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Abstract

Purpose – The purpose of this paper was to explore what kind of ethical competence healthcare managers need in handling conflicts of interest (COI). The aim is also to highlight essential learning processes to develop healthcare managers' ethical competence.

Design/methodology/approach – A qualitative study was performed. Semi-structured interviews with ten Swedish healthcare managers from different care providers were carried out twice and analysed through step-wise categorisation.

Findings – Four categories of COI were revealed and two ways (passive and active) in which COI were handled. Ethical guidelines did not help the healthcare managers to handle the COI, and none of the managers made use of any sort of systematic ethical analysis. However, certain ethical competence was of great importance to identify and handle COI, consisting of contextual understanding, rational emotions, some theoretical knowledge and a suitable language. Organising work so that ethical analysis can be carried out is of great importance, and top management needs to clearly express the importance of ethical competence and allocate resources to allow adequate learning processes.

Originality/value – This paper highlights the management level and focuses on how work-integrated learning-processes can enable ethical competence. Ethical competence at the management level is essential both to comply with the constitution and legal requirements regarding healthcare, and so that managers are able to analyse COI and justify their decisions.

Keywords Workplace learning, Healthcare managers, Conflicts of interest, Rational emotions, Ethical competence

Paper type Research paper

Introduction

Much research during the past decades has reported increased ethical demands in healthcare (Höglund, 2005; Kälvemark Sporrong *et al.*, 2007). To meet this development, ethical codes and principles have been developed to guide action in medical practice. Furthermore, ethical rounds (Svantesson *et al.*, 2008) and moral case deliberation (Widdershoven *et al.*, 2009) are methods that have been applied to increase the agents' competence in dealing with ethical challenges in healthcare. The implementation of ethical rounds (Kälvemark Sporrong *et al.*, 2007) and ethical committees (Førde *et al.*, 2007) has also been examined. Research on ethical competence in healthcare has primarily focused on nursing staff and medical practice. Also, organisational learning in relation to healthcare ethics and practical wisdom has been examined (Carrol and

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Edmondson, 2002; Rowley and Gibbs, 2008). However, ethical competence in relation to the healthcare *manager* task is less often studied.

Health legislation in Sweden requires managerial responsibility from both a patient and a supervisory perspective. For this purpose, there shall be a specific manager (head of department) who represents the care provider and has the overall management responsibility (Swedish Health Care Act, 1982, p. 763). The healthcare manager can be a doctor or a nurse but also someone without medical education. The healthcare manager has the operational responsibility to put legal and political intentions and decisions into action, as well as professional medical ethics. When the healthcare manager is not a doctor, there is a medically responsible doctor in charge. Hence, the importance of generic competence in healthcare management is emphasised.

As the healthcare manager has the responsibility to decide about the employees' preconditions to provide good and safe care on equal terms to all citizens, ethical competence for healthcare managers is an urgent research question. The healthcare manager is also expected to take responsibility for decisions in *conflicts of interest* (COI) and ethical dilemmas (Helgesson, 2012), which are everyday issues for healthcare managers (Falkenström, 2012).

Many people with different backgrounds work in healthcare, and their own health is many times threatened by work-related stress (Ljungblad *et al.*, 2014). Patients come from different social circumstances and have different lives and beliefs. Deficiencies in working conditions, which partly cause stress, affect how care is provided. This in turn may lead to poorer quality of care and shortcomings in patient safety. In addition to technological and medical advances, contradictions in political, legal, administrative and professional control systems also make healthcare an ethically challenging work environment. The healthcare managers often work alone in the different decision-making processes, and COI may occur at different organisational levels.

The healthcare manager has considerable financial responsibility. To make decisions about such questions without ethical analysis and well-grounded ethical arguments may result in understaffed care units, stress-related long-term sick leave and care injuries. All three of them are, at least to some extent, avoidable and very expensive. In other words, handling the budget is a requisite but insufficient management tool in healthcare. It needs to be complemented by ethical considerations (Falkenström, 2012). But still there is a gap in the understanding of ethical competence in relation to the healthcare managerial responsibility and assignment.

This paper aims to contribute to a deeper understanding of what ethical competence healthcare managers need in relation to their specific task of handling COI in an ethically responsible manner. Ethical competence is in the following understood as a broader concept, consisting of different competencies. The aim is also to discuss workplace learning as a potential for enhancement of healthcare managers' ethical competence. We intend to answer the following research questions:

RQ1. What kinds of COI do healthcare managers encounter in their work?

RQ2. What competencies are important for managers to handle COI?

RQ3. What kinds of learning processes are necessary to develop and apply ethical competence?

Conceptual framework

Healthcare managers' identification and handling of COI actualise the concept of competence. In recent research on workplace learning, competence appears as a central concept, although somewhat ambiguously defined. Mulder, *et al.* (2007) discuss competence as a multidimensional concept, depending on the context of the users. The authors state that the traditional cognitive approach within this field of research should be extended to also encompass social and emotional aspects. Consequently, they propose the following definition of the concept of competence:

> Our own point of view in this discussion is rooted in our definition of competence, which is the capability to perform and to use knowledge, skills and attitudes that are integrated in the professional repertoire of the individual (Mulder, *et al.*, 2007, p. 82).

