



Australian
National
University

The Ethics of Codes of Ethics

A thesis submitted for the degree of Doctor of Philosophy of
The Australian National University

By Kerrie Jean O'Rourke

1 August 2017

© Copyright by Kerrie Jean O'Rourke 2017

All Rights Reserved

Research Contribution Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university. To the best of the author's knowledge, it contains no material previously published or written by another person, except where due reference is made in the text.

Signed: 

Dated: 1 August 2017

Kerrie Jean O'Rourke

This thesis word length: 62 189 and so in accordance with the *ANU Procedure: Higher degree by research - submission and examination of theses*, this thesis does not exceed the maximum length for a Doctor of Philosophy thesis of 100,000 words exclusive of footnotes, tables, figures, maps, bibliographies and appendices.

Acknowledgements

First and foremost I want to thank Professor Elim Papadakis for patiently providing advice and support to develop and finish this thesis. I would also like to acknowledge Professor Jacqueline Lo for her encouragement and assistance and to thank both her and Professor Christian Barry for their timely insights. I am exceptionally grateful to Professor Peta Bowden for her help getting this thesis started and her assistance in getting an earlier version of Chapter 4 published. Finally, I especially want to thank my friends and family for their faith that I would finish it.

Professional editor Nicole Arioli provided copyediting and proofreading services, according to the guidelines laid out in the university-endorsed ‘Guidelines for editing research theses’.

This research is supported by an
Australian Government Research Training Program (RTP) Scholarship.

Abstract

Medical codes of ethics have long been understood as social contracts and have evolved in the way they are developed in some countries to reflect this, through regular consultation processes and periodic updates. If the medical code of ethics is breached, then attention often turns to those who breach the code rather than to a search for some inadequacy of the code that failed to change behaviour.

By contrast, business codes of ethics are developed for a number of reasons, including legal compliance, and are not always developed in such a way that they can adequately reflect the extant social contract. When the social contract is breached by individuals of a corporation, attention often turns to the code in an attempt to identify the inadequacies that allowed the breach.

This thesis examines the philosophical, empirical and historical research to discover how codes of ethics are perceived in the research, what the empirical investigation of codes of ethics tells us, and how codes of ethics have evolved. It reveals that theories to support the notion that codes of ethics for business are social contracts have been developed only relatively recently. It also reveals that while there is broad acceptance of this notion, there is little evidence to indicate that some of the usual processes used to develop codes of ethics are geared towards producing a social contract. This thesis argues that the development process for a code is fundamental to its capacity to reflect the social contract, but that this aspect of codes is poorly studied. A framework which outlines the approaches used for developing a code of ethics is offered in this thesis to facilitate understanding and inform discussion of the issue.

Studies of codes of ethics for business tell us some empirical information, but the quality of many primary studies is poor and meta-analyses are few. This fact provides an opportunity to identify and discuss gaps and assumptions in the research to help provide direction for future research efforts. The history and evolution of medical codes of ethics in the UK are used as a case study to demonstrate how business and researchers could re-frame thinking about business codes of ethics and their development.

The Ethics of Codes of Ethics has two predominant objectives. Firstly, it provides a critique of existing approaches to both the development and implementation of codes of ethics. Secondly, it provides constructive suggestions for changes to the way business

codes of ethics are conceived, developed and researched. This dual (critical and constructive) approach is used to highlight how codes of ethics actually need to be developed in such a way that they better reflect the social contract between a business and the society in which it operates. It is only by reflecting the social contract between business and the society in which it operates that codes of ethics become inherently ethical documents.

List of Abbreviations

AC – Affective commitment

AMA – American Medical Association

CC – Continuance commitment

CSR – Corporate Social Responsibility

ECT – Ethical Climate Theory

GMC – General Medical Council

HBR – Harvard Business Review

ISCT – Integrative Social Contracts Theory

MSF – Médecins Sans Frontières

NASMM – National Association of Senior Move Managers

NC – Normative commitment

NHS – National Health Service (UK)

UK – United Kingdom

US – United States

Table of Contents

The Ethics of Codes of Ethics	
Research Contribution Declaration	i
Acknowledgements	ii
Abstract.....	iii
List of Abbreviations.....	v
Tables	5
Figures.....	6
Foreword	7
What is Ethics?.....	8
What is a Code of Ethics?	9
Codes of Ethics in Medicine and Business	12
Research into Codes of Ethics.....	13
Thesis Question.....	15
Thesis Aim	15
Thesis Hypotheses.....	16
Structure of the Thesis	17
Limitations	19
Challenges	21
Concluding Points	22
PART 1 – Theory and Observation.....	24
Chapter 1: Codes of Ethics – Social Contracts	25
Introduction	25
Different Ways to Look at Codes of Ethics	26
Thinking of Codes of Ethics as Social Contracts.....	29
Social Contract Theory	32
Integrative Social Contracts Theory.....	35
The Leverage of the Professional Organisation	37
Summary	39
Conclusion	39
Chapter 2: Studies of Codes of Ethics	40
Introduction	40
Early Expectations of Codes of Ethics – Baumhart’s Study.....	42
Building on Baumhart’s Study.....	44
Cressey and Moore – An Early Study in Codes of Ethics	50
Approaches and Limitations in Studies of Codes of Ethics.....	51

Disparate Approaches to Research.....	52
Presumptions Regarding the Importance of Demographics.....	54
The Dearth of Quality Research on Codes of Ethics	55
Summary	67
Chapter 3: Meta-analyses.....	69
Introduction.....	69
Discussion – Meta-analyses Regarding Ethical Behaviour or Attitudes	70
Study 1 – The Borkowski and Ugras Study (1998)	71
Study 2 – The Davis and Rothstein Study (2006).....	72
Study 3 – The Kish-Gephart, Harrison and Treviño Study (2010).....	73
Study 4 – The Pan and Sparks Study (2012)	75
Study 5 – The Jackson, Meyer and Wang Study (2013).....	77
Discussion on the Combined Findings of the Meta-analyses	79
Variables Associated with Ethical Behaviour.....	80
Variables Associated with Unethical Behaviour.....	83
Variables Which Provided Inconclusive Results	84
Discussion of Findings	86
Meta-Analyses of Education/Instruction.....	87
Study 5 – Haws Study (2001)	88
Study 6 – Winston Study (2007).....	89
Study 7 – Waples et al. Study (2009).....	90
Summary	93
Conclusion	94
PART 2 – History and Evolution.....	96
Chapter 4: Historical Development of Codes of Ethics.....	97
Preludes to Codes of Ethics – Commandments, Oaths and Honour.....	97
The First Organisational Code of Ethics.....	99
The Spread of Codes of Ethics.....	102
The Evolution of Codes of Ethics	106
The Scandalous Seventies, Eighties and Nineties	109
The Changing Emphasis of Codes of Ethics.....	112
Summary	114
Concluding Reflections.....	115
Chapter 5: The Changing Style of Codes of Ethics	116
Introduction.....	116
The Origins of <i>Good Medical Practice</i> (2013).....	117
Comparing <i>Medical Ethics</i> with <i>Good Medical Practice</i> (2013)	120

Contextual Comparison.....	121
Structural Comparison	123
Philosophy Comparison	126
Content Comparison	128
Style of Expression Comparison.....	132
Comparing the Process of Development.....	133
Summary	133
Conclusion	134
PART 3 – Discussion and Conclusion.....	135
Chapter 6: Development Approaches to Codes of Ethics.....	136
Introduction	136
Developing Codes of Ethics – Three Approaches	138
The Bespoke Approach.....	138
The Template Approach.....	142
The Modeled Approach.....	144
Factors which Impact on the Choice of a Code Development Approach	145
The Impetus to Develop a Code.....	146
The Resources Available.....	146
The Timetable for Development	146
Whether Internally Developed or Outsourced	146
The Code Author.....	147
Messaging Choices	148
Culture and Codes	150
Developing Effective and Ethical Codes	151
Summary	153
Conclusion	154
Chapter 7: The Ethics of Codes of Ethics	155
Are Codes of Ethics Ethical?	155
Codes of Ethics as an Extension or Expression of the Law	158
A Hierarchy of Norms?.....	161
Codes of Ethics and Globalisation.....	162
Stakeholder input in a Globalised Environment	166
Summary	169
Conclusion	170
Chapter 8: Conclusion.....	171
Key Themes in the Thesis	175
Shifting Motivations, Static Expectations.....	175

The Effectiveness of a Code Depends on Why it was Written	175
Research into Codes of Ethics Could be Improved	176
Both Legal and Ethical Concepts Inform Social Contracts	177
How Should a Code of Ethics be Developed?	178
Are Codes of Ethics Ethical?	179
Key Findings	179
Implications of the Thesis for Future Research	185
Appendix 1: Meta-analyses Findings.....	187
Appendix 2: Concepts Comparison	196
Bibliography.....	214

Tables

Table 1 – Factors that Correlate with Ethical Behaviour.....	82
Table 2 – Factors that Correlate with Unethical Behaviour.....	84
Table 3 – Factors that Gave Mixed Results or had no Correlation with Ethical Behaviour	85
Table 4 – Meta-analysis Results: Ethical Education.....	92
Table 5 – Articles of <i>Medical Ethics</i> which have been retained in some form in <i>Good Medical Practice</i> (2013)	130
Table 6 – Issues/Gaps and Trends.....	180
Table 7 – Findings: Meta-analyses of Ethical Behaviour/ Attitudes	187
Table 8 – Findings: Meta-Analyses of Education/ Instruction	191
Table 9 – Concepts Comparison between <i>Medical Ethics</i> and <i>Good Medical Practice</i> (2013).....	196

Figures

Figure 1: Ethics Standards Adoptions by Year.....41
Figure 2: Codes of Ethics – A Timeline.....107

The Ethics of Codes of Ethics

Foreword

Codes of ethics for business are commonly declared to be ineffective by researchers and commentators. The history of codes of ethics tells us that the idea to have a code of ethics was embedded in medicine long before it spread to business. While codes of ethics in medicine have continued to evolve in response to community expectations and are well accepted, business ethics researchers continue to investigate how to make business codes of ethics work.

Codes of ethics are a social contract and accordingly, they should in some way reflect community expectations of conduct. It may be that they narrowly reflect a legal requirement, as is the case in some businesses, or that they holistically address and reflect many broader complex and nuanced issues, as is the case in medicine in many western countries.

The research on business codes of ethics so far has included a somewhat Sisyphean effort to discover how to change the behaviour of individuals with a code of ethics. If an individual breaches a code of ethics then one should look to the individual to take responsibility, not to the code of ethics for being ineffective. Yet researchers and commentators continue to inquire into the effectiveness of codes of ethics when investigating ethical decision-making in business organisations. If we are to question a code of ethics, then it need only be in regard to whether it adequately reflects what the community expects (i.e. the extant social contract).

It is worth considering re-framing thinking about business codes of ethics to ask whether business codes of ethics adequately articulate the social contract or not. This thesis primarily seeks to address the following:

Codes of ethics for business are meant to be constructive, guiding documents. However, these codes of ethics are commonly declared to be ineffective by researchers and commentators. Therefore a gap appears to exist between what codes of ethics promise and what they deliver. Is there any way to bridge this gap? If so, then how? Can we learn lessons from the history and philosophy of medical codes of ethics

which would re-frame thinking about business codes of ethics and their development to ensure that they are constructive, relevant and ethical documents?

This question is important because no organisation is immune to ethical lapses. Instances of ethical scandals abound not only in business, but also in government, not-for-profit, volunteer, religious and sporting organisations and the medical profession. Even though incentives and disincentives to comply with a code of ethics may have some effect, simply having a code of ethics will not prevent an ethical lapse. Individuals exercising choices will sometimes make unethical choices regardless of the existence of guidance or rules. A code of ethics can, however, articulate the social contract and inform realistic expectations and understandings of conduct. It may even challenge organisational members to consider the impact of their actions in the context of broader community expectations rather than the traditionally narrow focus which has been limited to expectations of the organisation's internal community.

What is Ethics?

The word *ethics* is derived from the Greek word *ēthikos*, meaning 'character'.¹ Ethics is concerned with what behaviour is considered right, what behaviour is considered wrong, and how the difference might be understood. Ethics is variously described, often in similar or contrasting terms with other concepts that guide behaviour (normative concepts or social norms). This is because there are areas of commonality and difference between ethics and the other normative concepts. These concepts include law, morality, social mores, conventions and customs. Leading authors on the subject often distinguish these concepts by referring to them as different systems, realms, rules, obligations, phenomena, principles, standards, responsibilities or normative forces (Smith, 1997, p. 121; Spaak, 2003; Svensson & Wood, 2003).

¹ The Oxford English Dictionary states the following:

Etymology: Originally < Middle French *ethiques*, *ethyques* title of a treatise on morals by Aristotle, branch of knowledge dealing with moral principles (both c1370; compare earlier *ethique* ethic n.), use as noun of plural of *ethique*, *ethyque* ethic adj., after post-classical Latin *ethica* Aristotle's Ethics (c1330, c1440 in British sources; compare *liber ethicorum* book of Ethics (from c1250 in British sources)), itself after ancient Greek *ἠθικά* (plural noun) treatise on morals (Aristotle). (OED Online, 2017)

Conducting oneself ethically is understood to be increasingly important in modern business organisations. This applies to the individual member of the organisation as well as the organisational entity. The conduct of an entity is sometimes described by the term corporate social responsibility.

The way that the ethics of a decision might be determined can vary. One approach is to reconcile a decision according to one of the philosophical theories of ethics, including virtue ethics or deontology, utilitarianism or rights theory. Another is to couch the probable outcomes of any decision in less formal terms such as the three tests recommended by Badaracco:

1. The Newspaper Test (How would you want it reported as a headline in tomorrow's paper?)
2. The Golden Rule test (How would you feel if it was done to you?)
3. The Best Friend Test (What would someone who knows and respects you think about your decision?) (Rosenbaum, 2006).

Another approach might be to refer to documents, resources or agreements that are designed by an organisation to guide ethical behaviour in the organisational context, and this is where codes of ethics become relevant.

What is a Code of Ethics?

There are a plethora of labels attached to ethically germane statements produced by organisations. These labels include, but are not limited to:

- codes of ethics
- credos
- mission statements
- codes of conduct
- business principles
- corporate ethics statements
- values statements
- codes of practice
- ethics policies

- compliance standards
- corporate philosophy (Boudreaux & Steiner, 2005; Farrell & Cobbin, 2000; Kaptein & Schwartz, 2008; McDonald, 2009; Schwartz, 2004; Skubic & Stening, 2009; Stevens, 2009).

There are no universally agreed criteria for identifying a code of ethics (Esterhuizen, 2006, p. 105; Kaptein & Schwartz, 2008, p. 112; Messikomer & Cirka, 2010, p. 57). The challenges associated with identifying a document as a code of ethics is an issue raised by some authors who have undertaken studies or provided commentary on the subject (Cressey & Moore, 1983; McDonald, 2009; Stevens, 1994). However, in general terms, a code of ethics will usually express the principles, values, rules, protocols, behaviours, courtesies or laws which purportedly guide the manner in which the ends of the organisation are achieved. In today's modern business environment, codes of ethics are often either a legal or administrative requirement or a necessary accoutrement for organisations who wish to project an image of being socially responsible.

For the purposes of this thesis, the term 'code of ethics' is understood to be a catch-all phrase used to refer to any document or statement (regardless of its given title) which an organisation upholds as *a guide to inform members and other stakeholders of the organisational understanding of conduct deemed to be ethical*. The term 'stakeholders' refers to those who have an interest in the way a business is conducted. A non-exhaustive list of stakeholders includes employees, management, suppliers, organisations in supply chains, communities from where raw materials are sourced, consumers, shareholders and disposers of the product or by-products. In essence, 'stakeholders' includes anyone from the community at large. This very broad interpretation is consistent with the Stakeholder Theory of R. Edward Freeman (Freeman, 2010). The term 'ethical' is used here to encompass both the conduct of individual organisational members and the collective behaviour of an entire organisation (as understood by the term *corporate social responsibility*). For the purposes of this thesis, it is also important to note that a code of ethics is considered to be different from an oath, given that codes are not performative utterances (Sulmasy, 1999).² Accordingly, while the Hippocratic Oath was

² Sulmasy states the following regarding performative utterances:

Oaths, like promises, are performative utterances. But oaths are generally characterized by their greater moral weight compared with promises, their public character, their validation by transcendent appeal, the involvement of the personhood of the swearer, the prescription of consequences for failure to uphold their contents, the generality of the scope of their contents, the prolonged time frame of the commitment, the fact that their moral force remains binding in spite of failures on the part of those to whom the swearer makes the commitment, and the fact that

undoubtedly a precursor to the first medical code of ethics, such an oath is not considered to be an organisational code of ethics for the purposes of this thesis.

Codes of ethics are typically treated in the academic literature as having discreet types. Generally speaking there are codes for professional ethics, medical ethics, business ethics and those of various industries such as media, financial planning and so on. Much of the research into code effectiveness is generated by those with an interest in codes of business ethics. Despite viable explanations and theories that support the understanding that codes of ethics are social contracts, they are not always interpreted as such within the field of business ethics research.

Codes of ethics are statements (referred to by various names) formulated by organisations to inform or guide members and other stakeholders of the organisational understanding of conduct deemed to be ethical in achieving organisational ends. This thesis will demonstrate that such statements (and documents) share a common heritage and a similar impetus for their genesis despite the wide variety in the type of organisation that codes of ethics are used in. Codes of ethics, regardless of which organisation they apply to, are subject to similar influences and challenges (see *Chapter 4: Historical Development of Codes of Ethics*).

Often the undertone in writings about codes of ethics can be somewhat judgmental. For example, codes are thought to be mere “window dressing” if they are not of a particular style or do not contain certain content (Stevens, 2009). Furthermore, some of the literature criticises the legalistic style of some codes (Bowden & Surma, 2003, p. 20). These criticisms are valid when the context for the enactment of such codes is devoid of legal compliance (i.e. involuntary) and the intention in adopting the code was for some other purpose such as to provide guidance for ethical behaviour. However, if, for example, a breach of the code is a trigger for sanction of an employee, then tight legalistic language may be necessary to support any ensuing administrative process.

This thesis attempts to look at codes objectively. There is no judgment made about motivations to adopt codes. For example, compliance with legislation is considered as legitimate a reason to implement a code as any attempt to create a genuinely ethical climate.

interpersonal fidelity is the moral hallmark of the commitment of the swearer. Oaths are also distinct from codes. Codes are collections of specific moral rules. Codes are not performative utterances. (Sulmasy, 1999, p. 329)

Both imperatives, in their way, are reflections of the social contract but at different levels of governance. This is because legislation is a representation of the social contract that applies in a community as a whole, while the creation of an ethical climate may be restricted in its application to a single organisation. In both cases the motivation to adopt a code is valid. However, the particular motivation will still be important in understanding why one style of code might be preferred and another style is not useful or effective in the context.

There is, however, a dearth of quality empirical research on the subject of codes and their effectiveness. This thesis argues that there is limited empirical evidence on which to draw any definitive conclusions about the following issues:

- the approach taken to developing a code
- the effectiveness of codes
- the appropriateness of codes of ethics.

In summary, much more work needs to be done in this space, both in terms of gathering more empirical evidence and the systematic analysis of that evidence. This thesis examines the research and identifies the assumptions that impact on it in order to identify where the gaps exist and to offer a constructive approach that will assist in moving thought on codes of ethics forward.

Codes of Ethics in Medicine and Business

Codes of ethics have become ubiquitous in modern business organisations (Adams et al., 2001). However, there is little research evidence to support the assumption that the adoption of a code of ethics by a business organisation positively influences ethical behaviour. This set of circumstances begs the following questions:

- What is it that we expect ethics codes to do, and why?
- Do codes of ethics fulfill these expectations?

The response to these two questions reflects the constructive aims of this thesis on *The Ethics of Codes of Ethics*. These constructive aims involve a heuristic approach which enables the generation of ideas and creation of avenues for further research.

Research into codes of ethics is largely limited to the history of medical codes of ethics and the normative aspects or empirically measurable effects of business codes of ethics. Medical codes of ethics are important because they have the longest history and have ultimately developed to become nationally recognised documents in a number of countries including Australia, United States (US) and United Kingdom (UK). By contrast, businesses have only relatively recently begun to adopt codes of ethics and are apt to take a more parochial approach, tending to produce organisational-level documents. This difference can be explained away by the fact that medical practitioners have organised into a profession with centralised registration bodies that self-regulate. Business professionals do not have a similarly centralised approach. In the case of a business it is the entity which is registered rather than the individual. Regulation tends to be by legal means rather than the sanction of peers.

The difference in approaches to developing codes of ethics between the two fields is stark. Related to these differences in development are assumptions and understandings about the role of codes of ethics in business and the expectations that surround acquiring one. These differences are revealed tacitly by the focus of the research conducted on codes of ethics for business.

Research into Codes of Ethics

Codes of ethics are a social phenomenon that has been largely investigated by business studies scholars, philosophers and medical historians who tend to look at codes empirically, philosophically and historically, respectively. This thesis is therefore interdisciplinary rather than solely from the discipline of business or history or philosophy. It brings together aspects from each of these somewhat disparate fields in order to inform the examination of how codes of ethics have developed, how they are understood and how their utility might be enhanced.

Empirical enquiry undertaken by business studies scholars is both prolific and fraught with difficulty. It informs us less than we may hope. This type of research is hampered by a lack of agreed definitions and a tendency to studies that are methodologically flawed (Kaptein & Schwartz, 2008, p. 111). The methodological limitations of much of this research restrict the

contribution which can be made to the knowledge of codes of ethics. In cases where more methodologically sound primary empirical research or literature reviews have been undertaken, evidence of synthesis or meta-synthesis capitalising on this research (or systematic review and meta-analysis) is scant, impeding the formulation of theories. An analysis of the research information available reveals not only the focus and direction of research so far, it also reveals areas underlying assumptions and aspects that are, as yet, unexplored. Secondary analysis of primary research into codes of ethics is an area that could benefit from further research (see *Chapter 2: Studies of Codes of Ethics* and *Chapter 3: Meta-analysis*).

Philosophical enquiry allows us to examine the reasoning underlying the concept of codes of ethics and gives us a framework for understanding such documents (see *Chapter 1: Codes of Ethics – Social Contracts*). Historical research traces the heritage of codes of ethics and invariably identifies the key events which influenced code development (see *Chapter 4: Historical Development of Codes of Ethics*).

This thesis draws on historical works from both medical and business sources and finds a common heritage. It provides a review of the literature from studies of business ethics and recognises findings of value. It identifies the limitations inherent in much of the empirical research and suggests avenues for future research.

A major contribution of this thesis is the original work which has been done outlining a framework describing the various approaches to ethics code development. This framework is proposed to facilitate future research identifying the development approach as a variable in investigations into the effectiveness of codes of ethics (see *Chapter 6: Development Approaches to Codes of Ethics*).

From research in the philosophical tradition this thesis argues that ethics codes are situated in the realm of social contract theory, and specifically exemplify a micro-contract as defined under Integrative Social Contract Theory. However, it is not always the case that a document which is called a code of ethics is developed with a social contract in mind, or in any way resembles one when drafted. The micro-contract has certain features that need to be addressed. Code development must therefore allow for the construction of a meaningful

micro-contract (this concept is examined more fully in *Chapter 5: The Changing Style of Codes of Ethics* and *Chapter 6: Development Approaches to Codes of Ethics*).

Using data from studies of business ethics, both the imperative for the development of a code of ethics and the method of development of a code of ethics are discussed in this thesis as likely influences on the style of document that is produced.

Thesis Question

As noted above, this thesis primarily seeks to answer the following question:

Codes of ethics for business are meant to be constructive, guiding documents. However, these codes of ethics are commonly declared to be ineffective by researchers and commentators. Therefore a gap appears to exist between what codes of ethics promise and what they deliver. Is there any way to bridge this gap? If so, then how? Can we learn lessons from the history and philosophy of medical codes of ethics which would re-frame thinking about business codes of ethics and their development to ensure that they are constructive, relevant and ethical documents?

Secondary questions that this thesis seeks to answer are:

- Have the assumptions regarding codes of ethics affected the success of code effectiveness in business?
- To what extent is the purpose/content of codes of ethics reflective of changing values/legislation in different contexts?
- Does the method/approach to the development of codes of ethics influence how effective codes are in achieving their stated outcomes?

Thesis Aim

The Ethics of Codes of Ethics aims to contribute to the knowledge on codes of ethics in both conceptual and practical ways. It does this by adopting both a critique of existing approaches and constructive suggestions for alternative approaches. Conceptually, the thesis examines the history and evolution of organisational codes of ethics, pulling together the otherwise disjointed information from various disciplines into a cohesive narrative. Practically, the thesis identifies tacit assumptions and elements that have been overlooked or inadequately

investigated in the research to date which could lead to more effective design and use of codes of ethics in organisations. A framework is offered to facilitate discussion and research into code development approaches. The expectation is that this thesis, by adopting both a critique of existing approaches and constructive suggestions for alternative approaches, will be the start of a much-needed intervention in the research and development of codes of ethics for business.

Thesis Hypotheses

Business codes of ethics are often not developed in such a way that they reflect the social contract in ethical terms. Although the legal social contract may be adequately reflected, the ethical social contract seems more elusive in business codes of ethics. Medical codes of ethics have evolved to better reflect the ethical social contract, and at this point the effectiveness of the medical code is not questioned in the research.

It is likely that some assumptions which drive the empirical research of business ethics are flawed. In business research there is evidence that theories of social contracts have developed support for a model of business codes of ethics much like that of the medical code of ethics. However, the empirical literature is largely focused on hunting for variables that impact code effectiveness rather than examining the important process of code development and the ways in which code development approaches may lead to a better reflection of the social contract.

The following hypotheses are tested in this thesis:

- The philosophical evidence supports the need for the adoption of a social contract approach to business codes of ethics.
- The empirical research reveals assumptions underpinning such research regarding codes of ethics in terms of their capacity to effect change or of the impact of certain variables (e.g. age, gender, education).
- The code design process is an overlooked variable in the development of business codes of ethics.

Structure of the Thesis

The thesis is divided into three parts:

Part 1 – Theory and Observation

This part of the thesis explores basic understandings of how codes of ethics are described, analysed and interpreted in the research literature. Research findings on codes of ethics of both medicine and business are critiqued. Some conclusions based on empirical research are tested through the examination of meta-analyses findings, and some assumptions in the research are identified.

Part 1 consists of the following three chapters:

- ***Chapter 1: Codes of Ethics – Social Contracts*** discusses the various philosophical understandings of codes, leading to a focus on Integrative Social Contracts Theory.
- ***Chapter 2: Studies of Codes of Ethics*** is a review of the literature. It identifies key studies and discusses the limitations inherent in them, including the difficulties with the use of non-standard and undefined terms.
- ***Chapter 3: Meta-analyses*** discusses the meta-analyses which could be found in the literature search and the conclusions which can be drawn from them.

Part 2 – History and Evolution

Part 2 traces the development of codes of ethics and describes events that have shaped modern codes of ethics in both medicine in the UK and business in the US as well as globally. Part 2 also evaluates the differences between the modern code of ethics for medical practitioners that is used in the UK today, and the first medical code of ethics written for the Manchester infirmary in the late eighteenth century.

This explanation of the history and evolution of codes of ethics reveals that the profession of medicine in the UK has embraced a broad consultative approach to the development of the medical code of ethics. In contrast to this approach, the research literature indicates that business codes of ethics are routinely developed with much more limited input, which is usually sought only from management and/or employees.

Part 2 consists of the following two chapters:

- ***Chapter 4: Historical Development of Codes of Ethics*** traces the development of codes of ethics from the first modern organisation known to use one through to the present day where they are used across the globe in a multitude of diverse organisations. An earlier version of this chapter was published by the thesis author in 2010 under the name Kerrie Griggs (Griggs, 2010).
- ***Chapter 5: The Changing Style of Codes of Ethics*** compares the differences between the first medical codes of ethics in the UK and the document used today.

Part 3 – Discussion and Conclusion

The final part of the thesis seeks to address some of the gaps which are detectable in the research literature. Specifically it identifies the lack of discussion on development approaches, and provides a framework to begin this conversation. This part of the thesis also explores whether codes of ethics are ethical, how this determination might be made and suggests constructive approaches to creating an ethical code. This part also contains the conclusion.

Part 3 consists of the following three chapters:

- ***Chapter 6: Development Approaches to Codes of Ethics*** notes that codes are developed by various methods and there is no categorisation of the different approaches to code development in the literature. Accordingly, no research could be found that considers a correlation or causation between code development technique and desirable features such as quality, usefulness or effectiveness. This chapter outlines the identification of three different approaches to the writing of either a new code of ethics or the revision of an existing code:
 1. The Bespoke Approach
 2. The Template Approach
 3. The Modeled Approach.

The content of this chapter serves to provide a framework to discuss code development and then to apply this as a variable in future research into the effectiveness of codes of ethics.

- **Chapter 7: *The Ethics of Codes of Ethics*** discusses the possibility of a national model code of ethics for business such as those that have evolved in medicine and other professions.
- **Chapter 8: *Conclusion*** is a discussion of the concepts raised in the previous chapters and a summation of the overall thesis concept with suggestions regarding the avenues for future research.

Limitations

The thesis has the following limitations:

- Studies of western English speaking countries are the main source of research material; therefore, the examination of codes of ethics is limited to sources from the UK, the US, Australia and Canada and journal articles published in English that examine European countries. This undoubtedly focuses discussion of business ethics mostly on first world countries with significant economic power and resources. Accordingly, there is no significant discussion of business ethics in countries like China, Russia, Korea or India. These countries have significant impact in a globalised environment and yet may have some domestic policies that do not accord with the ethical positions taken in countries such as the US and Canada.
- A larger number of the articles relating to business ethics are drawn from studies in the US.
- It is restricted to a deep examination of medical codes of ethics in the UK. Research on the very early medical codes of ethics in the UK is dominated by Baker and some bias may be evident due to the limited sources that discuss this topic.
- The dearth of quality empirical research on the subject of codes and their effectiveness renders it much harder to draw definitive conclusions about the approach taken to developing a code, the effectiveness of codes and the appropriateness of codes of ethics.

Accordingly, this thesis limits its observations to the research of medical codes of ethics in the UK and business codes of ethics in western developed countries. There is no attempt to extrapolate the conclusions to accommodate a global view, although the difficulties of globalisation are acknowledged in *Chapter 7: The Ethics of Codes of Ethics*.

The shortcomings of the empirical research are discussed at length in *Chapter 2: Studies of Codes of Ethics*. Throughout the thesis, but particularly in Chapter 2, some constructive observations for the improvement of empirical research are identified in the research literature. In *Chapter 3: Meta-analyses*, some new approaches to empirical research are proposed based on the collated findings of meta-analyses which focus on business ethics research.

This interdisciplinary thesis brings together the historical context and development of medical codes of ethics and compares and contrasts that with the context and development of business codes of ethics. By examining some landmark studies and the available meta-analyses on the variables that influence the effectiveness of business codes of ethics and business ethics education, we can begin to identify some other less examined variables which are more likely to impact the effectiveness. We are also able to discern that the method of development of codes of ethics is not adequately researched as a possible variable that influences the effectiveness of codes of ethics.

This thesis provides a view of codes of ethics from the philosophical, empirical and historical realms. In bringing together this information it reveals the varied reasons why so many organisations have a code of ethics, exposes some of the research findings and identifies issues that could be addressed to facilitate improved future research.

This thesis argues that codes of ethics can serve various functions as an organisational tool, but that often the desired function of promoting ethical behaviour is not realised and the reasons for this are not well researched or understood. The thesis reviews the literature on ethics codes and provides a historical and philosophical view of ethics code development. This reflection is imperative to the practical purpose of raising the standards of ethical practice in contemporary organisations. It is time to understand where ethics codes came from and why they developed, then to take stock of the contemporary assumptions that underpin understandings of their nature and roles.

Challenges

There were two major issues that arose in undertaking this research:

1. The primary challenge was the inconsistency in language used in relation to codes of ethics. Many primary research studies touch on this point, raising issues including the various labels applied to documents which could be considered codes of ethics and the way concepts are differently expressed in the various disciplines. Examples include the terms used for a code of ethics: code of conduct, professional code, credo, values statement and so on. Some other terms involved in the research project were not standardised. For example, some research on the effectiveness of codes failed to define effectiveness.

The decision was taken to be as inclusive as possible in the interpretation of what constituted a code of ethics for the purposes of this thesis. Hence the definition which was applied refers to any document or statement (regardless of its given title) which an organisation upholds as a guide to inform members and other stakeholders of the organisational understanding of conduct deemed to be ethical. This definition seeks to capture the intent of the document rather than risking exclusion of information or data due to an arbitrarily applied title.

2. The second significant challenge was in sourcing primary research of sufficient quality. Studies are extremely variable in their approaches across disciplines. Data is often drawn from very particular contexts and then the conclusions are generalised, data points are often too few to provide statistically viable samples or studies rely on surveys where self-reporting or hypothetical reasoning is involved rather than more objective methods. This observation is supported by comments and data in some of the meta-analyses (see *Chapter 3: Meta-analyses*).

This difficulty in sourcing quality primary research was valuable in its own right as it allowed the observation that improvements could be made in the approaches to research; these are articulated in *Chapter 2: Studies of Codes of Ethics* and explored in depth in *Chapter 6: Development Approaches to Codes of Ethics* and *Chapter 7: The Ethics of Codes of Ethics*. Further, the search for meaningful data led to an examination of meta-analyses in an effort to identify data that had greater statistical viability; this both

validated the observation that quality primary research was difficult to find and provided evidence of those variables which affect ethical behaviours and attitudes.

Concluding Points

This thesis examines the evidence and argues that codes of ethics for business can, and should, be developed in such a way that they reflect the extant social contract between all affected stakeholders. This requires that the organisation look at the perspectives of those external to the organisation. Such input has the potential to critique insular understandings that are held within an organisation and to effectively reveal the different, possibly higher, expectations held by the broader community. The code of ethics used by medical practitioners in the UK provides a point of comparison that is used to contrast the current approach taken in business with a viable alternative which recasts the purpose, aim and evaluation of codes of ethics.

The presumption that acquiring a code of ethics will change behaviour is not supported by current research into business ethics. Attempts by researchers to correlate physical variables such as age and gender to ethical decisions have established weak correlations at best and have not grown the body of knowledge on codes of ethics. However, the research does support the idea that for a code of ethics to be effective, then it needs to be enforced in some way.

This thesis questions the assumptions in the research and outlines reasons to develop codes of ethics that reflect the social contract. An original contribution to the field of knowledge is made through the development of a framework by which to organise thoughts and discussions on code development.

This is important because, without explicitly revealing the reason why a particular code of ethics was created and the development process used, it is not possible to determine whether or not the code is serving the purpose for which it was created i.e. whether or not it is effective. The reason to have a code and the process used to develop it provide relevant context for the investigation of whether it is useful or effective.

The process of development of a code is an important factor in establishing the code as an ethical document. This thesis explains why a code of ethics must have input from affected stakeholders to be an ethical document, but that the current research suggests there is little consideration given to stakeholders external to the organisation being involved in the development of a code of ethics. In the context of a globalised environment, producing an ethical code of ethics presents significant challenges.

PART 1 – Theory and Observation

This part of the thesis explores basic understandings of how codes of ethics are described, analysed and interpreted in the research literature. Research findings on codes of ethics of both medicine and business are critiqued. Some conclusions based on empirical research are tested through the examination of meta-analyses findings, and some assumptions in the research are identified.

Chapter 1: Codes of Ethics – Social Contracts

Introduction

Codes of ethics in businesses have become increasingly popular since the 1970s for a number of reasons, including the aspiration to be seen as a profession, as part of efforts to self-regulate to avoid external regulation, to bolster the reputation of an organisation, and to comply with legal requirements. Business has had less success with this approach than the professions, especially the profession of medicine.

This thesis asks whether we can learn lessons from the history and philosophy of medical codes of ethics which would re-frame thinking about business codes of ethics and their development to ensure that they are constructive, relevant and ethical documents. This chapter contributes to the answer by examining the philosophical theories that have been developed to explain how codes of ethics might influence behaviour. It is evident that the idea of codes of ethics as social contracts is the most developed and widely accepted theory. This is true for medical codes of ethics as well as for business codes of ethics.

A social contract is defined by the Oxford Dictionary as “an implicit agreement among the members of a society to cooperate for social benefits, for example by sacrificing some individual freedom for state protection” (Oxford Living Dictionaries, 2017). The Stanford Encyclopedia of Philosophy presents the basic idea of the social contract as “the agreement of all individuals subject to collectively enforced social arrangements shows that those arrangements have some normative property (they are legitimate, just, obligating, etc).” Nonetheless, the authors of this piece then observe that: “Even this basic idea, though, is anything but simple, and even this abstract rendering is objectionable in many ways” (D’Agostino et al., 2017).

The discussion below explores some of the different ways which have been used to discuss the normative theory underpinning codes of ethics and demonstrates that social contract theory has become widely accepted by researchers. This chapter explores the evolution of social contract theory and the difficulties which traditional social contract theories fail to address. It then explains how the more recent development of Integrative Social Contract

Theory is applied to understanding codes of ethics, whether they be medical or business codes of ethics.

Different Ways to Look at Codes of Ethics

In their article “A Corporate Culture Pattern to Manage Business Ethics”, Claver, Llopis and Gascó (2002) claim that the reason for having a code of ethics is intuitive, stating: “It is obvious that in principle individuals are more ethical if a corporation has a written, formal code, and less ethical otherwise” (Claver et al., 2002, p. 156). However, the early history of codes of ethics indicates that the primary imperative for organisational codes of ethics to be developed was as an endeavor of self-regulation (see *Chapter 4: Historical Development of Codes of Ethics*). In an apparent effort to indicate that action is being taken to address the problem of its members straying from the ethical path, organisations across the globe have increasingly adopted codes of ethics (Griggs, 2010).³ Once a code of ethics has been formulated, the individuals belonging to the organisation might reasonably be expected to be cognisant of it.

Codes of ethics enunciate the principles, values, rules, protocols, behaviours or courtesies which guide the manner in which the ends of the organisation are achieved. However, ethics deals with understandings of morality and is by nature reliant on subtle and particular interpersonal perceptions. It is a field of inquiry which is largely guided by societal expectations and the impact of the integrity of personal choices on relationships within a society.

Given the unique ethical considerations which arise in different organisations, the cultural variance of members, and the flux in membership that many contemporary organisations experience, there are bound to be differences in assumptions, values, opinions, understandings and expectations which come to light in the context of the day-to-day activities of the organisation. There is, therefore, a pragmatic imperative to unify the expectations of what constitutes ethical conduct among the stakeholders of an organisation. However, what is often overlooked in the research literature is that there may be stakeholders outside the organisation whose expectations are different to those of internal stakeholders. The code of ethics may fail to address the concerns of external stakeholders such as the

³ This paper was published by the thesis author under a different surname. Large parts of the text of this article are utilised in *Chapter 4: Historical Development of Codes of Ethics*.

communities and interest groups in those places where the goods or services are manufactured or marketed.

The term ‘stakeholders’ in this context refers to those who have an interest in the way a business is conducted. It includes, but is not limited to, business owners, employees, management, suppliers, organisations/communities in supply chains, communities from where raw materials are sourced, consumers, shareholders and disposers of the products or by-products of the activities undertaken by the organisation. In essence, the term ‘stakeholder’ can include many different people who are internal or external to the organisation, including the community at large.

One approach to articulating and achieving a shared understanding of the expectations around ethical conduct is for an organisation to adopt a code of ethics. However, there are particular considerations regarding the way expectations are expressed within a code of ethics which can impact on whether the code of ethics is perceived as a constructive or relevant document.

The contemporary tendency to attempt to codify ethics information is often based on an understanding that ethics can be articulated in a law-like form. Bowden and Surma (2003) explain that addressing matters of ethical concern in codified form “suggests an underlying commonality: that ethics is amenable to law-like expression.” This is because “the term ‘code’ carries with it the sense of a set of rules that are systematically related and an understanding of morality as some kind of impartial knowledge of do’s and don’ts”. They suggest that a possible historical reason for this codified form of expression may be attributed to “popular perceptions of the commandments of many religious traditions” (Bowden & Surma, 2003, pp. 20–21).

Religious beliefs and understandings of both legal and ethical conduct are often strongly connected. Existing legal and ethical positions are often guided by faith-based understandings. An example of this is the primacy of the sanctity of life held by the Roman Catholic Church in accordance with the fifth commandment, “You shall not kill”, applied to ethical analyses of abortion, euthanasia and medical research (Vatican Archives, 1997).

Rothkamm (2008), a commentator who has examined this “sacral-legal overlap”, observes that an “examination of comparative history supports the hypothesis of a sacral-legal overlap, according to which legal systems emerge from and usually remain closely connected to, spiritual settings”. He also notes the influence of the codified Ten Commandments, commenting that they are “perhaps the most famous example in the collective memory of the western world” of a “detailed code of social behaviour” (Rothkamm, 2008, p. 301). The tendency for such linkages to be made is testament to the marked longevity of the adoption of a codified approach to the social contract. It should be no surprise that smaller organisations such as corporations have, to some degree, emulated codification as the preferred approach.

However, modern codes rarely draw authority directly from religious doctrine. As early as 1983, Cressey and Moore (1983, p. 59), in their study of a collection of early US business codes of ethics, observed that, “although a few codes draw upon Christian or other religious doctrine, the most commonly cited metaphysical principle is simply that virtue has its own reward”. Other theories explaining the normative influence of codes must therefore be considered.

Walker (2007), a feminist philosopher, claims that the “theoretical-judicial” model of morality has gained prominence, particularly in the United States. She asserts that many normative theories of morality based in “utilitarian, contract, neo-Kantian or rights based” approaches fit this model which, she argues, represents morality as “a compact, propositionally codifiable, impersonally action-guiding code within an agent, or as a compact set of law-like propositions that ‘explain’ the moral behavior of a well formed moral agent”, and she goes on to clarify that this is in the sense of “‘explaining’ what should happen” (Walker, 2007, p. 8).

Walker (2007) is not comfortable with this understanding of morality. Her criticisms include the fact that it is intellectualist, rationalist and individualist, yet simultaneously impersonal. Instead, she asserts that morality is an “interpersonal and collaborative responsibility”. In short, she identifies it as being highly subjective (Walker, 2007, pp. 9–10). This analysis is thought-provoking, not least because it flags one of the challenges of attempting to reduce moral understandings to systems, and what must be overlooked when one seeks to further reduce these systems to codes.

In addition to the theories discussed above, Verbos et al. (2007, p. 18) list “stockholder theory, stakeholder theory, relativism, idealism, social contract, volitionism and post-conventional corporate moral responsibility” as other theories that have been put forward to characterise the “normative theoretical perspectives proposed to explain corporate ethical principles”. This indicates that there are arguably many viable ways for philosophical constructs to frame a discussion about the authority of codes of ethics.

Baker (1993, p. 868), in his discussion of medical codes of ethics, identifies a philosophical shift in medical codes of ethics from a teleological approach to regarding them as a social contract that came about as a result of the adoption of Thomas Percival’s code of medical ethics by the American Medical Association. (See also *Chapter 4: Historical Development of Codes of Ethics* and *Chapter 5: The Changing Style of Codes of Ethics*).

Cressey and Moore (1983, pp. 59–60) also identify the social contract as the “dominant legal-political principle used to give added weight” to the codes they studied in 1983. The development of social contract theory has evolved since Baker’s observations in 1993 and even since Cressey and Moore’s 1983 study, and now Integrative Social Contract Theory provides a more nuanced lens through which to examine and understand codes of ethics.

Thinking of Codes of Ethics as Social Contracts

Where an organisation has a code of ethics, it has been argued that the organisational member has a duty to follow the code or, otherwise, exit the organisation and forego any attendant privileges. An example of this argument is articulated by Davis (1991) in his journal article “Thinking Like an Engineer”. In his analysis of the events which led to the Challenger space shuttle disaster in 1986, the decision by one particular engineer to acquiesce to pressure from management led to loss of life. In his discussion of the engineer’s privileges and responsibilities to society, Davis critiques this decision in terms of the code of ethics for engineers—the social contract that reflects the expectations society holds of an engineer. It should be noted that the engineering code of ethics is regarded as a professional code of ethics and has been adopted nationally in the United States among engineering peak bodies (American Society of Civil Engineers, 2016; National Society of Professional Engineers, 2017).

The final flight of the Challenger space shuttle ended in disaster on 28 January 1986, when the shuttle exploded shortly after takeoff. The events leading up to the disaster and the decisions made by engineer Robert Lund have subsequently been used as the basis of case studies for engineers studying ethics. Davis (1991) offers his analysis and opinion of where the ethical failure lay in this case. The conclusion he draws points to a failure by Lund to recognise and respect a commitment and norm of reciprocity which implicitly applied to the situation on account of the engineering code of ethics of 1985 (National Society of Professional Engineers, 1985).

Davis (1991) focuses on the actions of Robert Lund, the Vice President of Engineering of Morton Thiokol Incorporated (the company contracted by NASA to design and build the Solid Rocket Boosters). Davis examines the crucial decision by Lund to allow the launch to proceed despite being aware of the possible dangers and being advised by his team of engineers not to.

According to the *Report of the Presidential Commission on the Space Shuttle Challenger Accident*, the launch of the mission was “postponed three times and scrubbed once from the planned date of January 22, 1986” (Presidential Commission on the Space Shuttle Challenger Accident, 1986a). When the Challenger was finally launched on 28 January 1986, it exploded 73 seconds into the flight, resulting in the deaths of seven astronauts. The cause of the explosion originated in the right Solid Rocket Motor in a joint between its two lower parts. The specific failure was “the destruction of the seals that are intended to prevent hot gases from leaking through the joint during the propellant burn of the rocket motor” (Presidential Commission on the Space Shuttle Challenger Accident, 1986b).

The report thoroughly details the events involved and makes nine recommendations. It was determined that the accident occurred because key decision makers were not aware of the “initial written recommendation of the contractor advising against the launch at temperatures below 53 degrees Fahrenheit and the continuing opposition of the engineers at Thiokol after the management reversed its position”. The report goes on to say that “if the decision makers had known all of the facts, it is highly unlikely that they would have decided to launch 51-L on January 28, 1986” (Presidential Commission on the Space Shuttle Challenger Accident, 1986c).

Davis (1991, p. 158) argues that Lund acted contrary to his professional code of ethics which required he “hold paramount the safety, health and welfare of the public”. The requirement to do so is stated explicitly no less than three times in the document. Also, under 2(b) of Professional Obligations listed in the Code of Ethics for Engineers (1985), it states:

Engineers shall not complete, [sic] sign or seal plans and/or specifications that are not of a design safe to the public health and welfare and in conformity with accepted engineering standards. If the client or employer insists on such unprofessional conduct, they shall notify the proper authorities and withdraw from further service on the project. (National Society of Professional Engineers, 1985)

Davis (1991) asserts that Lund was morally bound to adhere to the code. He reasons that because Lund “voluntarily accepts the benefits of being an engineer (by claiming to be an engineer), he is morally obliged to follow the (morally permissible) convention that helps to make those benefits possible” (Davis, 1991, p. 160). Davis proclaims that “a code of ethics is a convention between professionals” where a profession is defined as “a group of persons who want to cooperate in serving the same ideal better than they could if they did not cooperate” (Davis, 1991, p. 153).

In this particular code of ethics, the responsibility and expectations are explicitly articulated. Statements acknowledging this ‘convention’, however, are not universal in codes of ethics. In the case of the engineering code of ethics of 1985, which would have been the extant version at the time of Lund’s decision, the Rules of Practice section is explicit. It states the following at 1(a):

Engineers shall at all times recognize that their primary obligation is to protect the safety, health, [sic] property and welfare of the public. If their professional judgment is overruled under circumstances where the safety, health, property or welfare of the public are endangered, they shall notify their employer or client and such other authority as may be appropriate. (National Society of Professional Engineers, 1985)

Davis (1991) characterises the code of ethics of engineers as a “kind of (morally permissible) convention” because it “provides a guide to what engineers may reasonably expect of one another”. Davis goes on to point out that the code does more than simply state expectations by explaining that it should “also provide a guide to what we may expect other members of our profession to help us do”. He then states that if “part of being an engineer is putting safety first, then Lund's engineers had a right to expect his support”; and that “when Lund's boss asked him to think like a manager rather than an engineer, he should, as an engineer,

have responded, ‘Sorry, if you wanted a vice-president who would think like a manager rather than an engineer, you should not have hired an engineer’” (Davis, 1991, pp. 154–155).

Davis’s characterisation of the engineering code of ethics is, in philosophical terms, a form of social contract (as defined above by the authors of the Oxford Living Dictionaries, 2017).

The idea that there is some kind of social contract seems central to the understanding of the role of a code of ethics. McGraw (2004, p. 235), in considering whether professional codes of ethics are “enforceable, legitimate, and just”, asserts that “the social contract tradition in ethics is the best framework for the analysis of these codes of ethics, because a professional code is essentially an agreement made by members of a social group, who agree to obey the rules of the contract because of a perceived mutual benefit”. Similarly, medical codes of ethics have long been understood to be a form of social contract (Cruess & Cruess, 2014).

Social contract theory has a long history in philosophy and has relatively recently been further developed in a way that facilitates a better understanding of codes of ethics.

Social Contract Theory

The idea of a social contract can be traced back to the ancient Greek philosophers. Plato (c. 427 – 347 B.C.E.) captured an articulation of the social contract when he wrote *Crito*. In the book, Socrates is in prison, and in a few hours he will be put to death. Socrates explains to his friend Crito why he accepts his death sentence and will not attempt to escape his fate. He states that he will be considered to be “breaking the covenants and agreements” which he made freely, “not in any haste or under any compulsion or deception, but having had seventy years to think of them”. He notes that he had always had the option to leave the city for another which was governed in a way he approved of, yet he chose to remain. If he now chose to escape, he would make himself look “ridiculous” (Plato, 2009).

Socrates is effectively explaining that the covenants of his city state were part of the social contract he freely entered into, and that he could have chosen to exit the contract at any time by leaving the city. Accepting the decision that he be put to death is fulfilling his part in the social contract between the government and the people.

While Plato has captured the idea of a social contract, it is the moral and political philosopher Thomas Hobbes (1588–1679) who is credited with conceiving social contract theory. In *Leviathan* (first published in 1651), Hobbes articulates his conception of the state of nature in which all men are equal in ability and that this leads to “equality of hope in the attaining of our ends”. He deduces that in such a state where two people want the same thing for themselves, they “become enemies” and “endeavour to destroy or subdue one another” (Hobbes, 2016, chapter 13).

Accordingly, Hobbes asserts that life under these conditions would be “solitary, poor, nasty, brutish, and short” (Hobbes, 2016, chapter 13). Hobbes holds that self-restraint is required from men in the interests of their self-preservation and being able to lead more content lives. In order to achieve this, Hobbes proposes a contract between the people and a sovereign to transfer rights. In giving the “right of government in sovereignty”, a society is also giving the “right of levying money to maintain soldiers, and of appointing magistrates for the administration of justice” (Hobbes, 2016, chapter 14).

