Ethical considerations in phenomenological research

Wendy Walker examines some important ethical issues that researchers need to consider before and during phenomenological research. She argues that failure to address such issues means putting at risk the rights of research participants.

Introduction and aims
Implementation of the Department of Health’s Research Governance Framework for Health and Social Care (DH 2001, 2005) has placed increased responsibility on researchers to demonstrate continuous quality improvements in research practice. This includes careful planning, preparation of documentation and adherence to independent review processes to ensure that research meets the required ethical standards. This article examines ethical issues that required consideration when planning a research study using phenomenological research techniques. Key aspects of a quality research culture are explored and strategies to promote the dignity, rights, safety and wellbeing of those involved in the research are presented.

Phenomenology
Phenomenology is acknowledged as a suitable methodology for gaining insight into the essence or structure of the lived experience (Rose et al 1995). The nature of inquiry is to search for truth and understanding from the perspectives of those being studied and is especially useful when a phenomenon of interest
has been poorly defined or lacks conceptualisation (Polit and Hungler 1999). Emphasis is placed on co-operative researcher-participant relationships and open-ended dialogue to appreciate fully the participants’ perceptions of events (Knaak 1984). This implies the use of qualitative methods of data collection that allow the researcher entrance to the informants’ world and access to their experiences as lived (Polit and Hungler 1999).

Topics appropriate to this research methodology include those central to the life experiences of humans (Streubert and Carpenter 1999) and may be classified as ‘sensitive’ areas of inquiry due to the potential for intrusion into the private sphere (Lee and Renzetti 1993). This in turn draws attention to issues of ethical significance that may be encountered throughout the research process.

**Presenting a case for the research**

Munhall (1988) suggests that the question to be asked from an ethical perspective is: ‘Toward what goal and for what end?’ The Department of Health (DH) (2001, 2005) also makes explicit the requirements of the researcher in terms of providing justification for the study from an ethical perspective. The DH argues that research that needlessly duplicates other work or is not of sufficient quality to contribute something useful to existing knowledge is in itself unethical.

Once a topic for research had been selected by the author, a detailed literature review helped to refine ideas, improved understanding of the research problem, assisted in the development of the research aims and gave early indication of the most appropriate study design. Polit and Hungler (1999) suggest that familiarisation with previous studies can be useful in alerting the researcher to unresolved research problems and can provide a foundation upon which to base new knowledge. Alternatively, Streubert and Carpenter (1999) advocate postponing the literature review until data analysis is complete in order to obtain the purest description of the phenomena under investigation. As a lecturer responsible for evidence-based teaching, I considered it unrealistic to suspend personal knowledge and judgement on the research topic. Furthermore, Clifford (1997) suggests that searching the literature can help researchers determine whether their study is an original piece of work – an important consideration for PhD students.
issues in research

Justification for the study
The practice of witnessed resuscitation – that is, ‘the process of active “medical” resuscitation in the presence of family members’ (Boyd 2000) – is a controversial issue that has generated considerable discussion and debate within the literature during the last two decades. Despite a growing trend towards acceptance of this phenomenon, there remains a lack of empirical evidence to support decision-making in practice and the credibility of existing research has been criticised (RCN 2002). The majority of research has been conducted outside the UK in acute (secondary) care settings, and researchers have predominantly taken a positivist approach through the use of retrospective surveys to examine staff’s and relatives’ perceptions of this practice, leaving the life-world of participants largely unexplored. Furthermore, no attempt has been made to research this phenomenon from the viewpoint of UK accident and emergency ambulance staff who encounter bystanders during cardiopulmonary resuscitation (CPR) outside of hospitals.

What goals?
The goals were:
- to gain insight into the lived experience of accident and emergency ambulance staff who encounter bystanders during CPR outside of hospitals
- to increase understanding of the effects of having bystanders present during CPR outside of hospitals and, in doing so, add to the knowledge available on this subject.

To what end?
It is anticipated that the findings of this study will provide a clearer description and deeper understanding of the phenomenon of witnessed resuscitation, without which ‘future studies to identify and test therapeutic measures will be built on an incomplete knowledge base’ (Woods and Catanzaro 1988). The research imperative, therefore, is to contribute to the existing body of knowledge on this topic, generating theories that may be tested at a later stage using quantitative methods.

