

## Judging the ethics of qualitative research: considering the 'ethics as process' model

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### Abstract

Decision-making about the ethics of qualitative research is problematic where the research design is emergent, and the balance between risks and benefits for research subjects are difficult to ascertain prior to study implementation. The discourses of health/medical research ethics and those of social research are shown to be divergent and, furthermore, where ethics committees tie themselves to the health/medical model of ethical decision-making, qualitative research approaches can be disadvantaged. Having demonstrated the dual discourses and their relevance to qualitative research ethics, a critical review of current approaches to maximising the success of qualitative research proposals being considered for approval by ethics committees is undertaken. This leads to a call for a system of monitoring qualitative research so that the 'benefit to risk' ratio is always on the side of benefit. This has implications for the ways in which ethics committees are organised and the ways in which they function.

**Keywords:** ethics committees, qualitative research, research ethics

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### Introduction

The role, function and subsequent conduct of Local Research Ethics Committees (LRECs) and Multi-centre Research Ethics Committees (MRECs) are increasingly becoming matters for debate. This debate has resulted, at least in part, from the claims of a substantial body of social scientists, that qualitative research is being treated unfairly and disadvantaged by ethics committees. Such claims are particularly apposite given the contemporary blurring of both health and social care and research and consequent questions about the remit of the extant ethics committees. The recent publication of a substantial section on health and social care research ethics in a Department of Health document on Research Governance (Department of Health 2001a), together with their consultation paper on research ethics (Department of Health 2001b) has raised the profile of this debate. Neither document provides any

specific consideration of how to judge the ethics of qualitative research with an emergent design and as such this will provide the focus for what follows in this paper.

The historical emergence of two dissimilar discourses for the ethics of social, as opposed to health/medical, research provides some explanation for the difficulties in judgements about the ethics of qualitative research undertaken by LRECs and MRECs in the UK and beyond. In this paper the two discourses are disentangled to show how the operations of ethics committees may disadvantage some research approaches. The paper then identifies and critically assesses 'repair procedures' aimed at maximising the success of qualitative research proposals submitted to ethics committees. It is argued that a more equitable method of judging the ethics of qualitative research involves a monitoring procedure of ethics over the research period.

## The dual discourse of ethics in health and social care research

### The development of the health/medical research ethics discourse

The field of bioethics grew from the experience of Nuremberg, where it was found that researchers cannot always be trusted to put the interests of research subjects first and certain protections should therefore be in place. Participants should be informed about the nature and outcomes of the research and be free to decide whether or not to participate without any affect on the care they receive (see Gelling 1999, p. 564). These, together with other ideas, were formalised in the Declaration of Helsinki (World Medical Association 1964, Lacey 1998, Gelling 1999, Smith 1999). Amended on only four occasions since 1964, the 1996 version states in the Introduction, amongst other things that:

It is the mission of the physician to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfillment of this mission.

and

Biomedical research ... must conform to generally accepted scientific principles. (Article 1)

and

The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experimental protocol which should be transmitted for consideration, comment and guidance to a specifically appointed committee independent of the investigator and the sponsor ... (Article 2)

In light of the original Helsinki Declaration, the Royal College of Physicians in Britain recommended the implementation of ethics committees in 1967 and the Department of Health empowered hospitals to operate such committees in 1998. The Royal College of Physicians issued guidelines for their operation in 1984 and have continued their involvement in debates over research ethics ever since (e.g. see Royal College of Physicians 1986, 1990, 1996, Holley & Foster 1998, Foster & Holley 1998). Writing in 1990, the Royal College argued that the objectives of local research ethics committees (LRECs) would be to, '... maintain ethical standards of practice in research, to protect subjects of research from harm, to preserve subjects' rights and to provide reassurance to the public that this is being done' (Royal College of Physicians 1990, p. 3). This was followed by Department of Health recommendations for setting up LRECs (Department of Health 1991) and, later, guidelines for their operation (Department of Health 1994).

Problems with researchers having to submit the same proposal to several LRECs for geographically dispersed work has led more recently to the setting up of five regional MRECs in England, with one each for Scotland, Northern Ireland and Wales (Department of Health 1997).

