

Bob

Bob chose answers reflecting Stage 5a (Morality of social contract - Social welfare morality) style of responses most frequently. This is a principled style of reasoning. His "P" score of 43 is however said to represent conventional reasoning. This contrast in results according to preferred reasoning style to overall reasoning style perhaps suggests that Bob is currently transitioning between conventional and principled reasoning. This is perhaps also reflected in his case discussion where he comments

> I take comfort in the fact that our very rapidly advancing
> medical treatments can cause policy to stand in the way of

> the course of nature and force choices on people.   (Bob
>
> Case Study with Ethical Decision Making Framework pg 3)

The above statement is perhaps suggesting that Bob has a sense of tension/conflict between rules and individual choices which would be consistent with transitioning from conventional moral reasoning to principled reasoning. It may also represent however his valuing of an ethic of "care" over an ethic of justice, and may also explain why his "P" score reflected a conventional approach to ethical decision making. The validity of Kohlberg's theory of moral judgement development (and thus Rest's Defining Issues Test) has been challenged by some current scholars, both in relation to the theory being based on a male only sample and a model that justice is the most important consideration when making ethical decisions (Gilligan, 1982; Gillon, 1979).   Gilligan (1982) further suggests an ethic of care approach to an ethical dilemma will always reflect a "conventional" style of Kohlbergian moral reasoning despite for example, sophisticated consideration of the people involved in the dilemma.

Clara

Clara's preferred style of moral reasoning was Stage 4 (Social system morality), a conventional reasoning style. Her "P" score on the DIT was however 53 indicating she reasoned in a principled way, thus highlighting inconsistencies in the possible interpretations of the DIT. However as was discussed with Bob this may reflect that she is currently transitioning between conventional and principled reasoning. Unfortunately, the disc containing her written case study responses was blank and the data was unable to be retrieved. The computers used were university computers so the data was not saved elsewhere. Thus her ability to apply moral reasoning to a standard case was unable to be assessed.

When reflecting on her experiences making ethical decisions during the data gathering process Clara felt it was easier to think about the decision on her own before discussing it with others. However, she felt more confident of her decision after coming to a group consensus

> I guess when you are with a group it's the feeling that you've come to some agreement and there's that feeling like, I don't know, safety in numbers…And it's the product of all those different ideas and views coming together…And that makes you feel more comfortable… (Individual Interview Clara Line 117-122)

Thus it would appear that whilst Clara most commonly chose responses involving a rule governed response she was able to also consider principled responses and perhaps therefore could be considered cognitively ready to learn ethical decision making according to principles but is currently transitioning.

Donna

Donna most frequently chose answers reflecting Stage 5 (Morality of social contract - Social welfare morality) style of responses. This is a principled style of reasoning. Her overall P score of 43.3 however suggests that she was mostly operating with a conventional or rule governed approach to ethics.

Again this discrepancy between the two DIT scores may represent a student who is transitioning between conventional and principled reasoning. This explanation may be further supported in Donna's case because she emphasised in her individual interview the importance of reflecting on ethical dilemmas/decisions in the first instance, but following that personal reflection identified a need to discuss them with another person to benefit from their perspective.

Eliza

Eliza chose the majority of her responses reflecting principled ethical reasoning of the Stage 5 Social welfare style. Her P score of 56.7 also indicated that she tended to solve ethical dilemmas presented in the DIT according to principles of justice rather than conventions.

This ability to go beyond rules and conventions is perhaps reflected in the choice of potential actions discussed by Eliza in the case study.

> "Whether or not to encourage the patient to continue with oral intake privately." (Eliza Case Study with Ethical Decision Making Framework)

Also that:

> "Patient may be palliative therefore (sic) whether Mr Jones can be allowed oral intake anyway." (Eliza Case Study with Ethical Decision Making Framework)

Thus it appeared that Eliza was able to reason ethically beyond her own belief of what was ethically correct in regard to patient longevity. In this way, she was able to consider the bigger picture involving patient preference. This determined the ultimate form of her recommendations that is working around the hospital system to continue to support the patient eating in private. This would appear consistent with the ethical reasoning development suggested by her DIT score.

Gerry

Gerry predominantly chose answers reflecting Stage 5a (Morality of social contract - Social welfare morality) style of responses. This is a principled style of ethical reasoning. Her "P" score of 58.3 also reflected a consistently principled approach to ethical reasoning.

Given that Gerry's approach to ethical judgements involved a social contract

style of reasoning it is perhaps not unexpected that she reported finding the group decision making task the easiest, and that she would have been keen to have a group feedback session on the outcomes of all the activities:

> I thought, I think that it would be good as well to have a
> feedback time, of giving out what people did in this
> situation and maybe having a bit of a brainstorm. So that we
> could see 'Oh that was a good idea'. Because I kind of felt
> like I did it and then, although there is no right or wrong
> answer, I would have liked to have heard what other people
> did… (Gerry Individual Interview Lines 239-244)

Thus from a learning readiness perspective Gerry appeared willing to consider the grey areas of ethical decision making and cognitively appeared to have the ability to accept that there was no clear right or wrong answer and that it was about the formulation of a group norm.

4.3.3.2 Implications of the DIT results

The DIT was used as a tool to examine the cognitive development component of learning readiness. The core group students' DIT stage of moral judgement development appeared to be reflected in other responses they provided. In particular it would appear that some of the students who were producing Stage 4 rule governed responses on the DIT, similarly in their own stories and discussions were looking for rules and guidelines when attempting to make ethical decisions. Likewise, some students who were demonstrating Stage 5 principled reasoning on the DIT were beginning to demonstrate more abstract, bigger picture, more principled type thinking in their own cases and stories.

From a cognitive development perspective the DIT may be used as an indicator

of a student's learning readiness to learn a principled approach to ethical decision making. The results from the DIT suggesting that the majority of students are using conventional, that is rule based reasoning, rather than principled forms of ethical reasoning (the whole group average and most frequent "P" score was less than 50, and the most preferred stage of ethical reasoning was Stage 4 conventional, rule governed), is very relevant to our exploration of student learning. As described earlier in this chapter much of the explicit ethics curriculum students are taught during their course, involves learning a theoretical model based on the application of ethical principles. Speech Pathology Australia expects that eligible members will be able to uphold the Code of Ethics which aspires to members utilising ethical principles in decision making (McAllister, Kilminster, Brown, & Anderson, 2002; Speech Pathology Australia, 2000).

Even amongst the core group of students only three consistently exhibited a preference for a principled approach to moral judgements. Another three appeared to be in transition between a conventional rule-governed approach and a principled approach on the DIT. This was reflected in their other data. Two of the students demonstrated only a conventional rule governed approach and again this was supported by their other data. Educators need to consider whether they are setting students up for failure, or increased challenge in the area of ethical practice when many are perhaps not cognitively ready to apply abstract ethical principles to situations requiring ethical decision making. To prevent this struggle, educators may need to consider providing increased scaffolding and support to students when ethical decisions are to be made.

Given that the ethics curriculum in third year involves teaching and application of ethical principles it would be interesting to know where the three students

identified as transitioning to principled reasoning were performing prior to that academic teaching. Do they and the two students displaying only conventional reasoning require extra teaching in this area?

When interpreting the DIT results another consideration is, whether in speech pathology as a so called "caring" profession, is an ethic of care overriding principles based on justice? It is interesting that Donna who demonstrated a conventional approach to ethical decision making, stresses the importance of empathy to her professional practice. McAllister (2006) goes further to suggest that it may be that the application of principles can be useful for ethical dilemmas - the so called extraordinary events - but that they have less to say about everyday ethical practice which goes beyond a particular patient. However could a narrative ethics approach provide a more holistic way of considering an ethical dilemma? In the everyday situations of speech pathology practice could an ethic of care approach to ethical practice be more applicable? In the broader practices associated with speech pathology, such as determining who receives services, are virtue ethics such as the discernment and honesty more appropriate? (See Section 2.2.2.1 for further discussion of various approaches to professional ethical practice.)

There are some obvious design faults in the scoring of the test itself. For example, the inability to achieve a P score of 100. In relation to ethical development the underlying premise of cognitive development theory remains relevant, namely, that the ability to reason ethically, particularly in a more abstract principled way, may occur developmentally.

Perhaps the usefulness of the DIT in this study is to highlight that not all students may be ready to reason according to ethical principles. Teaching the application of ethical principles needs to be structured in such a way that students who may be still

developing this type of thinking can be given the necessary structures and scaffolding to engage in the learning. It may also highlight the need for the speech pathology curriculum to present more than just a principled base theoretical model to underpin ethical practice. By introducing other models of ethical practice, for example an ethic of care, the development of ethical reasoning and practice in student speech pathologists may also be facilitated. Just as multiple theoretical models of language development are presented to students so too multiple approaches to ethical practice could be presented to and practiced by students. This may in turn facilitate students' ability to reason ethically using a model which fits them and the situation in which they find themselves.

4.3.4 Emotional Engagement

4.3.4.1 Influence of emotional engagement on learning readiness

As discussed earlier in this chapter and in more detail in the literature review a fundamental aspect of student learning readiness is their motivation for learning. One way of motivating students to learn is to engage their emotions. With regards specifically to education in ethical practice Hay refers to the concept of making moral imaginations (Hay, 1998). This section provides examples of students' emotional engagement in ethical practice situations and how it may have influenced their readiness to learn more.

During the course of their individual interviews most of the core group students described situations involving ethical dilemmas that had brought out strong emotional responses. These situations and their perceived impact on student learning readiness are described below.

Anthea

Anthea identified fear, a very powerful emotion, as stimulating her reflection on

her ability with regards to ethical practice.

> And I thought I had a fairly good knowledge of you know
>
> different situations and how I should act ethically or
>
> morally…And that scares me thinking how many other
>
> situations are there out there that I have no knowledge about.
>
> How am I going to know how to react then? (Anthea Group
>
> Interview Lines 571-578)

This identification of a critical gap in her practice knowledge may become a motivator for further learning in the area.

At other times in her interview Anthea also expressed that during a clinical placement she had experienced stress, another strong emotion, in relation to the management decisions for a frail patient receiving palliative care, who was aspirating while swallowing. She felt this situation involved an ethical decision she did not have the experience to make.

> "I think probably the situation was stressful…just coming to
>
> terms with it [i.e., the decision]. Being faced with the life
>
> and death issue like that when I hadn't really been exposed
>
> to that." (Anthea Individual Interview Line 191-196)

Some of her discomfit appeared related to clinical knowledge:

> "I guess it was almost, realizing the level of responsibility
>
> you had making sure you had correctly diagnosed their
>
> swallowing status because major decisions were going to be
>
> made from that." (Anthea Individual Interview Line 197-
>
> 199)

But much of her discomfit appeared related to her confidence in the ethical

decision she was trying to make.

> It was hard for me to put my judgment on that [whether or
>
> not the patient should be fed orally] because I could really
>
> see both sides and it was almost a bit scary the way I could
>
> swap from side to side so quickly depending on the next
>
> piece of information I achieved. (Anthea Individual
>
> Interview Line 145-148)

In this situation Anthea felt she had useful supervision from her field educator to work through the decision making process, and thus it provided a key learning experience in the area of ethical practice. Highlighting the impetus emotional engagement gave to her learning.

Andrew

Andrew attributes two stories of the ethical situations encountered in his own practice with significant emotional involvement and significant amounts of learning. In one situation, where a patient was made nil by mouth, he realised that the information he gave the family was cold and clinical and full of jargon because of his own discomfit with the situation.

> In future I will be … I'll know…Well maybe not know. But
>
> hopefully I'll just be able to take a deep breath and think
>
> about what information they do specifically want…Not
>
> what I want to blurb out to them. (Andrew Individual
>
> Interview line 253-257)

On reflection in this situation he wanted to learn to be more comforting. Andrew perhaps illustrated through this story the development of an ethic of care. In the second ethical dilemma he described, he was too comforting, since he had inappropriate physical contact with a female client when she cried.

"There is a lot of physical contact. There was too much

physical contact. I suppose for my defence that under the

circumstances I didn't think it could be misread as anything

else." (Andrew Individual Interview Line 327-329)

But could these two stories also reflect an internal conflict between wanting to follow an ethic of care and an ethic based on principles? Following discussion with his supervisor (who was present at the time) he felt he needed to be much more aware of how actions may be interpreted in this professional situation. Thus have these emotionally charged situations facilitated his learning around shifting his clinical encounter from a personal ethical response to a professional ethical response? For example, in another professional practice story told by Andrew about scheduling patients, he realised that

It was stressful to begin with. Because it was a battle, that

first particular dilemma - who I wanted to see [when]. And

I know I like Mr. Such and Such so I was more likely to see

him first but that's not always the best method of operation.

Because Mrs. Such And Such may be more functional first

thing in the morning so I should really go and see her. So

from the outset I think the stress was there. The stress was

higher but I knew who I should prioritise. (Andrew

Individual Interview Line 179-185)

Thus Andrew's engaged emotions appeared to force him to confront the ethical aspect of his clinical decision making, resulting in further learning in the area of professional ethical practice.

Bella

Bella described two situations where her professional ethical practice was called into account. In the first story Bella describes events that resulted in her feeling like she was being victimised, a passive pawn in a larger event outside her own locus of control.

> …the placement where I was at there were lots of meetings
> about it and lots of covering - we've got to make sure that
> nothing happens, that there are no repercussions from this.
> And stuff like that. And I kind of thought in the end, 'Ok,
> they're covering themselves and they're covering their client
> but who's looking after me?' If something does come out
> about this person, the first person they're going to look at is
> me. (Individual Interview Bella Line 178-185)

However, despite the discomfit she appears to learn from this experience. When a second situation presented itself, this time concerning the amount of direct supervision required by a student, from the outset Bella took a more active role in seeking an ethically acceptable solution rather than allowing the debate to go on around her. She raised the issue of supervision when her field educator wasn't present and then attended the staff meeting where it was to be discussed

> "During their staff meeting they included me in that process
> by asking me what, how they were going to deal with this
> sort of situation." (Individual Interview Bella Line 270-272)

The outcome to the second ethical dilemma, although not her personally preferred option, was therefore much more acceptable to Bella. Bella actually felt like an active agent, a more competent ethical professional in managing the second ethical challenge.

Bob

Bob describes experiencing strong emotions of horror and anxiety when faced with ethical dilemmas around feeding palliative patients during his clinical placements.

> "…cause my initial reaction was sort of one of horror."
> (Bob Individual Interview Line 211)

> "So in order to reduce my own anxiety levels with the
> decision I decided to talk to people who were detached from
> it…." (Bob Individual Interview Line 193- 194)

Ultimately he gains support for dealing with these emotions not by seeking out his supervisor but by discussing the situation with family and friends. One wonders whether by discussing it with his supervisor he could have gained some professional insights more quickly which may have diffused some of the emotion. One could wonder whether discussing the situation with family and friends was ethical. Bob's perception however is that he and his supervisor had very different ethical approaches and thus he was reluctant to consult the supervisor. His supervisor believed in comfort care and Bob believed strongly in not harming patients in any circumstance.

> I wasn't at the time comfortable that I was agreeing with my
> supervisor, on our course of action…That's a hard one. I guess
> sort of our backgrounds were different in deciding what should
> happen. (Bob Individual Interview Line 125-131)

However despite this Bob indicated that his approach to ethical dilemmas may also have changed as a consequence of his professional learning. He described a case from his own experience where originally he did not want to feed an aspirating patient, who still had decision making capacity, because of the harm it could cause

the patient. However by the end of the encounter Bob had changed his point of view.
Bob now accepted the patient's choice of palliative care, despite the implications that
eating and drinking may actually cause the patient's demise.

> Yes, definitely. Because my initial reaction was sort of one
> of horror. During the placement not only with this one
> patient but also with the other ethical dilemmas that I found
> myself facing. Um I realised that um death is not as …sort
> of…
>
> it's not always the worst option for a lot of people in these
> situations and I learnt to understand and respect their rights
> to, to um not want to continue in the state that they were in.
> And to deal with issues like palliative care. Which I
> strongly disagreed with, to start with. (Bob Individual
> Interview Line 211-216)

Thus Bob's self identified strong emotions appear to be associated strongly with
a huge development in his learning about professional ethical practice.

Clara

Clara is very explicit about emotions stimulating her learning and motivating her
to seek out her field educator and maximise her learning about the best course of
action.

> I think it was helpful because I think, I think it would be
> horrible feeling to be in an ethical dilemma and thinking
> that's all on your shoulders and you had to have the burden
> of that responsibility all by yourself. So it was nice,
> particularly because I don't have a lot of experience, it was
> nice to talk to her about it… And get some guidance about

the best course of action next. (Clara Individual Interview

Line234-239)

In her very assumptions about not having a lot of experience Clara is further

demonstrating her actions as an ethical professional to seek guidance to ensure she

does no harm.

<u>Donna</u>

Donna clearly identifies a personal emotional response to an ethical challenge.

This makes her approach her field educator who uses it as a teaching moment from a

professional perspective, which in turn changes Donna's own thinking.