Social contract theory is the theory that “persons’ moral and/or political obligations are dependent upon a contract or agreement among them to form the society in which they live” (Friend, n.d.). This idea of reciprocity is fundamental to the social contract. In terms of the Challenger space shuttle incident and the argument Davis (1991) puts forward, this reciprocity is central to his claim that in order to obtain the ‘right’ to be called an engineer, Lund had voluntarily contracted with his engineering peers and society to uphold the code of ethics.

Social contract theory continued to develop after Hobbes, especially with the contribution made by John Locke (1632–1704), whose work *The Second Treatise of Government* conceives of a very different state of nature to that envisaged by Hobbes. Locke asserts that the state of nature is for all men “a state of perfect freedom to order their actions, and dispose of their possessions and persons, as they think fit, within the bounds of the law of nature, without asking leave, or depending upon the will of any other man” (Locke, 2016, chapter 2).

Importantly, Locke also introduces the concept of consent into social contract theory. He identifies that “by consenting with others to make one body politic under one government” an individual puts themselves “under an obligation, to every one of that society, to submit

to the determination of the majority, and to be concluded by it” (Locke, 2016, chapter 8). According to Locke’s theory, consent is essential to the social contract—without consent there is no contract.

This idea was further developed by Jean-Jacques Rousseau (1712–1778), who published *Of The Social Contract, Or Principles of Political Right (Du contrat social ou Principes du droit politique)* in 1762. Rousseau asserts that “one is obligated to obey only legitimate powers”. He argues that power taken by force is not legitimate, and that “conventions remain as the only basis of all legitimate authority among men” (Rousseau, 2012, p. 167).

Rousseau talks of “natural freedom”—that is, the freedom enjoyed in the state of nature limited only by the “individual’s force”; and “civil freedom”—that is, the freedom which the social contract has allowed and which is limited by the “general will”. He later explains that entering into a social contract leads to the loss of a man’s natural freedom and the “unlimited right to everything that tempts him and that he can get”. However, the benefit gained is “civil freedom and property in everything he possesses” (Rousseau, 2012, p. 176).

And thus, in Rousseau’s understanding of social contract theory, one exchanges natural freedoms for conventional (artificial) freedoms and, in so doing, allows a general will of the populace to be established by convention.

Further significant development of social contract theory occurred when Rawls articulated his idea of “justice as fairness” in *A Theory of Justice* (1971). Instead of presupposing the conditions which might exist in a state of nature, Rawls introduces the notion of how stakeholders in a society, without knowledge of their position within that society (i.e. under the “veil of ignorance”), might fairly decide upon the principles which will govern that society in an impartial way. Only after this “conception of justice” has occurred can other matters such as legal guidance be developed in accordance with their chosen principles.

Rawls (1971, p. 210) proposes that there are two principles which would be agreed under the veil of ignorance, namely “equality in the assignment of basic rights and duties” and “that social and economic inequalities, for example inequalities of wealth and authority, are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society”.

Rawls (1971, p. 209) explains that a society founded on the principles of justice as fairness is as close as a society could get to being “voluntary” and this way “its members are autonomous and the obligations they recognize self-imposed”.

The work of the social contract theorists mentioned above builds a picture of the social contract as tacit or explicit agreements made between members of a community to create an environment which is to their mutual benefit. Each of the theories is, however, very general and highly conceptual and not designed to address contextual questions which arise in something as specific as a code of ethics.

Accordingly, codes of ethics do not neatly fit with the abstracted high-level political depiction of a social contract that was offered by the early theorists, and yet they are often referred to as social contracts in the research. Donaldson and Dunfee (1999) describe the traditional social contract theories as providing “a blurry, if essentially correct picture”. Using the theory of John Locke as an example of the problematic nature of such vagueness, they explain that Locke’s theory, which holds that a government should respect the right of citizens to property, fails to describe exactly how to respect this right. They ask, “Does it follow that they should forbid any ‘taking’ of property as unjust? Or only that they should compensate any ‘taking’? And, by the way, just what constitutes ‘taking’?” (Donaldson & Dunfee, 1999, p. 20).

In order to address issues of context while maintaining a higher conceptual model, Donaldson and Dunfee (1999) developed an integrative model of social contracts which provides a useful, and now broadly accepted framework, for the analysis of codes of ethics.

Integrative Social Contracts Theory

During the 1990s, Donaldson, a professor of legal studies, and Dunfee, a business ethicist, collaborated to refine the social contract theory for business. In 1999 they published *Ties That Bind*, which presented and described Integrative Social Contracts Theory (ISCT). This theory identifies two different types of contract: the “macro-contract” and the “micro-contract”. The macro-contract “refers to broad, hypothetical agreements among rational people” which are “designed to establish objective background standards for social

interaction.” This includes such high level principles as respect for the rights of people; that is, the general principles identified by the traditional social contract theorists discussed above. The micro-contract or “extant” contract refers to actual agreements, whether formal or informal, that exist “within and among industries, national economic systems, corporations, trade associations, and so on”. Donaldson and Dunfee (1999) cite “ethical principles accepted by accountants or lawyers” as an example of micro-contracts and thus explicitly identify codes of ethics as micro or extant social contracts. Their model of ISCT presents the social contract as a combination of macro-contracts and micro-contracts in an effort to “capture the strengths of each, even as it misses respective weaknesses” (Donaldson & Dunfee, 1999, pp. 19–20). It is this combining of the concepts which makes their theory integrative.

ISCT provides us with a framework to examine codes of ethics in a way that had not been possible with earlier social contract theories. In ISCT the macro-contract provides the boundaries within which any social contracting takes place. These boundaries are universal principles referred to as “hypernorms” in ISCT.⁴ There is no definitive list of hypernorms—they are necessarily a product of the community using the language and concepts understood by that community (Donaldson & Dunfee, 1999, p. 55). Donaldson and Dunfee (1999, pp. 60–61) do, however, identify 11 points of evidence in support of a principle having hypernorm status, and three possible points of rebuttal.

The terms of the macro-contract may be somewhat general or vague, but that fact allows the contractors a “free moral space” in which to fashion the more detailed micro-contract, a circumstance which Donaldson and Dunfee describe as “the freedom of individuals to form or join communities and to act jointly to establish moral rules applicable to the members of the community, a freedom that, as we have seen, macro contractors would endorse”. The society or organisation is then free to adopt micro-contracts that “reflect the community’s particular goals, environments, resources, experiences and so on. These rules would specify boundaries for economic behavior while reflecting the moral preferences of the members of the community” (Donaldson & Dunfee, 1999, p. 38).

⁴ Hypernorms belong to one of three categories:

1. Procedural hypernorms, which encompass the rights of voice and exit.
2. Structural hypernorms that are necessary for political and social organisation, such as the right to private property, and the right to fair treatment under the law.
3. Substantive hypernorms, which specify fundamental concepts of the right and the good (Donaldson & Dunfee, 1999).

If we once more reflect on the space shuttle Challenger disaster discussed above, and the case of Lund and his decision to allow the shuttle to launch, even though Davis (1991) effectively argues that the code of ethics was violated, a strong case can be made that, in fact, a hypernorm of workplace safety was violated in this instance.

The Leverage of the Professional Organisation

Professional organisations arguably have the power to chastise unethical conduct and, perhaps, influence ethical conduct. This situation is often considered to be a unique feature limited to the professions. However, the case of Lund discussed above demonstrates that business is also able to exercise significant influence and power. This influence and power can be either ethical or unethical; sadly, the influence was unethical in the Lund case.

Because codes of ethics for the professions are usually issued by the body that maintains registration of the profession, there is a capacity to limit or withdraw registration as a consequence of non-compliant behaviour. The first edition of *Good Medical Practice*, which is the code of ethics for medical practitioners in the UK (see *Chapter 5: The Changing Style of Codes of Ethics*), was published in 1995. The following statement appears immediately after the cover and before Clause 1:

Being registered with the General Medical Council gives you rights and privileges. In return, you must meet the standards of competence, care and conduct set by the GMC. (General Medical Council, 1995)

This statement makes it clear that registration and the rights and privileges which accompany it can be withdrawn. However, individuals working in business organisations may have no equivalent oversight body, nor the requirement to register personally with a central body to conduct their business. In business it is usually the entity (i.e. the corporation) which conducts the businesses which are required to be registered. Accordingly, the only options to chastise individuals in the corporate world are administrative, such as demotion or sacking, or recourse to civil or criminal law.

Given that individuals in business may not have the lever of registration, or the concomitant buffer from direct legal challenge that sometimes arises through peer regulation, it is entirely understandable that the social contract for business would be more attuned to legal

requirements. This is a context difference between business and medicine which may have a direct bearing on the language and expression used in a code of ethics.

However, not all occupations that could be considered as professions register with a governing body. Abbott (1988) examines understandings of what a profession is, and describes the various theories of professional development. Traditional theories drew from the well understood models of medicine and law and identified a sequence of events leading to professionalisation, including the development of a professional registration body and of a code of ethics. Abbott chose instead to interrogate the interrelationships between occupations, and he defined professions as “exclusive occupational groups applying somewhat abstract knowledge to particular cases” (Abbott 1988, p. 8). He proposed that the system of professions is a complex dynamic where tensions sometimes arise in who controls a particular type of work. The survival of any profession is dependent on its “abstracting ability to define old problems in new ways” (Abbott, p. 30). It is abstraction that allows a profession to seize ownership of work previously unclaimed, or belonging to the jurisdiction of another occupation and, to be meaningful, any formalities or structure (such as codes of ethics) must be considered in the context of abstraction.

Accordingly Abbott has presented a framework wherein, business management can be tested to determine whether it is a profession where a professional code of ethics could be brought to the businesses they manage. Abbott’s framework would allow the categorization of business managers as professionals. Alternatively, Abbott’s framework could be used to test whether the employees of any particular business constitute a profession, which is much more likely to be influenced by contextual considerations such as the nature of the business and the type of work undertaken by the employees.

Where a business manager follows the code of ethics of a professional organisation then education about the code is the responsibility of the both professional organisation and the individual. However, where a code of ethics is unique to an organisation, such as a business, it is the responsibility of the business organisation to provide suitable training about their codes of ethics and ethical decision-making to all employees, including managers.

Summary

In summary this chapter has described the growth in business codes of ethics since the 1970s and touched on some of the reasons for that growth. It has also described the associated development of research into business codes of ethics. It has examined the idea that codes of ethics are social contracts which, under the framework of Integrated Social Contract Theory can best be described as a type of micro-contract.

Conclusion

An understanding of codes of ethics as a form of social contract has developed and is now well supported in the literature. The interpretation of codes in terms of a micro-contract as described by Donaldson and Dunfee (1999) situates codes of ethics within in a larger structure bound by hypernorms. To breach a hypernorm is unavoidably to breach a code of ethics where that code properly reflects the social contract.

When considering the Challenger space shuttle example, the concepts articulated in ISCT are useful in explaining the nature of the ethical breach in terms of social contract theory. When the public was placed in danger, a hypernorm was violated and the Code of Ethics for Engineers (1985) was breached. In this way the engineering code was reflective of the social contract that engineers have with society.

At least two things can be intuited from this way of viewing codes of ethics. The first is that to be legitimate the code must reflect societally held attitudes of proper conduct. The second is that when such a code is breached (as exemplified in the Challenger case) it is the individual who fails, not the code. This concept of where the locus of control is perceived to lie is fundamental to how codes of ethics are studied, particularly codes of ethics written for business organisations, and is explored further in *Chapter 2: Studies of Codes of Ethics*.

A further point to consider is that the social contract for business will be more likely to be informed by the legal social contract because, in the absence of the disciplinary function bestowed by a professional organisation in the case of professional business managers, business discipline is either administrative or legal in its recourse.

Chapter 2: Studies of Codes of Ethics

Introduction

Apart from organisations of medical practitioners, and a small spread of professions such as law and accounting, codes of ethics were not broadly adopted by business organisations before the mid-1970s (see Figure 1). Prior to this there is little in the way of research on ethics codes. However, in the 1980s, shortly after ethics codes started to become popular with the business community, the academic literature began to build. Many papers at this time were centered on exploring notions of organisational ethics. It was not until the mid-1990s that significant numbers of studies were undertaken on the effects of codes of ethics and questions were raised about their utility.

Figure 1 demonstrates some marked peaks in ethics standards adoption in 1974 to 1976, 1980, 1988 and 1993. The authors reason that 1980 and 1993 were peak years due to “triggering events in the business environment immediately prior to those years”. They relate the 1993 peak to the 1991 “implementation of the United States Sentencing Commission” (Weaver et al., 1999, p. 286). Applying this reasoning, correlations can be made for other years such as the peak in code acquisition in the mid-1970s which corresponds with a drop in public confidence and an effort to avoid regulation as a result of foreign bribery scandals involving hundreds of US companies. The high level in 1988 correlates with the deregulation and privatisation policies of the Reagan administration (1980–1988). These events are discussed further in *Chapter 4: Historical Development of Codes of Ethics*.

Codes of ethics that are written for business organisations are generally developed by the individual organisation, often without broad consultation, sometimes only in consultation with employees and management, and occasionally without any consultation. There are many studies, most of which have been undertaken in the United States, which attempt to measure the effectiveness of business-related codes. Often these studies imply that such codes are not effective and suggest that other ways of causing ethical behaviour are needed. The failure to act ethically is therefore in some way linked to shortcomings with the codes or other externalities rather than to the individual or group who fails to make ethical choices.

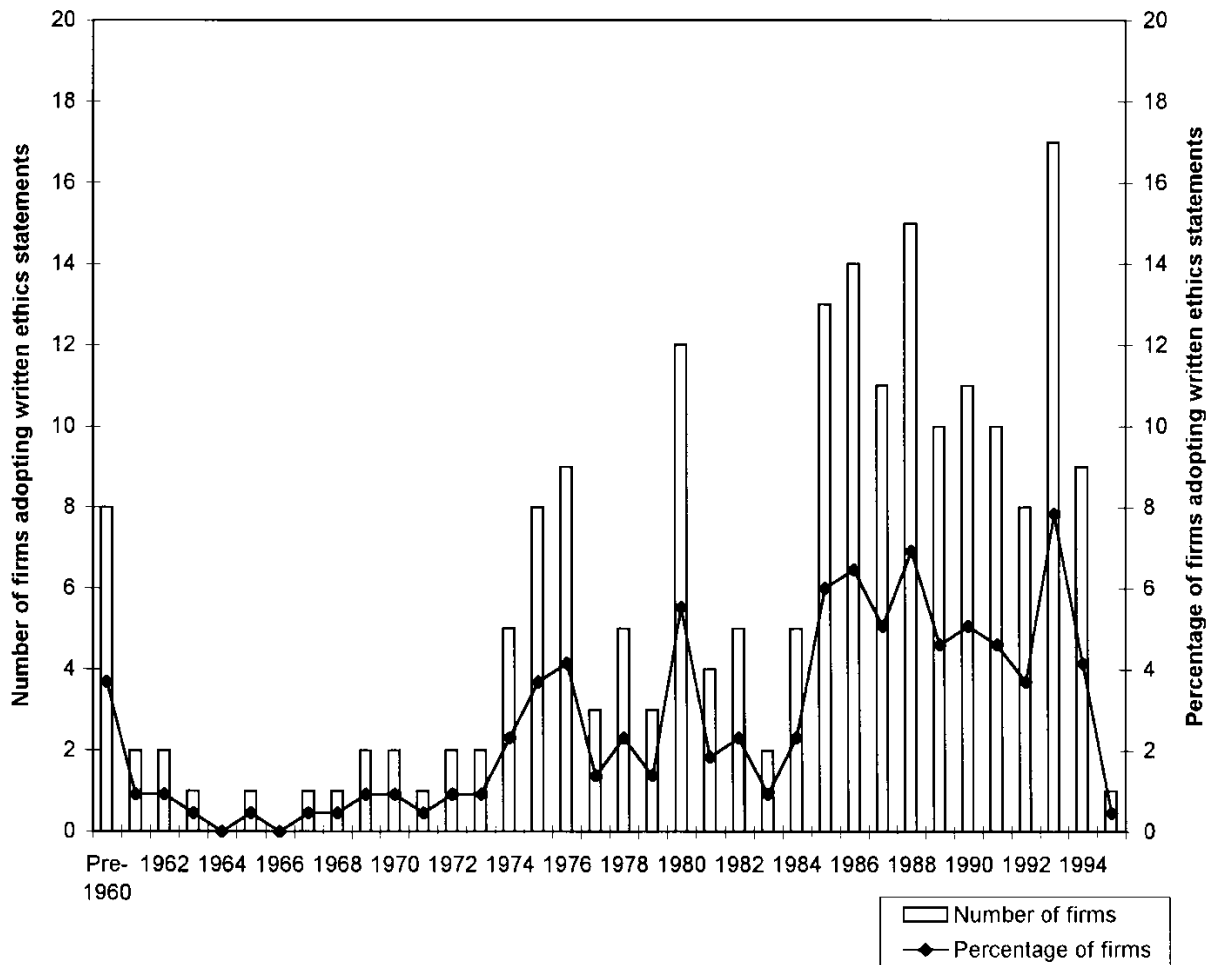


Figure 1: Ethics Standards adoptions by year.

The number and percentage of business organisations adopting a formal ethics code or standard in a given year (n = 217; 1995 January/February only) (Weaver et al., 1999, p. 286).

By contrast, codes of ethics used in medicine exist as documents that reflect the understanding of medical ethics which has been developed over a much longer history. Today these medical codes are often finalised only after broad public consultation, after which such a code can be considered to be something like a statement of societal consensus on what constitutes ethical conduct for doctors. They effectively attempt to articulate the terms of the social contract that doctors have with the communities they practise in. Ethical action then becomes a choice made by an individual doctor. A failure to act ethically is not perceived as the lack of effectiveness of the code; it is instead a personal and professional shortcoming of the individual doctor who failed to adhere to societal expectations.

A key issue relating to this thesis is that researchers rarely study the effectiveness of medical codes of ethics. No meta-analysis on this topic could be found. However, researchers frequently study the effectiveness of business codes of ethics. There is a fundamental difference between the internal locus of control in ethical decision making perceived to exist in medicine, and the external locus of control that is perceived to exist in business. In the latter case, such researchers often conclude that business codes are not at all effective, simply because of where the locus of control is perceived to lie. *A code of ethics does not control the choices of the individual; only the individual can control their choices.*

A code is effective only in terms of whether it properly articulates the ethical standards of the society, whilst compliance with the code (i.e. the effectiveness) is entirely about the choices made by individuals.

The idea that codes of ethics need to clearly articulate the social contract—the micro-contract—is not reflected in studies of codes of ethics for business. To demonstrate this point, a number of business studies have been examined and are discussed below.

Early Expectations of Codes of Ethics – Baumhart’s Study

In 1961, well before this proliferation of codes of ethics began, a study was undertaken by Reverend Raymond C. Baumhart S.J.⁵ He published his findings in the *Harvard Business Review* (HBR) (Baumhart S.J., 1961). Baumhart’s study provides a unique perspective on perceptions of how businessmen thought codes of ethics might work.

The study was based on 1700 responses to a questionnaire distributed by HBR to 5000 “executive readers”. The listed “highlights” of the study include a response to the following questions:

How do you feel about an effort to develop a code of ethical practices for your industry? How would you react if a group of experienced executives in your industry tried to draw up such a code? (Baumhart S.J., 1961, p. 166)

Response:

As a help in correcting unethical practices, most executives would welcome a written code of ethics for their industry. But this code must have “teeth,” be capable of

⁵ The postnominal ‘S.J.’ denotes a Jesuit and stands for ‘Society of Jesus’.

enforcement, and embody specific guides for conduct if it is to do the job. (Baumhart S.J., 1961, p. 7)

Seventy one per cent of respondents were in support of this idea.

In answer to the survey question “Will a code work?”, Baumhart (1961) notes that respondents agreed a code of ethics would be difficult to enforce, didn’t know if this approach would work in very competitive situations, and were cynical about the behaviour of other businessmen (whom, they believed, would violate a code if they thought they would not be detected) (Baumhart S.J., 1961, pp. 168–170). However, Baumhart’s article also notes that there are many examples provided by respondents of “courageous decisions made for ethical reasons” (Baumhart S.J., 1961, p. 176).

In his conclusion Baumhart states that:

Only the candor of our respondents made this report possible. Presumably, they chose to reveal these business shortcomings in the hope of remedying them. Our recommendations for action are based on the confidential opinions generously supplied by HBR readers. It is their hope, and ours, that industry will act on these candid sentiments by rectifying behavior from within, rather than delaying until regulation comes from without. (Baumhart S.J., 1961, p. 176)

Despite this hope, history has shown that attempts to rectify behaviour from within were too little and too late and that regulation ‘from without’ did indeed occur (see *Chapter 4: Historical Development of Codes of Ethics*).

Since Baumhart’s article was published, a range of studies, surveys and analyses of codes of ethics using differing methodologies has been undertaken. Their focus has been on the understandings and uses of codes of ethics and their effectiveness. It is important to note, however, that most studies do not explicitly define the term ‘effectiveness’.

An examination of these studies reveals that when researchers look to study the ‘effectiveness’ of codes they tend to focus almost exclusively on (often hypothetical) behavioural influence on organisational members, or their knowledge of and reference to the code. No studies could be found where researchers attempted to directly measure whether the code of ethics was, for example, used by stakeholders to identify or articulate the nature of issues which need to be addressed by the organisation; for example, to frame a customer

complaint about the conduct of the organisation or its members. This is to say, there is a lack of enquiry into any alternative or 'secondary' forms of utility other than a direct impact of the finalised ethics code on the behaviour of organisation members. Codes of ethics within the business context do not appear to be understood as social contracts that acknowledge or speak to the community outside the organisation.

Another aspect of effectiveness which is not considered in the literature is whether the process of development of a code incites a discussion in an organisation or among stakeholders of the organisation about what is an appropriate ethical standard. The development process of a code of ethics may be the only catalyst for such discussions. These and other less direct, perhaps less obvious, ways in which codes of ethics may be seen as effective provide a potential source for further research.

The assumptions and methodology being applied in the research are such that it is almost a foregone conclusion that the bulk of research finds ethics codes wanting. Accordingly, it is no surprise that the studies and articles to date have overwhelmingly concluded that codes of ethics only contribute to changing the behaviour of organisation members if they are supported by other measures (Hyman et al., 1990; Webley & Werner, 2008; Wickham & O'Donohue, 2012).

Building on Baumhart's Study

Brenner and Molander, inspired by Baumhart (1961), conducted a similar survey fifteen years later. The 1976 survey was completed by 1227 readers of the *Harvard Business Review* (HBR) of the 5000 who were polled. Brenner and Molander (1977) noted the following significant changes in the business environment which had developed since the Baumhart study:

A sustained period of economic euphoria which began in 1961 has been replaced by recession, inflation, and resource scarcity. Charges of corporate irresponsibility relative to critical issues of the 1960s and 1970s (minority relations, consumerism and the environment) combined with recent disclosures of corporate wrongdoing at home and abroad have raised serious questions about the trend in business's standards. (Brenner & Molander, 1977, p. 63)

In their analysis, Brenner and Molander (1977, p. 61) suggested that changes in behaviour between 1961 and 1977 may be attributed to "higher legal standards and government enforcement".

This explanation arises from their analysis of the survey questionnaire, which was designed around the following main questions:

1. Has business ethics changed since the 1960s?
2. If it has, how and why has it changed?
3. Are codes the answer to the ethical challenges business people currently face?
4. What is the relationship between ethical dilemmas and the dilemma of corporate social responsibility? (Brenner & Molander, 1977, pp. 57–59).

In their analysis of the questionnaires, Brenner and Molander (1977) found no definitive answer to their first two questions. They did conclude, however, that the respondents in 1976 were more cynical than those in 1961 about what they indicated they would do in a particular situation compared with what they think the average executive would do.

With regard to the third question, “Are codes the answer to the ethical challenges business people currently face?”, they concluded the following:

While respondents in 1976 are less certain of a code’s efficacy than were their counterparts in 1961, these expectations support an argument many observers have made: the mere existence of a code, specific or general, can raise the ethical level of business behavior because it clarifies what is meant by ethical conduct. However, to an even greater extent than those in 1961, our respondents think a code is limited in its ability to change human conduct: 61% feel people would violate the code whenever they could avoid detection and only 41% feel the code would reduce underhanded practices. (Brenner & Molander, 1977, p. 66)

Such a response indicates that even at this stage in ethics code history, certain limitations regarding the effectiveness of codes of ethics were perceived.

The questionnaire also included a supplementary question on which area ethical codes could have an impact:

In general, the responses suggest that codes can be most helpful in those areas where there is general agreement that certain unethical practices are widespread and undesirable. Ethical codes do not, however, offer executives much hope for either controlling outside influences on business ethics or resolving fundamental ethical dilemmas. This is not to minimize the potential for codes to have an impact in narrow areas of concern. It is to emphasize that regardless of form they are no panacea for unethical business conduct. (Brenner & Molander, 1977, p. 68)

This insight that codes of ethics have a role to play, but a limited one, is not the assumption of a great many of the later studies on codes, which instead seem to assume that ethics codes should be documents which either provide solutions to ethical dilemmas, or which can be utilised as enforceable agreements that define ethical conduct, or both.

In response to the fourth question, “What is the relationship between ethical dilemmas and the dilemma of corporate social responsibility?”, analysis showed that respondents agreed that social responsibility is an ethical issue for both the individual business person and the corporation (Brenner & Molander, 1977, p. 68).

In 1983 Hattwick, Shin and Wall addressed what they perceived as a major limitation in studies such as those done by Baumhart (1961) and Brenner and Molander (1977). The limitation they sought to address was that these previous studies were directed toward the ‘elite’ rather than business leaders as a whole. Their study, which was published in 1985, sought to overcome this bias. Their survey was sent to 700 chief executive officers from a random sample of the 10 000 largest US corporations. The surveys were mailed to “top level officials in business” to ensure that responses did not include the opinions of lower level managers, educators and government officials (Hattwick et al., 1985, p. 158). They received 119 useable responses.

The survey by Hattwick, Shin and Wall (1985) sought to answer the following four questions:

1. What is the business leaders’ view of the “just society”?
2. What ethical beliefs and practices are associated with the leaders’ view of a just society?
3. What are the sources of the ethical standards which business leaders use in business?
4. What methods of dealing with ethical issues in business are favored by business leaders? (Hattwick et al., 1985, p. 159)

The survey instrument contained statements to which respondents were asked to indicate their level of agreement (ranging from strongly agree to strongly disagree). In their assessment of the responses to the 11 statements relevant to the first question, the researchers concluded that the business leaders surveyed felt that a just society focuses on “individual freedom, equality of opportunity and individual responsibility” (Hattwick et al., 1985, p. 163). This response may be attributed to the cultural bias of conducting the survey

in the United States—it is probable that a survey of European or Asian business leaders would return different results.

The second question, “What ethical beliefs and practices are associated with the leaders’ view of a just society?”, was split into six components. The survey asked what ethical ideals and practices are found in American business leaders in general, in dealing with consumers, in dealing with employees, in dealing with the community, in dealing with stockholders, and in dealing with competitors. A selection of the findings is provided below:

- In relation to American business leaders in general, the researchers commented that a conflict between ethical standards used in business and those used in private life might be expected, but that only 20 per cent of respondents indicated that this duality does exist, while more than 94 per cent of respondents indicated that the ethical standards they apply at home are as high as those they apply in their business (Hattwick et al., 1985, pp. 163–164).
- In relation to consumers, 97.5 per cent of respondents agreed that protecting the customer was in the self-interest of the business, and more than 60 per cent agreed that government regulations to protect consumers were needed for labelling (80.5 per cent), safety (69.5 per cent), truth in lending (67.8 per cent) and price fixing (67.8 per cent) (Hattwick et al., 1985, p. 166).
- In relation to employees, 88.1 per cent of the business leaders indicated that employees should not have to participate in practices that they considered unethical (Hattwick et al., 1985, p. 168).
- In relation to the community, 96.6 per cent agreed in equal opportunity hiring and promotion, 85.6 per cent agreed the company should reduce pollution even if that meant reducing profits, and 89 per cent agreed that the company should make a financial contribution to community activities (Hattwick et al., 1985, p. 172).
- In relation to other stakeholders, 75.4 per cent disagreed that short profit runs should be maximised, 100 per cent agreed that the firm should earn a satisfactory return for stockholders, and 93.2 per cent agreed that the company should seek to maximise long run profits (Hattwick et al., 1985, p. 175).
- In relation to competitors, 91.5 per cent disagreed with the notion that if one firm engages in unethical conduct, the others will follow, and 53.4 per cent disagree with

the statement that antitrust laws promote a higher standard of ethics (Hattwick et al., 1985, p. 176).

In response to the third question, “What are the sources of the ethical standards which business leaders use in business?”, 87.3 per cent of the business leaders identified the company’s code of ethics as a source, 90.6 per cent indicated their professional code of ethics, 82.2 per cent identified the formal company policy and procedures as a source, 81.3 per cent indicated peer pressure as an influence, 68.7 per cent indicated prevailing industry practice, 72.8 per cent indicated the boss’s perceived preference, and 90.7 per cent of respondents indicated that their family experiences were an influence. Other sources of influence identified were church experiences (83.1 per cent), educational experiences (84.8 per cent), and society’s moral climate (72 per cent) (Hattwick et al., 1985, p. 178).

Responses to the fourth question, “What methods of dealing with ethical issues in business are favored by business leaders?”, indicated that individual executives should manage ethical issues as they arise (85 per cent) and that operating officers should deal with ethical issues at the operating level (80 per cent) (Hattwick et al., 1985, p. 180). The authors also noted an “interesting paradox” regarding codes of ethics. This is because professional codes of ethics were viewed as having “extensive influence on the standard of ethics” while only “forty-two per cent said that an industry-wide code of ethics should be developed” and “only 20 per cent of the respondents utilized such codes in their organizations” (Hattwick et al., 1985, p. 183).

The authors concluded that ethics in business was on a par with ethics in the family or church. However, the authors also expressed concern that the results to the survey may have been artificially high because the business leaders who responded to the survey could be considered to have done so due to their “social responsibility” to participate and therefore, “in those cases where business ethics appeared quite high in the survey, it is possible that the true percentage of American business leaders who see things so positively is not as high as revealed by this survey” (Hattwick et al., 1985, p. 185).

The difficulty in drawing general conclusions from the research available on codes of ethics is significant and, as the Hattwick et al. study demonstrates, the best intentions to fill gaps in

the research are sometimes limited by low response rates or methodology. Only 119 useable responses were received from the 700 survey questionnaires that were mailed out. This represents a response rate of 17 per cent and this low figure is a consideration when weighing the significance of the results.

The Baumhart study has been used to inform a number of later studies, as noted by Glenn and Van Loo (1993): Fulmer's studies of students in 1967, 1968, 1971 and 1974, the studies of Brenner and Molander in 1977, and of Becker and Fritzsche in 1987, who focused on business practitioners. Further, several other studies used a few of Baumhart's original questions: Glen and Van Loo note the use of individual questions from Baumhart's study by Greyser in 1962, McHale in 1970, and Purcell in 1977 (Glenn & Van Loo, 1993, p. 835).

In 1993 Glenn and Van Loo published the results of their survey of more than 1600 business students, using 13 questions of the 19 that appeared in Baumhart's original survey. The results were compared to those studies from 1961 to 1993 conducted by Baumhart, Fulmer, and Brenner and Molander, asking the same questions of business practitioners and business students. Using Baumhart's criteria of ethical conduct, Glenn and Van Loo (1993, p. 836) concluded that in general "students make less ethical choices than business practitioners". The authors were unable to deduce a reason for this and advised that the finding should be "treated with caution" because it was based on a hypothetical scenario. A similar caution is attached to their finding that in both the student and the practitioner populations, attitudes remained relatively stable over time (Glenn & Van Loo, 1993, pp. 842–843).

The evidence on attitudes towards codes of ethics led Glen and Van Loo to conclude that codes were perceived to lift the "ethical level of business" but that this had become less the case over time. In the ranking of those factors which influence business decisions, codes of ethics were ranked third. The authors reported that rather than being seen as a means to stop unethical behaviour, codes of ethics were employed by management to "clearly define limits and to ward off unethical requests" (Glenn & Van Loo, 1993, p. 844).

While it was possible for Glenn and Van Loo to source empirical studies of attitudes to ethics which dated from the early 1960s, it was not until the mid 1970s that codes of ethics for business were available in sufficient numbers to study.

Cressey and Moore – An Early Study in Codes of Ethics

In the mid-1970s scandal erupted in the US business world as more than 400 American companies were found to have made questionable or illegal payments to foreign government representatives (US Department of State's Bureau for International Narcotics and Law Enforcement, 2000). Public confidence in business fell and the spectre of increasing government regulation was looming. In response, many corporations revised or generated a code of ethics (Cressey & Moore, 1983). Despite this attempt at self-regulation in order to prevent external regulation, the Foreign Corrupt Practices Act (FCPA) was introduced in 1977.⁶

In 1983 Cressey and Moore published the results of a study on codes of ethics in a paper titled "Managerial Values and Corporate Codes of Ethics", which examined the corporate codes of ethics of 119 corporations that were collected by the Watson Library in New York between 1975 and 1979. This frequently cited work is considered to be an important early study of corporate codes of ethics. It was undertaken at the beginning of the ethical code movement which had developed in the wake of the corporate scandals in 1975 and calls for more government regulation of corporations (Cressey & Moore, 1983).

Cressey and Moore (1983) examined the policy areas covered in the codes, the authority base of the documents, the guidance provided on seeking clarification, and compliance procedures detailed in the codes in an effort to ascertain whether these codes resulted in higher levels of corporate social responsibility. They did not examine the effectiveness of codes in relation to corporate personnel:

Our study did not address the question of effectiveness. Interviews with external and internal auditors of large corporations convinced us that there is no practical way of measuring any effects the codes might have had on the conduct of corporate personnel. Most auditors were confident, however, that the codes have made a difference. Other persons with access to corporate records, and in a position to observe the behavior of corporation personnel have noted the same thing. (Cressey & Moore, 1983, p. 73)

Cressey and Moore (1983) assert that improvements in business ethics at the time are not attributable to codes of ethics, but are more likely to be the result of "structural changes that

⁶ "The Foreign Corrupt Practices Act of 1977 ... was enacted for the purpose of making it unlawful for certain classes of persons and entities to make payments to foreign government officials to assist in obtaining or retaining business" (US Department of Justice, 2017).

modify some aspect of the corporate organization or business practices” (for example, the enactment of the FCPA). However, they concede that this claim is based on “admittedly shaky evidence” (Cressey & Moore, 1983, pp. 73–74).

Cressey and Moore (1983, p. 74) state that the codes studied were “not dramatically effective in other respects”. Here they are referring to the use of codes to avoid government regulation, and for reputation management in shaping opinion that corporations had become more ethical and more socially responsible. Overall, they concluded that corporate codes of conduct had not done much to provide assurance to the public of the private sector’s dedication to “protecting and promoting the public interest” (Cressey & Moore, 1983, p. 75).

Following the introduction of the FCPA in 1977, there was a lull in ethics code popularity (see Figure 1). The pace picked up again in the early 1990s. In 1991, the United States Sentencing Commission promulgated a new chapter of the Federal Sentencing Guidelines. The new guidelines gave organisations an incentive to have in place an effective compliance program and encouraged the development of formal ethics programs in many US firms (Murphy, 2002, p. 699). One such incentive was that the size of any fine imposed by the courts for an offense became conditional on the existence of a compliance or ethics program (Izraeli & Schwartz, 1998, p. 1048). Some codes of ethics became a prudent mitigation measure or, as Adams et al. (2001, p. 200) characterise them, “legal self-defense mechanisms”. While this meant that there were more codes of ethics, they were not necessarily impacting on behaviour.

Approaches and Limitations in Studies of Codes of Ethics

Since the mid-1990s many largely qualitative studies have been undertaken looking at various aspects of codes of ethics. However, the studies have been of variable quality. A significant proportion of them exemplify the challenge in achieving good research design; and the studies have found it difficult to draw general conclusions from research on this topic. The common approaches and limitations in studies of codes of ethics are discussed below.

Disparate Approaches to Research

As early as 1990 Kahn identified problems with the approach that was being taken by researchers of business ethics. He interviewed 32 researchers and noted that research in this area was split into two fields: it was either normative or contextual. Normative research was concerned with how individuals ought to conduct themselves, whereas contextual research focused on the “contexts of ethical and unethical behavior” (Kahn, 1990, p. 312). The two approaches were not integrated. Kahn observed that some researchers had identified that there was a need to “bridge the gap between normative and contextual concepts and, more generally, between prescriptive and descriptive research”. Kahn explained that this circumstance had been caused by “different researchers working with the concepts from two categories, yet having little overlap”. Kahn predicted that the gap would be addressed when “new concepts and methods are created that reflect both normative and contextual understandings and, ultimately, that connect academic research to organizational practice” (Kahn, 1990, p. 313).

In his analysis of the 32 interviews with the business ethics researchers, Kahn (1990, p. 314) identified what he refers to as four “images” which he described as the “metaphors researchers use (both knowingly and not knowingly) as analogies for their work”. The images included “ethics as conversation, history, vision, and communities”.

Kahn’s conversation image reflects an understanding among researchers that obtaining moral knowledge is a two-step process where individuals first question themselves in order to fully understand their own thoughts before openly questioning others and exploring the differences in thought that arise in the community. Kahn (1990, p. 315) explained that such conversations can initiate change at both the individual and systemic level, and reasoned that this image prompts researchers to “provide languages through which people may have ethics conversations”. Indeed, this is precisely what this thesis does in *Chapter 6: Development Approaches to Codes of Ethics*.

Kahn’s history image includes both the history of the ethical principles and the history of ethical issues which are “embedded in the particular histories of organizations”, serving as “anchors” that “either support or weigh down” ethical enquiry (Kahn, 1990, p. 316).

Kahn's vision image refers to the presumption within research that ethical enquiry can bring clarity, leading to enhanced understandings and awareness. The vision image also refers to an imagined ideal and a quest for that imagined future (Kahn, 1990, p. 317).

Kahn's community image is to be found in the research literature in three different forms. The first of these is "organizations as communities", which assumes the existence of a tacit social contract. The second form is "communities of beliefs and values that organization members carry with them into work situations", such as religious values. The third is the "business ethics research community itself" which was mentioned as something that needed to be developed (Kahn, 1990, pp. 317–318).

Kahn (1990) argued that development of the field of business ethics research required "embracing a research agenda that extends the theory and practice of creating dialectical, historical, imaginative and communal connections". Kahn posited that such an approach would develop "powerful theoretical frames and concepts" as well as "create conditions for ethical behaviour both in organizations and from organizations". It would also "create a group of researchers whose work together allows for the development of theory and practice in such a frankly interdisciplinary area" (Kahn, 1990, p. 319).

Kahn went on to propose a framework to address the gap in research. This framework included a collection of 43 questions arranged according to the four images and their subsets. To date, Kahn's paper has been cited 198 times (Google Scholar, 2017), but 27 years on and despite Kahn's observations and suggestions, little seems to have changed in the field of business ethics research.

In 2009 Wempe identified that one of the problems which ensued in the research originated from the dichotomy between facts and values that existed in the twentieth century, and the resulting split between empirical and normative methods of inquiry. Wempe infers that this pervasive thinking delayed the formulation of integrated theories (Wempe, 2009, pp. 745–747). It was not until 1990 that an integrative theory by Donaldson and Dunfee situated codes of ethics as social micro-contracts. This concept was discussed in detail in *Chapter 1: Codes of Ethics – Social Contracts*.

Presumptions Regarding the Importance of Demographics

In early studies of organisational ethics some authors expressed hope that the future would bring positive change. For example, in 1988, Jones and Gaultschi published the results of a 1985 study of the attitudes of 455 MBA students from 12 US learning institutions. The authors provide the context of public perceptions at that time as being partly framed by events which included the 1982 filing for bankruptcy of the Fortune 500 listed Manville company in an attempt to avoid compensating victims of work-related asbestos disease; the December 1994 Union Carbide pesticide plant gas leak in Bhopal, India which killed approximately 10 000 people; and the 1985 guilty plea by brokerage house E.F. Hutton to 2000 counts of wire and mail fraud (Jones & Gaultschi III, 1988, p. 231). Based on responses to their survey, the authors concluded that the “future executives” they had studied demonstrated a “sensitivity toward ethical issues that is tempered primarily by their perceived organizational authority and the requisites of prevailing organizational culture”. This finding was correlated more strongly with the female participants in the study because the women were seen to demonstrate “a greater tendency to take action when they perceive a questionable business practice than do their male counterparts”. The authors predicted that the increasing feminisation of the workplace might therefore deliver a shift in behaviour because “as women managers become commonplace it may well follow that corporate behavioral norms will be affected positively” (Jones & Gaultschi III, 1988, p. 245).

Jones and Gaultschi’s study is one that assumes that the culture of organisations is influenced by a range of variables, the increasing feminisation of management being one variable that was thought to be particularly relevant by the authors. Variables, such as demographics, which are presumed to impact on the culture of an organisation, are commonly the subject of research in business journals.

Meta-analyses of studies on ethical behaviour (see *Chapter 3: Meta-analyses*) weakly support the impact of some demographic variables on ethical choices. However, they also suggest that the version of the future posited in Jones and Gaultschi’s study of the more ethical corporate world under the influence of the commonplace female manager has not materialised.

The Dearth of Quality Research on Codes of Ethics

As one element which may have a cultural impact, codes of ethics have been examined in various ways in the literature. However, research into whether codes are effective is limited in terms of high quality empirical evidence. Articles in the academic literature often have little rigour and contain opinions that are not supported by evidence, or based on very small sample sizes. It is also common for studies to be conducted on student participants which, as demonstrated in *Chapter 3: Meta-analyses*, distorts the results.

The use of surveys or questionnaires which are reliant on hypothetical situations and responses is one approach that is commonly used. However, while this methodology is often a valid approach, it also invites conjecture about objectivity, interpretations and bias. Another common approach is to examine the language or concepts in written codes of ethics. While this may reliably analyse content, it does not provide any insight into the usefulness of codes or otherwise evaluate codes in ways that are helpful for improving the theory or practice of code development or application.

In 2008 Kaptein and Schwartz examined the results of 79 empirical studies that investigated the effectiveness of codes of ethics. However, the results were mixed. The authors attribute this to “varying definitions of key terms; deficiencies in the empirical data and methodologies used; and a lack of theory” (Kaptein & Schwartz, 2008, p. 111).

An example of this can be seen when Adams et al. (2001, p. 200), who do not explicitly define effectiveness, observe that there is “relatively little empirical evidence regarding the effectiveness of codes of ethics on perceptions and behavior in organizations ... or even of individuals’ understanding and recall of the content of such codes”.

This is a recurring problem with studies on this topic. The Adams et al. study measured the degree of effectiveness by interpreting interviewee perceptions, and they then identify the research method as a limitation (Adams et al., 2001, pp. 209–210). Schwartz (2004) includes the Adams et al. study in his review of the literature for the presentation of findings of his own study, and notes that while many studies have been undertaken in an attempt to determine whether codes of ethics influence behaviour, the results of these studies were mixed. Almost half (10 of 22 studies) found that codes were effective (Adams et al. was one

of these ten studies). Two of the 22 studies concluded that the correlation was weak, while the remaining ten studies determined “no significant relationship between the two variables”. Schwartz notes that whilst these studies “examine the potential effect of codes, they do not provide an explicit definition of ‘code effectiveness’ beyond ‘influencing behavior’” (Schwartz, 2004, p. 325).

Schwartz then points out that there may be other factors to consider. He observes that what the empirical studies on code effectiveness which were included in the literature review for his paper “fail to take into account is that the mere introduction of a code is only one potential factor in encouraging ethical behavior” (Schwartz, 2004, p. 325).

With ethics codes having become so popular, there has been increasing scope for the study of them. However, measuring their effectiveness has proved particularly challenging. The apt selection of the salient aspects of codes of ethics and the concomitant application of a robust methodology is not a notable strength of much of the research on codes of ethics.

Research Methodology

Schwartz’s 2004 study also identified one of the major issues that arise in studies on codes of ethics; namely, weaknesses in methodology. He reviewed the methodological approach used in the 22 different studies cited in his review of the literature and observed that only three of those had “used in-person interviews as a research methodology to investigate codes”. The other methodologies employed included surveys, an “in-basket exercise” and a laboratory experiment (Schwartz, 2004, p. 327).

Studying the Variables that Matter

Studies on codes of ethics are often looking at similar variables such as demographics or leadership approaches but there are other variables which could be considered in the research that are under-studied or overlooked. This is discussed in more depth in relation to the code development process in Chapters 5 and 6.

In 1999 Weaver et al. sought to describe the state of formal ethics practice in the mid-1990s of Fortune 1000 companies (comprised of 500 industrial and 500 service companies in the

US). In late 1994 and early 1995 a survey was distributed to 990 organisations of which 26 per cent (i.e. 257 organisations) responded. The survey allowed for the possibility that ethical issues may be addressed in formal documents other than a code of ethics, and questions were framed accordingly. The results show that 98 per cent of firms had developed a formal ethics document of some kind, 78 per cent had a code, 67 per cent had information in policy documents, and 22 per cent employed other approaches including posters and speeches. The authors observed that this result indicated that organisations were taking a “multi-pronged approach to setting forth their standards of appropriate conduct” (Weaver et al., 1999, p. 285).

Other results of interest from this survey were that the vast majority of firms reported that they distribute ethics policies to at least 80 per cent of their management staff (Weaver et al., 1999, p. 287). Approximately 90 per cent of firms required some form of acknowledgement of receipt of the ethics code or policy on at least one occasion from employees, and 45 per cent did so annually. The study also contained questions regarding the managerial responsibilities for implementing or supporting ethics policies, whether corporate level external ethics evaluations were undertaken, whether the firm had standardised procedures for dealing with alleged ethical violations, the level of involvement of top management in corporate ethics, and communication and the frequency with which communications (other than the ethics code or policy) were sent to employees on ethics and conduct issues (Weaver et al., 1999, pp. 287–291). In essence, this study was looking for possible variables which are often not accounted for in other studies.

The authors observed that a formal ethics program had become the “taken-for-granted method of fostering corporate ethics”, however they warned that this was “no guarantee that they alone are adequate to the task”. Further, they cautioned against assuming that firms without a formal ethics program are unethical firms, explaining that “there are countless other messages organization members receive. Therefore, any effort to assess what corporations are doing to encourage good ethics ultimately must look at the rest of the organization, in both its formal and informal aspects” (Weaver et al., 1999, pp. 293–294).

In 2005, Stevens, Steensma, Harrison and Cochran undertook a Gallup Poll of senior financial executives of 414 firms. The results suggested that ethics codes can play a significant role for overall firm performance. However, executives needed to be convinced of the

benefits of the codes to the firm and provided with training on how to use the codes (Stevens et al., 2005). Familiarity with the code accompanied by a positive perception of it, training in the use of codes and an interest in upholding professionalism were each identified as successful supporting elements for effective codes of ethics.

One factor repeatedly linked to the effectiveness of codes in a number of studies from the mid-1990s onwards is the culture of the organisation (Claver et al., 2002; Cooke, 1991; Dobson & Dobson, 2003; Dobson, 2005; Lagan, 2004; Sinclair, 1993; Svensson & Wood, 2003; Weaver, 1995).⁷ Links between codes and culture are complex and provide opportunities for further investigation across a number of disciplines.

Webley and Werner (2008, p. 409) note that “the underlying assumption of the concept ‘corporate culture’ is that organizations are culture-producing phenomena”. This is an interesting observation and explains the tendency of some researchers to investigate the factors that may influence the culture of an organisation. Webley and Werner (2008, p. 409) describe ‘corporate culture’ as a normative concept that “refers to the way employees and others perceive the organization’s behaviours and attitudes with reference to ethical norms and values drawn from wider value systems”.

Webley and Werner (2008) did not reference the work of Martin and Cullen, who in 2006 published their meta-analytic review of studies of ethical climate theory (ECT). Martin and Cullen were examining the development of ECT over time and any relationships that had been identified in the literature. The description that Martin and Cullen (2006, p. 176) offer for ethical climate theory is as follows: “In its original formulation, ECT represented a descriptive map of ethical decision-making and actions within an organization based on philosophical and sociological theory”. Martin and Cullen (2006, p. 177) agree that the contemporary perspective holds that “a variety of climates are present both within and across organizations. These work climates may influence behaviors of the organizational actors to a great degree”. This supports the assertion of Webley and Werner (2008, p. 409) that organisations are understood to be culture-producing.

⁷ Note: Svensson and Wood (2003, p. 353) view ethics as being influenced by two parameters: time and culture: “As time moves on, culture evolves and as a consequence ethical standards change”. This can be seen in the changing awareness of the importance of issues such as the humane treatment of animals, the need to know how to deal ethically with emerging technologies and rising concern about environmental ethics. The product of this is that understandings of ethics are not necessarily consistent over time.

To add to the already clouded picture, Messikomer and Cirka (2010, p. 58) observe that a significant amount of research on codes of ethics fails to control for characteristics such as code content or the “larger culture in which the code is embedded”. They go on to explain that the “absence of consensus on a definition of a code and its core elements, as well as inconsistent methodologies” contribute to the “mixed findings in studies of code effectiveness”.

Nevertheless, some researchers have tended to assert (albeit in sometimes guarded language) that codes of ethics may be effective. However, the key to this efficacy is that codes are supported in some other way that reinforces their value. To illustrate the approaches that have been taken and the variable value of the contributions, some examples are provided below.

In 1994 Boeyink published the results of a study which sought to “determine whether codes of ethics are an effective means of enforcing social responsibility” (Boeyink, 1994, p. 894). In 1991 Boeyink visited the newsrooms of *The Indianapolis Star*, the Owensboro (Kentucky) *Messenger-Inquirer* and the *Shelbyville (Indiana) News* to conduct on-site interviews and observations. His study was principally based on the interviews conducted in three US newspaper newsrooms, although he does not provide detail of how many interviews were undertaken.⁸ Editors and reporters were asked to “identify recent cases which had raised ethical questions” (Boeyink, 1994, p. 894). Key participants in the most frequently mentioned cases were then identified and interviewed regarding the details, key points of the debate and the case’s resolution. Boeyink’s methodology states:

At the end of each interview, standardized questions focused on the role of ethical codes, ethical principles, and the cases themselves. Copies of stories, memos related to cases, codes, and policy manuals were collected. Finally, key editors were interviewed about policy. (Boeyink, 1994, p. 894)

Boeyink (1994) found different models of ethical decision-making were followed in each of the newsrooms. His three principal findings were as follows:

1. Written ethical standards were rarely invoked in the resolution of cases, *even when the code was relevant to the case.*
2. Nonetheless, under certain conditions ethical rules, including both written and unwritten guidelines, were still part of the larger ethical culture in the newsroom.

