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## Building workforce capacity for ethical reflection in health promotion: A practitioner's experience

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By Annabel Axford and Drew Carter

### **Abstract**

Health promotion does not have a Code of Ethics, though attempts have been made to assist practitioners in their understanding and application of ethical concepts. This article describes and analyses one such attempt, sustained from 2006 to 2014 in rural South Australia. The attempt comprised capacity building activities that were informed by principles of organisational change management, especially the principle of creating champions. The article also presents a framework, largely comprising ethical questions, that might help practitioners as a prompt and guide to ethical reflection. The framework was developed to be as accessible as possible in light of the diverse educational backgrounds found in rural settings. Finally, the article highlights some philosophical dimensions to the framework and defends its role, proposing that ethical reflection is integral to good practice and never simply the province of theorists. The article does all

this with a view to stimulating discussion on how to increase the frequency and quality of ethical reflection undertaken by health promotion practitioners.

## Introduction

Embedding ethical reflection into routine health promotion practice continues to be a challenge internationally. In particular, there has yet to emerge a formal Code of Ethics that might consistently prompt and shape ethical reflection for health promotion practitioners. In 2007, Mittelmark invited progress toward precisely such “a serviceable ethic for daily work”, hoping also that a clearer professional identity for health promotion practitioners might emerge as a result [1, p. 78]. He observed the following:

Though we have the cornerstone of an ethic for health promotion, in the Ottawa Charter and in other principled documents that have followed, we have yet to build sufficiently on the cornerstone; an ethic for practice has yet to be codified [1].

While this problem remains, it has not gone unnoticed, and local attempts have at least been made to assist practitioners in their understanding and application of the sort of professional standards (or “Competencies”) that have since been explicitly formulated in Australia [2].

This article describes and analyses one such attempt at assisting practitioners in their ethical reflection, sustained from 2006 to 2014 in rural South Australia. In effect, the article describes an attempt at embedding ethical reflection into health promotion practice through capacity building activities, which were informed by some principles of organisational change management [3, 4, 5, 6, 7]. Loosely speaking, those principles were: involve all layers of the organisation; create a sense of ownership over the change; communicate the simple message; implement system changes as a means of building a better culture; and, in particular, create “champions”, people who will promote change both actively and by example [8, 9, 10]. The attempt at capacity building is described to stimulate discussion toward fostering more routine and comprehensive ethical reflection in health promotion practice. The article presents a framework, largely comprising ethical questions, that might be useful to practitioners, especially in thinking through ethical considerations as part of formal applications for the ethical review of health promotion activities. The framework was developed to be as accessible as possible in light of the diverse educational backgrounds found in rural settings.

Anecdotal evidence suggests that ethical awareness and reflection is still limited in health promotion practice, at least in some parts of Australia: practitioners tend to veer away from the vagueness of ethics and, in this respect, are still in need of help. This article provides an example of how that help might be provided.

## Building capacity in rural South Australia

In 2006, South Australia's health department undertook an internal audit of the health promotion capacity of its workforce in a particular rural region, utilising checklists developed for similar purposes in Canada [9]. The audit made clear that limited capacity existed in two key areas.

First, the programme planning, and the evidence bases being used, were poor. Allied health practitioners, administration staff and nurses usually worked as the Project Officers responsible for planning health promotion activities. These professionals tended to be proactive and practical – by nature, training or both – so they would sometimes replicate health promotion work that they had seen presented at conferences without thorough examination of how that work might need tailoring to the local context.

Second, there was little consideration of the harms that health promotion activities could inadvertently cause, and even if the question of harms was considered, there was insufficient reflection on the sorts of things that might constitute harms. For instance, there was a lack of thinking about the sustainability of activities, especially about the community expectations that might be encouraged but then frustrated when programme funding was discontinued. Furthermore, skills were lacking in identifying conflicts of interest, as demonstrated on one occasion when some health promotion practitioners partnered with a bank. The bank had requested access to the raw health data that would be collected as part of the health promotion activity. The bank would then have been in a position to share the health data of bank clients with internal insurance teams,

violating clients' privacy and potentially compromising their insurance coverage. The health promotion practitioners trusted the local bank staff, being acquainted with them personally, and they were overwhelmingly happy to have secured the bank's support, especially in the form of funds. Nobody asked 'Why would the bank want the raw health data?' This example provides a reminder of one of the reasons why ethical reflection is important in health promotion: health promotion can incur harms.

