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On-the-Job Ethics - Proximity Morality Forming in Medical School: A grounded theory analysis using survey data

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Abstract

On-the-job-ethics exist in all businesses and can also be called proximity morality forming. In this paper we propose that medical students take a proximity morality stance towards ethics education at medical school. This means that they want to form physician morality "on the job" instead of being taught ethics like any other subject. On-the-job-ethics for medical students involves learning ethics that is used when practicing ethics. Learning ethics includes comprehensive ethics courses in which quality lectures provide ethics grammar useful for the ethics practicing in attitude exercises and vignette reflections in tutored group discussions. On-the-job-ethics develops professional identity, handles diversity of religious and existential worldviews, trains students described as ethically naive, processes difficult clinical experiences, and desists negative role modeling from physicians in clinical or teaching situations. This grounded theory analysis was made from a questionnaire survey on attitudes to ethics education with 409 Swedish medical students participating. We analyzed over 8000 words of open-ended responses and multiple-choice questions using classic grounded theory procedures, but also compared questionnaire data using statistics such as multiple regression models. The paper gives an example of how grounded theory can be used with a limited amount of survey data.

Background

Medical ethics is different from other subjects taught at medical school and the importance of formal ethics courses has been questioned (Hafferty & Franks, 1994). Some medical schools combine instruction in bioethical principles with teaching of humanities programs (Andre, Brody, Fleck, Thomason & Tomlinson, 2003). The teaching of ethics varies in Swedish medical schools from interspersed lectures to formal ethics

courses. We designed a questionnaire survey in order to elucidate how Swedish medical students view the ethics education in medical schools (Thulesius, Sallin, Lynöe & Löfmark, 2007; Lynöe, Löfmark & Thulesius, 2008). Many students gave input to the ethics course curriculum: Should ethics be taught in lectures or learned through group discussions? Should the ethics course be a separate course among others, or should it be part of other courses with lectures and group discussions interspersed? Should it come early or late in the medical school curriculum? Should the literature be specific ethics literature or novels and short stories with relevant ethical content? From multiple-choice responses we found that strong ethics interest was associated with frequent experiences of physician teachers as good role models and an absence of poor role models (Lynöe *et al*., 2008). In the present study we wanted to explore what was going on in medical schools regarding the medical ethics education by analyzing open-ended survey responses together with response data from multiple-choice items.

Method

We constructed a survey on attitudes towards the medical ethics education during 2005 as a request from the delegation of medical ethics of the Swedish Society of Medicine. Swedish medical students from the 1st, 5th and 11th (last) term participated. The survey consisted of 14 items, of which 10 had a total of 59 multiple-choice response options and generous space for open-ended comments, and 4 items were open-ended only, see Table 1.

The overall response rate to the questionnaire survey was 36%, and varied between different centers from 13% to 83%, with a total of 409 respondents, 308 women (75%) and 101 men (25%). More than half (220/409) of the respondents gave one or more written open comments amounting to >8000 words. These comments were transcribed into Word from handwritten text. "Walking survey" data from informal interviews with four physicians, of which two has been teaching medical ethics at medical school for many years, were also analyzed (Glaser, 1998, p 214).

At some centers a whole term would drop out since the responsible teacher failed to hand out the survey. Yet, the response patterns of the different questionnaire items did not

differ significantly between schools with low and high response rates when different logistic regression models were applied to the data (Lynöe *et al*., 2008). The most comprehensive open responses came from last term students. Thus the most experienced students gave the biggest input to the analysis of the qualitative data - the main data source for this study.

We analyzed open-ended comments and multiple-choice responses by classic grounded theory (GT) procedures according to Glaser (1978; 1992; 1998; 2001; 2003; 2005; 2007). The GT dictum "all is data" was taken ad notam in this study. We thus compared both qualitative responses and quantified multiple-choice items in the same analysis. Multiple-choice results were dichotomized, analyzed in logistic regression models, and compared with open-ended responses. The GT analysis began with open coding trying to answer the questions "what is going on?" and "what concept does this data represent" or "what concept that explains what is going on catches the latent pattern in this data?" and most important: "what are the participants main concern and how are they continually trying to resolve it?" Theoretical memos were written, typed, or drawn in the comparative process as soon as open coding started. This paper was sorted and written up from more than 4000 words and many dozens of pages of typed and handwritten memos.

"Memos are the theorizing write-up of ideas about substantive codes and their theoretically coded relationships as they emerge during coding, collecting and analyzing data, and during memoing" (Glaser, 1998). Memoing is "the core stage of grounded theory methodology" (Glaser, 1998), and should be done at any time and place in order to capture creative ideas. The analytic procedures were done with experience from earlier GT studies (Thulesius, Håkansson & Petersson, 2001, 2004; Sandgren, Thulesius, Fridlund & Petersson, 2006; Thulesius & Grahn, 2007).