In summary, the LRECs are commissioned to operate by health authorities. The present consultation paper proposes a membership of 12–18 people (Department of Health 2001b, para. 6.1, p. 10). This is higher than the previously recommended eight to 12 members of 'sound judgment and relevant experience' appointed and drawn from a wide range of backgrounds. As well as medical and nursing staff, there should also be two lay committee members. The committee should make its decisions in relation to research which involves NHS patients past or present, access to patient records or for research taking place on NHS premises, though further categories may be added as suggested in the Department of Health consultation document (Department of Health 2001b, para. 3.1, p. 5). The MRECs will have a similarly wide range of membership of up to 18 persons and will have specific expertise across a number of research areas and methodologies and will consider proposals for research being undertaken in several geographical areas.

### The development of the social research ethics discourse

Lacey (1998) points to the fact that, unlike research in the health and medical fields, social research remains largely 'ethically deregulated'. The debate over the ethics of social research has developed significantly over the past three decades or so. In an early review Bulmer argued that the long-running debate over covert research (see Erikson 1967, Douglas 1976, Denzin 1982, Bulmer 1982, Ramcharan 1988) brought '... out most clearly some of the principles which guide the conduct of social research' (Bulmer 1982, p. 247). These include principles such as 'informed consent'; safeguarding 'privacy' as well as assuring 'confidentiality' and/or 'anonymity'; not accessing the field in deceptive or fraudulent ways; 'preventing harm' for the subjects arising out of research. These principles have appeared widely in a series of codes of ethics published by recognised associations over the years (e.g. British Sociological Society 1993) and in academic literature on social research (e.g. Eisner 1991, House 1993). Apart from being unenforceable, and with no sanctions on perpetrators of unethical work, such codes have further difficulties. For example, where codes propose that there should be no harm (avoiding maleficence) to subjects, questions still arise about what exactly constitutes 'harm'.

An alternative approach in considering the ethics of qualitative research has been to compare the ethics of qualitative and quantitative approaches. Lincoln & Guba (1989) argue that in positivist approaches 'respondents values are systematically disregarded as mere opinions with no foundation in scientific knowledge' (Lincoln & Guba 1989, p. 225). Positivist science has failed ethically, since many researchers from the quantitative side have found substantiation for breaking ethical rules (Lincoln & Guba 1989, p. 226). A major shortcoming of the 'comparative method of ethical judgment' such as that of Lincoln and Guba, is that each side may point to the shortcomings of the other without recognising that this does not substantiate a *laissez faire* attitude to their own ethical stance. Nor does it address the gap between theoretical prescriptions and the realities of fieldwork that have been bemoaned for some time (Dingwall 1980, Punch 1986, Ramcharan 1988). This gap between theory and practice, particularly in relation to qualitative research, is being filled by a new literature on 'ethics as a process' which is considered later in this paper.

### Health/medical and social research ethics – a common discourse?

Lacey (1998) has contended that the social medical/health research ethics fields share common principles that she identifies with the seminal work of Beauchamp & Childress (1979). Ethics committees seek to identify from amongst competing claims of researchers, research subjects and the public the balance of ethical risks against the potential benefits, what Beauchamp & Childress (1979) refer to as 'justice'. In making this judgement, Beauchamp and Childress argue the need to establish that the research subject's 'autonomy is respected', and that the principle of 'nonmaleficence' (i.e. the obligation to avoid harm) is observed. The degree to which research is likely to affect research subjects' lives and the degree to which they are fully aware of the nature, intentions and both personal and public outcomes of the research are central to these concepts. The level of 'discomfort' caused by the research in these terms has to be set against 'beneficence', i.e. the obligation to provide positive outcomes, or benefits.

It may be argued that these principles represent unspoken commonalities between the discourses of social and medical/health research ethics but they do not appear in their discourses as unifying themes. On the contrary, the discourse of social research has largely eschewed the judgement of research by formal and independent committees and has relied on a common-sense approach to ethics. Peer review of the ethics of any piece of research has been *ex post facto*. A working

knowledge of ethical considerations through reading such material appears to be seen as sufficient knowledge for its application to the research process itself by researchers wishing to enter the field. The problem with this, and with lack of regulation is that a strong case can be made for the good served by any research. Many covert studies, for example, have seen researchers gaining or maintaining access to the field by mutilating their bodies to simulate carcinoma (Buckingham 1976), using plastic surgery to disguise their identities (Sullivan 1958) or faking psychiatric symptoms (Caudill *et al.* 1952, Rosenhan 1973). In perhaps the most famous of such studies Humphreys (1970) acted as a look-out for men participating in homosexual acts, took down their car number plates and later interviewed them as part of a public health survey. He argues that this 'harmless activity', i.e. homosexuality, should not be driven underground. Humphreys proposes, despite the invasion of privacy and deceit involved in his research, that in essence his method exposed the group to little risk compared to the prospective benefits of the work. But without some form of regulation there is a danger that the public, i.e. those upon whom we rely as researchers for data, may be alienated from participating in future research.