I think in the first couple of times, it was discussion with my

supervisor of … I'd be like …I can't believe they're not

going to do it and ra ra ra...And she would … and it would

be that rationale … you know that almost like you've got

that little person in your head that says … Just kind of a

bigger one of that kind of saying why do you think she's

reacting in that way? What do you think might be the issues

because of that? And why do you think that is and that sort

of thing. And then just me having the opportunity to think

about that. Thinking OK hang on there is this to consider.

(Donna Individual Interview Line 141-151)

Again, the student's own emotional response triggers a learning opportunity in

the area of professional ethical practice.

<u>Eliza</u>

Eliza found that a theoretical approach to learning professional ethical practice,

that is, learning through academic course work or theoretical cases, was less

enlightening, since she felt the need to engage emotionally with the topic.

> I really feel I've learnt all of my opinions and ethical
> behaviours and everything like that from my placements and
> from practical experience and from observations. I feel like
> attempts to teach it in Issues in Professional Practice have
> been really trying…Because I don't feel it [sic] certainly
> didn't affect me at all. It's not something I suddenly went
> wow now I'll start listening to people… (Eliza Group
> Interview Lines 506-508)

Eliza clearly illustrates how a lack of engagement with people within the formal academic teaching meant she was not affected emotionally and that this actually resulted in a lack of motivation to learn.

Gerry

Gerry told a story of an unsettling ethical dilemma where she initially had a very strong emotional reaction.

> I was sitting there just getting so mad because I just didn't
> agree with what she was saying at all… And I thought, how
> dare you comment on stuff you don't know about, and make
> judgments when you don't know what actually happened,
> and I actually knew what happened, because this was my
> supervisor. It made me so mad that I couldn't do anything
> and I was just sitting there going grrrh (angry sound). Just
> getting so frustrated. (Gerry Individual Interview Line 132-
> 140)

After this emotional trigger Gerry was motivated to learn how to deal with the dilemma professionally. She felt that she needed to step back and think before she acted or before her emotions got (more?) involved. In the situation described she felt

unable to seek outside direction in how to manage the situation. However her description demonstrated that she learnt professionally from the situation.

4.3.4.2 Implications of the importance of emotional engagement on student learning of ethical practice

Each of the core group students spontaneously illustrated that their emotional engagement in an ethical issue gave them the motivation to seek an answer. This seeking of an answer involved learning both from their own reasoning processes and reflection, but importantly it gave them an incentive to use the learning resources available to them, such as field educators, university staff, friends and families.

Several students mentioned that it was only the emotional engagement with cases from real life which stimulated an interest in learning professional ethical practice. Some authors suggest that students learn ethical practice through the use of vignettes. (Hay, 1998; Hebert, Meslin, Dunn, Byrne, & RossReid, 1990). This may be useful as an introduction however for this group of students it is real life experiences which appeared to create a state of learning readiness; that is, a desire to learn more about professional ethical practice. The implications of this for academic staff are the importance of using students' own cases to illustrate the principles and processes they are trying to teach through their formal ethics curriculum (Christakis & Feudtner, 1993; Hundert, Douglas-Steele, & Bickel, 1996).

For some students, particularly more concrete learners, teaching in the area of ethics may need to be both explicit and contextualised (Goldie, Schwartz, & Morrison, 2004). Making teaching explicit and contextualised highlights the importance of field educators flagging ethical issues that occur in students' professional practice. To provide explicit and contextualised learning opportunities through both the field placement and academic course opportunities for students to debrief the positive and negative professional ethical dilemmas and situations

encountered need to be provided (Feudtner, Christakis, & Christakis, 1994; Hundert et al., 1996).

This can facilitate student learning of professional ethical practice and reinforce positive learning (and mediate negative observations) through opportunities for students to formally reflect on these professional practice situations and the emotions they engender (Leget, 2004; Osborne & Martin, 1989).

4.3.5 Summary of the key implication of the results for student learning readiness

The results from the research data reported in this chapter clearly indicate that teachers of professional ethical practice need to consider the impact of key pedagogical factors on student learning. Individual student learning readiness in terms of their cognitive development of moral judgement did appear to influence self reported approaches to ethical issues. Emotional engagement with the topic and the situation also clearly influenced the amount of active learning of professional ethical practice engaged in by the students. Real life experience in the clinical practicum also appeared to increase learning motivation. These learning readiness factors in turn have been shown to have implications for the need for considering the place in the curriculum content, structure and timing of student learning of ethical practice, if the entry level standards for ethical practice set by Speech Pathology Australia are to be achieved by all entry level graduates.

5 EFFECTIVENESS OF STUDENT LEARNING IN PROFESSIONAL ETHICAL PRACTICE

5.1 Introduction

In Chapter 4 the data relating to student learning readiness were reported and discussed. This chapter continues to address aspects of student learning but this time with regards to the effectiveness of student learning. It also explores factors which students identified as facilitating their learning of professional ethical practice. Chapter 6 will explore student learning from the teachers' perspective. Academic and field educator data will be presented to provide insights into teaching approaches and strategies used to facilitate student learning professional ethical practice. The assessment of student competence in the area will also be discussed.

The first section of this chapter provides a content analysis of course outline documents which provide evidence of the formal, written curriculum experienced by this cohort of students in the area of ethical practice. Next, results from the student case study, focus group and individual interviews are used to illustrate student mastery of the curriculum related to ethical practice. The results are considered both with regards to the formal curriculum experienced and current professional expectations for entry level professional competency. The final section of this chapter reports students' insights into what has personally influenced their effective learning of professional ethical practice.

5.2 Student competency in professional ethical practice

5.2.1 Review of Key Concepts in the Literature

It can not be assumed that undergraduate students, without specific teaching in the area of professional ethical practice, have the knowledge, skills and attitudes required to meet the challenges required to practice ethically without specific

learning (Rest, 1988; Triezenberg & Davis, 2000). Student speech pathologists are intentionally taught aspects of ethical practice through planned curriculum (including practicum) experiences. The effectiveness of curriculum interventions in the area of professional ethical practice is notoriously difficult for any profession to measure either formally or informally through standard assessments (Roff & Preece, 2004; Thornton, Callahan, & Nelson, 1993).

To demonstrate, the attainment of curriculum goals, in the area of ethical practice students' should be able to demonstrate their movement through the cognitive learning processes associated with knowledge integration (Anderson & Sosniak, 1994) [45]. The depth and integration of a students' learning can be measured by analysis of their topic knowledge and comprehension, and their ability to apply, synthesise and evaluate their learning (Phillips, 2006).

5.2.2 Key curriculum inputs

5.2.2.1 Knowledge

The group of students involved in this study experienced explicit teaching in the area of foundation theoretical knowledge required for professional ethical practice. A review of the summary of topics undertaken from 1996 to 1999 (Russell, 1999) indicates explicit ethics teaching in the subjects SPTH 2302 Issues in Professional Practice 2:

> "This topic provides students with theoretical constructs in preparation for Clinical Practicum. It aims to provide the student with…knowledge of some areas of legal professional responsibility and some basic professional ethics…."

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[45] See section 2.3.3.1 Fostering Deep learning for a description of Bloom's Taxonomy which describes ways of assessing knowledge integration.

And in SPTH 3304 Issues in Professional Practice 3:

> "This topic is designed to deepen and broaden students'
>
> skills in… professional ethics.…"

Further detailed Topic information gives the exact content of this teaching. In SPTH 2302 this included teaching about confidentiality. In SPTH 3304 it involved two ethics workshops. These workshops included teaching on Beauchamp and Childress's (1994) ethical principles as described and expounded in Bioethics and Clinical Ethics (Mitchell, Kerridge, & Lovatt, 1996) and application of these principles in case studies. The Australian Association of Speech and Hearing Code of Ethics and the charter for South Australian Public Health System Consumers were discussed (South Australian Health Commission, 1996). Providing students with opportunities to apply ethical principles in case studies may also indirectly introduce ideas related to narrative ethics[46], for example in considering why the person may respond as they do in the given situation. The issues raised by the case studies may also lend themselves to an analysis using an ethic of care[47], in short, what decisions result in the most caring outcome for this particular patient in their particular circumstance. Narrative ethics and ethic of care approaches to ethics are not explicitly addressed in the IPP3 ethics workshops, although as a predominantly female[48] health care profession which often provides services to individuals in the community and even in the client's own homes, these approaches would appear overwhelmingly relevant to speech pathology practice.

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[46] Narrative ethics is an approach to ethical reflection in which the context of the person (personal, cultural and social) is used as the basis for determining the most appropriate course of ethical action (ATEAM, 2001).

[47] Ethics of Care as an approach rejects "abstract impersonal approaches to ethical analysis" rather prioritising caring as the "…most important moral principle…" (ATEAM, 2001).

[48] It has been argued that ethical principles based on a more abstract system of justice are less likely to be used by women (Gilligan, 1982).

This raises the question of whether the formal ethics curriculum provided to these speech pathology students is adequate. The literature review in Chapter 2 certainly presents a range of ethical theories and approaches relevant to health professional ethical practice but only one is explicitly taught in this curriculum. Might this limited offering restrict students' understanding of what ethics is?

5.2.2.2 Skills and Attitudes

Improving students' knowledge base is not the only teaching goal of academic staff. A discussion paper by a working group on behalf of the Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools highlights the importance of teaching skills and attitudes for professional ethical practice (ATEAM, 2001).

Skills for effective ethical practice include generic clinical problem solving, critical thinking, reasoning, team work and the application of theory into practice as well as the specific ethical awareness and moral reasoning skills. Other ethical practice skills include communication, negotiation and collaboration about ethical issues with patients, families and team members. Importantly it also includes skills often essential for putting ethical decisions into practice such as addressing institutional restraints (ATEAM, 2001).

Attitudes relevant to speech pathology ethical practice include honesty, integrity, including non-discrimination, trustworthiness, empathy, compassion, respect (for patients, families and the health care team), responsibility, and self assessment including reflection on practice (ATEAM, 2001; Speech Pathology Australia, 2000).

Analysis of the summary of topics and detailed topic information indicates that many of these attitudes and skills are addressed throughout the four years of the speech pathology program experienced by this cohort of students. For example, the

first year topic SPTH 1401 Speech Pathology in the Community, introduces the concept of team work, clinical processes including clinical reasoning and an understanding of the demographics of the communities in which they will work and starts the process of reflection through the keeping of a clinical log book. The second year topic, SPTH 2302 Issues in Professional Practice 2, introduces to students underpinning ethical practice skills such as rapport building, interviewing, and counselling. In third year, attitudes such as empathy are encouraged through topics such as SPTH 3201 Audiology where the aim of the topic is to give students an appreciation of the problems faced by people who have a hearing impairment. Also SPTH 3409 Swallowing and Dysphagia addresses how students will determine management decisions, provide education and counselling, and participate in multidisciplinary teams. Issues in Professional Practice 3, SPTH 3304, not only includes the explicit "ethics workshops" (see above) it also further develops ethical practice skills such as counselling, managing conflict, and so on. In fourth year, SPTH 4302 Issues in Professional Practice 4 continues to encourage students to reflect on their practice and critically evaluate their ongoing professional development needs.

Thus the skills and attitudes required for professional ethical practice appear to be broadly addressed across all four years of the Flinders University speech pathology curriculum through more of the clinically based topics. This integrated teaching of skills and attitudes may not be immediately recognised if the curriculum was examined for only explicit references to ethics teaching. Given this greater integration of the teaching of the skills and attitudes of ethical practice it will be interesting to see whether students demonstrate increased competency in these areas of ethical practice.

5.2.3 Student Mastery of Professional Ethical Practice

5.2.3.1 Introduction

Twenty students agreed to their case study discussion designed for the project but completed as part of their IPP4 topic, being included in the project (See Section 3.5.3 Data Collection for a description of the case study). Five students chose to complete the task using a computer. Of these, two of the discs handed in were blank when opened for analysis some time after the data collection was completed and the task was therefore unable to be repeated. Unfortunately these discs belonged to two of the core group students. One student provided their own story for case study. Otherwise the provided case study was used. (See Appendix 2a: Written Case Discussion.)

The system used to analyse and describe the complexity of the content of student responses to the case study was devised by the researcher and is described in detail in Section 3.4.2.2. Essentially students' case study responses were analysed across four main content areas: identification of relevant clinical information; identification and prioritisation of ethical issues; recognition of the role of stakeholder; and, provision of management plan options. (See Appendix 2c: Analysis Guide for Case Discussion; and, Appendix 2d: Rating Guide for Written Case Discussions.) Overall ratings of the case study discussions with and without the ethical decision making guide are summarised for each student. The results of this analysis and a discussion of the group results are provided in this section.

5.2.3.2 Students' clinical reasoning skills

<u>Results of the content analysis of the clinical information presented in the student case discussions</u>

Health professionals not only need to construct a knowledge base around a disorder or procedure. They also need to have the reasoning skills to learn to adapt and apply this knowledge in the real world context of the practice environment. The

first step of being able to adapt and use knowledge is the identification of background personal and clinical information relevant to the case. Identification of further information required may inform both clinical assessment and management decisions. Student participants' ability to identify clinical information provided in the case study and additional information they would seek is reported. The case study concerned a patient with a swallowing disorder known as dysphagia. Dysphagia assessment and management is a key area of practice for speech pathologists particularly those working with adult clients.

As soon to graduate speech pathology students, it was somewhat disturbing to note, that a third of students were unable to identify relevant clinical information about the case satisfactorily[49] when discussing the case study independently. The fact that all but one student could identify the relevant clinical information with the decision making prompts provided by the ethical decision making guide would suggest that the majority of students had at least satisfactory knowledge but lacked skills to apply this knowledge without prompts. The students' limited spontaneous response suggests that they had not yet necessarily integrated the information into a consistently applicable form. The paucity of response may also have related to the fact that it was not a case they had directly experienced.

Transferability of knowledge out of the real life context can also often be limited (Sarason, 1985). The majority (two thirds) of the students did in fact have satisfactory or higher ratings in this area when independently completing the case discussion See Table 12 below.

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[49] The rating guides were not piloted however were based on the researcher and research assistant consensus. Both of whom were university educators of allied health professionals

Table 12 Students ability to recognise and identify relevant clinical information

Description of response	Evidence required for each description	# of students	
		Independent case study analysis	Guided case study analysis
Unsatisfactory	None or minimal evidence that relevant clinical information was identified. Basic patient personal and diagnostic information given. (Less than 3/5 pieces of salient information identified)	6	1
Satisfactory	Basic relevant clinical and personal information was identified. (3/5 salient pieces of information identified)	7	11
Very Satisfactory	Identification of essentially all relevant clinical information provided. (4-5/5pieces of salient information)	5	5
Excellent	Identification of all relevant clinical information provided, that is 5/5 pieces and a statement related to relevant additional information required	-	1
	Total	18	18

Discussion of clinical reasoning data

The apparent lack of knowledge integration in the area of dysphagia management reported above may have related in some part to the fact that a number of students had not for various reasons completed their final clinical practicum.

It may have also related to the fact that not all students would have had an acute adult placement where management of acute dysphagia would be common. Thus not

all students may have therefore had opportunities to integrate their academic knowledge of acute dysphagia management with actual clinical practice. Also the case discussion did not arise from their own clinical experience for seventeen of the eighteen students. They may have been less engaged with the reality of the task and may perform better in the real life context. So whilst the underlying knowledge base existed for 90% of the students this knowledge base was not readily accessible or spontaneously applied by a third of group until cues/prompts were provided.

These results are consistent with other studies which suggest students struggle to integrate learnt information. Students need time and opportunity to test, reject, modify and confirm academic knowledge in the practice setting before being able to integrate it into their knowledge base (Terry and Higgs, 1993). Students often cannot solve clinical problems and that it is in clinical settings they have opportunities to apply their academic knowledge and professional knowledge (Scholten and Laurence, 1999).

5.2.3.3 Students' foundation knowledge of professional ethical reasoning

Of most relevance to this study of professional ethical practice is the ability of students to identify and prioritise the ethical dilemmas or potential ethical dilemmas raised by the case study. This involves students recognising and understanding the basic ethical principles taught and the relevant terminology. For example, an understanding of informed consent is dependent on the foundation knowledge of autonomy, patient rights and paternalism (ATEAM, 2001). As with the key critical clinical information, almost a third of the students were unable to independently identify any ethical dilemma in the case provided.

However, in contrast to this group, another third of the students were able to independently identify that there were multiple ethical dilemmas in the case

presented. When provided with the guide all students were able to recognise that there was at least one ethical issue at stake (See Table 13).

Table 13 Evidence of students' ability to recognise and prioritise ethical issues

Description of response	Evidence required for each description	# of students	
		Independent analysis	Guided analysis
Unsatisfactory	No evidence of recognition that there are ethical issues involved in the case or denial that there were any ethical dilemmas presented.	5	-
Satisfactory	Recognition of one ethical dilemma.	6	7
Very Satisfactory	Recognition of multiple ethical dilemmas.	7	11
Excellent	Recognition of not only multiple dilemmas but also that the resolution of them may lead to conflict thus an attempt to prioritise the dilemmas for consideration made.	-	-
	Total	18	18

The results described in Table 13 are further illustrated by the six core group students who provided case study discussions (those completed independently and with the ethical decision making guide), which were analysed in more depth through a narrative analysis framework (See Appendix 10: Narrative Analysis Framework.[50]) Each student's case study response was analysed as a story of the ethical dilemma presented.

