AN EXPLORATION OF THE MOTIVATION OF HEALTH PROFESSIONALS WHO COMPLETED A MASTER OF BIOETHICS AT MID-CAREER

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Abstract

This study examined how health professionals who completed a master of bioethics (MBE) degree at mid-career make sense of their decision to pursue the degree and how its attainment has impacted their sense of well-being in the workplace. Ryan and Deci’s Self-Determination Theory (SDT) provided the theoretical framework for this retrospective study. SDT explores how a person’s sense of motivation and well-being in the workplace may be impacted by the fulfillment of their psychological needs for autonomy, competence, and relatedness gained through the MBE education. Semi-structured interviews were conducted with five MBE alumnae from a master of bioethics degree program at a medical school in the Northeast. Transcripts were analyzed using Interpretative Phenomenological Analysis to identify themes. Four main themes emerged: intrinsic and career motivators, novelty, student experience, and post MBE career transitions. Drawing upon intrinsic motivation to care for others, this interdisciplinary degree program pushed these mid-career professionals to resolve professional conflicts, improve their confidence and competence, broaden their perspectives, move beyond their professional boundaries, and enhance their connections to a vibrant ethics community. Findings were interpreted in light of recent studies on motivation, burnout, moral distress, adult learning, and career transitions. Opportunities for program improvement and support structures for mid-career students are recommended.

*Keywords*: bioethics, adult learning, graduate education, motivation, self-determination theory, Master’s degree
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Chapter One: Introduction to the Study

The purpose of this Interpretative Phenomenological Analysis study is to understand and describe the motivation of mid-career health professionals who complete a master of bioethics degree at a medical school in the Northeast. The study seeks to understand how these professionals make sense of their decision to pursue the degree and how its attainment has impacted their sense of well-being in the workplace. Motivation is defined in the research as being moved to do something. A motivated person is “energized or activated toward an end” (Ryan & Deci, 2000, p. 54). A mid-career health professional is a person between the ages of 35-55 who works in a professional capacity in health care (such as a doctor, nurse, social worker, physician’s assistant). Knowledge generated through this study is expected to inform academic program development and admissions strategy for graduate and bioethics education programs.

Statement of the Problem

Health professionals experience a variety of stressors that can lead to burnout or poor patient care (Arnetz, 2001; Aust, Rugulies, Skakon, Scherzer, & Jensen, 2007). As adults gain career experience and proficiency, numerous professional development opportunities and requirements are considered which align with their goals, needs, and resources (Cable, Knab, Tham, Navedo, & Armstrong, 2014; Ikenwilo & Skåtun, 2014; Miller, Bligh, Stanley, & Al Shehri, 1998; Pool, Poell, Berings, & ten Cate, 2015, 2016). Workplaces are improved by practitioners who develop problem-solving and critical reflective learning skills through advanced learning activities (Kasworm, 2011). Master’s degrees provide a valuable option for revitalizing mid-career health professionals who desire to improve practice, gain knowledge, and expand career opportunities (ASHE, 2005; Belasco et. al, 2014; Cable et. al, 2014; Kasworm, 2011; Magnus, 2002; Pool et. al, 2015, 2016; Sisti, 2002; Watkins, 2011). However, completing
a master’s degree is not an easy task. Internal and external motivating factors impact student persistence through master’s programs. Embarking upon a master’s degree program at mid-career is a challenge taken on by a select group of individuals who may share similar driving forces and perspectives.

The master of bioethics is an interdisciplinary degree focused on ethics in medicine. Students are drawn to the study of bioethics from a wide range of professions both within and outside of health care (Magnus, 2002; Sisti, 2002). Professionals engaged in the field of bioethics include, but are not limited to: physicians, attorneys, nurses, social workers, researchers, philosophers, clergy, politicians, and journalists. The field has grown in response to the ethical challenges and questions that arise with the rapid advances and discoveries in the life sciences (Faden, 2004; Thehastingscenter.org, 2016). The Presidential Commission on the Study of Bioethics Issues states “graduate-level training for professionals…can create a cadre of individuals with a dual competence in both their field and in ethics” (United States, 2016, p. 81). Graduate training programs in bioethics have shown dramatic growth over the past two decades (Faden, 2004; Kuczewski & Parsi, 2002; Lee & McCarty, 2016; Magnus, 2002; Sisti, 2002; United States, 2016), yet little empirical research has been done to explore the factors that lead mid-career health professionals to attain these degrees.

The master of bioethics (MBE) program at Northeast Medical School (pseudonym) launched in the fall of 2015. The program is offered as a one-year full-time or two-year part-time program with all classes being held at the medical school in an urban New England city. The program targets mid-career professionals from a range of disciplines with limited spots available for recent traditional-age graduates of bachelor’s degree programs (post-bacs). Selling points of the MBE include a practical capstone experience, academically rigorous coursework,
an interdisciplinary cohort of students and faculty, and the prestige of a Northeast Medical school degree. In the admissions process, post-bac applications outnumber applications from mid-career professionals. However, program directors and others in the field of bioethics contend that a master of bioethics is most appropriate for those who have professional training and experience (Magnus, 2002). To ensure the master of bioethics program is designed and marketed appropriately, it is important to understand why and how mid-career health professionals are motivated to complete a master of bioethics program. Therefore, this study seeks to investigate how mid-career professionals make sense of their motivation to pursue a master of bioethics degree.

**Significance of the Research Question**

The rationale for this study is the researcher’s interest in expanding research on educational motivation at mid-career to address the recruitment and program support strategies for the master of bioethics degree program at Northeast Medical School. This research is important on many levels. First, at the program level, findings may be used to tailor recruitment and program structures to engage and support mid-career students. At the community level, energized MBE students and graduates can improve their work settings through increased competence and knowledge. Finally, at the society level, greater numbers of professionals can be prepared to understand, address, and manage the bioethical issues arising in emerging technologies, human subjects research, clinical decision making, public health emergencies, and other complex matters (United States, 2016).