In contrast, the bioethical discourse arises and has been sustained over a long period by the concerns, and through the leadership, of physicians. The approach is based on an implicit assumption of the relationship between the medic and their patient and is therefore one about ensuring patients are protected. Despite these observations, the ethics of biomedicine have been formalised, and an organisational solution found, to balance the interests of those parties involved in research, i.e. patients, research subjects and the public.

There seem to be several reasons why a reconciliation between the health/medical and social research discourses is warranted. The first is simply that, despite their common interest in the ethics of research, there seems to have been a divergent evolution of ideas with lessons to be learned from each field. In Britain, with the blurring of roles between health and social care, particularly in the community, it is likely that more and more research might be construed as involving NHS patients, and, as such, would therefore need ethics committee approval. Moreover, a substantial amount of research within the social science field has been of a qualitative nature and there are a huge number of publications which claim, some more strongly than others, that qualitative research is being treated unfairly and disadvantaged by ethics committees (Hunt 1992, p. 350, Parker 1993, Kent 1997, p. 186, Williams 1997, p. 18, Lacey 1998, p. 216, Lyttle 1998, p. 42, Gauld & Macmillan 1999, Gelling 1999, p. 564). The remainder of this paper therefore

seeks to describe how qualitative research is disadvantaged by ethics committees and to critically consider a range of solutions proposed in the literature.

### The organisation of ethical decision-making on qualitative research

Speaking of ethics committees in Sweden, which have drawn heavily on the Helsinki Agreement in their operation Lynoe *et al.* (1999) argue that, 'A poorly designed study is by definition unethical' (Lynoe *et al.* 1999, p. 152), a point recently repeated in the Department of Health (Department of Health 2001a, para 2.5.1, p. 12). For ethics committee members making such judgments about research proposals, and whose decisions must take place *prior to* the experimental or data collection phase, it means there has to be a clear idea about what constitutes the 'well designed' as well as the 'badly designed' project. This is a *methodological issue* about research design and adherence to the veracity of any one methodology over others is likely in such circumstances to disadvantage some methods, whilst privileging others.

The methodological nature of research design is well demonstrated by considering alternative versions of Lynoe *et al.*'s adage: *Not every 'well designed' project is, by being well designed, ethical.* For example, double-blind studies may be the best design for a proposed randomised controlled trial (RCT) but, if implemented, mean that subjects hoping for a cure from a new treatment or drug would not be sure they would be receiving the treatment or placebo. As Kent (1996) argues:

since many trials are performed at a time of much upset and uncertainty, the additional burden of agreeing to random allocation to treatments can be intolerable (p. 1518).

Indeed, good design may conflict with what is required to make a project ethical, i.e. to make some studies ethical may require that a project is suboptimal in terms of its design.

A counterpoint to the above is that, 'not all research which starts with an unclear design is, by virtue of having an initially unclear design, unethical'. Some literature supports this position. For example, Glaser & Strauss (1967) point out that a researcher approaches the area of study with 'a general wonderment' purposefully avoiding posing a clearly defined research question (Glaser 1992). Stern (1991) describes how, in sticking to some qualitative designs, proposals may be disadvantaged in seeking ethics committee approval. Some of her colleagues, she tells us, have a philosophical problem with providing ethics committees with 'concrete numbers of participants' in advance of a study. They believe that such practice represents a

deviation away from the qualitative paradigm. The answer, Stern (1991, p. 149) argues, is quite simple, i.e. that the researcher provides an 'educated guess' of sample numbers.

The research of the Booths (Booth & Booth 1994, 1998) provides another example. Their sample was recruited through networking because of the difficulty of identifying parents with learning disabilities. It was unclear the extent to which the research participants would be able to respond to research questions and a largely unstructured approach was therefore taken in collecting the data. Yet these studies appear to have been undertaken with the highest ethical standards and to have produced vital information about the ways in which services can and should intervene to support learning disabled people in their family and parenting roles. Some of the experiences from this and other research have also led to further discussions about the ethics of research with vulnerable subjects (Booth 1999).