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50 This narrative analysis is a literary tool not an analysis of the story from a narrative ethics perspective.

The abstract (a summary of the main point of the narrative) highlighted which ethical dilemmas or principles (Beauchamp & Childress, 1994) the students identified as critical in their case study response.

In the students' case study responses no explicit mention was made of ethical principles by any of the core group students. In fact, Andrew explicitly states that there is no ethical issue at stake. Implicitly, Donna, Eliza and Bob discuss issues that demonstrate an awareness of the principles of autonomy (e.g., is the patient able to make informed decisions), justice (e.g., resource allocation), and legal requirements. Bob, Anthea, and Bella demonstrate awareness of the principles of beneficence (that is, doing good or improving the patients' quality of life). Anthea and Bella also discussed issues suggesting an awareness of non-maleficence (or doing no harm, not wanting to make the patient more unwell).

Evidence of the ethical practice skills of ethical awareness and ethical reasoning

These results indicating difficulty in the explicit identification of ethical issues may be related to the lack of foundation knowledge for a third of the students. However, given that 100% of the students were able to identify at least one ethical issue for consideration when prompted by the ethical decision making guide, it may also reflect a lack of the specific skill of ethical awareness, that is, the ability to recognise ethical issues present in professional practice situations.

The results also suggest that the professional ethical reasoning skills of students may not have been well developed. For functional professional ethical practice, speech pathologists are not only required to have the ability to identify ethical issues (which requires foundation knowledge and ethical awareness) but also the ethical reasoning ability to see a more complete view of perhaps competing issues and

weigh up the pros and cons of each. The Speech Pathology Australia Code of Ethics requires practising therapists to have this skill; that is, the ability to weigh up principles, values and standards of practice to develop and maintain ethical practice (McAllister, Kilminster, Brown, & Anderson, 2002). Thus this area of ethical practice is considered a foundation skill.

Ethical decision making guides as a tool to facilitate students' ethical practice skills of ethical awareness and ethical reasoning

This possible deficit in the skill areas of ethical awareness, and ethical reasoning, has implications for student participants' ongoing need for support and structure around ethical decision making as new graduates.

In the new Speech Pathology Australia Ethics Education package (McAllister et al., 2002) an ethical decision making guide is provided, but perhaps academic staff and field educators need to explicitly teach its use with students, highlighting it as a resource for professional ethical practice? A guide certainly appeared to assist students involved in this study to provide more detailed reasoned responses than they were able to make spontaneously. When asked under which of the data gathering situations he found it easiest to make an ethical decision Bob reported that it was with the case study with the ethical decision making framework (guide). He added not that he actually wrote more as a result of using the guide but he implied it facilitated his thinking.

> …I didn't actually add a lot from the unguided to the guided
>
> but it was certainly easier thinking about it. And easier
>
> coming up with. Like I came up with the same sort of ideas.
>
> But it sort of got embellished a little bit with the guided
>
> [i.e.,case study] which I thought was worthwhile

embellishment." (Bob Individual Interview Line 29-34)

Similarly Eliza found the ethical decision making framework in the case discussion helped her to add detail to her response.

> I certainly added a lot more detail. And it, it was a lot
> more…I'm not quite sure of what the word I'm looking for
> is… It was a lot more knowledgeable. It was based on
> things that were, you know more pertinent. So things like
> the Will and things I wasn't considering in my narrow view
> of what a Speech Pathologist does in a, in a hospital. Not
> actually having done it myself as I've always had a
> supervisor there. (Eliza Individual Interview Lines 27-33)

Whilst the ethical decision making guide appeared to help the students in this study consider the situation in more detail and facilitated their decision making. The guide did not however appear to facilitate ethical awareness and reasoning in their day to day professional practice of speech pathology. McAllister (2006) supports this finding about decision making guides not facilitating everyday ethical awareness and reasoning. Students perhaps require a deeper level of ethical awareness to even begin to apply it in everyday practice situations. This result has implications for educators which are discussed further below.

Heightening ethical awareness skills through flagging ethical decisions and dilemmas in the practicum

Certainly the content of the case study discussions with regards to the identification and prioritisation of ethical issues appears to confirm the researcher's informal observations that stimulated this study in the first place, namely that many students and new graduates had difficulty identifying what it is (that is, the actual dilemma) that makes them uncomfortable when faced with a clinical situation

containing an ethical dilemma. This is summed up well by Anthea's regard for her own clinical experience, Anthea felt her own knowledge was insufficient:

> "When faced with them [viz. ethical decisions] in the
>
> clinical situation. I still felt my knowledge wasn't great
>
> enough in those areas. (Anthea Individual Interview Line
>
> 251-252).

This in turn has implications for field educators and the amount of support they need to provide students like Andrew who, following reflection on the case with the ethical decision making framework, explicitly states:

> "I don't see any ethical dilemma as the wife is the patient's
>
> next of kin…." (Andrew Case Study Discussion p. 3)

He felt there was no ethical dilemma because the wife could make what ever decision she wanted with regards to her husband's management. Similarly, when asked whether he had encountered any ethical dilemmas during his clinical practice to date he responded:

> "I don't think so. I don't think. It hasn't leapt out in front of
>
> me to say I'm an ethical issue um, how are you going to deal
>
> with me." (Andrew Individual Interview Line 102-104)

Thus field educators and supervisors of new graduate professionals may need to be responsible for explicitly flagging ethical dilemmas and ethical practice decisions. Through making this awareness explicit it may facilitate students making the link between theory and practice.

Donna sums up beautifully the benefits of this behaviour to the development of professional ethical practice:

And having, having a supportive supervisor who can

identify like this is probably likely that this will be an

ethical dilemma. How can I help the student to work

through this? I just don't think you can undervalue that.

(Donna Individual Interview Line 241-244)

It may also require the experienced field educator to flag deeper ethical practice issues that are not about ethical dilemmas per se. For example, how to resolve workplace conflicts in a manner that demonstrates respect for other team members, and foster a collaborative approach to patient care; how to approach the sharing of patient information with other team members; social ethical concepts such as individual versus common good and their effect on resource allocation to health promotion versus disability management.

Reflection on practice as a facilitator of learning integration

As Donna has stated so clearly above it is not enough for field educators just to help students identify ethical dilemmas. They must also help students structure the integration of their knowledge base into actual professional practice. Certainly Bella thought this is how she learnt her professional ethical practice. Repeatedly in her individual interview, Bella revisited the idea of learning from experience and being able to apply that learning to future situations:

Like I have been taught over the past couple of placements

when there has been ethical issues is how to then deal with

those ethical issues… And to recognise there is an ethical

issue coming up.… (Bella Group Interview Line 485-487)

Well you see for me the first big ethical issue came up. And

I didn't realise to start with, and neither did my supervisor

that there would be an ethical issue. And it wasn't until that we'd kind of gone in a little bit, into the placement that suddenly it became an issue and then it was interesting then to see how they worked through it and how it was worked out. (Bella Group Interview Line 491-494)

Other students, such as Clara and Donna found that reflecting on situations through discussions with their field educators was invaluable.

I think it was helpful because I think it would be a horrible feeling to be in an ethical dilemma and thinking that's all on your shoulders and you had to have the burden of that responsibility all by yourself. So it was nice, particularly because I don't have a lot of experience it was nice to talk to her about it… And get some guidance about the best course of action next. (Individual Interview Clara Line234-239)

I think in the first couple of times, it was discussion with my supervisor of…I'd be like…I probably shouldn't say this and bag myself. 'I can't believe they're not going to do it and ra ra ra...' And she would…and it would be that rationale… you know that almost like you've got that little person in your head that says…Just kind of a bigger one of that kind of saying why do you think she's reacting in that way? What do you think might be the issues because of that? And why do you think that is and that sort of thing. And then just me having the opportunity to think about that. Thinking ok hang on, there is this to consider. (Donna Individual Interview Line 141-151)

This relates to what Schön (1983, 1987) would consider to be the so called reflection before action and reflection on action. Gerry certainly felt that a key issue in dealing with ethical dilemmas was to step back and think before you acted or before your emotions get involved.

Eliza goes as far as saying you can not learn professional ethical practice without reflection on real life practice:

> I really feel I've learnt all of my opinions and ethical
> behaviours and everything like that from my placements and
> from practical experience and from observations. I feel like
> attempts to teach it in Issues in Professional Practice have
> been really trying… Because I don't feel it [sic] certainly
> didn't affect me at all. It's not something I suddenly went
> 'wow now I'll start listening to people'. It's just something
> I've done out of necessity and I've learnt to do it. (Eliza
> Group Interview Lines 506-508)

Conclusion

The case study tasks and the core group students' reflections on the task certainly highlight some key factors influencing students' learning of the knowledge base for professional ethical practice. These include the use of explicit scaffolding such as the ethical reasoning framework document, the importance of field educators identifying ethical issues, and demonstrating for students how they work through their ethical reasoning processes in real life situations.

5.2.3.4 Demonstration of other fundamental ethical practice skills

Communication and Teamwork

Data from both case study discussions and the core group student individual stories of ethical dilemmas were used to demonstrate student awareness of and

potential ability in the ethical practice skills. These included generic professional skills such as communication but more importantly, ethical practice skills, such as negotiation and collaboration about the implementation of ethical management decisions (See Table 14). This appears to be an area of relative strength for speech pathology students with almost a third responding in a very satisfactory or excellent way, even without the decision making guide.

Table 14 Students' use of communication and teamwork skills

Description of response	Evidence required for each description	# of students	
		Independent analysis	Revised analysis (with guide)
Unsatisfactory	No evidence of attempting to include others (patient, family, professional team, field educator/mentor) in the setting of management goals.	3	1
Satisfactory	Setting of management goals involved consultation with at least one other party.	10	10
Very Satisfactory	Setting of management goals involved all parties directly mentioned in the case study.	4	6
Excellent	Setting of management goals involved all parties mentioned in the case study and in addition identified relevant extra parties/resources to be consulted (e.g., hospital ethics committees).	1	1
	Total	18	18

It is interesting that communication and team work skills are explicitly addressed from semester 1 year 1 of the speech pathology course, with collaborative peer

teaching and learning a key methodology in the course. Is this the reason why 90% of students exhibited satisfactory or higher awareness in this area, at least with the ethical decision making framework prompts? Or is it that work on professional communication and team work would explicitly occur in every field education placement experienced by students from their clinic observations in first semester first year to their final week as a student clinician? Both these factors and a combination of these factors would certainly maximise opportunities for students to integrate the learning of skills in these key professional practice areas. They may account for the greater demonstration of knowledge in these areas.

Students may require further help to both integrate the use of these professional communication and teamwork skills, and to use these skills with more senior staff in the workplace. Bob expressed perhaps a lack of skill in this area when discussing his experience of the group ethical decision making task with his peers:

> "The sort of most powerful person in the group tended to have the biggest, biggest [sic] influence." (Bob Individual Interview Line 41-42)

These results suggest that some students may require ongoing explicit teaching, particularly in the area of ethical practice, from field educators and supervisors/mentors in the field upon graduation. This may particularly be the case if their opinion differs from others in the team or the family (ATEAM, 2001).

<u>Collaborative action</u>

The ability of a student to design and propose multiple ways forward, that is multiple potential management plans, may be vital in their collaboration and negotiation with others (patients, families, health care team) and ultimately in their

ability to act ethically. In the case study the potential ability for collaborative action

was in part measured by the student's ability to create and provide the reasoning

behind multiple action plans. See Table 15 below.

Table 15 Evidence of students' ability to provide a management plan

Description of response	Evidence required for each description	# of students	
		Independent analysis	Guided analysis
Unsatisfactory	Provision of only one management solution.	4	1
Satisfactory	Discussion of two alternative plans of action.	10	8
Very Satisfactory	Discussion of more than two plans of action.	4	9
Excellent	Extensive discussion of management options and their implications for the parties affected by the plan.	0	0
	Total	18	18

Summary

Whilst communication, team work and collaborative action skills appear as

relative strengths for this group of students, under pressure they may still require the

support and assistance of field educators and supervisors/mentors in the workplace.

This may particularly be the case when everyday ethical decisions or approaches to

ethical practice need to be determined rather than when ethical dilemmas need to be

resolved.

5.2.3.5 The development of attitudes critical for ethical practice.

Speech pathology students may come to their course of study with the attitudes

which underpin professional ethical practice in place. However, how is this to be

measured? How do we ensure that those attitudes and values are there by the time

they graduate if they are not there at the start of their studies? Certainly the speech pathology curriculum throughout the four years as experienced by the student participants (described earlier in this chapter) explicitly focused on attitudes and values. The focus group interview provided the core group of students with an opportunity to identify the qualities and virtues they valued in people, and the guidelines to follow for living an ethically good life. When discussing their own experiences of an ethical dilemma in their individual interview, each of the core group of students also had an opportunity to illuminate some of the ethical practice attitudes they had developed. The values and attitudes mentioned by at least a third of the core group of students are provided in Table 16 below.

Table 16 Attitudes and Values discussed by the core group of students as being important to ethical practice

Attitude/Value	Coding definition	# of occurrences of attitude or value	# of core group students identifying this attitude or value
Empathy and compassion	The ability to put yourself in another person's shoes and understand their challenges.	12	7
Respect	For other people and their point of view.	9	4
Critical self-appraisal	Being aware of personal and professional weaknesses or errors.	8	6
Commitment to life long learning	Always being ready to improve professional practice.	5	3
Honesty	Telling the truth when dealing with others.	4	3
Responsibility	Taking professional responsibility for	4	4

decisions and actions.

Some of the values embedded in the recent Speech Pathology Australia code of ethics are absent from the discussions of the students. Absent are values such as professional services taking precedence over personal interests and aims, seeking to protect clients' individuality and rights, not discriminating on the basis of race, gender, religion, sexual preference, marital status, age, disability, beliefs and contribution to society or socioeconomic status. This may mean that some explicit teaching in this area is required (Speech Pathology Australia, 2000). Another key ethical practice attitude that appears to be missing from this list is a commitment to self care. Self care is an essential underpinning attitude in the prevention of disengagement from people and professional burnout (ATEAM, 2001). Whilst the research questions may not have been sensitive enough to elucidate this area of ethical practice it may be an area that requires more explicit attention.[51]

It appears values and attitudes are difficult to teach (ATEAM, 2001). The Flinders Speech Pathology curriculum through the Issues in Professional Practice stream does appear to attempt to address this through explicit teaching on anti-discrimination, respect for client rights, understanding and respect for the individual. Yet it was some of these attitudes and values that students failed to mention in their individual and group interviews. The literature does provide some strategies to improve student development in the area of attitudes and values. Strategies described include debriefing on the everyday encounters and role modeling (ATEAM, 2001; Brown & Lamont, 1998).

Summary

Whilst there appear to be some key attitudes that are necessary for professional ethical practice we cannot assume that all who enter a course have these attitudes innately. Many of the core group students were able to demonstrate through their retelling of practice stories an awareness of many attitudes relevant to ethical practice. Ideas for further development of this area include debriefing and careful role modeling by those they encounter.

5.3 Students' own descriptions about personal and professional influences on their learning of professional ethical practice

Data pertaining to personal and professional influences on student learning of professional ethical practice were gathered and analysed from two sources for each of the core group students. The first was their group interview where they were explicitly asked where they thought they had learnt their professional ethical behaviour (See Appendix 4, Focus Group Questions). Secondly, in some of the individual student interviews, mention was made of processes that had influenced student learning of professional ethical practice.

5.3.1.1 Academic Influences

Nine examples were identified of students mentioning the positive influence of their academic course work on their learning of ethical practice. This was the third most cited influence. More importantly perhaps were the specific examples given by students of skills development and teaching approaches. that had contributed to their ethical practice development. Teaching of a key professional ethical knowledge base was identified as important. For example:

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[51] This explicit teaching around the topic of self care for the health professional has occurred in the Flinders University speech pathology course as an addition to Issues in Professional Practice stream.

But ethics [i.e., ethics course] is good as far as when you do come up to some ethical problem …Like I have been taught over the past couple of placements when there has been ethical issues is how to then deal with those ethical issues rather than…And to recognise there is an ethical issue coming up.…(Bella Group Interview Lines 483-487)

Or when talking about the academic course:

It hasn't actually changed your ethical beliefs, all it's done really is highlighted to me.

Like before when you were talking about Wills, well I didn't know that that's not really an ethical decision it's just a lack of knowledge about that area. So it wasn't a fact that it changed my ethics about it. It just changed my knowledge of another factor that needs to be brought into the situation to make a decision. (Bella)…

That's sort of the key... I think we are applying ourselves to professional Speech Pathology just as we are applying our ethics as people to our knowledge of Speech Pathology issues…then we just have to have the knowledge base to make them. (Bob) (Bella and Bob Group Interview Lines 513-524)

Being taught active listening skills was also highlighted as important to the development of students as ethical professionals.