Munhall (1988) identifies the potential for conflict between the research role that uses people as a means to further knowledge (utilitarianism) and the profes-
sional duty of the nurse to treat individuals as ends in themselves (deontological ethical system). She goes on to offer some reconciliation by reminding readers of the individual’s decision to join the research enterprise voluntarily through the process of informed consent, possibly even collaborating in the research for the purpose of advancing a cause of their own. My belief is that the end result of further knowledge justifies the means of involving people in the research. Not only will this assist in the planning of emergency care services outside of hospitals, but may also inform the policy and practices of healthcare personnel based in secondary care settings, where the presence of lay persons during a resuscitation attempt is yet to be fully sanctioned.

**Beneficence and non-maleficence**

Two of the most fundamental ethical principles applicable to research are beneficence and non-maleficence (Eddie 1994), which encompass the maxim ‘above all, do no harm’. In assessing the potential adverse effects, risks or hazards for research participants, it was acknowledged that recollection of a resuscitation event might be distressing. Those with experience of CPR will recognise the situation as critical, demanding skilled technical intervention, as well as being highly charged emotionally. This is captured by Quinn (1998) who defines cardiac arrest as ‘the ultimate medical emergency’. It could therefore be argued that research to investigate bystander presence during CPR fulfils the criteria of a sensitive topic – that is, one that has the potential to arouse strong emotional responses (Cowles 1988). Practical concerns included recognition that discussing a life-threatening event such as resuscitation may be distressing and painful for people who are bereaved. Any staff member with bereavement issues was therefore advised not to participate in the study.

**The phenomenological interview**

The strategy for generating knowledge in phenomenological research typically involves conversational techniques, with the unstructured interview identified as a valuable approach when collecting data on sensitive topics (Fielding and Thomas 2001). Potential participants were informed that their involvement in the interview would last approximately one hour and, with their consent, a tape recorder would be used to help collect data accurately.
Smith (1992) suggests that ‘any theoretical framework for ethical interviewing must begin with the interviewer’. This includes giving due consideration to the sensitivity of the material and extended self-disclosure. Confidence to proceed was drawn from past experience of conducting face-to-face interviews as a researcher and clinician in acute and critical care situations. It is acknowledged, however, that immersion in the lived experience of others may render the researcher vulnerable (Robley 1995).

Sque (2000) recommends a period of preparation to allow those carrying out an investigation to feel confident in their skills. There is also a need for support systems and periods of reflection to minimise the probability of what she describes as ‘mortification of self’. Mindful of the emotive topic of resuscitation, a support system of debriefing with a colleague qualified in mental health was built into the research process.

Kavanagh and Ayres (1998) stress the importance of assessing participants for signs of distress during research on sensitive topics and identifying strategies for minimising discomfort. In the event that participation in the interview caused the informant emotional distress, it was made clear that participant welfare would take priority over the research. Acknowledging that follow-up support may be required, the participant information sheet also contained detail on available sources of help. This is supported by Coyle and Wright (1996), who argue that ‘it is ethically questionable for researchers to address sensitive issues without being equipped to deal with resultant distress’.

In contrast, it was considered that participation in this study might prove to be an effective way of helping the interviewee understand his or her experience by engaging in cathartic disclosure. Holloway and Wheeler (1995) suggest that ‘research interviews can be therapeutic, although therapy is not their purpose’. Nevertheless, it was made clear to participants that this benefit could not be guaranteed.

Informed consent

According to Polit and Hungler (1999), ‘informed consent means that participants have adequate information regarding the research, are capable of comprehending the information, and have the power of free choice, enabling them to consent to or decline participation in the research volunteer-
The process is embedded within the principle of respect for autonomy and includes providing participants with information about the benefits and risks of the research (Holloway and Wheeler 2002). Despite efforts to predict all the risks at the outset of the study, Smith (1992) warns that it cannot be known for certain what the interview will uncover. Thus, in qualitative research, consent is often viewed as ‘an ongoing, transactional process’ (Polit and Hungler 1999) known as ‘consensual decision making’ or ‘process informed consent’ (Streubert and Carpenter 1999). In other words, ‘continually informing and asking permission establishes the needed trust to go on further in an ethical manner’ (Munhall 1988).

A further consideration in phenomenological research is recognition that the lived experience of those who are recruited to participate may render them vulnerable and less able to act autonomously. It is therefore imperative that the researcher avoids exploitation of people’s vulnerability (Polit and Hungler 1999), respects the individual’s right to self-determination (Burns and Grove 1999) and remains sensitive to factors that may limit the individual’s freedom to decline to participate (Cook 1995).