The emphasis on professionalism implies that competence is embedded in a context of institutionalised professional norms and ethics (Ellström, 2001). Furthermore, this conceptual reasoning entails that professional practitioners' actions are negotiated and evaluated in a social practice, which frames what counts as competence. These social processes of negotiation and evaluation include aspects of power and structural and relational opportunities to participate (Billett, 2006). Billet describes the relations between individual and social agency as interdependent, and he argues that studies of learning and competence construction need to consider this interdependence to fully understand the complexity of these matters. In a similar way, Paloniemi (2006) states: "[…] competence contains both individual and collective dimensions, and they are understood to interact with each other in everyday practice" (Paloniemi, 2006, p. 440).

Of particular interest in this paper is ethical competence. Ethics deals with questions such as "What should we do?" and "How should we lead our lives?" Notions of "good" and "right" are at the core of the reasoning. Ethical dilemmas and/or COI can arise from conflicting values, norms and interests, where there may be good reasons for more than one course of action and no clear answers are at hand. As a choice has to be made, the loss of at least one value or interest is unavoidable. Hence, ethics is not only about making the right decision in a given dilemma but also about justifying the decisions and choices made. According to well-established theories within moral philosophy, an action is guided as right or wrong according to its consequences (for example in utilitarian thinking) or according to its conforming to ethical rules or duties (so called deontological arguing). These traditions are mirrored in the four well-known ethical principles developed by Beauchamp and Childress (2009), namely, the principles of autonomy, non-maleficence, beneficence and justice. The principles of autonomy and justice are derived from deontological reasoning, meaning that the moral agent has a duty to respect human dignity in every person as well as to treat everyone as equals, regardless of the consequences of his or her actions. The principles of non-maleficence and beneficence are central in a utilitarian framework, where they would imply that the best action is the one where the total wellbeing is maximised by promoting good consequences and limiting harm.

Deontological and utilitarian theories, as well as ethical principles, focus on how to act in ethically difficult situations. Another line of arguing holds that it is the character of the moral agent that should be at the fore. Such arguing is called virtue ethics and a basic assumption in such models is that a good person performs good actions. Virtues (i.e. desirable character traits), such as empathy, courage and patience, are learned

through experience, practice, role-models and good examples (Armstrong, 2006; Begley, 2005).

The traditional view on ethics is that ethical decision-making requires impartiality and rationality (Rachels and Rachels, 2010). This means that judging a situation morally is not possible if we are too closely related to the person and if our judgement is influenced by emotions. Against this, Nussbaum (1997, 2001) has argued that there are no clear boundaries between rational judgments and emotions. Rather, emotions in themselves are a kind of judgements. In Nussbaum's view, emotions can thereby be more or less adequate. This leads her to argue for rational emotions, i.e. reflected judgements based on both reason and emotion. Rational emotions have an object and are related to values. They are, according to Nussbaum, essential for a well-grounded ethical judgement.

Jormsri *et al.* (2005) have argued that ethical competence in healthcare consists of three dimensions, namely, perception, judgement and behaviour. *Perception* in this case means that the moral agent should possess the ability to identify ethical dimensions and value conflicts that are at stake in a certain situation. *Judgement* is defined as the ability to weigh pros and cons in relation to the identified value conflict, and *behaviour*, finally, as the ability to act on the judgement that has been performed. A somewhat different terminology is used by Eriksson *et al.* (2007), who have argued that ethical competence should include aspects of both virtue ethics and traditional action-guided reasoning, based in utilitarian and deontological reasoning. Hence, ethical competence in their view is a matter of *being* (personal character), *doing* (acting according to judgements made based on rules and principles) and *knowing* (familiarity with moral traditions as well as laws and guidelines for one's work). Compared to Jormsri *et al.* (2005), the concept of *knowing* relates to perception and judgement and *doing* to the concept of behaviour. What differs between these two positions is the virtue aspect that is emphasised by Eriksson *et al.* (2007) and which has no direct equivalent in Jormsri *et al.*'s (2005) position. In this study, ethical competence is related to the managers' tasks, which are embedded in the context of healthcare organisation and society.

The processes through which ethical competence, as well as other forms of competence, is created and developed can be conceptualised as different kinds of learning processes. Workplace learning and practice-based learning are often described as the contextual driving forces in the construction and emergence of knowledge and performing abilities. These processes are individual as well as collective activities. Kim (2004) describes individual learning as a twofold, experience-based process through which individuals acquire knowledge and skills (know-how) and create conceptual understanding (know-why). These "operational" and "conceptual" learning processes are on-going processes of knowledge creation through reflections on concrete experiences and socialisation processes at the workplace or in an organisation (Kolb, 1984; Senge, 1990). Nonaka and Takeuchi (1995) distinguish between implicit and explicit knowledge in the organisation. They describe implicit knowledge as a subjective and tacit knowledge which needs to be articulated and made explicit through dialogue to promote learning processes in an organisation. According to Kim (2004), organisational learning is a kind of collective learning, which includes organisation members' collective actions and development of shared mental models. The organisation's shared mental models contain important collective experiences and conceptual knowledge and are captured as routines and frameworks in the organisation.

Thus, the collective learning processes, including collective critical reflections, are vehicles for a potential transformation of individual experiences into shared knowledge and collective competence in the organisation (Ohlsson, 2014). Through these processes, the organisation members create a shared conceptual understanding and a collective competence to solve tasks and handle problems. Moreover, the collective reflections help them to identify conflicting interests and underlying contradictions in the organisation, which may serve as triggers for increased awareness and further learning.

