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RESEARCH

Health visitor professional education and post-qualification clinical supervision: how well does it equip practitioners for dealing with ethical tensions associated with promoting the public health agenda to individual clients?

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Aim: To explore how well professional education and post-qualification clinical supervision support equips health visitors to deal with ethical tensions associated with implementing the public health agenda while also being responsive to individual clients. **Background:** Current health policy in England gives health visitors a key role in implementing the government's public health agenda. Health visitors are also required by their Professional Code to respond to the health-related concerns and preferences of their individual clients. This generates a number of public health-related ethical tensions. **Methods:** Exploratory cross-sectional qualitative (interpretive) study using 29 semi-structured individual interviews with health visitors, practice teachers and university lecturers exploring how well health visitors' professional education and post-qualification clinical supervision support equips them for dealing with these ethical tensions and whether they thought further ethics education was needed. Interviews were audio-recorded, transcribed and analysed thematically using a Framework approach. **Findings:** Health visitors' professional education did not always equip them to deal with ethical tensions, which arose from delivering public health interventions to their clients. However, the majority of participants thought that ethics could not be taught in a way that would equip health visitors for every situation and that ongoing post-qualification clinical supervision support was also needed, particularly in the first year after qualifying. The amount of post-qualification support available to practising health visitors was variable with some health visitors unable to access such support due to their working circumstances and pressures on staff time. Literature on the ethical tensions associated with evidence-based practice; public health ethics and ethics of care might be useful for health visitors in gaining greater understanding of the ethical tensions they face. This could be introduced as part of health visitors' professional education or on post-qualification study days.

Key words: clinical supervision; community health nursing; ethics; nursing education; public health

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Background

The United Kingdom's Nursing and Midwifery Council (NMC) register has three parts, covering nurses, midwives and specialist community public health nurses (SCPHN). The NMC registers SCPHNs separately because public health nursing has distinct characteristics, including responsibilities to work with populations as well as individuals. This may mean taking decisions on behalf of a community without having direct contact with every individual in that community (NMC, 2004).

SCPHN education programmes prepare students to enter a practice-based profession at a level beyond initial registration as a nurse or midwife. The Standards of Proficiency developed for the programmes include one relating to 'Ethically managing self, people and resources to improve health and wellbeing' (NMC, 2004). Successful completion of the programme leads to the Professional award of SCPHN (health visitor) and registration on the third part of the NMC register.

Health visitors lead and deliver the Healthy Child Programme (Department of Health, 2009), which aims to promote good health and prevent illness by offering an evidence-based programme of support from pregnancy throughout the preschool years. They work in community settings, often visiting people in their own homes from bases in clinics, GP surgeries or Sure Start Children's centres.

Successive government policy documents in the United Kingdom have identified health visitors as having a key role in implementing public health agendas (Department of Health, 1999a; 1999b; 2000; 2001; 2002; 2004; 2006; 2007; 2010; 2011). Health visitors' work has always incorporated a public health element, but this has been explicitly emphasised in recent years, and a number of health issues that health visitors address, including breastfeeding and smoking cessation, have been identified as national priorities. For some health issues, primary care organisations are given targets to reach, for example the percentage of babies who are breastfed to at least six weeks. In response, these organisations adopt various strategies to encourage their staff to work towards these targets, and ensure they collect data to document their achievement.

However, health visitors work with clients on an individual basis and are also required to abide by their NMC Code. The Code tells them 'you must listen to the people in your care and respond to their concerns and preferences' (NMC, 2007: 3). A professional obligation to respect individual client preferences (often associated with respecting their personal autonomy) is not always readily compatible with some approaches to promoting public health targets and Cowley and Frost (2006) have noted that health visitors may experience ethical dilemmas as they are required to both respect clients as individuals and to protect and support the health of the wider community.