Motivation is an “essential ingredient” to learning (Boyd, 1965). At mid-life, many factors may reduce motivation to engage in professional development activities (Miller et al., 1998). The variety and number of master’s programs available to mid-career professionals has
expanded with medical-related master’s degrees increasing from 5.6% in 1980 to 9.1% of total master’s degree awarded in 2001 (ASHE, 2005). As master’s degree programs become more numerous and diverse, competition to attract the best cohorts of students increases. The reasons and priorities reported by graduate students vary significantly between disciplines (Hardré & Hackett, 2015). Developers of academic programs interested in attracting and retaining mid-career health professionals must consider what drives this cohort of learners toward a specific formal degree program when there are several educational options. The information gained through this study will enable faculty and administrators to enhance aspects of their programs and outreach in ways most likely to yield a cohort of students who will benefit from the experience (Henderson, 2005; Kahn & Tollman, 1992).

As health care systems adapt in response to medical innovation, politics, and financial pressures, mid-career health professionals can become morally distressed and burned out which can negatively impact patient care (Arnetz, 2001; Grady et al., 2008; Lamiani, Borghi, & Argentero, 2017; Salyers et al., 2017). The benefits of mid-career engagement in advanced degree programs extend not only to the students themselves, but also to their enriched learning and improved work environments (Agger-Gupta & Etmanski, 2014; Kasworm, 2011; King, 2003; Pool et al., 2015, 2016). A study of mid-career professionals experiencing life transitions found that participants enrolled in higher education programs had greater career excitement and a better outlook on their future than those who were not enrolled (O’Connor & Wolfe, 1991). Increased involvement in higher education programs may result in revitalization rather than attrition of experienced providers. Advanced degree programs targeted toward mid-career health-care professionals may invigorate hospital systems; improving the lives of health-care providers, and the patients and families for whom they provide care. With the information gained
through this study, academic programs can strategically focus admissions and retention efforts, health care employee benefits policies may be enhanced, and well-educated health professionals can raise the bioethics literacy of their workplaces and communities.

The Presidential Commission for the Study of Bioethical Issues states that health care clinicians must “resolve dilemmas, understand the obligations of our professions, and attend to the broader, social impacts of our work” (United States, 2016, p. 53). This report advocates for bioethics education inside and outside the classroom from primary through graduate and professional schools (United States, 2016). Bioethics master’s degrees have experienced significant growth in multidisciplinary and flexible environments (Kuczewski & Parsi, 2002; Lee & McCarty, 2016; United States, 2016). Specifically, between 2003 and 2013, the number of institutions granting master’s degrees in bioethics grew from four to thirty (Lee & McCarty, 2016).

Students enrolled in bioethics programs gain moral confidence and opportunities to expand their career into more meaningful work (Grady et al., 2008; Magnus, 2002; Sisti, 2002). By supporting their employees’ attainment of a “more inclusive, discriminating, permeable, and integrative perspective” (Mezirow, 2001, p. 5), hospitals can increase the likelihood that moral action will be taken when complex cases are presented. This may reduce instances of moral distress in hospital staff and improve patient care (Epstein & Hurst, 2017; Grady et al., 2008). Medical advances continue to present opportunities to create and sustain life. Well-educated practitioners are needed to address the moral dilemmas set forth in local, national, and global arenas.
Research Problem and Research Questions

The purpose of this study with graduates of a master of bioethics degree program is to explore how and why they chose to pursue the MBE at mid-career and how that decision has impacted their workplace motivation. This study seeks to answer two questions:

1. How do MBE graduates make sense of their motivation and decision to enroll in a master of bioethics degree program at mid-career? and
2. How has the MBE degree program impacted their sense of motivation and well-being at work?

Definition of Key Terminology

Mid-career health professional – A person between the ages of 35-55 years old who works in a professional capacity in a health care setting.

Motivation – Intention and activation to pursue something, to act, or to behave in some way for some reason.

Master’s degree – Post-graduate or advanced degree that can be earned before or after a terminal degree typically completed in one to three years.

The following section of this chapter includes a description and discussion of Self-Determination Theory (SDT) that serves as the theoretical lens for this study.

Theoretical Framework

This study will use self-determination theory (SDT) to understand the educational motivation of working professionals who recently completed a Master of Bioethics degree. Initially developed by Deci and Ryan in 1985, self-determination theory offers a broad
framework for the study of human motivation, fulfillment, and psychological wellness. SDT is an organismic, empirical approach that considers how social, environmental, and individual factors impact people’s sense of initiative and performance through the satisfaction of their psychological needs for competence, relatedness, and autonomy. (Deci & Ryan, 1985, 2000; Deci, Vallerand, Pelletier, & Ryan, 1991; Merriam, Caffarella, & Baumgartner, 2007; Ryan & Deci, 2000b, 2017; “Selfdeterminationtheory.org,” n.d.; Walters, Silva, & Nikolai, 2017).

SDT is a phenomenological approach that relies on reflection and self-analysis making it a good fit for an Interpretative Phenomenology Analysis study (Ryan & Deci, 2017). Self-determination theory has been used in both qualitative and quantitative studies to analyze and understand human motivation in multiple environments including education (Deci, Koestner, & Ryan, 2001; Deci et al., 1991), professional development within health care (Nilsen, Olafsen, Steinsvåg, Halvari, & Grov, 2016; Tjin A Tsoi, de Boer, Croiset, Koster, & Kusurkar, 2016; Wouters et al., 2017), the work place (Deci, Olafsen, & Ryan, 2017; Deci & Ryan, 2000; Olafsen, Niemiec, Halvari, Deci, & Williams, 2017; Ryan & Deci, 2017) and many other contexts.

SDT posits that humans are innately predisposed to improve and expand their potential through the satisfaction of three basic psychological needs: competence, relatedness, and autonomy. The need for competence refers to a person’s sense of feeling effective and masterful as opposed to inadequate or deficient (Olafsen et al., 2017). A second need, relatedness, involves developing satisfying connections with and caring for important others. Autonomy concerns the extent to which people experience their behavior as chosen or as intentional, rather than being externally compelled or pressured (Ryan & Deci, 2017). Ryan and Deci (2000a, 2000b) define intrinsically motivated behaviors as those that are freely engaged out of interest, fun, or
challenge without regard for a tangible reward. Extrinsically motivated behaviors, on the other hand, are done to comply with an external regulation or achieve a certain result (Ryan & Deci, 2000a). Research has found that intrinsic motivations are the most pervasive in learning and development (Deci et al., 2001; Ryan & Deci, 2000b; Van den Broeck, Van Ruysseveldt, Smulders, & De Witte, 2011). Individual differences and social contexts that support or thwart the satisfaction of the needs for competence, relatedness, and autonomy impact intrinsically motivated behavior and self-regulation with improved performance and well-being associated with higher levels of autonomous motivation (Ryan & Deci, 2017).