⁸ A limitation of this study is that it was relatively small.

3. In the two newspapers with a visible concern for comprehensive ethical rules, two factors seemed critical: a commitment from newsroom leadership to ethical principles *as institutional standards* and an environment in which ethical issues were regularly discussed. (Boeyink, 1994, p. 895)

Boeyink (1994) does not provide detailed information of his methodology, only a synthesis of his impressions. For example, he does not state how many interviews were undertaken; only how many days he spent in each newsroom. Boeyink concludes that “the presence of a code is unlikely to be valuable in a setting in which no one has reason to pay attention to its content” and that:

ethical guidelines are likely to be important when newsroom leadership is committed to institutional standards, when newsroom discussions of the ethics of controversial cases are encouraged, and when a culture of ethical sensitivity is fostered. (Boeyink, 1994, p. 902)

However, the Boeyink study draws loose and generalised conclusions from a data set too small to be statistically valid.

In 1995 Badaracco and Webb looked specifically at how a group of predominantly young managers define, think about and resolve ethical issues. In the study, 30 recent graduates of the Harvard MBA program participated in in-depth interviews. The method of analysis of the interviews was not explicitly described by the authors. Implications of their study included, among other things, the following regarding codes of ethics:

- Ethics codes can be helpful, though not decisive, particularly if they are specific about acceptable and unacceptable behavior and provide advice on handling “gray area” matters ...
- Young managers are much more likely to believe that a code means what it says if the code is enforced. This means punishing individuals who are guilty of violating the code. It also means letting the organisation know that these infractions have been punished ...
- If a company’s leaders are not going to make an unremitting effort to high ethical standards, and if they will not investigate and discipline violators of codes of conduct, they should abandon or avoid creating company ethics credos, announcing their personal dedication to high ethical standards, and implementing other parts of the standard, corporate business ethics program. They may simply be setting themselves up to be viewed with suspicion and cynicism. (Badaracco Jr & Webb, 1995, p. 24)

Like many of the papers produced on this topic in the 1980s and 1990s, the paper by Badaracco and Webb (1995) lacks the necessary detail to ascertain whether their method and conclusions are valid. However, it is worth noting that the final implication at the third dot

point correlate somewhat with the findings of the 1961 survey by Baumhart mentioned above and the perception that there is a need for the code to “have teeth” (Baumhart S.J., 1961, p. 7).

In 1998 Cleek and Leonard undertook a literature review of earlier analyses of codes of ethics in addition to their own study of the responses to a questionnaire survey by graduate and undergraduate business students at a large university. To determine whether or not having a code of ethics influenced the answers to the survey, students were asked to imagine that they had just started working as a regional production manager for a medium-sized manufacturing firm. Information about the fictitious organisation included that it “strives to maintain a strong organizational culture, the backbone of which was their Corporate Code of Ethics” (Cleek & Leonard, 1998, p. 624). However, only about half of the students were actually provided with the code of ethics. The questionnaire asked seven questions about vignettes which focused on issues including coercion, conflict of interest, the environment, and company and personal liability. Answers allowed respondents to make one of three choices: to be ethical, to be unethical, or to not make a decision. Six other questions in the questionnaire asked for demographic information.

One hundred and forty nine responses were subjected to analysis. The data showed that respondents who were told they did not have a code of ethics did not respond significantly differently to those who were told they had one. The authors concluded that “codes of ethics are not powerful enough tools to affect ethical decision-making behavior”, noting that a limitation of this study was that the respondents may not have been provided with sufficient detail in the scenarios to provide adequate responses (Cleek & Leonard, 1998, p. 627).

In 2001 El'fred and Koh undertook a study of MBA students in Nanyang Technological University (Singapore). The study was developed to investigate the incremental influence of the code of ethics, the code-supporting variables⁹ and organisational ethics variables¹⁰ on organisational ethical behaviour (El'fred & Koh, 2001).

⁹ Code-supporting variables include communication, enforcement and use of the code.

¹⁰ Organizational ethics variables include top management support for ethical behavior, the association between ethical behavior and career success, and ethical climate.

The researchers used a survey questionnaire which presented three vignettes and respondents were asked to rate from 1 to 10 the likelihood that a particular action would be taken by their organisation in each of the hypothetical situations. The ratings were averaged across the three scenarios in order to assess ethical behaviour. Of the 400 surveys distributed, 237 useable responses were received.

Responses were subjected to a statistical analysis known as a t-test to determine whether the difference between the averages of any two groups was statistically significant in order to ascertain the incremental influence of the code of ethics. They were also subjected to another statistical analysis (regression analysis) to determine the results for the supporting and organisational variables. The t-test results indicated “a significant positive influence of codes of ethics on ethical behavior” (Elfred & Koh, 2001, p. 365). The regression analysis demonstrated that code-supporting variables, particularly the enforcement of the code, influenced ethical behaviour “significantly beyond the mere existence of a code of ethics” (Elfred & Koh, 2001, p. 367). It also demonstrated that organisational ethics variables, particularly top management support for ethical behaviour and the association between ethical behaviour and career success in the organisation, can enhance ethical behaviour beyond the influence of a code of ethics and the code-supporting variables.

The previous two studies discussed are both reliant on vignettes rather than being based on actual situations and behavioural observations. While this approach is valid, it is limited by the hypothetical nature of the situations presented. The lack of standardisation in the approach to research on the effectiveness of codes is noted by Kaptein and Schwartz (2008), who identify six different research methods, including: desk research, laboratory experiments, perceptions about practice, objective data on practice, vignettes and multiple methods. The authors contend that “much of the variance in the findings of empirical studies regarding the effectiveness of business codes could be explained by the use of different research methods” (Kaptein & Schwartz, 2008, p. 115). The study below uses observation rather than hypothetical scenarios, and corrects for some variables.

In 2002 Farrell, Cobbin and Farrell published the findings of a study that set out to “measure the consistency of the observed behavioural patterns among employees and to investigate the possible association of high consistency with particular ethics strategies” (Farrell et al., 2002a, p. 468). This approach was taken to avoid the use of self-reporting and the associated

“serious social desirability biases”, to avoid the vignette method for reaching decisions on hypothetical situations and the limitation from “lack of evidence that demonstrates a link between the choices made in hypothetical situations and subjects’ ethical behaviour in real events” and the lack of direct observation inherent in attitude surveys (Farrell et al., 2002a, pp. 469–471).

In framing their approach, the researchers noted that “the difficulty lies in measuring their behavioural outcomes. The lack of adequate operational definitions in many codes has precluded the possibility of measuring their impact” (Farrell et al., 2002a, p. 469). Questionnaires and supporting material (i.e. information sheets and reply-paid envelopes) were provided to personnel from eight large Australian business enterprises. Employees and top managers received different questionnaires which “required respondents to report on 40 specific behavioural patterns that formed part of the culture of the organisation” (Farrell et al., 2002a, p. 474). Responses were analysed for the consistency and congruence¹¹ of behavioural patterns rather than the morality of behaviours. The researchers concluded that there was no association between the consistency of the observed behavioural patterns among employees and particular ethics strategies, and that “the strongest ethical culture affecting behaviour in these corporations came from an external, shared environment (not less than 60 per cent). The study did not identify the source” (Farrell et al., 2002a, p. 488).

In 2004, Von der Embse, Desai and Desai published their research, which set out to:

assess the extent to which organizational ethics codes, credos and policies are implemented by managers and supervisors in their work; and second, to identify and assess the principal factors that determined the level of consonance between stated ethical policies and values and their actual practice (Von der Embse et al., 2004, p. 146).

The authors used a web-based questionnaire which was answered by mid-level managers and members of the National Management Association.

¹¹ Congruence is used by the authors of the study to describe the “degree of correspondence of the behavioural patterns of employees as observed and reported by fellow employees with the knowledge held by top management of the patterns, as they are believed by these managers to exist in an organisation” (Farrell et al., 2002a, p. 472).

The study identified the independent variable as the aggregate of seven “ethical safeguards”.¹² The main dependent variable was the extent of the ethics code and policy application by managers at basic levels of practice. Eleven areas of ethical practice were assessed and the responses were aggregated to obtain an overall measure of ethical practices.¹³ Analysis of Variance (ANOVA)¹⁴ and t-test analysis methods were applied to the 150 responses they received. The authors concluded the following: “This study supports and extends previous observations that simply having ethical codes and policies does not guarantee ethical practices throughout the organization” (Von der Embse et al., 2004, p. 151).

In 2001 Wotruba, Chonko and Loe published the results of their study of 286 company executives from the direct selling industry that all used the same code of ethics. The authors concluded that “codes are likely to be more useful when their contents are more clearly understood” and that “an ethics code familiar to managers and judged by them as useful will also impact the overall ethical climate perceived by those managers” (Wotruba et al., 2001, p. 66).

In 2005 John Dobson claimed that the key to effective ethics codes depends on individuals correctly defining their self-interest as “commitment to the profession and to the community”, and if a code of ethics which is founded on this understanding of professionalism is actively implemented, it will follow that the success the individual strives for will be attained (Dobson, 2005, p. 64). Maintaining professionalism is not a variable that is commonly measured or corrected for in studies on ethics codes.

In their 2006 meta-analytic review of the “continuities and extensions of ethical climate theory”, Martin and Cullen note the scarcity of studies that replicate prior research and the tendency of studies investigating similar concepts to use different measures (Martin & Cullen, 2006, p. 176). Similarly, Pan and Sparks note in their 2012 meta-analysis that “the great

¹² The seven ethical safeguards included a formal code of ethics; a values statement or credo; written general ethics policies; written specific ethics policies; a strong, cohesive ethical culture; ethical training in place and available; and ready access to the ethical code or guidelines when needed (Von der Embse et al., 2004, p. 148).

¹³ The eleven areas of ethical practice included: electronic communication; employee relationships; staffing; quality and productivity; ethical dilemmas; reporting wrong-doing; legal matters; safety and health; communications; customers; and organisational priorities (Von der Embse et al., 2004, p. 148).

¹⁴ Analysis of Variance: A technique which tests differences between two or more groups by comparing the variation between the groups with the variation within them (this is one-way ANOVA). This technique can be thought of as an extension to the 2 sample t-test, or as linear regression with only categorical explanatory variables (SurfStat Australia, 2014).

diversity that exists in approaches to measuring ethical judgments raises serious concerns of validity” (Pan & Sparks, 2012, p. 88).

In 2008 Kaptein and Schwartz investigated the mixed results in 79 empirical studies looking at the effectiveness of codes of ethics. Of the 79, 28 found that codes were significantly effective, 13 found a weak indication that codes were effective, 26 found no significant correlation, 11 studies returned mixed results and one study found a significant negative relationship. The authors proposed possible reasons for the diverse findings on the effectiveness of codes of ethics; namely:

- confusion caused by different definitions applied to key terms
- more ambitious codes of ethics are less likely to be considered effective
- the smaller and less diversified the empirical basis of a study is, the more the research findings will vary
- the research findings will show greater variation as a greater variety of research methods are used (Kaptein & Schwartz, 2008, pp. 113–117).

Kaptein and Schwartz determined that there was a need for a research model to guide research in the area of code effectiveness, and they proposed an “integrated research model for the effectiveness of business codes” (Kaptein & Schwartz, 2008, pp. 117–118). The authors note the importance of the code development process, code content, and the method of implementation. However, they proposed that effectiveness should be measured against the following measures:

- expectations of stakeholders
- environmental and organisational characteristics
- objectives of the organisation
- the development process (noting that “to date there is no empirical study which relates the impact of the code to the process in which the code has been developed and/or updated” (Kaptein & Schwartz, 2008, p. 119))
- code content
- the existence of any “sub-codes” and the degree to which they “elaborate” the main code
- the way in which a code is implemented
- the personal (including demographic) characteristics of those subject to the code

- the internal organisational context, including organisational structure, culture and approaches to code enforcement
- the conduct of organisation members (Kaptein & Schwartz, 2008, pp. 114–120).

Acknowledging the complexity of researching the effectiveness of codes of ethics, and that no single study prior to 2008 had examined all of the above measures, Kaptein and Schwartz (2008) offered their “five essential ingredients for doing promising research into the effectiveness of business codes” which include:

- applying a valid methodology
- applying sufficient control variables
- understanding the impact of different organisational factors
- proving causality
- allowing a significant time frame with multiple measurements of effectiveness over time (Kaptein & Schwartz, 2008, pp. 120-122).

As at April 2017, no research could be found that had undertaken to investigate all of the measures proposed by Kaptein and Schwartz (2008). However, Kaptein (2011) has since produced a rigorous empirical study of 2390 US workers which examined code content, the frequency and quality of communication activities surrounding the code, and the “embedding” of the code in the organisation by management (i.e. the degree to which codes of ethics are embedded in the organisation). The results of the study show that a code of ethics is best supported by communication activities that are “accessible, understandable, and useful to its audience” rather than the frequency of communications, and that a code which addresses a more varied range of issues correlates more negatively with unethical behaviour. However, it is the way that a code is embedded by management that matters most. Embeddedness is demonstrated by having reasonable targets that encourage compliance with the code of ethics, not authorising code violations to achieve business outcomes, and being receptive to reporting of breaches of the code and then responding appropriately to such reports (Kaptein, 2011, p. 247).

Summary

Essentially what we can see from the discussion above is that ethics codes have become increasingly popular since the 1970s and therefore have been increasingly available for academic study. Some of the earlier studies were well structured with statistically significant data points and have provided valuable historical data which can be used to benchmark against subsequent studies of similar design.

A plethora of studies have been undertaken since the 1980s and they have more often suggested that codes of ethics have a marginal effect, if any, on corporate culture. Many of the studies undertaken have contained significant definitional and methodological flaws which have rendered them virtually worthless in terms of contributing to the academic understanding of codes of ethics.

The recurrent message in the studies mentioned above is that studying codes of ethics is a difficult endeavour. Studying the effectiveness of codes of ethics is pointless without first defining the term ‘effectiveness’, and, even then, it is a fraught process. However, the evidence before us suggests that if codes of ethics are used in isolation they make very little, if any, impact on ethical behaviour. The advice mentioned above, provided to Cressey and Moore (1983, p. 73) more than 30 years ago by auditors of large corporations—that “there is no practical way of measuring any effects the codes might have had on the conduct of corporate personnel”—seems to have been borne out.

Bearing in mind that there has been a tendency in the past to divide ethics research into normative or empirical studies, there is also a risk of the underlying assumption that one strand deserves more consideration than the other (Haimes, 2002, p. 89). Concurrent with this limitation is the effect of having very little research that has been conducted with an integrated approach from which to draw any conclusions.

For over 30 years the impact of ethical codes in various organisations and countries has been questioned, studied and found wanting, and yet despite this, the popularity of codes of ethics continues to grow. This seems confounding until one looks more closely at the variables that can be correlated with ethical and unethical decision making and the other factors that play into the decision to adopt a code of ethics. The latter is discussed further in *Chapter 4: Historical*

Development of Codes of Ethics and *Chapter 6: Development Approaches to Codes of Ethics*. The former is discussed in *Chapter 3: Meta-analyses*.

Chapter 3: Meta-analyses

Introduction

Meta-analysis is the use of combined data from multiple studies to identify a common effect or the reasons for a variation. The technique was first developed for the social sciences in the late 1970s and is now used in many disciplines as a tool for finding answers which cannot be found with any certainty with a single study (Shadish, 2015).

In order to overcome some of the limitations of singular studies into codes of ethics discussed in detail in Chapter 2, and to interrogate any variables that have been found to impact on ethical choices or behaviour, meta-analyses were examined.

Searches for meta-analyses and ethics yielded relatively few relevant papers considering the volume of individual studies available. Only 11 potentially useful studies were identified (Borkowski & Ugras, 1998; Davis & Rothstein, 2006; Haws, 2001; He & Cai, 2012; Jackson et al., 2013; Kish-Gephart et al., 2010; Pan & Sparks, 2012; Martin & Cullen, 2006; Tully & Winer, 2014; Winston, 2007; Waples, et al., 2009). This low discovery rate would indicate that meta-analysis is not a common approach to the study of codes of ethics.

Some authors of the meta-analyses comment on the low numbers of studies that are suitable for use in a meta-analysis (Davis & Rothstein, 2006, p. 417; Jackson et al., 2013, p. 97; Kish-Gephart et al., 2010, pp. 11, 23) and most point to areas that require further research to provide the necessary data for future analysis. Of the eleven meta-analyses found, five are concerned with ethical behaviour or attitudes. Three of the eleven focus on education and instruction, although one of these, the “(Mini) Meta-Analysis” by Haws, was actually not a properly structured meta-analysis and yielded no information of value and therefore was not useful for this discussion (Haws, 2001). Winston’s 2007 research made unsupported statements and was therefore not considered to be a reliable source, although the findings have been tabulated in the Appendix (Winston, 2007). This left only one useable paper on education and instruction: the study by Waples et al. (2009). Three meta-analyses were not relevant to the thesis topic: the study by Tully and Winer (2014), which examines consumer attitudes to corporate social responsibility; the paper by Martin and Cullen (2006), which

reviews the academic development of the framework of ethical climate theory; and the paper by He and Cai (2012), which is concerned with the ethics of employment relations in China.

Discussion – Meta-analyses Regarding Ethical Behaviour or Attitudes

To facilitate the discussion, the meta-analyses have been grouped by area of study, arranged chronologically and then allocated a number. The details are listed below and the findings have been summarised in Tables 1, 2 and 3. Full tables are in Appendix 1.

- Study 1 – 1998 meta-analysis (56 studies analysed): Borkowski, Susan C., and Yusuf J. Ugras. “Business students and ethics: a meta-analysis.” This study sought to examine the relationship between ethical attitudes/behaviour and the variables of age, gender and undergraduate major
- Study 2 – 2006 meta-analysis (12 studies analysed): Davis, Anne L., and Hannah R. Rothstein. “The effects of the perceived behavioral integrity of managers on employee attitudes: a meta-analysis.” In this study, the authors examined the relationship between employee attitudes and the behavioural integrity of managers generally and then examined the variable of gender, and whether the respondent was considering their immediate supervisor or someone more organisationally distant.
- Study 3 – 2010 meta-analysis (136 studies analysed): Kish-Gephart, Jennifer J., David A. Harrison, and Linda Klebe Treviño. “Bad apples, bad cases, and bad barrels: meta-analytic evidence about sources of unethical decisions at work.” This study investigated the relationship between nine individual characteristics, seven moral issue characteristics and six organisational environment characteristics on unethical choice in terms of intention and behaviour.
- Study 4 – 2012 meta-analysis (65 studies analysed): Pan, Yue, and John R. Sparks. “Predictors, consequence, and measurement of ethical judgments: review and meta-analysis.” This study aimed to review the literature to identify relevant antecedents

and consequences of ethical judgments in order to help resolve inconsistent or conflicting results and to analyse the effect sizes of student samples.

- Study 5 – 2013 meta-analysis (The total number of studies analysed was not stated in the paper): Jackson, Timothy A., John P. Meyer, and Xiao-Hua Frank Wang. “Leadership, commitment, and culture: a meta-analysis.” This study examined the relationships between leadership styles and employee commitment and whether this varies with societal culture.

Study 1 – The Borkowski and Ugras Study (1998)

In their 1998 meta-analysis of 56 studies conducted on business students between 1985 and 1994, Borkowski and Ugras were looking for the relationship between ethical attitudes/behaviour and the variables of age, gender and undergraduate major, while correcting for publication bias and cultural influences. Of the 56 studies, 47 were suitable to use to test their null hypothesis (H_1) that the meta-analysis would “reveal no significant differences between male and female business students in ethical behaviour” (Borkowski & Ugras, 1998, p. 1118) and 35 were used to test the null hypothesis (H_2) that the meta-analysis would “reveal no significant differences between younger and older business students in ethical behavior” (Borkowski & Ugras, 1998, p. 1119). The authors employed the voting (counting) method and then applied statistical analysis to calculate the primary effect size. The method of calculation varied depending on how the statistics were presented in the primary study (i.e. χ^2 , t -tests, F -tests or probabilities).

In their conclusion, the authors note that they could not reject the null hypothesis on the relationship between undergraduate major and ethical attitudes/behaviour because the results were “mixed”. However, they claim that the meta-analyses support a relationship between gender and ethical attitudes/behaviour. They deduce that “women seem to demonstrate more ethical attitudes/behavior than men”, but they are quick to add that “this does not mean that women are more ethical than men”. They note that responses to hypothetical dilemmas were measured and that this “does not necessarily translate to more ethical behaviour when confronted by real-world situations” (Borkowski & Ugras, 1998, p. 1124). This outcome therefore provides no resolution to the null hypothesis.

Borkowski and Ugras (1998, p. 1124) conclude that age is a significant factor influencing ethical attitudes/behaviour and determined that the null hypothesis could be rejected: “Attitudes/behaviour seem to become more ethical with age, supporting Kohlberg’s (1984) theory that individuals exhibit increasingly moral behavior as they mature.” The only limitation of the meta-analysis noted by Borkowski and Ugras is that it is confined to students in United States-based business programs.

The findings of this 1998 meta-analysis provide an interesting contrast with those of the 2010 meta-analysis completed by Kish-Gephart et al. and another completed in 2012 by Pan and Sparks.

Study 2 – The Davis and Rothstein Study (2006)

In 2006 Davis and Rothstein used the data from 12 studies to examine the relationship between employee attitudes of “job satisfaction, organizational commitment, satisfaction with the leader and affect toward the organization” and the perceived behavioural integrity of managers (Davis & Rothstein, 2006, p. 407). The authors hypothesised that a strong positive correlation would be found between employee attitudes and the perceived integrity of the manager. They further hypothesised that the correlation would be higher where employees were predominantly female, and stronger for immediate supervisors than organisationally distant ones. An identified limitation of this study was the small sample size.

Eight of the 12 studies reported age, seven of the 12 reported tenure; ten studies were undertaken in business organisations and two in universities. Nine of the 12 reported on job satisfaction. Eleven were from published sources, six of these being sourced from the *Journal of Business Ethics*. Eight of the studies were conducted in the US.

The results were inconclusive with regard to gender but revealed a solid correlation between perceived behavioural integrity and employee attitudes and a predominantly stronger correlation with immediate managers than organisationally distant ones (although this finding is accompanied with a caution due to the small sample size wherein four studies reported on the perceptions of the immediate boss and three to more senior managers) (Davis & Rothstein, 2006, p. 415).

Study 3 – The Kish-Gephart, Harrison and Treviño Study (2010)

The 2010 research by Kish-Gephart, Harrison and Treviño was based on a much larger sample size than the 1998 meta-analysis by Borkowski and Ugras. The authors were investigating the relationship between unethical behaviour at work and certain characteristics of both the individual and the moral issue.

The authors included data from 136 studies. They also took measures to correct for publication bias and convert reported statistics. The nine characteristics of individuals (i.e. the “bad apples”) that were analysed included cognitive moral development, idealism, relativism, Machiavellianism, locus of control, job satisfaction, gender, age and education level. They also examined findings on seven characteristics of the moral issue at hand (i.e. the “bad cases”) (which they also refer to as the “moral intensity”), and they reported on three elements of the organisational environment (i.e. “bad barrels”), namely ethical climate, ethical culture and codes of conduct.

The underlying theory they rely on is Rest’s 1986 ethical decision-making model wherein “intention precedes behaviour” and so, intention can be used as a proxy for behaviour in circumstances when behaviour cannot be studied. Therefore, unethical intention and unethical behaviour are treated as “one overarching construct” (Kish-Gephart et al., 2010, p. 2).

Kish-Gephart et al. test 16 hypotheses in this study regarding the relationship of the variables to unethical choices (resulting in a rather difficult-to-interpret expression of findings as double negatives). The findings in relation to the nine characteristics of individuals indicated a negative correlation between unethical choices and the characteristics of: cognitive moral development, idealism and higher job satisfaction. A positive correlation was indicated for relativism, Machiavellianism, and external locus of control. Age was correlated weakly and negatively with unethical choices. Gender was weakly correlated, with men making unethical decisions more frequently than women, and education level was “not inversely linked to unethical choices” (there is no way to know if this can be interpreted as meaning education is linked to ethical choices).

In contrast to the findings in the 1998 meta-analysis by Borkowski and Ugras in relation to the demographic characteristics of age and gender, the authors made the following statement:

Although demographics are among the most frequently investigated groups of variables in behavioral ethics (see O'Fallon & Butterfield, 2005), our meta-analytic results suggest either weak or null relationships between age, gender, and education level and unethical choices. (Kish-Gephart et al., 2010, p. 20)

The seven moral issue characteristics that were analysed included concentration of effect, magnitude of consequences, probability of effect, proximity, social consensus, temporal immediacy, and general moral intensity. These characteristics were selected based on a model proposed by Jones (1991). The findings of the meta-analysis demonstrated that in a “good case”, or what the authors characterise as at the “positive end of the spectrum for any of the six separate moral intensity dimensions”, the respondent was more likely to choose an ethical alternative. In the “bad cases,” unethical alternatives were “more easily chosen” (Kish-Gephart et al., 2010, p. 20).

The authors also determined that there was a high degree of interrelationship between magnitude of consequences, concentration of effect, probability of effect and temporal immediacy, while the characteristics of social consensus and proximity were “relatively independent” (Kish-Gephart et al., 2010, p. 20).

The 2010 meta-analysis findings related to the organisational environment characteristics suggest that organisations create social environments that can impact on choices at the level of the individual. The analysis considered six organisational environment characteristics including egoistic ethical climate, benevolent ethical climate, principled ethical climate, ethical culture, code existence, and code enforcement. The findings suggested a positive correlation between egoistic ethical climate and unethical choices. By contrast, a benevolent ethical climate, principled ethical climate and strong ethical culture had a negative correlation with unethical choices. The findings indicated that ethical culture was strongly related to all three types of ethical climate as well as ethical code enforcement (Kish-Gephart et al., 2010, p. 21).

Study 3 was the only meta-analysis that could be found that investigated whether having a code of ethics impacted on behaviour/attitudes. The analysis showed that codes are not effective in changing behaviour. The authors state the following:

Our meta-analysis revealed that the mere existence of a code of conduct has no detectable impact on unethical choices, despite the considerable amount of statistical power that comes from doing a meta-analytic summary. One likely explanation is that codes of conduct have become so ubiquitous that they have lost their potency. They have become ground rather than figure. Another possibility is that codes are often little more than a facade. (Kish-Gephart et al., 2010, p. 21)¹⁵

Of particular interest in the findings was that code enforcement can have a strong negative correlation with unethical choices, indicating that it is the enforcement rather than the code itself that drives ethical decision-making. Interestingly, this finding endorses the instinctive view expressed by respondents to Baumhart's 1961 study where respondents stated that codes must "have 'teeth' to be capable of enforcement" (Baumhart, S.J., 1961, p. 7).

The findings of Study 3 indicate that demographics do not influence ethical choices, but that the character of both the moral issue and the organisational environment does. The findings also indicate that merely having a code of ethics does little, whereas enforcing a code of ethics can have a significant effect on unethical choices. Therefore, the act of enforcing consequences for breaching a code is a key element in changing behavior, and the authors recommend that future research should focus on "how codes can be effectively enforced to shape behavior" (Kish-Gephart et al., 2010, p. 21). This study does not, however, examine the content of codes of ethics nor the way those codes were developed and so we cannot know whether either of those factors play a role.

Study 4 – The Pan and Sparks Study (2012)

The 2012 meta-analysis by Pan and Sparks analysed 65 studies on ethical judgments. The study used many of the same antecedents as the 2010 meta-analysis. The authors identified the following three groups of possible antecedents to ethical judgments:

- personal demographic characteristics: age, sex, education, income, work experience
- psychological and philosophical characteristics: idealism and relativism, Machiavellianism, locus of control, religiosity, ethical awareness

¹⁵ The authors here make reference to the principle of perception that causes the background of an image to be discernible from a figure. The principle is used in interpreting Gestalt images.

- perceived characteristics of the act: deontological and teleological evaluations, moral intensity, ethical environment, consequence of ethical judgments, behavioural intentions.

The authors tested 16 hypotheses in their search for variables that made ethical judgments more or less strict. Many of the variables tested were the same as those examined by Kish-Gephart et al. in Study 3, although the findings varied slightly.

The authors concluded the following:

The meta-analysis helps quantitatively support the generally consistent relationships between ethical judgments and several other variables. These include gender, idealism, relativism, Machiavellianism, ethical awareness, deontological and teleological evaluations, moral intensity and the outcome variable, behavioral intentions. (Pan & Sparks, 2012, p. 88)

As with the 1998 meta-analysis by Borkowski and Ugras (Study 1), this research supported the hypothesis that gender is related to ethical attitudes, specifically that the ethical judgments of women will be stricter than those of men. Unlike the 1998 meta-analysis, this research found no significant correlation between ethical judgment and age.

The finding that higher education is correlated with less strict ethical judgments supported the null hypothesis. The authors assessed that this could be explained because education leads to enhanced reasoning, and that “open minds” might take a less strict approach. Because higher education is correlated with higher income, the correlation between less strict ethical judgments and higher income could be similarly explained (Pan & Sparks, 2012, p. 88).

One objective of the 2012 meta-analysis was to analyse data to compare student samples (such as those that were the subject of the 1998 meta-analysis) with non-student samples. There was a significant difference and the authors claimed that this was “qualified evidence” to indicate that “student samples systematically produce greater effect sizes than non-student samples”. Because of this inflation in the effect size, the authors go on to caution researchers to “utilize samples that more readily permit generalizability of results” (Pan & Sparks, 2012, p. 88).

Study 5 – The Jackson, Meyer and Wang Study (2013)

The 2013 meta-analysis by Jackson, Meyer and Wang was designed to test the relationships of different leadership styles on three types of the psychological mindset of the individuals in an organisation.¹⁶ The leadership styles are described in the following way:

- Transformational/charismatic: idealised by followers, demonstrates charismatic behaviours, shows confidence that followers can achieve difficult goals, urges creative solutions to problems, treats followers as individuals with unique needs
- Contingent reward: followers are rewarded when agreed objectives are met
- Management-by-exception: followers are only engaged when mistakes are made
- Laissez-faire: total disengagement (Jackson et al., 2013, p. 85).

The three mindsets are described in the following way:

- Affective commitment (AC): “Employees with strong AC *want* to remain”
- Normative commitment (NC): “Those with strong NC *ought* to remain”
- Continuance commitment (CC): “Those with strong CC believe that they *have* to remain” (Jackson et al., 2013, p. 86).

The authors explain their interest in these three components of commitment as being due to the different consequences they each have for “on-the-job behavior”. They quote research by Meyer et al. (2002), which demonstrated a strong positive correlation between AC and “job performance, organizational citizenship behavior (OCB), and attendance”, and a less strong positive correlation of these outcomes with NC, while CC was found to be “unrelated, or negatively related, to these behaviors” (Jackson et al., 2013, p. 86).

The 2013 meta-analysis examined the relationship between transformational/charismatic leadership and both AC and NC. It also examined the relationship between AC and contingent reward leadership, active management-by-exception leadership and laissez-faire leadership. The meta-analysis further sought to establish whether differences in culture influenced the relations between the various leadership styles, and to identify whether there were moderating effects of societal individualism-collectivism on the relationship between all three commitment mindsets (i.e. AC, NC and CC) and transformational/charismatic

¹⁶ The authors of this study have used the three-component model of commitment developed by Meyer and Allen (1991), Meyer and Allen (1997), and Meyer and Herscovitch (2001).

leadership. The final aim of the 2013 meta-analysis was to determine whether societal-level power distance/hierarchy was a moderator in the relationship between AC and contingent reward leadership.

On first impression, this meta-analysis does not appear to include an examination of ethical attitudes/behaviour. However, the authors base their thinking on an argument put forward by Gellatly et al. (2006), who reasoned that NC is “experienced as a moral imperative” when strong AC is present, and that “when accompanied by weak AC and strong CC it is experienced as an indebted obligation (i.e., a need to do what is expected)” (Jackson et al., 2013, p. 86).

The 2013 meta-analysis is considered to be of interest to the topic at hand because of the asserted positive correlation of AC with the desire to do what is right. AC is therefore a variable that is being tested for correlation with more ethical decision-making.

The authors do not explicitly state how many studies in total were used in the 2013 meta-analysis, although from the tabulated data it is possible to conclude that the number was at least 116 (Jackson et al., 2013, p. 91).

The results of the 2013 meta-analysis are summarised below:

- Transformational/charismatic leadership is positively related to both AC and NC.
- Contingent reward leadership style is positively related to AC.
- Management-by-exception is positively related to AC (Note: in this case the credibility interval straddled zero).
- Laissez-faire leadership is negatively related to AC.
- The relationship between transformational leadership and AC was not affected by societal individualism-collectivism.
- In countries that value collectivism the relationship between transformational leadership was stronger for NC and CC.
- In societies with higher levels of power distance/hierarchy the relationship between contingent reward leadership and AC was stronger.

The authors of the 2013 meta-analysis found a greater number of studies had been undertaken on AC than on either NC or CC and noted this as one of the limitations of the analysis. They also noted that the application of “culture codes” (a term that refers to the coding procedure undertaken in preparation for extracting data from the individual studies used in the meta-analysis) was challenging and potentially imprecise (Jackson et al., 2013, p. 97).

From the perspective of implications for ethics research, the results of this 2013 meta-analysis suggest that transformational leadership in any culture may encourage followers to make more ethical choices. However, in societies where there are higher levels of power distance/hierarchy the contingent reward leadership style may encourage followers to make more ethical decisions.

Discussion on the Combined Findings of the Meta-analyses

The findings from the five meta-analyses concerned with ethical behaviour or attitudes have been summarised and split into three tables. Table 1 lists the factors that correlate with ethical behaviour or a leadership style that could influence ethical behaviour; Table 2 contains those factors that correlated with unethical behaviour; and Table 3 contains those factors that either gave mixed results or had no correlation.

The variables that were analysed in two or more of the studies include:

- age: studies 1, 3 and 4
- gender: studies 1, 3 and 4
- moral intensity: studies 3 and 4
- ethical climate: studies 3 and 4
- Machiavellianism: studies 3 and 4
- education: studies 3 and 4.

These variables are discussed below.

Variables Associated with Ethical Behaviour

Frequently, the instrument used in studies looking for correlations between demographic characteristics and ethical or unethical behaviour is the Defining Issues Test. This test is based on the work of Kohlberg, a developmental psychologist whose theory of cognitive moral development proposes six stages of increasing sophistication. The defining issues test was designed as an “assessment of the understanding and interpretation of moral issues” (Thoma & Dong, 2014, p. 55). The defining issues test and/or Kohlberg are cited in Studies 1, 3 and 4. Study 3 explains the significance of the defining issues test in some detail (Kish-Gephart et al., 2010, pp. 2–3).

In framing their null hypothesis on gender as a possible variable, the authors of Study 1 noted that “Gilligan (1982) maintains that females address ethical issues through a ‘care’ or responsibility oriented framework, while males employ a ‘justice’ or rights oriented approach, as posited by Kohlberg (1984)” (Borkowski & Ugras, 1998, p. 1118).¹⁷

Study 1 found that “women seem to demonstrate more ethical attitudes/behaviour than men”. However, the authors downplayed this finding somewhat with the comment that “reacting more ethically to fictional dilemmas does not necessarily translate to more ethical behavior when confronted by real-world situations” (Borkowski & Ugras, 1998, p. 1124).

In regard to age, the authors of Study 1 noted that Kohlberg had theorised that age was positively linked to moral development. The findings supported this correlation and the authors noted that “attitudes/behaviour seem to become more ethical with age, supporting Kohlberg’s (1984) theory that individuals exhibit increasingly moral behaviour as they mature” (Borkowski & Ugras, 1998, p. 1124).

Study 3 directly examined the relationship between cognitive moral development and unethical intention and unethical behaviour. The results found that cognitive moral development was negatively related to unethical choices.

¹⁷ The works referred to in this quote are: *In a Different Voice: Psychological Theory and Women’s Development* (Gilligan, 1982, cited in Borkowski & Ugras, 1998, p. 1118) and *Essays on Moral Development* (Kohlberg, 1984, cited in Borkowski & Ugras, 1998, p. 1118).

With regard to gender differences, Study 3 found a weak correlation with gender, indicating that men are more likely to make unethical choices than women. In light of this finding, the authors explain that “the findings counter theories that males and females differ markedly in how they puzzle through ethical dilemmas” (Kish-Gephart et al., 2010, p. 20).

Study 4 cites Kohlberg’s theory that “people who better understand complex and nuanced issues will display more sophisticated levels of moral reasoning” within the framing of the null hypothesis, which posits that “as education increases ethical judgements become less strict”. The null hypothesis on education was supported by the findings (Pan & Sparks, 2012, p. 85).

In Table 1 below, we can see that some variables were investigated in two or more studies. Of the variables that were analysed in multiple studies, we can be moderately persuaded that increasing age, gender (i.e. being female), the moral intensity of an act and a strong ethical climate are positively correlated with more ethical behaviours/attitudes:

- Studies 1 and 3 concluded that increasing age correlates (albeit weakly in Study 3) with more ethical or less unethical behaviours/attitudes, while Study 4 concluded that age was not significant.
- The ethical judgment of women was found to be stricter than that of men in Studies 1, 3 and 4.
- Moral intensity was associated with more ethical behaviour and attitudes in Studies 3 and 4.

Ethical climate was identified as a variable in Studies 3 and 4. However, in Study 3 it was examined in three component dimensions: benevolent, principled and egoistic, whereas in Study 4 it was investigated as a whole. Study 3 concluded that there was a positive correlation between benevolent and principled climates and ethical behaviour/attitudes, but a negative correlation between egoistic climate and ethical behaviour/attitudes. In Study 3 one of the dimensions of ethical climate, i.e. the principled climate, may be significant to the empirical investigation of codes of ethics. This study was the only meta-analysis which looked at the variables of code enforcement and existence of a code.

Table 1 – Factors that Correlate with Ethical Behaviour

Study Number	Authors	Findings
1	Borkowski and Ugras (1998)	Gender: Women seem to demonstrate more ethical attitudes/behaviours than men (47 of 56 studies used in this analysis)
1	Borkowski and Ugras (1998)	Age: Attitudes/behaviours seem to become more ethical with age (35 of 56 studies used in this analysis)
2	Davis and Rothstein (2006)	Perceived behavioural integrity of managers and employee attitudes: Strong correlation (12 of 12 studies used in this analysis)
2	Davis and Rothstein (2006)	Perceived behavioral integrity of managers who are immediate supervisor versus someone more organisationally distant: Considerably stronger relationship when considering immediate manager (4 of 12 studies of immediate supervisors and 3 of 12 studies of organisationally distant managers used in this analysis)
3	Kish-Gephart et al. (2010)	Cognitive moral development was negatively related to unethical choices (22 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	Idealistic moral philosophy was negatively related to unethical choices (10 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	Higher job satisfaction was related to a lower likelihood of unethical choices (20 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	Age (i.e. increasing age) was weakly negatively correlated with unethical choices (35 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	Moral issue characteristics: <ol style="list-style-type: none"> 1. Concentration of effect: 6 of 136 2. Magnitude of consequences: 10 of 136 3. Probability of effect: 4 of 136 4. Proximity: 7 of 136 5. Social consensus: 8 of 136 6. Temporal immediacy: 7 of 136 7. General moral intensity: 7 of 136
3	Kish-Gephart et al. (2010)	There is a weak inverse relationship between the strength of the benevolent ethical climate and unethical choices (9 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	There is a weak inverse relationship between the strength of the principled ethical climate and unethical choices (10 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	A strong ethical culture is negatively related to unethical choices (12 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	A strong negative link was found between code enforcement and unethical choices (7 of 136 studies used in this analysis)
4	Pan and Sparks (2012)	Ethical judgments of women are stricter than those of men (21 of 65 studies used in this analysis)

4	Pan and Sparks (2012)	As idealism increases, ethical judgments become stricter (9 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	As ethical awareness increases, ethical judgments become stricter (5 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	The more seriously an act departs from deontological norms, the stricter the ethical judgment (4 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	The more negative the teleological evaluation of an act, the stricter the ethical judgment (5 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	As the moral intensity of an act increases, ethical judgments become stricter (6 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	The stronger the ethical climates of an organisation, the stricter ethical judgments become (18 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	The meta-analysis produced “qualified evidence that student samples systematically produce greater effect sizes than non-student samples.” (p. 88)
5	Jackson et al. (2013)	Transformational/charismatic leadership is positively related to affective commitment (116 studies used in this analysis)
5	Jackson et al. (2013)	Transformational/charismatic leadership is positively related to normative commitment (i.e. obligation to remain) (30 studies used in this analysis)
5	Jackson et al. (2013)	Contingent reward leadership style is positively related to AC (51 studies used in this analysis)
5	Jackson et al. (2013)	In countries that value collectivism the relationship between transformational leadership was stronger for normative commitment
5	Jackson et al. (2013)	In societies with higher levels of power distance/hierarchy the relationship between contingent reward leadership and affective commitment was stronger

Variables Associated with Unethical Behaviour

As can be seen in Table 2 below, Study 3 identified a weak correlation with gender, indicating that men are more likely to make unethical choices than women. This finding was supported by the findings in Studies 1 and 4 above that found that women make more ethical (or stricter) ethical decisions than men.

The variables that were found to correlate more strongly with unethical behaviour included higher income and education, having an external locus of control and an egoistic environment. However, findings on education were mixed and education was found to have no correlation with ethical behaviour in Study 3, as is discussed below.

Of course, Machiavellianism (which is unethical by definition) and relativism correlated with less ethical behaviour and were identified as a variable in both Studies 3 and 4.

Table 2 – Factors that Correlate with Unethical Behaviour

Study Number	Authors	Findings
3	Kish-Gephart et al. (2010)	Gender correlated weakly, with men making more frequent unethical choices than women (60 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	A relativistic moral philosophy is positively related to unethical choice (12 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	Machiavellianism positively influences unethical choice (11 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	An external locus of control is positively related to unethical choices (11 of 136 studies used in this analysis)
3	Kish-Gephart et al. (2010)	A stronger egoistic climate increases the likelihood of unethical choices (12 of 136 studies used in this analysis)
4	Pan and Sparks (2012)	As education increases , ethical judgments become less strict (4 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	As income rises , ethical judgments become less strict (3 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	As relativism increases, ethical judgments become less strict (9 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	As Machiavellianism increases, ethical judgments become less strict (3 of 65 studies used in this analysis)
5	Jackson et al. (2013)	Laissez-faire leadership is negatively related to affective commitment (15 studies used in this analysis)

Variables Which Provided Inconclusive Results

Table 3 below details those variables that provided mixed results or no correlation with ethical behaviour. As noted above, education level was not inversely linked to unethical choices in Study 3. However, Study 4 found that as education increases, ethical judgments become less strict. The authors of Study 4 posit that this may be because “education may open minds and enhance reasoning such that ethical judgments become less stringent” (Pan & Sparks, 2012, p. 88).

Apart from education, the other variables that returned findings that did not correlate with ethical behaviour included the subject chosen in the undergraduate major, the perceived

behavioural integrity of managers when analysed according to the gender of the respondent, age, work experience, and having an internal locus of control.

Most relevant to this thesis is the empirical finding that the existence of a code of ethics had no correlation with ethical behaviour.

Table 3 – Factors that Gave Mixed Results or had no Correlation with Ethical Behaviour

Study Number	Authors	Findings
1	Borkowski and Ugras (1998)	Undergraduate major: No relationship between ethical attitudes/ behaviour and undergraduate major could be found (30 of 56 studies used in this analysis)
2	Davis and Rothstein (2006)	Perceived behavioral integrity of managers by gender of respondents: No significant correlation (9 of 12 studies used in this analysis, where 3 of 12 were predominantly female subjects)
3	Kish-Gephart et al. (2010)	Education level was not inversely linked to unethical choices (22 of 136 studies used in this analysis) ¹⁸
3	Kish-Gephart et al. (2010)	There was neither a discernible positive or negative correlation between the existence of a code of conduct and unethical choices (19 of 136 studies used in this analysis)
4	Pan and Sparks (2012)	A relationship between increasing age and stricter ethical judgments was not significant (15 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	A relationship between increasing work experience and less strict ethical judgments was not significant (7 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	Correlations between increasing internal locus of control and ethical judgments were not significant (3 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	Correlations between increasing religiosity and ethical judgments were not significant (5 of 65 studies used in this analysis)
4	Pan and Sparks (2012)	Correlations between ethical environment and ethical judgments were not significant (4 of 65 studies used in this analysis)
5	Jackson et al. (2013)	Management-by-exception is positively related to affective commitment but in this case the credibility interval straddled zero (25 studies used in this analysis)

¹⁸ The expression of findings in this study is somewhat baffling; this particular finding is expressed as a double negative because of the way the null hypothesis was worded, and has been interpreted as: no correlation could be established between having a higher education level and a preference to make unethical choices.

5	Jackson et al. (2013)	The relationship between transformational leadership and affective commitment was not affected by societal individualism-collectivism
5	Jackson et al. (2013)	In countries that value collectivism the relationship between transformational leadership was stronger for continuous commitment

Discussion of Findings

From the five meta-analyses discussed above it is noted that the correlation of age, gender and education level on ethical decision-making is strongest in smaller meta-analyses containing exclusively (or a high proportion of) student samples, and is not supported in the larger analyses of more diverse studies. The factors that are correlated with ethical behaviour are largely comprised of certain positive character traits, philosophies and leadership styles as well as the practice of code enforcement. The factors correlated with unethical behaviour are related to the extent of the consequences, self-interest, higher income and a laissez-faire leadership style. The finding that student sampling influenced results is a point that needs to be considered when interpreting data.

The conclusion that can be drawn from this data is that both leadership style and personal character traits are more likely to affect ethical behaviours and attitudes than demographic traits.

Of particular note is the finding that having a code of ethics was not correlated with either ethical or unethical behaviours or attitudes. The premise that merely having a code makes an organisation more ethical is therefore not supported by this research.

It is clear that for successful meta-analysis to be conducted in the future there is a need for more primary research to be structured in ways that can be subjected to meta-analyses. There is little evidence to support further investigation of demographic issues or the presence of a code of ethics as a factor in ethical decision making, but research examining specific character traits in leaders may be productive.

Davis and Rothstein (2006, p. 417) recommend further study be undertaken examining the influence of the relative level of the leader to the employee and examining the relationship between attitudes and behaviours and behavioural integrity. Jackson et al. (2013, p. 98)

express the hope that future research will examine “the nature of the relationship between leadership and commitment and how these linkages vary across cultures”. Kish-Gephart et al. (2010, p. 11) note that no studies were available that examined both intentions and behaviour in the same study and that this is an area that requires empirical investigation. They also recommended that future research should “explore both the contextual or organizational conditions that might moderate individual difference effects and the mix of individual differences in a sample that might buffer or strengthen environmental effects” (Kish-Gephart et al., 2010, p. 23). Pan and Sparks (2012, p. 88) suggest future research “focus on variables with theoretically sound relationships to ethical judgments but for which no empirical relationships have been established”.

Notably, none of the meta-analyses in this section investigated ethics education as a factor that may influence ethical behaviour or attitudes. Two separate meta-analyses were found that investigate the issue of education. These are discussed below.

Meta-Analyses of Education/Instruction

If an ethics code alone does not make an organisation more ethical, then should organisations look to ethics education to influence behaviour? Three papers calling themselves ‘meta-analyses’ could be found that investigate ethics education: studies by Haws (2001), Winston (2007) and Waples et al. (2009).

Haws 2001 study, “Ethics Instruction in Engineering Education: A (mini) Meta-Analysis”, was not useable because it did not apply a genuine meta-analytic methodology to the data in the 42 primary research studies it drew on and the conclusions were not supported by any evidence. Winston’s 2007 study was also limited in its approach and therefore its usefulness. Winston did not apply the usual methodology and instead drew on a relatively restricted primary data set which was used merely to calculate the percentage of the total studies by characteristics, such as the journal they were found in.

This left Waples et al.’s 2009 study as the only useable option. The summary of the results is in Table 4. This meta-analysis is limited by the small number of studies (25 in total) that were able to be drawn on. All three papers are discussed below.

Study 5 – Haws Study (2001)

Haws analysed 42 papers which had been published between 1996 and 1999 that “dealt with some aspect of engineering ethics instruction” (Haws, 2001, p. 223). Haws was interested in six approaches used in ethics instruction; namely: professional codes, humanist readings, theoretical grounding, ethical heuristics, case studies and service learning.

Haws asserts that engineering is a more attractive profession to “*convergent* thinkers”, but that ethical behaviour is linked to “*divergent* thinking” and so engineers need to be trained to consider possibilities “beyond the narrow realm of engineering” by “engaging in unfettered discourse with non-engineers” on the subject of ethics. He identifies three “enabling objects” required to formulate, defend and evaluate ethical issues, including: enhancing divergent thinking, helping to see the perspective of non-engineers and providing a “common vocabulary of ethical articulation” (Haws, 2001, p. 223).

Haws (2001) does not apply a statistical methodological analysis to the source data. Instead he states simply how many of the 42 papers discussed each of the six approaches, and then discusses the approach in general terms. For example, he identifies that 12 of the 42 papers referred to the existence of the engineering code of ethics. His only analysis is limited to a statement that “most (although not all)” of the authors of the 12 papers “seem to recognize” that the code of ethics for engineers is “effective primarily at Kohlberg’s preconventional (authoritarian) and to a lesser extent conventional (associational) levels of moral development” (Haws, 2001, p. 224). This analysis is vague and incomplete and was not robust in its design or methodology, and so was not useful for this thesis.

If we can look beyond the superficiality of Haws’s empirical analysis, we discover that the ideas he articulates resonate with an understanding of codes of ethics as a social contract that benefit from broad stakeholder input (as discussed in *Chapter 1: Codes of Ethics as Social Contracts*, and *Chapter 6: Development Approaches to Codes of Ethics*). Haws notes that because the code of ethics for engineers was written “by engineers, for engineers, it does nothing to help engineers see ethical dilemmas through the eyes of non-engineers”. He goes on to claim that the code of ethics for engineers is “platitudinous and contributes nothing to our students’ understanding of either ethical systems, or the shared language in which ethical problems

and solutions are couched” (Haws, 2001, p. 224). However, Haws provides no empirical evidence to support this claim.

In his conclusion, Haws asserts that while the six pedagogical approaches “may all have value”, they do not all have the same value as enabling objects (Haws, 2001, p. 227). It is not clear how these concluding remarks are supported by the data.

Because of the low level of analytical analysis in the Haws paper, it was not included in the analysis undertaken in this chapter.

Study 6 – Winston Study (2007)

In 2007 Mark D. Winston analysed 36 studies in what he has called a meta-analysis. Winston sought to address the following three questions:

1. What methodological approaches have been used to study ethics education and its impact?
2. What factors have served as the bases for measuring the impact of ethics education?
3. What segments of the academic and professional populations have been studied, with regard to the impact of ethics education? (Winston, 2007, p. 231)

The questions are ambitious. However, the analysis is relatively superficial and conducted quite differently from any of the meta-analyses mentioned to this point. Rather than extract individual data points from each study and subject that data to analysis, Winston has grouped each of the individual studies by nine different characteristics then expressed them in percentage terms of the 36 total studies. For example, he has limited the studies collected to those published in the previous 10-year period and then grouped the studies by year of publication. This exercise in no way relates to his research questions or findings. Further, no moderating characteristics are considered or tested for. In terms of statistical power and useable correlations of data, it is arguably a very weak style of analysis.