*Research design and ethics are not one and the same.* A 'design' that accords the observer the ability to prospectively adjudge on the balance of probabilities that it will meet ethical standards is all well and good. But it is not true to say that one in which the design emerges will, necessarily, be ethically unsound. It is simply that it does not provide *the grounds for prior judgements on ethics*, since the balance of probabilities cannot be established over risk or benefit until the research procedures become clear over the data collection period. Despite this, the Department of Health (2001b) draft document of ethics committees asserts that,

Whilst the nature and scope of research may be changing, the necessity for a prior favorable ethical opinion before any research may be started remains central to Research Governance – and this will remain the single important prerogative of Research Ethics Committees (preface, p. 1).

A further point can be adduced from the arguments above, one that might be referred to as the 'myth of the gold standard'. Research undertaken from different perspectives using different methods addresses different problems and produces different forms of knowledge. Each approach is empowered by its methodology to do so, but is limited in addressing other problems, issues or hypotheses and questions. Qualitative research has the potential to generate questions about the assumptions underlying service delivery, e.g. Goffman's (1961) work on total institutions or Benner's (1984) work on the development of nursing expertise. Qualitative research has contributed to evidence-based medicine, for example in the field of asthma treatment (Green & Britten 1998). Such studies can provide in-depth understanding of people's lives through narrative methods (Atkinson & Walmsley 1999) which establish

both positive and negative principles that should attach to services (Grant & Ramcharan 1999) or establish concepts for operationalisation in quantitative studies (Henwood & Pidgeon 1994). Qualitative research is therefore an invaluable tool and should not be dismissed on either methodological grounds or on the grounds that sometimes prior judgements about the ethics of a study are difficult.

Two central contentions emerge from the above. *Ethics committee members should not either jointly or severally use methodologies as the only locus for their ethical decision-making.* By implication, they should be open-minded about the potential and prospective gains produced by a number of different research approaches. Second, *to be fair to methodologies with emergent designs, ethics committees should have an organisational form capable of dealing fairly with the ethics of such research.* A number of potential repairs have been suggested to the qualitative research ethics question and these debates and potential solutions are considered below.

### **Present debates and solutions to judging the ethics of qualitative research**

Solutions to judging the ethics of qualitative research and relevance to the ethics committee system might be categorised into three areas 'playing the system', 'replacing the system' and 'changing or adapting the system'.

#### **Playing the system**

Accepting the LREC and MREC system as it stands, some authors have limited themselves to giving practical advice (Williams 1997, Lyttle 1998) or 'playing the game' as Williams wryly puts it. This widespread advice relates to: how 'informed consent' should be handled and produced in applications and for potential subjects (Kent 1996); being well informed about who sits on the ethics committee; speaking to the chair, members and/or the secretary prior to submission; having a colleague peer review your proposal; and, seeking to legitimate your approach by asking a respected research colleague for a testimonial or a letter of support.

Some writers argue the need for a set of standards capable of establishing the credibility of qualitative research (Beck 1993, Popay *et al.* 1998, Gault & Macmillan 1999) and not simply seeking to justify its methodology (Gault & Macmillan 1999). Amongst the suggestions within this approach are that the design: (i) should use a range of methods; (ii) should corroborate research findings with participants; (iii) should allow the production of materials that can be tested against future research; and (iv) should be auditable.

In another approach, some organisations have set up their own ethics boards (perhaps in a half-way house to the IRB system in the U. S.). Their proposals are therefore systematically reviewed internally in relation to their ethics prior to submission to the LREC or MREC. This approach may lead to lobbying of committees and may disadvantage smaller research units without the resources to support such activity.

The above approaches establish important principles such as being knowledgeable, being trained, establishing good working relationships between the parties and at all times optimising the credibility of any qualitative proposal. However, solutions that 'play the system', whilst leaving it intact, have the disadvantage of leaving the basic problem facing qualitative researchers unresolved in terms of decision-making by ethics committees.

#### **Replacing the system**

Within nursing, a growth area for research and qualitative research in particular, there have been calls for nursing only ethics committees (Hunt 1992, Parker 1993, Marks-Maran 1994, Mitchell & Fletcher 1998). Here it is argued that 'nursing ethics ... needs to rely on other principles, and therefore criteria or frameworks appropriate to ethical principles in nursing ethics need to be created' (Marks-Maran 1994, p. 54). In a similar approach Parry (1998) argues that '... there is a case for a separate LREC for research in Community and Public Health and General Practice' (Parry 1998, p. 3). To the authors' knowledge there is at present only one LREC area that has reorganised in this way. In Oxfordshire, four ethics committees operate: the LREC, a mental health committee, a students ethics committee and the Applied and Qualitative Research Ethics Committee (AQREC). AQREC grew directly out of a previous group known as the Nursing and Allied Professions Ethics Committee (NAPREC), which itself emerged after negotiations between senior nurses and the Oxfordshire Health Authority that commissioned the local LRECs.