**Self-determination’s Mini-theories**

Within the self-determination theory framework, six mini-theories have been developed that correspond to different aspects of motivation and psychological integration (Ryan & Deci, 2017). Each mini-theory provides a unique focus area for the evaluation of motivation. The mini-theories include: cognitive evaluation theory, organismic integration theory, causality orientations theory, basic psychological needs theory, goal contents theory, and relationships motivation theory. A brief synopsis of each mini-theory follows along with how they pertain to this study.

**Cognitive evaluation theory.** The first mini-theory focuses on how the environment impacts intrinsic motivation. In their meta-analysis of 128 experiments, Deci, Koestner, and Ryan (2001) found that rewards influence a person’s perceptions of competence and autonomy. In adults, feedback (verbal rewards) enhanced intrinsic motivation due to increased perceived competence. However, expected or tangible rewards decreased the sense of autonomy resulting in a reduced intrinsic motivation. When people are intrinsically motivated, they tend to learn more deeply, be more creative, and perform better at tasks requiring high-quality engagement.
Deci et al., 2001, 2017; Ryan & Deci, 2017). This mini-theory suggests that an educational program aligned to a professional’s career interests (intrinsic motivation) aimed at increasing feelings of competence and autonomy through faculty and peer feedback may result in a high level of motivation.

Organismic integration theory. In contrast to CET’s focus on intrinsic motivation, organismic integration theory (OIT) is concerned with how extrinsic forces such as social regulations and work policies impact behavior through processes of internalization and integration. In optimum situations, the values of regulations within a social or work context are identified and integrated into a person’s sense of self (Deci & Ryan, 2000). OIT proposed an “autonomy continuum” anchored by controlled and autonomous regulatory processes. In order from least to most autonomous, these types of motivations include external regulation, introjection, identification, integration, and intrinsic motivation (Deci & Ryan, 2000; Ryan & Deci, 2000b; Ryan & Deci, 2000; n.d.; selfdeterminationtheory.org). Investigators have contrasted autonomous (intrinsic, identified) with controlled (introjected, external) motivation finding that higher quality behavior and persistence is associated with greater relative autonomy (Deci et al., 2017; Deci & Ryan, 2000; Ryan & Deci, 2017). In numerous studies on employees and work organizations, autonomous motivation predicted less burnout, work exhaustion, and turnover while controlled forces resulted in the opposite results (Deci et al., 2017). Using an OIT lens, one may evaluate how autonomous factors aligning with interest and identity compare in their motivational impact to more controlling concerns such as compliance and hospital regulations in the decision to engage in the advanced study of bioethics.

Causality orientations theory. The focus of causality orientations theory (COT) is on individual differences in motivational tendencies. Three causality orientations are defined:
autonomous, controlled, and impersonal. An autonomous orientation tends to be intrinsic, integrated, and identified. Controlled orientation tends to follow introjected and external regulations. Finally, impersonal orientation is associated with amotivated or unregulated tendencies (Deci & Ryan, 1985; Ryan & Deci, 2017). Three types of social contexts align parallel to these orientations and are called autonomy-supportive, controlling, and amotivating. The healthiest development and personality integration are found in autonomy-supportive settings with autonomously oriented people. Controlled environments and orientations result in more rigid and defensive behavior. Impersonal orientation and amotivating settings result in the poorest well-being. According to COT, motivational orientations may be “primed” through changes in the environment such as managerial behaviors that encourage autonomy and feelings of competence and relatedness (Deci et al., 2017; Deci & Ryan, 2000). This mini-theory helps explain why people from the same work setting may perform more or less effectively. It may also be used to analyze why certain people are driven to engage in further education while their colleagues are not.

**Basic psychological needs theory.** The fourth SDT mini-theory, basic psychological needs theory (BPNT), focuses on the relationship between the satisfaction of needs and a person’s well-being. BPNT asserts that satisfaction of the basic psychological needs for autonomy, competence, and relatedness fosters well-being and increases resilience by strengthening inner resources. Ill-being and increased vulnerabilities for defensiveness and psychopathology may be elicited by toxic or abusive environments that frustrate a person’s basic psychological needs (Vansteenkiste & Ryan, 2013). As most working adults have experienced both need-fulfilling and need-thwarting environments, BPNT offers a lens into how these
environments (including the work-setting and the MBE program) impact a person’s sense of vitality.

**Goal contents theory.** Seven important life goals or aspirations considered by SDT’s fifth mini-theory include: personal development, meaningful relationships, community contributions, physical fitness, financial wealth, recognition or fame, and pleasing appearance or image. The first four goals are considered intrinsic aspirations while the last three are extrinsic (Deci et al., 2017). Goal contents theory (GCT) theorizes that a strong focus on extrinsic aspirations leads to diminished well-being while intrinsic pursuits lead to greater happiness. This is largely due to the tendency of extrinsic goals to be controlled rather than autonomous and to be less satisfying of the basic psychological needs (Ryan & Deci, 2017). Van den Broeck, Van Ruysseveldt, Smulders, and De Witte (2011) found that intrinsically motivated employees who participated in professional learning opportunities were less emotionally exhausted than employees who favored extrinsic aspirations. Students may aspire to earn an advanced degree for extrinsic (prestige, money, recognition from others) or intrinsic (personal development, community contributions) purposes. Although both intrinsic and extrinsic reasons factor into one’s decision to pursue a master’s degree, according to GCT, students who have intrinsic aspirations will likely be more satisfied after attaining the degree.