"Certainly some of the active, the real active listening [i.e., skills] I've developed it through this course… I'm listening to you and I'm focusing on you." (Andrew)

"…So how have you learnt that, if you think that is an important ethical behaviour, how have you learnt that do you think?" (Interviewer)

"…Because if I haven't gained all the information I need to gain from what they are telling me I'm starting off on the back foot. I can't help them 'cos I've not listened to what they've said…" (Andrew Group Interview Lines 467-476)

The ethical decision making framework introduced in the case study exercise was also raised as an important tool (Appendix 2b: Guided Case Discussion). Perhaps this approach was identified because the interviewer had used this teaching methodology just prior to the group and individual interviews:

"I find it a little hard not having an answer and I understand that but having a framework was helpful. Like that guided discussion that will be a very good candidate for being laminated." (Bob Individual Interview Line 243-245)

Group discussions were also mentioned by Gerry as useful for her ability to work through an ethical dilemma.

It is important to note that some students felt ethics could not be taught. They commented:

"I don't think you can teach [pause] teach ethics." (Gerry)

"I was about to say that." (Eliza)

"…It's like I don't think you can teach empathy. I don't think you can teach lots of the things that go along. It's like I think everyone's an individual and everyone will have their individual beliefs and that is why there are these ethical

dilemmas." (Gerry)

(Gerry and Eliza Group Interview Lines 478-481)

In fact in her individual interview Eliza went on to say that she thought efforts to teach ethics, at least in the academic subject, Issues in Professional Practice was not effective or encouraging:

"I feel like attempts to teach it [viz ethics] in Issues in

Professional Practice have been really trying…." (Eliza

Group Interview Lines 507-508)

Her tone implied it had been a tedious experience. Interestingly in the interviews students recalled little about sessions where ethical theory had been explicitly taught. They also did not mention the teaching about legislation often considered relevant to consider when making ethical decisions (e.g., The Palliative Care Act and The Patient Charter). Similarly there was no mention of the explicit treatment of confidentiality or any of Beauchamp and Childress's principles (1994) of biomedical ethics. This lack of recognition of the theory underpinning professional practice is not exclusive to ethical practice knowledge (Scholton, 2000; Scholton and Laurence,1999). In fact, a perennial challenge for academics is to help students make the links between theory and practice and actually recognise the importance of the underpinning theory to their clinical reasoning and practice (Higgs, 1997; Higgs & Jones, 1995; Higgs & Jones, 2000; McAllister, Lincoln, McLeod, & Maloney, 1997).

5.3.1.2 Practicum influences

Experience was clearly the most frequently cited influence on the development of ethical practice by students themselves. It was coded twenty three times. This experience included life experience as well as experience during practicum

placements. This combination of life and practicum experiences influencing learning is summed up well by Eliza:

> "I really feel I've learnt all of my opinions and ethical
>
> behaviours and everything like that from my placements and
>
> from practical experience and from observations." (Eliza,
>
> Group Interview Lines 506-508)

As Eliza did above, several students talked about learning through observing others (including their field educator) as they worked through an ethical situation. Students spoke of observing "how it was done":

> "Observations of your supervisors and going to people
>
> yourself maybe good experiences and bad experiences and
>
> kind of moulding them all." (Gerry Group Interview Line
>
> 456-457)

The importance of this professional socialisation through observation has been observed in other areas as a powerful influence on student learning (Best & Rose, 1996; Ewan, 1988b; McAllister, 2001). All aspects of a field educator's professional behaviour including their ethical behaviour (McAllister, 2001) may be scrutinised by students and can influence student's ethical practice development in both a positive and negative way. Particularly in the medical literature on the learning of ethical practice negative role modelling has been linked to ethical erosion in students and new graduates (Brockett, Geddes, Westmorland, & Salvatori, 1997; Christakis & Feudtner, 1993; Feudtner, Christakis, & Christakis, 1994; Satterwhite, Satterwhite, & Enarson, 2000).

Students found more direct interactions with field educators a powerful influence on their learning of ethical practice.

I realised that sort of straight after the session when

[supervisors name] said. Because it was just a reaction of

mine because I felt I never had a client cry on me before

because this was fairly early in the placement…So how do I

deal with that? And I thought the best thing is to really

show some concern...I showed concern [laughter] with just

a little too much physical contact. (Andrew Individual

Interview Line 361-366)

Students described a variety of field educator interactions which facilitated their learning about ethical practice. These field educator interactions included: flagging there was or could be an ethical issue; debriefing situations containing ethical dilemmas; providing guidance through reflecting with the student on experiences of ethical decision making after the event; and the field educator questioning or reviewing the student's reasoning behind their own action or behaviour or ethical standpoint. These interactions were not always actively sought by students or did not always have a positive outcome, particularly when the student perceived they had a different ethical approach to their field educator:

"That was probably quite a big dilemma because I wasn't at

the time comfortable that I was agreeing with my

supervisor…On our course of action…That's a hard one…In

deciding what should happen." (Bob Individual Interview

Lines 123-131)

In the practicum situation students also emphasised the value of learning about ethical practice from peers through discussion with other students or team members encountered on practicum.

I think I discussed with…the other student. And with

family and we used to have group supervision…it was

really good one afternoon a week where everyone would

come and say 'I've got this client I did this, this and this.

We had this problem what does everyone else think?...What,

are there other alternatives you would have

suggested?'…Because I think one of the biggest ethical

dilemmas I had was when I had a young boy who had

suffered a head injury and he was returning to school. And

I had a meeting with his teacher and I really felt the teacher

didn't take on board anything I said or and this child was

going to be thrown back into a classroom where I think he

was going to sink instead of swim. And being able to

discuss that with the team and you know with people more

experienced with me. I think I really learnt how to

acknowledge 'this is my emotional response'…'How do I

move on from the emotional response to the constructive

professional response and the plan from that.' I think is

what it was." (Donna Individual Interview Line 161-182)

This effectiveness of collaborative models of peer learning is discussed by

McLeod and others as an effective generic model of learning in clinical education

(McAllister et al., 1997), which is obviously also applicable to student learning of

ethical practice.

All the students were able to describe at least one professional ethical dilemma

they had encountered in their practicum experiences. The students were unable to

articulate an analysis of these dilemmas at a deeper level, for example, by labelling

the ethical principles involved. This perhaps, again, shows difficulty with the

integration of theory and practice. None of the students described their field educators as making this link explicit for them. Helping students move from ethical theory into practice should be what an ethical practice education program should aim to achieve (Thornton et al., 1993).

No student described incidents that undermined or contradicted their formal ethics teaching. It is difficult to say if this is because they did have close supervision and guidance and therefore did not observe negative incidents, or whether they were simply not discussed in the interview situations.

5.3.1.3 Other influences/Useful Learning Strategies

Personal life experience was the most frequently cited learning influence on students with regard to ethical practice. This learning from life appeared very valuable to students. (See the previous section on Practicum influences).

Students reported that their families were a strong influencing factor on their development as both an ethical person and as an ethical professional:

> "But certainly parents…so it mainly came from
>
> parents…and that kind of changed my way of thinking."
>
> (Bella Group Interview 346-349)

> I think a lot of it carries over from being taught it from my
>
> parents and my school and from my friends and just a
>
> general ability to deal with people. You know you've been
>
> taught to be courteous and you've been taught to be
>
> sympathetic if someone's telling you something, just
>
> stressing. It's just those things you've grown up with that
>
> you are now applying to people that have more problems
>
> than my general circle of friends do so. (Eliza)

> …I didn't feel like I had to start afresh. (Gerry)

Conscience, the internal voice, was also cited as an important influence on students' actions in situations requiring ethical decisions:

> I suppose your conscience is a pretty good indicator really
> of how you tend to rule your life ethically and morally
> really… That you have a little niggle in the back of your
> mind thinking 'no that's not quite right' then it is probably
> pretty accurate. It is for me. (Anthea Group Interview Line
> 284-290)

The societal institutions of formal religion and school, as well as society in its broadest sense were also mentioned more than once as influences on personal and professional ethical development. Eliza sums up this generic influence well when she says:

> "I think a lot of it carries over from being taught it from my
> parents and my school and from my friends and just a
> general ability to deal with people." (Eliza Group Interview
> Line 459-460)

5.3.1.4 Summary

Students were able to identify many influences on their development as ethical people and ethical professionals. Given the broad age range of students it was helpful to note the importance given to experience. It highlights the need for educators to use students' own experiences in teaching the knowledge foundations for ethical practice and for field educators to be able to assists students to link theory and practice in real time. It was also interesting that many students were very aware that their ethical formation as people influenced their professional ethical practice.

This links in well with the idea that rather than putting on a professional mask the student speech pathologist adds another layer of the Russian Doll (McAllister, 2002) when learning professional ethical practice. That is, personal ethics and morality lay a foundation for professional ethical practice. However, explicit teaching and learning is required to add the professional layer of ethical knowledge, skills and attitudes to the foundational layer of personal ethics and morality.

5.4 Summary

This chapter has explored how students' learning of the knowledge, skills and attitudes of professional ethical practice has been influenced and measured. Students demonstrated limited mastery of both clinical and ethical reasoning in the case study provided and in their own stories of ethical dilemmas. Almost a third of the students were unaware that there was an ethical issue at stake without a written prompt being provided. These results demonstrated perhaps the limited effectiveness of student learning of the ethical practice knowledge base and even more fundamentally ethical awareness. In contrast, the results suggested that the more generic professional skills also relevant to ethical practice such as collaborative action were present. Students were also able to demonstrate a range of attitudes and values essential for ethical practice.

Students highlighted the importance of contextualised learning as critical in their development of ethical practice skills. Practicum experiences allowed the flagging of dilemmas by field educators. Students also benefited from scaffolding provided by tools such as the ethical decision making framework as well as scaffolding provided by their educators. Students also identified the demonstration of a field educator's ethical reasoning during reflection on a case as of vital importance for their learning. Students acknowledged too, that they do not come to university as a blank slate, but

rather add professional knowledge, skills and attitudes to existing life experiences,

and that these very life experiences in turn may influence both their readiness and

ability to learn and integrate their learning of professional ethical practice.

6 EDUCATOR PARTICIPANTS

6.1 Introduction

6.1.1 Introduction to the Chapter

In the preceding two chapters results of students' data on their learning readiness
for professional ethical practice and their ability to demonstrate competence in the
area were presented and discussed. Students described teaching strategies and
personal and professional resources that supported and facilitated their learning of
professional ethical practice. This chapter presents the perspective of academic and
field educators on the teaching of professional ethical practice. It also discusses the
educators' perceptions of the personal and professional resources available to
students to support their practice. The results of the educator interviews are
discussed in the context of the literature on university teaching and the teaching of
ethical practice.

Initially, the results of the academic staff interviews (which explored how
academics believe they have addressed the teaching of professional ethical practice
to this cohort of students) are presented. The subsequent section presents and
discusses the results from the field educator interviews. It also presents the field
educators' views on the resources students bring to the practicum with regards to
professional ethical practice. The field educators identify the opportunities during
the placement which they used to develop students' knowledge, skills and attitudes in
the area of professional ethical practice.

By exploring the academic and field educator structured and spontaneous

opportunities for teaching ethical practice[52], rich triangulation of the study data is achieved. It adds two other dimensions to students' views on how they had learnt professional ethical practice.

6.1.2 Ethical practice as a foundation competency for graduating speech pathology students

Ethics is a foundation subject in health science education in general (Fish & Cole, 1998; Fish & Twin, 1997; McAllister, 2001)and speech pathology curricula in particular (ASHA, 1993; McAllister, Kilminster, Brown, & Anderson, 2002). In an integrated curriculum the "…knowledge, skills and attitudes comprising professional competency are progressively developed through classroom, lab and clinical settings" (McAllister, 2001). Learning in the field facilitates the integration of a practice knowledge base introduced in the academic curriculum (Higgs, 1992). Field education opportunities are often great motivators for both deep and elaborated student learning (McAllister, 2001). The new COMPASS™[53] assessment tool includes ethical practice knowledge, skills and attitudes as part of the generic competency professional practice set and as sub sets of CBOS[54] related skill sets, perhaps reflecting both the task specific and generic nature of ethical practice (Speech Pathology Australia, 2006).

The examination of approaches used with this group of students to facilitate the development of their foundational ethical knowledge, ethical awareness, clinical reasoning skills (including ethical reasoning), communication and group work skills (ATEAM, 2001; Triezenberg & Davis, 2000) may provide insights into the effective

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[52] These spontaneous and structured teaching opportunities are described by this study as 'teaching moments'.

[53] The Speech Pathology Australia produced student assessment tool for use across courses Australia wide. (See Section 2.3.4 for a more detailed description)

[54] CBOS is the document detailing the competency based occupational standards for speech pathologists entering the profession in Australia.

learning strategies for the development of critical attitudes and values required for professional ethical practice (Speech Pathology Australia, 2000; Triezenberg & Davis, 2000). The importance of practicum experiences for facilitation of students' integration of theory and practice and for the provision of further opportunities to develop ethical practice skills such as communication and the ability to reflect on ethical dilemmas will also be investigated.

Academic and field educators in this study were asked to identify how they addressed the teaching of professional ethical practice. In short, what they taught and how they taught it. They were also asked to comment on whether they employed particular strategies to teach ethics and to comment on whether these strategies were explicit or implicit.

6.2 Academic Educator Participants

This section will discuss the results of interviews with the academic educators by providing: the background to the experiences they brought to the task of ethics education; how educators feel they facilitated the development of students' knowledge, skills and attitudes of ethical practice; the particular strategies educators used and how they assessed students in this key curriculum area.

6.2.1 Introduction to the Academic Educator participants

6.2.1.1 Una

At the time of interview Una had been working as a university educator for at least ten years. Prior to working at Flinders University, she had experience as a field educator. Her two major areas of teaching were Issues in Professional Practice[55],

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[55] Issues in Professional Practice is the topic stream which addresses introduction to the profession, professional skills and processes, quality assurance, community education, counselling, ethics and workforce preparation. It also includes time to brief and debrief students with regards to any practicum observations or placements.

where she taught across all four years of the course, and an area of clinical expertise. She also provided practicum placements to groups of students in third and fourth year in her area of speciality. She also conducted and supervised research in her area of speciality.

6.2.1.2 Unwin

Unwin had been teaching at Flinders University for seven years at the time of the interview. He taught a large first year theoretical topic and team-taught Issues in Professional Practice in second and sometimes third year. He also provided third year practicum placements and supervised honours and post-graduate research students. Prior to working at the University he had been a field educator and research advisor.

6.2.1.3 Ursula

Ursula had been working for over twelve years at Flinders University at the time of interview. She taught clinical topics across the second and third years of the course. She also provided practicum placements in both paediatric and adult clinics. Prior to working at the University she had been employed to provide practicum placements in the field. She has also been involved in research into student learning.

6.2.2 Teaching an Ethical Knowledge Base

The academic educators indicated that they conveyed pertinent ethical practice knowledge in both explicit and implicit ways. Areas of professional ethics that they reported teaching explicitly included treatment efficacy, confidentiality, joint decision making, client centred practice, relevant legislation, and professional codes of ethics:

> "…I dedicate time to looking at um, the clinician being able
>
> to demonstrate clearly the efficacy of their treatment. And

I think that's part of the ethics of working with clients."

(Ursula Individual Academic Interview Lines 84-87)

"…We do address the basic…Some of the basic ethical

principles about you know being honest with your client.

And um the clients needs come first…Confidentiality. They

are explicitly addressed." (Unwin Individual Academic

Interview Lines 105-108)

"And we do things like go through the professional

association's code of ethics. We discuss the implications

for students. We go through the health commission's pack

Patients' Rights Charter." (Una, Individual Academic

Interview Lines 87-90)

Another area of ethical knowledge observed by the researcher as being explicitly

taught by academic staff (as part of the subject IPP3) included ethical principles

(based on the Beauchamp and Childress's 1994 model as described and illustrated in

Mitchell, Kerridge and Lovatt (1996)). Students participated in two compulsory

workshops which had the goal of explicitly teaching and applying these principles.

Implicit teaching also occurred. Key areas of ethical knowledge described by

academic participants as being taught included ethical principles (autonomy, client's

rights, justice, and beneficence, i.e., doing good), ethics of care (modelling concern

for clients), and narrative ethics, for example, considering the person holistically

including familial, social, and economic factors.

So I do try and do it by modelling. And by showing my

concern for clients.   And giving my view as people as a

whole - not just a "disorder," i.e., the need to consider the

person in their context…And also I guess my background,

from some family therapy training, makes me more overt

about the person in the family or the person in the context

than perhaps some other people might be. And so I guess

that's implicit. (Una Individual Academic Interview Lines

75-82)

Specific virtues, for example honesty, trust, respect, were mentioned often by the academic participants. (See Section 6.2.4 for further detail.) They did not however link these individual virtues with the theory of virtue ethics (as described in Section 2.2.2.1).

So whilst aspects of these approaches to ethical practice were reported as being taught explicitly, the underlying ethical model to which they related did not necessarily appear to be labelled and made explicit. In other words, it was not placed in the context of a particular theoretical ethical approach to professional practice. This was particularly so with regards to aspects of narrative and virtue ethics which appeared highly valued by academic staff but were not necessarily linked to an underlying theoretical approach. The lack of explicit identification of ethical theories underlying approaches to ethical practice by academic staff may have an impact on students having the theoretical background and vocabulary to identify and explain their approach to ethical practice.