Discovery of Grounded Theory by Glaser & Strauss (1967) is the most quoted reference for any single method analyzing qualitative data according to Google Scholar search (12830 citations December 2008). GT has the inductive approach to generate hypotheses explaining how participants in a studied substantive area resolve their main concern. Thus, GT conceptualizes "what is going on" in the field of study by the "constant comparative method", another name for GT. This

indicates a constant comparison of data during an iterative research process, which involves open coding, memoing, theoretical sampling (data collection based on hypotheses from the ongoing analysis), selective coding (recoding data based on concepts from the ongoing analysis), sorting and writing up (sorting memos in piles based on concepts in the theory and then writing up the sorted piles into a paper or book). Classic GT analysis aims at conceptual theories abstract of time, place and people and differs from most methods using qualitative data by presenting explanatory concepts instead of descriptions. Many clinical research methods consider persons or patients as units of analysis, whereas in GT the unit of analysis is the incident not the person(s) involved (incident = a distinct piece of action, or an episode, as in a story or play). The number of incidents being coded and compared typically amounts to several hundred in a GT study since every participant often reports many incidents. When comparing many incidents in a certain field, the emerging concepts and the relationship between them are in reality probability statements and therefore GT should not be considered a qualitative method but a general method that can use any type of data. The results of GT are not reports of facts but an integrated set of conceptual hypotheses. Validity in its traditional sense is consequently not an issue in GT research, which instead should be judged by fit, relevance, workability, and modifiability (Glaser, 1978; 1998). Fit has to do with how close concepts fit with the incidents they are representing, and this is related to how thorough the constant comparison of incidents to concepts was done. A relevant study deals with the real concern of participants and captures attention. The theory works when it explains how the problem is being solved with much variation. A modifiable theory can be altered when new relevant data is compared to existing data. A GT is never right or wrong, it just has more or less fit, relevance, workability and modifiability, and readers of this paper are asked to try its quality according to these principles.

Proximity Morality Forming by On-the-job Ethics

In this study we analyzed student attitudes and "what was going on" in the medical ethics education and found that students learn ethics on the job. This can also be conceptualized as **proximity morality forming** since students practice medical ethics in close connection with colleagues and patients. This

proximity morality forming also includes comprehensive ethics courses with tutored small groups. Proximity morality forming involves **learning ethics** where "ethics grammar" comes from selected high quality lectures. **Practicing ethics** is done when patient cases and clinical issues are discussed in interactive groups and in the clinical setting. This can also help students to deal with emotionally difficult situations. Attitude exercises using vignette reflections are done in "ethics labs". To desist negative role modeling is a function of the ethics courses where reflected professionalism is developed for diverse medical students in a heterogeneous world.

On-the-job-ethics in medical school - How? Forming physician morality by learning ethics takes place in quality lectures on ethics, preferably given by professional ethicists. These lectures provide students with a basic "ethics grammar" about ethical principles and concepts. This feeds the interactive group discussions and improves their quality concerning ethical issues.

"Professional lecturers from the faculty of arts (are wanted)" (first term student). Forming physician morality by practicing ethics is done in the interactive discussion groups, but also in the "ethics lab" where students work with practical, sometimes challenging attitude exercises and vignette reflections. These stimulate critical thinking about current ethical problems in clinical training. It requires that the participants position themselves ideologically, and for some attitude exercises also physically. Attitude exercises are often done in case studies.

"A case is presented and different opinions (re the case) represented by four different corners. One can go to any corner and argue against the other corners and eventually change corners" (last term student).

On the job morality forming in medical school is typically done in interactive discussion groups. In these groups the learning and practicing go hand in hand. The discussion groups also have a support network function allowing professional role growth within a permissive context where ethical and value-laden issues are discussed and tried. The structure ideally consists of tutored groups that repeatedly work with case study approaches, discuss ethical principles, and continue during internship (i.e. in Sweden this is the paid physician work that

starts after medical school at the University). Within a frame resembling the clinical setting students grow their own ethical attitudes and shape their individual physician morality. Group discussions provide good training for handling ethical difficulties since real world medical ethics consist of unique complex situations often involving several people. One goal of interactive ethics group discussions is to understand what appropriate physician behavior is.

"(we need) group discussions with teachers making sure that everyone develops decent ethical values as physicians" (fifth term student)

"ethics discussion forums should be based on tutored small groups (to prevent people with strong views from dominating)" (last term student)

"every section could end with ethical discussions related to the specific subject, psychiatry/internal medicine/surgery" (last term student)

On-the-job-ethics in medical school – Why?

Why would medical students want to form physician morality on the job? The deliberate forming of a physician morality seems necessary for various reasons, and several student responses dealt with arguments for ethics education in general and forming physician morality on the job in particular:

Professionalizing

Since professional identity requires moral reflection this is an important argument for on-the-job-ethics.