According to Argyris (1990), contradictions are latent organisational defence patterns explained by structural, social and emotional factors. Defensive reasoning in the organisation, often based on fear, tends to block serious attempts to identify alternative strategies for development. Therefore, identification and ethical handling of contradictions and COI certainly concern strong emotional aspects of learning in the workplace (Argyris, 1990; Benozzo and Colley, 2012; Falkenström, 2014). Pedagogic *interventions* to facilitate workplace learning, or work-based learning, are strategically important with regard to competence development in organisations (Billett, 2010; Döös and Wilhelmson, 2011; Evans *et al.*, 2011; Falkenström, 2014; Grill *et al.*, 2015; Ohlsson, 2014).

In this study, we have used our theoretical concepts to understand and critically analyse what kind of ethical dilemmas the healthcare managers encountered in their work and what kind of values were at stake. These concepts also provide analytical tools in our attempt to identify, describe and discuss essential ethical competencies and facilitation of learning and competence development. We discuss practical implications for competence development in the final section of this paper.

Design and method

The study had an explorative qualitative design. Semi-structured interviews were conducted with ten healthcare managers (heads of department) with varying background in education and care specialisation in the Stockholm region, Sweden. Nine of them were interviewed twice, as one manager could not be reached for the second round of interviews about one year later. To prepare the managers prior to the first interview, they were asked to reflect on a specific COI that they had experienced at work and considered important in the healthcare context. During the first part of the first interview, the managers were asked to tell their story as concretely and detailed as possible. What was the COI about, which values and interests were at stake and how did they handle the COI in practice? This part of the interview lasted for about 45 minutes, and the interviewer only asked questions of clarification during this phase. The purpose was to develop a concrete, clear and rich picture. During the second part of the first interview, which also lasted for about 45 minutes, a semi-structured interview guide was used to ensure that we got all the information we needed to answer our research questions. A semi-structured interview guide was also used in the second round of interviews. All interviews were recorded and transcribed verbatim.

To conduct two interviews with the same informant turned out to be a fruitful method, as the informants were more relaxed and open the second time. Their responses seemed more honest and exhaustive. This might be as they had become familiar with both the interviewer and the subject.

To acquire a variety in the data, a strategic selection was made. Managers from emergency care, primary care, psychiatry, anaesthesia and surgery, home care, daily

activities, disability and rehabilitation, paediatrics and maternity were included. Five women and five men participated, from both publicly run healthcare facilities and private providers.

Data from all interviews were analysed and categorised together through a step-wise method (Lindseth and Norberg, 2004). First, the text was read through several times to obtain a sense of the meaning of the whole text. Thereafter, quotes were selected, condensed and labelled with a code. Subsequently, the codes were sorted into categories, and finally, two themes were identified. Thematic research questions helped us from the beginning to find answers to central questions (Kvale, 2006). At the same time, we tried to be open to discovering new valuable dimensions in relation to the object of study.

An initial analysis was done by the first author. Thereafter, all authors discussed the content and composition of the categories and themes. In this process, minor changes and redefinitions were made so that consensus was reached. However, no big changes were made compared to the initial analysis. The analysis process is described in Table I. Themes and categories are described in Table II. The categories are not exclusive but sometimes overlap. In the following, each category will be illustrated by quotes.

Results

The analysis revealed a wide range of COI that the healthcare managers encountered in their daily work. Different ways in which the managers handled them were also identified.

Identification of COI

Four, not mutually exclusive, categories of COI emerged: system conflicts, loyalty conflicts, power conflicts and conflicts on scarce resources and priority-setting. Although all COI to some extent are about priorities and related to different steering

Table I.
Examples of the content analysis

Meaning unit	Condensed meaning unit	Code	Category	Theme
When clinically stressful situations arise, we look at the contract, and then you look at what exactly should be performed. The contract says we should give equal care and care at the right time and proper care and whatever it is called. But we get money for performance and rehabilitation plans and all that sort of things. And then finances come first. It's a risk	The contract says we should give equal care, but we get money for performances. And then, finances come first	Conflicting demands between care providing and reimbursement systems	System conflicts	Identification of COI

Table II.
Themes and categories

Themes	Identification of COI	Ways of handling COI
Categories	System conflicts	Active ways
	Loyalty conflicts	Passive ways
	Power conflicts	
	Conflicts over scarce resources and priority-setting	

systems, the categorisation is motivated by the need of partly different competencies to handle each one of them.

System conflicts. System conflicts concerned contradictions within and between the different control systems, namely, the political-, the administrative-, the legal- and the professional control systems. System conflicts could also include conflicting interests between values and priorities in the management logic and values and priorities within professional ethics. More particularly, these all-embracing system conflicts involved weighing and prioritising patients' needs, patient safety and work environment against political and economic goals. In most cases, the informants seemed not to manage to strike a balance between professional ethics and business management when dealing with system conflicts. The managers seemed to easily accept that economic goals were given priority over ethical considerations such as quality of care. Managers also appeared relatively unprepared to argue for the ethical values at stake. For example, the managers' interpretation of the care agreement tended to hamper and even rule out any possibility of them taking on adequate ethical responsibilities in line with health and medical purposes. One manager said:

> When clinically stressful situations arise, we look at the care agreement, and then you […] look at what exactly should be performed. The care agreement says we should give equal care and care at the right time and proper care and whatever it is called. But we get money for performance and rehabilitation plans and all that sort of things. And then the finances come first. It's a risk.