**Relationships motivation theory.** The sixth SDT mini-theory, relationships motivation theory (RMT), concerns the qualities and consequences of close relationships and social belonging. Satisfaction of all three basic needs within relationships is associated with more secure attachment, authenticity, and emotional resilience, as well as higher relationship-specific vitality and wellness. RMT can be used to evaluate the role of personal, collegial, supervisory, advising,
and mentoring relationships that impact learning motivation (Deci et al., 2017; Nilsen et al., 2016; Olafsen et al., 2017).

**Self-Determination Theory Motivation Bridging Professional and Educational Motivations**

SDT’s mini-theories considered together provide foci for the study into mid-career motivation to pursue a Master of Bioethics degree. Figure 1 shows how the core elements of self-determination theory can be applied to the connection between professional contexts and degree aspirations. This model was based on the basic model of self-determination theory in the workplace developed by Deci, Olafson, and Ryan (2017, p. 23).

![Diagram](image-url)
The model illustrates how the independent factors of workplace context, individual differences, and relationships are mediated by the satisfaction or frustration of basic psychological needs and autonomous or controlled forms of motivation. These factors impact work behaviors and feelings of wellness. These independent factors may lead to the decision to pursue the MBE degree and are represented by a one-directional arrow. The MBE pursuit in this model may both mediate and/or be impacted by how and why the student chose to pursue the degree. Double-sided arrows connect the degree completion outcome to the key mediators: satisfaction of basic psychological needs and autonomous or controlled motivations. This represents the interplay between how the pursuit of the degree facilitates or frustrates the student’s basic psychological needs for autonomy, competence, and relatedness and whether the education itself fulfills intrinsic purposes or fosters the integration of introjected or controlled regulations. While also considered an end result, achieving the MBE degree should enhance a student’s competence, relatedness, and autonomy in the workplace resulting in feelings of vitality and improved job performance. At the same time, feelings of inadequacy or poor performance may impact the decision to enroll. Therefore, the two directional arrows between MBE pursuit and work behaviors and wellness represent the interchange between these dependent factors and the MBE pursuit as a mediator of motivation.

**Critics of Self-determination Theory**

Self-determination theory provides a more humanistic view than that of behaviorism. Behaviorists believe that human behavior is conditioned and determined by external forces in environment. Underlying assumptions of behaviorism include a focus on observed behavior, how the environment shapes behavior, and a learning process driven through reinforcement and contiguity (Merriam et al., 2007). Behaviorists, such as Skinner, are not concerned with internal
emotions or insights, but rather focus on manipulation and observed behavior changes (Elias & Merriam, 2004; Ryan & Deci, 2017). This philosophy provides adults with little self-control or decision-making abilities and is not appropriate for a study on why an adult chooses to enroll in advanced education.

As a contrast to behaviorism, humanist education is student-centered with the goal being for a student to become “self-actualized” (Elias & Merriam, 2004). One model developed by Abraham Maslow is a “hierarchy of needs” in which humans move toward self-actualization after ensuring lower-levels needs are satisfied. At the lowest level are physiological needs, followed by safety, belonging, esteem, and finally self-actualization (Elias & Merriam, 2004). This process moves from external influences and basic needs to an inherent, yet not always fulfilled, intrinsic “need” to be your best. As this study is focused on high-functioning, well-educated adult students whose basic needs are fulfilled, self-determination theory extends the concept of self-actualization to provide a framework for the multiple factors that play into motivation to pursue an advanced degree in bioethics.

Major criticism of SDT came from Cameron & Pierce (1996) who argued through their meta-analysis of 96 studies that rewards do not decrease intrinsic motivation and that reinforcements may increase intrinsic motivation. Deci, Koestner, and Ryan (2001) responded with a meta-analysis concluding that Cameron and Pierce’s analysis was “seriously flawed”. They found that tangible rewards significantly undermined intrinsic motivation lending further support for Cognitive Evaluation Theory (CET). However, verbal rewards increase competence and have been shown in SDT studies to increase motivation. The sheer number of SDT studies used in quantitative and qualitative studies provides support for a continued analysis within this framework.
Reiss (2012) argues that the intrinsic-extrinsic dualism described in SDT lacks the scientific criteria of construct validity, measurement reliability, experimentally controlled studies, and the elimination of other reasonable alternatives. He argues for a more multi-faceted approach to motivation and identified 16 universal needs including: acceptance, curiosity, eating, family, honor, idealism, independence, order, physical activity, power, romance, saving, social contact, status, tranquility, and vengeance. These needs may be prioritized differently, but are present in all human beings. While this theory provides some insight into human motivation, it lacks the psychological components and interplay between the self, the social context, and internalization of extrinsic regulations that can be achieved using SDT.

Rationale for using Self-determination Theory

Self-determination theory has been widely studied for over 30 years and provides a broad framework to study human motivation. Master’s degrees represent a bridge between academia and the workplace offered in formats desirable for working adults (ASHE, 2005). SDT has been used in a wide variety of settings with the most closely aligned settings to this study being in education and employment settings. In addition, SDT has been applied to health care and medical education environments providing insights and validity for a medical school context. Therefore, this study will build upon prior SDT studies in education, workplace, health care, and medical education.

Application of Self-determination Theory

For the purposes of this research, it is important to consider the multiple contexts through which working adults are motivated to pursue advanced education. Through its six mini-theories, SDT offers multiple dimensions through which a person may be driven. SDT
recognizes the strength of intrinsic motivation, but also factors in how relationships, work contexts, personal orientations, aspirations, and psychological well-being impact why people do what they do. Through the flexible use of open-ended questions, subjects can reflect and share how each of these factors impacted their pursuit of the Master of Bioethics degree. Using the SDT framework, responses can be analyzed to evaluate how subjects made sense of their experience in fulfilling their basic psychological needs for autonomy, relatedness, and competence through advanced education.

**Conclusion**

Well-educated practitioners are needed to respond to and manage the ethical dilemmas resulting from biological advances in the life sciences (United States, 2016). The Master of Bioethics degree program provides an opportunity for mid-career professionals to gain ethical competence in their chosen fields to improve and safeguard health care systems, human subjects research, public health, and society at large (Faden, 2004; Kuczewski & Parsi, 2002; Lee & McCarty, 2016; Magnus, 2002; United States, 2016). Students who engage in the MBE program at mid-career can practically and quickly integrate learning into their work setting (Kuczewski & Parsi, 2002). They bring insights from their work experiences into the classroom making them an extremely valuable resource for other students in the program. However, mid-career students are more challenging to recruit than recent graduates due to increased responsibilities and other factors. Despite these challenges, mid-career students have been motivated to pursue and complete the degree and have expanded their careers in new directions.