Potential tensions between concerns to respect personal autonomy and efforts to promote the health of the wider population are important issues in a developing literature on public health ethics (Bayer *et al*., 2007; Dawson and Verweij, 2007; Holland, 2007; Calman, 2009). Renewed interest in public health led to awareness that individually oriented medical/nursing ethical frameworks can be inappropriate when a population-based perspective is adopted and emphasis placed on disease prevention rather than treatment (Kass, 2001; Callahan and Jennings, 2002; Bayer and Fairchild, 2004). A number of theoretical and conceptual models/frameworks have subsequently been developed to help public health professionals consider the ethical implications of their work (Kass, 2001; Childress *et al*., 2002; Nuffield Council on Bioethics, 2007; Tannahill, 2008), and calls have been made to pay more attention to the institutional processes that shape and constrain ethical dialogue and practice (Austin, 2007).

Empirical research studies have identified a number of important ethical tensions and concerns that public health nurses can face in their day-to-day practice (Beidler, 2005; Clancy and Svensson, 2007; Moules *et al*., 2010). Several authors have also highlighted a need to strengthen the support given to these nurses to help them deal appropriately with these issues and concerns. For example, Berggren *et al*. (2005) found that clinical supervision could provide an opportunity for practitioners to reflect on ethically difficult situations, strengthen professional identity, help them to integrate theory and practice, and support the development of ethical competence.

As recent government policy documents (Department of Health, 2007; 2010; 2011) seek to involve health visitors more explicitly in efforts to

improve population health, there is the potential for experiences of ethical tension to be exacerbated and the need for support to be heightened.

Aims

The work reported here was part of a larger project that aimed to investigate:

1) How health visitors experience, perceive and manage any ethical tensions arising from aspects of their work relating to the pursuit of public health goals in the context of care for individual clients.
2) How well their professional education and post-qualification clinical supervision support equips them to deal with ethical tensions associated with this role.

Findings relating to the first aim have been reported separately (submitted). This paper focuses on findings relating to the second aim.

Design

Exploratory cross-sectional qualitative (interpretive) study using semi-structured interviews.

Methods

Sampling, recruitment and consent

Health visitors and health visitor educators were purposively recruited on the basis that they were uniquely placed to comment on their experiences and that their roles would enable them to provide detailed understanding of the issues relevant to the research aims.

Attempts were made to ensure that the samples were as diverse as possible in order to optimise the chances of identifying the complete range of factors associated with the phenomenon being investigated (Ritchie and Lewis, 2003). Health visitors and practice teachers were recruited from two English Primary Care Trusts (PCTs – the main primary care provider organisations), one covering a large city and the other covering a smaller city, a number of towns and rural areas. The researchers also sought to include health visitors and practice teachers from different backgrounds and with varying levels of experience, but were reliant for this on a range of individuals opting into the study. Information about the study was presented at four locality-based monthly professional meetings for health visitors, where participant information booklets and reply forms and stamped addressed envelopes were provided for those interested in participating. The information explained that the interviewer was a health visitor.

The United Kingdom Standing Conference on Health Visitor Education sent information about the research to university-based health visitor educators in the United Kingdom, inviting them to send a reply form to the researcher if they were interested in participating.

Appointments were arranged to discuss the study in more detail with individuals who expressed interest. They took place at potential participants' work bases (GP surgeries, clinics or health centres for health visitors and practice teachers, university offices for university educators). Individuals who were willing to be interviewed after this discussion signed a pre-interview consent form to confirm that: they had read and understood the information booklet for the study and had any questions satisfactorily answered; they understood that participation was voluntary and that they were free to withdraw at any time without their employment or legal rights being affected; they agreed to the interview being recorded; they understood that the information they gave would be kept confidential and in accordance with the Data Protection Act (1998) and they agreed to take part in the study. At the end of each interview, the participants were asked to sign a post-interview form to indicate consent to the research team publishing anonymous quotations from the interview. All participant forms were stored in a locked drawer in a university office.

Approval to conduct the research was obtained from the NHS National Research Ethics Service and relevant NHS Research and Development offices.

