Peer Commentary

Seeking proof where the subject is ill-defined and the outcomes limited. A response to "Does Ethics Education Influence the Moral Action of Practicing Nurses and Social Workers?

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Abstract

The authors of this study concludes that ethics education has a positive influence on moral confidence, moral action and the use of ethics resources by nurses and social workers. A crucial limitation of the study is that it does not provide any way for respondents to indicate what they understand by ethics nor the ethical content of their educational programs, thus we cannot properly assess the basis of the respondents confidence about their professional and ethical responsibilities. This is reinforced by the possibility that respondents' ethical understandings have been shaped by experiences independent of formal education programs. Moreover, the findings that in-service ethical training is strongly correlated with moral confidence and action are problematic because what counts as ethics, rather than law or hospital policy for example, is not elucidated.

Grady et al (2008) report on a survey that they claim bears out the hypothesis that ethics education has a positive influence on moral confidence, moral action and the use of ethics resources by nurses and social workers. We are at one with these authors regarding the importance of inquiry into the efficacy, or otherwise, of ethics education for health care professionals. However, we think that basic features and assumptions of the survey are flawed, and that consequently the research cannot sustain the hypothesis.

Ethics is a complex and internally contested dimension of human life. Much of ethics is disputed - from the scope of ethics itself, through issues concerning frameworks of appropriate thought and action, to specific problem areas such as euthanasia, stem cell research, decisions regarding good care for patients, and so on. Given this, we think that the authors' survey format is inadequate to the task and that a qualitative or mixed methods approach would have been more appropriate for such an inquiry (Pope and Mays 1995).

Even if one accepts that a survey may be the best means for examining these questions, there are a number of limitations to this study that profoundly limit the validity and generalisability of the results. The sample of respondents is overwhelmingly Caucasian (83%) and female (85%); there is no assessment of the participants moral confidence or ethical sensitivity prior to receiving ethics education, and there is no serial or longitudinal analysis that may tell us something about how 'robust' the reported dispositions of respondents are.

In our view, however, the central shortcoming of the survey is that the authors nowhere provide any indication either of what they take ethics to be or of the actual content of the variety of ethics programs encompassed. We are informed only that the ethics programs include basic and advanced

professional programs, and continuing education and in-house training programs. Without further specification of such things as the content range of programs, key emphases, types and stringency of assessment, etc, the significance of the survey results cannot be established.

For example, given the potentially wide range of issues available to educators (as indicated above) we cannot tell *what* the respondents understood as *their* 'ethical issues' and 'professional responsibilities' (Grady et al 2008, 8); nor do we know what *reasons they had* for this understanding. Indeed, we cannot know whether the formal education programs alone were the primary source of ethical understanding for the respondents – as opposed to other independent learning (respondents' own reading, discussions with colleagues, life experiences, etc).

This is particularly relevant to the finding by the authors that respondents who had undergone continuing education were more likely to be more confident and to take moral action. Without some indication of the content of these programs, we cannot evaluate the finding. For example, the in-house programs might strongly emphasise local policy and procedures, managerial imperatives, legal requirements, etc. This might well account for more (locally relevant) confidence and tendency to (locally relevant) action; but there may be little that explicitly or directly addresses ethics.

Without information about the content of the education programs, and without independent specification by the authors as to what is central to ethics here, we have no way of assessing the implicit assumption that confidence in moral judgement, disposition to use ethical resources and likelihood of taking moral action are significant criteria of the efficacy of ethics education.

To illustrate, the measure of confidence in the survey comprises questions regarding confidence in justifying ethical decisions, in preparedness to deal with ethical issues faced, and about "professional responsibilities and scope of practice regarding ethical issues" (Grady et al 2008, 5). The survey depends on self-reporting by respondents. But we cannot tell if a given respondent's confidence in justifying a decision, say, is grounded in some demonstrable skill in moral perception and judgement, or simply a sense of empowerment through exposure to a formal program and acquisition of relevant language. Confidence may, or may not, be justified: it cannot be self-validating. And without relevant specific information regarding the educational base of this confidence, the survey provides no independent way of validating the putative ethical significance of the confidence reported.