To better understand the factors that influence the decision of mid-career professionals to enroll and complete the Master of Bioethics degree program, the theoretical framework of self-determination theory was chosen. This framework serves to focus on how workplace contexts,
individual differences, relationships, and aspirations are mediated by the basic psychological needs for competence, relatedness, and autonomy in the pursuit of a Master of Bioethics degree. SDT studies have been conducted in workplace, education, and health care settings and this study will bridge these arenas. The following chapter contains a literature review describing studies involving professional development and adult education, workplace motivation and stressors, and the field of bioethics that led to the research problem being studied.
Chapter Two: Literature Review

In this literature review, the health-care workplace context, career, and continuing education factors impacting the motivation of mid-career professionals to pursue a master of bioethics degree (MBE) are explored. Well-educated practitioners are needed to improve and safeguard health care systems (United States, 2016) and mid-career MBE graduates gain dual competency in their profession, practically and rapidly integrating their learning into their work setting (Kuczewski & Parsi, 2002). In order to recruit, engage, and educate professionals capable of protecting and managing ethical dilemmas in the life sciences, a greater understanding of factors impacting the motivation of mid-career professionals to pursue advanced study in bioethics is vital. The purpose of this study with recent graduates of a master of bioethics degree program is to explore how and why they chose to pursue this degree at mid-career.

Understanding the convergence of careers in health care, mid-life factors, formal and informal education, and the nature and importance of the field of bioethics itself can provide a lens into how the pursuit of the MBE may be driven by the satisfaction or frustration of basic psychological needs for autonomy, competence, and relatedness of health-care professionals. The review is organized as follows. First, information and research about health professions, stressors and challenges in the health care workplace, and mid-career concerns are described. Next, the literature review discusses professional education and career development generally and specifically for health professionals. Adult education theory and research, educational requirements unique to health professions, and formal education and master’s degrees are examined. Finally, the growing and expanding field of bioethics, bioethics education, and the emerging popularity of the master of bioethics degree in the United States and at Northeast Medical School are shared.
The databases used to search for the literature include Scholar One Search, PubMed, Google Scholar, Proquest, and EBSCO. Data was also extracted from the National Center for Education Statistics’ Integrated Postsecondary Education Data System (IPEDs).

**Workplace Context for Mid-Career Health Professionals**

Professionals working in a health profession experience unique motivations and workplace environments that impact their wellness and desire to engage in additional educational opportunities. The initial decision to embark upon a career in healthcare is often made in college or even during childhood. As professionals mature and attain goals they had set for their careers and personal lives, they may be driven to satisfy basic psychological needs that have been thwarted or to continue developing new goals. According to goal contents theory (SDT mini-theory), progress and attainment of intrinsic goals yields especially enhanced wellness while extrinsic goal pursuit and fulfillment is less associated with wellness (Ryan & Deci, 2017).

**Motivation and Wellness in Health Professionals**

People choose careers in health-care for a variety of reasons. Nurses, nursing students, and nurse directors cite a desire to help, caring, and a sense of achievement and self-validation (Newton, Kelly, Kremser, Jolly, & Billett, 2009) as well as a genuine interest and practical reasons for choosing their career (Jirwe & Rudman, 2012). Common reasons for choosing a career in medicine include a desire to help people and mankind, employment prospects and satisfaction, professional autonomy, self-esteem, intellectual curiosity, an interest in human relationships and saving lives (Bengtsson & Ohlsson, 2010; McHarg, Mattick, & Knight, 2007; Pagnin et al., 2013). Social workers are motivated to help those who face suffering and distress while making meaning of their own lives and potentially healing themselves (Buchbinder, 2007).
Common themes in these health professions include a desire to help and heal, striving for personal challenge and self-esteem, meaning-making, and general interest.

Health care workers were found to rate stronger than other types of professionals in “work drive” and “conscientiousness”, two traits significantly correlated to career satisfaction (Richardson, Lounsbury, Bhaskar, Gibson, & Drost, 2009). While many cite helping others as motivation to enter a health profession, the concept of altruism in paid health care careers has been criticized as incompatible with the current financial drivers of health care and culture of medicine (Burks & Kobus, 2012). Pay, however, is an important element in job motivation with the desire to accomplish quality work more psychologically driven than the interest in financial incentives (Ryan & Deci, 2017). Health professions are guided by the principles of integrity, care for patients, and healing. Individuals who feel purpose and value in their jobs, receive clear feedback, and have a sense of ownership and capability to carry out their responsibilities become more autonomously motivated. This results in better performance, increased learning, and enhanced well-being (Deci et al., 2017). Therefore, managers and health-care systems should focus on supporting workers’ needs for competence, relevance, and autonomy to motivate these driven and conscientious professionals as opposed to using pay to control or incentivize performance.

**Workplace stressors and challenges**

Health-care professionals treat patients and families during highly emotional and difficult times. The health care work setting has a number of stressors including threats of violence, financial constraints, and physical challenges which can impact the mental health and wellness of health professionals (Aust, Rugulies, Skakon, Scherzer, & Jensen, 2007; Richardson et al., 2009; Wyatt, Anderson-Drevs, & Male, 2016). Madara and Burkhart (2015) assert that physicians are
intrinsically motivated by the medical profession’s values of providing the best care for patients using effective tools and meaningful data. This motivation, however, can be thwarted by financial incentives and systems that diminish time with patients. Reduced intellectual stimulation and control along with increasing demands at work may also frustrate health professionals (Arnetz, 2001; Havaei, MacPhee, & Dahinten, 2016; Pakkala, 2010a).