6.2.3 Teaching Ethical Practice Skills

Overwhelmingly academic staff placed great emphasis on the development of student's reflective practice skills. Staff explicitly provided opportunities for students to reflect on ethical dilemmas; for example, through providing case discussions, in clinical core subjects, and during the professional practice streams:

At times I have posed dilemmas and used group work. To

have students discuss those issues. For instance, one of the

things I've done is to do some role play. To create a couple

of decisions requiring, that are ethical dilemmas, there's no

right response…and had students take different roles…Of

the care-giver and the client, the doctor, the nurse, the

lawyer those sort of things. So I've structured triggers to

bring those feelings and thoughts to the surface. And reflect

upon them. So I've given them some meat. As the basis for

reflection. (Ursula Individual Academic Interview Lines

309-325)

Academics also stressed the importance of teaching skills integral to ethical

practice, for example, people skills, co-operative learning, acknowledging

contributions of others, group work skills and collaborative action skills. Unwin

reported that often these skills were developed in topics outside the professional

practice stream and were often not explicitly linked to their importance in

professional practice in general and ethical practice in particular.

6.2.4 Teaching Ethical Attitudes

All three academic staff most frequently mentioned the attitude of respect as the

ethical attitude they taught students. The notion of a respectful attitude took many

forms: respect for peers, team members, clients, families; and, respect for students

themselves. For example when Unwin spoke of teaching ethics to second year

students in IPP2 he spoke about:

"So building up that sort of model of um, operating through

respect and trust.…"(Unwin individual Academic Interview

Line 99-101)

Ursula spoke of how she felt it was important to model respectful behaviour in all her interactions with students:

> And, and similarly I will very often ask a student's
>
> permission to use their written work…and then I include, if
>
> they don't mind I include their name on that assignment.
>
> You know acknowledge contributions by other people….
>
> So that is kind of implicit demonstration of ethics…Ethical
>
> behaviour…. (Ursula Individual Academic Interview Lines
>
> 130-148)

But like much of the teaching in the area of ethical practice, whilst the academic staff members were very conscious and intentional in the importance they placed on ethical practice, they were not necessarily explicit with students that these concepts, behaviours and attitudes were a fundamental part of being an ethical professional. As Una commented:

> I guess they do get covered in 1 [viz. IPP 1] in the sense that
>
> we do talk about professional behaviour, respect for clients
>
> and some of those issues that pertain to…But it is not
>
> explicitly under a banner that says ethics. (Una Individual
>
> Academic Interview Lines 51-53)

Other attitudes highlighted by the academic staff as being focused on by them in their teaching of ethical practice included having a client-centred approach, the importance of honesty in professional interactions, and professional behaviours such as courtesy.

6.2.5 Role of Assessment

Many university educators see assessment as a driver of student focus, and

therefore, by default, student learning; this may be particularly so in high content, high pressure courses such as speech pathology. It was consequently important to explore with academic educators how professional ethical practice was assessed for the cohort of students participating in this study.

6.2.5.1 Assessing knowledge

According to Una, the co-ordinator of IPP3, the topic in which ethical principles are taught, explicit assessment of the ethical principles taught in the course did not occur:

> "There is no direct assessment of the ethics component."
>
> (Una, Academic Staff Interview Line 106)

Unwin, who also taught in the Professional Practice Stream, felt that the knowledge base underpinning professional ethical practice was not explicitly assessed in his topic:

> …not directly. I think it is, again because I guess the ethics
> I'm involved with is in more orientation and practice...I
> guess. In terms of specific knowledge that you would want
> to test there is no obvious way. (Unwin Individual
> Academic Interview Lines 210-214)

6.2.5.2 Assessing Skills

Unwin felt that communication skills, relevant to professional practice including ethical practice, are formally assessed in IPP2.

> "…we assess their ability then to communicate that [i.e., the
> results] in a meaningful way." (Unwin Individual
> Academic interview Lines 217-218)

He also felt that group process skills, also an important aspect of ethical practice

were assessed by other academics during the course. He believed this explicit assessment was a useful way of highlighting the importance of the group process skills given to students, and felt that adopting this explicit assessment of these skills was something he would consider in the future:

> …And she [another member of staff] actually gets the
> students as a group to evaluate the group process. Actually
> it is part of the assessment um, process and ah that may be
> an area. I think there may be some value in that. I may go
> down that route as well…it is a way of making them take it
> seriously as an explicit thing to work on. (Unwin Individual
> Academic Interview Lines 267-272)

6.2.5.3 Assessing Attitudes

Unwin believes that empathy and compassion is assessed indirectly in IPP2 when discussing assessing students' ability to communicate and tailor that communication for another person:

> The closest indirect aspect of that, I think would be more in
> terms of their [i.e., the student's] willingness to take into
> account…or their perception, their ability to take into
> account the perspective of another person. (Unwin
> Individual Academic Interview Lines 220-222)

He also feels that ethical attitudes are easier to assess in the practicum setting:

> "So I have a sense of leaving it until they have actually
> begun their clinical practice and it is more a thing that can
> be evaluated as part of their [clinical] competence." (Unwin
> individual Academic Interview Lines 237-238)

Ursula feels that being able to demonstrate attitudes of professional responsibility and critical self appraisal through the ability to measure treatment efficacy is an important part of ethical practice that she assesses:

> I dedicate time to looking at um, the clinician being able to demonstrate clearly the efficacy of their treatment…And I think that's part of the ethics of working with clients…To see whether it is making an improvement, a contribution or not…

For example:

> in aphasia therapy…half the value of that topic [viz., assessment of that topic]…
>
> students have a case study and they show me how they would go about demonstrating efficacy. (Ursula Academic Individual Interview Lines 84-98)

6.2.5.4 Assessing overall professional ethical practice

From a curriculum standpoint, professional ethical practice may be indirectly assessed by the final IPP 4 assignment in which students are required to reflect on their professional development. If it occurred, this assessment would be indirect at best:

> In the fourth year IPP topic it is not directly assessed but it does partially come into the assessment. In the assessment that the students do which is a reflection on their development as a professional…While it is not explicit I have known students to comment on issues, which sort of reflect their sort of ethical dilemmas…And how that helped their or changed them…But not all students do. And it is

not something I require them to do. (Una , Academic Staff

Interview Lines 108-118)

From a field practice perspective it was somewhat unclear as to whether ethical

practice per se was assessed explicitly by the academic staff:

> I guess in the clinical context I would again not…well I
>
> guess it is explicit…if students breached what I consider to
>
> be appropriate professional ethics they certainly wouldn't be
>
> passing and so…And they would know it straight
>
> away…there is a separate section in the clinical protocols
>
> for the professional behaviour…yes I guess.… (Una,
>
> Individual Academic Interview Line 118-126)

6.2.6 Teaching strategies employed

Of interest was the embedding throughout the course of the teaching of ethical

practice by the three academic staff. An integrated ethics curriculum is certainly

presented by the ATEAM (2001) as a solution to pressure on curriculum time for

teaching ethical practice in its broadest sense.   From the interviews of the academic

staff it was very clear that they were intentional in their teaching of the knowledge,

skills, and attitudes required for professional ethical practice. What was less

apparent however was making the link for students that the activities they reported as

facilitating learning ethical practice had this intent (for example using co-operative

learning groups to teach respect and collaborative action). Myser et al., (1995)

highlight the importance of linking ethical knowledge with its practical application

for students.

Similarly, academic staff clearly were intentional about modelling ethical

practice and building it into the curriculum. Modelling is highlighted by many

authors as a powerful way of promoting ethical behaviour (ATEAM, 2001; Cloonan et al., 1999; Evans & Macnuaghton, 2004; Thornton et al., 1993). However, the academic staff interviewed did not report making the links between their modelling and the theoretical ethical underpinnings of their actions explicit to students.

It is interesting to note however that the students' ability to demonstrate the skills and attitudes relevant to ethical practice, such as communication and joint decision making, were their areas of relative strength in their case study results. This perhaps reflects the effectiveness of the holistic embedding of the teaching of these skills throughout the academic curriculum. Certainly Rohwer and Sloane (1994) suggest the deepest most integrated learning occurs when multiple forms of learning are provided particularly opportunities for students to apply learning in the real world. For the purposes of external curriculum review[56] and competency based assessment (such as the COMPASS™) it might be useful to make explicit the links between skills taught and their relevance to ethical practice both for students and external organisations.

Academic staff reported employing many other strategies to engage students in learning ethical practice. Strategies included using real life examples and clinical experiences. Leget (2004) suggests that this will facilitate emotional engagement and thus learning in ethics. Another strategy used was providing opportunities for students to reflect on personal experiences of ethical dilemmas. Schön (1984) suggest that reflection on practice is helpful for student learning particularly in the "grey" areas of practice of which ethical practice could certainly be considered. Academic staff also spoke of assisting students to use a framework for ethical

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[56] For an Australian speech pathology course to be accredited with Speech Pathology Australia formal curriculum reviews are conducted every five years.

decision making. Using a decision making framework is an ethics teaching strategy supported by Purtillo (1993). Ursula described role play as a way of engaging students with their emotions around ethical dilemmas. Role play as a strategy for engaging student moral imaginations was discussed by Hay (1998). Thus, clearly the teaching strategies described by the participating academics link well to the current literature on facilitating student learning of ethical practice highlighted in Chapter 2.

There were teaching strategies outlined in Chapter 2 which appeared to receive less emphasis by the academic educators. One of these was the strategy of consistently making the links to ethical practice explicit through out their teaching. Brown, et al., (1998) certainly emphasised the benefits of making explicit links. Classroom opportunities for students to explicitly practise ethical reasoning beyond the application of Beauchamp and Childress's ethical principles appears to have been limited. Higgs (1997) suggests that opportunities to practice reasoning skills in the classroom can be a safe way of exploring options without negatively impacting on a client or clinical situation. Provision of guides to support ethical reasoning such as those discussed by Myser et al., (1995) or Purtillo (1993) were not provided to students by academic educators early in their ethical practice formation. Use of additional teaching strategies by academic staff may further support students' development of ethical practice.

6.3 Field educator participants

It is not only academics who influence student learning. Field educators have a key role in educating students for professional practice. Field educators were therefore interviewed to provide a third perspective on both teaching strategies to facilitate student learning and student competence in the area of professional ethical practice.

6.3.1 Introduction to the field educator participants

6.3.1.1 Fiona

Fiona's employment focus

Fiona worked with a paediatric population in a community health setting. She was one of two Speech Pathologists in her workplace. Community Health Centres work under a specified philosophy of a social view of health[57] that determines the population eligible for services in addition to the service delivery model. The model used is a primary health model[58] which means Fiona and her students are involved in health promotion and health prevention activities with other professionals in the centre, and the predominant service delivery is not one-on-one clinical services. As a senior speech pathologist she provides a practicum placement to a pair of the students.

Common ethical dilemmas encountered by Fiona in her work place

Fiona identified a huge range of potential ethical practice concerns in her day-to-day work. Some of these struggles called on her ethical practice knowledge and ethical reasoning, and application of ethical principles. As examples:

1. Whether people who have private health cover, and could access private services should be offered services through their centre, in other words choosing to do the most good to the most needy versus equitable access to all versus generic need for more resourcing;

2. Respecting autonomy, by avoiding paternalism, when parents truly believe their child does not need services and will grow out of their difficulty;

3. Maintaining confidentiality of client information when providing referral information to other health service providers.

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[57] This social view of health addresses issues such as socioeconomic status when addressing health and disability.

[58] As described in the Ottawa Charter.

Many of the situations she described illustrated professional ethical practice attitudes. As examples:

1. Doing the right thing by referring the child to the appropriate service when they have been inappropriately referred to her service, even though parents may perceive this as their being fobbed off. In her opinion this is important for the practice of ethical attitudes of honesty and integrity;

2. When suggesting parents seek private services, providing guidance to families about the type of service required to empower them in their decision making about the best practioner for their child, without favouring a particular private provider. For Fiona this is an important approach for maintaining ethical integrity in her practice;

3. Not providing services, for example complex counselling, that she did not feel qualified to provide. Demonstrating an attitude of critical self appraisal;

4. Being committed to life-long learning by maintaining a current knowledge base.

<u>Fiona's ethics education background</u>

Fiona could not recall any formal ethics education within her course curricula. She felt she had learned ethical practice during placements and on the job. She thought issues such as the need for confidentiality were discussed explicitly by academic staff. She also recalled that much of what was expected with regards to ethical behaviour was either:

> "…discussed explicitly or implicitly displayed by
>
> supervisors." (Fiona Field Educator Interview Line 120)

6.3.1.2 Faye

<u>Faye's employment focus</u>

Faye worked for the state education system in preschools with 3-5 years old

children and the staff who worked with them. Although direct clinical services were provided, a major focus of her work was training and development of staff to work with children with communication disorders. The service philosophy was based on improving children's ability to access the curriculum. She also worked with families where-ever possible. She had one final placement student.

Common ethical dilemmas encountered by Faye in her work place

Faye felt confidentiality was a significant ethical issue for her because both teachers and families were her clients. Another area of ethical challenge identified by Faye was disclosing the severity of the diagnosis to parents. Ethically she felt that she needed to be honest but she was concerned about the resources available to care and help parents work through the implications of the diagnosis. Having previously worked in community health Faye felt her present organisation had much less influence on her own ethical development.

Faye's ethics education background

During her own education as a speech pathologist Faye felt she had limited formal teaching in the area of professional ethical practice:

> We had one - I think it was one lecture on it…So it was um
> in fourth year and it was part of…I have no idea of what
> topic it was. But it was sort of, sort of one thing but you
> actually had to do an assignment around ethics…Like pick a
> particular part of the code of ethics and do some assignment
> on it.   But yeah my memory's not great as to what I did or
> what it was about. (Faye Individual Field Educator
> Interview Lines 65-71)

6.3.1.3 Flora

<u>Flora's employment focus</u>

Flora worked for an organisation based in regions providing intensive, regular and consultative services to children and young people with a primary diagnosis of a physical disability. The organisation had adopted a family-centered[59] approach to service delivery. Flora also works in an intensive program for young children with significant speech and language disabilities. She shared supervision of a fourth year student with a colleague during the data collection period.

<u>Common ethical dilemmas encountered by Flora in her workplace</u>

Flora felt she often had to decide between doing no harm and respecting patient or client autonomy. One example she gave was when her assessments indicated current feeding techniques were putting a child's airway at risk, but at the same time she believed she needed to respect a parent's right to decide how they fed the child. Flora also felt that prescriptions of alternative communication devices could reveal ethical dilemmas. Parents often requested inappropriate and expensive high-tech devices that their child could not use and this prevented both the appropriate prescription (doing good) and diminished the pool of equipment resource funding available to other clients (justice). Professional integrity was also often an ethical challenge for Flora when parents insisted they wanted their child's therapy to focus on talking when in reality they would only have limited if any verbal communication. Flora's professional recommendation would be to facilitate the child's communication with an alternative device.

<u>Flora's ethics education background</u>

Flora recalls having an hour or two of lectures in her final week of university on

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[59] Family centred approach as described by Flora means the service is there to work on what the family identifies as its primary need and input is designed to be able to be carried out by the significant others (including other paid services) in the child's life.

ethics. She recalled a lawyer also coming to speak to them at that time. Importantly, Flora recalls that ethical training also occurred in her student placements, particularly during weekly group tutorials with other students on acute adult placements:

> "So sort of formally I think it was only maybe really that
>
> sort of last week (at University), but more informally
>
> through discussion groups it was within the placements."
>
> (Flora Individual Field Educator Interview Line 228-229)

It was significant that Flora felt her learning of ethical practice during the placement was much more relevant as:

> "You had the issues there. And you know you had to deal
>
> with them then…." (Flora Individual Filed Educator
>
> Interview Lines 233-235)

6.3.1.4 Frances

<u>Frances's employment focus</u>

Frances worked in an acute teaching hospital with adult clients, providing inpatient services. She provided placement to a pair of students during the data collection period.

<u>Common ethical dilemmas encountered in Frances's workplace</u>

Frances had a very holistic view of her professional ethical practice. She identified many aspects of her practice involving ethical decisions. These included: prioritisation of patients; management decisions concerning the Department and its impact on others (e.g., acting as a patient advocate against management decisions); maintaining balance as a field educator between the patient's and student's best interests; and, respecting patient autonomy around feeding decisions yet balancing this with the need to do no harm.

<u>Frances's ethics education background</u>

Frances remembers being taught about keeping records confidential and "stuff like that" at some time during the second year of her course. She recalled no other teaching of ethics.

6.3.1.5 Fabrina
<u>Fabrina's employment focus</u>

Fabrina worked in a rural setting and was responsible for a rural and remote caseload of adult and paediatric inpatients and outpatients. Despite being a hospital based service they work from a community health or primary health philosophy, with a parent and family focus. During the data collection period two students were offered placements but only one student was placed with Fabrina.