The problem of limited workforce capacity, as revealed by the government's internal audit, may have existed in part due to four complexities specific to the rural workforce [11].

First, the rural workforce is known for recruitment and retention problems [12, 13]. There tend to be skills shortages, and the few people who have both the needed skills and the willingness to work in rural areas are in such demand that they can readily move on to new jobs [14]. Second, if new staff come from metropolitan areas, they can fail to appreciate how, and how much, rural communities can differ from one another [11]. Third, geographical isolation means that many health promotion practitioners cannot engage in the face-to-face conversations that facilitate the in-depth exploration of issues such as ethical issues [11].

Finally, the rural workforce features a diversity of education levels [15]. For instance, in audited region of South Australia, some administrative staff had secondary school qualifications, while others had been specifically trained at a technical college. Some health professionals had been trained purely within the hospital setting (e.g., nurses

trained some years ago), while others had attended university to complete Bachelor degrees and, in a minority of cases, Masters degrees [16]. The frequent lack of university study may have reduced these health promotion practitioners' exposure to 'ethics', considered as explicit and systematic ethical reflection informed by critically scrutinised concepts [17]. In turn, this seemed to have resulted in practitioners not only lacking professional capacity, but also in their being intimidated about building such capacity. At the mere mention of ethics, some health promotion practitioners virtually threw their hands up in the air. This phenomenon, personally observed by the first author of this article, helped to clarify for her one of the key challenges in health promotion: in the academic literature, different frameworks offer multiple options for undertaking ethical reflection in the interests of improving practice [17, 18, 19, 20, 21, 22, 23, 24, 25, 26], but there is limited guidance for dealing with the diversity of understanding and education levels on the ground, especially in rural areas. One of the main aims of this article is therefore to present a framework developed to assist health promotion practitioners to engage in systematic and explicit ethical reflection with precisely this diversity in mind. This framework is introduced below.

From 2006 onward, medical, nursing and some allied health streams were moving to national registration and standards, including ethical-practice standards [27]. However, such standards tended to be light on detail, and principles of organisational change management suggest that such standards tend to require appropriate supports to result in changes in practice. Competencies were formally introduced to the health promotion profession [2], offering something of a framework for ethical practice but no real guidance as to how the competencies might be acquired, especially by rural

practitioners, who suffered limited access to short-course education due to the cost and inconvenience of attending far-away training. Moreover, the Competencies were unaccompanied by any mechanism of enforcement or reward, such as formal accreditation. Therefore, practitioners needed other reasons to take them seriously.

From 2008-2011, an organised attempt was made within the South Australian health department to build the capacity of health promotion practitioners within one rural region to undertake ethical reflection as part of their routine practice. The attempt drew on principles of organisational change management [3, 4, 5, 6, 7], especially in emphasising the role of “champions” in effecting wider change [8, 9, 10]. Practitioners were encouraged to engage positively with the attempt, and to take seriously the new Competencies with which it was intentionally aligned, through the offer of both Continuing Professional Development (CPD) points and formal qualifications through Australia’s Technical and Further Education (TAFE) system.

The attempt focused mainly on investing in *people*, namely the health promotion practitioners themselves. However, *processes* were also invested in due to the retention problems faced by the rural workforce. The attempt took the form of four interlinked components:

- Component 1. A framework for ethical reflection tailored to health promotion practice: the Health Promotion Ethics Framework.
- Component 2. An introductory session on ethics as it relates to health promotion.

Component 3. A short course spanning six months in which participants learned about programme planning and evaluation, together with the role of ethical reflection.

Component 4. The addition of two prompts to a routinely used web-based programme planning tool [28]: “Describe the steps that have been taken to ensure that this project is equitable and ethical”; and “Does this project require ethics approval?”.

The framework for ethical reflection (Component 1) was imparted during both the introductory session (Component 2) and the short course (Component 3). It was also presented as a resource for answering the ethical questions added to the web-based planning tool (Component 4). During the short course (Component 3), participants were trained in the use of the web-based planning tool (Component 4) and given the opportunity to gain experience in conducting ethical reflection as part of using it.

Means for sharing past and future applications to Human Research Ethics Committees (HRECs) were also introduced. This aimed to address the problem of rural practitioners not always appreciating how rural communities could differ and thereby require different approaches. It also aimed to overcome the geographical isolation that impeded the collaborative exploration of ethical issues.