A longitudinal fifteen-month study of 267 unit leaders in the health care industry demonstrated that frustration of the basic psychological needs for autonomy, competence, and relatedness is associated with higher levels of work-related stress and somatic symptom burden (headaches, etc.), which in turn is associated with higher levels of emotional exhaustion, turnover, and absenteeism (Olafsen et al., 2017). Work-family conflict (WFC) is prevalent among clinicians, particularly younger physicians starting families, with major sources of WFC involving irregular schedules, high workload, and working under pressure (Mache et al., 2015). Health care professionals also experience personal, interpersonal, and clinical conflicts on the job with regard to team coordination, disagreements about of patient care plans, and professional role representation (Bochatay et al., 2017).

The challenges described above may result in burnout for health care professionals (Bochatay et al., 2017; Pakkala, 2010b; Salyers et al., 2017; Shanafelt et al., 2017). Burnout is defined as high emotional exhaustion and depersonalization with diminished personal accomplishment caused by chronic stress of medical practice (Salyers et al., 2017; West, Dyrbye, & Shanafelt, 2018). Burnout is more common among physicians than among other US workers with the greatest risk for those in front line specialties (Shanafelt et al., 2012). Consequences include substance abuse, depression and suicidal ideation, and poor self-care for physicians; reduced productivity, increased turnover, and increased costs for health care systems; and lower
quality care, increased medical errors and longer recovery time for patients (West et al., 2018). There is an abundance of research on the consequences and nature of burnout among health professionals (Rotenstein et al., 2018), with less focus on methods to address and improve health professional and organizational wellness (Wallace, Lemaire, & Ghali, 2009). An empathic approach to medicine, mindfulness, and self-reflection is recommended to reduce stress and improve health care (Burks & Kobus, 2012). Healthcare systems and individual clinicians should share responsibility for finding solutions to this problem (West et al., 2018).

**Mid-career concerns**

Mid-career employees play a central role in the workplace, mentoring younger workers, filling leadership roles, and providing stability for the institution. Numerous life transitions take place over a forty or fifty-year career (Hansman & Mott, 2010; Smith & Taylor, 2010). While many studies of career motivation and retention focus on younger workers or more generally on career professionals, some research has focused on mid-career or mid-life within the health professions and in other contexts.

Attitudes and values may change throughout a career in health care. A study comparing professional values in social work students to mid-career practitioners found the values of altruism, creativity, and innovation were rated most important to students, while relationships with supervisor and stability were most important to mid-career practitioners (Giurgiu & Marica, 2013). Mid-career nurses were found to perceive new graduates as having a weaker work ethic and being less loyal to the profession (Yarbrough, Martin, Alfred, & McNeill, 2017a). Negative attitudes about work and “mid-career blues” may result from occupational exposure to physiological and emotional stress (Pakkala, 2010a). Satisfaction with a nursing career was found to be lowest at mid-career with greater satisfaction during early and late career (Coshow,
Davis, & Wolosin, 2009). Compared with early or late-career physicians, those at mid-career worked more hours, had the lowest satisfaction with their chosen specialty and work-life balance, the highest rates of emotional exhaustion and burnout, and were over twice as likely to plan to leave medical practice for reasons other than retirement (Dyrbye et al., 2013). These studies illustrate how practitioners’ views can change once in the work setting and, specifically, how they may become less satisfied and creative.

Midlife can be a challenging time with many commitments competing for one’s attention including caring for both younger children and elderly parents (Lachman, Teshale, & Agrigoroaei, 2015). To find balance, many midlife professionals shift from a focus on advancement and make adjustments at work and home. Some avoid a promotion or consider a lateral move to provide new challenges without drastic change in responsibility (Maddox-Daines, 2016). Nurses may switch to a part-time schedule, but can find it difficult to stay engaged on the floor and take advantage of learning opportunities (Pool et al., 2015). Opportunities for professional development, a sense of teamwork, and aligned institutional values and priorities increase job satisfaction and retention of mid-career nurses (Yarbrough et al., 2017a). Nursing leaders’ may have their competence and relatedness needs fulfilled through relationships with peers and subordinates, yet find that a lack of support from superiors frustrates their autonomy and diminishes their well-being (Nilsen et al., 2016). A study of midlife working adults found that the needs for security, relatedness, and control at work impact well-being with financial/security needs being most important (Kim, Fouad, Maeda, Xie, & Nazan, 2018). These studies highlight how mid-career workers compromise aspects of their career to find balance and security, but these sacrifices may also impact their motivation and job satisfaction.
While mid-career professionals may face balance, survival, and autonomy frustrations, this time is also shown to be associated with goal achievement, motivation for growth and improvement, and optimism (Lachman, Röcke, Rosnick, & Ryff, 2008). A mixed-methods study of forty-five to fifty-five year-old men evaluated two developmental phenomena relevant to many at mid to late career: personal growth and generativity, or a desire to contribute to current and future generations (Arnold & Clark, 2016). Workers with a “forward momentum orientation”, associated with career advancement or change, are interested in learning, self-improvement, and guiding others in ways that improve or sustain individuals, organizations, and communities. Four themes were found in these workers: care for others’ well-being, care for others’ growth, concern for society, and making a positive impact. People may also undergo a process of “mid-career reframing” as they change careers goals or direction. This identity development process involves relational, emotional, practical and cognitive reflection and learning (Brown, 2015a; Brown & Bimrose, 2014). Four key dimensions found to foster career adaptabilities for mid-career adults include: learning through challenging work; updating or mastering a new base of knowledge; learning beyond work interactions; and being self-directed and self-reflexive (Brown, Bimrose, Barnes, & Hughes, 2012). The importance of learning, improvement, goal achievement and reframing career goals at mid-life is clear.

**Conclusion**

Health professionals share a common desire to help others, tend to be more conscientious and hardworking, and value doing important, meaningful work. Factors in the health care workplace can cause health professionals to feel burnout due to a lack of control, time pressures, and patient issues. Balancing the many roles of mid-life may result in extrinsic forces thwarting the ability to learn, grow, and contribute. However, mid-life presents an opportunity to shift
priorities and reflect on career changes to improve the future. Therefore, health professionals are uniquely situated at mid-career to consider new learning and development goals to improve autonomy, competence, and relatedness leading to enhanced wellness.