The purposive/instrumental rationality seemed to permeate the managers' way of thinking. The example below also indicates difficulties in striking a balance between the purposive/instrumental rationality and value rationality (Weber, 1978). It also indicates some difficulties in integrating ethics into the real work processes:

> It is difficult to insert […] another dimension in such a situation when everybody looks at these million kronor amounts […] presented on Power Point, you look at one picture after another, various scenarios and then it's just finances and figures that is there.

But in some situations, there were managers who seemed to act in a more ethically competent way. For example, one manager, who is also a paediatrician, was angry about getting too little compensation for the intensive care that they gave. At the same time, the manager was angry because there were others who were cheating in the financial reimbursement system to get more compensation than they were entitled to. The situation also affected the working environment negatively. The medically responsible nurse said she would resign if the pre-conditions for good care did not improve, otherwise she would not be able to take responsibility for patients. Even if the manager was angry, he did not appear to act in an emotionally un-reflected manner. As we can see below, this manager seemed to develop rational emotions by obtaining information on the facts and to use a reflexive manner. Finally, the manager was also acting in accordance with the rational emotion:

> First I found out what it looked like in the financial systems […] I have joined the central DRG group (Diagnose Related Groups, used as reimbursement system) to understand - how can it be so weird? […] And when I heard a lot of nonsense about how to run the financial systems, which is totally unacceptable to me as head of department […] I went directly to the head of division and said: 'It must not be like this.'

Loyalty conflicts. Loyalty conflicts occurred, for example, between the managers' willingness to be loyal to their own moral convictions and conscience, as to the health professionals and patients, or to the owners or political and administrative requirements such as demands that the budget is in balance, or to a certain group of patients. The example below illustrates a loyalty conflict in relation to patients and nursing staff. The quote describes a situation when the manager was dealing with meetings where aggressive, provocative and threatening psychiatric patients in some way had been abused by nursing staff, who at that moment did not find a more worthy and competent way to act. In some cases, the threat was serious, and the nursing staff really had to do whatever it could to protect themselves, the patients or other persons. In other cases, according to the informant, the nursing staff could have acted in a more professional way, without abusing the patient:

> This is an ethical dilemma and I have talked with many patients following physical restraint resulting in post-traumatic stress disorder, when we so to speak, have created a new ailment due to our actions […].

The manager seemed unsure about how to communicate and deal with such COI in a sufficiently well reflected manner from an ethical perspective. The manager said:

> I felt bad every time I realised physical restraint had been poorly managed and indirectly led to suicide. This is an ethical dilemma for me because you can't just say to someone 'you have acted in a way which led the patient to commit suicide', because then we would have another person who feels bad too, but on the other hand you can't just avoid doing anything.

Power conflicts. All COI are surrounded by power structures, and aspects of power are included in most COI. Stakeholders are superior and subordinate to each other in the healthcare organisation; a medically responsible physician has often more of a say than a nurse. Informal exercise of power is an aggravating circumstance. In ethics, however, the ideal is to let the quality of arguments determine, rather than the hierarchical position. To exemplify power conflicts, one manager who was part of the executive management team at a hospital said that the management team became very quiet when they were discussing the redistribution of hospital beds as a result of cost cutting. In discussions of more trivial issues, people could become very involved. Why was the management team so quiet this time? The manager said:

> I think you are hiding because it's scary, because someone else might have more or less power […]. It's a matter of redistribution of power, who should decide here?

In action, when the healthcare managers made decisions in the COI, it looked as if they allowed the finances to decide at the expense of ethical analyses. They did, for example, not use any kind of model for systematic ethical analyses, and they reported no established communicative forms for common peer analysis of practical ethical problems in the managers' work processes. Instead, what they did often exemplified the dominance of financial demands. However, there seemed to be good opportunities for informal conversations in the organisation.

The managers appeared to avoid raising ethical issues with other managers, they also appeared to avoid active prioritisation and ethical impact assessments. The healthcare managers seemed to lack clear ethical arguments to offer resistance to the dominant management logic. In other words, the results indicate that when managers

handled the different COI, they did not manage to strike a balance between professional ethics and business management.

Conflicts over scarce resources and priority-setting. The healthcare manager's duty is also to make intended and transparent priority-settings. In Sweden, three ranking principles for healthcare priorities are decided by the parliament (SOU, 1995, p. 5), namely, the principle of human dignity, the principle of needs and solidarity and the principle of cost-effectiveness.

Conflicts concerning priority-setting can be divided into value priorities and needs priorities. The healthcare managers were often concerned with patients' needs and how to prioritise. Through the analysis, we tried to understand how, concretely, the managers proceeded to prioritise in a specific situation. How did they analyse and reason before making decisions? Which arguments did they use to justify their decisions? However, we did not find any clear answers to these questions. Instead, we found that when resources were scarce the managers tried to the best of their ability to allocate resources between patients. One manager put it this way:

> […] the patient's welfare first, then the need of resources and after that the costs. If it does not work with the financial resources available, well then I start backwards so to say. What can we do? And how can we treat a patient with a certain diagnosis as safely as possible with limited resources?