Data collection

Interviews were conducted at participants' work bases. They varied in length but averaged around 45 minutes. Topic guides were used to help ensure coverage of key topics, via open, non-leading questions and flexible follow-up probes in a conversational style. The topics included participants' views on: the ethical tensions faced by health visitors in implementing public health interventions to their clients; the extent to which the SCPHN course prepared health visitors for dealing with these tensions; sources of support for

health visitors in practice; and the need for further ethics education.

All interviews were audio-recorded. A total of 29 semi-structured interviews were carried out between March and August 2008. Seventeen were with health visitors and 12 with health visitor educators (nine university-based educators and three practice teachers). Recruitment and interviewing of both health visitors and educators took place during the same time period. All those who returned reply forms expressing an interest in taking part in the study were interviewed. Because a good range of health visitors and educators were included in these samples and because similar issues were recurring and no new issues emerging in the more recent interviews, the research team agreed that no further recruitment was needed.

Data analysis

Interviews were transcribed verbatim and personal identifiers removed. The matrix-based Framework approach to qualitative data analysis was used to facilitate rigorous and transparent management of data (Ritchie and Spencer, 1994).

Analysis was led by J.G. but in order to ensure quality co-authors read transcripts, discussed the interpretation of data and the development of codes and checked coding and charting. This scrutiny of interviews by the whole research team was an important way of ensuring that leading questions had been avoided or were recognised during the analysis.

Twelve broad thematic domains were identified for health visitor participants and 11 for educators. The resulting thematic charts were circulated to all members of the research team to ensure that the analytical process was scrutinised at each stage.

In the illustrative quotations presented below, health visitors are labelled HV 01–HV 17 and educators are labelled Ed 01–Ed 12 with practice teachers identified by an additional PT designation.

Findings

The sample included 17 female health visitors with diverse working backgrounds. They represented a cross-section of ages and had been in practice for various lengths of time. Nine had been qualified between 1 and 10 years; five had been qualified between 10 and 20 years and three had been qualified for between 20 and 30 years. They had varying case-load numbers, worked in both affluent and less affluent areas and engaged with clients who represented a wide range of socio-economic groupings and national/ethnic backgrounds including British, Polish, African, Asian, Pakistani, Bangladeshi and Somali. Some health visitors worked as part of a team but maintained their own identifiable case-load, some worked corporately on large combined case-loads and others worked alone on their own case-load.

All three practice teachers and nine university-based lecturers were female. The practice teachers were all also employed as health visitors. They supervised health visitor students gaining practical health visiting experience as part of the SCPHN course. They had been qualified for between 7 and 24 years. The lecturers were all qualified health visitors and were employed by and based in universities in England, Scotland and Wales. Their main responsibilities were teaching health visitor students enrolled on the SCPHN programme. The main topics that they taught included health promotion; research methodology; policy in practice; Health Needs Assessment; development of the Family Nurse concept and leadership and management.

In the sections that follow we consider participants' views on how well health visitors' professional education and post-qualification clinical supervision support equips them to deal with the ethical tensions inherent in delivering the public health agenda while respecting the autonomy of individual clients. We also present participants' views on further ethics education requirements.

The ethics component of SCPHN courses

None of the university educators reported offering a specific ethics module on their SCPHN courses although two educators included one or two sessions where ethical frameworks were introduced and case scenarios discussed. Most educators reported that ethics teaching was woven into other modules such as Public Health, Health Promotion or Foundations for Practice. Classroom discussion on the ethical tensions introduced in these teaching sessions and issues that students identified from their practice placements was encouraged. These classroom discussions were identified as the main method used to prepare

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health visitors to deal with ethical tensions in practice. A number of educators spoke of how such discussion developed students' critical thinking ability and provided opportunity to reflect with others on decisions made in practice:

> *… in the way we deliver the curriculum a lot of it is about discussion… we have a chance for them to bring issues in from practice where you do actually get the ethical issues coming up.*
>
> *Ed 05*

> *I think the one thing that helps them to make good judgements is opportunity within the course…to have time to reflect with others …about how good that decision was and really celebrating good practice and questioning things that perhaps could have been done better.*
>
> *Ed 06*

The classroom discussions which included an ethics component covered exploration of: students' own values; concepts of health; the extent to which their employing organisation protocols directed their work; universal versus targeted health visiting services; working in partnership with clients; and ethical tensions associated with the use of health promotion models.