Winston asserts in his conclusion that the research “indicates the factors contributing to the complexity of ethical decision making include competition, the emphasis on individual success and contribution to organizational success, and the overestimation of ability to make ethical decisions” (Winston, 2007, p. 248).

Again, it is not clear how these concluding remarks are supported by the data. The results of the analysis are tabulated in Appendix 1.

Study 7 – Waples et al. Study (2009)

In 2009 Waples et al. published a meta-analysis of 25 business ethics instruction programs. As with the other meta-analyses on ethical behaviour/attitudes, the authors of this study commented on the difficulty in sourcing quality research, noting the “paucity of empirical studies examining ethics instruction” (Waples et al., 2009, p. 134). The authors note that the three key issues arising in the literature include:

- the absence of a true goal set for the instruction of business ethics. Three different approaches were identified, including:
 - an awareness of ethical issues
 - exposing the moral reasoning method of managers
 - determining the reactions and behaviours of individuals within the context of the organisation.
- lack of agreement over who should teach ethics—philosophers, business people or both
- lack of standardisation in regard to the moral theories used to form the basis of ethics instruction (Waples et al., 2009, pp. 134–135).

The authors examined the following seven factors which are believed to be effective in ethics instruction:

- criterion type (i.e. the goals of the instruction should be matched with the criterion measure in the evaluation. In this meta-analysis six different criteria were reported on: moral reasoning, perceptions of the ethical behaviour of others, perceptions of one’s own ethical behaviour, ethical judgment, ethical behaviours, and ethical awareness)
- study design
- characteristics of participants
- quality of instruction
- instructional content, noting that there will be different instructional content depending on whether the training is designed around cognitive skills (i.e. moral

reasoning), social skills (i.e. ethical awareness), or social-cognitive processes (i.e. ethical decision-making).

- general instructional program characteristics
- characteristics of instructional methods.

The findings indicated that overall business ethics instruction is minimally effective. Moral reasoning was the only criterion that showed a marked positive correlation with the effectiveness of business ethics instruction. Perceptions of others, perceptions of self, ethical judgments and ethical awareness all had a small effect but notably ethical behaviours were found to have no effect. The results are summarised in Table 4 below and tabulated in detail in Appendix 1.

Of the remaining six factors investigated, the largest correlations to effective business ethics instruction for each factor were:

- study design: studies using a pre-test and post-test and a control group design produced a “medium-sized” correlation with the effectiveness of business ethics instruction.
- characteristics of participants: there was a large correlation for participants who are older and working.
- quality of instruction: instruction from someone with a background in finance or accounting was the highest (medium correlation). The authors also found that class sizes greater than one hundred produced higher correlations than those less than one hundred.
- instructional content: programs that included content on standards, responsibilities (societal and fiduciary), conflicts of interest and reporting ethical violations produced a medium correlation.
- general instructional program characteristics: standardised programs and programs that were incorporated into other established programs produced a medium-sized correlation.
- characteristics of instructional methods: shorter periods of instruction (i.e. less than one month) produced a large correlation.

When discussing the implications of their meta-analysis the authors state that, while codes of ethics are valued as “bases for ethics instruction – and may in fact help to direct ethical decision-making – these codes are often not enough”. The results suggested “that instructors begin to employ a cognitive approach to ethical education – one with a focus, in particular, on the strategies individuals may apply in a given situation to solve ethical problems” (Waples et al., 2009, p. 148).

This meta-analysis therefore reinforces the idea that codes alone are not enough. But, in this instance, they provide a concrete solution; namely, a cognitive approach to ethics education.

Table 4 – Meta-analysis Results: Ethical Education

Study	Data points	Findings
7 Waples et al. (2009)	Overall business ethics instruction effectiveness	The overall effectiveness of business ethics instruction was found to be minimal.
	Role of individual criteria	Moral reasoning had a large effect on the effectiveness of business ethics instruction. Perceptions of others had a small to moderate effect on the effectiveness of business ethics instruction. Perceptions of self, ethical judgments and ethical awareness had a small effect on the effectiveness of business ethics instruction. Ethical behaviours had no effect on the effectiveness of business ethics instruction.
	Study design characteristics	Pre-test post-test with control group had the highest effect size while other designs (e.g. longitudinal) had the smallest effect size.
	Field of investigator	Finance/accounting had the largest effect size while marketing had the smallest effect size. ¹⁹
	Author conducted instruction	The effect size was slightly larger when the author of the study conducted the instruction.
	Was the study funded?	The effect size was significantly larger when the study was funded. ²⁰

¹⁹ This has been interpreted in the following manner: if the investigator was from a finance background then it was more frequently found that ethics education was effective than if the investigator was from a marketing background.

²⁰ This has been interpreted in the following manner: if the research was funded then it was more likely to find that ethics education was effective. This implies that funding creates a bias.

Participant characteristics	Business ethics instruction shows more consistent effects for older working populations. There was little difference in results looking at gender . The results suggest that business ethics instruction shows more consistent effects for older working populations and that populations without incentives outperform those who have incentives (Note: the number of data points available for this analysis was very small).
Quality of instruction	Both quality of instruction of the program and quality of the design had larger effect sizes.
Instructional content	Based on the per cent of variance and the narrow confidence interval, it is possible that instructing job-specific skills leads to enhanced learning and performance. Programs that covered domains or standards had higher effects than those that did not. Cognitive strategies for the reasoning of ethical issues had slightly higher effects than social interactional strategies. Covering potential pitfalls is more important than covering the basic principles.
General instructional program characteristics	Programs that are standardised are better.
Characteristics of instructional methods	Shorter instructional periods are better.

Summary

The meta-analyses discussed above provide us with some evidence of factors which correlate with either ethical or unethical decision-making or effective ethical instruction. In all there were 21 variables which correlated positively with ethical behaviour/attitudes (see Table 1). In summary, the findings demonstrate that the demographic factors of age and being female are variables that correlate weakly with ethical decision making. The moral intensity of the ethical issue and a strong ethical climate are factors that are more convincingly correlated with making more ethical decisions.

Only one meta-analysis reported on the effect of codes of ethics and it found neither a positive nor a negative correlation existed between having a code of ethics and unethical behaviour.

There were eight factors that correlated with less strict or unethical decision-making (see Table 2). These variables include being a male, having a relativistic moral philosophy, Machiavellianism, an external locus of control, an egoistic climate, more education, higher income and laissez-faire leadership. However, the tendency for the more highly educated to make less strict moral decisions may be due to them being more “open-minded”. It is also likely to be the case that education and higher income are somewhat linked.

Of the variables tested 12 were found to have mixed or no correlation with either ethical or unethical decision-making. Importantly for this thesis, the impact of codes of ethics was examined in a meta-analysis which was undertaken with a relatively robust approach by Kish-Gephart et al. (2010). The analysis indicated that having a code of ethics could not be correlated with ethical behaviour or attitudes.

Only one of the meta-analyses, which was conducted by Waples et al. (2009), adequately investigated factors that correlate with effective ethical instruction. Ethical instruction overall was found to be minimally effective, but could perhaps be at its best when the program had the following features:

- the instruction was short in duration
- the instruction was standardised
- course content focused on standards and responsibilities
- the instructor came from a finance or accounting background
- the audience numbered greater than 100 people
- the audience was comprised of older, working participants.

One of the implications identified by Waples et al. (2009) was that codes of ethics, while instructive, are insufficient on their own.

Conclusion

This analysis of the meta-analyses does not support the case for an organisation to acquire a code of ethics if the desired outcome is to change behaviour/attitudes. Further, it does not

support the argument that either undertaking or requiring ethics education will have more than a minimal effect.

Given that the somewhat sparse empirical evidence does not support the notion that a code of ethics makes a difference to organisations, it is somewhat surprising that codes of ethics continue to be so popular. The next section of this thesis will explain the historical context of the conceptualisation and spread of such codes. It demonstrates that contemporary expectations of what can be achieved by adopting a code of ethics are an artifact of their historical adoption by the medical profession and the positive effect on the profession that has been attributed to medical codes of ethics.

PART 2 – History and Evolution

This part of *The Ethics of Codes of Ethics* traces the development of codes of ethics and describes events that have shaped modern codes of ethics in both medicine in the UK and in business in the US as well as globally. Part 2 also evaluates the differences between the modern code of ethics for medical practitioners that is used in the UK today, and the first medical code of ethics written for the Manchester infirmary in the late eighteenth century.

This explanation of the history and evolution of codes of ethics reveals that the profession of medicine in the UK has embraced a broad consultative approach to the development of the medical code of ethics. In contrast to this approach, the research literature indicates that business codes of ethics are routinely developed with much more limited input—usually that input is sought only from management and/or employees.

Chapter 4: Historical Development of Codes of Ethics²¹

This chapter discusses the development of codes of ethics to provide historical awareness and in order to construct an historical continuum which reveals the change over time of the applications of codes of ethics from the profession of medicine, to the other professions and then to more diverse organisations (Tosh & Lang 2006, pp. 6-37).

Preludes to Codes of Ethics – Commandments, Oaths and Honour

The notion of organisational ethical codification has its specific pedigree in the medical profession in Britain of the late eighteenth century. However, prior to codification, the ethics of the medical profession in western society is commonly (although contentiously) understood to be historically influenced by the Hippocratic Oath.²² The authorship of the oath is uncertain, although Pythagoras is considered a possible author (Carrick, 1985; Jonsen, 2000). The oath laid out expectations of acceptable behaviour and invoked the wrath of the gods should the swearer breach the oath. This particular oath is less popular now—reasonably so, as it was a product of its time, swearing to the Grecian gods and forbidding the use of surgery (Edelstein, 1943). In more recent times, the popularity of medical practitioners taking oaths has been increasing. In 1928, 28 per cent of medical graduates in the United States took an oath (Theunissen, 2007). By 1997 oaths of some kind were employed in nearly all medical schools in the United States and in approximately half those in the United Kingdom. Oaths taken include modernised derivatives of the Hippocratic Oath or the Prayer of Maimonides, institutional oaths or the Declaration of Geneva (Hurwitz & Richardson, 1997).

Precisely what is understood by the swearing of an oath is a matter that has been examined by Sulmasy (1999) in his article “What is an Oath and Why should a Physician Swear One?” Sulmasy identifies codes as distinct from oaths, describing codes as “collections of specific

²¹ An earlier version of this chapter was published by the thesis author in 2010 under the name Kerrie Griggs (Griggs, 2010).

²² The oath is to be found in a collection of 70 documents known as the Hippocratic collection, so named because they were attributed to Hippocrates of the Asklepiads, otherwise known as Hippocrates of Cos (460–370 B.C.E). The degree to which the oath influenced the actual practice of medicine is contentious (see Jonsen, 2000, pp. 1–4).

moral rules” and observing that “they do not commit future intentions and do not involve the personhood of the one enjoined by the code”. By contrast, he describes oaths as “performative utterances” (Sulmasy, 1999, p. 329). He observes that oaths transform the swearer: “The swearer puts himself or herself at issue in an oath. The swearer’s standing as a person; as a moral agent is put at risk in an oath, without reference to the utility of that standing” (Sulmasy, 1999, p. 332).

A further point of difference is that oaths are linked to the concept of honour. The concept of honour has arguably changed in western society over the past 200 years. Peter Berger (1983) argues that honour, with very few exceptions, is all but obsolete. He claims it is associated with the hierarchical order of a society, and is a direct expression of status.²³ Berger contrasts the decline of honour with the rise of dignity as a concept to be valued in modern society. He characterises it as follows: “The concept of honor implies that identity is essentially, or at least importantly, linked to institutional roles. The modern concept of dignity, by contrast, implies that identity is essentially independent of institutional roles” (Berger, 1983, p. 177).

Berger (1983, pp. 176–179) observes that dignity is, in modern times, understood to transcend social differentiators such as race, colour, sex, age and position, whilst honour is dependent on the existence of stable institutions and the institutional roles they provide. The decline of such institutions is a feature of modernity and, Berger asserts, a causal factor in the obsolescence of the concept of honour. Where an individual cannot draw upon a position in an institution to define identity, that individual must look elsewhere.

Robert Baker (1999) asserts that a problem with oaths and honour emerged within the British medical profession at the beginning of the nineteenth century. He observes that this was a period where ideals of “gentlemanly honour” were pervasive in professional oaths. Since the integrity of professional conduct was so closely associated with the character of the

²³ Berger posits that:

Concepts of honor have survived into the modern era best in groups retaining a hierarchical view of society, such as the nobility, the military, and the traditional professions like law and medicine. In such groups honor is a direct expression of status, a source of solidarity among social equals and a demarcation line against social inferiors. Honor indeed, also dictates certain standards of behaviour in dealing with inferiors, but the full code of honour only applies among those who share the same status in the hierarchy. In a hierarchically ordered society the etiquette of everyday life consists of ongoing transactions of honor, and different groups relate differently to this process according to the principle of “To each his due”. It would be a mistake to understand honor only in terms of hierarchy and delineations. To take the most obvious example, the honor of women in many traditional societies, while usually differentiated along class lines, may pertain in principle to women of *all* classes. (Berger, 1983, p. 174)

practitioner, any implication that a practitioner's character was "less than honorable" could cause irreparable damage to their reputation. This motivated slighted practitioners to go to "extraordinary lengths" to protect their "good name and reputation". They did this by a number of means including legal challenges, fighting duels and the exchange of "hostile pamphlets" (Baker, 1999, pp. 3–4).

This situation, where the concept of honour had become a problematic distraction from the core business of healing, was an ongoing risk for the health of the profession and the patients. In a context where an oath's reliance on honour had apparently reached its use-by date, it seems reasonable that alternative methods of conveying the notion of being voluntarily faithful to standards which demonstrate a respect for the dignity of both oneself and others would arise. This is the space in which codes of ethics have evolved. However, the historical trend for medical graduates and others informed by an organisational code of ethics to increasingly take oaths would indicate an apparent failure of many codes of ethics to adequately address this fundamental issue. This may be due to code content, or the perceived lack of normative force associated with codes of ethics. Either way, the situation seems to have arisen whereby oaths are taken which are not underscored by archaic notions of honour, and codes of ethics are being written which do not adequately address the notion of dignity for all.

The First Organisational Code of Ethics

Thomas Percival (1740–1804), a medical practitioner and moral philosopher from Manchester, England, was the first person known to publish a document recognisable as a code of ethics for a specific organisation. In 1792, in a climate of fever epidemics and executive level problems at the Manchester Infirmary, management requested he draft a set of rules for the hospital. In 1794 Percival reworked these rules in order to develop a model for other hospitals; he included rules for private and public practice, and renamed the work *Medical Jurisprudence* (Pickstone, 1993, p. 169). In 1803 the work was again revised and published as *Medical Ethics, or, A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons* (Baker, 1993b, p. 141).

The term ‘code of ethics’ with which we are now so familiar and by which the document is generally referred to, would appear to be an abbreviation and conflation of Percival’s alternative titles. The work contained the following explanation for the title in the Author’s Preface:

This work was originally entitled “Medical Jurisprudence;” but, some friends having objected to the term *Jurisprudence*, it has been changed to *Ethics*. According to the definition of Justinian, however, Jurisprudence may be understood to include moral injunctions as well as positive ordinances: — “Juris praecepta sunt haec; honeste vivere, alterum non laedere, suum cuique tribuere.” (Percival, 1849, p. 26)²⁴

Percival refers here to Justinian, Emperor of Rome in the late fifth and early sixth century, whose achievements included the completion of the *Corpus Juris Civilis*. This collection of documents included Justinian’s *Codex*, which was a book of Roman laws that superseded all existing laws; the *Digest*, concerned with jurisprudence; the *Novels*, which were laws written after the code; and the *Institutes*, written as textbooks for legal scholars. This corpus formed the basis for, and strongly influenced, European law (Davis, 2003, p. 434). The Latin quotation Percival has included derives from the *Institutes* and both the alternative title and the use of the quotation point to the influence of Justinian’s texts in the formulation of *Medical Ethics*.

Percival’s purpose was didactic rather than legalistic. Davis (2003, p. 435) also notes the Justinian influence in Percival’s work and explains that “Percival’s subtitle was intended to tell his readers that he was not publishing a code (strictly speaking), that is, an authoritative systemization (a systemization with the force of law)”. Davis argues that Percival’s intention was “to teach rather than legislate: hence his subtitle’s use of ‘institutes’ and ‘precepts’ rather than, say, ‘laws’, ‘regulations’, or ‘duties’. What he published was a ‘code’ only in an extended sense, a systematic treatment (much like Justinian’s *Institutes*)”.

Baker (1993, p. 180) claims that in 1794 Percival distributed a printed version of *Medical Jurisprudence* to 25 people including 15 physicians, four barristers/lawyers, three clergymen/theologians and three laypersons. Percival took their comments into account before publishing the revised work as *Medical Ethics*. The reasons for his friends’ objections to the inclusion of the word “jurisprudence” in the original title are a matter for speculation,

²⁴ The Latin phrase quoted by Percival translates to: “The precepts of the law are these: to live justly, not to injure anyone, and to render to each person what is due”, and is a quotation from Justinian’s *Institutes* I, I, 3.

but clearly, to include “ethics” in the title was not Percival’s original intention; it was a compromise on his part.

Crowther (1995) asserts that despite Percival’s success in publishing his work, instruction in medical ethics in the nineteenth century remained incidental to the more systematic instruction of medical jurisprudence until as late as 1984. She notes that in this environment ethics was distanced from the “professional, moral and social concerns” of Percival (Crowther, 1995, p. 173). Crowther also notes the pragmatic imperative of teaching ethics in a legal context, “since most of the teaching on the subject has aimed to instruct future doctors and lawyers in ethical issues which can be tested in court” (Crowther, 1995, p. 174).

Where an individual is operating in an environment where legislation is not applicable or existing legislation is not tested, it seems reasonable to manage the inherent risk of further regulation or litigation by acting according to an ethical code that has been agreed upon by peers. Indeed, regardless of whether it was taught formally, Percival’s code of ethics appears to have been designed with this in mind.

Percival’s *Medical Ethics* was a practical guide to avoiding both the interpersonal and legal hazards of medical practice and maintaining the necessary functional relationships that a medical practitioner was obliged to engage in to practice effectively and respectably in Manchester, England at the end of the eighteenth century. The document was the length of a small novel at 195 pages, but written in an aphoristic style. Its contents pointed the practitioner’s attention to the importance of everyday events that, if handled thoughtlessly or without due diligence, might become problematic. It is possible that the fatherly tone of the work was due to two factors. Firstly, Percival’s writing style may have been influenced by his earlier writings, including a three volume set of books aimed at gentlemen and their families entitled *A Father’s Instructions to His Children; consisting of moral tales, fables and reflections, adapted to different periods of life, from youth to maturity, and designed to promote the love of virtue, a taste for knowledge, and an early acquaintance with works of nature*. Secondly, Percival claimed that *Medical Jurisprudence* was originally written for his son James, who also studied medicine, and this may have shaped the tone of the work (Pickstone, 1993, pp. 165–170).

The Percivalian code of ethics was the first of its kind. It constituted a new genre of document relevant to an organised group of individuals working collaboratively. It was a

radical departure from the more personally owned and self-regulated social mores, or any oath which predated it. The autonomy of the medical practitioner was a tacit assumption on which the Percivalian code was based. The code dealt with appropriate understandings of patients' rights (such as they were at that point in history) and detailed an approach to the practice of the profession in terms of relationships with patients, other professionals, employers and the judiciary.

Percival eventually separated the code into four chapters: the first dealing with professional conduct relative to hospitals or other medical charities, the second with professional conduct in private or general practice, the third detailing the conduct of physicians toward apothecaries, and the fourth concerning professional duties in cases which required knowledge of law. Chapter 4, 'Duties Relative to the Law', is almost twice as long as the other three chapters combined and is exclusively a piece on jurisprudence.

Percival was a well-respected practicing physician, bestowing legitimacy and sincerity upon the work. His publication could arguably be considered as a package of wisdom gained from experience which would have served well as a guide for the nascent physician, and both a reference and reminder for the well-practised. However, a less charitable interpretation held by John Pickstone contends that the document was written to "defend, and so perhaps preserve, a passing order" (Pickstone, 1993, p. 172). Despite Pickstone's interpretation of events, it would appear that a protracted and relatively stable period in British medical ethics code history resulted. There was little change in British medical codes of ethics over the following century (Jonsen, 2000, p. 62), and the idea to fashion a code of ethics extended to medical organisations abroad and then to non-medical organisations.

The Spread of Codes of Ethics

The first codes of ethics in both the United Kingdom (UK) and the United States (US) were medical codes of ethics. Chapter 1 of Percival's *Medical Ethics, or, a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons (Medical Ethics)* was the first code of ethics specific to a medical organisation. The first chapter of *Medical Ethics* was initially

written in 1792 at the request of the Physicians and Surgeons of the Manchester Infirmary specifically for use by doctors at the Manchester Infirmary (Percival, 1849, p. 21).²⁵

Percival's original papers, including the original version of the code, were lost during the bombing of Manchester in World War II (Baker, 1999). The first chapter of *Medical Ethics* is the closest available text to Percival's first version of the code. Percival confirms this in the Author's Preface:

The first chapter of the following work was composed in the spring of 1792, at the request of the Physicians and Surgeons of the Manchester Infirmary: and the substance of it constitutes the code of laws, by which the practice of that comprehensive institution is now governed. The Author was afterwards induced, by an earnest desire to promote the honour and advancement of his Profession, to enlarge the plan of his undertaking, and to frame a general system of Medical Ethics; that the official conduct and mutual intercourse of the Faculty might be regulated by precise and acknowledged principles of urbanity and rectitude. (Percival, 1849, p. 21)

Chapter 1, the original code for the Manchester Infirmary, was titled: *Of Professional Conduct, Relative to Hospitals, or other Medical Charities*. The subsequent three chapters of *Medical Ethics* were added to deal with duties of the practitioner in various other settings and were titled: Chapter 2: *Of Professional Conduct in Private or General Practice*, Chapter 3: *Of the Conduct of Physicians towards Apothecaries*, and Chapter 4: *Of Professional Duties in Certain Cases which Require a Knowledge of Law*. The four chapters were published together as *Medical Ethics* in 1803.

Within *Medical Ethics* Percival had made distinctions between the various medical practitioners (i.e. physician, surgeon and apothecary) and also various types of patients. Such distinctions were uniquely appropriate to the British context and when elements from this code were adapted abroad they instead simply referred to 'physicians' and 'patients' (Baker, 1993, p. 868). In the following century, many medical organisations were formed in the British colonies which were influenced by Percival's code or adaptations of it.

Throughout the nineteenth century, Anglo-American medical organisations were established. These organisations reformed and professionalised medical practice. Shortt (1983) outlines that with the advent of the Apothecaries Act of 1815 the many private medical schools in London were complemented by the establishment of medical schools associated with University and King's Colleges. The Manchester school was established in

²⁵ The first chapter was drafted in 1792 for the Manchester infirmary; the first edition of the book *Medical Jurisprudence* was drafted in 1794 for hospitals and medical charities. This draft was revised and published as *Medical Ethics* in 1803.

1824. In 1832 the Provincial Medical and Surgical Association was established. This eventually became the British Medical Association in 1856. In 1858 the General Medical Council was established for qualified practitioners. In the US almost all of the states in the Union had a medical society and local societies by 1830. The American Medical Association (AMA) formed in 1847 and a further 15 national specialist groups formed before 1902. Similar events occurred across the western English speaking world, including Canada. By the 1880s, Anglo-American medical practitioners had professionalised via the establishment of medical schools, licensing standards, medical societies and journals (Shortt, 1983, pp. 53–54).

In Australia the states established autonomous branches of the British Medical Association (BMA) between 1879 and 1911. The first federal meeting was in May 1912 (Australian Medical Association, 2015b). The Australian Medical Association was formed in 1961 (Australian Medical Association, 2015a).

Baker (1993c, p. 865) claims that “*Medical Ethics* was immediately treated as authoritative, especially by the Americans”. The first organisational code of ethics in the United States was that of the Boston Medical Organization. Titled *Boston Medical Police (Boston Police)*, it was published in 1808 and was based on Percival’s *Medical Ethics*. Baker outlines the timeline of uptake of ethical codes by medical organisations in the US:

Between 1817 and 1842, thirteen American medical societies adopted codes based on the *Boston Police*, while the Baltimore and New York State societies adopted codes based directly on Percival. In 1847, the newly formed American Medical Association (AMA) Drafted a code modelled on Percival, to such an extent that many passages were taken directly from *Medical Ethics*. (Baker, 1993c, p. 865)

The pace of uptake of codes of ethics by organisations abroad is testament to Percival’s approach and an indication that others were keen to replicate the success achieved in Manchester in 1792. Within the space of eleven years, from 1792 to 1803, the organisational code of ethics had evolved from being aimed at the practitioners at one discreet organisation in Manchester to all members of the Faculty—a broader organisation in its own right.²⁶ Five years later, in 1808, Percival’s concept had spread to the US and the first organisational code based on Percival’s code had been further developed to suit the US context. The

²⁶ Where Percival refers to ‘the Faculty’ in *Medical Ethics* he is referring to the “faculty of hospitals” (Baker, 1993b, p. 141). It is therefore clear that the intended audience for *Medical Ethics* has been broadened beyond the medical practitioners of the Manchester Infirmary.

development of a US national-level code for the American Medical Association (AMA) occurred 44 years after *Medical Ethics* was published.

Codes based on the Percivalian code were adopted by medical societies (local organisations of medical practitioners) in the United States as early as 1808 (Baker, 1993b, p. 179). Despite this, the public image of the American medical profession was in disarray. Jonsen (2000, p. 67) writes that “codes of ethics were weak remedies for the disdain in which the American public held the profession”. He claims that many of those who were practising were “hardly educated, barely literate, dirty, and dangerous”. Those practitioners who were better educated and competent tended to be “quarrelsome and contentious among themselves”, and that “medical students had the reputation of being unruly and coarse”.

Realising that more needed to be done to restore the status of the profession, a new order evolved which sought improvements in education through standardised curriculum and state based licensure (Jonsen, 2000, p. 69). In 1847, the American Medical Association (AMA), a national organisation representing medical practitioners, was established. In that first year, the Association published the AMA code of medical ethics, which was also based on Percival's code. This particular code remained extant until 1957 (Backof & Martin, 1991, p. 101).

Other professions in America began to establish their own codes of ethics 60 years later, beginning with the American Association of Accountants in 1907 and the American Bar Association in 1908. The impetus for both of these professions was, purportedly, the industrialisation of the nation and subsequent social and economic pressures that came of this, but the acquisition of a code was also an attempt to bring status to the professions (Backof & Martin, 1991, pp. 99–101). By the end of the 1940s the concept of developing ethical codes specific to a plethora of different organisations seems to have taken root in the United States.

The Evolution of Codes of Ethics

Since these early developments in organisational ethics, codes of ethics in the professions have been adapted to deal with changing political, social and economic values, and with changing technologies, in order to maintain relevance and to better reflect the extant social contract. This relates directly to the central question of the thesis; namely, should business codes of ethics be developed in such a way that they better reflect the social contract and the society?

Figure 2 is a timeline of the events which shaped the development of codes of ethics as we know them today. While business has had similar drivers to adopt codes of ethics, many of these codes are still generated at the organisational level and there has been little focus to ensure that the content of these codes is a reflection of the social contract. A higher level approach to codes of ethics in business, such as that taken in the medical profession, could assist with the articulation of the social contract.

The events of the Second World War brought matters of ethics into sharp focus for the profession of medicine, particularly the 1947 Nuremberg Trials, which dealt with the conduct of Nazi doctors and medical administrators responsible for harmful experiments on prisoners and other unwilling subjects during the war (Jonsen, 2000, p. 100). Pence (2004, p. 274) observes that one of the issues confronting the judges at Nuremberg in their evaluations was that no code of ethics existed to guide the conduct of experiments on captive persons. Their verdict “referred to 10 principles of permissible experimentation, which afterward came to be known as the *Nuremberg code*”.

Among other things, the Nuremberg Code required the voluntary consent of the subject and made clear the duty of the researcher to cease experiments which transpired to be harmful (Jonsen, 2000, pp. 100–101). The challenge that this created for scientific medicine was related to the fact that when testing new treatments, there would be some studies that placed the patient at risk without the certainty of benefitting the patient. This circumstance led to the development of bioethics as a separate field of ethical enquiry (Jonsen, 2000, p. 102).

Year	Event
1792	UK: Percival's code (later to become chapter 1 of <i>Medical Ethics</i>)
1794	UK: Medical Jurisprudence
1803	UK: <i>Medical Ethics, or, A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons</i>
1808	US: <i>Boston Medical Police (Boston Police)</i> published by Boston Medical Organization.
1815	UK: Apothecaries Act
1824	UK: Manchester School established
1830	US: almost all of the states in the Union had a medical society and local societies by 1830
1832	UK: Provincial Medical and Surgical Association was established
1817-1842	US: Thirteen American medical societies adopted codes based on the <i>Boston Police</i>
1847	US: The American Medical Association formed. AMA code of medical ethics published
1856	UK: Provincial Medical and Surgical Association becomes the British Medical Association
1858	UK: General Medical Council established
1880-1890	US, UK, Canada, Australia: Anglo-American medical practitioners had professionalised via the establishment of medical schools, licensing standards, medical societies and journals
1902	US: 15 national specialist groups had formed in America by 1902
1907	US: American Association of Accountants establishes a code of ethics
1908	US: American Bar Association
1879-1911	Australia: the states established autonomous branches of the British Medical Association (BMA) between 1879 and 1911
1912	Australia: The first federal meeting of the Australian Medical Association held in May
1913	US: <i>The Penny Idea</i>
1940	US: Codes of ethics common in many US organisations
1943	US: Johnson & Johnson credo
1947	Nuremberg Trials lead to the creation of the Nuremberg code.
1940-1960	US: Pastor Reinhold Niebuhr promotes decent working conditions and wages
1969	US: Hastings Centre for bioethics established
1960-1970	US: Development of business courses and texts pertaining to corporate social responsibility
1970	US: Milton Friedman publishes <i>The Social Responsibility of Business is to Increase its Profits</i> in the New York Times
1971	US: Kennedy Institute of Ethics opened
1972	US: Unethical nature of the Tuskegee study of syphilis exposed by the media
1977	US: <i>Foreign Corrupt Practices Act</i> passed
1979	US: <i>Principles of Biomedical Ethics</i> by Beauchamp and Childress
1979	UK: Thatcher Government era of deregulation begins
1970-1980	US: Establishment of centres dealing with business ethics and a rise in business conferences on social responsibility
1980	US: Business ethics began developing into an academic field and becoming institutionalised. Australia: Codes of ethics gain popularity in Australian Companies
1986	UK: Illegal share support scheme involving Guinness
1980-1988	US: Deregulation and privatisation policies of the Reagan administration
1990	US: Insider trading by the Chief Executive Officer at Drexel Burnham Lambert
2002	US: the Sarbanes-Oxley Act of 2002, which requires disclosure regarding the adoption of a code of ethics for senior financial officers (see <i>Chapter 6 – Development Approached to Codes of Ethics</i>)

Figure 2: Codes of Ethics – A Timeline

The sciences were now in an age of unequalled discovery and technological progression. Jonsen (2000) claims that in this post-war period there was a growing concern within the scientific community regarding the “ambiguity” of advances in the medical sciences. He claims that scientific conferences in the 1950s and 1960s were increasingly attended and informed by philosophers and theologians. He asserts: “Their appearance at these events drew the wide-ranging discussions into more articulate and organized expositions” (Jonsen, 2000, p. 115).

The first independent research centre dealing with bioethics was established in 1969 and is today known as the Hastings Center. Soon after, in 1971, the Kennedy Institute of Ethics was opened. The opening of these institutions was an indication of the growing legitimacy and perceived need for dedicated research in the nascent field of bioethics.

In other fields too, attention to ethics was increasing and evolving. Richard De George identifies five phases in the development of business ethics in the United States. The earliest phase is prior to 1960, a period in which he identifies the incursion of religion in the form of Papal encyclicals, Catholic social ethics and the influence of the protestant Pastor Reinhold Niebuhr’s work with respect to the promotion of decent working conditions and wages. The second phase is 1960–1970. This was a time of social revolution which caused a shift in the importance of social issues in business and the subsequent development of business courses and texts pertaining to corporate social responsibility. These first two phases De George describes as “ethics in business” rather than business ethics proper (De George, 1987, pp. 201–202).

The third phase was the 1970s, when the field of business ethics began to develop and philosophers began to introduce ethical theory and philosophical analysis. Of the philosophers, De George explains that the development of medical ethics up to this point had made this possible; in particular, “Rawls’s *A theory of Justice* legitimized philosophical concern with economic issues” (De George, 1987, p. 202).

It is of particular significance that De George identifies this link between the development of medical ethics and business ethics. This identifies the common heritage of modern organisational codes and may explain why the term ‘code of ethics’ has been adopted across organisations.

The 1970s saw the establishment of centres dealing with business ethics and a rise in business conferences on social responsibility, as concerns about the public image of business grew in the wake of a number of high profile corporate scandals (De George, 1987, p. 202). It is probable that, at least in part, this growth was fueled by various ethical scandals and the new context of de-regulation of business.

Resistance to the notion of Corporate Social Responsibility (CSR) also manifested in 1970. An article by American economist Milton Friedman was published in the New York Times which argued “there is one and only one social responsibility of business—to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game, which is to say, engages in open and free competition without deception fraud” (Friedman, 1970). Friedman was an influential and respected figure who would go on to win a Nobel Prize in Economic Sciences in 1976.

The fourth phase De George calls “the first half of the 1980s: the period of initial consolidation”. During this phase business ethics was developing into an academic field and becoming institutionalised. In the fifth phase, “the 2nd half of the 1980s and beyond”, business ethics had become a legitimate academic field taught in a plethora of institutions and included analysis, clarification, theorising and research (De George, 1987, pp. 207–209). These latter three phases since 1975 encompassed a period of considerable growth in the number of corporate ethics codes in the United States (Stevens, 1994, p. 63).

The Scandalous Seventies, Eighties and Nineties ...

Despite all the developments detailed above, the 1970s became the decade of scandals. In 1972, the Tuskegee study of syphilis became headline news. The study had been underway for approximately 42 years. It involved 399 African-American syphilitic subjects who were deceived into believing they were receiving treatments for a fictitious condition when in fact they were being tested for the signs and symptoms of syphilis. Treatment and information was conspiratorially withheld from the subjects so that the natural progression of their disease could be observed and recorded until their death (Pence, 2004, pp. 270–300). The racist nature of the study, the inherent deception, the exposure to harm of subjects and their

families, and lack of informed consent, all in the name of furthering medical knowledge, caused the Tuskegee study to become an infamous case study of ethically wanting research.

Some of the consequences from the Tuskegee study included the creation of federal government regulations on research and a re-examination of traditional medical ethics. The 1970s and 1980s was the era when scholarly interest in the new field of bioethics gained pace, with significant contributions such as *Principles of Biomedical Ethics* by Beauchamp and Childress (1979). The skills developed in this discipline were then applied to business.

In time, organisations outside the professions, especially large businesses, acquired codes of ethics. Early adaptors included J. C. Penney, an American retailer, which issued *The Penney Idea* in 1913—a list of seven brief guidance statements to staff expressing a commitment to upholding specified values and high levels of customer service (Oliverio, 1989, p. 370). Another early adaptor was Johnson & Johnson, a medical supply company, with their credo in 1943, which lists the responsibilities as perceived by the company community, to various stakeholders (Johnson & Johnson, 2008). The tenor of both of these codes of ethics is aspirational and places service to stakeholders above all else.

Stevens (1994) observes that corporate codes of ethics originated from professional codes of ethics. She also observes that one factor that has contributed to codes of ethics becoming so commonplace is because contemporary corporations can be held legally responsible for the actions of their employees. Stevens (1994, p.64) explains that corporate criminal liability is based on the doctrine of *respondeat superior*: “let the master answer”. Under this principle a master may be held liable for the wrongdoings of their servants.²⁷ Stevens (1994, p. 64) explains that corporate codes of ethics were “constructed partly as a defense against *respondeat superior*” and, as time went on, there were yet more reasons for businesses to adopt a code of ethics.

These additional reasons include government policies on deregulation and privatisation. As suggested by Ciulla (1992), deregulation and privatisation brought about by the policies of the Reagan administration (1980–1988) and the Thatcher Government (1979–1990) focused on decreasing reliance on government for the provision of goods and services. She states:

²⁷ Stevens draws the term *respondeat superior* from *Black's Law Dictionary* (Black, 1983, p. 681).

“During the regulated days many companies worked under the assumption that they were ethical if they followed the law ... For some deregulation meant ‘what is no longer prohibited is permitted’” (Ciulla, 1992, p. 141).

Ciulla (1992, p. 141) asserts that corporate scandals, such as the illegal share support scheme which occurred at Guinness in 1986 and the insider trading by the Chief Executive Officer at Drexel Burnham Lambert in 1990, prompted managers “to think about the ethics of their employees”.

This is similar to the pattern of events identified by Backof and Martin (1991) who, in their examination of the professions, assert the links between industry deregulation, a subsequent rise in scandalous behaviour, and the use of codes of ethics in order to indicate that self-corrective action was being taken by the organisation.

Despite being subject more or less concurrently to similar government ideologies, the tendency for European companies to acquire a code of ethics was much delayed. In 1990 Langlois and Schlegelmilch (1990, p. 520), investigating this phenomenon, opined that “U.K. companies regard corporate codes of ethics as the latest import from Wall Street and therefore of little relevance to British industry”.

In 1988 Langlois and Schlegelmilch analysed the responses from a survey by 189 of the largest English, French and German firms to reveal that 41 per cent of companies had codes of ethics whereas in the US the mid-1980s figure was 75 per cent. They estimated at this point that Europe was more than eight years behind America in this regard (Langlois and Schlegelmilch 1990, p. 532). So, it would seem, were Australian business organisations, which also largely began to produce codes of ethics in the 1980s. Kaye (1992, p. 860), in summarising the results of a survey conducted in 1990 of 26 of the largest companies in Australia, concluded that codes of ethics in Australian corporations were a “recent phenomenon”. He questioned whether this was perhaps “some kind of ‘fashion’ influence from the United States of America”, noting that “codes of ethics do not have a high profile in business and do not appear to be extensively or rigorously used in Australian business corporation”.

In 1983 Cressey and Moore (1983) published a landmark study, “Managerial Values and Corporate Codes of Ethics”, which is often cited in business ethics literature.²⁸ This study is an empirical analysis of 119 corporate guidelines on business ethics which form part of the Watson Collection.²⁹ This collection represents some of the earliest American corporate codes of ethics. Cressey and Moore report that these documents were collected by the Business Roundtable and Conference Board between 1975 and 1979 in response to the corporate scandals of 1975³⁰ and the resultant fledgling “ethical code movement” which developed in its wake. However, the passing of the *Foreign Corrupt Practices Act* in December 1977, which regulated the offshore activities of US companies, brought about a sudden decline in the creation of ethics codes (Cressey & Moore, 1983, pp. 53–54).

Cressey and Moore took the opportunity to detail the involvement of Fortune 500 companies’ documents in their study—comprising more than 60 per cent (i.e. approximately 71) of the 119 companies.³¹ Fortune 500 companies are the top 500 American public companies as determined by their gross revenue. The generation of codes of ethics by corporations has steadily climbed through the decades and, with the increasingly deregulated and globalised environment in which businesses operate, the trend to acquire a code of ethics has spread abroad.

The Changing Emphasis of Codes of Ethics

The idea pioneered by Percival with his code went on to be adopted and adapted time and again and, to a large degree, along with this went the label ‘code of ethics’. The term is now commonplace as a generic descriptor, regardless of the actual title of the documents. Given Percival’s unease about using the word ‘ethics’ in the title of his original code, it is little wonder that, with the passage of time and the diverse spread of environments for which

²⁸ This paper uses the terms “codes of ethics” and “conduct codes” interchangeably; however, when determining which documents to include in their study, the authors limited the material to those which demonstrated a concern for the corporations’ “linkages with the rest of the business community or the larger society” (Cressey & Moore, 1983, pp. 53–55).

²⁹ The Watson Collection is a collection of documents held in the John H. Watson Library in New York. The documents were assembled with the assistance of the Business Roundtable and the Conference Board with the intention of providing a collection that could be used by corporations that were establishing or reviewing codes of ethics (Cressey & Moore, 1983, p. 54).

³⁰ The authors assert “about five hundred U.S Public corporations were implicated in a web of questionable and illegal activities that stretched around the world” (Cressey & Moore, 1983, p. 53).

³¹ Farrell et al. (2002a, p. 153) note the disputed accuracy of this figure, quoting a range of studies that were undertaken between 1980 and 1990 that set the figure between 56 and 77 per cent.

codes were being written, others became uncomfortable about the name of such documents too.

Joanne Ciulla's research in the early 1990s involving interviews with European business managers prompted her to conclude that "many people object to the term 'business ethics' and prefer to characterise ethical problems as managerial problems" (Ciulla, 1992, pp. 134–135). Perhaps because of this objection, organisational managers continue to search for suitable descriptors within their comfort zone by re-badging their ethics codes with labels such as business principles, credos, values statements and the like. The term 'code of conduct' is now commonly used. However, these codes of conduct may or may not include ethically germane statements.

Robin et al. (1989, p. 66) observe: "One of the similarities among codes of ethics is their tendency to be legalistic". The authors here are referring to the predominance of "Thou shall..." and "Thou shall not..." language employed in the code content of the corporations they studied.

Consistent with a lack of agreement or standardisation with regard to naming codes, the content of such codes can be very variable. On this point, Farrell et al. (2002b, p. 159) observe that the "appropriate subject matter for corporate codes of ethics has not been resolved by rational argument, agreement or otherwise" and that there appeared to be "little in the way of consensus among corporation officials as to the proper subject matter of a code of ethics".

Codes of ethics continue to be written by individual organisations and it is common for such codes to include both legal requirements and ethical guidance.³² This is perhaps the result of pragmatic imperatives in the organisational environment where the aim is not to precipitate philosophical discourse or to instruct readers about what ethics is or is not, but to inform members quickly and effectively how to be compliant with workplace expectations.

³² Examples are easily found and include the Code of Conduct and Ethics of the NSW Police Force (2008), which provides ethical guidance at point 4: "treat everyone with respect, courtesy and fairness", as well as a legal obligation at point 6 instructing members to "comply with the law whether on or off duty". Instances where legal expectations have been included in a code of ethics are also very common; for example, the Code of Ethics of the Health Information Management Association of Australia (1992), point 4: Members should "not engage in dishonesty, fraud, deceit, misrepresentation or other forms of illegal conduct that adversely reflect on the profession or the individual's fitness for membership in the profession".

However, this situation ably demonstrates the difference between ‘then’, when Percival wrote his code, and ‘now’. The social contract has changed. There are new laws which influence or reflect the social contract and those laws are being referenced in codes of ethics.

Some theorists have pointed out that to be effective codes of ethics should reflect the actual moral difficulties encountered by those using them and be developed with the involvement of code users (Kaptein & Wempe, 1998; Seshadri et al., 2007).

In other words, it would seem that it has become acceptable to use these documents to briefly point to matters already regulated or tested by law. This change in focus tends to make codes of ethics less about ethics and more about law, less about practical wisdom and more about compliance. Such codes have little utility in terms of offering actual ethical guidance because they are limited to representing only that dimension of the social contract concerned with following the laws of a society. In terms of a social contract such codes of ethics arguably reflect elements of the macro-contract, but may omit articulation of the micro-contract.

The need for contextual guidance within organisations on matters requiring sensitive ethical judgment precipitated the adoption and spread of codes of ethics. If codes of ethics continue to evolve so that there is an increasing tendency to reference legal responsibilities at the expense of actual ethical guidance, then the social micro-contract will not be fully reflected in those codes of ethics.

Summary

It can be seen from this brief history that, in an effort to bring an explanation of acceptable standards of behaviour to organisation members, the formation of a code of ethics has become the tool of choice. The inspiration came from Percival’s code written for the Manchester Infirmary in the late eighteenth century and has spread to other organisations and across the globe.

When business organisations began to take up codes of ethics it became usual practice to draft a code for the specific organisation, and this remains the case today. This contrasts with the approach taken by the medical profession to evolve towards national codes.

Over time there were various corporate scandals which influenced code adoption or content and spawned new regulations. There have been some very specific regulatory levers which encouraged code adoption. All of these events have shaped expectations about codes of ethics and in some ways limited the focus of some codes such that they do not adequately reflect the social micro-contract, but merely a segment of it; specifically, the expectation to comply with regulations.

Concluding Reflections

While the evolutionary path of codes of ethics for medicine moved towards national documents, codes of ethics for business are generated as organisational level documents. This has left many organisations without an agreed national expression of the social contract for business. Following the example of the medical profession and establishing a nationally recognised code of ethics for business that adequately reflects the social contract could benefit business organisations.

Chapter 5: The Changing Style of Codes of Ethics

Introduction

Historically the practice of medicine has been complemented by an awareness of ethics in some form. Accordingly, it is not surprising that the first organisational code of ethics was developed in the medical setting.

Because codes of ethics for medical practitioners have had the longest history, they have also had the longest evolution, and the development timeline which has been described in *Chapter 4: Historical Development of Codes of Ethics* provides insights into how and why codes of ethics evolve in other contexts.

The earliest organisational code of ethics for medical practitioners, Percival's *Medical Ethics*, provides a snapshot of the state of medical ethical thought in the UK in the late 1700s. It informs us about aspects of the social, philosophical and ethical priorities of the time; it gives insight into understandings of the acceptable doctor-patient and doctor-doctor relationships; it reveals the limitations in scientific knowledge that existed; and it explicitly describes the way in which it was developed, including a list of the professional qualifications of the 15 stakeholders who were invited to provide feedback.

The current code of ethics, the 2013 edition of *Good Medical Practice* (General Medical Council, 2013a)³³, reflects a national consensus of the most current state of ethical thought in the UK today; it discusses the contemporary relationships of importance to medical practitioners and incorporates consideration of the many advances in medical science that are integral to the delivery of modern medical care. The development of this code is informed by anyone who considers themselves to be a stakeholder.

The reason for choosing these two particular documents for comparison is that they both are documents from the UK which provide ethical guidance exclusively to medical

³³ Subsequent general references to this current edition will be shown as *Good Medical Practice* (2013). This edition is available for download on the website of the General Medical Council:
http://www.gmc-uk.org/static/documents/content/GMP_.pdf

practitioners and both are regarded as authoritative documents. *Medical Ethics* was the first-of-a-kind document targeted at medical practitioners, and it was written in the UK, and *Good Medical Practice* (2013) is the most recent document of that kind targeted at medical practitioners in the UK.

These two documents provide points of comparison, delivering an opportunity to contrast ethical priorities, scope and approaches to code development. By determining those ethical issues which have been retained, removed or re-scoped, we can obtain a view of the shifts in ethical thought, and in code development approaches.

This chapter executes a systematic comparison between Percival's code *Medical Ethics* and the code in use by medical practitioners in the UK today, *Good Medical Practice* (2013). This original work provides evidence for an analysis of shifting ethical priorities and code development approaches. It reveals which developments have occurred, what elements have endured and the shifts in ethical thinking over time. It then considers what other organisations can learn from this.

The Origins of *Good Medical Practice* (2013)

In the UK currently, the code of ethics that applies to all medical practitioners who are registered with the General Medical Council of the United Kingdom is *Good Medical Practice* (2013). The most recent version was published in March 2013 (General Medical Council, 2013a). It was updated on 29 April 2014 to include an additional paragraph requiring doctors to have knowledge of the English language (General Medical Council, 2013a, p. 1).

The history of the development of the code of ethics of the General Medical Council has many parallels with the circumstances and events that accompanied the development of Percival's *Medical Ethics* (see *Chapter 4: Historical Development of Codes of Ethics*). In the early 1970s many medical practitioners were unhappy, the safety of patients was compromised, and the reputation of the profession was at risk. The General Medical Council introduced and then enforced its code of ethics, and the situation markedly improved.

The General Medical Council was established under the Medical Act 1858 following lobbying by physicians, surgeons and apothecaries who sought to limit the competition presented by lesser-trained “healers”. The responsibilities of the council included the registration, discipline and education of practitioners (Irvine, 2006, p. 202).

Initially the General Medical Council “adopted a passive, narrow role”, deferring to the more established medical institutions. Professional discipline charges were mostly related to matters such as “adultery, criminal behaviour, and breaches of professional etiquette ... freedom from canvassing for patients and advertising” (Irvine, 2006, p. 204).

In the 1970s there was a mounting number of issues that the General Medical Council had failed to manage in its relationships with its members and with the Royal College of General Practitioners. It had also failed to effectively deal with cases involving ill or drug-addicted doctors, and the influx of overseas doctors required to staff the NHS. When the General Medical Council began to charge a registration fee, the majority of practitioners refused to pay, which triggered the Government to instigate the ‘Merrison Committee of Inquiry into the Regulation of the Medical Profession; report and papers’.³⁴ The General Medical Council opposed the committee’s “exploration of a code of conduct”, preferring to base its advice to practitioners on case-law (Irvine, 2006, p. 205).

In 1979, following the Merrison Inquiry, the membership of the General Medical Council was expanded and the Council also became responsible for “advice on professional standards and ethics” and practitioners’ “fitness to practise” (Irvine, 2006, p. 207). However, in 1998 the media reported on several high profile failures of the medical system that were known to the General Medical Council, but on which they had failed to act in a timely manner. It was not until three doctors from Bristol hospital were found guilty of serious misconduct by the General Medical Council in relation to one of these cases and the Council then “had its findings fully endorsed by the Privy Council following an appeal” that the General Medical Council came of age.

³⁴ Merrison Committee of Inquiry into the Regulation of the Medical Profession; report and papers (1972–1975).

From 1963 (possibly earlier) until 1993 the General Medical Council published a document colloquially referred to as “The Blue Book” but published under four different titles over the thirty year period. The Blue Book described the roles and functions of the organisation and had information on disciplinary procedure and later iterations introduced the term “fitness to practise”. It was updated and re-published every year or two until 1993. The Blue Book preceded the Council’s first code of ethics, which was published in 1995 as *Good Medical Practice* (General Medical Council, 2017a).

Between 1963 and 2006 there was a significant change in focus of the content of the ethical advice published by the General Medical Council. An interesting analysis was completed in 2010 by Gill and Griffin who conducted a “tag cloud analysis” on the first Blue Book, *Functions, Procedures, and Disciplinary Jurisdiction* (1963), as well as a later version, *Professional Conduct and Discipline – Fitness to Practise* (1980), and the 1995 and 2006 editions of *Good Medical Practice*. The authors chose to analyse these particular texts because, in the 43 years between the earliest and latest texts, there had been significant changes to the practice of medicine and “one might expect to see changes in general position of doctors in society reflected in the guidance offered to them” (Gill & Griffin, 2010, p. 320).