The quote above indicates that the ethical core value of patient safety sometimes could become a relative value. Managers from different specialties reasoned in a similar way. Sometimes, it also appeared that the managers did not always act in accordance with their prioritisation:

> First of all, I think that it is the patient's needs […] that will guide […] then we cannot always act like that, the way we want to […]. But it should still be a proper prioritisation, it should be figured out […].

Although clinical ethics may be the doctor's responsibility, the manager may need to understand emotionally complicated dilemmas to offer time, space and support. A need for value priorities may for instance arise in connection with the issue of when to terminate treatment. What values are at stake? And what ethical values should come before others? On basis of what? What are the consequences in the long term and in its entirety?

> We know that nurses earlier than doctors may feel that there is nothing more to be done to help the patient. But it is the doctors who will meet the families' anxiety, longing and hope. It's […] really hard and, at the same time the patients and their families lose the opportunity to prepare themselves for death.

Different ways of handling COI

Through the analysis, different ways of handling COI were also detected. Among those, two main patterns of handling COI emerged: *active ways* and *passive ways*. When handling them in an *active way*, the healthcare managers grasped the ethical dilemmas, reflected upon them and made decisions to do their best. This did not always mean that they were using ethical concepts, ethical guidelines, ethical analytical tools or rational emotions (Nussbaum, 2001). Actually, none of the informants used any form of systematically structured analysis model. Rather, the managers tended to handle COI in

the same way as any other leadership problem. Listening to one's feelings or conscience, but without reflecting systematically upon values at stake, putting into contextual facts, dialogue and formulating arguments that could bring an action legitimacy may also lead the manager ethically astray. In other words, the active way does not automatically mean that ethical competence was manifested.

However, in a few cases, it was obvious that some ethical competencies were expressed. For instance, one manager was intentionally listening to her conscience to reflect critically upon how to act to take on ethical responsibility. She said that her conscience was often a reminder to reflect critically, particularly in a position of power, on how she used that power. When she had a bad conscience, she said that she saw it as a signal that she maybe had not thought enough. The quote below is taken from a scene in the interview where this manager in general terms was talking about the importance of feelings in handling COI:

> Feelings makes you observant of issues that you otherwise might not have noticed. […] Sometimes you can just ignore them […] but sometimes they make you aware of something that you have absolutely not understood.

In the quote below, which has also been commented upon above, another manager in a *concrete situation*, succeeded to transform his feelings of anger into rational emotions by critical reflection and to acquire contextual facts before taking adequate action (Nussbaum, 1997, 2001):

> First I found out what it looked like in the financial systems […] I have joined the central DRG group (Diagnose Related Groups, used as reimbursement system) to understand - how can it be so weird? […] And when I heard a lot of nonsense about how to run the financial systems, which is totally unacceptable to me as head of department […] I went directly to the head of division and said: 'It must not be like this.'

The quote above also indicates that moral virtues such as sense, justice and courage guided the manager's action.

However, the managers said time is often in short supply, and conflicting values from different interest groups tended to become a burden. The work environment was also dominated by stress, fatigue and frustration, managers said. On several times, the managers expressed that they seldom had time for dialogues on ethics. However, *the passive ways* of handling COI also seemed to depend on lack of knowledge, virtues, reluctance, organisational culture as well as painful, irrational emotions. In the example of passive ways below, the manager had just presented a new shift-work schedule without involving the nursing staff in the new plans. This lack of dialogue resulted in some of them giving up and choosing to resign immediately. The manager said:

> I said I could look at their proposals, if there were any, but there was no dialogue.

Among the passive ways to deal with COI, resignation to the political and financial requirements seemed to underlie most of them and thereby inhibit initiatives of individual and collective ethical responsibility. Some managers said that "You must quit if the result is negative", and that "the goal is a balanced budget". "If your budget is balanced, you can do whatever you want", a manager said. Although it was contrary to the managers' beliefs, they often gave priority to the finances in the decision about the current COI – without any ethical analysis. Short-time financial considerations were thereby given priority.

Discussion and conclusion

The findings showed that different kinds of COI were frequently present in the healthcare managers' work, and that their ethical competence was often not sufficient for the task of handling COI. However, the analysis revealed both strengths and shortcomings regarding ethical competence. The managers tended to handle the COI in both active and passive ways, many times adjusting their actions in a more or less instrumental way.

Common ethical guidelines did not seem to be helpful when the managers handled COI. Of course, they were relatively familiar with such guidelines, but they did not seem to reflect more deeply on them or use them to identify, analyse and act in accordance with them. This is a remarkable result, given the current emphasis on explicit ethical guidelines as a solution to ethical dilemmas. However, through the discussion, we will especially emphasise the importance of the manager's individual and collective ability to develop rational emotions as one ethical core competence (Nussbaum, 1997, 2001). This ability is important because almost all COI consist of emotional challenges, self-interests and defensive routines that can lead ethically astray. Emotional challenges are part of ethical conflicts.