Students' own values

A number of educators reported that it was important for students to explore their beliefs and feelings about issues in order to be aware of judgments they might be making:

> *…we do ethical issues, for example, around working with different cultures, working with diversity, challenging people's sort of value judgements around, for example…why women do stay in violent relationships, challenging people's values around disciplining children…we do all those sorts of things… throughout the whole programme.*
>
> *Ed 11*

Concepts of health

Educators were keen to ensure that students had wide concepts of health and understood that while lifestyle changes might improve aspects of clients' physical health, they would not necessarily improve health overall if the clients were still living with other problems such as debt or domestic abuse:

> *… they might reduce how much they drink and they might eat loads more fruit and veg. and they might go and get all their kids immunised… but they might not feel any healthier because the debt collector might still be knocking at the door; they might still be living in an abusive or violent relationship so their health might not be any better as far as they view their health… so I think it's just how people view health and is health for the whole person or is it just for physical health?*
>
> *Ed 01*

Employing organisations' protocols

Educators also reported discussing with students the extent to which their employing organisations' (PCT) protocols directed their work while out in practice, and whether or not it was acceptable to leave some problems hidden because health visitors lacked time to go and find them:

> *… a lot of the time they seem to be directed by the Trust's protocols or a tick list or a check list as opposed to really searching for their needs…and its trying to get them to say OK, well they might not fall into your little checklist of vulnerable but it doesn't mean they won't have a problem.*
>
> *Ed 01*

Universal versus targeted health visiting services

The issue of whether health visiting services should be provided universally or targeted was reportedly covered while looking at family-centred work. Universal services are interventions available to a whole population group that has not been identified on the basis of increased risk whereas targeted approaches focus on sections of the population who have identified needs or risk factors (Cowley, 2008). Educators sought to cover issues such as who decides who receives a health visiting service and what would the likely consequences be if people discovered that only certain people were being seen by a health visitor:

> *When we're looking at the family centred work we start looking at things like…universal*

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services as opposed to targeted services…we touch then on some of the ethical issues around…who decides who gets seen and who doesn't get seen…what would be the impact if somebody found out they were being seen and their friends weren't being seen?

Ed 01

Partnership working

Discussion on ethical tensions was reported to take place when students received teaching on the importance of working in partnership with clients and families. A number of educators identified the importance of partnership working in order that realistic changes could be suggested, which took into account issues such as whether the timing was right for the client to make the change:

…they have to be realistic…and it has to be in concordance with the person that you're delivering it to…it's not what you want it's what that person needs and wants…at the right time…that's very important for me to teach the students that it has to be the right time.

Ed 03

Health promotion models

Students received teaching on theoretical health promotion models and a number of educators reported that ethical tensions emerged and were discussed during these teaching sessions. Four university educators (Ed 05; Ed 10; Ed 11; Ed 12) mentioned Prochaska and Diclemente's Stages of Change Model (Prochaska and Diclemente, 1986) as being useful for teaching students to assess individual clients to ascertain what stage they were at with regards to changing certain health behaviours, and then to match interventions accordingly:

I think Prochaska and Diclemente is a very good model for behaviour change…it's having knowledge of what's appropriate at what stage that would help the practitioner to know how to engage with that person and be more successful in that behaviour change.

Ed 10

Four university educators (Ed 01; Ed 05; Ed 10; Ed 12) reported using Beattie's model (Beattie, 1991) to teach students the importance of addressing health issues from both population and individual perspectives, combining top-down legislative policy with bottom-up partnership working with clients. They suggested this model could encourage thinking and discussion about issues such as when it is acceptable to override individual autonomy for the sake of the public good. For example:

…things like adding fluoride to the water-…that immediately detracts from somebody's autonomous rights. But for those very vulnerable children in that population we know that it has a huge impact on their dental caries.