Tag cloud analysis is a technology that creates a visual interpretation of the frequency of word use in a document and the authors, while recognising the limitations of this very objective type of analysis, could see the possibilities of using this approach as an “entry point into discussions” about the discourse of a text whilst minimising abstraction (Gill & Griffin, 2010, p. 321).

In the 1963 Blue Book the word “doctor” was the most frequently occurring word. The tag cloud analysis produced a word cloud that emphasised the words “disciplinary, register and council”, and to a lesser degree the words “convictions, improper and offence”, which the authors interpreted as reflecting the “judicial nature of the document” (Gill & Griffin, 2010, p. 318).

Analysis of the 1980 Blue Book revealed that the word “doctor” was still the most frequently used word, but also that the words “information” and “relationship” had become more prominent, and the use of the word “misconduct” instead of the legal terminologies used in

the 1963 document. The authors noted that the singular word “patient” was not used at all, but the plural form “patients” had a high usage, perhaps reflecting a shift in focus away from the individual doctor-patient relationship (Gill & Griffin, 2010, pp. 318–319).

In the 1995 edition of *Good Medical Practice* “doctor” does not appear at all. The dominance of the terms “practice”, “colleagues” and “team” were interpreted to mean that team-work was more usual and the frequent use of new terms including “care”, “treatment” and “providing” reflected a more service-orientated approach. The loss of “committee”, “council” and “disciplinary” was seen to indicate a move away from self-regulation.

In the 2006 edition of *Good Medical Practice* “patients” was the most frequently used word and the language of service-orientation was predominant, with frequent use of the terms “information”, “arrangements”, “providing” and “treatment”; decreased use of the term “professional” was evident.

Gill and Griffin’s interpretation is that the “more managerial tone” taken by the General Medical Council since 1995 has “replaced the language of professionalism”, a change which they acknowledge as being essential to the survival of any professional body in today’s environment. They consider that this change may even constitute the “re-professionalising” of medical practice (Gill & Griffin, 2010, pp. 320–321).

The discussion below comparing Percival’s code with *Good Medical Practice* (2013) takes a different approach but also reveals the nature and scale of the changes that have occurred in the evolution of codes of ethics for medical practitioners in the UK over the 210 years from 1803 to 2013.

Comparing *Medical Ethics* with *Good Medical Practice* (2013)

Medical Ethics and *Good Medical Practice* (2013) can be compared on a number of different levels. The discussion below focuses on context, structure, philosophy, content, expression and the process of development.

Contextual Comparison

Medical Ethics was drafted in 1792 in the middle of the Scottish Enlightenment when philosophical thought was undergoing a revolution. The influence of philosopher David Hume had led to the development of a modern theory of medical ethics by John Gregory, Professor of Practice and Physic at Edinburgh University (Baker, 1993, pp. 863–864). The publication of Gregory’s lectures in 1772 preceded the writing of *Medical Ethics* by 20 years. *Medical Ethics* was written in response to the destabilisation of local medical practice in an environment of disease and disputes.

In the late eighteenth century in England, society had become divided on the issue of reform in favour of democracy versus traditional British government and social arrangements supported by the loyalists (National Archives UK, n.d.).

In Manchester in particular, during a period of increasing industrialisation in the 1780s and 1790s, typhus epidemics were a growing problem.³⁵ Many people believed the cause to be the recently established spinning mill at Radcliffe, less than 10 kilometres from Manchester, and the public were increasingly concerned. Also at this time, there was a falling out between two of the most established and influential Manchester medical families and the management of the Manchester Infirmary.

As a result, two competing medical institutions came to exist in Manchester. One was the Manchester Infirmary, a voluntary charity hospital established in 1752 which was funded and managed by subscribers, and which in 1790 encouraged the expansion of staff to number six physicians and six surgeons (Pickstone, 1985, pp. 11–19). The other was the Manchester Maternity Hospital³⁶ founded in 1790 in protest at the expansion of staff at the Manchester Infirmary. The Manchester Maternity Hospital was run by two families, the Halls and the Whites, who, according to Pickstone and Butler (1984, p. 237), sought to protect their own interests by monopolising the medical management of pregnancy and childbirth cases in Manchester at the time.

³⁵ Typhus is a series of infectious diseases transmitted by a louse that can lead to death (Encyclopædia Britannica, 2006).

³⁶ The Manchester Maternity Hospital was also known as the ‘Manchester Lying-in Charity’ or the ‘Manchester Lying-in Hospital’ and later known as ‘St Mary’s Hospital’.

Disagreements between the institutions were aired publically in newspapers throughout 1790 (Pickstone, 1993, pp. 167–168). It was following this dispute in 1792 that the Trustees of the Infirmary asked Thomas Percival to draft guidance on professional behaviour to ensure that the arguments of 1790 would not be repeated. Percival's advice was later incorporated into the Infirmary rules (Pickstone & Butler, 1984, p. 242).

In the late eighteenth century caesarean deliveries were associated with high mortality rates and thus were controversial. In 1798 another dispute arose between the institutions, this time involving Dr John Hull, a surgeon who had moved to Manchester in 1796 and was associated with the Manchester Maternity Hospital recently established by Dr Charles White.³⁷ In 1798 Hull had performed two caesarean operations; in both cases the child had survived, but the mother had died. Hull became involved in a public war of words with Dr William Simmons, a senior Infirmary surgeon. Both Hull and Simmons released publications arguing their opposing perspectives on the merits of such an operation (Churchill, 1994, p. 17). The argument divided the Manchester medical profession into caesareanists, who were generally affiliated with the Manchester Maternity Hospital, and anti-caesareanists, who were generally affiliated with the Manchester Infirmary (The Lancet, 1935). This disunity was the context in which Percival finalised and published *Medical Ethics* in 1803.

The first edition of *Good Medical Practice* was published in 1995 by the General Medical Council (Royal College of General Practitioners/General Practitioners Committee, 2008). It was written in the context of “Consumerism ... Clinical guidelines and clinical audit”, combined with contemporary expectations of management, a high quality medical industry, and patient autonomy (Irvine, 2006, p. 207).

Good Medical Practice (2013) is the most recent version of the code of ethics for medical practitioners in the UK (General Medical Council, 2013a). It is produced by the General Medical Council—the independent regulator for doctors in the UK (General Medical Council, 2016a). *Good Medical Practice* (2013) is written for the 245,000 doctors on the UK medical register (General Medical Council, 2016c), and is published in two languages: English and Welsh.

³⁷ Charles White (1728–1813) helped establish the Manchester Public Infirmary (later the Manchester Royal Infirmary) in 1752, where he worked until 1790 (Wikipedia, 2016).

Since *Medical Ethics* was published the profession has grown substantially and contemporary codes of ethics are written for a more extensive and diverse audience of medical practitioners. As an indication of how the situation has changed, data from the UK in 2007 revealed the following:

Women were 42% of all the general practitioners (GPs) working in the NHS in England in 2007 (14,003 out of 33,364). Within the hospital and community health services (HCHS) women comprised 28% of all the 33,674 NHS consultants. (Elston, 2009, p. 3)

Projections based on these figures estimated that the percentage of women in the National Health Service medical workforce in England could reach 50 per cent by 2022 (Elston, 2009, p. 39).

To better describe the evolution of the British medical code of ethics, it is useful to examine the differences between *Medical Ethics* and *Good Medical Practice*. This is undertaken below by looking closely at the structural differences, the philosophical differences and the drafting approach differences between the two codes.

Structural Comparison

Percival's original papers, including the original version of the code, were lost during the bombing of Manchester in World War II (Baker, 1999). The first chapter of *Medical Ethics* is the closest available text to Percival's first version of the code. Percival confirms this in the Author's Preface:

The first chapter of the following work was composed in the spring of 1792, at the request of the Physicians and Surgeons of the Manchester Infirmary: and the substance of it constitutes the code of laws, by which the practice of that comprehensive institution is now governed. The Author was afterwards induced, by an earnest desire to promote the honour and advancement of his Profession, to enlarge the plan of his undertaking, and to frame a general system of Medical Ethics; that the official conduct and mutual intercourse of the Faculty might be regulated by precise and acknowledged principles of urbanity and rectitude. (Baker, 1999, p. 21)

Chapter 1, the original code for the Manchester Infirmary, was titled: *Of Professional Conduct, relative to Hospitals, or other Medical Charities*. While *Medical Ethics* was originally only one chapter long, another three chapters were later added, consisting of articles dealing with the conduct of the practitioner towards the patient in various environments in which doctors practised in

Manchester. The subsequent three chapters that were added were titled: Chapter 2: *Of Professional Conduct in Private or General Practice*, Chapter 3: *Of the Conduct of Physicians towards Apothecaries*, and Chapter 4: *Of Professional Duties in certain Cases which require a Knowledge of Law*. The four chapters were published together as *Medical Ethics* in 1803. *Medical Ethics* was the first of its kind—a stand-alone document in print with a limited number of copies.

With the publication of the 1803 edition of *Medical Ethics*, Percival had made distinctions between the various medical practitioners (i.e. physician, surgeon and apothecary) and between various types of patients. Such distinctions were uniquely appropriate to the British context, and reflect that the document was written for a very specific audience of local practitioners who were all sharing similar working conditions in terms of facilities and their patient base.

It is important to note that the context for which Percival wrote *Medical Ethics* was limited to an audience of his peer practitioners working in the Manchester Infirmary in the late eighteenth and early nineteenth century, whereas the current audience for *Good Medical Practice* (2013) is doctors registered with the General Medical Council (General Medical Council, 2013a, p. 4). For example, Percival's code was written at a time when only men were recognised as medical practitioners, and the language he uses reflects this, referring as he does to "Medical gentlemen" or "gentlemen of the Faculty" (Percival, 1849, pp. 31–32). Further, there are two articles in Chapter 1 where guidance is specific regarding considerations in the management of female patients which presume that the medical practitioner is not a female (Percival, 1849, p. 29 and p. 41).

The original code of ethics written by Percival in 1792 and titled *Medical Ethics* became Chapter 1 in the 1803 edition of *Medical Ethics*. This chapter contains 31 articles of 1 to 2 paragraphs each. When the additional three chapters were added the document became 92 articles long and had expanded in scope to include guidance for apothecaries. In terms of referencing other works, Percival refers only to Aikin's *Thoughts on Hospitals* in Chapter 1 at article 15.³⁸ No mention is made of other support materials. *Good Medical Practice* (2013), in comparison, references 22 other documents (General Medical Council, 2013a, pp. 25–26).

³⁸ This book, written in 1771, contains a letter written by Percival. The book discusses hospital architecture and the effect of the hospital environs on the patients, and the nature of the cases. He argues that hospitals should be primarily designed to cater for the surgical care of the wounded and the diseased (Aikin, 1771, p. 30).

Good Medical Practice (2013) is a series of 80 clauses and divided into parts called ‘domains’ (General Medical Council, 2013a). The first six clauses provide a framework regarding the relevance and interpretation of the document. Following this, four domains are identified:

- Domain 1: Knowledge, skills and performance – Clauses 7-21
- Domain 2: Safety and quality – Clauses 8-30
- Domain 3: Communication, partnership and teamwork – Clauses 31-52
- Domain 4: Maintaining trust – Clauses 53-80.

Good Medical Practice (2013) is the core code of ethics but it is supported by other documents and resources. The development of internet technology has allowed the General Medical Council to provide worldwide public electronic access to *Good Medical Practice* (2013) and its 22 references, 31 explanatory documents and other learning materials (General Medical Council, 2017c). The electronic format also allows timely updates such as the most recent addition on 29 April 2014.³⁹

Good Medical Practice (2013) includes references to explanatory guidance. A complete list of explanatory guidance is at the end of the booklet. All guidance is available on the website, along with:

- learning materials, including interactive case studies which show how the principles might apply in practice (General Medical Council, 2017b)
- cases heard by “fitness to practise” panels, which provide examples of where a failure to follow the guidance has put a doctor’s registration at risk (General Medical Council, 2017d).

This additional material shows us that the guidance on relevant matters has become specialised and what remains can be more condensed but not isolated from other guidance. It shows that the thinking of what is ethical guidance and what it refers to has become more developed.

³⁹ On 29 April 2014 the following paragraph was added at 14.1 “You must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK” (General Medical Council, 2013, p. 7).

As *Medical Ethics* was the first document of its kind, there was little scope for referral to other related or similar documents. In contrast, *Good Medical Practice* (2013) contains two pages of references which provide further guidance or information on concepts raised including consent, acting as a witness in legal proceedings and good practice in prescribing medicine (General Medical Council, 2013a, pp. 25–26), thus eliminating the need to include those issues in the primary document. Some of these types of issues were addressed by Percival (1849), with the addition of three chapters to *Medical Ethics* dealing with legal considerations and apothecaries.

Percival chose to detail particulars of situations rather than articulating higher level principles and advising the exercise of judgment, which is the style of *Good Medical Practice*. Accordingly, Percival adopted a relatively wordy style in his aphoristic presentation of the information. For example, if we look at how each document discusses professional conduct towards peers, we can see that Percival uses long-winded and emotive language. He also uses the term ‘should’ rather than ‘must’ and describes actions by the negative way they may be perceived, rather than by any positive intentions that may have inspired them.

Essentially, the medical code of ethics has maintained its structure as a document composed of clauses while an evolution has occurred in the philosophical approach, the refinement of the content—including the development of other related supporting documents which address particular issues in more detail—the style of expression and the method of drafting the code of ethics.

Philosophy Comparison

When *Medical Ethics* was drafted the dominant philosophical influence on medical thought at the time was the Humean sympathy of philosopher David Hume. His ideas had been transmitted to medical students through the lectures of Gregory and become well accepted through the years.

Baker (1993c) identifies that the shift in the philosophy of medical codes of ethics to the social contract occurred in the latter half of the 1700s. He bases this on an assessment of the

lectures of John Gregory published in 1772 as *Lectures on the Duties and Qualifications of a Physician*. Baker states:

Yet, as Gregory appreciated, any attempt to teach traditional virtue ethics, that is, teleological ethics, to an eighteenth-century scientific audience was problematic because the very ‘modernity’ of modern science lies in its presupposition of a mechanistic conception of causation – a conception incompatible with the idea of a *telos* (an aim or purpose). (Baker, 1993c, p. 861)

The evolution of the medical code of ethics from a philosophy of Humean sympathy into a form better reflecting the extant social contract is thought by Baker to be due in part to the adoption by the American Medical Association of Thomas Percival’s code of medical ethics coupled with the influence of political philosopher John Locke’s theory of natural law and natural rights (Baker, 1993c, p. 868). Baker notes that historically, medical practitioners in the UK had their privileges bestowed by Royal charters whereas the Americans were starting professional organisations without grants:

The very idea that organizations require governmental recognition affronted the Lockean heritage of Americans, who in the *Declaration of Independence*, *The Constitution* and the *Bill of Rights*, envision governmental powers not explicitly delegated to the government, as reserved to people themselves. These differences are reflected in most American codes, including the 1847 AMA code which, unlike Percival’s, takes the form of an explicit tripartite social contract directly between professionals, patients, and the public. (Baker, 1993a, p. 189)

The notion of rights has endured and expanded over time and characterises a fundamental shift in the concepts and language used in *Medical Ethics* compared to the modern code.

Good Medical Practice (2013)

No one philosophical theory of ethics captures the entirety of ideas expressed in *Good Medical Practice* (2013). There is a mixture of deontological, rights-based and virtue ethics throughout the document. The document strives to reflect the social contract between medical practitioners, their patients and colleagues in the UK and has a mixture of content theoretically supported by various models of ethical thought.

Duties of the doctor are expressed in terms of what “must” be done and include maintaining confidentiality (clauses 23, 69 and 73), supporting the patient to maintain their health (clause 2), referring patients appropriately in the event of a conscientious objection (clause 52), and not engaging in inappropriate relationships (clause 53) (General Medical Council, 2013a).

The modern code represents a blend of patients' rights and doctors' rights. Patient rights include the right to privacy (clauses 2 and 47), dignity (clauses 2, 25, 47 and 56) and confidentiality (clauses 23, 69 and 73), the right to seek a second opinion (clause 16) and the right to make joint decisions about treatments (clause 52). Doctors' rights include the right to not be abused by colleagues (clause 59), and the right to conscientious objection (clause 52) (General Medical Council, 2013a).

The striking difference between *Medical Ethics* and *Good Medical Practice* (2013) is the emergence of patients' rights in *Good Medical Practice* (2013) compared with the pervasive paternalism that is expressed in *Medical Ethics*. The priority afforded to patient autonomy and the recognition of the need for shared decision making better represents the modern social contract.

The virtues of honesty and integrity (clause 65) have somewhat more prominence in the modern code. By contrast, *Medical Ethics* justified deception of the patient under certain circumstances and presumed the integrity of the doctor.

Content Comparison

The 31 articles in the original *Medical Ethics* (i.e. Chapter 1 of the 1803 publication) were assessed to identify the core concept that they contain and then compared with the concepts contained in *Good Medical Practice* (2013). Table 9 in Appendix 2 is a fuller analysis of concepts contained in *Medical Ethics* compared to *Good Medical Practice* (2013).

It is important to note that the concepts that were included in *Medical Ethics* were sometimes more procedural in nature than ethical and yet *Good Medical Practice* (2013) replicates a number of these concepts.

Table 5 is a summary of the 30 concepts identified in the 31 articles of Chapter 1 of *Medical Ethics*. Eighteen have been retained in some form in *Good Medical Practice* (2013). Thirteen concepts have not been retained and of these at least three are the subject of guidance in an alternative document such as a clinical guideline or government published guideline.

Therefore more than half of the concepts in *Medical Ethics* remain relevant today, although the scope and expression of the concept may be somewhat altered.

Table 5 – Articles of *Medical Ethics* which have been retained in some form in *Good Medical Practice* (2013)

Article	Concept	Retained	In other guidance material
1	Maintaining professionalism	Yes	
2	Limiting the patient's choice of practitioner	No	
3	Attending to the psychological needs of the patient	Yes	
4	Not holding discussions in the presence of the patient	No	
5	Patient confidentiality and	Yes	Yes
	Improper relationships	Yes	
6	Restricting the access of the clergy to patients	No	
7	Providing legal advice regarding wills	No	
8	Prescribing of effective medicines	Yes	
9	Treating colleagues with respect	Yes	
10	Adhering to a complaints procedure	Yes	
11	Working within the limits of competence	Yes	
12	The development of new remedies via experimentation	No	
13	Continuing professional development	Yes	Yes
14	Maintaining records	Yes	
15	Triage	No	Yes
	Making the best use of resources	Yes	
16	Do no harm	Yes	
17	Facilitating truthful communication	Yes	
18	Working collaboratively with colleagues	Yes	
19–21	Arriving at an opinion	No	
22	Managing patient anxiety by concealing information	No	
23	Managing the number and type of people who attend the operating theatre	No	Yes
24	Prioritising Sunday worship	No	
25	Optional removal of blood marks for the management of patient anxiety	No	Yes
26	Not judging the lifestyle of patients	Yes	
27	Reforming sinners	No	
28	Working within the limits of competence	Yes (see Article 11)	
29	Monitoring and improving the quality of work	Yes	
30	Caring and advocating for vulnerable patients	Yes	Yes
31	Taking part in procedures to which one has an objection	No	

Good Medical Practice (2013) introduces 43 whole clauses and 4 partial clauses which contain new concepts. These can largely be divided into the following categories:

- Definitions
- Consent
- Infection control
- Communication
- Training/teaching
- Continuity of care
- Working in partnership with patients
- Insurance
- Research
- Advertising
- Legal or disciplinary proceedings
- Honesty in financial dealings.

Many of these issues were not considerations in Percival's time, and others have increased in importance. The changes in code content are reflective of changing societal expectations and the recognition that the patient is a stakeholder with a voice rather than an object of paternalism.

It is notable that in relation to the issues which have endured over time, a few of these are somewhat applicable to the business environment. Noting that medicine outside of public hospitals has long been practised in a small business environment and is now somewhat corporatised, this means that medical practice has needed to grapple with the same issues that businesses do.

The language used in expressing these concepts is often different in the business environment to that in the medical setting and this is an important consideration when reflecting the social contract—that is, that it uses the language of those it applies to and makes sense (Freeman & Harris, 2009, p. 688).

The concepts of being truthful, adhering to a complaints procedure, and monitoring and improving the quality of work are expressed in the medical code and are easily identified in a business code of ethics. For example, treating colleagues with respect and the concept of working collaboratively with colleagues in the medical code of ethics may be expressed in similar terms in business codes of ethics or otherwise it may be couched as avoiding workplace bullying and harassment, or acting in culturally sensitive ways.

However, there are other concepts which are communicated in the language of medicine which would be applicable in the business environment, but would have a very different focus. For example, the concept of maintaining proper records in medical practice is primarily focused on the patient treatment records whereas corporate codes of ethics are more likely to be focused on financial records or communication records.

There are other concepts that are expressed very differently but are still applicable in both business and medical codes of ethics. The concept of ‘do no harm’ in medicine applies to patients but in business applies to the ecological environment.

Style of Expression Comparison

Points to note when comparing the style of expression used in *Medical Ethics* to that used in *Good Medical Practice* (2013) include:

- the use of gender neutral language in *Good Medical Practice* (2013) compared with the assumption of maleness of the medical practitioner in *Medical Ethics*
- the use of ‘should’ in *Medical Ethics* compared with the use of ‘must’ in *Good Medical Practice* (2013)
- the overtly paternalistic style of the language used in *Medical Ethics* compared with the instructional style of language used in *Good Medical Practice* (2013)
- references in *Medical Ethics* to the poor, reminding practitioners that they should show compassion and understanding.

Note: ‘duty’ is used in *Medical Ethics*, but inferred in *Good Medical Practice* (2013) through the use of ‘should’ and ‘must’, as shown in Article 5:

In *Good medical practice*, we use the terms ‘you must’ and ‘you should’ in the following ways.

- ‘You must’ is used for an overriding duty or principle.
- ‘You should’ is used when we are providing an explanation of how you will meet the overriding duty.
- ‘You should’ is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance (General Medical Council, 2013a, p. 5).

Comparing the Process of Development

The difference in the methods used to draft *Medical Ethics* and *Good Medical Practice* (2013) is reflective of the evolution of the code of ethics for medical practitioners into a national document, advances in electronic communications, and shifting societal expectations.

In writing *Medical Ethics*, Percival drew upon regulations from other hospitals, *Lectures on the Duties and Qualifications of a Physician* by John Gregory, and *An Enquiry into the Duties of Men in the Higher and Middle Classes of Society in Great Britain Resulting from Their Respective Stations, Professions and Employment* by Reverend Thomas Gisborne (Baker, 1993, p. 865). The first draft of the code (*Medical Jurisprudence*) was circulated to 25 people for comment (15 physicians, four barristers/lawyers, three clergymen/theologians and three laypeople). Percival took their comments into account, including the suggestion to change the title of the document, before publishing the revised work in 1792 as *Medical Ethics* (Baker, 1993, p. 180).

In stark contrast, *Good Medical Practice* (2013) was developed from a public consultation process which sought to review the 2006 version of the document. The initial consultation received input from 68 organisations and 2029 individuals. The 2006 guidance was then analysed and incorporated before a revised draft was used as the basis for a formal consultation (General Medical Council, 2016b).

Summary

The profession of medicine in the UK was the first to adopt and retain a code of ethics and therefore has the most evolved code. This chapter has provided a systematic comparison between the first medical code of ethics in the UK and the most recent version in terms of

context, structure, philosophy, content and expression. This comparison reveals the change in priorities over time. It also reveals that elements of *Medical Ethics* have endured and can be recognised in *Good Medical Practice* (2013). The persistence of thought on ethical practice is reflected by approximately half of the concepts expressed in *Medical Ethics* being retained in the modern code of ethics.

Conclusion

The process of developing new codes has become broader and more sophisticated and has adapted to better represent the social contract. This is evidenced by the inherent recognition that patients are stakeholders with a voice in the articulation of patient's rights.

The consultative approach taken by Percival in the development of *Medical Ethics* was the pioneering effort compared to the public consultation process undertaken for *Good Medical Practice* (2013), but the sentiment to gain the input of stakeholders is unmistakable. The oversight of not including patients as stakeholders may be due to the pervasive paternalism, the absence of patient lobby groups, or the fact that *Medical Ethics* was written with the intent to reflect a social contract that was primarily between doctors themselves with the aim of eliminating the disputes that were disrupting the practice of medicine at the time.

PART 3 – Discussion and Conclusion

The final part of the thesis seeks to address some of the gaps which are detectable in the research literature. Specifically it identifies the lack of discussion on development approaches, and provides a framework to begin this conversation. This part of the thesis also explores whether codes of ethics are ethical, how this determination might be made and suggests constructive approaches to creating an ethical code. This part also contains the conclusion.

Chapter 6: Development Approaches to Codes of Ethics

Introduction

A central premise of this thesis is that in an era when codes of ethics have become a mainstream feature of so many organisations, there is considerable opportunity for enquiry into the way codes are produced, and the contextual considerations which shape the way codes are written in order to inform the way they might be developed in the future. However, investigations into the methods by which codes of ethics are developed are scant (Messikomer & Circa, 2010, pp. 55–58). Only a small number of studies could be identified that discuss or examine the development approaches used in the creation of codes of ethics (Messikomer & Circa, 2010; Romani & Szkudlarek, 2014, p. 176; Schwartz, 2004). Consequently, there is a lack of evidence relating any particular code development processes to code usability and there is a gap in the knowledge of this aspect of codes of ethics.

No studies or commentaries could be found that suggest a classification system which identifies codes of ethics according to the approach taken to develop them, although some commentators refer to various approaches in an *ad hoc* fashion; for example, see McDonald's reference to the "off-the-peg approach" (McDonald, 2009, p. 347) or Webley and Werner's reference to codes of ethics development approaches as: "company specific", "obtained from textbooks", and "adapted from that of another business", also noting that "companies might 'outsource' their ethics by asking consultants to provide a code of ethics" (Webley & Werner, 2008, p. 407). A classification system would be a useful first step in beginning the conversation on the various approaches in use and critiquing their relative merits. This chapter makes an original contribution by proposing a framework to approach and discuss the development of codes of ethics.

This chapter will explore some of the methods currently being employed for the development of organisational codes of ethics and some of the challenges that contemporary organisations face. It will then present an original framework to facilitate further discussion and research in the following sequence: firstly, I will propose that there are, broadly speaking, three different approaches which can be taken by organisations when developing a code of ethics; secondly, I will discuss the pros and cons of the alternative approaches in order to bring to light possibilities for improving approaches to code development methods in

different contexts; thirdly, I will discuss the relationship between organisational culture and the ethical environment.

It is possible that the approach taken to develop a code of ethics may have a significant bearing on the success of the final product. Indeed, commentators examining codes from different aspects have intuitively attributed perceived strengths or shortcomings in some codes with the development process undertaken in the creation of those codes (Bowden & Surma, 2003, p. 23; Kaptein & Wempe, 1998, pp. 857–858). For example, Robert Baker attributes the “extraordinary influence” of Percival’s *Medical Ethics* to syncretism. Percival had drawn on regulations from other hospitals, John Gregory’s *Lectures*, and *An Enquiry into the Duties of Men in the Professions* by Reverend Thomas Gisborne. He had also consulted with lawyers and clergymen before it was finalised. Baker states:

Medical Ethics is thus an essentially syncretic work, which capitalized on practical experience as well as legal, medical, philosophical, and theological reflection, synthesizing them in one grand but concise amalgam. (Baker, 1993c, p. 865)

However, other organisations have codes of ethics which have been developed through a different approach than that taken by Percival. Many of these organisations also have a less tailored and less proven ethics code heritage to draw on than was even available to Percival. Some are complying with a legal obligation to acquire a code of ethics and some operate in an environment where technological developments are rapid and/or there is an increasingly globalised context. These factors can present challenges for drafting codes of ethics suitable to the operating environment.

Without first identifying the various development approaches, it is difficult to begin the conversation about the influence of the code development process on the final product. Because no existing categorisation of the different approaches to code development could be found in the literature, I have provided a framework for categorising the different approaches to the writing of either a new code of ethics or the revision of an existing code in order to begin this discussion:⁴⁰

1. The bespoke approach
2. The template approach

⁴⁰ As mentioned above, Webley and Werner (2008) mentioned that codes could be “company specific”, “obtained from textbooks”, and “adapted from that of another business”; also that “companies might ‘outsource’ their ethics by asking consultants to provide a code of ethics” (Webley & Werner, 2008, p. 407). These groupings are similar to the approaches I have proposed.

3. The modeled approach.

There are undoubtedly cases where the argument could be made that a particular code is a hybrid of two or more approaches (e.g. where a template approach has been subject to input from all stakeholders). However, at this stage there seems no imperative to postulate all the remote possibilities. Only if further studies were to ascertain that hybrid approaches were commonly used would this provide evidence of the need for further categorisations.

These approaches have been identified through empirical analysis of the following information sources:

- actual processes promulgated by organisations that have produced codes
- advice or information offered by organisations with an interest in assisting the production of codes
- studies comparing codes.

In my description and discussion of these approaches below I draw no conclusions regarding which approach will produce the most effective code of ethics because there is insufficient evidence to support such conclusions, although unsubstantiated opinions on the relationships are more readily available. Each approach has some potential merit and potential disadvantage but it will not be until further study of the effects of different development approaches has been undertaken that any causal relationships can be identified.

Developing Codes of Ethics – Three Approaches

Below are descriptions of three possible approaches to code development that have been identified. These classifications are deliberately described at a high level to facilitate any future research on development approaches. The development of more detailed sub-categorisations, or further high-level classifications, is an area that would benefit from further research.

The Bespoke Approach

The bespoke approach is undertaken specifically by expert(s) who have knowledge of that organisation, who have consulted with all relevant stakeholders, and who have given due consideration to their various perspectives. Business organisations taking this approach may

use different language choices to express the approach, possibly referring to such a document as a co-designed policy. The code produced is structured in a tailored manner exclusive to the context of that specific organisation. One of the challenges inherent in producing a bespoke code of ethics is the correct identification and inclusion of all the relevant stakeholders.

An example of a code developed by the bespoke approach is Percival's *Medical Ethics*, which was written in 1803 for members of the medical faculty following a consultation process, with input from lawyers and clergymen (see *Chapter 4: Historical Development of Codes of Ethics*) (Baker, 1993b, p. 141).

Notably, Percival did not consult with patients on the code he drafted. This omission may be due to the dominant philosophical thought of the day of Humean Sympathy⁴¹, based on the writings of philosopher David Hume and taught to medical students of the day. In 2012, Bourke, in her interrogation of the changing definitions of clinical sympathy described the situation. According to Bourke (2012, p. 442), a key factor in explaining fundamental changes in “the theatre of clinical sympathy” relates to the “perceived value of affect in the healing process”. She argues that before the technological advancements in biological medicine around the turn of the nineteenth and early twentieth centuries, sympathy was significant not only because it reflected “gentlemanliness and professionalism”, but because: “the alleviation of pain itself depended upon a physician convincingly acting out his sympathy. In other words, prior to the development of effective drug regimes, the profound influence of the mind over the body was central to the alleviation of pain.” As Bourke points out, John Gregory, who lectured to medical students at the time, referred to this idea in his *Lectures on the Duties and Qualifications of a Physician*, written in 1772 (Bourke, 2012, p. 442).

Accordingly, it is unlikely that it would have occurred to any of the doctors of the day, or to those from other professions who were asked to review the draft, to view the patient as a stakeholder whose views needed to be taken into account.

⁴¹ Hume describes sympathy in this way:

No quality of human nature is more remarkable, both in itself and in its consequences, than that propensity we have to sympathize with others, and to receive by communication their inclinations and sentiments, however different from, or even contrary to our own (Hume, 1896, p. 218).

The bespoke approach is still preferred by the medical profession in the UK and each iteration draws on the previous code as well as input from a diverse range of stakeholders, including the public. Recognition of patient autonomy is a more recent phenomenon and has become integrated into the modern code and its development process (General Medical Council, 2016b).

This method of developing a code structure by the bespoke approach is likely to require a drafting phase, at least one consultation phase, and analysis of consultation feedback before finalisation of the code. Therefore, the potential disadvantages of this approach may include that it requires a longer time to complete than some of the other approaches, or that it consumes proportionately more of the organisation's resources. However, it is possible to create a bespoke code through a relatively modest approach, and Percival's original code is one example of this.

The bespoke approach is considered by some commentators to be superior to the other code development approaches (Kaptein & Wempe, 1998; Messikomer & Cirka, 2010; Webley & Werner, 2008). In pursuing and incorporating a range of stakeholder perspectives, this is potentially a more inclusive and thorough approach than some other code development options. Participation of organisation members has been assumed by some commentators to generate a sense of ownership and support among code users who have been involved in the development process. For example, Romani and Szkudlarek (2014, p. 176) observe that "employee involvement in the code development process progressively emerged as one of the conditions for the creation of a code of ethics enacted in the organization". Similarly, Webley and Werner (2008, p. 410) state: "It is axiomatic that employees be consulted on the ethical issues they encounter in day-to-day business so that the code can address these and so make it meaningful and relevant." Snell and Herndon (2004, p. 84) hypothesise that genuine consultation with employees leads to a code that is perceived as more relevant by those employees, and Schwartz (2002, p. 32) explains that companies have a moral obligation to involve employees in the development of a code of ethics "if they are to live up to the universal moral standards of respect and fairness".

For Messikomer and Cirka (2010) the reason for supporting this conviction is that full participation of members of an organisation is required in order to ensure consideration of as many issues as possible. Otherwise, they argue, the final product will be "less useful as a

guide for behaviour” and may be viewed as “irrelevant to their own experience” by employees (Messikomer and Cirka, 2010, p. 59).

However, the participation of organisation members in the code development process may not necessarily enhance the level of active support (otherwise referred to as “buy-in”) of organisation members. In a study involving 57 interviews of employees, managers and ethics officers at four large Canadian companies in 2004, Schwartz (2004, p. 332) found that only one-third of respondents felt that it was “important to know that employees were involved in the creation or revision of the code”. Most of these respondents also felt that while their “participation in the creation of the code would not necessarily increase buy-in for the code”, it would “increase the chances that the code's content would be relevant and realistic”. Schwartz observes that “this finding seems to contradict the literature discussing the necessity of employee involvement in the code creation process in relation to enhancing code ‘buy-in’, at least for the majority of respondents”.

In the light of Schwartz’s observations, the bespoke approach may be indicated where an existing code is being revised because of feedback from code users that it contains irrelevant or unrealistic guidance. However, further research is required before this is established. In essence though, if stakeholders perceive the guidance as irrelevant or unrealistic, this is just another way of saying that the code fails to reflect the social contract.

The inclusion of stakeholders other than managers and employees in the development of a code of ethics is less discussed in the research literature. Schwartz (2002, pp. 32–33) argues that stakeholder inclusion can be supported on the basis that there may be impacts on them, but it should be limited because they are “not obligated to comply with the provisions which the company sets out in its code”. Yet even though some stakeholders are not required to comply with the code, the emphasis of the social contract could be significantly shifted by an incorporation of the issues that particularly concern them. For example, a business that establishes an operation in a community where sensitivities are particularly high in relation to the safety of the products produced, preservation of the ecology or noise pollution could incorporate consideration of these priorities into the code and thus more accurately reflect the social contract for that community. Therefore, an organisation will have stakeholders who are affected by what is included in the code of ethics, and stakeholders who are affected

by what is excluded from the code of ethics. (This concept is discussed in relation to the ICKA code of ethics in *Chapter 7: The Ethics of Codes of Ethics*).

It must be acknowledged that broadening the list of stakeholders who could have input into a code of ethics presents potential management challenges, which may include such issues as misidentification of relevant stakeholders, irrelevant or misguided input from stakeholders, undue influence on the consultation from well-resourced stakeholders, discovering diametrically opposed views from different stakeholders, elevated expectations of stakeholders to influence the outcome, and an inability to consult with relevant stakeholders e.g. future generations. Issues such as these could be minimized through reasonable expectation-setting, clear communication and a well-managed consultation process. Regular review of the code of ethics is the mechanism that allows for corrections to be made if a significant issue is discovered to have been wrongly included, poorly expressed or overlooked.

The bespoke approach appears to be the instinctively preferred approach by some organisations. For example, the UK Institute of Business Ethics, a registered charity which promotes business ethics, advises a bespoke approach and outlines a nine-step process which includes the suggestion of holding focus groups with stakeholders and employees (Institute of Business Ethics, 2012). The superiority or otherwise of this approach has not been established by empirical research at this stage, although the more ethical nature of this approach has been established.

The Template Approach

The template approach is where the creation or structure of the code is based on guidance provided in a template such as a step-by-step guide to a process, or a document template. An example is the advice of the US Ethics and Compliance Initiative, an online resource for the ethics and compliance profession, which recommends a code outline that includes seven parts:

1. Memorable Title
2. Leadership Letter
3. Table of Contents
4. Introduction-Prologue
5. Core Values of Organization
6. Code Provisions-Substantive Matters

7. Information and Resources (Ethics & Compliance Initiative, 2016)

A more specific example from the US is the 2005 article by Boudreaux and Steiner aimed at electric cooperatives⁴². The authors, while admitting that there is not a one-size-fits-all solution, recommend the following eleven sections be included in a code of ethics:

1. Cover page and statement of values
2. Introduction and explanation of the purpose of the Code of Ethics
3. General corporate and personal standards of conduct
4. Conflicts of interest
5. Confidentiality of information
6. Member communications
7. Financial practices and record keeping
8. Legal and regulatory compliance
9. Reporting of violations
10. Employees and director education
11. Monitoring and enforcement (Boudreaux & Steiner, 2005, p. 5)

The authors then provide a sample of what such a code would look like in Attachment B of their paper. This article was generated in response to increased interest in the compliance requirements of the revised US Sentencing Guidelines and the Sarbanes-Oxley Act of 2002, which requires disclosure regarding the adoption of a code of ethics for senior financial officers.⁴³

The template approach to code development may be the most attractive option for some organisations, particularly in situations where the code is being written for compliance purposes and must conform to legal requirements; where those drafting the code have no

⁴² In the mid-1930s, 90 per cent of rural homes in the US were without electric service. In 1935, the Rural Electrification Administration (REA) was established and a lending program to provide electricity services to rural areas was initiated. However, it was farmer-based cooperatives that utilised the scheme rather than power companies. Today, approximately 99 per cent of farms in the US have electricity. The majority of these are locally owned rural electric cooperatives providing services on a not-for-profit basis. REA is now known as the Rural Utilities Service (RUS) and is part of the US Department of Agriculture (America's Electric Cooperatives, 2017).

⁴³ SEC. 406. CODE OF ETHICS FOR SENIOR FINANCIAL OFFICERS.

(a) CODE OF ETHICS DISCLOSURE.—The Commission shall issue rules to require each issuer, together with periodic reports required pursuant to section 13(a) or 15(d) of the Securities Exchange Act of 1934, to disclose whether or not, and if not, the reason therefor, such issuer has adopted a code of ethics for senior financial officers, applicable to its principal financial officer and comptroller or principal accounting officer, or persons performing similar functions.

(b) CHANGES IN CODES OF ETHICS.—The Commission shall revise its regulations concerning matters requiring prompt disclosure on Form 8-K (or any successor thereto) to require the immediate disclosure, by means of the filing of such form, dissemination by the Internet or by other electronic means, by any issuer of any change in or waiver of the code of ethics for senior financial officers.

(c) DEFINITION.—In this section, the term “code of ethics” means such standards as are reasonably necessary to promote— (1) honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships; (2) full, fair, accurate, timely, and understandable disclosure in the periodic reports required to be filed by the issuer; and (3) compliance with applicable governmental rules and regulations.

experience in writing such guidance; where the organisation is small with very limited resources; or for satellite organisations under the guidance of their parent organisation requiring a harmonised approach. However, this approach is potentially limited by the availability of a template that fits well with the context of the organisation at hand.

In cases where a template approach is employed there is nothing to prevent consultation with stakeholders, but there are inherent limitations and risks in following a rigid structure that may impact on the incorporation of stakeholder input. For example, if it is necessary for compliance purposes to incorporate a leadership letter, but the stakeholders object to this on the basis that such an inclusion is authoritative or alienating, then the wishes of the stakeholders may be overlooked in order to achieve the necessary requirements for compliance.

However, there are circumstances where the template approach may also be used to build on an established and proven approach. Where an existing code is being revised and amended due to shifting circumstances such as stakeholder feedback, technological innovation or new legislation/legal precedent requiring minor amendment to an existing code, then the organisation is effectively using a template approach where the template is a previous iteration of their own code.

The Modeled Approach

The modeled approach is where an organisation adopts an established code, or sections of a code, from model codes or from the codes of similar organisations. For example, in their 2003 examination of the codes of ethics from seven Australian universities, including the University of New South Wales (UNSW), Murdoch University (MU) and the University of Western Australia (UWA), Bowden and Surma (2003, p. 23) observe: “Each of the UNSW’s, MU’s and UWA’s codes contain whole paragraphs that duplicate others verbatim”.

In the cases examined by Bowden and Surma (2003) some of the universities had used the modeled approach. The modeled approach implies that organisations that are alike will have the same issues to contend with and are prepared to adopt the same approach as similar organisations on particular points. This assumes that the wording used by other organisations has successfully identified and articulated an issue that is relevant to stakeholders.

While such modeling may also be interpreted as adopting a ‘united front’ or ‘best practice’ approach, some risk remains that it may also imply that input from stakeholders has not been sought or has not been incorporated, that the production of the code has been rushed, or that specific contextual differences between organisations have not been considered. Indeed, Bowden and Surma (2003,) in their critique of this approach, articulate their concern about what may be overlooked:

The borrowing from or duplication of other texts to write a code of ethics for an individual institution seems to deny the pivotal function of texts as contextually significant, embroiled in a network of unique social and interpersonal practices and values. Some overlap in codes might be expected given the similarities in institutional function, but wholesale borrowing in this way suggests a lack of connection with the organizational-specific ethos. (Bowden & Surma, 2003, pp. 23–24)

As is the case with the template approach, using the modeled approach does not prevent consultation with stakeholders, but the final product is less likely to be a verbatim copy of the original model if there has been incorporation of stakeholder input.

McDonald (2009) observed that the modeled approach (which she calls the “off-the-peg approach”) was declining in popularity:

From the initial off-the-peg approach, where companies significantly plagiarised their codes from other organisations, greater effort is being made to write codes for the needs of a specific organisation. (McDonald, 2009, p. 347)

This observation by McDonald provides further secondary evidence of the practice of organisations using the modeled approach. McDonald’s historical review reveals a trend towards more tailored codes of ethics, with greater outward focus that addresses broader themes that concern external stakeholders, such as the environment (McDonald, 2009, pp. 347–348). The declining usage of the modeled approach may reflect its limitations in this regard.

Factors which Impact on the Choice of a Code Development Approach

As mentioned previously, there is insufficient evidence in the literature to determine whether one method of code development is superior to any other for a given circumstance. The

method which is used to develop a code will then, in the end, undoubtedly be informed by pragmatic considerations including, but not limited to the following:

The Impetus to Develop a Code

An organisation may move to generate a code of ethics for diverse reasons⁴⁴; however, they can be broken down into two types: voluntary or compulsory. Voluntary motivations include the explicit articulation of values already in the culture of an organisation for the benefit of stakeholders; the enunciation of a direction for cultural change within an organisation; and the production of a code for image or reputation management. Compulsory motivations include generation of a code for legal or administrative compliance. The impetus for the development of a code may affect whether a code must be generated within a particular timeline, and who its audience will be. The impetus driving the creation of a code is also thought to affect the code content and tone (Webley & Werner, 2008, p. 407).

The Resources Available

Organisations are differently resourced and some will be able and willing to invest more heavily in the code creation process than others. Very small organisations may not have the manpower, funding or expertise to develop a code of ethics and may opt for a template or modeled approach rather than a bespoke approach in the absence of any real choice.

The Timetable for Development

Timelines may be imposed for legal, contractual or administrative reasons, which in turn will become a consideration regarding which of the approach options can be achieved in the time available.

Whether Internally Developed or Outsourced

The decision to outsource code development to an external consultant may include consideration of whether any of the organisation members has the requisite availability, experience or background to produce the code in-house rather than to engage an external

⁴⁴ Bondy et al. (2006) identify four different groups of motivations for code adoption: stakeholder regulation, stakeholder communication, competitive advantage and mitigation of risks and/or threats.

consultant. It is possible that an organisation will outsource code development as a preferred option rather than as a necessity, especially in cases where members of the organisation are known to be equal to the task, but it is not deemed an efficient use of their time.

The Code Author

Organisations today may have the option of having their code of ethics authored in-house or enlisting assistance from persons external to the organisation to draft a code of ethics. Depending on the resources available to the organisation or the impetus for the production of a code, an organisation may choose to engage someone with knowledge of a specific discipline, such as philosophy or law, that is not available within the organisation. Alternatively, someone who has experience in drafting codes of ethics or who has the appropriate cultural or administrative insight may be desired in other instances.

Examples of organisations which provide consulting services for writing codes of ethics include The Institute for Business Ethics in the United Kingdom⁴⁵, The Josephson Institute in the United States⁴⁶, and The Institute for Global Ethics in the United States.⁴⁷

The practice of engaging expertise from outside the organisation to produce a code of ethics raises concerns about the limitations of the resultant document. Webley and Werner (2008, p. 407) explain that codes of ethics were being produced to comply with legislation such as the Sarbanes-Oxley Act 2002 and that because of this “many codes are drawn up by lawyers focusing on a particular set of issues listed in legislation”. They state that this approach risks “missing a number of other ethical issues on which those working for the organisation would appreciate guidance”. It would seem though, that the issue raised by Webley and Werner has more to do with the process of seeking and responding to stakeholder input than with who is the author of the code.

An organisation may opt for an external consultant when there is no organisation member who is suitable or available to develop the code. Conceivably, this approach may be necessary

⁴⁵ <http://www.ibe.org.uk/advice/50> [Accessed 1 October 2014]

⁴⁶ <http://josephsoninstitute.org/business/blog/2010/12/ten-steps-to-designing-a-comprehensive-ethics-program/> [Accessed 29 July 2014]

⁴⁷ <http://www.globalethics.org/What-We-Do/Consulting.aspx> [Accessed 1 October 2014]

if an organisation is operating in unfamiliar or complex environments. One example of this may be during the multinational expansion of an organization, where the new involvement of foreign laws or different cultural environments requires expertise unavailable from within the organisation.

Research which investigates the impact of code authorship on code acceptance or effectiveness is, again, difficult to find. While the issue of authorship may raise particular concerns and generate very strong opinions, an empirical basis in support of such opinions has not been established.

One issue raised when considering code authorship is the language and tone used in the code (sometimes referred to as the voice of the code). This aspect in the development of codes of ethics is frequently mentioned in the research literature and thus can be understood to be very important to code users.

Messaging Choices

Researchers and commentators will often loosely classify codes using terms such as prescriptive or aspirational (inspirational is another term sometimes used to describe aspirational codes). When this occurs the author is usually describing one of the messaging choices of codes of ethics. The prescriptive code is a set of rules or statements that restrict certain behaviours with the intent of producing particular outcomes. In contrast, the aspirational code is a more lofty expression of idealised values or behaviours. Often the aspirational code does not provide detail on the practical application of the values in context (Farrell & Cobbin, 2000, p. 181).

A prescriptive code allows less interpretation than an aspirational type of code, and the amount of opportunity that remains for interpretation is an issue identified in the research. One of the “dilemmas” that Kaptein and Wempe (1998) identify is finding a balance between requirements for conformity with the policies of the organisation while allowing for individual opinions and responsibility. They note that the view of stakeholders outside an organisation is likely to be “fragmented” if the actions of individuals acting for the organisation do not seem cohesive. They also assert that “too much emphasis on unity rewards conformism and ultimately leads to an inflexible organization which is not open to

internal or external criticism” (Kaptein and Wempe, 1998, p. 858). The notion that Kaptein and Wempe are describing here is reminiscent of Donaldson and Dunfee’s concept of “moral free space” (Donaldson & Dunfee, 1999, p. 55) (see *Chapter 2: Studies of Codes of Ethics*).

According to Bowden and Surma (2003, p. 23), such authoritative voices “smother” rather than “endorse”, “seeming to impose a pressure on code users, in particular, to act from the place of the other, to *mimic* a behavior ... A behaviour that actually belongs (perhaps exclusively) to someone else, some other interest, other motives, other moral purposes”.

The voice used in a code of ethics is often a point of interest for commentators. Kaptein and Wempe (1998), for example, explain that the formulation of the principles of a code of ethics can be negative—expressed in terms of what not to do; or positive—expressed in terms of what to do. They outline that both approaches have drawbacks, namely that negative formulations can be interpreted as threatening and failing to provide guidance about what to do instead, while it is difficult to verify that a positive formulation has been abided by (Kaptein and Wempe, 1998, p. 858). This latter point is important as it identifies one of the major difficulties in observing or measuring actual compliance with a code.

In Schwartz’s (2004) qualitative study, the tone of the code was one of the factors investigated. Schwartz observed that a number of commentators had decided without evidence that codes were “too negative in tone, a series of ‘thou shalt nots’”, and viewed such codes as “more of a controlling, top down instrument” which may be “less effective in influencing behavior in a positive fashion”. To test the validity of these assertions, Schwartz asked the research participants if they believed their codes were “too negative in tone”. He found that, in fact, most employees believed that their codes “should be negative in tone”. Accordingly, Schwartz observed that “this finding appears to contradict what one tends to find in the literature on codes. Respondents expected their codes to be negative in order to be effective, in other words, to have the ability to clearly identify what behavior is expected or prohibited” (Schwartz, 2004, p. 329).

Culture and Codes

The terms ‘organisational culture’ and ‘organisational ethical culture’ are often used in discussions regarding the impact codes of ethics may have on organisations. In 1999 Key provided the following articulation of what these two terms mean:

Organizational ethical culture is a specific dimension of organizational culture that describes organizational ethics and predicts organizational ethical behaviour. To date, no research has definitively demonstrated that an identifiable ethical culture exists and that it can be measured. (Key, 1999, pp. 217–225)

The expectation that a code of ethics alone has some capacity to alter the organisational ethical culture is evidenced tacitly in analyses of high profile ethical lapses where a failure to follow a code is seen as failure of that code to influence organisational ethical culture. In 2008 Webley and Werner pointed out that the ethical failures of Enron, Shell, BP and Cadbury Schweppes all exemplified companies that had explicit ethics policies but unethical behaviour (Webley & Werner, 2008, pp. 406–407).