As emotional challenges tend to influence the handling of COI, a systematic ethical analysis may support the process. However, only one manager had participated in an external training programme aimed at learning systematic ethical analysis, including how to weigh up and prioritise between conflicting values and interests in healthcare practice. Nevertheless, the manager did not seem to perceive that this knowledge could also be used within the context of the manager's assignment and specific managerial tasks. Against this background, critical perspectives are easy to lose when handling COI, and thereby it is not easy to formulate well-grounded ethical arguments to justify a decision regarding a specific and contextualised COI. From a learning perspective, this means that managers act mainly in an operational and non-reflective way, which indicates a lack of conceptual learning and therefore a restricted understanding or awareness of ethical challenges (Kim, 2004).

Painful emotions such as anger, sadness or feelings of frustration and resignation were often manifested when the managers were struggling with COI. Some of them seemed to manage the emotional challenge. However, when handling COI *in passive ways*, resignation seemed to be the only emotion manifested. In those cases, emotions could therefore not be developed into rational emotions (Nussbaum, 1997, 2001). Rather, it happened that managers felt powerless and not even tried to influence the situation. In addition, managers often seemed to automatically conform to instrumental and financial arguments without considering any ethical argument to balance the different logics. Hence, when acting in a passive way, ethical competence cannot be applied. Accordingly, the managers sidestepped their ethical responsibility – sometimes even when they were aware of the risks. According to Armstrong (2006) and Begley (2005), this cannot be counted as an expression of virtue ethics.

Nonetheless, as shown by the results, it is perfectly possible for healthcare managers to transform emotions into rational emotions (Nussbaum, 2001) by reflecting on them in relation to the present object and trying to understand contextual facts before taking adequate action. Thereby, it is possible both to increase their ethical awareness about a current COI and to use their own and others' rational emotions as driving forces to act in an ethically responsible manner and to proceed the ethical competence development.

This does not mean that it is easy. Therefore, it is reasonable to claim that different kinds of pedagogical interventions that promote development of rational emotions are of great value to increase ethical competence in the workplace.

Sometimes, the managers also expressed frustrations in the collegial conversations, but generally they tended to avoid a critical ethical dialogue within the management team.

As dialogue is essential in the collective learning process, it seems reasonable to conclude that the management team did not appear as a collective learning potential for the managers (Ohlsson, 2014). This in turn means that the managers did not have organisational or structural support for important communicative activities to learn to handle ethical issues together.

It is reasonable to presume that a trustful climate makes the dialogue, reflection and critical ethical analysis easier. To avoid deficient or uninformed learning-processes that can lead managers ethically astray, we also recommend some professional guidance, both informal and structural, in how to deal with managerial practical ethics in the workplace (Falkenström, 2012). This guidance may also be helpful in developing rational emotions, which in turn can increase a climate of trust.

To enable workplace learning that includes both individual and collective learning-processes to apply and develop ethical competence in relation to the managerial assignment, some kind of organisational interventions would be of great importance. Regular management meetings and budget processes are examples of on-going work-processes and action-arenas (Döös and Wilhelmson, 2011) where ethical competence in relation to managerial assignment potentially could be both applied and developed in a communicative way. However, COI and irrational emotions may occur even in relation to these tasks and make dialogues difficult and sensitive for both the manager and others involved. In addition, admitting flaws, asking for help and allocating time are not strong managerial characteristics (Schön, 2009). The healthcare managers therefore need competencies to deal with both their own and others' feelings and work-related taboo topics so that an adequate dialogue about the actual core-question can take place (Sandahl *et al.*, 2010; Falkenström 2012, 2014; Grill *et al.*, 2015).

With reference to Kim (2004), "conceptual" and "operational" knowledge could also be developed and integrated within ordinary meetings, given that the managers already have assimilated some formal education in ethics. Durable effects require a lot of opportunities for reflection and practice. They also require that contextual circumstances such as the organisations' power structures have been taken into consideration.

Preparing and organising work processes in this way could help individual managers, as well as management teams, to achieve a suitable ethical competence in relation to their task of handling COI. By combining the formal education (to ensure theoretical ethical contents and some practical tools) and the experiential learning processes while handling the COI (Kolb, 1984), both individual and collective learning processes, and mental models, can be shared. By approaching the development of ethical competence in this way, it might also be possible to secure the interdependent relations between individual and social agency to fully understand the complexity of the COI (Billett, 2006).

To manage the emotional challenges mentioned above, which include coping with uncertainty and one's own and others' weaknesses and fear, managers may need professional support besides operational and conceptual learning processes. This could

hopefully enable possible existing defensive routines to be identified and replaced by adequate routines and further ethical competence development (Billett, 2010; Döös and Wilhelmson, 2011; Evans *et al.*, 2011; Falkenström, 2014; Ohlsson, 2014).

When a COI has been identified for common reflection, a supervised meeting or ethical round can make it possible to learn about concepts, dialogue and methods for systematic reflection (Kälvemark Sporrong *et al.*, 2007). However, it appears to be particularly challenging to create such learning opportunities in the workplace for the managerial assignment because managers are reluctant to expose their uncertainty. Therefore, managers may need to be prepared for such learning opportunities by some individual professional support and by an unambiguous clarity in the job description.

Based on the empirical results and the analysis, we claim that certain ethical competencies seem to be of great importance for the healthcare managers when handling on-going, contextualised COI. We conclude that those core competencies are necessary to be able to apply and develop managers' ethical competence in healthcare organisations.