There are other prospective systems to replace the LREC and MREC systems, for example, the Institutional Review Board system operated in the U. S. In this system each institution (e.g. a university) undertaking research is required to set up its own ethics committee or Institutional Review Board. These boards will ensure that any publicly funded research is likely to meet strict ethical standards. As well as submitting a standard form for each piece of research, spot checks organised at federal level are also undertaken on individual studies. The system of regulation has sanctions and penalties which can apply university-wide as well as to any

single study, so it is in the interests of the IRBs to be undertaking their role to the highest standards.

The Oxfordshire and IRB models seem to have worked well. There are, however, a number of possible problems associated with these approaches. It would not be easy to reorganise ethics committees after many years of developing to their present form in Britain. Moreover, in taking up a model similar to that in Oxfordshire, the organisation of ethics along professional lines may be conflictual, setting profession against profession, creating a two-tier system that privileges some research over others (Parker 1993) and leading to the worst form of paternalism in which professions dispute 'ownership' of their patients (Cartwright 1988). It may also be more bureaucratic with proposals having in the end to be submitted to several relevant committees.

### Changing or adapting the system

The recommended composition of LRECs is supposed to reflect different stakeholder interests and should, theoretically at least, not vary too much, either in their operation or in their decisions about proposals. Despite this, various concerns have been raised because studies demonstrate differences between committees in response time, application forms, administrative niceties (Garfield 1995, While 1995) and, of more concern, vastly different responses to the same proposal (Gilbert *et al.* 1989, Harries *et al.* 1994, Middle *et al.* 1995). Other studies have looked at differences of ethical viewpoint between the committees, researchers and the public, i.e. those groups with some stake in the research. (Kent 1997, Lynoe *et al.* 1999). The results of these studies seem to indicate that ethics committee views were 'less liberal' than the public and that nonresearchers were less likely to see methodological design, or the right of committees to judge methodological design, as important in decisions about ethics. They also indicated a 'normative influence', in which committees were, over time, more likely to intervene than take a *laissez-faire* attitude to submitted proposals. From the above findings, a number of further solutions have emerged in relation to qualitative research. These include: widening the range committee members (Lacey 1998); taking more care in selecting members for committees (Parker 1993); providing more training about research methods (Department of Health 2001b, para. 4.11, p. 8); and decentralisation of decision-making, e.g. of postgraduate students to trusted supervisors (Parry 1998).

Decentralising decision-making *may* have an impact on the nature of ethical decision-making over qualitative research. Moreover, the approaches reviewed so far point to the need for training in qualitative research for

LREC/MREC members, recruiting more qualitative researchers to such committees and ensuring user/carer representation. But even with such changes, there still remains a problem. How can ethical judgements of qualitative research be undertaken? How is the balance between risk and benefit assessed prior to the data collection phase?

### Discussion: the ethics as process model

Social research is largely, unlike, for instance, drug trials, *not a treatment* that will or will not have an intended *specifiable* outcome. Consequently, the question should be raised: Do the same rules apply to such research as apply to treatments that have the potential to change the life of a human physically and, perhaps, irremediably?

In response to this question, it is worth highlighting a recently emerging theme in literature on the ethics of qualitative research within both the health (Usher & Arthur 1998, Seymour & Ingleton 1999) and social care (Booth 1999, Stalker 1998) fields. This idea might be summarised as the 'ethics as process' model. In this view qualitative research is unlike much quantitative or medical research. Trust with research participants is established and then maintained over time. Consent needs to be re-established on a regular basis, as does the right to withdraw from the study, a point hinted at but not made explicit in the recent draft consultation on ethics committees (Department of Health 2001b, para. 9.16, p. 19). Reflecting this, a new, more appropriate, literature has slowly been emerging. The literature addresses such issues as: avoiding the 'delusion of alliance' (Stacey 1988), in which informants reveal more than they intend; 'member checks', i.e. discussion of findings with participants to make sure they are being faithfully represented (Acker *et al.* 1983, Rodgers 1999); how to establish that consent is informed on an 'on-going' basis or that there has been no coercion or pressure exerted for participants to continue (Lipson 1994, Knox *et al.* 2000); how to avoid pressurising participants, manage suggestibility and compliance in interviews with vulnerable subjects (Brown & Thompson 1997); developing a practical response to participants' autonomy (Dworkin 1988); how to manage the general 'terms and conditions' of the research relationship and recognise when relationships become intrusive (Stalker 1998); how to handle relationships that develop with vulnerable and otherwise lonely people (Booth 1999); and when individualised consent, as opposed to 'collective consent', of groups or communities is required (Lloyd *et al.* 1996, Clear & Horsfall 1997).