However, the underlying assumptions made in such analyses are increasingly challenged by current research. For example, in 2010 Messikomer and Cirka summed up the current direction of thought, that a system of measures is required, with the following statement:

A written code of ethics, no matter how carefully designed and constructed, is only one component of an organization’s ethics program, and its presence is not sufficient to prevent unethical behavior – as experience, unfortunately, has borne out time and time again. (Messikomer & Cirka, 2010, p. 55)

Similarly in 2013 Schwartz hypothesised that the following three key elements are needed in business to build ethical culture to minimise illegal activities:

1. A set of *core ethical values* infused throughout the organisation in its policies, processes, and practices;
2. A formal *ethics program*, including a code of ethics, ethics training, an ethics hotline, and an ethics officer; and
3. The continuous presence of *ethical leadership* (i.e., an appropriate tone at the top as reflected by the board of directors, senior executives, and managers). (Schwartz, 2013, p. 41)

However, whether codes of ethics reflect organisational culture, or shape it, or do both, is one aspect of codes that is often examined in the research. For example, Romani and

Szkudlarek (2014, pp. 173–191) contend that an ethical identity may well exist prior to the “ethicalization” process.⁴⁸

In 2011 Romani and Szkudlarek embarked on a qualitative investigation of an emerging professional group of interculturalists.⁴⁹ The interculturalists had no code of ethics at the time of the study, yet were found to demonstrate a professional ethical identity in collective conversations. Romani and Szkudlarek (2014, p. 174) argue that this ethical identity can influence the development of a code of ethics and that the “relationship between code of ethics and ethical identity can be more reciprocal than currently argued in the literature”.

It would appear that what Romani and Szudlarek (2014) are actually observing is evidence of the extant social contract being reflected in the code of ethics—a concept which is discussed in detail in *Chapter 1: Codes of Ethics – Social Contracts*.

Developing Effective and Ethical Codes

Developing a code of ethics clearly entails a number of considerations. Whether the resultant code is effective though, depends on how effectiveness is understood and measured. Webley and Werner (2008), for example, presume that the effectiveness of a code is related to the production of a broad, values-based code that speaks to organisation members at all levels.

Firstly, Webley & Werner (2008, p. 406–407) propose that a code should address a broad range of issues, including “wider obligations or commitments to all of the organisation’s stakeholders”, rather than being limited to a “narrow set of issues such as conflicts of interest, gifts and hospitality and use of company assets”. Secondly, they link the effectiveness of the code to whether the code is “values-based and providing guidance on how to handle ethical dilemmas”, or a “set of rules that the employees are expected to follow (‘do it or else’)”. Thirdly, they point out that a code might only focus on the behaviour of employees and remain silent on the behaviour of directors, and “thus exclude the most important decision makers in the organisation” (Webley & Werner, 2008, p. 407).

⁴⁸ Ethicalisation is defined as “a process with some forms of argued linearity, especially regarding the necessity to have ethical business policies to create an organisational ethical identity” (Romani & Szkudlarek, 2014, p. 174).

⁴⁹ Romani and Szkudlarek identify interculturalists as “trainers, consultants, teachers, or other professionals working with a theme of cultural differences or cultural diversity”. The study looked at members of the Society for Intercultural Education Training and Research (Romani & Szkudlarek, 2014, p. 174).

The presumption that the articulation of ethical values is essential to the effectiveness of a code of ethics overlooks the possibility that the organisation may have had another impetus to create the code, such as legal or administrative compliance. If the code is created for compliance purposes and its existence satisfies the extant legal or administrative requirement, then by that measure it is, logically speaking, an effective code of ethics. To not relate the impetus for the design of a code to the measurement of its effectiveness is inherently inconsistent, yet this is not uncommon in studies of codes of ethics.

It is often a presumption that the impetus for developing a code is to articulate ethical values or change the behaviour of individuals. Codes rarely state the impetus explicitly and this omission allows for such presumptions to be made. Although it may seem exceptionally reasonable to expect that a code of ethics will be about ethical values—and therefore its adequacy could be measured in relation to such values—in reality, this measure is only useful in cases where the impetus for development is to express the ethical values of the organisation. When this is not the case, any analysis regarding effectiveness will be prone to a negative finding.

Schwartz (2005) makes a similar point regarding the narrowness of the development approach:

A corporate code of ethics that is based merely on the desired moral values of the individual CEO, the legal department, or even an ethics consultant, is arguably a relativistic document that merely suits the objectives of the author. While such a code may serve certain purposes, such as leading to certain desired behavior on the part of the employees or the organization, the code might not be sufficiently ethically grounded, and remains susceptible to ethical critique. (Schwartz, 2005, p. 30)

Taking this logic one step further, it is also questionable to presume that codes of ethics will either reflect or impact on organisational culture if they are not specifically designed with this effect in mind. However, commentators on this topic generally appear to be uncomfortable with the idea that codes may be developed for a reason other than to reflect or shape organisational ethical culture.

It is also probable that organisations may not wish to reveal their actual motives for code development; as such revelations would, in some cases, debunk any illusions of appearing to be interested in ethical matters when this is not actually the primary concern. For example,

Messikomer and Cirka (2010) acknowledge that organisations produce codes of ethics for the “wrong” reasons. Citing examples such as Enron and World Com, they articulate their reasoning regarding why an “ethically valid” code development process is preferable:

Considering only code content, in effect, divorces the code from the process that led to its formulation, and thus from the organization, its members and the stakeholders it is intended to serve. We assert that while content is certainly important, unless its developmental process is values-based, participative, and led by ethical managers, it is much less likely to be effective. In addition, an ethically valid process contributes to organizational culture building where people have an awareness of values, implicit values are made explicit, and everyday behaviour is more likely to be positively impacted because the formal code is owned by members and used to guide choices. (Messikomer & Cirka, 2010, p. 66)

Chapter 7: The Ethics of Codes of Ethics explores the concept of whether codes of ethics are ethical and explores Messikomer and Cirka’s understanding of an ethically valid process in more detail.

The idea that implicit values become explicit in a code of ethics is a way of saying that a code of ethics articulates the social contract. The values that are implicit underpin the culture of an organisation. The relationship between codes of ethics and the culture of an organisation is frequently explored in the academic literature and it is important to discuss the research on this in more depth.

Summary

As anticipated in the introduction, this chapter discusses how the impetus for the development of a code of ethics and the code development process are two factors that significantly influence the degree to which a code will reflect the social contract. While assumptions by researchers about the impact of these factors are discernable in the literature, these two variables are rarely examined in the research.

In order to deal with the glaring absence in the literature of a framework to discuss the process of development of a code of ethics, this thesis has filled the gap by developing a framework for this. It has done so by identifying three basic development approaches:

1. The bespoke approach, which is dependent on input from affected stakeholders
2. The template approach, which relies on following a pre-determined format
3. The modeled approach, which borrows from pre-existing codes.

The chapter has then elaborated on the advantages and disadvantages of each approach, and while opinions have been expressed in the research literature regarding which might be the best approach, there is insufficient research evidence to ascertain that any one model provides a superior approach.

However, there are a number of valid reasons why one code development approach may be chosen over another, including the impetus to acquire a code, the resources which are available for the task of drafting a code, the amount of time available to develop the code and whether the code will be written in-house or outsourced. Each of these factors has the potential to influence the final product.

Finally, the Chapter argues that the adequacy of the final product can only be judged in relation to the impetus for the development of the code. If the code was developed for a particular purpose then the adequacy of the code in fulfilling that purpose is the only measure that can be reasonably applied.

Conclusion

This chapter proposes an original framework to of the development processes of codes of ethics in order to facilitate discussion and research into the impact of the development process on the usability of a code of ethics. This chapter leads to the question of whether a code of ethics is ethical or not, and whether this is related to the way in which the code has been developed. The next chapter, *The Ethics of Codes of Ethics* explores whether codes of ethics are ethical and how this determination might be made.

Chapter 7: The Ethics of Codes of Ethics

Are Codes of Ethics Ethical?

A fundamental question that is sometimes raised in the literature concerns whether codes of ethics are ethical. By this, commentators are generally questioning the motivation for having a code and whether the code is of benefit to the community to which it applies, and to other stakeholders in society. Occasionally the tone of a code will be mentioned. Examples of this were noted in 2002 by Farrell et al., who observed that codes of ethics containing content that “removed discretion” from their audience were “ethically incoherent because they were dictatorial and this conflicted with the very notion of ethics and the empowerment of the individual to make moral decision” (Farrell et al, 2002b, p. 159).

However, there is a more fundamental philosophical question that is sometimes challenged in the literature: whether those who are affected by the introduction of a code of ethics should have a voice in the code development process or input into its content.

In 2010 Messikomer and Cirka published a paper detailing both the process of development and the implementation of an “ethically valid” code of ethics for the National Association of Senior Move Managers (NASMM). The authors drew on three principles identified by Newton in 1994, namely “participation in development, validity in content, and authenticity of leadership” (Messikomer and Cirka, 2010, pp. 55–56).

The NASMM code of ethics took two years to develop, involved the participation of organisation members which included the active participation of the leadership, and utilised workshops facilitated by the authors to identify the organisation’s core values before the drafting of the code began. The draft was then provided to the Board of the NASMM who established an Ethics Task Force to review and finalise the code (Messikomer and Cirka, 2010, pp. 59–63).

It is notable that Messikomer and Cirka (2010) do not appear to have sought input from stakeholders outside the organisation such as consumer representatives or lobby groups from the aged community. Further, the success of the code is assumed by the achievement of

consensus within the organisation, and not by any other means. So, as recently as 2010 the approach taken in the development of the NASMM code of ethics is presented as contemporary and asserted to be ethically valid, yet the methodology is not very different from the approach taken by Percival over 200 years ago in his development of the first code of ethics—it is only the scale of the organisation that differs.

In 2004 McGraw considered whether professional codes of ethics were “enforceable, legitimate and just” (McGraw, 2004, p. 236). McGraw, looking at professional codes through the lens of ISCT, argues that historically, medical codes of ethics and the codes of ethics used by lawyers have been self-serving to those professions in so far as their anti-advertising clauses were anticompetitive until challenged by law (McGraw, 2004, p. 239).

Criticism of a different kind has been leveled at business ethics. For example, in a strongly worded paper published in 2010, Sternberg concludes that business ethics, including organisational mission statements, “seem innocuous, but they reflect confused and dangerous doctrines” and that these “imperil not just business profitability, but the existence of business itself” (Sternberg, 2010, p. 47).

Sternberg (2010) asserts the following:

- A fundamental confusion exists because of the erroneous conflation of the terms “business” and “corporation”—a business being an organisation that trades in goods and services, whereas a corporation is an organisation that exists for any reason agreed by its shareholders.
- There has been a failure to recognise that business exists solely to maximise “long-term owner value”.
- “Stakeholder Doctrine” is not compatible with business because the notion of running a business for the benefit of all stakeholders is fundamentally at odds with maximising long-term owner value.
- Conventional business ethics usurp the primary business purpose, and deny the basic human rights of the business owner by encouraging stakeholder appropriation of their assets.
- The notion of the social contract “asserts that business and corporations must submit themselves to society’s requirements, lest society prevent them from operating” and

that this is “extortion” and, when enshrined in law, it becomes a “threat to human rights” (Sternberg, 2010, p. 41).

- Business ethics is about “conducting *business* ethically” and can be reduced to two “constraints” of “*Ordinary Decency*” and “*Distributive Justice*” (i.e. fostering contributions to develop long-term owner value such as merit-based promotion) (Sternberg, 2010, pp. 45–46).

Sternberg’s particular interpretation of codes of ethics is not widely reflected in the literature. Indeed, Schwartz has observed the “assumption appears pervasive among academics and the business community, and governments that corporate codes of ethics are *prima facie* ethical in terms of their content and use” (Schwartz, 2005, p. 27).

In 2005, Schwartz, examined studies which looked at moral theory in relation to corporate codes of ethics and noted a widespread failure to identify universal moral values of business, which, he observes, are similar to the hypernorms of ISCT. According to Schwartz, the insufficiency of the search for universal moral values for corporate codes of ethics is “a glaring gap in the research” (Schwartz, 2005, pp. 30–31). In an effort to address this shortcoming, Schwartz analysed information from corporate codes of ethics, global codes of ethics and business ethics literature, and deduced six universal moral values: trustworthiness, respect, responsibility, fairness, caring and citizenship. However, as Schwartz recognises in his discussion of the limitations of his analysis, the main flaw is that he “merely attempts to establish a consensus across various sources in order to generate a set of universal moral values for codes of ethics” (Schwartz, 2005, p. 30). His study, as he himself points out,

does not provide the necessary justification for the values themselves, beyond identifying that they have been supported by business ethicists or moral theorists in the business ethics literature. A truly normative (i.e. non-descriptive) analysis would have examined whether the consensus itself is supported on ethical grounds. (Schwartz, 2005, p. 39)

He then draws on Donaldson and Dunfee (1999, p. 57), who highlighted the fact that “convergence of hypernorms within a society does not necessarily ensure that the hypernorms themselves are ethical (e.g., slavery, Hitler’s Nazi regime)” (Schwartz, 2005, p. 39).

Other ways to question the ethics of codes of ethics are centred on whether the content of a code is reflective of the social contract as it applies to ethics. Indeed, further into his

discussions of the limitations of his work, Schwartz touches on this by noting that “other stakeholder groups such as regulators, customers, or suppliers could be surveyed or interviewed to indicate the values they believe to be of fundamental importance” (Schwartz, 2005, p. 40).

Interestingly, Schwartz goes on to make the point that there are occasions where the laws of the country in which a business operates are not aligned to an established hypernorm and this creates a dilemma (Schwartz, 2005, p. 40). The interpretations of codes of ethics in relation to law can serve to reveal some of the complexity of the relationship between ethics and the law. The type of clash such as Schwartz refers to is one end of the spectrum of concern, whereas total subjugation of ethics to law is at the other end. Some of these interpretations are discussed below.

Codes of Ethics as an Extension or Expression of the Law

In *Chapter 1: Codes of Ethics – Social Contracts* it was noted that religious beliefs and understandings of both legal and ethical conduct are strongly connected because many legal and ethical positions are often guided by faith-based understandings. There are many ways to explore and dissect the contents and boundaries of related concepts that can lead to either a deeper understanding of those concepts or a widening chasm of confusion between them. Ethics and law are two such concepts that invite these types of responses.

Given the overlap between the concepts of ethics and law, articulating the difference between them is not a simple task. However, Campbell and Glass (2000) nicely capture the essence of the issue that divides opinion with the following description of the difference between ethics and law:

Ethics rests primarily on the voluntary actions of individuals, whereas law is a collectively articulated set of rules backed by the state’s power to coerce and sanction. (Campbell & Glass, 2000, p. 475)

Indeed it is the perception of the state having power over actions previously considered to be voluntary that arises as a concern in the literature.

Codes of ethics are sometimes understood as being an arm of the legal system, depending on the type of organisation that the code of ethics applies to. For example, McGraw (2004, p. 237) contends that where a legal requirement exists to be a member of a profession in order to provide the services of that profession, the professional code of ethics is “an extension of the legal system”. Other circumstances where codes of ethics might readily be seen as extensions or expressions of the law are where an extant legal or administrative rule requires that an organisation has a code of ethics.

Compliance with the US Sarbanes-Oxley Act of 2002, which requires disclosure regarding the adoption of a code of ethics for senior financial officers, is an example of a law which compels the adoption of a code of ethics. In order to comply with the law in this case, a number of questions come to mind: Should specialist lawyers be exclusively responsible for drafting codes of ethics to ensure the code is compliant with the law? And again, where does this place the force of ethics in relation to the force of law? Indeed, does this situation create a legal imperative to act ethically? These are the type of questions that arise when discussing the implications of having a non-voluntary code of ethics.

Codes of ethics are sometimes defined as “soft law”. In their examination of the legal status of codes of ethics, Campbell and Glass (2000), as mentioned above, describe ethics as resting “primarily on the voluntary actions of individuals, guided by their own consciences”. By contrast, they define law as “a collectively articulated set of rules backed by the state’s power to coerce and sanction”. In this article, a code of ethics is defined as a “non-legislative, non-regulatory” source which is generated by a “professional or quasi-governmental” body (Campbell & Glass, 2000, p. 473). Professional codes of ethics are identified as “soft law” due to their “uncertain legal status” (Campbell & Glass, 2000, p. 475).

The authors explain that there are arguments for and against the use of soft law in a court of law. Soft law may be disregarded “if the standards set by it are inadequate for ensuring that reasonable care and diligence are exercised in the execution of professional responsibilities”. The other argument is that soft law “should be shown deference by a court, given that judges do not usually have sufficient expertise in the field from which the standard emanates and thus are not fit to substitute their own views for professional opinion” (Campbell & Glass, 2000, pp. 475–476). The authors note that American and Australian courts have “discretion to refuse to be bound by norms established by the medical community”. This can be the

outcome where the court finds that “current professional practice does not meet the legal standard of reasonableness” (Campbell & Glass, 2000, p. 481).

All of the concerns described above are concerned with the loss of the voluntary nature that arises when ethics becomes subsumed by law. The irony is that sometimes communities actively pursue the conversion of ethical standards to legal rights. In this way, ethical standards are sometimes understood to be a precursor to law. Examples of historically significant, community-held ethical understandings that led to legislative changes include the abolition of slavery in the US, women’s suffrage and animal rights. Rothkamm (2008, p. 307) posits that the time lag between ethical change and legal change may occur because “moral principles must first stabilise themselves before they can act as stabilisers of the legal system”. If this is the case, then absorbing ethics directly into law diminishes the ethical realm somewhat as a stable progenitor of changes to legislation. There is a dynamic element in ethical determinations. General principles and values such as honesty, respect, loyalty and confidentiality may remain relatively timeless, but historical, social and technological changes shift expectations and the possibilities for action, and therefore demand changes in ethical judgments. There are valid reasons to consider the benefits of being one step ahead of the law and more in tune with certain societal values than awaiting legislation. This is of particular importance when an organisation is operating in new environments or with new technologies.

However, codes of ethics are often written as documents that are subordinate to the law and any clauses that might be ahead of the law will invariably need to harmonise with extant laws, however out of step with community ethical standards they may be, otherwise such a document could be seen to incite illegal actions. Concerns centering on the primacy of the law can lead to efforts to clarify the hierarchy of norms both in the research literature and in the actual codes of ethics.

In an effort to establish a clear hierarchy in which to situate codes of ethics, there are commentators who declare the subordination of codes of ethics to the law (McGraw, 2004, p. 242). Actual codes of ethics will sometimes contain clauses that are designed to defuse the potential for conflicting advice between the code and the law such as the precautionary insertion of legal disclaimers, or statements declaring the code subservient to any laws of the state (an explicit admission that codes of ethics are not understood to carry the force of law).

A disclaimer is an understandable measure when the complexity of the legal and ethical interface is considered or when there is a rapid evolution of a technology that could outpace both ethical and legal guidance.

Despite efforts to separate ethics from the law, codes of ethics can still fall short of expectations by subtle means such as the tone of expression. Robin et al. (1989) observe that “one of the similarities among codes of ethics is their tendency to be legalistic”. The authors here are referring to the predominance of “Thou shall ...” and “Thou shall not ...” language employed in the code content of the corporations they studied (Robin et al., 1989, p. 66).

Commentators often refer to the tone used in codes of ethics and the law-like expression that may be used. The tendency to lean towards a systematised legalistic model of ethics may have possible explanation in the dominant culture in which ethics codes have been incubated.

Ciulla (1992) has argued that the dominance of legal norms in American culture has rendered it difficult for some key actors to consider ethics other than in legal terms. She cites the example of President Bush Sr., who after being elected to the presidency, appointed a lawyer as his “ethics czar”: “The basic job of the czar was to revise the rules on government ethics. However, the scandals that took place involving White House employees had far less to do with rules than they had to do with the idea that individuals had lost sight of what it meant to be a public servant” (Ciulla, 1992, p. 142).

Ciulla (1992) implies that ethics in this instance is a misunderstood concept. She intimates that dealing with ethics as a set of rules in a legal framework misses the point that the problem of ethical conduct lies in individual understandings of the meaning of occupational purpose and the role of the individual in the larger scheme of things. We might also extrapolate from what Ciulla is saying that rules and lawyers distract from the main game of ethics and introduce an element of confusion.

A Hierarchy of Norms?

Ciulla (1992) makes a good point. There is a significant grey area to be navigated when trying to discern law from ethics or determine where ethics is perceived to sit in a hierarchy of societal norms. Some laws are founded by ethical considerations, while others have no ethical

content, or are frankly unethical. The authority of the law is determined by its enforcement and enforceability as much as it is by the contribution of society to its development, ongoing acceptance and application.

Laws, like codes of ethics, are a form of social contract. Further, both types of social contract can exist in varying quality. Ultimately, it is not productive to attempt to isolate understandings of law from ethics as they apply to codes of ethics—while differences and likenesses exist between the concepts, the interrelationship is complex and nuanced and the effort to separate the concepts of ethics and law distracts us from the reality that they are both social contracts with considerable overlap. This is at times a positive feature and at other times creates undesirable side effects.

Percival's intuition to label the very first code of ethics 'Jurisprudence' and his subsequent, seemingly unenthusiastic, acquiescence to his peers in labeling the work a code of ethics indicate that the grey area between the two philosophical endeavours was recognised from the outset. That the problem continues today more than two hundred years on is testament to the fact that there is an unresolved or irresolvable issue.

Codes of Ethics and Globalisation

The history of codes of ethics shows us that medicine in the UK and other countries has trended towards a national-level code of ethics whilst business has largely maintained an organisation-level approach. The problem for many business organisations is that the marketplace is global and for multinational firms in particular there is a significant challenge presented through the absence of an international approach to codes of ethics.

Multinational firms exist in an environment where there is often a tension that accompanies globalization, as they attempt to operate according to the cultural norms of different jurisdictions while trying to standardise their products and achieve efficiencies.

Donaldson (1996) articulates the central issue at play here:

When we leave home and cross our nation's boundaries, moral clarity often blurs. Without a backdrop of shared attitudes, and without familiar laws and judicial

procedures that define standards of ethical conduct, certainty is elusive. (Donaldson, 1996, p. 48)

Since 1996 there have been a number of ethical failures involving multinational firms and the attempted remedies taken in the US have influenced corporate ethics code acquisition globally. Such actions and reactions have provided cause to consider whether there might be the beginning of a solution in articulating principles for national codes of ethics for business, and possibly a global code of ethics for business.

However, one of the challenges of maintaining relevance and context in codes of ethics is the extent of cultural variation that exists across the operating environment to which the code applies. Globalised organisations are particularly challenged in this regard. In 2002 Asgary and Mitschow noted that “the concept of international business ethics was relatively new” (Asgary and Mitschow, 2002, p. 239). They identified bribery, human rights issues including child labour, and environmental issues as reasons for companies to have a code of ethics based on globally accepted standards (Asgary and Mitschow, 2002, p. 240). Yet, what is considered bribery in one culture may be interpreted as legitimate payments in another.

Globalisation has been happening for centuries but has increased markedly since the 1900s (O'Rourke & Williamson, 2002). Despite the long history, in terms of constructing suitable codes of ethics, globalisation continues to create one of the most significant challenges to business organisations today.

Lagan (2004) listed some of the incidents that have exemplified the ethical challenges that can accompany the opportunities that come with globalisation. She refers to Nike and Adidas, which were both shamed due to their use of sweatshop labour in Asia; Ford and Bridgestone for marketing products known to be faulty and compromising safety; and BHP, which was responsible for causing environmental damage by allowing tailings from a copper mine to flow into the Fly River in Papua New Guinea. She observes that these incidents “all serve as painful reminders that what is deemed ethical by society extends beyond the law and illustrate that dependence on traditional risk management advisers, such as lawyers, can blindsides a Board to these new external accountabilities” (Lagan, 2004, p. 20).

The organisations Lagan mentions were subject to extensive adverse publicity for their ethical failures. These cases became headlines around the world.

Effectively, in all of the cases cited by Lagan (2004) the corporations were answerable to society. The combined action of interest groups and global media coverage has become an informal mechanism that threatens good reputation and status on a global scale with a power that rivals the law.

Similarly, Seshadri, Raghavan and Hegde (2007) identify another list of firms to highlight the breadth of the impact of corporate ethical failure in multinational firms: “Enron, Tyco, and WorldCom ... brought the issue of violation of ethics to the global centrestage” (Seshadri, et al., 2007, p. 65). The authors state the pragmatic imperative to find a way through: “While the perspectives of culturally diverse people across countries differ, the need to execute business based on ethical practices is fast becoming universal” (Seshadri et al., 2007, p. 65).

Reconciling the sometimes dissimilar ethical expectations of culturally diverse stakeholders is a vast challenge. Matters can also be complicated by the different legal frameworks that apply in different countries.⁵⁰ Despite the importance of this issue to business, there is little research investigating the most suitable approaches to this problem.

Roth et al. (1996, p. 151), referring to public relations activities, postulate that “an international set of principles for practice is feasible”. The authors cite Donaldson’s list of ten human rights which can be applied to international moral agents (published in 1989), De George’s seven guiding principles for multinational enterprises (published in 1986)⁵¹, and the 1986 Caux Round Table code of ethics as evidence that “new thinking” was occurring in the area (Roth et al., 1996, pp. 157–158).

⁵⁰ For example, the Sarbanes-Oxley Act of 2002, also known as the Public Company Accounting Reform and Investor Protection Act of 2002, has created the need for multinational firms listed on the American Stock Exchange to satisfy a number of conditions, including having a code of ethics for financial officers (Grinberg, 2007, p. 3).

⁵¹ Donaldson’s (1989) list of ten minimal human rights are: the right to freedom of physical movement; ownership of property; freedom from torture; a fair trial; non-discriminatory treatment; physical security; freedom of speech and association; minimal education; political participation; and the right to subsistence. De George’s (1986, pp. 39–46) seven principles proposed to guide multinational enterprises (MNEs) in ethical conduct: MNEs should: do no intentional direct harm; produce more good than bad for the host country; contribute by their activities to the host country’s development; respect the human rights of their employees; pay their fair share of taxes; respect the local culture and work with it, not against it; and cooperate with the local government in the development and enforcement of just background institutions.

The Caux Round Table, which is “an international network of principled business leaders working to promote a moral capitalism” (Caux Round Table, n.d.), advocates an “approach to responsible business” (Caux Round Table, 2010). The Principles for Globalization offered by the Caux Round Table include Principles for Governments, in addition to Principles for Business (Caux Round Table, 2003).

Since the late 1980s, there have been a number of attempts to deduce the universal values that may be relevant to a global level code of ethics for business. For example, Asgary and Mitschow (2002, pp. 242–243) suggest 16 high-level principles to include in an International Business Code of Ethics.

In 2005 Schwartz analysed information from corporate codes of ethics, global codes of ethics and business ethics literature (including the paper by Asgary and Mitschow and the work of the Caux Round Table mentioned above) to distil the following six core values:

1. Trustworthiness (including notions of honesty, candor, integrity, reliability, and loyalty);
2. Respect (including notions of civility, autonomy, and tolerance);
3. Responsibility (including notions of accountability, excellence and self-restraint);
4. Fairness (including notions of process, impartiality, and equity);
5. Caring (including notions of concern for the welfare of others, as well as benevolence); and
6. Citizenship (including notions of respecting the law and protecting the environment). (Schwartz, 2005, p. 36)

The tendency towards presenting a relatively brief list of high-level principles as a code of ethics is understandable considering that the audience is global and therefore from diverse cultures. The need to identify and express the social contract requires that only those ethical understandings that are already harmonised between the cultures are suitable and limits the detail and number of principles that can be included. Integrative Social Contract Theory identifies such understandings as hypernorms. An example of a medical organisation with a global reach is Médecins Sans Frontières (MSF). MSF is a non-government organisation that provides medical humanitarian aid in natural disasters, war zones and epidemics around the world. It operates offices in 28 countries and employs more than 35,000 people across the world. MSF has opted for a charter limited to just five principles (Médecins Sans Frontières, 2017). Limiting the degree of detail in codes of ethics is just one consequence that tends to occur with globalisation; another is discussed below.

Stakeholder input in a Globalised Environment

Andersen and Skjoett-Larsen (2009) published an article which examined corporate social responsibility (CSR) in global supply chains. Noting that there is no agreed definition of CSR, they define the term as having two elements: one “describes the relationship between *business* and *the larger society*” and the other makes reference to “*voluntary activities* in the area of social and environmental issues” (Andersen & Skjoett-Larsen, 2009, p. 77).

The authors observe that in the global context, companies are sometimes placed under substantial social pressure to change the unsafe or exploitative practices of those international trading partners that constitute their supply chain. They cite some examples of companies that have attracted significant negative media attention over this issue, including the large US firms Nike and Walmart⁵² (Andersen & Skjoett-Larsen, 2009, p. 77).

Nike became embroiled in controversy throughout the 1990s when the poor working conditions in some of its supply chain factories became the focus of change advocates. Nike’s suppliers in Indonesia were underpaying employees, supply factories in Cambodia and Pakistan were using child labour and conditions for workers in the supply factories in China and Vietnam were poor (Locke et al., 2007, p. 25). Around the same time, Walmart also attracted media attention because its suppliers in Bangladesh were using child labour (Gereffi & Christian, 2009). Early efforts by the companies to deny responsibility for the circumstances of employees in the factories that manufactured their products were ineffective. The experiences of both Nike and Walmart effectively exposed articles of a tacit social contract between multinational firms and their customers that were previously unnoticed or ignored. It became clear that Nike and Walmart were considered responsible for the treatment of workers in companies that they did not own, and that they could not successfully justify continuing to support and profit from exploitative and unsafe work practices in their supply chain.

Since the events of the 1990s both Nike and Walmart have taken measures to rectify the issues and so avoid further criticism and reputational damage. In 1992 Nike acquired a code of conduct that “required its suppliers to observe some basic labour and environmental/health standards”. However, following criticism that the code was not being

⁵² Walmart is also spelled Wal-Mart in some of the literature.

enforced, Nike began to impose standards on its suppliers. In 1998 Nike mandated minimum age requirements for workers in their supply chain and occupational health and safety standards in their organisations (Locke et al., 2007, p. 25). Since 2005 Walmart has made public its efforts to work with suppliers to support more ethical practices, with particular focus on the environment (Gereffi & Christian, 2009, p. 585).

The issues faced by Nike and Walmart are not limited to US firms. IKEA, the Swedish furniture and homewares retailer, was facing increasing scrutiny for the environmental practices of some of its suppliers throughout the 1990s. IKEA was in a position to take a more pro-active approach to maintain the good reputation of the company and, in an effort to “relate actively to the environmental and social conditions of its suppliers”, developed a “code of conduct in relation to its suppliers”. The code was developed internally and then in 2000 “IKEA formally presented the requirements of the code of conduct to all its suppliers around the world” (Andersen & Skjoett-Larsen, 2009, p. 79). The code development process undertaken by IKEA does not appear to have involved obtaining input from the suppliers or other external stakeholders like consumer groups.

IKEA’s web page explains that their code (referred to as IWAY) is based on international conventions and declarations including the United Nations Universal Declaration of Human Rights (1948), the International Labour Organisation Declaration on Fundamental Principles and Rights at Work (1998), and the Rio Declaration on Environment and Development (1992) (IKEA, 2016).

The code itself deals with issues of health and safety, administration, environmental protection and the prevention of child labour and forced or bonded labour (IKEA, 2008). IKEA also set a compliance system in place to ensure that suppliers adhere to the code (Andersen & Skjoett-Larsen, 2009, p. 80).

IKEA’s approach is an interesting one because it has drawn its principles from high-level documents which, arguably, are all endeavours to express a global social contract of some kind. Each of these documents has been developed with input from representatives from multiple countries, and so they have all been developed with stakeholder consultation already. Drawing on such authoritative documents has, it seems, served as a proxy for consultation with some external stakeholders. However, while the three documents that have

been chosen represent some type of consensus on internationally held principles affecting employees and the environment, there is no sign of any document that articulates the voice of one of the largest stakeholders—the consumer. The perspective of the consumer may have been presumed to be known and therefore fully addressed in attending to worker safety and the environment. However, other concerns that consumers might have, such as their own safety, are not expressed in the code of ethics.

This absence of reference to a high-level document addressing consumers' rights makes it plausible that the rights of a very important stakeholder were overlooked. Recent legal action taken against IKEA further cements this notion. From 2002 to 2016 IKEA sold approximately 29 million pieces of furniture in Canada and the US. These chests and dressers had not been fitted with a mechanism to anchor them, and were prone to tip over in some circumstances. In July 2015, after three child deaths had been attributed to IKEA's furniture, a recall was issued. This recall was updated in November 2016 when the death of a fourth child was discovered. There have been a further 41 "tip-over incidents" reported which resulted in 17 injuries to children aged under 10 years of age. In the US, voluntary industry standards have been available since at least 2006. The specific standard that applied in this case was US voluntary industry standard (ASTM F2057-14). It had been released in 2014 (US Consumer Product Safety Commission, 2016). On 20 December 2016 *The New York Times* reported that the parents of three of the children who were killed had taken legal action and reached a "tentative settlement" of \$50 million (Bromwich, 2016).

While there is no evidence to support any assertion that if IKEA had consulted with consumer groups during the development of its code of ethics these unfortunate outcomes could have been prevented, the circumstances give pause for thought. The IKEA case demonstrates the importance of identifying and then giving voice to important stakeholders when developing a code of ethics with a global perspective and that reflects the social contract. Even though IKEA management took measures to adequately reflect the social contract in regard to working conditions and the environment, the consumer as a stakeholder may have been overlooked.

Summary

The question of whether codes of ethics are ethical has been raised in the literature in relation to the benefits such codes bring to stakeholders and to whether those stakeholders have any input into the development of the code.

Research into business codes of ethics suggests that to date business organisations have taken a limited view of who the relevant stakeholders are and thus who is included in the code development process. There is acceptance that employees are important stakeholders, but often they are the only stakeholders other than managers who are acknowledged in the research. Indeed, some researchers claim that input from organisation members is sufficient to consider the code ethical. Research is silent on the input of other stakeholders such as clients, neighbouring residents, local authorities, government bodies or environmental groups.

While there may be debate over whether there is any ethics in codes of ethics, there seems little doubt that there is often an element of the law in codes of ethics. Whether that element is considered to be due to the tone of the code, the author of the code, an explicit statement about laws or the hierarchy of norms, or considering codes of ethics as extensions of the legal system, this aspect of codes of ethics is deemed worthy of comment by a number of commentators. Pragmatically it is quite difficult to separate the concept of law from that of ethics in many cases. What we can be certain of is that both ethics and the law are forms of social contracts.

One of the biggest challenges for business is the increasingly globalised environment. Mismatches between local and country-of-origin understandings of ethical conduct are one dimension that complicates the situation; another is the different legal structures and priorities practised in various countries.

While the literature shows that there has been some thought towards compiling a global set of ethical principles or values, there has been little in the way of development towards the identification of the set.

Conclusion

This chapter offers the constructive suggestion that the concept of who is a relevant stakeholder in a code of ethics should be significantly broader than the research currently suggests. Broader input into the development of a code of ethics that involves stakeholders outside the organisation informs the members of the organisation about perceptions and expectations of the broader society in which the organisation is situated. It also has the potential to produce a more ethical document. Obtaining input from a broad range of stakeholders can raise the bar for organisation members in regard to expectations of ethical conduct. In this way codes of ethics can provide an externally informed challenge to the organisational culture which may be generating limiting ideas or insular beliefs about ethical conduct.

Chapter 8: Conclusion

The idea of an organisational code of ethics had its genesis over 200 years ago at a hospital in Manchester in the United Kingdom, and the impetus for the development of this code was to influence organisational culture to establish good order and function within a hospital in Manchester. Codes of ethics were soon adopted by other similar organisations for similar reasons, but as time passed and the range of organisations adopting codes became more diverse, new reasons for the development of codes of ethics emerged. However, the generic label of ‘code of ethics’ has endured.

Historically, codes of ethics developed first in medicine, and then in most of the other professions, and much later in business and other organisations. The motivations for adopting a code of ethics have changed since the first code was written, particularly for businesses. This has affected the content and the process of development, but apparently not the expectations about what can be achieved by introducing a code of ethics.

Because of the historical context there is a fundamental difference in the approach taken to develop modern medical codes of ethics in many western countries compared with western business codes of ethics, and this thesis has explored that difference. Very little research effort has been focused on the code development process and, to assist in opening the discussion on this aspect of codes, three approaches for developing a code are identified and discussed: the bespoke approach, the template approach and the modeled approach.

Medical codes of ethics in countries including the United Kingdom, Australia and New Zealand have evolved to become national documents. Commonly, such documents are written at a high level with community input and represent both societal and professional understandings of the ethical considerations of medical practice. These codes have been developed in such a way that they adequately reflect the social contract.

Codes of ethics in businesses have become increasingly popular in the last fifty years or so. There have been a number of reasons for the proliferation of such codes, including the desire to influence the organisational culture by articulating the ethical values of the organisation;

the aspiration to be seen as a profession; to fend off external regulation with preemptive self-regulation; to manage the organisation's reputation; to mitigate risk; and to comply with legal or administrative requirements.

The proliferation of codes has been accompanied by a rise in the amount of related commentary, inquiry, examination and analysis. This interest in codes comes from a broad range of disciplines, including philosophy, business, management and law. However, the multidisciplinary interest in codes has produced silos of data, analysis and theory rather than a cohesive overview of codes of ethics.

The Ethics of Codes of Ethics has provided an interdisciplinary examination of philosophical, empirical and historical research on codes. This synthesis of the scholarship on codes of ethics has revealed that philosophically, codes of ethics are thought about in a variety of ways. However, Integrative Social Contracts Theory (ISCT) is the most highly developed applicable framework. There is a great deal of empirical research on business ethics, but much of this research is poorly structured or lacks statistical rigor. As a result, there are very few meta-analyses. Those meta-analyses that could be found have been limited by the low numbers of good quality primary studies in the field. For empirical research to be more meaningful, future research needs to not only be methodologically sound but to examine variables such as the code development process.

There is a fundamental difference in the understanding of the functions of codes of ethics in medicine and in business that sets them apart—namely, that in medicine the responsibility lies with the individual practitioner to be compliant, not for the code to be effective; in business, the responsibility is assumed to lie with the individual, but there is an underlying angst that the code is ineffective if behaviour is not ethical. This is telling because it reveals an assumption that codes of ethics can somehow actually change behaviour.

Another way of saying this is that the research generally presumes that the locus of control in relation to codes of ethics is not understood in the same way for business as it is in medicine. As businesses have adopted codes and these have been studied, the tendency has been to look to the code for explanations of ethical lapses, with the intent of identifying the deficiency or ineffectiveness of the code of ethics. However, very few studies have focused on how codes are developed and whether they adequately articulate the social contract.

There is a stark difference in how codes of ethics have evolved in the medical arena compared with the business sphere. Medical codes of ethics have evolved to be national documents reflective of community standards and any breach is interpreted as a failure on the part of the individual practitioner. Researchers do not make an effort to investigate the factors that correlate with more or less compliance with codes of ethics in medicine. The code of ethics for medical practitioners in the UK that is examined in this thesis is an example of a code which is representative of community standards and expectations. In other words, it is a document that adequately reflects the social contract that is understood to exist between medical practitioners and the community that they serve.

This thesis has also investigated the idea of whether ethics codes are ethical documents and what criteria might be applied to determining whether or not they are ethical. Current thought is that the ethical nature of a code can be correlated to whether it has had input from affected stakeholders during the code development process, which presents significant challenges to the development of a national or global code of ethics for business organisations.

This thesis challenges the concept of who is a relevant stakeholder in a code of ethics, suggesting that broader input into the development of a code of ethics which involves stakeholders outside the organisation is desirable. Such an approach informs the members of the organisation about perceptions and expectations of the broader society and has the potential to produce a more ethical document.

The Ethics of Codes of Ethics has sought to contribute to the knowledge on codes of ethics in both a conceptual and practical way. Conceptually the thesis has examined the history and evolution of medical codes of ethics in the UK and codes of ethics in business to demonstrate the significant events that influenced the adoption of codes in medicine, other professions and in business. In practical terms, the thesis has examined the research and identified tacit assumptions which have influenced the direction that the research on business ethics has taken to date. Presenting the historical, philosophical and empirical evidence to challenge these assumptions is one of the key ideas behind this thesis.

This thesis has discussed the way codes of ethics are developed and identified three development approaches: the bespoke approach, which is dependent on input from affected stakeholders; the template approach, which relies on following a pre-determined format; and the modeled approach, which borrows from pre-existing codes. The pros and cons of each approach have been explored and discussed in terms of whether alternative approaches to code development could be beneficial for business.

This *Ethics of Codes of Ethics* has demonstrated that codes of ethics are a form of social contract. Although it has long been accepted that this was the case, the theoretical work of Donaldson and Dunfee on Integrative Social Contract Theory has provided a well-accepted model for explicitly understanding codes of ethics in this way. This thesis has demonstrated that producing a code of ethics that adequately reflects the social contract is the primary objective in developing a code of ethics. Reflecting the social contract must necessarily reflect the positions of all stakeholders in the contract, but it is not always the case, particularly in business, that all the stakeholders are identified and given the opportunity to provide input into the development of a code of ethics.

In circumstances where the stakeholders are inadequately consulted in the development of a code of ethics, the ethics of the document is brought into question. In order to be an inherently ethical document as well as an adequate reflection of the social contract, a code of ethics needs to be produced in a manner that is inclusive of the perspectives of all the various stakeholders. When a code that is produced in such a way is breached, it is not, and cannot ever be, a failure of the code. The onus lies with the individual or individuals who chose to disregard the social contract.

Herein lies the essential difference between the medical code of ethics in the UK and business codes of ethics: the UK medical code produced by the General Medical Council is arguably produced under conditions that promise an adequate reflection of the social contract, while many business codes of ethics are written at an organisational level without adequate regard to all the stakeholders in the social contract. This means that there are opportunities for business to borrow techniques such as those employed for the production of the medical code of ethics of the UK, which would assist in efforts to reflect the social contract.

Key Themes in the Thesis

Shifting Motivations, Static Expectations

An examination of the history of codes of ethics has demonstrated that the motivations for adopting a code of ethics have changed over time. These shifting motivations have affected the content, but not the expectations which have developed about what can be achieved by introducing a code of ethics.

The research on business codes of ethics tacitly demonstrates that there is an expectation that codes will somehow affect behaviour and that measurement of their effectiveness in changing behaviour is possible. Efforts have been made to identify influential variables such as age, gender, education and leadership style. Research of this type does not exist in relation to medical codes of ethics in the UK, inferring that such enquiry is not considered necessary.

The first medical code of ethics was written to eliminate disputes between doctors and was a reflection of the personal experience of the author, but had input from a group of interested parties. The notable exclusion of the most important stakeholder, the patient, can be explained by the widely held understanding of Humean sympathy which was the dominant philosophical thought at the time. However, that is something that has changed greatly over the past two centuries. The code of ethics for medical practitioners in the UK today reflects the more contemporary understanding of the autonomy of the patient.

The Effectiveness of a Code Depends on Why it was Written

The reason why an organisation may have chosen to have a code of ethics is rarely considered in the research. Yet many researchers are seeking to determine whether codes of ethics are effective, generally by attempting to measure behavioural change.

Without considering why a code has been drafted and what outcomes are expected from it, we cannot measure its effectiveness in fulfilling its role. Whether the code has been written in an effort to change behaviour, genuinely articulate the social contract, satisfy legal or administrative compliance requirements, or manage the reputation of an organisation will determine the outcomes which indicate effectiveness.

Research into Codes of Ethics Could be Improved

Codes of ethics have become increasingly popular since the 1970s. A plethora of studies have been undertaken since the 1980s that suggest that codes of ethics have a marginal effect on corporate culture. However, many of the studies are flawed in their design. Further, the traditional approach of dividing ethics research into normative or empirical studies has not been helpful in the development of integrated theories. Very few meta-analyses could be found that were relevant to ethical decision making or attitudes. These analyses either did not investigate or did not support the assertion that having a code could be correlated with ethical behaviour or attitudes, while the meta-analysis on ethics education indicated that codes require reinforcement.

An examination of the history of codes of ethics, starting from Percival's code written for the Manchester Infirmary in the late eighteenth century to the current day, shows that codes of ethics have spread to organisations across the globe.

When we compare which elements of *Medical Ethics*, the very first code of ethics, have endured and can be recognised in *Good Medical Practice* (2013), the code used today, we can see that approximately half of the concepts have been retained in some form for over 200 years. This is a tacit endorsement of the accuracy of the initial articulation of the medical social contract, as well as a reminder that views on what is ethical will change over time and need to be revisited, reviewed and recalibrated.

The consultative approach taken by Percival in the development of *Medical Ethics* has only recently being recognised by business organisations as valuable, and still the approach is arguably incomplete. *Medical Ethics* was written exclusively for medical practitioners with the aim of eliminating the disputes that were disrupting the practice of medicine at the time. The approach worked—the code was effective.

However, times have changed, and medical codes of ethics have changed to reflect this. The code used by the medical profession in the UK today is open to input from any imaginable stakeholder who chooses to contribute. The document is reviewed and updated every few years or as the need arises. The present code articulates what the public and patients can expect from their doctor and what doctors can expect from other doctors. The code in its current form is as close as we can expect it to get to an accurate reflection of the social contract and an ethical document.

Both Legal and Ethical Concepts Inform Social Contracts

The medical profession in many countries, including in the UK today, has established self-regulatory bodies and it is generally those bodies in the western English-speaking world that develop and enforce codes of ethics.

When business organisations began to take up codes of ethics it became usual practice to draft a code for the specific organisation, and this remains the case today. This is very different to the approach taken by the medical profession to pool their resources, self-regulate and evolve towards national codes.

Businesses do not have a structure like that of the medical or other professions, with centralised regulating bodies and registration processes for individuals to practice. In contrast, it is an entity that becomes registered as a business, and the regulation of businesses is largely via legal means. This is because, in the absence of the disciplinary function bestowed by a professional regulating body, business discipline tends to be meted out administratively or legally at the individual level, and via legal means at the organizational level. As a result, the social contract for business will be more likely to be informed by the legal social contract.

Over time various corporate scandals influenced code adoption or content and spawned new regulations. There have been some pieces of legislation in the US which have particularly encouraged code adoption. All of these events have shaped expectations about codes of ethics and in some ways limited the focus of some codes so that they do not adequately reflect the broader social contract, but merely a segment of it—specifically, the expectation to comply with legislation.

This evolutionary path of codes of ethics for business, which has led to codes being generated as organisational level documents, has left many organisations without an agreed national expression of the social contract for business. Following the example of the medical profession and establishing a nationally recognised code of ethics for business that adequately reflects the social contract could benefit business organisations.

How Should a Code of Ethics be Developed?

Whether a code of ethics reflects the social contract depends largely on the impetus for the development of the code and on the development process. Because these factors are rarely discussed or researched, this thesis has provided a framework to facilitate discussion on the process of development of a code of ethics. Three development approaches have been identified, including:

1. the bespoke approach, which is dependent on input from affected stakeholders
2. the template approach, which relies on following a pre-determined format
3. the modeled approach, which borrows from pre-existing codes.

There are advantages and disadvantages inherent in each approach but there is insufficient research evidence to support the use of any one model over another.

Pragmatic reasons why one code development approach may be preferred include the impetus to acquire a code, the resources which are available for the task of drafting a code, the amount of time available to develop the code and whether the code will be written in-house or outsourced.

An assessment regarding the adequacy of the final product can only be made in relation to the impetus for the development of the code. If the code was developed for a specific reason, then the question of whether the code addresses that particular issue is the only measure that can be reasonably applied.

What this thesis reveals is that research on codes of ethics could be improved by attention to the code development process. The thesis has demonstrated that there are a range of valid reasons to acquire a code and limitations to what can be expected of a code. Specifically, it finds that the reason for acquiring a code of ethics must be a primary consideration in determining whether the code is effective.

Further research on codes of ethics which investigates the impetus for code development and its relationship to the adequacy of the code is essential to further develop our understanding of how to produce codes that are fit for purpose.

Are Codes of Ethics Ethical?

The question of whether codes of ethics are ethical is complex. The ethical nature of codes of ethics may be determined by the benefits they bring to stakeholders and whether those stakeholders have had any input into the development of the code. While business codes of ethics may be developed in such a way that recognises that managers and employees are important stakeholders, the focus of the available research suggests that other stakeholders are largely overlooked.

Those researchers who question the ethical content of codes of ethics are often more convinced about the influence of the law in codes of ethics than the influence of ethics in codes of ethics. The literature contains commentary which raises concerns about the appropriateness of the use of a legalistic tone in codes, of lawyers being engaged as authors of codes, of ethics being seen as subordinate to law. There are also questions raised about whether some codes of ethics are extensions of the legal system. Because both ethics and the law can be considered to be social contracts and there is considerable overlap between the concepts, it would seem that any attempt to excise elements of law from codes of ethics is unlikely to be perfectly executed.

Indeed the influence of law on codes of ethics is unmistakable in the globalised environment in which multinational firms operate. Differences in legal and ethical understandings from one country to another invariably come into play. Whether the challenges of globalisation can be addressed by the formation of universally accepted principles of ethics is yet to be tested, although it is considered achievable by some researchers.

Key Findings

This interdisciplinary thesis, which examines research from the disciplines of history, philosophy and business studies, presents an original contribution to knowledge in the study of codes of ethics. In particular, *The Ethics of Codes of Ethics* identifies gaps in the research and identifies a variable for future study; namely, the development approach. Further, this thesis provides an original framework which describes the various approaches to ethics code development. A summary of the issues, gaps and trends is at Table 6 below. *Chapter 6: Development Approaches to Codes of Ethics* introduces this framework and proposes that it be a

starting point to facilitate future research, identifying the development approach of a code of ethics as a variable in investigations into the effectiveness of those codes.

Table 6 – Issues/Gaps and Trends

Issues/Gaps/Trends	How could this be addressed?
Issue: Whether codes of ethics adequately articulate the relevant social contract.	<ul style="list-style-type: none"> • Identifying relevant stakeholders and including them in the code development process. • Further research
Issue: Whether codes of ethics are inherently ethical documents	<ul style="list-style-type: none"> • Broadening the concept of who is a relevant stakeholder to include those external to the organisation.
Gap: Much of the research into codes of ethics is poorly designed	<ul style="list-style-type: none"> • Better designed research into codes of ethics.
Gap: Research into how the development process for a code of ethics impacts on the usability of the code of ethics	<ul style="list-style-type: none"> • Codes of ethics could include information on how their code of ethics has been developed using the framework proposed in Chapter 6. • Further research
Trend: While codes of ethics for business have become increasingly popular, the research has been conducted in silos (e.g. philosophy, business, management and law).	<ul style="list-style-type: none"> • Research on this topic could benefit from an interdisciplinary approach.
Trend: Expectation that a code of ethics will create ethical behaviour.	<ul style="list-style-type: none"> • Acknowledge that the purpose of the code is to adequately reflect the social contract and that behaviour is the responsibility of the individual.