In Table III, we have put together what we, in this study, have identified as ethical core competencies. In the light of our conceptual framework, we also display some practical guidance for ethical competence development.

As shown in Table III, some theoretical knowledge and understanding in ethics is necessary to achieve shared conceptual understanding as well as shared mental models (Ohlsson, 2014). This may also facilitate an adequate critical reflexive language (Nonaka and Takeuchi, 1995). Further, the individual and collective ability to develop rational emotions is essential to identify values at stake and to resolve defensive routines in a communicative way (Argyris, 1991; Nussbaum, 1997, 2001, Falkenström, 2014). Finally, the healthcare manager needs an ability to organise work-integrated individual and

Ethical core competencies	Practical guidance
Adequate theoretical ethical knowledge	Formal and informal education (Outside the workplace and workplace learning)
Ability to identify context-related COI	Individual and collective reflection to increase the ethical receptivity. Conceptual learning to put words on values at stake, experience-based reflection and dialogue
Adequate critical reflexive language to express and analyse COI	Conceptual learning, practice, dialogue and reflection, formulating and analysing ethical arguments, professional support
Ability to develop rational emotions	Theoretical knowledge, self-reflection, professional support
Ability to resolve defensive routines and to promote dialogue about the actual ethical core question	Gaining individual and collective insight about the value of resolving defensive routines. Conceptual learning, reflection, dialogue and professional support within ordinary work processes
Ability to organise work-integrated individual and collective learning processes aimed to increase ethical competence	Establish meeting procedures for continous critical ethical reflection and ethical analysis. Professional support. (Experience-based learning)

Table III. Ethical core competencies and practical guidance for ethical competence development

collective learning processes aimed to increase ethical competence (Kim, 2004, Döös and Wilhelmson, 2011 and Ohlsson, 2014).

Our study was qualitative, and we only have evidence for our participants' reported experiences and perceptions. In qualitative research, the aim is to capture a broad picture of perceptions of the studied question. Hence, you need to interview enough people to ensure sufficient variation in data, still not having so much material so that it is difficult to manage the data. In this case, the number of informants was quite small; ten healthcare managers were interviewed. However, the informants were interviewed twice, which resulted in a very large and rich material. The results cannot be generalised to a larger population. To confirm the frequency of the reported assumptions, quantitative studies are required. We do claim, however, that our investigation has captured significant aspects of ethical competence building in healthcare managers' work, and that the findings are transferable to similar contexts.

References

Argyris, C. (1990), *Overcoming Organizational Defense. Facilitating Organizational Learning*, Harvard University Press, Prentice Hall, NJ.

Argyris, C. (1991), "Teaching smart people how to learn", *Harvard Business Rewiew*, May-June, pp. 99-109.

Armstrong, A.E. (2006), "Towards a strong virtue ethics for nursing practice", *Nursing Philosophy*, Vol. 7 No. 3, pp. 110-124.

Beauchamp, T.L. and Childress, J.F. (2009), *Principles of Biomedical Ethics*, 6th ed., Oxford University Press, New York, NY.

Begley, A.M. (2005), "Practising virtue: a challenge to the view that a virtue centred approach to ethics lacks practical content", *Nursing Ethics*, Vol. 12 No. 6, pp. 622-637.

Benozzo, A. and Colley, H. (2012), "Emotion and learning in the workplace: critical perspectives", *Journal of Workplace Learning*, Vol. 24 No. 5, pp. 304-316.

Billett, S. (2006), "Relational interdependence between social and individual agency in work and working life", *Mind, Culture and Activity*, Vol. 13 No. 1, pp. 53-69.

Billett, S. (Ed.) (2010), *Learning Through Practice. Models, Traditions, Orientations and Approaches*, Springer, London.

Carrol, J.S. and Edmondson, A.C. (2002), "Leading organisational learning in health care", *Quality and Safety in Health Care*, Vol. 11 No. 1, pp. 51-56.

Döös, M. and Wilhelmson, L. (2011), "Collective learning: interaction and a shared action arena", *Journal of Workplace Learning*, Vol. 23 No. 8, pp. 487-500.

Ellström, P.E. (2001), "Integrating learning and work: conceptual issues and critical conditions", *Human Resource Development Quarterly*, Vol. 12 No. 4, pp. 421-435.

Eriksson, S., Helgesson, G. and Höglund, A.T. (2007), "Being, doing, and knowing: developing ethical competence in health care practice", *Journal of Academic Ethics*, Vol. 5 No. 2, pp. 207-216.

Evans, K., Guile, D. and Harris, J. (2011), "Rethinking work-based learning: for education professionals and professionals who educate", in Malloch, M., Cairns, L., Evans, K. and O'Connor, B. (Eds), *The Sage Handbook of Workplace Learning*, Sage, London.

Falkenström, E. (2012), *Verksamhetschefens etiska kompetens: Om identifiering och hantering av intressekonflikter i hälso- och sjukvården, (Doktorsavhandlingar från Institutionen för pedagogik och didaktik 12)*, Stockholms Universitet, Stockholm.

Falkenström, E. (2014), *Vårdchefens etiska dilemman: Strategier för bättre praktik*, Natur och Kultur, Stockholm.

Førde, R., Pedersen, R. and Akre, V. (2007), "Clinicians′evaluation of clinical ethics consultations in Norway: a qualitative study", *Med Health Care Philos*, Vol. 11 No. 1, pp. 17-25.