These studies provide an in-depth understanding of the complexities of the ethics of qualitative research that is based on sustaining relationships for a substantial

period, often with vulnerable groups. One might categorise this 'ethics as process' as being based on prior assumptions. In this view, the research process should be sustained as with any other human interaction with good intention, in such a way as to respect and not to undermine the person emotionally, socially or physically; the time-limited researcher/participant relationship should be managed, as should withdrawal from the field; the balance of participants' personal contribution against both the personal and wider benefits of the work should be made clear on a repeated basis; participants should check how they are represented in whatever is written in field notes at the very least (if not publications) and be actively encouraged to change what has been written; and an 'audit trail' should be created by the researcher as a record of their work. These ideas are commensurate with the 'dignity, rights, safety and well-being' (Department of Health 2001a, para. 2.2.1, p. 8) set out as the major ethical principles of research governance by the Department of Health.

In situations where a qualitative research proposal had clearly outlined the potential ethical dilemmas and suitable means of addressing these, it would be possible to assert that the risk : benefit ratio would *initially* be set close to 1. In monitoring the study over time, this ratio could be checked against the emergent benefits of the study. Such a monitoring function (see Berry 1997 in relation to G.P. trials) was previously provided for in the Department of Health guidelines for LRECs published back in 1991 and has also been suggested in relation to clinical trails (Weijer *et al.* 1995, Savulescu *et al.* 1996) but it appears not to have been widely used by ethics committees. However, in their most recent document the Department of Health has suggested the use of a system of reporting, but states specifically that the research ethics committee 'has no responsibility for subsequent proactive monitoring' (Department of Health 2001b, para. 7.16, p. 13). Yet, such a monitoring function may be a useful tool through which ethics committees can ensure that in qualitative research,

the goals of the research ... [do not] override the rights, health, well-being and care of research participants (Department of Health 2001b, para. 2.2, p. 4).

If there are substantial cost implications for a monitoring approach these could be offset through a routine charge for the submission of all funded proposals, the proceedings being administered centrally to avoid the possibility of accusations of bribery or corruption.

## Conclusions

Whilst making a case for an 'ethics as process' model in relation to qualitative research, there is no reason why

this model and the monitoring function implied for ethics committees should not be relevant to other research approaches. However, making arguments for an ethics as process model raises a number of further issues. Given that social research is not a treatment nor physically invasive, 'at what point is a person an individual in their own right and one who can choose for themselves whether to become involved in or to withdraw from a research project?'. A policy of least restrictive practice relating to the right of people to decide for themselves would better suit social researchers whose work in choosing samples has remained largely deregulated to date. Adopting such an approach may also reduce work loads of ethics committees and potentially offset the costs of monitoring qualitative research. However, where research does not have to be considered by a committee, there would have to be some questions addressed about how to maintain ethical standards in research given such deregulation. Moreover, given the widening of groups undertaking research, it will not be long before there is a substantial amount of research being undertaken by and for service users themselves. Such emancipatory and participatory research is likely to produce a further series of problems in the consideration of (qualitative) research ethics.

Despite these issues, the ethics as process model seems to provide a link between health and social care ethics which have travelled divergent paths up to now. In reviewing the literature on approaches to judging the ethics of qualitative research in ethics committees, the need for a monitoring function has been proposed. The only remaining approach which would be equitable to all research methods would seem to involve looking at the actual outcomes of research as opposed to either judging it prior to implementation or, as suggested above, during the process of the research being undertaken. Asking the question about accountability for both findings, their implementation and use is perhaps the most important part of establishing the 'actual' beneficence, nonmaleficence and justice of any research project. But 'grasping this nettle' is likely to be the most difficult and politically fraught of areas. For the researcher, such decisions raise the whole frightening spectre of a dominant group imposing its will upon academic freedoms, or against those with whom they simply disagree.

## Postscript

At the time of publication, the Department of Health has launched a consultation on 'An Ethical Review of Social Care Research' following on from their recent Research Governance and Ethics Committee publication (Department of Health 2001a,b).

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