<u>Common ethical issues in Fabrina's workplace</u>

Working in small communities Fabrina felt maintaining client confidentiality was a significant part of her professional ethical behaviour both within and outside work. She also felt courtesy and respect were important ethical attitudes relevant particularly to adult practice in her setting. Consent to information release was also a fundamental issue. Respecting patient autonomy when planning treatment was another area identified.

<u>Fabrina's ethics education background</u>

Fabrina could not recall any teaching on ethics during her undergraduate education.

6.3.1.6 Conclusion

The field educators represented a range of organisations and client populations served. All Field Educators identified a range of areas relevant to professional ethical practice arising in their particular workplace. Without exception these involved using ethical reasoning skills, attitudes and, at least at a subconscious level,

a knowledge of some ethical principals and approaches to practise. None made an explicit link to ethical theories in their discussion.

Of great interest was the limited formal ethics teaching they recalled during their own undergraduate education. This appears not only restricted to speech pathologists. Nicholas and Gillett suggest few senior doctors have had formal ethics education (Nicholas & Gillett, 1997). Only two of the five field educators mentioned their own ethics learning being influenced by their practicum experiences. This is in direct contrast to the students identification of practicum experiences as a powerful influence on their learning of professional ethical practice.

6.3.2 Ethical teaching moments during the most recent practicum placement

Fiona recalled no situations arising during the placement causing ethical dilemmas or distress for the students with whom she was involved. She did use the discussion of specific cases with students to highlight how her organisation's philosophy would influence how the case was approached. She also commented that the pair of students was very good at reflecting together and she may not have been aware of all situations that might have arisen.

Faye similarly felt her teaching of ethical practice had been somewhat ad hoc. After initial discussions with her student around confidentiality, other aspects of ethical practice were discussed when relevant to particular cases. She expanded on this to include discussions she and her student had about access to services and equity to access. Of particular interest was Faye's reported discussion with her student around professional self care as an aspect of ethical practice. One had a sense however, of Faye protecting her student from situations where she would be required to make ethical decisions independently:

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She didn't take a huge I guess role as far as decision making

in some of it. But, she was still part of it, observing a lot of

the process that was still happening. And just to get a feel

for how things actually do work. In the real life. (Faye

Individual Field Educator Interview Lines 344-347)

Flora felt most of her discussion of ethical practice was in the context of generic discussions of client management. She felt she did not explicitly discuss ethical decisions, but felt they were implicit in generic clinical discussions:

…I don't think I ever sat down specifically with [student's

name]…and said these are the ethical dilemmas or decisions

that you need to make. But certainly on describing and

informing her about the clients within the program, I think it

certainly was brought up from within each individual client

what ethical decisions that you may need to make…rather

than OK now I'm going to talk about the ethical information,

decisions that you may need to make. (Flora Individual

Field Educator Interview Line 498-514)

Fabrina reported similar experiences of implicit discussions around ethical decision making:

"Yes so I guess ethics were implied in clinical practice

rather than through explicit discussions." (Fabrina

Individual Field Educator Interview Line 191-192)

However she went on to recall a key teaching moment with an in-patient who refused active treatment. She worked through the issue:

…by talking the issues through with the student. Bringing

up issues to do with autonomy and working with a client.

The whole issue of respecting the patient's right to refuse
and learning to accept that. (Fabrina Individual Field
Educator Interview Lines 216-233)

Frances reported teaching explicitly about issues of confidentiality at the beginning of the student placements and following this up wherever necessary throughout the placement. She also identified several situations where ethical issues around the importance of respecting clients, the client's right to die when palliative, and the difference between comfort care and doing harm. She felt she had to revisit the scenario over several weeks with one particular student whose emotional response to the situation was very strong.

It is interesting to note that these field educators recalled limited explicit teaching in the area of professional ethical practice, except where it came to confidentiality. Likewise, they generally appeared to find it challenging to make their teaching of ethics explicit except around confidentiality. Despite identifying many areas of ethical challenge in their workplaces most of the ethical teaching appeared to occur implicitly as part of generic clinical decision making. This pattern of implicit teaching may explain why many of the student participants found it hard to identify ethical issues explicitly in their case studies.

6.3.3 Field educators' assessment of the resources students brought to the placement to facilitate their development of professional ethical practice

Four out of the five field educators felt that students were personally prepared for ethical practice. However, Frances felt that one of her students in particular did not have the emotional resources to deal with the dilemmas he faced. She also commented that both her students lacked both clinical and life experience to deal with the situations with which they were confronted.

Several field educators were less clear as to whether the students had the academic competence to deal with the ethical situations in which they found themselves. Indeed, Frances commented that she felt her students:

> "…didn't behave as if they had never heard of medical ethics..." (Frances Individual Field Educator Interview Line 284)

She felt that they didn't have the resources to deal with the issues they faced. Fabrina was not sure that her students accessed the academic knowledge in the area of professional ethics that they had. Faye felt for example that her student needed assistance understanding the implications of professional respect; her student found it difficult to draw the line between personal opinion and professional respect when other team members were commenting on one another.

Both Faye and Flora felt their students exhibited important ethical attitudes like a commitment to lifelong learning, knowing professional boundaries and asking for help. Fiona felt her student's ethical competence was reflected in her practice. Several field educators spoke of their expectation that students coming to placement would already possess an intrinsic ethical awareness or have learned knowledge of ethical behaviour before arriving:

> "I think though that supervisors generally assume [stress added to assume], that students are turning up, with a belief in ethical behaviour." (Fiona Individual Field Educator Interview Lines 122-123)

> "I also think speech paths come to the job with certain foundation traits that account for why the person chose this profession in the first place….Generic traits like

professional caring." (Fabrina Individual Field Educator Interview Lines 153-154)

"…and I had assumed that they would be provided with the latest ethics document as part of their Issues in Professional Practice." (Fiona Individual Field Educator Interview Line 529-530)

In summary, it appears that most of the field educators interviewed believed that students came to a placement with solid foundational knowledge, skills and attitudes for ethical practice.

6.3.4 Teaching strategies employed by field educators to facilitate the development of professional ethical practice.

As with the academic educators, modelling of ethical practice was viewed as an important teaching tool. Lincoln et al., (1997) and Harper-Simpson (1979) support this as a legitimate method of developing a professional role including that of an ethical professional. Both Fiona and Faye described situations where they as clinicians had faced ethical dilemmas during the placement and had explicitly discussed their decisions and actions with their student as a model for how to approach similar situations in the future:

I was having some ethical dilemmas…She [the student] wasn't involved with the client but she was aware. So I would often talk to her about issues.... So um I guess it was almost a case study that she could see and have a look at ways of dealing with that sort of issue….And I sort of filled her in with what happened with all of that and so…she kind of got the idea of it all. (Faye Individual Field Educator Interview Lines 179-203)

The explicit modelling, teaching and debriefing described by Fiona and Faye also may act as an antidote to the contention that modelling could be viewed simply as professional socialisation (McAllister et al, 1997) and promote conscious assimilation of students into an ethical professional culture (ATEAM, 2001).

Case discussions and reflections as a strategy have been discussed in the previous section 6.2.6 and were also highlighted as teaching strategies by field educators. The ATEAM (2001) support the use of clinical situations as opportunities for discussions and debriefings about ethics and even go as far as suggesting ethics may be learnt most effectively when students are faced with real life ethical practice.

As part of the case discussion the field educators described providing examples of their reasoning in the situation to assist the development of the student's ethical reasoning:

> "So I explained with them the process that I went
> through…guess I was able to explicitly explain the steps
> that I followed for that parent. And why I had made those
> decisions." (Fiona Individual Field Educator Interview
> Lines 480-493)

Titchen and Higgs (1995) and Myser et al, (1995) support the contention that ethical reasoning is a critical skill for those providing clinical care. These field educators overwhelmingly favoured a strategy involving case discussions and reflections on real life situations arising during placement, for the development of ethical practice in their students. This is not a surprising result, given that many of the educators felt they had learned their ethical practice skills during practicum or work experiences. Limited examples of intentional teaching in the area of ethical practice were highlighted by the field educators.

6.3.4.1 Conclusion

Unlike their academic counterparts field educators appeared much less intentional in their teaching of professional ethical practice. Like the academic educators they did not focus on making explicit to the students their ethical teaching. Even explicit assessment of students' ethical practice in the practicum at that time was limited. Only one item pertaining explicitly to ethical practice occurred on the assessment form and it was a binary score; either ethical practice was present or absent. Whether the intentionality of teaching will change with the introduction of new approaches to teaching and assessing ethical practice (such as the new Speech Pathology Australia Code of Ethics, Ethics Education package and COMPASS™ assessment package) only future research will demonstrate.

6.3.5 What do educators say about learning professional ethical practice?

Speech Pathology educators in this study appear aware of the power of reflection on practice as a learning tool. This is consistent with the literature on learning in speech pathology (McAllister, Lincoln, McLeod, & Maloney, 1997). The effectiveness of reflection in facilitating learning in the "grey area"[60] of ethical practice can not be overestimated. The explicit and implicit teaching strategies most often utilised across the academic and practicum curricula encompassed reflection on ethical situations and case discussions. Students acknowledged this as significantly influencing both their academic and practicum learning of ethical practice. It is worth considering too, whether educators could further enhance explicit learning of ethical practice through reflection by incorporating tools such as ethical decision making frameworks (McAllister et al., 2002; Purtillo, 1993). These incorporate

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[60] See discussions of Schön (Schön, 1983, 1987) in the literature review

prompts for considering the theoretical underpinnings of a particular ethical situation thus helping students explicitly make the link between theory and practice.

Resnick (1993) suggests that " the formal teaching of professional ethics remains underemphasized" and as a result many educators (including field educators) would not have had formal theoretical training in ethics. This lack of formal teaching was particularly apparent around areas of theoretical ethics including a biomedical principles approach, narrative ethics and ethics of care.

A low level of ethical education was certainly reported by field educators who participated in this study. Therefore, this may require intentional up-skilling in the area of professional ethical practice by the profession as a whole. The up-skilling of field educators should be a priority. This need for further ethical education has certainly been recognised by other health professions (Martinez, 2002). Formal ethics courses for multidisciplinary clinical staff have been described as one solution (Malek et al, 2000). Improving the theoretical knowledge base of all speech pathology educators with regards to professional ethics may assist the process of linking theory and practice more closely. As AASH 1994 suggest: "…principles of ethics can and must be taught with the same rigour that we would use to teach scientific method" (cited in Pannbacker, Middleton, & Lass, 1994).

Modelling ethical behaviour was identified as an important teaching tool by educators and as a learning tool by students. To take modelling beyond simple professional socialisation (Best & Rose, 1996) it is important for educators to explicitly discuss the knowledge, skill or attitude they are trying to explicate for students through the model. This may also assist students to be conscious of the intended key learning rather than making their own interpretation of the learning goal. The following example illustrates how educators identified modelling a theoretical

approach to ethics. Students identified learning from the educator's modelling but were unable to link the learning to a theoretical approach to ethics.

Both academic staff and field educators emphasised the importance of care in a way that is consistent with an extended ethic of care approach (Catchpoole, 2001; Gilligan, 1982; Gilligan & Pollak, 1988). Both academics and field educators appeared to approach this area of ethics education implicitly through modelling concerns for clients and students. Students acknowledged the power of observing their educators' demonstration of concern for clients and themselves. However, they were not able to link it theoretically to an ethic of care. Some authors may view this modelling of care as "professional socialisation" (Best and Rose, 1996). By articulating an ethic of care as a legitimate approach to ethical practice, educators can provide an explanation with their modelling and a structure for student observations. In this way, educators may make explicit the theoretical underpinnings for an ethic of care and legitimise this critical approach to ethical practice.

Similarly, many students and field educators recalled being taught about confidentiality and students recalled having it modelled by both academic and field educators. Neither the students, nor the field educators appeared to make the link between confidentiality and its theoretical underpinnings of the principle of autonomy from a principles approach to ethical practice (Beauchamp and Childress, 1994). Again, by making the link between theory and practice explicit, educators may provide a theoretical context for student learning, rather than students simply assuming from a socialisation model, that the profession of speech pathology values confidentiality.

In reflecting on the three domains of learning underpinning the ethical competence of health professionals (knowledge, skills and attitudes) this researcher

contends that the area of ethical attitudes appears least tangible and therefore the most difficult to teach. Yet the students participating in this project appeared to display well developed ethical attitudes to practice. Perhaps this sits well with comments by several authors (Best & Rose, 1996; McAllister et al., 1997) as to the important role of modelling respect, dignity in the development of most speech pathology students. These may be characteristic traits that even those educators without formal ethics training may display to students in their everyday practice. For as Koppelman (1999) suggests, students "…learn to be humane clinicians from their faculty" (p.1310).

6.3.6 Conclusions

This chapter has considered student learning of professional ethical practice from the educators' perspective. Academic and field educators are involved in and responsible for ensuring students are competent for practice as a speech pathologist. Educators were interviewed to understand how they contributed to students' learning in the area of ethical practice.

Academic staff described intentional teaching of foundational knowledge for ethical practice. They undertook this teaching explicitly and implicitly throughout the course. The research results suggested however, that they were often not explicitly teaching the underlying model or theory of ethical practice. Generic skills underpinning ethical practice were taught both within and outside professional practice streams by academic staff. They did report that in all their teaching they addressed specific skills such as ethical awareness and ethical reasoning. Academic staff also reported a key strategy of modelling attitudes for ethical practice throughout the course.

Academic staff assessed students in both the academic and practicum streams of

the course. Ethical practice skills and attitudes were formally assessed in the professional practice and clinical subject streams, and the practicum. However, academic staff did not assess the students' ethical knowledge base in any stream.

These results are interesting to consider in relation to student competency. Students exhibited greater competency in generic ethical practice skills and attitudes than they did in specific skills such as ethical awareness and ethical reasoning. The question needs to be asked: does the lack of assessment of ethical knowledge influence students' integration of ethical knowledge theory and thus ethical awareness in clinical situations? Many authors highlight how assessment may act as a driver for learning (ATEAM, 2001). An alternative question is: given that ethical practice skills and attitudes are embedded in academic and clinical subjects and the practicum throughout the course does this facilitate deep learning and student mastery? Certainly Best & Rose (1996) and Higgs (1992) would suggest integrated teaching does assist students' development of deeper learning.

Whilst few of the field educators could recall formal teaching in the area of ethical practice all were able to demonstrate both ethical awareness and ethical reasoning. These demonstrations did lack explicit reference to ethical theory. Although field educators recognised that students may have lacked an ethical knowledge base, they reported providing only limited specific teaching moments in this area. Certainly the data suggests that many of the students probably did not have an integrated ethical knowledge base! Importantly however, the field educators did indicate that in general students came to placements with the necessary personal prerequisites to learn ethical practice. In general, field educators appeared less intentional in their teaching of ethical practice, taking a somewhat implicitly pragmatic approach using strategies such as modelling, case discussion and reflection.

Students however identified placements as a key place for learning professional

ethical practice.

7 SUMMARY, CONCLUSIONS AND IMPLICATIONS

7.1 Introduction

The catalyst for this study was the observation of a critical incident involving a clinically competent final year, final placement student who was confronted by what I would consider to be a common practice situation in which ethical decisions needed to be made. The student was immobilised by the case. She was unable to demonstrate the ethical practice knowledge or skills required to formulate and implement a plan of action to resolve the dilemma.

In response to this situation I, as field educator employed by Flinders University, wanted to explore how student speech pathologists attending that university were learning professional ethical practice. I wanted to discover what factors (developmental, personal and educational) may have influenced their learning. I also wanted to gain some insights into students' competence in the area of ethical practice; I wanted some measure of the effectiveness of their learning. Thus this research project was conceived, designed, and implemented in the hope that the research might better inform and facilitate student learning in this fundamental area of practice.

7.2 Thesis summary

This thesis is an exploration of how student speech pathologists at Flinders University at the end of the twentieth century were learning the knowledge, skills and attitudes necessary for ethical practice. In the first chapter, the concept of professional ethical practice and its importance to the practice of health professionals in general and speech pathologists in particular was introduced.

The second chapter provided a review of the literature on the teaching and learning of ethical practice in the health professions and how this related to speech pathology students. The questions posed in this thesis were also outlined. Chapter three outlined the qualitative research process used, including the theoretical underpinnings, the study design and the methods used to obtain and analyse data. In chapter four I present and discuss the student data obtained from learning readiness assessments. Throughout chapter five student data relating to the effectiveness of their learning is discussed. Chapter six examines educators' perspectives on their own teaching and students' learning. This last chapter provides a brief summary of the thesis. It then presents the key conclusions from the study. The implications these conclusions may have for both the teaching of ethics to health students, and for further research, are also discussed briefly.

7.2.1 How the literature provides insights into teaching and learning principles related to ethical practice

In the literature review, medical, nursing, and allied health discourses were reviewed in order to understand what is actually meant by professional ethical practice. How this understanding of ethical practice is translated into goals for health professional students to learn and master was also examined. The literature on the teaching and learning as it might apply to professional ethical practice was reviewed from two perspectives: student readiness to learn, and how teaching and learning principles can be applied to ensure effective learning. The literature review made explicit some key generic learning and teaching considerations which when applied have the potential to increase the effectiveness of student learning in the area of professional ethical practice. These key factors include: cognitive development; motivation for learning; utilisation of adult learning approaches to foster deep learning; development of ethical reasoning skills; reflection on practice and

modelling of ethical attitudes and behaviours.