Grill, C., Ahlborg, G., Jr, Wikström, E. and Lindgren, E.C. (2015), "Multiple balances in workplace dialogue: experiences of an intervention in health care", *Journal of Workplace Learning*, Vol. 27 No. 4, pp. 267-281.

Helgesson, C.F. (2012), "Den mångfaldiga styrningen i hälso- och sjukvården: Orsaker och implikationer för de statliga myndigheternas roll", in Rognes, J. and Karlsson, A.K. (Eds), *Ledningssystem och styrning av vård*, Leading Healthcare, Stockholm, pp. 97-105.

Höglund, A.T. (2005), *Inga lätta val: Om riktlinjer och etisk kompetens vid prioriteringar i vården, En studie i empirisk etik*, Acta Universitatis Upsaliensis, Uppsala.

Jormsri, P., Kunaviktikul, W., Ketefian, S. and Chaowalit, A. (2005), "Moral competence in nursing practice", *Nursing Ethics*, Vol. 12 No. 6, pp. 582-594.

Kälvemark Sporrong, S., Arnetz, B., Hansson, M.G., Westerholm, P. and Höglund, A.T. (2007), "Developing ethical competence in health care organizations", *Nurs Ethics*, Vol. 14 No. 6, pp. 825-837.

Kim, D.H. (2004), "The link between individual and organizational learning", in Starkey, K., Tempest, S. and McKinlay, A. (Eds), *How Organizations Learn*, Thomson Learning, London.

Kolb, D. (1984), *Experiental Learning: Experience as the Source of Learning and Development*, Prentice Hall, Englewood Cliffs, NJ.

Kvale, S. (2006), *Den kvalitativa Forskningsintervjun*, Studentlitteratur, Lund.

Lindseth, A. and Norberg, A. (2004), "A phenomenological hermeneutical method for researching lived experience", *Nordic College of Caring Sciences*, Vol. 18 No. 2, pp. 145-153.

Ljungblad, C., Granström, F., Dellve, L. and Åkerlind, I. (2014), "Workplace health promotion and working conditions as determinants of employee health", *International Journal of Workplace Health Management*, Vol. 7 No. 2, pp. 89-104.

Mulder, M., Weigel, T. and Collins, K. (2007), "The concept of competence in the development of vocational education and training in selected EU member states: a critical analysis", *Journal of Vocational Education and Training*, Vol. 59 No. 1, pp. 67-88.

Nonaka, I. and Takeuchi, H. (1995), *The Knowledge Creating Company: How Japanese Companies Create the Dynamics of Innovation*, Oxford University Press, New York, NY.

Nussbaum, M.C. (1997), "Emotioner som värdeomdömen (Emotions as value judgments)", in Holm, U., Mark, E. and Persson, A. (Eds), *Tanke Känsla Identitet*, Anamma, Göteborg.

Nussbaum, M.C. (2001), *Upheavals of Thought, The Intelligence of Emotions*, Cambridge University Press, New York, NY.

Ohlsson, J. (2014), "Pedagogic challenges in the learning organization", *The Learning Organization*, Vol. 21 No. 3, pp. 162-174.

Paloniemi, S. (2006), "Experience, competence and workplace learning", *Journal of Workplace Learning*, Vol. 18 Nos 7/8, pp. 439-450.

Rachels, J. and Rachels, S. (2010), *The Elements of Moral Philosophy*, 6th ed., McGraw-Hill, New York, NY.

Rowley, J. and Gibbs, P. (2008), "From learning organization to practically wise organization", *The Learning Organization*, Vol. 15 No. 5, pp. 356-372.

Sandahl, C., Falkenström, E. and von Knorring, M. (2010), *Chef med känsla och förnuft: Om Professionalism och etik i ledarskapet*, Natur & Kultur, Stockholm.

Schön, D.A. (2009), *The Reflective Practioner, How Professionals Think in Action*, Basic Books, Farnham.

Senge, P. (1990), *The Fifth Discipline, The Art and Practice of the Learning Organization*, Doubleday, New York, NY.

SOU (1995), *Vårdens svåra val, Slutbetänkande av Prioriteringsutredningen*, Socialdepartementet, Stockholm.

Svantesson, M., Anderzén-Carlsson, A., Thorsén, H., Kallenberg, K. and Ahlström, G. (2008), "Interprofessional ethics rounds concerning dialysis patients: staff's ethical reflections before and after rounds", *Journal of Medical Ethics*, Vol. 34 No. 5, pp. 407-413.

Swedish Health Care Act (1982), 1982:763 C.F.R., Stockholm.

Weber, M. (1978), *Economy and Society: An Outline of Interpretive Sociology*, Guenther Roth and Claus Wittich (Eds), University of California Press, Los Angeles.

Widdershoven, G., Abma, T.A. and Molewijk, B. (2009), "Empirical ethics as dialogical practice", *Bioethics*, Vol. 23 No. 4, pp. 236-248.

Further reading

Benhabib, S. (1992), *Situating the Self: Gender, Community and Postmodernism in Contemporary Ethics*, Routledge, New York, NY.

Knapp, R. (2010), "Collective (team) learning process models: a conceptual review", *Human Resource Development Review*, Vol. 9 No. 3, pp. 285-299.

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