All Components, especially Component 1, were made as accessible as possible in light of the educational diversity of the rural workforce. The aim of Component 1 was to provide practitioners with a resource that would help to ensure a systematic and

consistent approach to considering ethical issues as part of routine practice. The Health Promotion Ethics Framework that resulted was comprised of ten headings, together with explanations of their meaning and relevance, along with questions under each heading that practitioners were encouraged to ask in relation to a proposed health promotion activity (see Appendix 1). This format was adopted to provide practitioners with greater clarity and precision regarding the kinds of ethical issues that could arise in the practice of health promotion. It was also adopted to make ethical reflection more approachable and less intimidating for practitioners, since anecdotal evidence had suggested that practitioners were tending to fear the word ‘ethics’, mistakenly thinking that if ethical issues were uncovered, then this was a bad thing and a horrific process awaited in needing to acquire formal approval from a review committee, e.g. a HREC.

The Framework was primarily developed by adapting the framework that, internationally, the youth sector had developed for prompting and guiding ethical reflection on professional practice [29]. Other points of reference used during the development of the Health Promotion Ethics Framework included: national healthcare standards [30]; the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research [31]; the Aboriginal Health Impact Statement, whose use is mandated by the South Australian health department [32]; broader research policies of the South Australian health department [33, 34]; and Patton’s “ethical issues checklist” for conducting qualitative research [35, p. 408]. The Framework was also developed with an understanding of three dominant theories within the field of public health ethics, as those theories are elaborated and situated by Holland: utilitarianism, liberalism and communitarianism [18]. Participants in the introductory session and the

short course (Components 2 and 3) were introduced to these theories in terms of their potential relevance for analysing the ethical acceptability of health promotion activities. The theories were discussed in terms of the importance of securing positive outcomes for people's welfare, respecting individuals' rights, and upholding a community's identity and *ethos*, especially in relation to Indigenous communities. Participants were invited to consider how these considerations often had to be balanced against one another.

Evidence of the feasibility and effectiveness of the capacity building effort that comprised Components 1-4 is limited and mostly anecdotal. Early attendees (n = 56) at the introductory session on ethics (Component 2) provided written feedback: 90% confirmed that the session would change their practice, with 5% confirming that it would not, and 5% being unsure. Informal feedback was also positive, as were peer-review evaluations of the short course (Component 3). Local employers were persuaded to list in relevant job descriptions attendance at the short course as a 'highly desirable' selection criterion, and 49 short-course participants went on to earn a Certificate III or IV [18], or a Diploma, in Population Health. Equipped with the Framework (Component 1), staff stated that they now felt ready to query ethical issues with a view to improving practice and that 'ethics' is not merely about HREC approval. Moreover, the number of HREC applications and approvals rose in the region: the number rose from zero applications in 2007 to 2-4 approved applications per year now. Finally, some of the regions' health promotion work is now award-winning, and Components 1-4 may have played some role in this.

## Philosophical analysis

Carter et al. interviewed health promotion practitioners to identify their guiding values [36]. Interviewees held that

health promotion strategies should be developed over time in respectful relationships, that practitioners should be flexible and responsive to communities, that interventions should build capabilities in communities, and that health promotion work should be sustainable.

Considered together as an effort of capacity building, Components 1-4 reflected these values, precisely while acting to foster them in health promotion practitioners.

Component 1 (the Health Promotion Ethics Framework that was developed) mainly takes the form of what Carter termed “questions to sensitise the user to ethical concerns” [37, p. 20]. It is consistent with the Ottawa Charter in at least three important respects. First, it evinces a clear emphasis on community consultation and partnership, implicitly envisaging “citizens as active contributors to their own health and the health of the public” [37, p. 24]. Second, it evinces a “socioecological approach to health” [38], whereby health is “the product of social, environmental and economic living conditions” [37, p. 20]. Finally, it evinces a concern for well-being and not simply health in a narrower sense.