The authors acknowledge that the use of self-reporting without a supplementary study of actual behaviours of respondents is a limitation of the study. Our view, however, is that even if a study of respondents' behaviour was included, this would not improve the situation: the significance of such behaviours would be dependent on the significance of the dispositions they are supposed to express, and our argument is that this latter significance cannot be shown within the terms of the survey.

The unavailability of information about the content of the education programs and the lack of authorial stipulation regarding a minimal ethical core vitiate the other findings as well. For example, the authors point to a correlation between little or no ethics education and respondents' lack of confidence regarding *use of ethical resources* in the workplace "…because they did not feel authorized or qualified, or found the service difficult to access" (Grady et al 2008, 12). But

the survey provides no grounds for validly inferring that ethics education would ground a confidence here. Some people may be timid or lacking in self-esteem – even if they were to be exposed to ethics education; and difficulty of access may be as much a matter of inadequate institutional information about the availability of such resources, or strict policy on access to such, etc, and may have little relationship to ethics education.

Similar comments apply to the findings on *moral action*. The authors report that the moral action item most "respondents were likely to take was "Talk with other members of my profession"", and that nurses "tended more often than social workers to choose " feel concerned but take no further action""(Grady et al 2008, 8). Unless we know independently what is supposed to count as ethically relevant, we cannot evaluate the significance of, say, talking with other members of one's profession (in regard to some concern). Such action is not self-evidently ethical: many non-ethical concerns might prompt such behaviour.

The authors nominate concern about moral distress amongst nurses and social workers as one factor motivating the survey. Moral distress is characterised as a being "caught between what they think might be best for their patients and the institutional constraints or overriding decisions of other health care professionals" (Grady et al 2008, 3). Linking moral distress thus understood to the survey's concerns at least potentially introduces some indication of what counts as ethical here: it has to do with practitioners' understanding of what's best for their patients. However, this does not strengthen the claims made regarding the survey's hypothesis. There are two related reasons for this. One, that while there is some credibility in the idea

that talking with other members of one's profession is action oriented to patient welfare, it is not clear how this could be a strong endorsement of the efficacy of ethics education: such action might be quite common amongst practitioners, and may be an expression of (ethically appropriate) professional concern uninformed by formal ethics education – even amongst those practitioners who have also been exposed to ethics education. Two, the survey gives us no way of telling whether respondents' looking to other members of their profession is motivated more by a desire (understandable) to relieve their own distress than to improve the situation of their patients.

If the purpose of ethics education for health care practitioners is, ultimately, securing appropriate care for patients, then research into the efficacy of such education needs, minimally, to be grounded in hypotheses regarding what counts as appropriate patient care, and in detailed specification of the education programs in question.

We have argued that the survey under review here fails to meet these requirements. Such research would also need to move beyond self-reporting of respondents, and also beyond purely 'cognitive response' data – which may do no more than confirm successful negotiation of an education program's assessment requirements, and have little to do with outcomes for patients. There would need to be investigation of relevant behaviour by respondents as well. Moreover, this behavioural investigation would need to be sensitive to the different intellectual and practice cultures of the different health professions and to the complex nature of health care action, and to control for the many formative influences on such action – including the

potentially great variety of factors which shape practitioners' moral stance regarding patient care.

Empirical research in bioethics continues to increase in scope and extent and is now a major feature of the ethics literature – particularly in nursing ethics (Borry 2006). If empirical research is to make any serious contribution to a better understanding of the context of bioethics, the theorisation of ethics or the very nature of ethics then it is vital that its research questions are clear, methods appropriate and conduct robust. Research that does not have these characteristics is more likely to obfuscate than illuminate.

References

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