"An open discussion forum on difficult issues and professional identity conflicts would make us better physicians." (last term student)

"Small groups during clinical training - discussing the professional physician role and work issues" (last term student on suggested ethics education during internship)

Diversity handling

We live in a society with increasing diversity and multiple religious views and this is dealt with in everyday on-the-job ethics.

"What is it really like in our secularized country? How can we say something is right when we don't share the same values" (fifth term student)

Medical students are different. Some are ethically naive, or not interested in ethics, and others even described as socially "autistic". The importance of ethics education is obvious for these groups.

"Only autistic people need ethics education" (last term student)

Processing emotional difficulties

Medical school can be both emotionally and ethically difficult with life and death issues pressing on. On-the-job-ethics discussions involve processing tough experiences from the clinical part of the education.

"Good with special ethics courses when we deal with sensitive issues" (last term student)

"We underestimate the power of what we can do for each other... An open forum for discussing difficult issues and identity crises during the education would make us better physicians" (last term student on importance of small discussion groups)

"Small groups discussing everyday problems and ethical issues in the workplace" (first term student on suggested ethics education during later internship)

Desisting negative role modeling

By defying ethics suppression and politically corrected ethics the influences of physicians/teachers as poor role models may be addressed and negative role modeling dealt with in the interactive groups. Some teachers and physicians were described as being "masters of opinion control" trying to neutralize discussions about ethically sensitive topics by putting the lid on discussions, and defending politically correct opinions.

"I prefer a good (neutral) clinician instead of zealous, ideologically motivated people" (fifth term student)

"Teachers gave too little space for own views – there was a correct key for the discussion" (last term student)

In a statistical analysis of the survey presented elsewhere

(Lynöe et al., 2008) we saw a significant relationship between a low interest in ethics and frequent experiences of poor role models and the absence of good ones in all three terms. For last term students, there was a significant association between a high interest in ethics and experiences of good role models and a preference for discussions in small groups.

"Personally I'm always ready to learn, although I do not always like being taught." ~ Winston Churchill (1874 - 1965)

The quote illustrates the students' attitudes towards medical ethics education in this study. They want to form their own physician morality on-the-job rather than being taught ethics. This is an example of the proximity ethics that influences the health professions today where "personal relationships and partiality override impartialist and universalist ethical considerations" (Nortvedt & Nordhaug, 2008). The present analysis suggests **proximity morality forming** as a name for what is going on when medical students learn ethics while becoming physicians. Another informal name for this concept is "on-the-job" ethics. This ideally takes place in comprehensive ethics courses where tutored groups openly discuss and reflect on difficult ethical topics and moral dilemmas. **Learning ethics** is done through high quality lectures supplying an *ethics grammar* that provide default ethical principles. These are used when **practicing ethics** in group discussions together with attitude exercises and vignette reflections in *ethics labs*. These interactive discussion groups also have a support network function. Here students process ethical problems in an environment where physician morality is allowed to form and grow on the job. Hence, rather than being served ideologically stained opinions students prefer to reflect and discuss different ethical attitudes.

To summarize its consequences proximity morality forming, or "on-the-job" ethics develops professionalism, deals with diversity issues, helps in processing difficulties, and desists negative role modelling in clinical teaching.

The students hoped for more interaction between students and teachers in a British study of university students' expectations of teaching (Sander, Stevenson, King & Coates, 2000). They also suggested that groups provide effective learning, and this view was most prominent among medical students. Those findings resemble the present study when it comes to

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preferences for teaching structures. In a Swedish study the authors suggested that interactive lecturing was a stimulant to a problem-based learning (PBL) program (Fyrenius, Bergdahl & Silen, 2005). This is in line with the need for good quality lectures to feed ethical discussions with ethics grammar and input from ethics labs in the present study. In a review of medical ethics teaching (Hafferty & Franks, 1994) the authors were nihilistic about its effects and suggested that critical determinants of physician identity operate not within the formal curriculum but in a subtler, less officially recognized "hidden curriculum". Also, medical education could be seen as a form of moral training of which formal instruction in ethics constitutes only a small piece. In a study investigating the effect of ethics education on physician morality it was concluded that moral development and ethical confidence were unaffected by ethics education (Gross, 1999). The goals of ethics education was conceptualized as having cognitive, behavior and attitudinal dimensions. Ethics was supposedly studied for its own sake contributing to "one's all around character". We agree with this author's conclusions, and our analysis suggests that instead of an emphasis on teaching, ethics and morality has to be learned on the job as discovered in a neonatal unit study of proximity ethics (Brinchmann & Nortvedt, 2001) As a reference to one's own morality, Levinas (1969) talks about "the other". Similarly, "the others" (fellow students and teachers/physicians) are necessary for understanding the suggested "on the job" morality development in our study.