Within the Framework, under the heading of ‘Duty of Care’, one can clearly discern an emphasis on two of the principles of biomedical ethics: beneficence and non-maleficence [39]: “Workers will act in the best interests of people, avoid exposing them to physical, psychological or emotional harm or injury, and always uphold the principle of ‘do no harm’.” The principle of non-maleficence (‘do no harm’) is given particular emphasis, and this emphasis is consistent with the emphasis that a liberal society such as Australia places on some fundamental rights of the individual. Meanwhile, repeated use of the word ‘community’ throughout the Framework also indicates a communitarian perspective. This perspective, commonly associated with health promotion, challenges the adequacy of liberalism in its foregrounding individuals, rather than communities, as the primary locus of moral concern. In the Framework, this communitarian perspective does seem supplementary to the liberal perspective, with individual rights, especially negative rights regarding the avoidance of harm, being implicitly deemed to be more important than the identity and strength of a community. Again, this emphasis mirrors Australia’s liberalism and, more widely, the prominence of human rights in global political discourse.

The Framework does not reflect a single ethical theory, but rather an occasion for ethical reasoning based on principles. As Carter has observed, “[r]easoning from principles is a common approach in bioethics, because it provides heuristics to support practical problem solving under time pressure” [37, p. 20]. Compared to theories, principles also tend to be simpler and thus more readily understandable, which helps to keep the Framework accessible and thereby useful to the diversity of health promotion practitioners for which it is designed. The Framework is also fairly pragmatic and

inclusive of a wide range of potential ethical issues, and in this respect it resembles Hoffman's checklist for canvassing potential ethical issues as part of assessing a health technology [40].

A practical tool for ethical reflection needs to be accessible to the profession for which it is designed. Therefore, efforts need to be made to cater for different education levels and casts of mind as they exist within that profession. The Framework reflects one such effort. Keeping things accessible does not automatically mean dumbing things down, though it does mean trying very hard to make things clear and direct. On the other hand, one risk of pursuing clarity and directness above all is to promote simplistic approaches to ethical reflection. Gaita argues that there are "pressures to simplification" within our culture, including even the charitable impulse "in a morally diverse and multi-cultural community to seek a common moral and political language – a kind of moral Esperanto" [41, pp 252-253]. The importance placed on government transparency and accountability may function as another pressure to simplification. Pressures to simplify things "make consequentialism – the doctrine that teaches that only the consequences of our actions matter morally, an almost irresistibly attractive political philosophy" [41, p. 253]. This is problematic to the degree that consequentialism can commend actions that we intuit to be immoral, and to the degree that consequentialism can "make most of our appreciative moral vocabulary redundant" [42, p. 81]. In other words, consequentialism can diminish our ways of speaking about important matters, and therein it can diminish us. Therefore, in putting together a set of questions to promote and guide serious ethical reflection within a profession, one needs to achieve accessibility but avoid over-simplification. Making the questions clear and

direct, but also quite numerous, may be one means of achieving this. The Framework seems to take this approach.

It is strange that the word ‘ethics’ should come to provoke exasperation of the kind marked by throwing one’s hands in the air. The word ‘ethics’ may excite this response for three reasons.

First, the word may strike people as utterly ambiguous, because it is too often used without context, just being dumped on the front door, as it were. The headings in the Framework go some way to providing a context in which the word ‘ethics’ can make more sense to people in their professional role.

Second, the word ‘ethics’, at least in some contexts, may have become a weasel word, a word that is used in ways that have become painfully routine and almost meaningless. Watson characterised such words – or, more precisely, tired uses of words – in terms of “clichéd, impenetrable, lifeless sludge” [43]. Again, it is strange that the word ‘ethics’ should have come to this, but perhaps it has in some circles, due to being used without sufficient context, and due to the final reason why it may provoke exasperation.

The word ‘ethics’ can intimidate people, because it is too often presented as delineating a field of scholarship that is impenetrably complex and, partly for that reason, the proper concern of others – in short, experts who aren’t you. But ethics are lived as well as studied, and there is a diversity of opinion as to precisely what the people paid to study ethics bring. The perception that ‘ethics’ is the proper concern of experts is not helped

by sentiments such as the following: “lists of principles alone cannot be detailed enough to support thorough ethical reasoning about a situation: to fully understand the principles requires familiarity with the complex concepts that underpin them” [37, p. 20]. Moral philosophers debate whether such statements are true, namely whether theory is really needed to reason well when it comes to ethical matters. How thoroughgoing must one’s thinking be to qualify as a justifying account of some action? In seeking to justify one’s action, can one appeal to a simple principle, or must one delve deeper to some theory that underpins and ultimately unifies principles? Gaita and other moral philosophers who apply insights made by Wittgenstein argue that general ethical theory is often redundant, if not downright misleading in its reductionism [42, 44].