7.2.2 Understanding the research process

The question of how to increase the effectiveness of learning and teaching of professional ethical practice specifically is as yet relatively unreported. Qualitative research methods were chosen to open up this new area of study.

The research process chapter (chapter three) provided information about the factors which influenced the choice of research paradigm used to investigate the questions posed by this study. Potential biases were also discussed. The second half of the chapter described in detail the actual data collection and analytical methods used to conduct the study.

7.2.3 Factors influencing student readiness to learn ethical practice

The combined results and discussion chapter reported and discussed the data pertaining to factors which may have influenced students' capacity to benefit from teaching in the area of professional ethical practice. Information related to students' cognitive development in the area of moral reasoning, and factors effecting their motivations for learning, were provided.

The results clearly indicated that educators in the area of professional ethical practice need to consider the impact of key pedagogical, learning readiness factors on student learning. Individual student learning readiness, in terms of their cognitive development of moral judgement, appears to influence self reported approaches to ethical issues. Student results illustrated how motivation for learning was influenced by emotional engagement and exposure to real life, practicum experiences.

7.2.4 Effectiveness of student learning

A second results and discussion chapter considered student data in relation to the

effectiveness of student learning in the area of ethical practice. A content analysis of course outline documents was used to provide evidence of the formal, written curriculum relevant to ethical practice experienced by students participating in this study. Next, results from the students' written case study completed both independently and with the ethical decision making framework plus data from focus group and individual interviews, were used to illustrate student mastery of curriculum goals related to ethical practice. The results were also considered with regards to current professional expectations for competent, entry level speech pathologists. Finally, students' insights into factors they felt personally had influenced their effective learning of professional ethical practice were reported.

In terms of results, students demonstrated limited mastery of ethical reasoning through the case study assessments and in the stories of managing ethical dilemmas told by core group students. Almost a third of all the students were unaware that there even was an ethical issue at stake without a written prompt being provided in the case study. These results demonstrated perhaps the limited effectiveness of student learning of the ethical practice knowledge base. In contrast to these results, generic professional skills relevant to ethical practice (such as collaborative action) were demonstrated more fully by students. Students were also, thankfully, able to demonstrate a range of attitudes and values essential for ethical practice.

Students highlighted the importance contextualised learning had in their development of ethical practice skills. Students acknowledged that they did not come to university as a blank slate, but rather that the professional knowledge, skills and attitudes of professional ethical practice were overlayed on life experiences.

7.2.5 Educators' contributions to student learning

The perspective of academic and field educators, as illustrated through their interview responses, on the teaching of professional ethical practice were presented in Chapter six. The educators' perceptions of the personal and professional resources available to students to support their practice were also reported. The field educators identified opportunities during the placement which they used to develop students' knowledge, skills, and attitudes in the area of professional ethical practice.

Academic staff described intentional teaching of foundational knowledge for ethical practice. Their results suggested, however, that often the underlying model or theory of ethical practice they were teaching was not made explicit. Key underpinning ethical practice skills (such as ethical awareness and ethical reasoning) were not reported as being addressed although teaching in this area was observed in ethics workshops. Throughout their courses academic staff reported modelling attitudes for ethical practice as a primary teaching strategy.

Academic staff were involved in student assessment in both the academic and practicum streams of their course. Ethical practice knowledge, underpinning professional ethical awareness and ethical reasoning, were not reported as being assessed formally. Generic ethical practice skills and attitudes were assessed and often in topics outside the professional practice stream. Interestingly in this study students exhibited greater competency in generic ethical practice skills and attitudes (such as communication, collaboration and respect) than they did in specific skills such as ethical awareness and ethical reasoning.

Few of the field educators could recall formal teaching in the area of ethical practice. All were, however, able to demonstrate both ethical awareness and ethical reasoning. Limited specific teaching moments with students in the area of ethical

practice were identified by the field educators. Field educators appeared less intentional in their teaching of ethical practice than academic staff. Students however identified field placements as a key place for learning professional ethical practice.

7.3 Conclusion

Ethical practice is a complex professional competency. This study has clearly demonstrated that professional ethical practice involves much more than moral reasoning. The importance given to competence in ethical practice is highlighted by community discussions, professional association code of ethics, and the compulsory ethics classes in accredited health profession courses. More particularly for speech pathologists, in the past seven years Speech Pathology Australia have demonstrated their commitment to ethical practice through the release of a new code of ethics for the association, an education package to teach the code, and a new assessment tool which includes multiple ways to measure competency in ethical practice in students.

The key findings of this study were that almost one third of students about to graduate as fully qualified speech pathologists were unable to independently identify an ethical dilemma in a written case study. Furthermore, almost sixty percent of students were unable to demonstrate principled ethical reasoning as measured by the Defining Issues Test.

These results are significant because eligibility to practice as a speech pathologist in Australia requires eligibility for membership of Speech Pathology Australia. Membership requires the observation of Speech Pathology Australia's Code of Ethics. This code is largely based on the application and prioritisation of ethical principles as the basis for professional ethical decision making. Furthermore,

Flinders University have recently introduced the Speech Pathology Australia produced COMPASS™ assessment tool as the measure for determining students are competent and are eligible for practice as speech pathologists. To pass the assessment requirements of the COMPASS™, entry level (competent) students are required to demonstrate evidence of both generic professional competencies and Competency Based Occupational Standards competencies. In the area of ethical practice these competencies include, for example, the ability to apply core principles underpinning ethical behaviour to all aspects of client care and daily practice.

This research raised as many questions as it answered. Questions for future research include:

- How does competency in professional ethical practice change and develop across the years of a student's professional education?

- What differences exist in the ethical practice competency of undergraduate versus entry level postgraduate speech pathology students?

- How does speech pathology students' competency in ethical practice compare to other student health professionals?

- How does the ethical practice competence of novice speech pathologists compare to experienced speech pathologists?

Answers to these questions must await another study.

7.4 Implications and solutions

This study suggests that perhaps as many as sixty percent of new graduate speech pathologists may be unable to demonstrate entry level competency in ethical practice

as currently required by Flinders University and Speech Pathology Australia. The student story that was a catalyst for this study may be only too familiar to students and educators alike.

This study also provides insights into possible solutions for improving student learning in the area of ethical practice. Primarily, educators of speech pathology students should make their teaching and assessment of ethical practice knowledge, skills, and attitudes more explicit. Integrating ethics teaching throughout all aspects of the course may also improve the effectiveness of student learning. Students may also benefit from field educators taking a more intentional approach to their teaching of ethical practice. To gain confidence in making their teaching more explicit, and where required more intentional, educators may benefit from access to professional development, particularly in the theoretical knowledge base and curriculum goals pertaining to ethical practice. Some resources for this have already been prepared by Speech Pathology Australia and are easily accessed by the profession in Australia. Opportunities for professional development in the area of professional ethics may also increase the conscious awareness of ethical practice teaching opportunities across the whole scope of professional practice for speech pathology educators.

Alternatively, the profession could accept that students are unable to meet current standards pertaining to ethical practice and that their development in this area of professional practice, as in many others, will continue to need to develop upon graduation. If we accept this premise Speech Pathology Australia may need to set a more relevant and achievable level of competence in ethical practice for its entry level practioners. If standards are to change, the profession will need to be made aware of the increased professional support and mentoring new graduate speech

pathologists may require in the workplace with regards to ethical practice. To provide this increased support, members of the profession may also want to seek additional professional development in this fundamental area of practice.

An aspect of ethical practice is commitment to life-long learning. The implications of this study exhort us as a profession to be life long learners in the area of ethical practice. Only in this way we can provide best practice supervision, support, mentoring, and education in the area of professional ethical practice.

7.5 APPENDICES

7.6 Appendix 1

7.6.1 Defining Issues Test Sample Question

7.7 Appendix 2a

7.7.1 Written Case Discussion

For the following case study (or if you prefer a personal case described by you) discuss those issues you think are important to consider in the ongoing management of the patient by you as part of the treatment team. Describe what actions you would take.

Mr Jones was a 69 year old resident of a nursing home. He required admittance to the Nursing home two years previously due to progressive dementia related to generalised cortical atrophy. He remained physically able but required 24-hour supervision due to his confusion. His wife was a daily visitor to the nursing home and his daughters visited weekly. He appeared to recognise them still.

He was admitted to City Hospital three weeks ago due to a right embolic CVA resulting in a dense left hemiparesis and impaired conscious state. During the first week he was unresponsive and received "comfort measures" only. (Subcutaneous fluids and nursing care.) He developed respiratory complications, which were not medically treated.

At the beginning of the second week he regained consciousness and was referred to Speech Pathology for an assessment of his dysphagia and to physiotherapy for management of his chest and assessment of his mobility. Bedside assessment indicated severe oral-pharyngeal dysphagia with clinical signs of aspiration. You recommend "Nil by Mouth" and discuss with the team the need for alternative nutrition and hydration. The treatment team decides to wait for further signs of spontaneous recovery due to his recent critical medical condition and previous level of function.

Daily swallow review indicates increasing awareness and interaction but no change in swallow status over the next week. He starts to receive IV fluids and antibiotics for his chest infection. Physically he improves and is able to be sat out of bed.

At the beginning of week 3 he continues to receive no nutrition. His chest condition has resolved. Whenever you see him for assessment he grabs the spoon and indicates he wants to eat. You hear him request "food". You again request consideration of alternative feeding as he still has signs of significant aspiration. The medical team is happy for him to be placed on an oral diet if he is "safe to swallow". You are informed by the intern (a junior Dr) that his wife does not want a feeding tube placed as prior to his dementia her husband commented he did not want to end up "a vegetable" and that he is "palliative" (ie about to die) anyway. It is now the end of the third week. What do you do?

7.8 Appendix 2b

7.8.1 Guided Case Discussion

Utilising the following prompts revisit you original discussion of the case. Add additional information if necessary. Use a different font/pen colour for your additional comments.

1. GATHER RELEVANT INFORMATION

   What is the pertinent information?

   Is there more medical/social/legal information you would like?

   Eg Is the illness or condition reversible?

   Is lifesaving treatment medically futile?

   What is the usual and customary treatment for this condition in the community?

   What is needed to provide comfort/prevent suffering?

   Is the patient brain dead or in a persistent vegetative state?

   What are the patient's preferences?

   Eg Is the patient informed?

   Is the patient competent?

   If the patient is not competent how can I discern what this patient would want? (Is there a Living Will / Medical Power of Attorney?)

   If the patient is not competent, how can I discern what this type of person would want? (Best Interests)

   What are the probable outcomes with regard to Quality of life?

   Eg Is there any hope for improvement from the present quality of life? In the patient/family's judgement? In your judgement?

   What External Factors may affect decision making?

   Eg Is the patient a public or private patient?

   Is the allocation of beds/resources an issue?

   Are there existing hospital policies?

   Is there existing relevant legislation?

2. IDENTIFY THE TYPE OF ETHICAL PROBLEM (EXISTING OR ANTICIPATED).

   Is there an ethical dilemma/s here? How would you describe those dilemmas?

   Do you anticipate any other dilemmas?

   What bioethical principles, rights and duties are relevant? (Eg autonomy, nonmalificence, benificence, justice, fidelity) For whom are they relevant? Why? When?

   Are there conflicts existing or anticipated between principles?

3. WHAT ARE YOUR PRACTICAL ALTERNATIVES?

   What courses of action are open to you?

   What are the possible outcomes for each of these actions?

   What are the long and short term implications for each course of action?

4. WHAT DO YOU ACTUALLY DO? WHY?

   Are there any limits to what you can or can not do? Why?

   Are there both immediate and delayed ways you can respond to this situation?

   How do you deal with how your actions make you feel?

   Adapted from Purtilo 1993 and Myser, Kerridge and Mitchell1995.

7.9 Appendix 2c

7.10 Analysis guide for Case Discussion

The following is a "best answer" example to the case discussion to be used as a scoring guide.

1. **Clinical Information**

7.11 nformation Provided	7.12 urther Information Required
7.13	*Background History*
7.14 ge:69 years	**7.15** ccupation/Interests
7.16 rogressive dementia due to cerebral atrophy	**7.17** ikes/Dislikes
7.18 hysically Able	**7.19** ontented/Distressed
7.20 4 Hour Care due to confusion	**7.21** ble to self care?
7.22 ecognises wife and daughter	**7.23** ikely to escape
7.24	**7.25** ecognises staff/room
7.26	*Presenting Complaint*
7.27 Embolic CVA	**7.28** here was the CVA located?
7.29	**7.30** ther Medical History (Hypertension,

esulting in dense L hemiparesis

diabetes, cardiac etc)

7.31
ecreased Conscious state

7.32

7.33   *Progression of Illness*

7.34   Week 1

- **Unresponsive**

7.35

- **Sub-Cutaneous Fluids**

7.36

- **Nursing Care Only**

7.37

- **Pneumonia no treated**

7.38

7.39   Week 2

- **Conscious**

7.40
eneral ability to communicate

7.41

7.42
ther signs of improved cognition

- **Referred for dysphagia assessment**

7.43

- **Severe oral-pharyngeal dysphagia, clinical signs of aspiration**

7.44

- **Nil By Mouth ?NET**

7.45

- **IVT Started**

7.46

- **Pneumonia treated with**

7.47

antibiotics	**ther Medical Treatments (eg anticoagulation)**
• **Mobilised sat out of bed**	**7.48** **ther signs of physical condition improving?**

7.49	Week 3

• **Remains NBM ?NET**	**7.50**
• **During Assessment grabs at spoon and verbalizes "food"**	**7.51** **ther signs of neurological resolution**
• **Pneumonia Resolved**	**7.52** **ther ongoing medical issues**

2. Ethical issues
Principles (Numbers = ranked importance)
• Autonomy

1. Respecting patient autonomy and his request for food
   Medical team versus family ?*patient* wishes
2. *?existence of Medical power of attorney/Palliative care directions*
   ?Incompetent non dying patient…Who decides?

• Veracity

? Week3 is he still "about to die" ie palliative?
3. Are the procedures ie placing a NET futile given the patient is expressing hunger?

• Beneficence

4. Who determines whether the patient's life pre or post
   Stroke is one of "quality" or not?
6. Why actively treat the pneumonia (Antibiotics and chest physio) but then not provide nutrition

- Non-maleficence

> 5. Initially to feed/treat or not to was a question of not doing further harm through prolonging an unconscious life

- Justice

> 7. Initially the "cost" of active measures, financially and the social, emotional cost to the family was a consideration.

3. Who needs to be involved in the situation?
- Hospital Team-Medical Team (Consultant, senior Registrar, intern)
  -Treating Team (Nurses, Physio, OT, Speech
  -Pathologist, Dietician, Neuro-psychologist, Social Worker)
  -Palliative care
  -Chaplin
  -Patient Advisor
  -Hospital clinical ethics board
- Family-wife-Daughter +/_ Other children
  -?Siblings
- Community-? Minister/Pastor
  -Nursing Home
- Guardianship Board

4. Management options
1. Don't feed at all
2. Alternative Feeding – NET in the short term
   - PEG in the long term if required
   - For a designated period of time only ie 2 weeks
3. Oral Feeding- Oral feeding for comfort only if patient is palliative
   - Oral feeding by family only and don't treat complications (ie aspiration pneumonia) Due to "Duty of Care" legal restrictions staff unable to feed in this circumstance.
   -Oral feeding with full treatment measures with hospital accepting legal implications
4. Transitional Oral feeding- Therapeutic introduction of oral intake in conjunction with alternative feeding/hydration options and full treatment

Appendix 2d

Rating guide for written case discussions

Both independent and guided case discussions will be rated according to the following criteria:

1. **NON-SATISFACTORY**
   - No attempt to identify relevant clinical information
     Evidence: None or minimal evidence that relevant clinical information was identified. Basic patient personal and diagnostic information given. (Less than 3/5 pieces of salient information identified)
   - Lack of recognition that there are ethical issues at stake
     Evidence: No evidence of recognition that there are ethical issues involved in the case or denial that there were any ethical dilemmas presented
   - No attempt to include others in the determination of management goals
     Evidence: No evidence of attempting to include others (patient, family, professional team, field educator/mentor) in the setting of management goals)
   - No recognition that there may be more than one management solution
     Evidence: Provision of only one management option
2. **SATISFACTORY**
   - Identification of basic clinical information
     Evidence: Basic relevant clinical and personal information was identified. (3/5 salient pieces of information identified)
   - Recognition of at least one ethical dilemma
     Evidence: Recognition of one ethical dilemma
   - Management plan that involves consultation with at least one other party
     Evidence: Setting of management goals involved consultation with at least one other party.
   - Discussion of at least 2 alternative management plans for action
     Evidence: Discussion of two alternative plans of action
3. **VERY SATISFACTORY**
   - Identification of all relevant information provided
     Evidence: Identification of essentially all relevant clinical information provided. (4-5/5pieces of salient information)
   - Recognition of multiple dilemmas
     Evidence: Recognition of multiple ethical dilemmas.
   - Management plan involves all directly mentioned parties
     Evidence: Setting of management goals involved all parties directly mentioned in the case study.
   - Discussion of multiple plans of action
     Evidence: Discussion of more than two alternative management plans.
4. **EXCELLENT**

- Identification of all relevant given information and additional information required.