Ethical conduct in gaining the consent from accident and emergency ambulance staff included the provision of explicit information about the research, taking into account the need for facts to be presented in a way that was understandable to the recipient and making sure that a contact point for further information was made available. Each participant was also given a two-week period to decide whether or not to take part, thus complying with professional guidance that recommends no untoward pressure or coercion is applied to potential participants when making choices (RCN 2004). Non-response was taken as indication of an unwillingness to participate and no further contact was made with individuals in such cases. Participants were also given the option to withdraw from the study at any stage without prejudice.

**Confidentiality and anonymity**

A further ethical consideration relates to the researcher’s responsibility to give assurances of confidentiality and anonymity (McHaffie 2000). Where anonymity is impossible – for example, in a face-to-face interview – every effort should be made to ensure that the principle of confidentiality is upheld.
Carpenter 1999). This implies that data will be used and reported in such a way that no one is able to identify the source (Behi and Nolan 1995).

Measures to ensure confidentiality of personal information included the secure storage of data and the use of a system of coding to protect the individual’s identity during the process of data analysis and in the publication of research results. Participants were also given written assurance that audio tapes would be destroyed on completion of the study. Abbott and Sapsford (1998) also recommend sampling widely. Sample sizes in qualitative research are typically small in contrast to quantitative research (Sandelowski 1986, Miles and Huberman 1994, Morse and Field 1996, Nieswiadomy 1998). For example, Ray (1994) identifies a single person or a group of eight to 12 participants for phenomenological studies directed toward discerning the meaning of experiences. This highlighted for me the need for caution in describing any particular resuscitation event, and a broad statement about the location of the research setting – ‘an ambulance service in the Midlands’ – was selected for use in publications.

A decision to conduct the research interviews at a venue external to the participants’ normal place of work was seen as an important feature of the study design to safeguard their privacy. It was also considered appropriate to remind participants before the interview of their responsibility to maintain the confidentiality and anonymity of clients, peers and colleagues when re-living their experiences.

Authenticity of data
Munhall (1988) argues that describing the experiences of others in the most faithful way possible is the most critical ethical obligation of the qualitative researcher. An important strategy in meeting this responsibility in phenomenological research is the notion of ‘bracketing’. The aim of bracketing is to suspend or set aside one’s beliefs about the phenomenon being studied in order to avoid influencing both the collection and interpretation of data (Oiler 1982, Knaack 1984, Cohen 1987, Jasper 1994). Although this practice is dismissed by some, Burns and Grove (1999) argue that there is still a commitment to identify beliefs, assumptions and preconceptions about the research topic at the beginning of the study for the purpose of self-reflection and external
review. Procedures built into the design of the study that sought to preserve the uniqueness of each participant’s lived experience included deliberation regarding an appropriate framework that would make explicit the procedural steps taken during phenomenological data analysis and that would provide a detailed decision trail. It was also proposed that preliminary findings would be viewed by a small team of academic staff to determine the accuracy of the interpretations.

Gaining permission to proceed
Tod et al (2002) view ethical probity in health service research as a tripartite concern that is reliant on the actions of ethics committee members and clinical research partners in addition to researchers themselves. Consistent with the ethical principles of research governance (DH 2001, 2005), representatives from the research setting were actively involved in the design of the study. This had the advantage of ensuring that the research was accepted and agreed upon by those participating in it, and appeared to pay dividends when seeking written approval from the chief executive of the research site for access to study participants.

It was agreed that research participants would be identified from a data sheet pertaining to cardiac arrest that was routinely completed by ambulance staff in the research setting and that this information would be obtained retrospectively, thereby preventing any disruption to routine emergency practice. An integral part of research governance is the requirement to obtain an independent scientific and ethical review of the proposed research. This included application to the local research ethics committee following the new electronic standard operating procedures that came into force on March 1 2004 (NHS 2004), although it should be noted that a revised online form (version 5.2) was released on October 30 2006, aimed at improving the researcher’s experience of the application process.

Conclusion
This article has considered ethical issues of importance when planning a research study using phenomenological research techniques. Adherence to ethical standards is arguably heightened when researching the lived experience,
calling for creative strategies in the research design and careful deliberation of
the potential risks involved. In striving to achieve a quality research culture,
measures to promote safety and wellbeing undoubtedly include preparation
and support for both the researcher and those who have consented to be
researched.

Wendy Walker MSc, Post-graduate Diploma in Adult Education, BSc, Diploma
in Professional Studies in Nursing, is a Lecturer, School of Health Sciences,
University of Birmingham, UK.

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