The professionalisation of ethical reflection is a double-edged sword. Its merits continue to be debated among bioethicists, for instance [45, 46]. On the one hand, it can prompt and guide meaningful ethical reflection. On the other hand, it threatens to shoulder out of serious and important discussions every non-professional, namely most of us. Moreover, it threatens to lighten the burden of ethical reflection that historically comes with being a practitioner in so many fields of endeavor. Why worry too much about what is right to do when other people are paid to worry for you? Why go into all that confusing business when other people are paid to become experts for you? These sentiments are important to discourage, therefore people who are paid to undertake ethical reflection do well to bring others along with them by creating accessible prompts and guides to reflection, such as the Framework presented in this article, and by not insisting on an expertise that makes impossible genuine dialogue [47].

## Conclusion

Anecdotal evidence suggests that, in rural South Australia, ethical reflection is now more embedded in routine health promotion practice, with workforce capacity having been built. Moreover, transferable materials, such as the Health Promotion Ethics Framework, now exist to help practitioners elsewhere. This article has described and analysed one effort of capacity building in order to foster broader discussion within the field of health promotion on how to increase the frequency and quality of ethical reflection undertaken by practitioners. The article has provided a Framework that could serve as a useful tool for practitioners, especially those with diverse educational backgrounds, as found in rural settings. It has also highlighted some philosophical dimensions to the Framework, and provided some observations in defense of its role in prompting and guiding practitioners to undertake ethical reflection: ethical reflection is integral to good practice, and never simply the province of theorists.

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## Appendix 1. Health Promotion Ethics Framework

### *Recognition of Aboriginal People*

Health promotion practitioners are culturally competent. This involves recognising that we live on the traditional lands and waters of the Aboriginal peoples of Australia. It involves recognising the importance of culture and land to Aboriginal peoples' self-esteem and sense of identity, and that health promotion practice and programmes need to reflect this.

- Do you have a clear understanding of the cultural needs of Aboriginal peoples and of the relationship to land that Aboriginal peoples' self-esteem and sense of identity involves?
- What are the enablers and barriers with respect to Aboriginal peoples' participation in your programme? (Include consideration of social, cultural or spiritual factors.)  
Is your programme 'hard-to-reach'?

### *People as the Primary Consideration*

Health promotion practitioners appreciate that the people they serve, engage and/or work to empower represent their primary consideration and responsibility. Practitioners are foremost accountable to these people. Practitioners' primary duty is to 'do no

harm'. The use of appropriate evidence, strategies and engagement techniques at all programme stages (planning, implementation and evaluation) is required to meet this duty.

- How does the programme work to put the people served as the primary consideration?
- Who else needs to be considered?
- How should you balance your duties to the people against your duties to the wider community and to relevant organisations? Whose interests should take priority, and why?

### *Duty of Care*

Health promotion practitioners consider and act in the best interests of people and communities. They avoid unduly exposing people and communities to risks of harm and injury (physical and otherwise) and to risks of marginalisation. They examine their personal and organisational standards and any professional duty-of-care statements.

- What risks does your programme pose? Consider risks to individuals, groups and the wider community.
- Will you ignore, eliminate or manage these risks? How will you eliminate or manage them?

- What is in place to prevent people from suffering harm, including from injury and abuse? How will you ensure that it remains in place?

### *Privacy and Confidentiality*

Health promotion practitioners respect people's rights to privacy and confidentiality. They understand how to respect those rights in different contexts and settings. They consider how organisational requirements and relationships within communities may pose problems for the preservation of privacy and confidentiality.

- What are some of the complexities around managing confidential relationships? For instance, health workers are often more visible and well-known in rural areas than in metropolitan areas.
- What difficulties can privacy and confidentiality requirements create for the health worker in your setting?

### *Boundaries*

Health promotion practitioners maintain boundaries between their professional practice and personal lives. They appreciate the importance of these boundaries in protecting themselves, other individuals and the wider community. They also examine these boundaries and what follows for relationships in the context of doing community work.

- What criteria do you use to determine where the boundaries are in your work with others?
- Are there boundary issues you need to be aware of?
- Specifically, what are the kinds of things that you might say or do that would cross the boundaries in your work with people?
- Advocacy or enabling people can involve pushing boundaries, i.e. taking measured risks. When should you push boundaries? What criteria do you use to help you make those judgements?