    (Identification of all relevant clinical information provided, that is 5/5 pieces and a statement related to relevant additional information required)

- Recognition of multiple and conflicting dilemmas and an attempt to prioritise them.

    Evidence: Recognition of not only multiple ethical dilemmas but also that the resolution of them may lead to conflict thus an attempt to prioritise the dilemmas for consideration made.

- Management plan involving all mentioned parties and relevant extra parties/resources.

    Evidence: Setting of management goals involved all parties directly mentioned in the case study and in addition identified relevant extra parties/ resources to be consulted (eg hospital clinical ethics committees)

- Extensive discussion of management options and their implications.

    Evidence: Extensive discussion of management options and their implications for the parties effected by the plan

Appendix 3

Group Dilemma Discussion

In this task you are to imagine you are all actually members of the Speech Pathology Department described.

You and your 4 colleagues are members of a Speech Pathology Department based at a rural Community Health centre and attached hospital. You are 250km from the closest city based service. You have responsibilities for the service provision to both inpatients and outpatients.

Your CEO has informed you due to severe service wide budget cuts enforced by the state government your outpatient service is to have a 20% budget cut. The CEO wants a description of your new outpatient service and a justification for the services cut/maintained on his desk by the end of the week.

At present your outpatient funding is utilised in the following ways:

1. Health Promotion Activities
   Eg Hearing Health Days (for local farmers and aboriginal communities)
   Communication for All displays (in local shopping centres, kindies, childcare centres, nursing homes etc)
   Participation in Centre wide anti smoking campaign
2. Rehabilitation to CVA and Head-Injured clients who may or may not have received inpatient rehabilitation. Often includes return to work programmes.
3. Assessment and treatment for language delayed and disordered children of all ages. (The Education Department are never able to fill the local position)
4. Assessment and treatment for phonologically delayed and disordered children of all ages.
5. Assessment and treatment of physically and intellectually disabled children and adolescents. (There is a local special school and group home which many of these clients attend)
6. Management of people following laryngectomy.
7. Visiting service to the local nursing home including dysphagia assessment and management.
8. Specialist Voice Clinic at the local hospital with the visiting ENT.
9. Basic audiology diagnostic service again with the visiting ENT.
10. Assessment of adults and children with fluency disorders.

Each area is currently equally funded.

Your Department is managed co-operatively through consensus decision making. How will you cut your current services? (There is already a 12-month wait for non-acute services) Remember you have to give your CEO justification for how you decide to cut the service. What other actions may you take as a Department? Why?

Appendix 4
Influences on ethical development.
Focus Group discussion Guide

1. INTRODUCTORY ROUND

- I introduce myself as a model mentioning my age, home situation, occupational interest, and relevant extra-curricular activities (eg Church affiliation, Interest in social justice issues, Sports)
- A "Round Robin" question

2. OPENING BROAD QUESTION

- Another "Round Robin" question.
- When I say the words "My Hero" who do you picture?

3. TRANSITION QUESTIONS

- What things do you value most and why?
- What qualities or virtues do you think are important for a rich and full life?
- What do you think are the most important guidelines for living a ethically good life? Where do you think your ideas about this came from?

4. KEY QUESTIONS

- What do you think are the most important factors in behaving as an "ethical" professional?
- Where do you think you have learnt this behaviour?
- Do you think your education as a speech pathologist either academic or clinical has influenced or changed your ethical behaviour?

Appendix 5

The influence of process on ethical decision making.
Student Interview Guide

You have discussed this morning 2 different scenarios which required ethical decision making.

Q1. In which situation was it easiest to come up with solutions to the problem?

Q2. Why was that situation easier?

Sometimes we change our first response to a situation.

Q3. Did your action plan change when you used the decision making guide?

Q4. Why did it change?

Q5. Did your immediate choice of who would continue to receive services change during the course of the group discussion?

Q6. Why do you think it changed?

Our feelings and emotions are often involved in situations of ethical dilemmas.

Q7. In which of the 3 situations did you feel most comfortable with the planned course of action?

Personal experiences of ethical dilemmas say more about how we manage things in the "real world".

Q8. Have you encountered an ethical dilemma in your clinical practise to date?

Q9. What processes did you use in that situation to determine your course of action?

Q10. Did they involve other people? Who?

Q11. Were those processes helpful or stressful?

Q12. Do you think you changed your initial reaction to the situation as a result of the process you used to deal with it?

Appendix 6

Academic educators interview guide.

1.BACKGROUND INFORMATION

- What subjects do you teach?
- How many years have you taught these subjects?
- What is your area of clinical expertise.

2. ETHICS
- In which subjects you teach do you feel the area of ethics is relevant?
- What is your approach to ethics teaching? Do you feel you teach implictly or explicitly about ethics?
- Do you assess students in the area of professional ethics? If yes, how do you do this?

3. PROFESSIONAL ETHICAL DECISION MAKING
- What do you believe are the most important factors to consider in professional ethical decision making?
- Do you have any particular strategies to help develop this skill in students?

Appendix 7

Field Educators Interview Guide

1. BACKGROUND INFORMATION
- How would you describe your work place?
- Do you work predominantly with adult or paediatric populations?
- How many final placement students did you have last semester?

2. UNDERSTANDING OF ETHICS
- Whilst an undergraduate did you receive any formal teaching in the area of ethics?
- What areas of clinical practise in your work setting require ethical decisions or practise?
- How much influence does your organisation have over ethical issues?

3. TEACHING MOMENTS
- During the last student placement how did you address the ethical dimensions of clinical practise with your student/s?
- Were there any situations that resulted in either ethical distress or dilemmas during the placement?
- How did you work through these with your student?
- Did you feel your student had the resources (academic and personal) to deal with this/these situations and learn from them?

Appendix 8a
STUDENT VOLUNTEER INFORMATION SHEET

You are invited to participate in the study of "How Student Speech Pathologists Learn Professional Ethical Decision Making."

The study aims to examine how exiting speech pathology students make professional ethical decisions and the factors contributing to their learning of this skill. More specifically it hopes to identify what intrinsic and extrinsic factors influence or improve learning in this complex skill area.

Ultimately it is hoped the results may highlight ways of facilitating student learning in professional ethical decision making. It is hoped the information thus obtained may be applicable to other groups of health professionals and perhaps other complex professional skills such as counselling.

Participation in the study will provide opportunities for reflection on the relevance of ethics and ethical issues in Speech Pathology and how they are taught or learnt

If you agree to participate, you will be asked if the activities and discussions you are involved in as part the morning session of Day 1 of IPP 4 can be recorded and analysed by the researcher. These may include:
- completion of a test of moral judgement development (~1 hour)
- an individual ethical dilemma case discussion (1- 1½ hours)
- a group ethical decision-making task (~1 hour)
- a group discussion on the influences on ethical development (~1 hour)

The groups will be the "working groups" of approximately 8 students created during IPP 4.

A sample of 6-8 consenting students, from one group, will also be asked to participate in an interview (~ ½ hour) to discuss the influence of various conditions on ethical decision making.

A selection of relevant academic staff will be asked to participate in interviews (~ ½ hour) on how they approach the teaching of ethics and professional ethical decision making within the academic course.

A selection of clinical supervisors will be asked to participate in interviews (~ ½ hour) on how they approach the teaching of ethical issues and solving of ethical dilemmas with the students they have on final placement.

Tape recordings may be made where applicable. Transcripts of individual and group interviews/discussions will be made available to participants for verification. At that time information may be withdrawn or amended by the participant. Interviews will be conducted at the participant's convenience.

Your participation in this study is entirely voluntary and all participants may withdraw from the study, at any time, without prejudice.

All records containing personal information will remain confidential to the researcher. No information which could lead to your identification will be released. Participants will be allocated a study number by the researcher and data will be

identified only by this number. Data and transcripts will be stored in FUSA Speech Pathology Department in a secured area.   In the group discussion, all participants will be asked to maintain the confidentiality of any information shared. If you would prefer to share sensitive material in a different forum, opportunities for individual interviews and/or debriefing with the researcher will be provided following the task.

At this time or during the course of IPP 4, if you have any ongoing worries, concerns or stress as a result the material discussed or experiences during your course, arrangements can be made for you to see your Speech Pathology Department Mentor or access services through the Universities student counselling service so these concerns can be discussed.

Should you require further details about the study, either before, during or after the study, you may contact Helen Smith Tel 81520828 or 82224000 page 1994.

This study has been reviewed by the Clinical Investigations (Ethics) Committee at Flinders Medical Centre. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make a confidential complaint, you may contact the Administrative Officer-Research, Ms. Carol Hakof (8204 4507).

Appendix 8b
EDUCATOR VOLUNTEER INFORMATION SHEET

You are invited to participate in the study of "How Student Speech Pathologists Learn Professional Ethical Decision Making."

The study aims to examine how exiting speech pathology students make professional ethical decisions and the factors contributing to their learning of this skill. More specifically it hopes to identify what intrinsic and extrinsic factors influence or improve learning in this complex skill area.

Ultimately it is hoped the results may highlight ways of facilitating student learning in professional ethical decision making. It is hoped the information thus obtained may be applicable to other groups of health professionals and perhaps other complex professional skills such as counselling.

Participation in the study will provide opportunities for reflection on the relevance of ethics and ethical issues in Speech Pathology and how they are taught or learnt

If you agree to participate, you will be asked if the activities and discussions you are involved in as part the morning session of Day 1 of IPP 4 can be recorded and analysed by the researcher. These may include:
- completion of a test of moral judgement development (~1 hour)
- an individual ethical dilemma case discussion (1- 1½ hours)
- a group ethical decision-making task (~1 hour)
- a group discussion on the influences on ethical development (~1 hour)

The groups will be the "working groups" of approximately 8 students created during IPP 4.

A sample of 6-8 consenting students, from one group, will also be asked to participate in an interview (~ ½ hour) to discuss the influence of various conditions on ethical decision making.

A selection of relevant academic staff will be asked to participate in interviews (~ ½ hour) on how they approach the teaching of ethics and professional ethical decision making within the academic course.

A selection of clinical supervisors will be asked to participate in interviews (~ ½ hour) on how they approach the teaching of ethical issues and solving of ethical dilemmas with the students they have on final placement.

Tape recordings may be made where applicable. Transcripts of individual and group interviews/discussions will be made available to participants for verification. At that time information may be withdrawn or amended by the participant. Interviews will be conducted at the participant's convenience.

Your participation in this study is entirely voluntary and all participants may withdraw from the study, at any time, without prejudice.

All records containing personal information will remain confidential to the researcher. No information which could lead to your identification will be released. Participants will be allocated a study number by the researcher and data will be identified only by this number. Data and transcripts will be stored in FUSA Speech Pathology Department in a secured area. In the group discussion, all participants will be asked to maintain the confidentiality of any information shared. If you would prefer to share sensitive material in a different forum, opportunities for individual interviews and/or debriefing with the researcher will be provided following the task.

At this time or during the course of IPP 4, if you have any ongoing worries, concerns or stress as a result the material discussed or experiences during your course, arrangements can be made for you to see your Speech Pathology Department Mentor or access services through the Universities student counselling service so these concerns can be discussed.

Should you require further details about the study, either before, during or after the study, you may contact Helen Smith Tel 81520828 or 82224000 page 1994.

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Appendix 9a

CONSENT TO PARTICIPATE IN RESEARCH

(Student Form)

I,……………………………………. request and give consent to my involvement in the research project "HOW STUDENT SPEECH PATHOLOGISTS LEARN THE PROCESS OF ETHICAL DECISION MAKING".

I acknowledge that the nature, purpose and contemplated effects of the research project, especially as far as they may affect me have been fully explained to my satisfaction by Helen Smith and my consent is given voluntarily.

I acknowledge as a participant in the project I will be asked to complete a "Moral Judgement Measurement" form in my own time (~60-90 minutes), my Ethical dilemma Case Study for IPP 4 will be collected for analysis by the researcher and my participation in the Ethics discussion for IPP 4 may be as a member of a research focus group and therefore recorded.

I have understood and am satisfied with the explanations I have been given.

I have been provided with a written information sheet.

I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.

I declare that I am over the age of 18 years.

Signature of research subject:…………………………..Date:………………..

Signature of witness:……………………………………

Printed Name of Witness:………………………………

I, Helen Smith have described to ……………………………the research project and the nature and effects of the procedures involved. In my opinion, this person understands the explanation and has freely given their consent.

Signature………………………… Date…………………… Primary Researcher

Appendix 9b

CONSENT TO PARTICIPATE IN RESEARCH

(Academic Educator Form)

I,……………………………………………. request and give consent to my involvement in the research project "HOW STUDENT SPEECH PATHOLOGISTS LEARN THE PROCESS OF ETHICAL DECISION MAKING".

I acknowledge that the nature, purpose and contemplated effects of the research project, especially as far as they may affect me have been fully explained to my satisfaction by Helen Smith and my consent is given voluntarily.

I acknowledge as a participant in the project I will be asked participate in an interview with Helen Smith on the teaching of ethics in Speech Pathology. The interview will be tape recorded and a verbatum transcription will be made by the researcher and provided to me for verification. I my request the inclusion or exclusion of further information at that stage.

I have understood and am satisfied with the explanations I have been given.

I have been provided with a written information sheet.

I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.

I declare that I am over the age of 18 years.

Signature of Interviewee:……………………….. Date:…………………………..

I, Helen Smith have described to ……………………………the research project and the nature of the information to be gathered. In my opinion, this person understands the explanation and has freely given their consent.

Signature……………………….. Date…………………… Primary Researcher

Appendix 9c
CONSENT TO PARTICIPATE IN RESEARCH
(Field Educators Form)

I,…………………………………………. request and give consent to my involvement in the research project "HOW STUDENT SPEECH PATHOLOGISTS LEARN THE PROCESS OF ETHICAL DECISION MAKING".

I acknowledge that the nature, purpose and contemplated effects of the research project, especially as far as they may affect me have been fully explained to my satisfaction by Helen Smith and my consent is given voluntarily.

I acknowledge as a participant in the project I will be asked participate in an interview with Helen Smith ethical issues encountered by students on their clinical placement. The interview will be tape recorded and a verbatum transcription will be made by the researcher and provided to me for verification. I my request the inclusion or exclusion of further information at that stage.

I have understood and am satisfied with the explanations I have been given.

I have been provided with a written information sheet.

I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.

I declare that I am over the age of 18 years.

Signature of Interviewee:……………………….. Date:…………………………..

I, Helen Smith have described to ………………………………the research project and the nature of the information to be gathered. In my opinion, this person understands the explanation and has freely given their consent.

Signature……………………….. Date………………… Primary Researcher

Appendix 10

NARRATIVE ANALYSIS FRAMEWORK

1. ABSTRACT- **A summary of the guts of the narrative/ What dilemmas do students have**

2. ORIENTATION/ DESCRIPTION

    WHO

    WHAT

    WHERE

    WHEN

    TIME FRAMES

    SETTING

3. COMPLICATING ACTION- **Sequence of events/ How they deal with the dilemma. What they do.**

4. EVALUATION/ WHY- **The significance and meaning of the actions and attitudes**

5. RESOLUTION- **What finally happened**

6. CODA- **Returns to present/ How did they learn to do this**

Based on Reissman 1993 pg 18 adapted from Labov 72,82 and Waletzky 67

7.53 Appendix 11

7.54 Distribution of scores on the DIT

Study No	% P	%A	6%	%5b	%5a	4%	3%	2%	Age
10	50	0	0	10	40	23.3	11.7	15	21
13	36.7	0	0	13.3	23.3	43.3	8.3	11.7	21
18	43.3	0	13.3	6.7	23.3	40	13.3		20
12	60	0	5	1.7	53.3	25	1.7	8.3	21
20	36.6	1.7	3.3	5	28.3	45	11.7		21
19	45	0	8.3	13.3	23.3	45	3.3	5	21
21	55	10	8.3	8.3	38.3	26.7	8.3		32
26	30	8.3	6.7	3	20	31.7	25	5	36
23	45	0	5		40	21.7	26.7	6.7	23
31	58.3	0	8.3	16.7	33.3	31.7	6.7	3.3	22
11	35	0	3.3	13.3	18.3	48.3	6.7	8.3	22
25	38.3	0	6.7	5	26.7	41.7	6.7	10	44
24	43.3	3.3	5	5	33.3	40	10		24
29	43.3	6.7	6.7		36.7	28.3	3.3	16.6	22
30	56.7	0	3.3	13.3	40	11.7	23.3	6.7	21
28	53.3	3.3	10	13.3	30	31.7	10	1.6	21
9	38.3	0	3.3	10	25	21.7	31.7	3.3	unk
17	25	11.7	5	3.3	16.6	43.3	11.7	5	23
6	40	6.7	5	1.7	33.3	28.3	11.7	13.3	20

Appendix 12

Examples of Atlas Ti Student Codes

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