This thesis has evaluated the evidence provided in the published research in relevant English language journals relating to codes of ethics in western business organisations and argued that codes of ethics for business can, and should, be developed in such a way that they reflect the social contract between business and the society in which it operates. An examination of the history, evolution and development of UK medical codes of ethics is presented as a case study that provides an example of one way in which a code of ethics has become widely accepted by the communities it serves. The content of this code is informed by broader societal expectations through a public consultation process and changes to the content are made on a regular basis. This particular code of ethics has had enduring success and its effectiveness is no longer questioned in the research. By adopting a dual (critical and

constructive) approach, this thesis has provided an extensive critique of existing approaches to the conceptualisation, development and research of codes of ethics. It has then developed constructive suggestions for changes to the way codes of ethics are conceived, developed and researched. These outcomes are reflected in the key findings of this thesis.

Business codes of ethics are expected to cause or contribute to behavioural change, and the research into business codes of ethics generally tends to examine factors that might potentiate or impede any such behavioural change. To date though, the research into business codes of ethics does not support the idea that codes of ethics change behaviour. It has been demonstrated in this thesis that high quality primary research in this area is lacking, and so the thesis has also incorporated an examination and analysis of the more statistically powerful meta-analyses that could be found. Relatively few meta-analyses were available, and those available could only provide rather weak evidence that increasing age, gender (i.e. being female), the moral intensity of an act and a strong ethical climate are positively correlated with more ethical behaviours and attitudes. The data from the meta-analyses more strongly confirmed that both leadership style and personal character traits were more likely to affect ethical behaviours and attitudes than demographic traits.

Only one meta-analysis could be found that investigated the premise that having a code of ethics makes an organisation more ethical. This meta-analysis concluded that having a code of ethics was not correlated with either ethical or unethical behaviours or attitudes. Yet, the assumption that adopting a code of ethics might somehow create more ethical behaviour in some people under some circumstances drives much of the research on business codes of ethics. The contribution this thesis makes is to question the assumptions and instead embrace the idea that codes of ethics can, at best, only reflect the social contract. Reflecting the social contract requires that those affected by the activities of the organisation be consulted. Effectively seeking broad input from all stakeholders has the potential to raise the standard of the expectations expressed in a code of ethics well beyond what might result from consulting only with those stakeholders who are internal to the organisation.

This means that the code of ethics for an organisation should be informed by the expectations of the broader community rather than being limited to the potentially insular views of organisation members. Working out how we can develop codes of ethics so that they do adequately reflect the social contract would be a more productive line of enquiry

than measuring the effectiveness of codes. However, there is no framework or common language to discuss the issue of code development.

In order to facilitate conversations on the matter of code development, an original framework outlining code development approaches has been put forward in this thesis. Aside from *ad hoc* references to development processes, no existing categorisation of the different approaches to code development could be found in the literature. This thesis has provided a framework for categorising the different approaches to the writing of either a new code of ethics for an organisation or the revision of an existing code of ethics.

The three development approaches to codes of ethics include:

1. The bespoke approach: this development approach aims to produce a code of ethics which is tailored to the organisation in terms of its structure and content.
2. The template approach: where the creation or structure of the code is based on guidance provided in a template, such as a step-by-step guide to a process, or a document template.
3. The modeled approach: where an organisation adopts an established code, or sections of a code, from model codes or from the codes of similar organisations.

This framework acknowledges that there are instances where one approach may be more appropriate for a particular organisation than another. These three possible approaches to code development are deliberately described at a high level. The development of more detailed sub-categorisations, or further high-level classifications, is an area that would benefit from further research.

When researchers examine codes of ethics for business they are frequently attempting to discover what makes codes effective, and yet they will often proceed down this path without investigating what particular effect the code was designed to have (i.e. the reason that the code was created), or the methodology by which the code was created. Without explicitly determining both of these pieces of information, it is impossible to determine the effectiveness of a code due to the contextual vacuum in which the investigation is undertaken. This framework provides a starting point for a conversation about, and investigation into, the development of codes of ethics. From this point we can concentrate

on improving development approaches to produce codes of ethics to ensure that they are relevant to the organisation and to the community in which that organisation operates.

An essential consideration when developing a code of ethics is whether or not the product will be an ethical document. In essence, this is about the motivation to adopt a code of ethics and whether the code is of benefit to the community to which it applies, and to other stakeholders in society. This can be tested by ascertaining whether those who are affected by the introduction of a code of ethics have had a voice in the code development process or the opportunity to provide input into its content. Obtaining input from a broad range of stakeholders can also allow the articulation of ethical standards held in the community which may be more strict than those of organisation members. Codes of ethics can therefore provide an externally informed challenge to an insular organisational culture.

This thesis has demonstrated that in order to be an inherently ethical document, a code of ethics must have input from affected stakeholders. In many organisations this will mean identifying stakeholders external to the organisation. However, current approaches portrayed in the research limit the recognition of stakeholders to management and, perhaps, employees or organisation members. The inclusion of stakeholders other than managers and employees in the development of a code of ethics is less discussed in the research literature. This thesis uses the term 'stakeholders' to refer to those who have an interest in the way a business is conducted. A non-exhaustive list of stakeholders includes employees, management, suppliers, organisations in supply chains, communities from where raw materials are sourced, consumers, shareholders and disposers of the product or by-products. In essence, 'stakeholders' includes anyone from the community at large. Even though some stakeholders are not required to comply with the code, the emphasis of the social contract could be significantly shifted (and elevated) by an attention to the issues that are of particular concern to them.

One significant problem for many business organisations is that they exist in a global marketplace. Multinational firms and those businesses with foreign suppliers face significant challenges in navigating the tensions that arise between the differing cultural norms of different countries and communities whilst trying to maintain standards and achieve efficiencies. There have been attempts to deduce the universal values which may be relevant

to a global level code of ethics for business, but an international approach to codes of ethics remains elusive.

Codes of ethics for medicine in Australia, the US and the UK are developed at the national level and through extensive consultation with stakeholders. The medical profession has, in effect, pooled its resources at the national level and acknowledged that practitioners are merely one stakeholder in the social contract by seeking input from all stakeholders. In contrast, business is developing codes at the organisational level, and the methodology for developing such codes varies according to factors such as the resources available to devote to the process. There is no research to support any conclusions in relation to the code development method on the utility of the code. However, arguments have been made at the philosophical level that without input into the code creation process from stakeholders internal to the organisation (such as employees and management), the document is inherently unethical.

The original medical code of ethics, *Medical Ethics*, was written approximately 200 years ago. This code was arguably not ethical because it failed to recognise the patient as a stakeholder during the development phase. What was thought to be ethical in regard to patient treatment at the time was heavily influenced by the dominant philosophical theories of David Hume. The author of the first medical code of ethics, Thomas Percival, drew on notions of Humean sympathy in the drafting of *Medical Ethics* and the belief that the medical practitioner understood the needs of the patient at least as well as the patient themselves. As a consequence of this philosophical belief, patients were not involved in the drafting process. Over time, philosophical understandings have changed and patient autonomy has become prime. The medical code of ethics in the UK is updated regularly and informed by a public consultation process. The consultation process is open to anyone and is of particular interest to a diverse pool of relevant stakeholders, including not-for-profit organisations that represent particular patient groups, consumer groups, organisations representing doctors, and business organisations.

This thesis does not suggest that every business organisation should perform a public consultation. Such an approach would be potentially onerous and unnecessary. However, it does suggest that codes of ethics could be better utilised if they adequately reflected the social contract. In order to reflect the social contract, and be an ethical document, affected

stakeholders should be identified and their input sought during the development phase. Codes of ethics for business would be more ethical and possibly more effective if stakeholder identification and engagement during the code development process was broadened beyond internal stakeholders. The field of medicine in the UK has had significantly more success in this regard and this thesis draws comparisons to the less successful approach taken by many business organisations.

It can be seen from the history of codes of ethics explored in *Chapter 4: The Historical Development of Codes of Ethics* that business has many reasons to create a code of ethics, including legal compliance, as an attempt to avoid regulation being imposed, as a genuine attempt to instill ethical behaviour, to express the terms of the extant social contract, and for reputation management.

However, codes of ethics in medicine have evolved over 200 years and the driving reason to have one is to articulate the social contract. Where the code of ethics adequately represents the social contract, the question of whether individuals or the organisations that they work for can execute their role in the social contract is more a question about the character of individuals than any failing of the code.

One of the limitations of this thesis was the scarcity of quality empirical research on the subject of codes and their effectiveness. While this fact has made it much harder to draw definitive conclusions, it has also provided the opportunity to identify gaps in the research and offer constructive approaches to begin filling those gaps. Throughout the thesis, but particularly in *Chapter 2: Studies of Codes of Ethics* and *Chapter 3: Meta-analyses*, the shortcomings of the existing research have been revealed. This in-depth examination of landmark studies and meta-analyses has resulted in the identification of an overlooked variable; namely, the code development process.

Implications of the Thesis for Future Research

This thesis details the evolution of codes of ethics for Medicine in the UK and contemporary business organizations as well as the evolution of research into them. It has described the gaps in current research and suggested areas for future research.

Future research on the subject of codes of ethics would benefit from standardizing terminology and focusing on as-yet unexplored variables including code development. To that end this thesis provides a conceptual framework to assist in discussion of code development approaches.

When researching the detail of these development approaches it would be beneficial to consider the extent to which a company should involve stakeholders, and which is the optimal stage of code development in which to involve stakeholders. It would also be helpful to investigate the best methods to engage stakeholders and whether different stakeholders require different levels of engagement. Building on these areas it would also be helpful to research the best ways to deal with conflicting stakeholder opinions when developing a code of ethics.

The Ethics of Codes of Ethics provides an interdisciplinary view of codes of ethics informed from philosophical, empirical and historical research. In bringing together this information it reveals the varied reasons why so many business organisations have a code of ethics, exposes some of the research findings and identifies issues that could be addressed to facilitate improved future research. It has demonstrated the way thinking about codes has developed, the way actual codes have evolved and the results of efforts to measure the impact that codes of ethics have. The thesis identifies assumptions and gaps in the knowledge and offers a starting point for discussing, considering and developing codes in a way that will better reflect the extant social contract. *The Ethics of Codes of Ethics* reveals the important factor that ensures that codes of ethics are ethical documents is the broad and inclusive engagement of relevant stakeholders in the development of the code of ethics. Future research needs to investigate how that key objective can be achieved.

Appendix 1: Meta-analyses Findings

Table 7 – Findings: Meta-analyses of Ethical Behaviour/ Attitudes

FINDINGS: META-ANALYSES OF ETHICAL BEHAVIOUR / ATTITUDES	
<p>1998 Meta-analysis (56 studies analysed): Borkowski, Susan C., and Yusuf J. Ugras, 1998, Business students and ethics: A meta-analysis, <i>Journal of Business Ethics</i>, 17(11), pp. 1117–1127.</p> <p>Aim: To examine the relationship between ethical attitudes/ behaviour and the variables of age, gender and undergraduate major.</p>	
Number of studies used in each analysis	Findings
Gender: 47 of 56	Gender: Women seem to demonstrate more ethical attitudes/behaviours than men
Age: 35 of 56	Age: Attitudes/behaviours seem to become more ethical with age
Undergraduate major: 30 of 56	Undergraduate major: No relationship between ethical attitudes/ behaviour and undergraduate major could be found.
<p>2006 Meta-analysis (12 studies analysed): Davis, Anne L., and Hannah R. Rothstein, 2006, The effects of the perceived behavioral integrity of managers on employee attitudes: a meta-analysis. <i>Journal of Business Ethics</i>, 67(4), pp. 407–419.</p> <p>Aim: To examine the relationship between employee attitudes and the behavioral integrity of managers generally, and then to examine the variable of gender, and whether the respondent is considering their immediate supervisor or someone more organisationally distant.</p>	
Number of studies used in each analysis	Findings
Perceived behavioral integrity of managers and employee attitudes: 12 of 12	Perceived behavioral integrity of managers and employee attitudes: Strong correlation
Studies of predominantly male subjects: 9 of 12	Perceived behavioral integrity of managers by gender of respondents: No significant correlation
Studies of predominantly female subjects: 3 of 12	
Studies of immediate supervisors: 4 of 12	Perceived behavioral integrity of managers who are immediate supervisor versus someone more organisationally distant: Considerably stronger relationship when considering immediate manager.
Studies of organisationally distant managers: 3 of 12	

<p>2010 Meta-analysis (136 studies analysed): Kish-Gephart, Jennifer J., David A. Harrison, & Linda Klebe Treviño, 2010, Bad apples, bad cases, and bad barrels: meta-analytic evidence about sources of unethical decisions at work. <i>Journal of applied Psychology</i>, 95(1), p. 1.</p> <p>Aim: To examine the relationship between nine individual characteristics, seven moral issue characteristics and six organisational environment characteristics on unethical choice in terms of intention and behaviour.</p>	
Number of studies used in each analysis	Findings
The Nine Individual Characteristics	
1. Cognitive moral development: 22 of 136	Cognitive moral development is negatively related to unethical choices
2. Idealism: 10 of 136	Idealistic moral philosophy is negatively related to unethical choices
3. Relativism: 12 of 136	A relativistic moral philosophy is positively related to unethical choices
4. Machiavellianism: 11 of 136	Machiavellianism positively influences unethical choices
5. Locus of control: 11 of 136	An external locus of control is positively related to unethical choices
6. Job satisfaction: 20 of 136	Higher job satisfaction is related to a lower likelihood of unethical choices
7. Gender: 60 of 136	Gender correlated weakly, with men making more frequent unethical choices than women
8. Age: 35 of 136	Age was weakly negatively correlated with unethical choices
9. Education level: 22 of 136	Education level was not inversely linked to unethical choices
The Seven Moral Issue Characteristics	
1. Concentration of effect: 6 of 136 2. Magnitude of consequences: 10 of 136 3. Probability of effect: 4 of 136 4. Proximity: 7 of 136 5. Social consensus: 8 of 136 6. Temporal immediacy: 7 of 136 7. General moral intensity: 7 of 136	All seven moral issue characteristics are moderately and negatively linked to unethical choices.
The six Organisational Environment Characteristics	
1. Egoistic ethical climate: 12 of 136	A stronger egoistic climate increases the likelihood of unethical choices
2. Benevolent ethical climate: 9 of 136	There is a weak inverse relationship between the strength of the benevolent ethical climate and unethical choices
3. Principled ethical climate: 10 of 136	There is a weak inverse relationship between the strength of the principled ethical climate and unethical choices
4. Ethical culture: 12 of 136	A strong ethical culture is negatively related to unethical choices
5. Code of conduct: 19 of 136	There was no discernable positive or negative correlation between the existence of a code of conduct and unethical choices
6. Code enforcement: 7 of 136	A strong negative link was found between code enforcement and unethical choice.

<p>2012 Meta-analysis (65 studies analysed): Pan, Yue, and John R. Sparks, 2012, Predictors, consequence, and measurement of ethical judgments: review and meta-analysis, <i>Journal of Business Research</i>, 65(1), pp. 84–91.</p> <p>Aim: To review the literature to identify relevant antecedents and consequences of ethical judgments in order to help resolve inconsistent or conflicting results, and to analyse the effect sizes of student samples.</p>	
Number of studies used in each analysis	Findings
The Five Personal Demographic Characteristics	
1. Age: 15 of 65	A relationship between increasing age and stricter ethical judgments was not significant
2. Sex: 21 of 65	Ethical judgments of women are stricter than those of men
3. Education: 4 of 65	As education increases , ethical judgments become less strict
4. Income: 3 of 65	As income rises , ethical judgments become less strict
5. Work experience: 7 of 65	A relationship between increasing work experience and less strict ethical judgments was not significant
The Six Psychological and Philosophical Characteristics	
1. Idealism: 9 of 65	As idealism increases, ethical judgments become stricter
2. Relativism: 9 of 65	As relativism increases, ethical judgments become less strict
3. Machiavellianism: 3 of 65	As Machiavellianism increases, ethical judgments become less strict
4. Locus of control: 3 of 65	Correlations between increasing internal locus of control and ethical judgments were not significant
5. Religiosity: 5 of 65	Correlations between increasing religiosity and ethical judgments were not significant
6. Ethical awareness: 5 of 65	As ethical awareness increases, ethical judgments become stricter.
The Five Perceived Characteristics of the Act	
1. Deontological evaluations: 4 of 65	The more seriously an act departs from deontological norms, the stricter the ethical judgment
2. Teleological evaluations: 5 of 65	The more negative the teleological evaluation of an act, the stricter the ethical judgment
3. Moral intensity: 6 of 65	As the moral intensity of an act increases, ethical judgments become stricter
4. Ethical environment: 4 of 65	Correlations between ethical environment and ethical judgments were not significant
5. Behavioral intention: 18 of 65	The stronger the ethical climate of an organisation, the stricter ethical judgments become.
The Effect Sizes of Student Samples	
The meta-analysis produced “qualified evidence that student samples systematically produce greater effect sizes than non-student samples” (Yue & Sparks, 2012, p. 88).	

<p>2013 Meta-analysis (the total number of studies analysed was not stated in the paper): Jackson, Timothy A., John P. Meyer, and Xiao-Hua Frank Wang, 2013, Leadership, commitment, and culture a meta-analysis. <i>Journal of Leadership & Organizational Studies</i>, 20(1) pp. 84–106.</p> <p>Aim: To examine the relationships between leadership styles and employee commitment and whether this varies with societal culture.</p>	
Number of studies used in each analysis	Findings
Leadership and Commitment	
1. Transformational/charismatic leadership relationship to affective commitment (AC): 116	Transformational/charismatic leadership is positively related to AC
2. Transformational/charismatic leadership relationship to normative commitment (NC): 30	Transformational/charismatic leadership is positively related to NC
3. Contingent reward leadership relationship to AC: 51	Contingent reward leadership style is positively related to AC
4. Active management-by-exception leadership related to AC: 25	Management-by-exception is positively related to AC (Note: in this case the credibility interval straddled zero).
5. Laissez-faire leadership related to AC: 15	Laissez-faire leadership is negatively related to AC.
Culture as a Moderator	
1. Whether societal level individualism-collectivism moderates the relationship between transformational/charismatic leadership and AC to the organisation: unstated	The relationship between transformational leadership and AC was not affected by societal individualism-collectivism
2. Whether societal-level individualism-collectivism moderates the relationship between transformational/charismatic leadership and NC to the organisation: unstated	In countries that value collectivism the relationship between transformational leadership was stronger for NC
3. Whether societal-level individualism-collectivism moderates the relationship between transformational/charismatic leadership and continuous commitment to the organisation unstated	In countries that value collectivism the relationship between transformational leadership was stronger for continuous commitment
4. Whether societal-level power distance/hierarchy moderates the relationship between contingent reward leadership and AC: unstated	In societies with higher levels of power distance/hierarchy the relationship between contingent reward leadership and AC was stronger.

Table 8 – Findings: Meta-Analyses of Education/ Instruction

FINDINGS - META-ANALYSES OF EDUCATION/INSTRUCTION	
<p>2007 Meta-analysis (36 studies analysed): Winston, Mark D., 2007, Ethical leadership and ethical decision making: a meta-analysis of research related to ethics education, <i>Library & Information Science Research</i>, 29(2), pp. 230–251.</p> <p>Aim: To determine:</p> <ol style="list-style-type: none"> 1. what methodological approaches have been used to study ethics education and its impact? 2. what factors have served as the bases for measuring the impact of ethics education? 3. what segments of the academic and professional populations have been studied, with regard to the impact of ethics education? 	
Number of studies used in each analysis	Findings
<p>Research methods: 36 of 36</p>	<p>27 studies (75%) used surveys 6 (16.7%) used content analysis 1 (2.8%) used interviews 1 (2.8%) used curriculum analysis 1 (2.8%) used case studies</p>
<p>Factors used for measuring the impact of ethics education: 36 of 36</p>	<p>22 studies (61.1%) measured perceptions or changes in perception 8 (22.2%) used curriculum analysis 16 (6.7%) examined reasoning/ cognitive development</p>
<p>Segments of the academic and professional populations that have been studied: 36 of 36</p>	<p>17 studies (47.2%) were of undergraduate participants 2 (5.6%) were of graduate students 5 (13.9%) were of undergraduate and graduate students 6 (16.7%) were of faculty and/or administrators 2 (5.6%) were of alumni 4 (11.1%) were of other participants</p>
<p>2009 Meta-analysis (25 previously conducted business ethics instructional programs were analysed): Waples, Ethan P., et al., 2009, A meta-analytic investigation of business ethics instruction, <i>Journal of Business Ethics</i>, 87(1), pp. 133–151.</p> <p>Aim: To examine the role of criteria, study design, field of investigator, participant characteristics, quality of instruction, instructional content, instructional program characteristics, and characteristics of instructional methods as moderators of the effectiveness of business ethics instruction.</p>	
Number of data points/effect sizes used in each analysis	Findings
<p>Overall business ethics instruction effectiveness: 38 of 38 data points from 25 studies</p>	<p>The overall effectiveness of business ethics instruction was found to be minimal</p>

<p><u>Role of individual criteria</u></p> <p>1. Moral reasoning: 10 of 38 data points</p> <p>2. Perceptions of others: 5 of 38</p> <p>3. Perceptions of self: 8 of 38</p> <p>4. Ethical judgment: 9 of 38</p> <p>5. Ethical behaviours: 2 of 38</p> <p>6. Ethical awareness: 2 of 38</p>	<p>1. Moral reasoning had a large effect on the effectiveness of business ethics instruction.</p> <p>2. Perceptions of others had a small to moderate effect on the effectiveness of business ethics instruction.</p> <p>3. Perceptions of self had a small effect on the effectiveness of business ethics instruction.</p> <p>4. Ethical judgments had a small effect on the effectiveness of business ethics instruction.</p> <p>5. Ethical behaviours had no effect on the effectiveness of business ethics instruction.</p> <p>6. Ethical awareness had a small effect on the effectiveness of business ethics instruction.</p>
<p><u>Study design characteristics</u></p> <p>1. Single group pre-test and post-test: 11 data points</p> <p>2. Pre-test post-test with control group: 8</p> <p>3. Post-test only: 7</p> <p>4. Other designs (e.g. longitudinal): 10</p>	<p>1. Second highest effect size (0.42)</p> <p>2. Largest effect size (0.55)</p> <p>3. Third highest effect size (0.23)</p> <p>4. Smallest effect size (0.03)</p>
<p><u>Field of investigator</u></p> <p>1. Management: 3 effect sizes</p> <p>2. Finance/accounting: 3</p> <p>3. Marketing: 12</p>	<p>1. Second highest effect size (0.22)</p> <p>2. Largest effect size (0.64)</p> <p>3. Smallest effect size (0.18)</p>
<p><u>Author conducted instruction</u></p> <p>1. No: 13</p> <p>2. Yes: 5</p>	<p>1. smallest effect size (0.35)</p> <p>2. largest effect size (0.45)</p>
<p><u>Was study funded</u></p> <p>1. No: 28</p> <p>2. Yes: 4</p>	<p>1. smallest effect size (0.23)</p> <p>2. largest effect size (1.07)</p>
<p><u>Participant characteristics</u></p> <p>1. Participant job a) Students: 24 b) Professionals: 13</p> <p>2. Prior instruction a) 21-40% : 10 b) 61-80% : 3 c) 81-100% : 2</p> <p>3. Sample size a) < 100: 11 b) ≥ 100: 27</p>	<p>1a) Smaller effect size (0.26) 1b) Larger effect size (0.39) indicating that business ethics instruction shows more consistent effects for older working populations.</p> <p>2a) Middle effect size (0.30) 2b) Smallest effect size (0.14) 2c) Largest effect size (0.63) Note: the number of effects available for this analysis was very small</p>

<p>4. Gender a) 70% Male: 6 b) Mixed gender: 23 (Insufficient female majority data was found)</p> <p>5. Sample age a) 70%≥35: 5 b) 70%<35: 15 c) Mixed ages: 4</p> <p>6. Incentives a) No incentives: 2 b) Incentives: 29</p>	<p>3a) Smallest effect size (0.14) 3b) Largest effect size (0.31) suggesting that larger samples sizes produce a greater effect.</p> <p>4a) (0.45) 4b) (0.40) indicating little difference between mixed gender and predominantly male.</p> <p>5a) Largest effect size (1.07) suggesting that business ethics instruction shows more consistent effects for older working populations. 5b) Smallest effect size (0.27) 5c) (0.41) Mixed age samples produced a larger effect than predominantly younger participants.</p> <p>6a) Largest effect size (1.63) suggesting that populations without incentives outperform those who have incentives. Note: the number of effects available for this analysis was very small. 6b) Smallest effect size (0.28)</p>
<p><u>Quality of instruction</u></p> <p>1. Instructional content: 21</p> <p>2. Instructional characteristics: 37 program</p> <p>3. Characteristics of instructional methods: 37</p>	<p>1a) 'Above average' had the largest effect size (0.61) 1b) 'Good' had the second highest effect size (0.50) 1c) 'Average' had the third highest effect size (0.45) 1d) 'Below average' had the smallest effect size (0.12)</p> <p>2a) 'Average and 'Above average' had equal highest effect size (0.34) 2b) 'Below average had the smallest effect size (0.21)</p> <p>3a) 'Above average' had the largest effect size (0.71) 3b) 'Average' had the second highest effect size (0.38)</p>

	<p>3c) 'Below average' had the third highest effect size (0.25)</p> <p>3d) 'Poor' had the smallest effect size (-0.10)</p>
<p><u>Instructional content</u></p> <p>1. Skills trained: 20</p> <p> a) Global: 12</p> <p> b) Specific job domain: 8</p> <p>2. Overarching skills: 24</p> <p> a) Strategies: 6</p> <p> b) Strategies and behaviours: 18</p> <p>3. General approach: 24</p> <p> a) Cognitive: 22</p> <p> b) Social interactional: 2</p> <p>4. Domain coverage (Academy of Management, 2008): 27</p> <p> a) No: 5</p> <p> b) Yes: 22</p> <p>5. Standard coverage: 20</p> <p> a) No: 5</p> <p> b) Yes: 15</p> <p>6. Problems in ethical decision making coverage: 20</p> <p> a) No: 5</p> <p> b) Yes: 15</p> <p>7. Strategies for ethical decision making coverage: 24</p> <p> a) No: 5</p> <p> b) Yes: 19</p>	<p>1a) Largest effect size (0.55)</p> <p>1b) Smallest effect size (0.50)</p> <p>2a) Largest effect size (0.57)</p> <p>2b) Smallest effect size (0.47)</p> <p>3a) Largest effect size (0.51)</p> <p>3b) Smallest effect size (0.33)</p> <p>4a) Smallest effect size (-0.14)</p> <p>4b) Largest effect size (0.39)</p> <p>5a) Smallest effect size (-0.14)</p> <p>5b) Largest effect size (0.39)</p> <p>6a) Smallest effect size (-0.14)</p> <p>6b) Largest effect size (0.39)</p> <p>7a) Smallest effect size (-0.14)</p> <p>7b) Largest effect size (0.39)</p>
<p><u>General instructional program characteristics</u></p> <p>1. Was the program standardised?</p> <p> a) No: 8</p> <p> b) Yes: 28</p> <p>2. Setting of instruction</p>	<p>1a) Smallest effect size (-0.02)</p> <p>1b) Largest effect size (0.36)</p> <p>2a) Smallest effect size (0.29)</p>

<p>a) No: 28 b) Yes: 3</p> <p>3. Organisation advocates instruction a) No: 12 b) Yes: 15</p> <p>4. Was instruction mandatory? a) No: 6 b) Yes: 24</p> <p>5. Primary purpose of instruction a) Educational: 28 b) Developmental: 3 c) Compliance: 2</p> <p>6. Was purpose also experimental? a) No: 19 b) Yes: 18</p> <p>7. Type of course a) Integrated: 13 b) Standalone: 19</p>	<p>2b) Largest effect size (1.66)</p> <p>3a) Smallest effect size (0.28) 3b) Largest effect size (0.52)</p> <p>4a) Largest effect size (0.57) 4b) Smallest effect size (-0.28)</p> <p>5a) Second largest effect size (0.29) 5b) Largest effect size (1.66) 5c) Smallest effect size (0.12)</p> <p>6a) Smallest effect size (0.17) 6b) Largest effect size (0.46)</p> <p>7a) Largest effect size (0.42) 7b) Smallest effect size (0.32)</p>
<p><u>Characteristics of instructional methods</u></p> <p>1. Length of instruction a) < 1 month: 5 b) 1-4 months: 5 c) 5+ months: 11</p> <p>2. Primary delivery method a) Classroom based: 13 b) Case based – classroom: 12</p> <p>3. Learning method a) Constant: 6 b) Variable: 13</p> <p>4. Practice a) Massed: 3 b) Distributed: 9</p> <p>5. Learning activity usage a) 0 – 3: 10 b) 4+: 14</p>	<p>1a) Largest effect size (1.04) 1b) Second largest effect size (0.44) 1c) Smallest effect size (0.31)</p> <p>2a) Smallest effect size (0.39) 2b) Largest effect size (0.54)</p> <p>3a) Largest effect size (0.99) 3b) Smallest effect size (0.37)</p> <p>4a) Largest effect size (1.66) 4b) Smallest effect size (0.39)</p> <p>5a) Smallest effect size: 0.23 5b) Largest effect size (0.51)</p>

Appendix 2: Concepts Comparison

Table 9 – Concepts Comparison between *Medical Ethics* and *Good Medical Practice* (2013)

Articles of Chapter 1: Professional Conduct relative to Hospitals or other Medical Charities, <i>Medical Ethics</i> (1803) and comparative passages in <i>Good Medical Practice</i> (2013)	Comment
<p>Article 1</p>	
<p>§ 1 HOSPITAL Physicians and Surgeons should minister to the sick with due impressions of the importance of their office; reflecting that the case, the health, and the lives of those committed to their charge depend on their skill, attention, and fidelity. They should study, also, in their department, so to unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence.</p>	<ul style="list-style-type: none"> • This concept of maintaining professionalism has been replicated in the modern code of ethics.
<p>The duties of a doctor registered with the General Medical Council are listed after the cover but before page 1 of <i>Good Medical Practice</i> (2013): Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.</p> <p>Knowledge, skills and performance</p> <ul style="list-style-type: none"> • Make the care of your patient your first concern. • Provide a good standard of practice and care. <ul style="list-style-type: none"> ○ Keep your professional knowledge and skills up to date. ○ Recognise and work within the limits of your competence. <p>Safety and quality</p> <ul style="list-style-type: none"> • Take prompt action if you think that patient safety, dignity or comfort is being compromised. • Protect and promote the health of patients and the public. <p>Communication, partnership and teamwork</p> <ul style="list-style-type: none"> • Treat patients as individuals and respect their dignity. <ul style="list-style-type: none"> ○ Treat patients politely and considerately. ○ Respect patients' right to confidentiality. • Work in partnership with patients. 	<ul style="list-style-type: none"> • Article 1 of <i>Medical Ethics</i> presumes there is a degree of dependence that the patient has on the medical practitioner and communicates that the patient should be encouraged to feel a certain way about the practitioner by virtue of the practitioner's manner. By contrast, <i>Good Medical Practice</i> is focused on the actions of the practitioner and the autonomy of the patient. The doctor is a partner in care even though an asymmetry still exists • The use of terminology is more exacting in <i>Good Medical Practice</i> (2013). Definitions/ explanations of five terms are footnoted throughout <i>Good Medical Practice</i> (2013) (see pages 4, 12, 13, 20). Additionally, the terms 'should' and 'must' are defined at Clause 5: <i>In Good medical practice, we use the terms 'you must' and 'you should' in the following ways.</i>

<ul style="list-style-type: none"> ○ Listen to, and respond to, their concerns and preferences. ○ Give patients the information they want or need in a way they can understand. ○ Respect patients' right to reach decisions with you about their treatment and care. ○ Support patients in caring for themselves to improve and maintain their health. <ul style="list-style-type: none"> ● Work with colleagues in the ways that best serve patients' interests. <p>Maintaining trust</p> <ul style="list-style-type: none"> ● Be honest and open and act with integrity. ● Never discriminate unfairly against patients or colleagues. ● Never abuse your patients' trust in you or the public's trust in the profession. <p>You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.</p> <p>See also the following clauses:</p> <p>1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.</p> <p>31. You must listen to patients, take account of their views, and respond honestly to their questions.</p> <p>32. You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.</p> <p>65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.</p> <p>68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.</p> <p>69. When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available.</p>	<ul style="list-style-type: none"> ○ <i>'You must' is used for an overriding duty or principle.</i> ○ <i>'You should' is used when we are providing an explanation of how you will meet the overriding duty.</i> ○ <i>'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance.</i> <p>In contrast, <i>Medical Ethics</i> does not offer definitions.</p>
---	---

Article 2	
<p>§ 2 The choice of a Physician or Surgeon cannot be allowed to hospital patients, consistently with the regular and established succession of medical attendance. Yet personal confidence is not less important to the comfort and relief of the sick poor, than of the rich under similar circumstances; and it would be equally just and humane to enquire into and to indulge their partialities, by occasionally calling into consultation the favourite practitioner. The rectitude and wisdom of this conduct will be still more apparent, when it is recollected, that patients in hospitals not unfrequently request their discharge on a deceitful plea of having received relief, and afterwards procure another recommendation that they may be admitted under the Physician or Surgeon of their choice. Such practices involve in them a degree of falsehood, produce unnecessary trouble, and may be the occasion of irreparable loss of time in the treatment of diseases.</p>	<ul style="list-style-type: none"> • This concept of limiting the patient's choice of practitioner has not been replicated in the modern code of ethics. • Article 2 is a tacit admission that the system is imperfect and patients will go to considerable trouble to find a way around it. • The defining of patients as rich or poor is particular to Percival; this would suggest that there were perceptions held by medical practitioners which demarcated the two types of patient.
<p>Compare with <i>Good Medical Practice</i> (2013) clause 16e: 16. In providing clinical care you must: e. respect the patient's right to seek a second opinion</p>	
Article 3	
<p>§ 3 The feelings and emotions of the patients, under critical circumstances, require to be known and to be attended to, no less than the symptoms of their diseases: thus extreme timidity with respect to venesection contra-indicates its use in certain cases and constitutions. Even the prejudices of the sick are not to be contemned, or opposed with harshness; for, though silenced by authority, they will operate secretly and forcibly on the mind, creating fear, anxiety, and watchfulness.</p>	<ul style="list-style-type: none"> • This concept of attending to the psychological needs of the patient has been replicated in the modern code of ethics.
<p>Clause 15a in <i>Good Medical Practice</i> (2013): 15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients you must: a. adequately assess the patient's conditions, taking account of their history (including symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient.</p>	
Article 4	
<p>§ 4 As misapprehension may magnify evils or create imaginary ones, no discussion concerning the nature of the case should be entered into before the patients, either with the House Surgeon, the pupils of the hospital, or any medical visitor.</p>	<ul style="list-style-type: none"> • This concept of not holding discussions in the presence of the patient has not been replicated in the modern code of ethics.
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 32, 50 and 68:</p>	

<p>32. You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.</p> <p>50. You must treat information about patients as confidential. This includes after a patient has died.</p> <p>68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.</p>	
Article 5	
<p>§ 5 In the large wards of an infirmary the patients should be interrogated concerning their complaints in a tone of voice which cannot be overheard. Secrecy, also, when required by peculiar circumstances, should be strictly observed. And females should always be treated with the most scrupulous delicacy. To neglect or to sport with their feelings is cruelty; and every wound inflicted tends to produce a callousness of mind, a contempt of decorum, and an insensibility to modesty and virtue. Let these considerations be forcibly and repeatedly urged on the hospital pupils.</p>	<ul style="list-style-type: none"> • These concepts of patient confidentiality and improper relationships/behaviour have been replicated in the modern code of ethics. • Improper relationships/ behaviour are the subject of the following three supporting documents to <i>Good Medical Practice</i> (2013): <ol style="list-style-type: none"> i. Maintaining a professional boundary between you and your patient (2013) (General Medical Council, 2013c) ii. Intimate examinations and chaperones (2013) (General Medical Council, 2013b) iii. Sexual behaviour and your duty to report colleagues (2013) (General Medical Council, 2013d).
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 25c, 50 and 53:</p> <p>25c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.</p> <p>50. You must treat information about patients as confidential. This includes after a patient has died.</p> <p>53. You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.</p>	
Article 6	
<p>§ 6 The moral and religious influence of sickness is so favourable to the best interests of men and of society, that it is justly regarded as an important object in the establishment of every hospital. The institutions for promoting it should therefore be encouraged by the Physicians and the Surgeons, whenever seasonable opportunities occur; and, by pointing out these to the officiating clergyman, the sacred offices will be performed with propriety, discrimination, and greater certainty of success. The character of a Physician is usually remote either from</p>	<ul style="list-style-type: none"> • This concept of restricting the access of the clergy has not been replicated in the modern code of ethics. • Article 6 of <i>Medical Ethics</i> refers to controlling the access of clergymen to

<p>superstition or enthusiasm; and the aid, which he is now exhorted to give, will tend to their exclusion from the sick wards of the hospital, where their effects have often been known to be not only baneful, but even fatal.</p>	<p>patients within the hospital whereas Clause 54 of <i>Good Medical Practice</i> (2013) is concerned with the communication of the personal beliefs of the practitioner. This would suggest at the very least either a shift in the responsibilities of practitioners away from controlling access to hospitals or a shift in the practices of clergymen away from exercising free access to patients.</p>
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 54: 54. You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.</p>	
<p>Article 7</p>	
<p>§ 7 It is one of the circumstances which softens the lot of the poor, that they are exempt from the solitudes attendant on the disposal of property. Yet there are exceptions to this observation; and it may be necessary that an hospital patient, on the bed of sickness and death, should be reminded by some friendly monitor of the importance of a last will and testament to his wife, children, or relatives, who otherwise might be deprived of his effects, of his expected prize money, or of some future residuary legacy. This kind office will be best performed by the House Surgeon, whose frequent attendance on the sick diminishes their reserve, and entitles him to their familiar confidence. And he will doubtless regard the performance of it as a duty; for whatever is right to be done, and cannot by another be so well done, has the full force of moral and personal obligation.</p>	<ul style="list-style-type: none"> • This concept of providing legal advice regarding wills has not been replicated in the modern code of ethics • <i>Medical Ethics</i> article 7 challenges assumptions about the poor, but offers some kind of legal counsel where it is likely that no one else would.
<p>No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).</p>	
<p>Article 8</p>	
<p>§ 8 The Physicians and the Surgeons should not suffer themselves to be restrained by parsimonious considerations from prescribing wine, and drugs even of high price, when required in diseases of extraordinary malignancy and danger. The efficacy of every medicine is proportionate to its purity and goodness; and on the degree of these properties, <i>caeteris paribus</i>, both the cure of the sick and the speediness of its accomplishment must depend. But, when drugs of inferior quality are employed, it is requisite to administer them in large doses, and to continue the use of them for a longer period of time; circumstances which probably more than counterbalance any savings in their original price. If this is the case, however, were far otherwise, no economy of a fatal tendency ought to be admitted into institutions, founded on</p>	<ul style="list-style-type: none"> • This concept regarding the prescribing of effective medicines has been replicated in the modern code of ethics • <i>Caeteris paribus</i> means ‘all other things being equal’

<p>principles of the purest beneficence, and which, in this age and country, when well conducted, can never want contributions adequate to their liberal support.</p>	<ul style="list-style-type: none"> • The lack of a similar clause in <i>Good Medical Practice</i> (2013) may reflect the organisation and regulation of the pharmaceutical industry.
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 16a and b: 16. In providing clinical care you must: a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient’s health and are satisfied that the drugs or treatment serve the patient’s needs b. provide effective treatments based on the best available evidence.</p>	
Article 9	
<p>§ 9 The Medical gentlemen of every charitable institution are in some degree responsible for, and the guardians of, the honour of each other. No Physician or Surgeon, therefore, should reveal occurrences in the hospital, which may injure the reputation of any one of his colleagues; except under the restriction contained in the succeeding article.</p>	<ul style="list-style-type: none"> • This concept of treating colleagues with respect has been replicated in the modern code of ethics • It is likely that this was one of the crucial articles in <i>Medical Ethics</i> that brought an end to the disputes between practitioners that were occurring in Manchester at the time.
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 35, 36, 37, and 59: 35. You must work collaboratively with colleagues, respecting their skills and contributions. 36. You must treat colleagues fairly and with respect. 37. You must be aware of how your behaviour may influence others within and outside the team. 59. You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance, and follow the guidance in paragraph 25c if the behaviour amounts to abuse or denial of a patient’s or colleague’s rights.</p>	
Article 10	
<p>§ 10 No professional charge should be made by a Physician or Surgeon, either publicly or privately, against and associate, without previously laying the complaint before the gentlemen of the Faculty belonging to the institution, that they may judge concerning the reasonableness of its grounds, and the measures to be adopted.</p>	<ul style="list-style-type: none"> • This concept of adhering to a complaints procedure has been replicated in the modern code of ethics • It is likely that this was one of the crucial articles in <i>Medical Ethics</i> that brought an end to the disputes between practitioners that were occurring in Manchester at the time.
<p>Compare with <i>Good Medical Practice</i> (2013) articles 24, 25c: 24. You must promote and encourage a culture that allows all staff to raise concerns openly and safely. 25c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.</p>	

Article 11	
<p>§ 11 A proper discrimination being established in all hospitals between medical and Chirurgical cases, it should be faithfully adhered to by the Physicians and Surgeons on the admission of patients.</p>	<ul style="list-style-type: none"> • This concept of working within the limits of competence has been replicated in the modern code of ethics.
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 14, 15c, 16a and 16d: 14. You must recognise and work within the limits of your competence 15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must: c. refer a patient to another practitioner when this serves the patient’s needs. 16. In providing clinical care you must: a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient’s health and are satisfied that the drugs or treatment serve the patient’s needs. d. consult colleagues where appropriate.</p>	
Article 12	
<p>§ 12 Whenever cases occur, attended with circumstances not heretofore observed, or in which the ordinary modes of practice have been attempted without success, it is for the public good, and in an especial degree advantageous to the poor, (who, being the most numerous class of society, are the greatest beneficiaries of the healing art,) that new remedies and methods of Chirurgical treatment should be devised. But in the accomplishment of this salutary purpose the gentlemen of the Faculty should be scrupulously and conscientiously governed by sound reason, just analogy, or well authenticated facts. And no such trials should be instituted without previous consultation of the Physicians or Surgeons, according to the nature of the case.</p>	<ul style="list-style-type: none"> • This concept regarding the development of new remedies via experimentation has not been replicated in the modern code of ethics. • This refers to research and while it refers to the public good and sound reason for trial, it is silent on informed consent. • <i>Good Medical Practice</i> (2013) has as a reference the supporting document: <i>Consent to Research</i> (General Medical Council, 2010). Research on human participants in the UK is covered by other laws and guidelines (UK Research Integrity Office, 2006), and <i>Good Medical Practice</i> (2013) requires a familiarity with those.
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 11, 12: 11. You must be familiar with guidelines and developments that affect your work. 12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.</p>	

Article 13	
<p>§ 13 To advance professional improvement, a friendly and unreserved intercourse should subsist between the gentlemen of the Faculty, with a free communication of whatever is extraordinary or interesting in the course of their hospital practice. And an account of every case or operation, which is rare, curious, or instructive, should be drawn up by the Physician or Surgeon to whose charge it devolves, and entered in a register kept for the purpose, but open only to the Physicians and Surgeons of the charity.</p> <p>Compare with <i>Good Medical Practice</i> (2013) clauses 7–13:</p> <p>7. You must be competent in all aspects of your work, including management, research and teaching.</p> <p>8. You must keep your professional knowledge and skills up to date.</p> <p>9. You must regularly take part in activities that maintain and develop your competence and performance.</p> <p>10. You should be willing to find and take part in structured support opportunities offered by your employer or contracting body (for example, mentoring). You should do this when you join an organisation and whenever your role changes significantly throughout your career.</p> <p>11. You must be familiar with guidelines and developments that affect your work.</p> <p>12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.</p> <p>13. You must take steps to monitor and improve the quality of your work.</p>	<ul style="list-style-type: none"> • This concept of continuing professional development has been replicated in the modern code of ethics • Compare the use of “should” in <i>Medical Ethics</i> and “must” in <i>Good Medical Practice</i> (2013) in this particular section.
Article 14	
<p>§ 14 Hospital registers usually contain only a simple report of the number of patients admitted and discharged. By adopting a more comprehensive plan they might be rendered subservient to Medical science and beneficial to mankind. The following sketch is offered with deference to the gentlemen of the Faculty. Let the register consist of three tables: the first specifying the number of patients admitted, cured, relieved, discharged, or dead: the second, the several diseases of the patient of the patients, with their events; the third, the sexes, ages, and occupations of the patients. The ages should be reduced into classes; and the tables adapted to the four divisions of the year. By such an institution, the increase or decrease of sickness; the attack, progress, and cessation of epidemics; the comparative healthiness of different situations, climates, and seasons; the influence of particular trades and manufactures on health and life; with many other curious circumstances, not more interesting to Physicians than to the community, would be ascertained with sufficient precision.</p>	<ul style="list-style-type: none"> • This concept of maintaining records has been replicated in the modern code of ethics • Both documents provide very specific instructions for record-keeping. In the case of <i>Medical Ethics</i> it seems to have been a very early form of data collection for analysis for quality improvement purposes or disease tracking.

<p>Compare with <i>Good Medical Practice</i> (2013) clauses 13, 19–23:</p> <p>13. You must take steps to monitor and improve the quality of your work.</p> <p>19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.</p> <p>20. You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.¹⁰</p> <p>21. Clinical records should include:</p> <ul style="list-style-type: none">a. relevant clinical findingsb. the decisions made and actions agreed, and who is making the decisions and agreeing the actionsc. the information given to patientsd. any drugs prescribed or other investigation or treatmente. who is making the record and when <p>22. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:</p> <ul style="list-style-type: none">a. taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessaryb. regularly reflecting on your standards of practice and the care you providec. reviewing patient feedback where it is available. <p>23. To help keep patients safe you must:</p> <ul style="list-style-type: none">a. contribute to confidential inquiriesb. contribute to adverse event recognitionc. report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at riskd. report suspected adverse drug reactionse. respond to requests from organisations monitoring public health. <p>When providing information for these purposes you should still respect patients' confidentiality.</p>	
--	--

Article 15	
<p>§ 15 By the adoption of the register recommended in the foregoing article, Physicians and Surgeons would obtain a clearer insight into the comparative success of their hospital and private practice; and would be incited to a diligent investigation of the causes of such difference. In particular diseases it will be found to subsist in a very remarkable degree: and the discretionary power of the Physician or Surgeon in the admission of patients, could not be exerted with more justice or humanity, than in refusing to consign to lingering suffering and almost certain death a numerous class of patients, inadvertently recommended as objects of these charitable institutions. “In judging of the diseases with regard to the propriety of their reception into hospitals,” says an excellent writer, “the following general circumstances are to be considered:—</p> <p>“Whether they be capable of speedy relief; because, as it is the intention of charity to relieve as great a number as possible, a quick change of objects is to be wished; and also because the inbred disease of hospitals will almost inevitably creep in some degree upon one who continues a long time in them, but will rarely attack one whose stay is short.</p> <p>“Whether they require in a particular manner the superintendence of skilful persons, either on account of their acute and dangerous nature, or any singularity or intricacy attending them, or erroneous opinions prevailing among the common people concerning their treatment.</p> <p>“Whether they be contagious, or subject in a peculiar degree to corrupt the air and generate pestilential diseases.</p> <p>“Whether a fresh and pure air be peculiarly requisite for their cure, and they be remarkably injured by any vitiation of it^a.”</p> <p>a. See Aikin’s <i>Thought on Hospitals</i>. P.21.</p>	<ul style="list-style-type: none"> • This concept of triaging has not been replicated in the modern code of ethics because such advice is the domain of the various clinical guidelines regarding triage. However, the concept of making best use of resources has been replicated. • This advice is framed as driving the best outcome for patients in relation to whether their condition is best relieved by their admission to hospital or not. It also contains an element of managing the allocation of resources.
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 25b and 56:</p> <p>25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.</p> <p>b. If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.</p> <p>56. You must give priority to patients on the basis of their clinical need if these decisions are within your power. If inadequate resources, policies or systems prevent you from doing this, and patient safety, dignity or comfort may be seriously compromised, you must follow the guidance in paragraph 25b.</p>	

Article 16	
<p>§ 16 But no precautions relative to the reception of patients who labour under maladies incapable of relief, contagious in their nature, or liable to be aggravated by confinement in an impure atmosphere, can obviate the evils arising from close wards, and the false economy of crowding a number of persons into the least possible space. There are inbred diseases which it is the duty of the Physician or Surgeon to prevent, as far as lies in his power, by a strict and persevering attention to the whole medical polity of the hospital. This comprehends the discrimination of cases admissible, air, diet, cleanliness, and drugs; each of which articles should be subjected to a rigid scrutiny at stated periods of time.</p>	<ul style="list-style-type: none"> • This concept of ‘do no harm’ has been replicated in the modern code of ethics. • This is about realising the limitations of the situation and not making a condition worse for the patient.
Article 17	
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 2 and 25b: 2. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability. 25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised. b. If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.</p>	<ul style="list-style-type: none"> • This concept of facilitating truthful communication has been replicated in the modern code of ethics. • The inclusion of this article in <i>Medical Ethics</i> may have also been a strategic move by Percival to keep the Faculty united and to limit the power of the charity.
<p>§ 17 The establishment of a committee of the gentlemen of the Faculty, to be held monthly, would tend to facilitate this interesting investigation, and to accomplish the most important objects of it. By the free communication of remarks, various improvements would be suggested; by the regular discussion of them, they would be reduced to a definite and consistent form; and by the authority of united suffrages, they would have full influence over the governors of the charity. The exertions of individuals, however benevolent or judicious, often give rise to jealousy, are opposed by those who have not been consulted, and prove inefficient by wanting the collective energy of numbers.</p>	<ul style="list-style-type: none"> • This concept of facilitating truthful communication has been replicated in the modern code of ethics. • The inclusion of this article in <i>Medical Ethics</i> may have also been a strategic move by Percival to keep the Faculty united and to limit the power of the charity.
Article 17	
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 24 and 25: 24. You must promote and encourage a culture that allows all staff to raise concerns openly and safely. 25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.</p>	<ul style="list-style-type: none"> • This concept of facilitating truthful communication has been replicated in the modern code of ethics. • The inclusion of this article in <i>Medical Ethics</i> may have also been a strategic move by Percival to keep the Faculty united and to limit the power of the charity.