Ed 10

Ecological models of health promotion integrate behavioural and environmentally based health promotion strategies. These were cited by two university-based educators (Ed 11; Ed 12) who thought they gave students an awareness of the complexities of behaviour change. Stokols (1996) suggests that an ecological model takes into account the fact that there is a dynamic interplay between personal and situational factors in health and illness at both the individual and population level. Educators saw a need to teach students the importance of knowing the client's context and the impact that changing behaviour might have on the individual and their whole family:

…being aware of the context in which that person is living their life, and the context in which they may or may not be able or want to use the advice that you're giving to them… things like the impact of health change, not just on one person within a family but perhaps on the whole family…I'd expect them to think about an ecological model of health promotion.

Ed 12

University educators' views on the adequacy of ethics teaching in the current curriculum

Most university educator participants thought their courses adequately prepared health visitors to deal with the ethical tensions they would face in practice, although this view was not shared by the health visitors in practice (see below), and a number of educators acknowledged that there was always scope for more consideration of these issues. One suggested drawing a variety of ethical issues together into a module which, combined with post qualifying supervision, would help

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equip newly qualified practitioners with the skills to make good decisions:

> *…it would be good to have more time that was dedicated specifically to ethical issues, perhaps in which we could draw in a variety of issues that we currently cover in disparate modules into a module…perhaps post-qualification…in that first year afterwards, and tying it up with supervision, that would be very, very beneficial because not only would it reduce the feelings of isolation…but also it would give you a grounding for the future decisions that you were making.*
>
> *Ed 12*

A number of educators reported a mismatch between the university curriculum and the work PCTs wanted health visitors to do once in post. This was recognised as a source of tension for health visitors:

> *I think there is a huge tension because to meet the requirements of the SCPHN courses, you've got to put a very heavy public health community population approach, I'm not sure that's what many of the PCTs want…I think that's why we set up quite a degree of tension between what students are taught health visiting is all about, and then what they see when they go out on practice and what they see when they go into work.*
>
> *Ed 02*

While some university educators acknowledged the value of increasing the ethics component in the curriculum, most thought that the application and modelling of how to deal with ethical tensions in practice was the role of practice teachers.

Practice teachers' views on preparing health visitors to deal with ethical tensions

The practice teachers agreed with the university educators in thinking that a key part of their role was teaching health visitor students to deal with the ethical tensions they faced in practice, as anticipatory classroom discussion alone could not suffice as preparation:

> *…it's definitely something that is learnt out in the field because just discussing it in a classroom just doesn't prepare you for it…you need to…see it in the raw.*
>
> *Ed 08 (PT)*

The practice teachers saw an important place for ethics education on the SCPHN course and suggested that both the timing and the disciplinary breadth of ethics teaching at university could be improved:

> *I think there could be certainly more training…towards the end of the course, or once they're qualified. I feel that students are very focused on assignments during their course…so once assignments were done, it would be quite nice for them to have a period of being free to look at these sorts of issues.*
>
> *Ed 08 (PT)*

> *I think it would be interesting to do a module purely on ethics…and looking at it from multi-agency…because obviously social workers have got a different agenda again and…physiotherapists or OT's (Occupational Therapists)..it would be interesting to see how it's actually implemented in practice.*
>
> *Ed 04 (PT)*

Health visitors' views on ethics education received

The health visitors gave varied reports of their ethics education. Some participants could not remember receiving any such education, whereas others had more or less vague recollections of discussions during their professional education or subsequent study days. While a number of participants felt that the ethics component of the SCPHN course could be strengthened, the majority thought that it was not a subject that could be taught in a way that would equip health visitors for every situation they might face. There was a broad consensus that ongoing post-qualification ethics support was needed:

> *It was nowhere near enough, nowhere near-…I'm not sure you can always teach somebody something like that though, because they're issues that you work at when you're doing the job…I don't think you can do ethics training and that would equip you for every situation…it's an ongoing thing.*
>
> *HV 01*

I think maybe it's the sort of thing now I'd like to look at more. It's more interesting when you've got a bit more experience…it would probably be nice to have some training.