Most data used for the GT analysis in this study are limited to written open comments to survey items and multiple-choice survey responses. We did not theoretically sample data outside of the survey apart from data from our own experience, both as medical students, physicians and teachers (all four authors of the paper by Thulesius *et al.* (2007) are physicians and two authors have experience of teaching medical ethics at medical school). Thus the constant comparison was done mainly with cross sectional written data, though "walking survey" data were also used (Glaser, 1998, p 214). Yet we conceptualized a tentative explanatory model of how 220 medical students want their education in medical ethics. This suggests relevance enough for generating a preliminary core variable GT. This theory is, according to the GT paradigm, not right or wrong. It is just a set of probability statements from which hypotheses are generated by constantly comparing available data. When presenting this

proximity morality forming model of on-the-job-ethics to physician colleagues and ethics teachers (both in Sweden and in the USA) the reactions have been positive with some exceptions. The model makes sense and seems to fit with experience. This indicates a certain workability, at least for Swedish and North American contexts.

Limitations

This paper proposes a model showing how medical students want their ethics education in medical school, but does not take into account their teachers' views. Also, our study is limited by the qualitative data being mostly written comments (O'Cathain & Thomas, 2004) in an otherwise multiple-choice survey with a partial response rate. As for the low response rates, the centers with the highest response rates (83%) had the same attitude pattern as those with low response rates (13%) (Lynöe *et al*., 2008). Thus the data seems generalisable enough to fit the requirements for an inductive study. The 11th term students gave the largest quantitative input of qualitative data and thus had a comparatively larger impact on theory generation. Whether this was a limitation is questionable. In our view it gave us more valuable longitudinal data. To use interview data by theoretically sampling outside of the survey might improve the model. We tried to compensate for this by also sampling dichotomized multiple-choice survey data analyzed by different statistical methods including multiple regression models (Lynöe *et al*., 2008). Thus, we also used quantitative data according to the GT maxim "all is data". Furthermore, we used as data four physicians' experience as "walking surveys". For possible future application in medical schools we intend to refine and modify the model and develop it through interaction with medical students and teachers.

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Table 1

Survey items 1-14	Number of multiple choice items	Number of open-ended responses*	Open-ended responses, word count
1. The general outline of the ethics education was valuable	5	36	251
2. The following modes of education were valuable	6	13	76
3. The education was valuable within the following specific fields	18	34	468
4. The education was valuable within the following general fields	7	22	252
5. Which specific or general areas were valuable? Please give examples!	0	55	410
6. This is my general attitude to ethics education	3	66	960
7. Have you experienced the following (regarding physicians/teachers)	4	24	238
8. Have you encountered (good and/or poor role models/situations that affected you)?	2	27	289
9. The following forms of examination were valuable	8	15	108
10. What was your required course literature (in the ethics education)?	0	94	560
11. How important was medical ethics education for you?	6	46	685
12. Please offer suggestions for changes of the design of the ethics course that would improve it	0	110	1352
13. Should ethics education continue during internship and residency? If yes, then how?	2	156	1422
14. Please supply further comments to the questions above.	0	38	1135
TOTAL	59	736	8206

The survey items and numbers of multiple-choice options and open-ended response word count.
*Total number of responders to open-ended items: 220

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Unprivatizing: A bridge to learning

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Abstract

Depression is a complicated condition situated in a cultural environment that often impedes learning. The purpose of this grounded theory study was to better understand depression from the perspective of those who are living with depression. Data were collected from many sources including document review and autobiographical literature; however, the primary data were collected through in-depth interviews. Fifteen individuals, thirteen women and two men, who felt they had learned both about and from their depression volunteered to participate in the primary interview process. Analysis of the data generated categories, properties and the core concept of unprivatizing. Through theoretical coding a process of learning about one's depression emerged which suggests that learning about one's depression can be experienced as a transitional and meaning-making process that occurs over an extended period of time and facilitates development.

Background

> The disease of depression remains a great mystery. It has yielded its secrets to science far more reluctantly than many of the other major ills besetting us. (Styron, 1990, p. 11)

Depression, or depressive illness, is often referred to as a constellation of disorders that depict a condition or disease which disrupts a person's mood, behavior, physical well-being, and thought (National Institute of Mental Health Depression Brochure, 2000; O'Connor, 1997; Thompson, 1996). Depressive illness is most often attributed to a complex interaction between physiological, psychological, and sociocultural factors (Mazure, Keita, & Blehar, 2002; Murthy, 2001; Surgeon General's Report on Mental Health, 1999). Depression is not a rare phenomenon nor is it without significant cost.

According to the National Institute of Mental Health (NIMH) (2000), in any given 1-year period, 9.5% of the population will suffer from a depressive illness. The World Health Organization