<p>a. If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.</p> <p>b. If patients are at risk because of inadequate premises, equipment*or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.</p> <p>c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.</p>	
Article 18	
<p>§ 18 The harmonious intercourse which has been recommended to the gentlemen of the Faculty will naturally produce frequent consultations, viz, of the Physicians on Medical cases, of the Surgeons on Chirurgical cases, and of both united in cases of a compound nature, which, falling under the department of each, may admit elucidation by the reciprocal aid of two professions.</p>	<ul style="list-style-type: none"> • This concept of working collaboratively with colleagues has been replicated in the modern code of ethics.
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 35 and 36: 35 You must work collaboratively with colleagues, respecting their skills and contributions. 36 You must treat colleagues fairly and with respect.</p>	
Article 19	
<p>§ 19 In consultations on Medical cases the junior Physician present should deliver his opinion first, and others in progressive order of their seniority. The same order should be observed in Chirurgical cases; and a majority should be decisive in both: but if the numbers be equal, the decision should rest with the Physician or Surgeon under whose care the patient is placed. No decision, however, should restrain the acting practitioner from making such variations in the mode of treatment, as future contingences may require, or a farther insight into the nature of the disorder may shew to be expedient.</p>	<ul style="list-style-type: none"> • This concept of arriving at an opinion has not been replicated in the modern code of ethics and is now the domain of clinical guidelines. • Prior to having an established scientific basis to support a diagnosis, there was a higher regard for practical experience and the role of the practitioner.
<p>No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).</p> <p>Although there may be a loose connection with clause 42: 42. You should be willing to take on a mentoring role for more junior doctors and other healthcare professionals.</p>	

Article 20	
<p>§ 20 In consultation on mixed cases the junior surgeon should deliver his opinion first, and his brethren afterwards in succession, according to progressive seniority. The junior Physician present should deliver his opinion after the senior Surgeon, and the other Physicians in the order above prescribed.</p>	<p>This concept of arriving at an opinion has not been replicated in the modern code of ethics and is now the domain of clinical guidelines.</p>
<p>No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).</p> <p>Although there may be a loose connection with clause 44:</p> <p>44. You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:</p> <p style="padding-left: 20px;">a. share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers.</p>	
Article 21	
<p>§ 21 In every consultation the case to be considered should be concisely stated by the Physician or Surgeon who requests the aid of his brethren. The opinions relative to it should be delivered with brevity, agreeably to the preceding arrangement, and the decisions collected in the same order. The order of seniority among the Physicians and Surgeons may be regulated by the dates of their respective appointments in the hospital.</p>	<p>This concept of arriving at an opinion has not been replicated in the modern code of ethics and is now the domain of clinical guidelines.</p>
<p>No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).</p>	
Article 22	
<p>§ 22 Due notice should be given of a consultation, and no person admitted to it except the Physicians and Surgeons of the hospital, and the House-Surgeon, without the unanimous consent of the gentlemen present. If an examination of the patient be previously necessary, the particular circumstances of danger or difficulty should be carefully concealed from him, and every just precaution used to guard him from anxiety or alarm.</p>	<p>This concept of managing patient anxiety by concealing information has not been replicated in the modern code of ethics. Matters of this nature are now more likely to be the domain of hospital procedural guidelines.</p>
<p>No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).</p>	

Article 23	
<p>§ 23 No important operation should be determined upon, without consultation of the Physicians and Surgeons, and the acquiescence of a majority of them. Twenty –four hours notice should be given of the proposed operation, except in dangerous accident, or when peculiar circumstances occur which may render delay hazardous. The presence of a spectator should not be allowed during an operation, without the express permission of the operator. All extra-official interference in the management of it should be forbidden. A decorous silence ought to be observed. It may be humane and salutary, however, for one of the attending Physicians or Surgeons to speak occasionally to the patient, to comfort him under his suffering, and to give him assurance (if consistent with the truth,) that the operation goes on well, and promises a speedy and successful termination.</p> <p>As a hospital is the best school for practical Surgery, it would be liberal and beneficial to invite in rotation two Surgeons of the town, who do not belong to the institution, to be present at each operation.</p>	<p>This concept of managing the number and type of people who attend the operating theatre has not been replicated in the modern code of ethics. Matters of this nature are now more likely to be the domain of hospital procedural guidelines.</p>
No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).	
Article 24	
<p>§ 24 Hospital consultations ought not to be held on Sundays, except in cases of urgent necessity; and on such occasions an hour should be appointed which does not interfere with attendance on public worship.</p>	<ul style="list-style-type: none"> • This concept of prioritising Sunday worship has not been replicated in the modern code of ethics. • Modern codes are more secular.
No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).	
Article 25	
<p>§ 25 It is an established usage in some hospitals to have a stated day of the week for the performance of operations. But this may occasion improper delay, or equally unjustifiable anticipation. When several operations are to take place in succession, one patient should not have his mind agitated by the knowledge of the sufferings of another. The Surgeon should change his apron, when besmeared; and the table or instruments should be freed from all marks of blood, and every thing that may excite terror.</p>	<p>This concept of optional removal of blood marks for the management of patient anxiety has not been replicated in the modern code of ethics and is now the domain of guidelines produced by the UK Department of Health (UK Department of Health, 2016).</p>
No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).	
Article 26	
<p>§ 26 Dispensaries afford the widest sphere for the treatment of diseases, comprehending not only such as ordinarily occur, but those which are so infectious, malignant, and fatal, as to be</p>	

<p>excluded from admission into infirmaries. Happily also they neither tend to counteract that spirit of independence which should be sedulously fostered in the poor, nor to preclude the practical exercise of those relative duties, “the charities of father, son, and brother,” which constitute the strongest moral bonds of society. Being institutions less splendid and expensive than hospitals, they are well adapted to towns of moderate size, and might even be established without difficulty in populous country districts. Physicians and Surgeons in such situations have generally great influence; and it would be truly honourable to exert it in a cause subservient to the interests of Medical Science, of commerce, and of philanthropy.</p> <p>The duties which devolve on gentlemen of the Faculty engaged in conduct of Dispensaries are so nearly similar to those of hospital Physicians and Surgeons, as to be comprehended under the same professional and moral rules. But greater authority and greater condescension will be found requisite in domestic attendance on the poor; and human nature must be intimately studied, to acquire that full ascendancy over the prejudices, the caprices, and the passions of the sick and of their relatives, which is essential to Medical success.</p>	<p>This concept of not judging the lifestyle of patients has been replicated in the modern code of ethics</p>
<p>Compare with <i>Good Medical Practice</i> (2013) clause 57: 57 The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient’s actions or lifestyle have contributed to their condition.</p>	
<p>Article 27</p>	
<p>§ 27 Hospitals appropriated to particular maladies are established in different places, and claim both the patronage and the aid of gentlemen of the Faculty. To an asylum for female patients labouring under syphilis it is to be lamented that discouragements have been too often and successfully opposed. Yet whoever reflects on the variety of diseases to which the human body is incident, will find that a considerable part of them are derived from immoderate passions and vicious indulgences. Sloth, intemperance, and irregular desires are the great sources of those evils which contract the duration and imbitter the enjoyment of life. But humanity, whilst she bewails the vices of mankind, incites us to alleviate the miseries which flow from them. And it may be proved that a Lock Hospital is an institution founded on the most benevolent principles, consonant to sound policy, and favourable to reformation and to virtue. It provides relief for a painful and loathsome distemper, which contaminates in its progress the innocent as well as the guilty, and extends its baneful influence to future generations. It restores to virtue and to religion those votaries whom pleasure has seduced or villainy betrayed, and who now feel sad experience that ruin, misery, and disgrace are the wages of sin. Over such objects pity</p>	<p>This concept of reforming sinners has not been replicated in the modern code of ethics</p>

<p>sheds the generous tear, austerity softens into forgiveness, and benevolence expands at the united please of frailty, penitence, and wretchedness 6.</p> <p>No peculiar rules of conduct are requisite in the medical attendance on Lock Hospitals: but, as these institutions must from the nature of their object be in a great measure shut from the inspection of the public, it will behove the Faculty to consider themselves as responsible in an extraordinary degree for their right government; that the moral, no less than the Medical purposes of such establishments may be fully answered. The strictest decorum should be observed in the conduct towards the female patients; no young pupils should be admitted into the house; every ministering office should be performed by nurses properly instructed; and books adapted to the moral improvement of the patients should be put into their hands, and given them on their discharge. To provide against the danger of urgent want, a small sum of money and decent clothes should at this time be dispensed to them; and when practicable, some mode should be pointed out of obtaining a reputable livelihood.</p> <p>6 See two reports, intended to promote the establishment of a Lock Hospital at Manchester, in the year 1774, inserted in the Author's Essays Medical, Philosophical, and Experimental, vol. ii. P. 263 (Works, vol. iv. P. 203)</p>	
<p>No equivalent or contrasting statement could be found in <i>Good Medical Practice</i> (2013).</p>	
<p>Article 28</p>	
<p>§ 28 Asylums for insanity possess accommodations and advantages, of which the poor must in all circumstances be destitute; and which no private family, however opulent, can provide. Of these schemes of benevolence all classes of men may have equal occasion to participate the benefits; for human nature itself becomes the mournful object of such institutions. Other diseases leave man a rational and moral agent, and sometimes improve both the faculties of the head and the affections of the heart. But lunacy subverts the whole rational and moral character, extinguishes every tender charity and excludes the degraded sufferer from all the enjoyments and advantages of social intercourse. Painful is the office of Physician, when he is called upon to minister to such humiliating objects of distress; yet grant must be his felicity, when he can render himself instrumental, under Providence, in the restoration of reason and in the renewal of the lost image of GOD. Let no one, however, promise himself divine privilege, if he be not deeply skilled in the philosophy of human nature; for, though casual success may sometimes be the result of empirical practice, the medicina mentis can only be administered with steady efficacy by him, who, to a knowledge of the animal economy and of</p>	<p>This concept of working within the limits of competence has been replicated in the modern code of ethics.</p>

<p>the physical causes which regulate or disturb its movements, unites an intimate acquaintance with the laws of association, the control of fancy over judgement, the force of habit, the direction and comparative strength of opposite passions, and the reciprocal dependences and relations of the moral and intellectual powers of man.</p>	
<p>Compare with <i>Good Medical Practice</i> (2013) clause 14: 14. You must recognise and work within the limits of your competence.</p>	
<p>Article 29</p>	
<p>§ 29 Even thus qualified with the pre-requisite attainments, the Physician will find that he has a new region of Medical Science to explore; for it is a circumstance to be regretted both by the Faculty and the public, that the various diseases which are classed under the title of insanity remain less understood than any others with which mankind are visited. Hospital institutions furnish the best means of acquiring more accurate knowledge of their causes, nature, cure; but this information cannot be attained, to any satisfactory extent, by the ordinary attention to single and unconnected cases. The synthetic plan should be adopted; and a regular journal should be kept of every species of the malady which occurs, arranged under proper heads, with a full detail of its rise, progress, and termination; of the remedies administered, and of their effects in its several stages. The age, sex, occupation, mode of life, and (if possible,) hereditary constitution of each patient should be noted; and, when the event proves fatal, the brain and other organs affected should be carefully examined, and the appearances on dissection minutely inserted in the journal. A register like this in the course of a few years would afford the most interesting and authentic documents, the want of which on a late melancholy occasion d was felt and regretted by the whole kingdom.</p> <p>d [alluding to the case of George III]</p>	<p>This concept of monitoring and improving the quality of work has been replicated in the modern code of ethics.</p>
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 13 and 22: 13. You must take steps to monitor and improve the quality of your work. 22. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:</p> <ol style="list-style-type: none"> a. taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary b. regularly reflecting on your standards of practice and the care you provide c. reviewing patient feedback where it is available. 	

Article 30	
<p>§ 30 Lunatics are in a great measure secluded from the observation of those who are interested in their good treatment; and their complaints of ill-usage are so often false or fanciful, as to obtain little credit or attention, even when well founded. The Physician, therefore, must feel himself under the strictest obligation of honour, as well as of humanity, to secure to these unhappy sufferers all the tenderness and indulgence compatible with steady and effectual government.</p>	<p>This concept of caring and advocating for vulnerable patients has been replicated in the modern code of ethics.</p>
<p>Compare with <i>Good Medical Practice</i> (2013) clause 27: 27. Whether or not you have vulnerable adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied.</p>	
Article 31	
<p>§ 31 Certain cases of mania seem to require a boldness of practice, which a young Physician of sensibility may feel a reluctance to adopt. On such occasions he must not yield to timidity, but fortify his mind by the counsels of his more experienced brethren of the Faculty. Yet, with this aid, it is more consonant to probity to err on the side of caution than temerity e.</p>	<p>This concept of taking part in procedures to which one has an objection has not been replicated in the modern code of ethics</p>
<p>Compare with <i>Good Medical Practice</i> (2013) clauses 52: 52. You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.</p>	

Bibliography

- Abbott, A., 1988. *The system of professions: An essay on the division of labor*. Chicago and London: The University of Chicago Press.
- Adams, J. S., Tashchian, A. & Shore, T. H., 2001. Codes of Ethics as Signals for Ethical Behavior. *Journal of Business Ethics*, 29(3), pp. 199–211.
- Aikin, J., 1771. *Thoughts on Hospitals*, London: Joseph Johnson.
- American Medical Association, n.d. *American Medical Association: E-History*. [Online] Available at: <http://www.ama-assn.org/ama/pub/category/8291.html> [Accessed 3 May 2016].
- American Society of Civil Engineers, 2016. *Code of Ethics*. [Online] Available at: http://www.asce.org/about_asce/ [Accessed 12 December 2016].
- America's Electric Cooperatives, 2017. *History: The story Behind America's Electric Cooperatives and NRECA*. [Online] Available at: <http://www.electric.coop/our-organization/history/> [Accessed 5 March 2017].
- Andersen, M. & Skjoett-Larsen, T., 2009. Corporate Social Responsibility in Global Supply Chains. *Supply Chain Management*, 14(2), pp. 75–86.
- Asgary, N. & Mitschow, M. C., 2002. Toward a Model for International Business Ethics. *Journal of Business Ethics*, 36(3), pp. 239–246.
- Australian Medical Association, 2015a. *Independence*. [Online] Available at: <https://ama.com.au/article/independence> [Accessed 28 December 2016].
- Australian Medical Association, 2015b. *One Voice*. [Online] Available at: <https://ama.com.au/article/one-voice> [Accessed 28 December 2016].
- Backof, J. F. & Martin Jr, C. L., 1991. Historical Perspectives: Development of the Codes of Ethics in the Legal, Medical and Accounting Professions. *Journal of Business Ethics*, 10(2), pp. 99–110.
- Badaracco Jr, J. L. & Webb, A. P., 1995. Business Ethics: A View from the Trenches. *California Management Review*, 37(2), pp. 8–28.
- Baker, R., 1993a. Deciphering Percival's Code. In: R. Baker, D. Porter & R. Porter, eds. *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Century Vol 1*. Dordrecht: Kluwer Academic Publishers.
- Baker, R., 1993b. The Formalization of Medical Ethics. In: R. Baker, D. Porter & R. Porter, eds. *The Codification of Medical Morality*. Dordrecht : Kluwer Academic Publishers, p. 141.
- Baker, R., 1993c. The History of Medical Ethics. In: W. F. Bynum & R. Porter, eds. *The Companion Encyclopedia of the History of Medicine Vol 2*. London ; New York : Routledge.
- Baker, R., 1999. Codes of Ethics: Some History. *Perspectives on the Professions*, 19(1), pp. 3–4.

- Baumhart, S.J., R. C., 1961. How Ethical are Businessmen? *Harvard Business Review*, 39(4), pp. 6-31.
- Beauchamp, T. L. & Childress, J. F., 1979. *Principles of biomedical ethics*. New York: Oxford University Press.
- Berenbeim, R., 2000. Global Ethics. *Executive Excellence*, 17(5), p. 7.
- Berger, P., 1983. On the Obsolescence of the Concept of Honor. In: S. Hauerwas & A. MacIntyre, eds. *Revisions, Changing Perspectives in Moral Philosophy*. Notre Dame: Notre Dame Press, pp. 172–181.
- Black, H. C., 1983. *Black's Law Dictionary (abridged 5th edition)*. St Paul, MN: West Publishing Company.
- Boeyink, D. E., 1994. How Effective Are Codes of Ethics? A Look at Three Newsrooms. *Journalism and Mass Communication Quarterly*, 71(4), pp. 893–904.
- Bondy, K., Matten, D. & Moon, J. 2006. *MNC Codes of Conduct: CSR or Corporate Governance?* [Online]
Available at:
<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.506.9104&rep=rep1&type=pdf>
[Accessed 7 October 2014].
- Borkowski, S. C. & Ugras, Y. J., 1998. Business Students and Ethics: A Meta-Analysis. *Journal of Business Ethics*, 17(11), pp. 1117–1127.
- Boudreaux, G. & Steiner, T., 2005. Developing a Code of Ethics. *Management Quarterly*, 46(1), pp. 2–19.
- Bourke, J., 2012. Pain, Sympathy and the Medical Encounter Between the Mid Eighteenth and the Mid Twentieth Centuries. *Historical Research*, 85(229), pp. 430-452.
- Bowden, P. & Surma, A., 2003. Codes of Ethics: Texts in Practice. *Professional Ethics*, 11(1), pp. 19–36.
- Brenner, S. N. & Molander, E. A., 1977. Is the Ethics of Business Changing? *Harvard Business Review*, 55(1), pp. 57–71.
- Bromwich, J. E., 2016. Ikea Reaches \$50 Million Settlement Over Deadly Furniture Accidents. *The New York Times*, 22 December. [Online]
Available at: <https://www.nytimes.com/2016/12/22/business/ikea-settlement-dresser-tip-over.html>
[Accessed 31 March 2017].
- Campbell, A. & Glass, K. C., 2000. The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research. *McGill Law Journal*, 46(2), pp. 473–489.
- Carrick, P., 1985. *Medical Ethics in Antiquity: Philosophical Perspectives on Abortion and Euthanasia*. Dordrecht: D. Reidel Publishing Company.
- Caux Round Table, n.d.. *About Caux Round Table*. [Online]
Available at: <http://www.cauxroundtable.org/index.cfm?&menuid=2>
[Accessed 12 January 2017].
- Caux Round Table, 2010. *Principles for Business*. [Online]
Available at: <http://www.cauxroundtable.org/index.cfm?menuid=8>
[Accessed 12 January 2017].
- Caux Round Table, 2003. *Principles for Responsible Globalization*. [Online]
Available at: <http://www.cauxroundtable.org/index.cfm?&menuid=103>
[Accessed 12 January 2017].

- Churchill, H., 1994. *Caesarean Birth: Conflict in Maternity Services*. A thesis submitted in partial fulfilment of the requirements of the Middlesex University. [Online] Available at: <https://eprints.mdx.ac.uk/6686/1/Churchill-phd.pdf> [Accessed 6 May 2014].
- Ciulla, J. B., 1992. Why Business is Talking About Ethics: Reflections on Foreign Conversations. In: J. Ogilvy, ed. *Revisioning Philosophy*. Albany, N.Y.: State University of New York Press, pp. 133–151.
- Claver, E., Llopis, J. & Gascó, J. L., 2002. A Corporate Culture Pattern to Manage Business Ethics. *International Journal of Value-Based Management*, 15(1), pp. 151–163.
- Cleek, M. A. & Leonard, S. L., 1998. Can Corporate Codes of Ethics Influence Behavior? *Journal of Business Ethics*, 17(6), pp. 619–630.
- Cooke, R. A., 1991. Danger Signs of Unethical Behaviour: How to Determine if Your Firm Is at Ethical Risk. *Journal of Business Ethics*, 10(4), pp. 249–253.
- Cressey, D. R. & Moore, C. A., 1983. Managerial Values and Corporate Codes of Ethics. *California Management Review*, 25(4), pp. 53–77.
- Crowther, M. A., 1995. Forensic Medicine and Medical Ethics in Nineteenth-Century Britain. In: R. Baker, ed. *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Centuries. Volume 2: Anglo-American Medical Ethics and Medical Jurisprudence in the Nineteenth Century*. Dordrecht: Kluwer Academic Publishers, pp. 173–190.
- Cruess, S. R. & Cruess, R. L., 2014. Professionalism and Medicine's Social Contract. *Focus on Health Professional Education*, 16(1), pp. 4–19.
- D'Agostino, F., Gaus, G. & Thrasher, J., 2017. Contemporary Approaches to the Social Contract. *The Stanford Encyclopedia of Philosophy*. [Online] Available at: <https://plato.stanford.edu/archives/sum2017/entries/contractarianism-contemporary> [Accessed 11 June 2017].
- Davis, M., 1991. Thinking Like an Engineer: The Place of a Code of Ethics in the Practice of a Profession. *Philosophy & Public Affairs*, 20 (2), pp. 150–167.
- Davis, M., 2003. What Can We Learn by Looking for the First Code of Professional Ethics? *Theoretical Medicine and Bioethics*, 24(5), pp. 433–454.
- Davis, A. L. & Rothstein, H. R., 2006. The Effects of the Perceived Behavioral Integrity of Managers on Employee Attitudes: A Meta-analysis. *Journal of Business Ethics*, 67(4), pp. 407–419.
- De George, R. T., 1986. Ethical Dilemmas for Multinational Enterprises: A Philosophical Overview. In Hoffman, Lange and Fedo, eds. *Ethics and the Multinational Enterprise: Proceedings of the Sixth National Conference on Business Ethics*. New York: Oxford University Press, pp. 39–46.
- De George, R. T., 1987. The Status of Business Ethics: Past and Future. *Journal of Business Ethics*, 6(3), pp. 201–211.
- Dobson, J., 2005. Monkey Business: A Neo-Darwinist Approach to Ethics Codes. *Financial Analysts Journal*, 61(3), pp. 59–64.
- Dobson, J. & Dobson, J., 2003. Why Ethics Codes Don't Work. *Financial Analysts Journal*, 59(6), pp. 29–34.
- Donaldson, T., 1989. *The Ethics of International Business*. New York: Oxford University Press.

- Donaldson, T., 1996. Values in Tension: Ethics Away from Home. *Harvard Business Review*, 74(5), pp. 48–62.
- Donaldson, T. & Dunfee, T., 1999. *Ties that Bind: A Social Contracts Approach to Business Ethics*. Boston: Harvard Business School Press.
- Edelstein, L., 1943. *The Hippocratic Oath: Text, Translation, and Interpretation*. Baltimore: Johns Hopkins Press.
- El'fred, H. B. & Koh, H. C., 2001. The Influence of Organizational and Code-Supporting Variables on the Effectiveness of a Code of Ethics. *Teaching Business Ethics*, 5(4), pp. 357–373.
- Elston, M. A., 2009. *Women and Medicine: The Future. A Report Prepared on Behalf of the Royal College of Physicians*. London: Royal College of Physicians.
- Encyclopædia Britannica, 2006. *Typhus disease*. [Online] Available at: <http://www.britannica.com/EBchecked/topic/611812/typhus#toc253300> [Accessed 5 May 2014].
- Esterhuizen, P., 2006. Is the Professional Code Still the Cornerstone of Clinical Nursing Practice? *Journal of Advanced Nursing*, 53(1), pp. 104–110.
- Ethics & Compliance Initiative, 2016. *Code of Conduct Construction and Content*. [Online] Available at: <http://www.ethics.org/resources/free-toolkit/code-construction> [Accessed 8 January 2017].
- Ethics Resource Centre, n.d. *Why Have a Code of Conduct*. [Online] Available at: <http://www.ethics.org/resource/why-have-code-conduct> [Accessed 20 April 2010].
- Farrell, B. J. & Cobbin, D. M., 2000. A Content Analysis of Codes of Ethics from Fifty-seven National Accounting Organisations. *Business Ethics*, 9(3), pp. 180–190.
- Farrell, B. J., Cobbin, D. M. & Farrell, H. M., 2002a. Can Codes of Ethics Really Produce Consistent Behaviours? *Journal of Managerial Psychology*, 17(6), pp. 468–490.
- Farrell, B. J., Cobbin, D. M. & Farrell, H. M., 2002b. Codes of Ethics: Their evolution, development and other controversies. *The Journal of Management Development*, 21(2), pp. 152–163.
- Freeman, R. E., 2010. *Strategic management: A stakeholder approach*. Cambridge university press.
- Freeman, R. E. & Harris, J. D., 2009. Creating Ties that Bind. *Journal of Business Ethics*, 88(supp. 4), p. 685–692.
- Friedman, M., 2016. A Friedman doctrine: The Social Responsibility Of Business Is to Increase Its Profits A Friedman business doctrine *The New York Times* (1923-Current file); New York, N.Y. [New York, N.Y] 13 Sep 1970: SM17. Available at: <https://search-proquest-com.virtual.anu.edu.au/docview/117925408/CDCBDA932A254FCCPQ/3?accountid=8330> [Accessed 4 February 2018].
- Friend, C., n.d. Social Contract Theory. *Internet Encyclopedia of Philosophy*. [Online] Available at: <http://www.iep.utm.edu/soc-cont/> [Accessed 13 January 2017].
- Gellatly, I. R., Meyer, J. P. & Luc, A. A., 2006. Combined Effects of the Three Commitment Components on Focal and Discretionary Behaviors: A Test of Meyer and Herscovitch's Propositions. *Journal of Vocational Behavior*, 69(2), pp. 331–345.

- General Medical Council, 1995. *Good Medical Practice (1995)*. Archived. [Online] Available at: http://www.gmc-uk.org/good_medical_practice_oct_1995.pdf 25416576.pdf [Accessed 23 January 2017].
- General Medical Council, 2006. *Good Medical Practice (2006)*. Archived. [Online] Available at: http://www.gmc-uk.org/good_medical_practice_archived.pdf 51772200.pdf [Accessed 23 January 2017].
- General Medical Council, 2010. *Good Practice in Research and Consent to Research*. [Online] Available at: http://www.gmc-uk.org/static/documents/content/Good_practice_in_research_and_consent_to_research.pdf [Accessed 23 January 2017].
- General Medical Council, 2013a. *Good Medical Practice (2013)*. [Online] Available at: http://www.gmc-uk.org/static/documents/content/GMP_.pdf [Accessed 30 December 2016].
- General Medical Council, 2013b. *Intimate examinations and chaperones (2013)*. [Online] Available at: http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp [Accessed 2 January 2017].
- General Medical Council, 2013c. *Maintaining a professional boundary between you and your patient (2013)*. [Online] Available at: http://www.gmc-uk.org/guidance/ethical_guidance/21170.asp [Accessed 2 January 2017].
- General Medical Council, 2013d. *Sexual behaviour and your duty to report colleagues (2013)*. [Online] Available at: http://www.gmc-uk.org/guidance/ethical_guidance/21185.asp [Accessed 2 January 2017].
- General Medical Council, 2016a. *Our role*. [Online] Available at: <http://www.gmc-uk.org/about/role.asp> [Accessed 30 December 2016].
- General Medical Council, 2016b. *Outcome of the initial engagement*. [Online] Available at: <http://www.gmc-uk.org/guidance/9878.asp> [Accessed 1 January 2017].
- General Medical Council, 2016c. *What we do - information for patients and the public*. [Online] Available at: http://www.gmc-uk.org/information_for_you/10433.asp [Accessed 30 December 2016].
- General Medical Council, 2017a. *Archived Ethical Guidance*. [Online] Available at: <http://www.gmc-uk.org/guidance/archive.asp> [Accessed 3 April 2017].
- General Medical Council, 2017b. *Decision tools and other learning materials*. [Online] Available at: <http://www.gmc-uk.org/guidance/20473.asp> [Accessed 23 January 2017].
- General Medical Council, 2017c. *Good medical Practice (2013)*. [Online] Available at: http://www.gmc-uk.org/guidance/good_medical_practice.asp [Accessed 2 January 2017].
- General Medical Council, 2017d. *When doctors don't follow the guidance*. [Online] Available at: <http://www.gmc-uk.org/guidance/21204.asp> [Accessed 23 January 2017].

- Gereffi, G. & Christian, M., 2009. The Impacts of Wal-Mart: The Rise and Consequences of the World's Dominant Retailer. *Annual Review of Sociology*, 35, pp. 573–591.
- Gill, D. & Griffin, A., 2010. Good Medical Practice: What Are We Trying to Say? Textual Analysis Using Tag Clouds. *Medical Education*, 44(3), pp. 316–322.
- Glenn, J. J. & Van Loo, M. F., 1993. Business Students' And Practitioners' Ethical Decisions Over Time. *Journal of Business Ethics*, 12(11), pp. 835–847.
- Google Scholar, 2017. *Toward an Agenda for Business Ethics Research kahn*, [Accessed 26 July 2017].
- Griggs, K., 2010. Codes of Ethics: Then and Now. *Australian Journal of Professional and Applied Ethics*, 12(1 and 2), pp. 80–94.
- Grinberg, E., 2007. The Impact of Sarbanes Oxley Act 2002 on Small Firms. *Honours College Theses*. Paper 56. [Online]
Available at: http://digitalcommons.pace.edu/honorscollege_theses/56
[Accessed 12 January 2017].
- Haimes, E., 2002. What can the Social Sciences Contribute to the Study of Ethics? Theoretical, Empirical and Substantive Considerations. *Bioethics*, 16(2), pp. 89–113.
- Hattwick, R. E., Shin, B.-G. P. & Wall, L. C., 1985. Business Ethics—Findings of a Survey of America's Business Leaders. *Journal of Behavioral Economics*, 13(2), pp. 157–185.
- Haws, D. . R., 2001. Ethics Instruction in Engineering Education: a (mini) Meta-analysis. *Journal of Engineering Education*, 90(2), pp. 223–229.
- He, Y. & Cai, T., 2012. The Ethics of Employment Relations in China: A Meta-analysis. *Chinese Management Studies*, 6(2), pp. 341–349.
- Health Information Management Association of Australia. 1992. *Code of Ethics* [Online]
Available at: <http://www.himea.org.au/>
[Accessed 28 February 2010].
- Hobbes, T., 2016. *Leviathan*. [Online]
Available at: <http://ebooks.adelaide.edu.au/h/hobbes/thomas/h68l/index.html>
[Accessed 13 January 2017].
- Hume, D., 1896. *David Hume, A Treatise of Human Nature (1896 ed.) [1739]*. [Online]
Available at: <http://oll.libertyfund.org/titles/hume-a-treatise-of-human-nature>
[Accessed 24 January 2017].
- Hurwitz, B. & Richardson, R., 1997. Swearing to Care: The Resurgence in Medical Oaths. *British Medical Journal*, 315(7123), p. 1671–1674.
- Hyman, M. R., Skipper, R. & Tansey, R., 1990. Ethical Codes are Not Enough. *Business Horizons*, 33(2), pp. 15–22.
- IKEA, 2008. *IWAY Standard*. [Online]
Available at:
http://www.ikea.com/ms/en_JP/about_ikea/pdf/SCGlobal_IWAYSTDVers4.pdf
[Accessed 31 March 2017].
- IKEA, 2016. *IWAY Our code of conduct*. [Online]
Available at: http://www.ikea.com/ms/en_AU/about_ikea/our_responsibility/iway/
[Accessed 31 March 2017].
- Institute of Business Ethics, 2012. *Nine Steps for Preparing a New Code*. [Online]
Available at: <http://www.ibe.org.uk/nine-steps-for-preparing-a-new-code/103/52>
[Accessed 8 January 2017].

- Institute of Business Ethics, 2012. *Ethical Values and Codes*, [Online] Available at: <http://www.ibe.org.uk/ethical-values-and-codes/102/52> [Accessed 8 January 2017].
- Irvine, D., 2006. A Short History of the General Medical Council. *Medical Education*, 40(3), pp. 202–211.
- Izraeli, D. & Schwartz, M. S., 1998. What Can We Learn from the US Federal Sentencing Guidelines for Organizational Ethics? *Journal of Business Ethics*, 17(9/10), p. 1045–1055.
- Jackson, T. A., Meyer, J. P. & Xiao-Hua, F. W., 2013. Leadership, Commitment, and Culture: A Meta-Analysis. *Journal of Leadership & Organizational Studies*, 20(1), pp. 84–106.
- Johnson and Johnson, 2008. *Our Credo*. [Online] Available at: http://www.jnj.com/sites/default/files/pdf/jnj_ourcredo_english_us_8.5x11_cmyk.pdf [Accessed 12 March 2014].
- Jones, T. M., 1991. Ethical Decision Making by Individuals in Organizations: an Issue-Contingent Model. *Academy of Management Review*, 16(2), pp. 366–395.
- Jones, T. M. & Gaultschi III, F. H., 1988. Will the Ethics of Business Change? A Survey of Future Executives. *Journal of Business Ethics*, 7(4), pp. 231–248.
- Jonsen, A. R., 2000. *A Short History of Medical Ethics*. New York: Oxford University Press.
- Kahn, W. A., 1990. Toward an Agenda for Business Ethics Research. *The Academy of Management Review*, 15(2), pp. 311–328.
- Kaptein, M., 2011. Toward Effective Codes: Testing the Relationship with Unethical Behavior. *Journal of Business Ethics*, 99(2), pp. 233–251.
- Kaptein, M. & Schwartz, M. S., 2008. The Effectiveness of Business Codes: A Critical Examination of Existing Studies and the Development of an Integrated Research Model. *Journal of Business Ethics*, 77(2), pp. 111–127.
- Kaptein, M. & Wempe, J., 1998. Twelve Gordian Knots When Developing an Organizational Code of Ethics. *Journal of Business Ethics*, 17(8), pp. 853–869.
- Kaye, B. N., 1992. Codes of Ethics in Australian Business Corporations. *Journal of Business Ethics*, 11(11), pp. 857–862.
- Key, S., 1999. Organizational Ethical Culture: Real or Imagined? *Journal of Business Ethics*, 20(3), p. 217–225.
- Kish-Gephart, J. J., Harrison, D. A. & Klebe Treviño, L., 2010. Bad Apples, Bad Cases, and Bad Barrels: Meta-analytic Evidence About Sources of Unethical Decisions at Work. *Journal of applied Psychology*, 95(1), pp. 1–31.
- Lagan, A., 2004. Must Ethics Forever Play Bridesmaid to Legal Compliance?. *Company Director*, 20(10), pp. 19–21.
- Langlois, C. C. & Schlegelmilch, B. B., 1990. Do Corporate Codes of Ethics Reflect National Character? Evidence from Europe and the United States. *Journal of International Business Studies*, 21(4), pp. 519–539.
- Locke, J., 2016. *The Second Treatise of Civil Government*. [Online] Available at: <https://ebooks.adelaide.edu.au/l/locke/john/l81s/index.html> [Accessed 17 January 2017].
- Locke, R., Kochan, T., Romis, M. & Qin, F., 2007. Beyond Corporate Codes of Conduct: Work Organization and Labour Standards at Nike's Suppliers. *International Labour Review*, 146(1/2), pp. 21–40.

- Martin, K. D. & Cullen, J. B., 2006. Continuities and Extensions of Ethical Climate Theory: a Meta-Analytic Review. *Journal of Business Ethics*, 69(2), pp. 175–194.
- McDonald, G. M., 2009. An Anthology of Codes Of Ethics. *European Business Review*, 21(4), pp. 344–372.
- McGraw, D. K., 2004. A Social Contract Theory Critique of Professional Codes of Ethics. *Journal of Information, Communication & Ethics in Society*, 2(4), pp. 235–243.
- Médecins Sans Frontières, 2017. *Médecins Sans Frontières / Doctors without Borders Charter*. [Online]
Available at: <http://www.doctorswithoutborders.org/about-us/history-principles/charter>
[Accessed 28 March 2017].
- Messikomer, C. M. & Cirka, C. C., 2010. Constructing a Code of Ethics: An Experiential Case of a National Professional Organization. *Journal of Business Ethics*, 95(1), pp. 55–71.
- Meyer, J. P., & Allen, N., 1991. A Three-Component Conceptualization of Organisational Commitment. *Human Resource Management Review*, 1(1), pp. 61–89.
- Meyer, J. P., & Allen, N., 1997. *Commitment in the Workplace: Theory, Research and Application*. Thousand Oaks, California: SAGE Publications.
- Meyer, J. P. & Herscovitch, L., 2001. Commitment in the Workplace: Toward a General Model. *Human Resource Management Review*, 11(3), pp. 299–326.
- Meyer, J. P., Stanley, D. J., Herscovitch, L. & Topolnytsky, L., 2002. Affective, Continuance, and Normative Commitment to the ORGANization: A Meta-Analysis Of Antecedents, Correlates, and Consequences. *Journal of Vocational Behavior*, 61(1), pp. 20–52.
- Murphy, D. E., 2002. Federal Sentencing Guidelines for Organizations: a Decade of Promoting Compliance and Ethics. *Iowa Law Review*, 87(2), pp. 697–719.
- National Archives UK, n.d. *The Struggle for Democracy: Britain and the French Revolution*. [Online]
Available at:
http://www.nationalarchives.gov.uk/pathways/citizenship/struggle_democracy/revolution.htm
[Accessed 5 May 2014].
- National Society of Professional Engineers, 1985. *Code of Ethics for Engineers (1985)*. [Online]
Available at: <http://ethics.iit.edu/ecodes/node/3274>
[Accessed 18 February 2014].
- National Society of Professional Engineers, 2017. *Code of Ethics for Engineers*. [Online]
Available at: <https://www.nspe.org/resources/ethics/code-ethics>
[Accessed 13 January 2017].
- New South Wales Police, 2008. *Code of Conduct and Ethics*. [Online]
Available at:
http://www.police.nsw.gov.au/data/assets/file/0015/4326/Code_of_Conduct_and_Ethics.pdf
[Accessed 28 February 2010].
- O’Fallon, M. J. & Butterfield, K. D., 2005. A Review of the Empirical Ethical Decision-Making Literature: 1996–2003. *Journal of Business Ethics*, 59(4), pp. 375–413.
- Oliverio, M. E., 1989. The Implementation of a Code of Ethics: The Early Efforts of One Entrepreneur, *Journal of Business Ethics*, 8(5), pp. 367–374.
- Olsen, L., 2004. *Making Corporate Responsibility Work: Lessons from Real Business*. Berkhamsted: Ashridge & British Quality Foundation.

O'Rourke, K. H. & Williamson, J. G., 2002. When Did Globalisation Begin? *European Review of Economic History*, 6(1), pp. 23–50.

OED Online, 2017. *Ethics, n.* Oxford University Press. [Online]

Available at:

<http://www.oed.com.virtual.anu.edu.au/view/Entry/355823?redirectedFrom=ethics#eid>
[Accessed 12 June 2017].

Oxford Living Dictionaries, 2017. *Definition of social contract in English.* [Online]

Available at: https://en.oxforddictionaries.com/definition/social_contract

[Accessed 13 January 2017].

Pan, Y. & Sparks, J. R., 2012. Predictors, Consequence, and Measurement of Ethical Judgments: Review and Meta-analysis. *Journal of Business Research*, 65(1), pp. 84–91.

Pence, G. E., 2004. *Classic Cases in Medical Ethics. Accounts of Cases that have Shaped Medical Ethics, with Philosophical, Legal and Historical Backgrounds.* New York: McGraw-Hill.

Percival, T., 1849. *Medical Ethics; or, A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*, third edition. Oxford: John Henry Parker.

Pickstone, J. V., 1985. *Medicine and Industrial Society: A History of Hospital Development in Manchester and Its Region, 1752–1946*, Manchester: Manchester University Press.

Pickstone, J. V., 1993. Thomas Percival and the Production of Medical Ethics. In: R. Baker, D. Porter & R. Porter, eds. *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Centuries. Volume One: Medical Ethics and Etiquette in the Eighteenth Century.* Dordrecht: Kluwer Academic Publisher.

Pickstone, J. V. & Butler, S. V. F., 1984. The Politics Of Medicine In Manchester, 1788–1792: Hospital Reform And Public Health Services in the Early Industrial City. *Medical History*, 28(3), pp. 227–249.

Plato, 2009. *Crito.* Translated by Benjamin Jowett. [Online]

Available at: <http://classics.mit.edu/Plato/crito.html>

[Accessed 12 February 2014].

Presidential Commission on the Space Shuttle Challenger Accident, 1986a. Events Leading up to the Challenger Mission. In: *Report of the Presidential Commission on the Space Shuttle Challenger Accident*. [Online]

Available at: <https://history.nasa.gov/rogersrep/v1ch2.htm>

[Accessed 14 February 2014].

Presidential Commission on the Space Shuttle Challenger Accident, 1986b. The Cause of the Accident. In: *Report of the Presidential Commission on the Space Shuttle Challenger Accident* [Online]

Available at: <https://history.nasa.gov/rogersrep/v1ch4.htm>

[Accessed 14 February 2014].

Presidential Commission on the Space Shuttle Challenger Accident, 1986c. The Contributing Cause of the Accident. In: *Report of the Presidential Commission on the Space Shuttle Challenger Accident*. [Online]

Available at: <https://history.nasa.gov/rogersrep/v1ch5.htm>

[Accessed 14 February 2014].

Rawls, J., 1971. *A Theory of Justice.* [Online]

Available at: <http://www.csus.edu/indiv/c/chalmersk/econ184sp09/johnrawls.pdf>

[Accessed 1 April 2017].

- Robin, D., Giallourakis, M., David, F. R. & Moritz, T. E., 1989. A Different Look at Codes of Ethics. *Business Horizons*, 32(1), pp. 66–73.
- Romani, L. & Szkudlarek, B., 2014. The Struggles of the Interculturalists: Professional Ethical Identity and Early Stages of Codes of Ethics Development. *Journal of Business Ethics*, 119(2), pp. 173–191.
- Rosenbaum, D., 2006. *Joseph Badaracco on How to Make a Tough Decision*. [Online] Available at: <http://www.cio.com/article/2445541/leadership-management/joseph-badaracco-on-how-to-make-a-tough--decision.html> [Accessed 19 February 2017].
- Rothkamm, J., 2008. On the Foundations of Law: Religion, Nature, Morals. *Ratio Juris*, 21(3), pp. 300–311.
- Roth, N. L., Hunt, T., Stavropoulos, M. & Babik, K., 1996. Can't We All Just Get Along: Cultural Variables in Codes of Ethics. *Public Relations Review*, 22(2), pp. 151–161.
- Rousseau, J.-J., 2012. On the Social Contract. In: J. T. Scott, ed. *The Major Political Writings of Jean Jacques Rousseau: The Two Discourses and the Social Contract*. Chicago: The University of Chicago Press, p. 167.
- Royal College of General Practitioners/General Practitioners Committee, 2008. *Good Medical Practice for General Practitioners*. London: Royal College of General Practitioners.
- Schwartz, M. S., 2002. A Code of Ethics for Corporate Codes of Ethics. *Journal of Business Ethics*, 41(1/2), pp. 27–43.
- Schwartz, M. S., 2004. Effective Corporate Codes of Ethics: Perceptions of Code Users. *Journal of Business Ethics*, Volume 55(4), pp. 323–343.
- Schwartz, M. S., 2005. Universal Moral Values for Corporate Codes of Ethics. *Journal of Business Ethics*, Volume 59(1), pp. 27–44.
- Schwartz, M. S., 2013. Developing and Sustaining an Ethical Corporate Culture: The Core Elements. *Business Horizons*, 56(1), pp. 39–50.
- Seshadri, D. V., Raghavan, A. & Hegde, S., 2007. Business Ethics: The Next Frontier for Globalizing Indian Companies. *Vikalpa*, 32(3), pp. 61–79.
- Shadish, W. R., 2015. The Meta-Analytic Big Bang. *Research Synthesis Method*, 6(3), pp. 246–264.
- Shortt, S. E., 1983. Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century. *Medical history*, 27(1), pp. 51–68.
- Sinason, D., 2005. Auditing the Ethical Environment. *Internal Auditing*, 20(6), pp. 3–8.
- Sinclair, A., 1993. Approaches to Organisational Culture and Ethics. *Journal of Business Ethics*, 12(1), pp. 63–73.
- Skubic, D. W. & Stening, B. W., 2009. What's in a Credo? A Critique of the Academy of Management's Code of Ethical Conduct and Code of Ethics. *Journal of Business Ethics*, 85(4), pp. 515–525.
- Smith, N., 1997. Strong Hermeneutics and Discourse Ethics. In: N. Smith, ed. *Strong Hermeneutics: Contingency and Moral Identity*. London and New York: Routledge, pp. 121–147.
- Snell, R. S. & Herndon, N. C., 2004. Hong Kong's Code of Ethics Initiative: Some Differences between Theory and Practice. *Journal of Business Ethics*, 51(1), pp. 75–89.
- Spaak, T., 2003. Legal Positivism, Law's Normativity, and the Normative Force of Legal Justification. *Ratio Juris*, 16(4), pp. 469–485.

- Sternberg, E., 2010. The Need for Realism in Business Ethics. *Reason Papers*, 31(Fall 2009), pp. 33–48.
- Stevens, B., 1994. An Analysis of Corporate Ethical Code Studies: “Where Do We Go From Here?”. *Journal of Business Ethics*, 13(1), pp. 63–69.
- Stevens, B., 2009. Corporate Ethical Codes as Strategic Documents: An Analysis of Success and Failure. *Electronic Journal of Business Ethics and Organization Studies*, 14(2), pp. 14–20.
- Stevens, J. M., Steensma, H. K. & Harris, D. A., 2005. Symbolic or Substantive Document? The Influence of Ethics Codes on Financial Executives' Decisions. *Strategic Management Journal*, 26(2), pp. 181–195.
- Sulmasy, D. P., 1999. What is an Oath and Why Should a Physician Swear One? *Theoretical Medicine and Bioethics*, 20(4), pp. 329–346.
- SurfStat Australia. 2014. *SurfStat Glossary*. [Online]
Available at: <http://surfstat.anu.edu.au/surfstat-home/glossary/glossary.html>
[Accessed 21 March 2014].
- Svensson, G. & Wood, G., 2003. The Dynamics of Business Ethics: a Function of Time and Culture. *Management Decision*, 41(4), pp. 350–361.
- The Lancet, 1935. A Chapter in Caesarean Section. *The Lancet*, 12 January, 225(5811), p. 102.
- Theunissen, C., 2007. It's About Time we had a Professional Oath in Psychology. *Australian Psychologist*, 43(1), pp. 55–60.
- Thoma, S. J. & Dong, Y., 2014. The Defining Issues Test of Moral Judgement Development. *Behavioral Development Bulletin*, 19(3), pp. 55–61.
- Tosh, J. & Lang, S., 2006. *The Pursuit of History: Aims, Methods and New Directions in the study of Modern History*, fourth edition. Dorchester: Pearson Education.
- Toulmin, S., 1982. How Medicine Saved the Life of Ethics. *Perspectives in Biology and Medicine*, 25(4), pp. 736–750.
- Tully, S. M. & Winer, R. S., 2014. The Role of the Beneficiary in Willingness to Pay for Socially Responsible Products: A Meta-Analysis. *Journal of Retailing*, 90(2), pp. 255–274.
- UK Department of Health, 2016. *Decontamination of surgical instruments (HTM 01-01)*. [Online]
Available at: <https://www.gov.uk/government/publications/management-and-decontamination-of-surgical-instruments-used-in-acute-care>
[Accessed 3 January 2017].
- UK Research Integrity Office, 2006. *3.7 Research Involving Human Participants, Human Material or Personal Data*. [Online]
Available at: <http://ukrio.org/publications/code-of-practice-for-research/3-0-standards-for-organisations-and-researchers/3-7-research-involving-human-participants-human-material-or-personal-data/>
[Accessed 2 January 2017].
- US Consumer Product Safety Commission, 2016. *Following an Additional Child Fatality, IKEA Recalls 29 Million MALM and Other Models of Chests and Dressers Due to Serious Tip-Over Hazard; Consumers Urged to Anchor Chests and Dressers or Return for Refund*. [Online]
Available at: <https://www.cpsc.gov/Recalls/2016/following-an-additional-child-fatality-ikea-recalls-29-million-malm-and-other-models-of>
[Accessed 31 March 2017].

- US Department of Justice, 2017. *Foreign Corrupt Practices Act*. [Online]
Available at: <https://www.justice.gov/criminal-fraud/foreign-corrupt-practices-act>
[Accessed 19 February 2014].
- US Department of State's Bureau for International Narcotics and Law Enforcement, 2000. *Fighting Global Corruption: Business Risk Management. Information for Global Businesses & Organizations on Navigating the International Anticorruption Environment*. [Online]
Available at: http://1997-2001.state.gov/www/global/narcotics_law/0005_inl_corruption.pdf
[Accessed 19 February 2014].
- Vatican Archives, 1997. *Catechism of the Catholic Church, Part Three Life in Christ, Section Two The Ten Commandments, Article 5 the fifth commandment*. [Online]
Available at: http://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a5.htm
[Accessed 13 January 2017].
- Verbos, A. K., Gerard, J. A., Harding, C. S. & Miller, J. S., 2007. The Positive Ethical Organization: Enacting a Living Code of Ethics and Ethical Organizational Identity. *Journal of Business Ethics*, 76(1), pp. 17–33.
- Victor, B. & Cullen, J.B., 1987. A Theory and Measure of Ethical Climates in Organizations. *Research in Corporate Social Performance and Policy*, 9(1), pp. 51–71.
- Von der Embse, T. J., Desai, M. S. & Desai, S., 2004. How Well are Corporate Ethics Codes and Policies Applied in the Trenches? Key Factors and Conditions. *Information Management and Computer Security*, 12(2), pp. 146–153.
- Walker, M. U., 2007. *Moral Understandings A Feminist Study in Ethics*. New York: Oxford University Press.
- Waples, E. P., Antes, A. L., Murphy, S. T., Connelly, S. & Mumford, M. D., 2009. A Meta-Analytic Investigation of Business Ethics Instruction. *Journal of Business Ethics*, 87(1), pp. 133–151.
- Weaver, G. R., 1995. Does Ethics Code Design Matter? Effects of Ethics Code Rationales and Sanctions on Recipients' Justice Perceptions and Content Recall. *Journal of Business Ethics*, 14(5), pp. 367–385.
- Weaver, G. R., Trevino, L. K. & Cochran, P. L., 1999. Corporate Ethics Practices in the Mid-1990's: An Empirical Study of the Fortune 1000. *Journal of Business Ethics*, 18(3), pp. 283–294.
- Webley, S. & Werner, A., 2008. Corporate Codes of Ethics: Necessary but Not Sufficient. *Business Ethics: A European Review*, 17(4), pp. 405–415.
- Wempe, B., 2009. Extant Social Contracts and the Question of Business Ethics. *Journal of Business Ethics*, 88(supp. 4), pp. 741–750.
- Wickham, M. & O'Donohue, W., 2012. Developing an Ethical Organization: Exploring the Role of Ethical Intelligence. *Organization Development Journal*, 30(2), pp. 9–29.
- Wikipedia, 2016. *Charles White (physician)*. [Online]
Available at: [https://en.wikipedia.org/wiki/Charles_White_\(physician\)](https://en.wikipedia.org/wiki/Charles_White_(physician))
[Accessed 30 December 2016].
- Winston, M. D., 2007. Ethical Leadership and Ethical Decision Making: a Meta-Analysis of Research Related to Ethics Education. *Library & Information Science Research*, 29(2), pp. 230–251.
- Wotruba, T. R., Chonko, L. B. & Loe, T. W., 2001. The Impact of Ethics Code Familiarity on Manager Behavior. *Journal of Business Ethics*, 33(1), pp. 59–69.