HV 14

Views on sources of support available for practicing health visitors

All categories of participants recognised the value of support for practising health visitors facing ethical tensions in the course of their work.

When asked about sources of support for dealing with any tensions arising from delivering public health interventions, the majority of health visitor participants talked primarily about health visitor colleagues:

My colleagues on the team…yeah…kind of unofficial informal clinical supervision.

HV 07

I would probably initially talk to colleagues… get their views and their opinions.

HV 08

Several recently qualified health visitors highlighted the particular importance of support in the first year after qualifying:

I think I could probably have done with more supervision personally when I first started…somebody I could go to and… discuss ethical matters.

HV 05

I made a lot of mistakes in my first year…it's a huge learning curve.

HV 01

Colleague support was accessed in a range of situations – from informal discussions over lunch or at the end of the day to more structured discussion at team meetings or shared learning sessions.

I think there's a lot of discussion that goes on with colleagues…when we come back in at lunchtime or at the end of the day…and a lot of peer support in how you deal with certain things.

HV 04

However, due to working circumstances, some participants were unable to access colleague support:

…talking through these issues with colleagues I guess but then that doesn't happen that much here now because I'm sort of working very much on my own.

HV 11

Educators also recognised that a lack of adequate resources could lead to an overstretched workforce within which colleagues were unable to support each other effectively:

Sometimes it can be quite hard…having management saying you have to work to this structure or that structure…and by the way, have you met this target? and then to have stuff from government…"well you need to be doing wider public health you need to do this and this".

Ed 01

A lot of them are worn out…they've seen so much change…big changes…not just structurally within PCTs but…electronic records…all this policy coming down on top of them, all these issues around safeguarding…going corporate from aligned GP. A lot of them just feel they're coming round in circles again and they're just getting worn out by it all.

Ed 11

Clinical supervision was considered important to give health visitors opportunities to reflect on ethical aspects of practice:

…clinical supervision…that is often where the key debates come in actually, reflection on practice. I think giving them the confidence to know that there's not always ever…totally right or wrong decision but that it's about safe practice.

Ed 05

Several participants noted, however, that the provision of formal clinical supervision had declined with resource cuts and pressures on staff time:

Well we have in the past done clinical supervision, but it's rather fallen by the wayside again, (laughs) as these things do, because of pressure.

HV 12

We had somebody come in to…train us up for clinical supervision, it was all very good, and then it was really destroyed because they cut down our health visiting days.

HV 13

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Discussion

As practitioners registered on the SCPHN part of the NMC register, health visitors have responsibility for working at both the individual and the population levels. They experience, and need to be familiar with, various kinds of ethical tension that can arise between individual and public health approaches (submitted). They need skills to 'ethically manage self, people and resources to improve health and wellbeing' (NMC, 2004).

The findings of our study suggest wide variation in the educational preparation of health visitors to deal with the ethical tensions they encounter in practice. None of the SCPHN courses included a separate ethics module: rather, ethics teaching is apparently woven through the whole course. A number of educators reported using particular health promotion models to introduce discussion of ethical tensions. They highlighted the strengths of their favoured models but did not comment on the weaknesses that have been identified in literature investigating ethical tensions in health promotion practice. Some of these weaknesses are significant. Prochaska and Diclemente's Stages of Change Model, for example, addresses health behaviour change at the individual level only. Bunton *et al.* (2000) argue that this leads to an oversimplification of thinking about behaviour change and neglects the wider socio-cultural, political and organisational issues that affect health.