### *Transparency, Honesty and Integrity*

Health promotion practitioners use best-practice engagement principles, which focus on openness, trust, respect and honesty. In this way, they enable others to access information and resources and to make decisions regarding participation in social activities. Practitioners act with integrity, adhering to the values of their profession and organisation, reflecting carefully if conflicts ever arise between these.

#### **Transparency**

- What are the implications of being open and truthful with people? Are there situations when it is not possible to be open and truthful in your work with others?
- Do you let stakeholders have access to people you work with? Could this pose ethical dilemmas?

- Do you make clear to individuals, groups and the community (1) who you work for and (2) what they can reasonably expect from you?
- Have you knowingly withheld information from people? Is this ever justifiable?

### *Social Context*

Health promotion practitioners appreciate the impact of social and cultural forces on people, and how certain settings can inhibit or enhance those forces. Practitioners ensure that their work is relevant, appropriate and responsive to people's needs, experiences and setting.

- Are you a 'fly-in-fly-out' practitioner? Do you live in the community with which you work? Does this affect how you may consider or address issues?
- How does inequity and inequality affect the people you work with?
- How do prejudice and stereotyping affect the people you work with? (Consider prejudice and stereotyping with respect to class, age, gender, race, and culture.)
- Could the nature of your work conflict with the social context in which you work? How might this shape how you work? For instance, trying to solve 'wicked' social problems could further marginalise a particular community.
- How can you build people's capacity so as to increase levels of personal and social responsibility for health and well-being?

## *Anti-oppressive Practice: Non-discrimination, Equity and Self-awareness*

Health promotion practitioners ensure that equity and equality of opportunity are promoted. They appreciate that non-judgmental approaches and respect for diversity are of paramount importance. They empower people to respect and celebrate both their own and others' cultural backgrounds, identities and choices. They empower people to ensure that everybody in their community has a fair go and receives their fair share of whatever their community has to offer.

### **Equity**

- How do you get beyond the labels or the stigma? Do you treat all people equally regardless of their race, gender, religion, disability or sexual orientation?
- Have you taken into account people's additional support needs?
- What are the advantages and disadvantages of targeting services?
- What are your personal values and beliefs, and how might this impact on your practice?
- How many people do you work with who are dissimilar to you? How do you deal with this? Do you find it difficult to work with people who have particular issues or difficulties?

### **Self-awareness**

- What strategies do you use to become more self-aware, especially in relation to your practice? How well do you know your strengths and weaknesses?
- How well do you respond to critical feedback from colleagues and other people?

## **Discrimination**

- Jones sees racism as having three different levels. To illustrate them, she talks about the gardener's tale. See Jones (2000) *Levels of racism: a theoretic framework and a gardener's tale*. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446334/> .
- Is institutionalised discrimination happening in a particular setting for a particular group? If so, how?
- Is personally mediated discrimination happening in a particular setting for a particular group? If so, how?
- Is internalised discrimination happening in a particular setting for a particular group? If so, how?
- What might need to be done to reduce discrimination in this setting for this group?

## ***Engagement and Collaboration***

Health promotion practitioners engage others and build their capacity to bring about the best possible outcomes for people and communities. They facilitate co-operation and collaboration among all by helping the collective voices of communities and stakeholders to have equal opportunities for participation and decision making when it comes to issues that are relevant to them. They promote solutions, not stand-offs.

- How do you manage conflict when views or even values differ while engaging with others?

- What do you think are the key factors that enable a practitioner and community to work effectively together? What are the things that get in the way?
- How do you think other agencies and the community perceive health workers?
- What are some of the main skills and attributes, both personal and professional, that promote co-operative working practices?

### *Knowledge, Skills and Self-care*

Health promotion practitioners keep abreast of the evidence and of new and emerging practices to ensure that they can meet their duties to the people and communities they serve. Practitioners compare their practice to the Australian Health Promotion Association's (AHPA's) *Core Competencies for Health Promotion Practitioners*. And they embrace life-long learning for themselves to help them develop best-practice programmes and services in communities.

#### **Knowledge and Skills**

- How are you encouraged to reflect on your practice and direct interventions with people? To what extent do you drive your own professional development and take responsibility for identifying your future learning needs?
- To what extent can you admit your mistakes and see them as opportunities for learning?

#### **Self-care**

- What are the characteristics of an organisational culture that promotes the health and well-being of staff? What steps can you take to ‘look after yourself’ in the workplace?
- How do you manage competing expectations and the resultant pressures?