**Professional and Career Development Options**

Health professionals are highly trained and continue their education throughout their careers. At mid-career, they bring considerable life and work experiences to the learning environment that shape the way they make meaning (Agger-Gupta & Etmanski, 2014; Howie & Bagnall, 2013; Kasworm, 2011; O’Connor & Wolfe, 1991; Taylor, 2007). Their engagement in advanced degree programs is not only beneficial to their careers and personal circumstances, but also brings valuable insights to the academic community while energizing and improving their work environment (Agger-Gupta & Etmanski, 2014; Kasworm, 2011; King, 2003). At mid-career, they balance family and other roles with their professional and educational aspirations and must weigh numerous factors when deciding how to spend their valuable time (Belasco, Trivette, & Webber, 2014; Hansman & Mott, 2010; Ikenwilo & Skatun, 2014; Kasworm, 2011; Kuczewski & Parsi, 2002; Miller et. al, 1998; Pool et al., 2015, 2016; Spencer, 2016; Vance, 2015; Watkins, 2011). This next section describes adult learning theories and research, pre-professional training, continued professional development requirements in health care, and Master’s degrees in particular.

**Adult learning theories and research**

Adults learn and develop throughout their lives (ASHE, 2005; Boucouvalas & Lawrence, 2010; Gorges & Kandler, 2012; Hansman & Mott, 2010; Kasworm, 2011; King, 2003; Mezirow, 1978; Rossing & Long, 1981). Andragogy, the study of adult learning developed by Malcolm Knowles in the 1950s, states that typical adult learners direct their learning based on their life
experiences and independent, mature self-concepts (Hansman & Mott, 2010). Assumptions of andragogy include: self-direction, learning through experience, readiness to learn, problem-centered orientation, and relevance (Merriam et al., 2007). In adulthood, learning is an ongoing endeavor best described using a circular model with previous participation strongly predicting further participation (Gorges & Kandler, 2012). Similarly, learning can be conceived as “progress along a continuum rather than crossing a singular threshold” (Trevitt, 2008, p. 495). A person builds upon previous knowledge and incorporates life experiences with information gained through informal and formal learning opportunities.

Motivation to learn occurs both internally and externally (Belasco, Trivette, & Webber, 2014; Bengtsson & Ohlsson, 2010; Hansman & Mott, 2010; G. E. Miller, 1990; Pool et al., 2015, 2016; Spencer, 2006; Vance, 2015; Watkins, 2011). Internal motivations include perceptions of relevance, value of learning, curiosity, and academic stimulation. External motivations include pressures from the work environment, licensing requirements, rewards, and removal of sanctions (Spencer, 2006). As adults no longer participate in compulsory schooling and have career and conflicting priorities, they are responsible for the choices they make in regards to their learning. McClusky’s Theory of Margin notes that adults seek balance between the “load” that depletes energy and “power” that allows them to function (Merriam et al., 2007). Life responsibilities, family and social supports, and accumulated skills and abilities comprise the margin of load and power. While internal motivations may be potent, external factors also play an important role in adult learning.

Two themes that come forth from the literature on adult learning are given further analysis: practical and relevant knowledge and developing a new “meaning perspective”.

Practical and relevant knowledge. Adults seek out classes and programs to improve their work performance, assist in advancement opportunities, and maintain professional licenses or certifications. Knowles (1980, as cited by Hansman & Mott, 2010) noted that adults are internally motivated toward problem-centered learning immediately applicable to their lives and can be prompted to learn by changing life roles. Miller, Bligh, Stanley, & Al Shehri (1998) described how mastery of a task or process enhances motivation to continue learning and refer to this as “competence motivation”. A qualitative study of nursing and medical students found that self-motivation, receiving feedback, choices of learning and assessment methods, and gaining knowledge applicable to clinical practice enhanced enthusiasm to study (Bengtsson & Ohlsson, 2010). Another study involving hospital workers found that “preparedness, participation, readiness, and relevance” were key factors in adult learning motivation (Hopstock, 2008, p. 425). Learning opportunities that are structured to engage and involve adults in practical and relevant content enhances motivation to learn.

In adulthood, perceived value and relevance are strongly correlated with motivation to learn while there may be a decline in learning evoked by curiosity or surprise (Rossing & Long, 1981). A meta-analysis of twenty-five years of research on workplace learning and training motivation, however, found no evidence for a decline in age-related learning motivation (Gegenfurtner & Vaurus, 2012). Nursing and medical students are highly motivated by learning that can be applied to clinical practice, their own curiosity, and learning with others (Bengtsson & Ohlsson, 2010). A quantitative study of 361 hospital personnel found that those working in high-risk areas for cardiac arrest were more motivated than others to participate in work-sponsored CPR courses as this training was more relevant to them (Hopstock, 2008). As adults become more competent in learning that can be immediately applied to solving problems
encountered in their personal and professional lives, motivation to continue learning increases (Miller et. al, 1998).

**Making meaning.** Transformative learning, a theory of adult development originally developed by Mezirow in 1978, is a process of developing new perspectives and insights based on reflection and reconsideration of past assumptions (Clark, 1993). In this model, critical reflection results in a learner’s recognition of his or her distorted or deficient views which then are replaced with a more accurate and inclusive perspective. This results in a permanent change in a person’s understanding or “meaning perspective” (Boucouvalas & Lawrence, 2010). Mezirow (1978) notes that maturity involves a movement toward “meaning perspectives that are progressively more inclusive, discriminating, and more integrating of experience” (p. 106). Transformative learning is a widely researched and discussed theory in adult education with research continuing to build upon the concepts of reflection, transformative relationships, and methods to foster transformative learning within higher education (Taylor, 2007).

Howie & Bagnall (2013) outlined the ten steps in Mezirow’s transformative learning process as: the disorienting dilemma, self-examination, a critical assessment of assumptions, recognition of change process, exploration of options, planning a course of action, acquiring knowledge and skills for implementing one's plan, trying new roles, gaining self-confidence and competence, and reintegration with new perspective. In her qualitative study of nineteen graduate students in New York after the September 11, 2001 terrorist attacks, King (2003) noted that reflection continued to be an important aspect of informing practice. “These learners identified aspects of changing perspectives, new ways of understanding themselves, others and their roles as teachers and learners through the 9/11 crisis” (King, 2003, p. 20). As learners moved through
the process of transformation, they went from a place of confusion and despair to a more open, accepting, and confident sense of being.