Our study also identified a striking consensus among university-based educators, practice teachers and practicing health visitors that an ethics component in health visitors' professional education, while important, would be insufficient to enable health visitors to cope with the ethical tensions they meet in practice and that ongoing post-qualification support would also be needed. This is consistent with the findings and recommendations of broader ethics education literature. The importance of forums for the discussion of ethically troublesome situations in particular has been highlighted (Kälvemark *et al.*, 2004; Woods, 2005; Grady *et al.*, 2008).

Our study showed that the practice teacher's role is of key importance in helping students deal with ethical tensions in practice. Proposed changes to the regulation and organisation of such roles give some cause for concern. Recognising the English government's plans to increase health visitor numbers (Department of Health, 2011) the NMC has highlighted opportunities for flexible approaches to SCPHN programme delivery, including a relaxation of the stipulation that practice teachers should support only one SCPHN student at any one time (NMC, 2011). It now proposes that a practice teacher could oversee a mentor on the SCPHN part of the register, and that the mentor would supervise the SCPHN student so practice teachers could support more than one student at a time. Concerns have been raised as to whether practice teachers are able to effectively support an increased number of students without compromising the standard of education delivered (Harries, 2011).

The following sections outline the ethical skills, knowledge and support that might be useful for health visitors, first as part of their pre-registration education and subsequently post-qualification.

Pre-registration ethics education

Health visitors require a thorough knowledge of the Nursing and Midwifery Code (NMC, 2007), which addresses key areas of professional responsibility, obligations and accountability and outlines key standards of ethical practice needed in order for trust in the profession to be justified. However, the Code does not provide health visitors with sufficient knowledge or understanding of the ethical tensions, which arise in practice, often as a result of them being required to juggle competing priorities and demands. Multiple complex judgements are needed in health visiting, which makes it unlikely that any ethical theory could be directly and easily applied. However, knowledge of relevant ethical frameworks and ethics literature might be helpful in enabling health visitors to gain greater understanding of the reasons why they experience ethical tensions in practice and facilitate reflection on these issues.

We suggest that three key bodies of literature could be particularly helpful: literature on the ethical tensions associated with evidence-based practice; public health ethics literature; and works on ethics of care approaches.

An ability to critique policies and strategies based on evidence-based practice could give health visitors insight into the sources of some of the ethical tensions they are likely to experience in practice and thus make them better placed to deal with these tensions.

For example, while health visitors may be taught on SCPHN courses to have a holistic view of health, this view may become problematic if they are required to work towards achieving their employing organisation's targets, which may not take into consideration the wider context of their client's situation. Although Primary Care Organisations may prioritise particular health issues and approaches to improve the health of a given population, their priorities may not be shared by all health visitors' clients, some of whom will reach different conclusions about particular health behaviours with regards to themselves. Knowing that and why even the most robustly evidence-based guidelines and targets oriented to promoting public health may be inappropriate for particular clients might enable health visitors to consider when it is appropriate to deviate from guidelines or to not prioritise targets given their duty of care to individuals. The evidence base for the benefits resulting from certain health behaviours is not the only factor relevant for clients when making decisions affecting their health and well-being.

Knowledge of the emerging body of public health ethics literature might also be helpful in understanding key ethical tensions associated with balancing individual and the population perspectives, for example in relation to the promotion of childhood immunisation. Knowledge of ethical frameworks such as the stewardship model (Nuffield Council on Bioethics, 2007) communitarian approaches and ethics of distributive justice (Bayer *et al*., 2007) can enhance appreciation of the debates about whether heath visiting services should be universally provided or targeted at specific groups of clients. Other issues analysed in this literature that are highly relevant to health visitors work are ethical concerns, which arise as a result of the preventive nature of public health programmes (Guttman and Salmon, 2004; Dawson and Verweij, 2007) and the potential pervasiveness of health promotion activities (Cribb, 2005).

Ethics of care approaches might also usefully support thinking about health visiting practice. Ethics of care approaches emerged in the early 1980s (Ruddick, 1980; Gilligan, 1982) and focus on the importance of developing caring relationships in which the values of trust, mutual concern and empathy are prioritised (Held, 2006). These resonate with the values expressed by health visitors in our study, as well as recommendations that health visitors develop trusting relationships and work in partnership with clients. Ethics of care approaches can be extended beyond the level of personal relationships to thinking about the structuring of society. They encourage a prioritisation of the raising of children and the fostering of trust between members of society that are highly relevant to health visitors' work in supporting parenting. Ethics of care approaches take a contextual view of personal autonomy (Botes, 2000), recognising that an individual's health decisions may be influenced by wider factors such as their income or the social norms of the groups of people they are in relationship with (Verweij, 2007). This is particularly the case when considering health behaviours such as smoking, method of infant feeding and immunisation uptake, which may be influenced by social norms. The ethics of care also accommodates a holistic approach, which many health visitors aspire to, and it encourages consideration of numerous factors relevant to ethical decision making. Within ethics of care approaches, each situation is deemed to be unique and there is a recognition that ethical decision making must accommodate the particular needs of the individuals involved (Botes, 2000). Again this resonates with the concerns expressed by participants in this study.

Post-registration support

The importance of post-qualification support was stressed by both the educators and the practicing health visitors who participated in this study. Informal support from colleagues and more formal clinical supervision were both recognised as necessary to help address mismatches between what is taught during basic professional education and what is experienced in the changing world of practice, to equip health visitors to make sound ethical decisions and to ensure they could feel supported in those decisions.

Health visitors in this and in other studies reported experiencing discrepancies between what they thought should be done in a given situation and what they were required to do as a result of organisational constraints. Such discrepancies can lead to 'moral distress' (Raines, 2000: 30). Individual coping strategies do not always suffice to manage moral distress, which

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can lead to stress-related disorders (Kälvemark *et al*., 2004). Although the NMC (2008) recommends that clinical supervision should be available to registered nurses throughout their careers and should be developed at a local level in accordance with local needs, both health visitors and those responsible for their professional education noted in this study that its provision was being eroded due to staffing arrangements and workload pressures.

Strengths and limitations of the research

The study benefited from the inclusion of health visitors and practice teachers who had worked for varying lengths of time within different kinds of organisation arrangement and among diverse populations in two contrasting Primary Care Trusts. It also benefited from the inclusion of university-based health visitor educators working in academic institutions from across the United Kingdom. However, only three practice teachers were included in the sample, and the study shows that their role is key in helping students deal with ethical tensions in practice.

A wide range of salient concerns and insights were generated during the interviews, but participants were recruited on an opt-in basis, and it may be that those who responded had particular reasons for choosing to participate in the study that were reflected in what they said. Other participants may have been too busy to respond or felt that they had little to contribute.

The fact that J.G. is a health visitor may have influenced decisions to take part in the study and what participants said and how during interviews. In particular, they may have been more likely to assume commonalities of understanding, but perhaps more willing to share points of personal and professional discomfort.

The topic guide was used in a way that allowed participants to discuss issues, which they perceived as important rather than being constrained by pre-set questions, and authors with different disciplinary backgrounds read the interview transcripts and discussed interpretation of data and refinement of analytic codes.

As with any exploratory qualitative interpretive study, we were able to identify a range of experiences and views relating to the topic of interest, including some that we had not anticipated, but we were unable to estimate the distribution of those experiences and views within the health visitor or health visitor educator populations.

Conclusion

There is a strong ongoing policy trend to involve health visitors more explicitly in efforts to improve wider population health through changing individual health behaviours. This policy, and the responses of some health care provider organisations to it, exacerbates the potential for health visitors to experience ethical tensions as they are required both to respect clients as individuals and to protect and promote the health of the wider community. Health visitors' professional education and post-qualification support do not always equip them to deal with these ethical tensions. Insights from potentially helpful bodies of literature have been identified, which could be introduced as part of health visitors' professional education. Effective post-registration clinical supervision support also needs to be available, particularly for newly qualified health visitors, to support them in ethical decision making.

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