O’Connor & Wolfe (1991) described a similar phenomenon for making meaning which they referred to as a “personal paradigm shift”. The model was developed from their exploratory study of sixty-four men and women experiencing midlife transitions. They describe a paradigm as a “system of assumptions, perceptions, expectations, feelings, beliefs, and values organized to understand an extensive range of situations and events” (p. 325). At mid-life, an anomaly may cause a questioning of beliefs, values, and assumptions. Time and experience refine a “crude and clumsy” (p. 326) version of a new paradigm into a higher level of meaning. Similar to transformational learning, this model describes a disorienting view or anomaly as the catalyst for reflection and eventual change.

A new meaning perspective provides not only a more inclusive understanding to those involved in the learning experience, their new outlook may result in more positive relationships with others (King, 2003; Taylor, 2007). Colleagues working with professionals engaged in a transformative learning process notice a shift in understanding and ability, yet cannot fully appreciate “the messiness of the process” (Agger-Gupta & Etmanski, 2014, p. 45). People experiencing significant paradigm shifts report more career excitement, greater feelings of enjoyment, and a more positive outlook on their future than their counterparts (O’Connor & Wolfe, 1991). The effects of their new perspective and the knowledge gained in the learning experience will likely lead to improved work settings and may motivate others to embark upon similar learning opportunities. The learning process is cyclical (Gorges & Kandler, 2012) and effects can be contagious (Agger-Gupta & Etmanski, 2014).
Adults are internally and externally motivated to gain practical and relevant knowledge that can help them make meaning in their lives and careers. As people are drawn to a career for a wide variety of internal and external factors, mid-career health professionals as a group may have specific factors in common that lead them to embark upon an advanced degree.

**Pre-professional training and requirements**

There are numerous prerequisites to enter a career in health care. While an associate’s degree may qualify nurses for certain positions, a bachelor’s degree (BSN or BS) from a four-year college and university is typically necessary to engage in the full scope of professional nursing practice. Nurses must also pass a nursing examination and apply for state licensure (American Nursing Association, n.d.). Most social workers complete a Master of Social Work (MSW) degree after completing a bachelor’s degree. Hundreds of hours of fieldwork, formal coursework, and a state licensure examination is typically required to practice social work. After gaining clinical experience, social workers can transition from Licensed Master Social Worker (LMSW) to Licensed Clinical Social Worker (LCSW) and finally Licensed Independent Clinical Social Worker (LICSW). To remain licensed, both nurses and social workers must continue engaging in professional development activities.

Doctors in the United States follow an even more extensive path. Prerequisite courses and the Medical College Admissions Test (MCAT) precede the medical school application. Four years of medical school classroom, clinical, and community experiences lead to the final year’s residency match. Residency training typically takes another three to seven years with many residents taking additional time to complete research. Two to three more years may be taken after residency to complete a fellowship in a subspecialty area (Association of American Medical Colleges, n.d.). While the path to enter into a health profession may be long and
demanding, the educational journey doesn’t end upon entrance to the field.

**Continuing Professional Education**

Despite in-depth preparation required to enter a health care profession, the continuous development of medicine, science, and technology, as well as the regulation of health care require that health professionals continue learning about new theories, research, evidence-based practice approaches, and advanced specialty knowledge throughout their career (Cervero & Daley, 2016; Ikenwilo & Skåtun, 2014; Pool et al., 2015, 2016). As new health-care workers enter the field, mid-level professionals must train new colleagues while continuing to develop and update their own skills and competencies (Cable et al., 2014; Pool et al., 2015, 2016; Spencer, 2006; Watkins, 2011).

Learning in the health care setting can assist in sustaining and improving patient care (Billett, 2016). On-the-job spontaneous learning, self-learning, ward-based activities, conferences, and symposia offer options to increase health care worker knowledge (Pool et al., 2015). Continuing Professional Education (CPE) includes courses, workshops, self-directed study, online activities, workplace in-service education, and university based offerings (Cervero & Daley, 2016). Some mid-career nurses choose to engage in learning to keep work interesting and change the routine (Pool et al., 2015, 2016). Informal learning may be triggered by dissatisfaction or an unplanned event and can be enhanced through critical reflection and stimulation of proactivity on the part of the learner to learn new skills, and implement solutions (Marsick & Watkins, 2001). Workplace learning can be enhanced through engaging in sequencing experiences (seeing before practicing), supervisor/mentor dialogue and rationale sharing, and self-directed learning (Billett, 2016).
Ikenwilo and Skåtun (2014) found that lack of motivation to engage in professional development courses was the least common barrier for doctors. Rather, doctors expressed concerns for insufficient clinical coverage, funding, and lack of quality programs. Time is noted as the most common barrier to engaging in advanced learning opportunities (Bengtsson & Ohlsson, 2010; Ikenwilo & Skåtun, 2014; Spencer, 2006). Therefore, mid-career health care professionals may be motivated to engage in learning activities, but may require flexible schedules and supportive workplaces and families to decrease the burden needed to participate in an educational program.

The Master’s Degree

An attractive option for many professionals seeking to advance their formal education is the master’s degree. "As a pivotal degree that bridges the baccalaureate, the doctorate, and the workplace, the master's degree has the capacity to continually evolve as a highly adaptable and affordable credential" (ASHE, 2005, p. 23). Master’s degrees often provide opportunities for part-time study and employer subsidies, connecting workplace and university learning (ASHE, 2005; Belasco et al., 2014). Master’s students and employers both benefit through advancement opportunities and improved work places. Employees gain problem-solving and critical reflective skills leading to improved practice and leadership at work (Kasworm, 2011). A master’s degree can be completed in significantly less time than a PhD, MD, or JD and may be offered in a flexible format (ASHE, 2005; Kuczewski & Parsi, 2002). While education and business-related master’s programs comprise the majority of master’s programs offered, medical-related master’s degrees have increased from 5.6% in 1980 to 9.1% of total master’s degree awarded in 2001 (ASHE, 2005). More recently, the data shows that this trend is continuing with 14% of the total master’s degrees conferred in 2016 being medical related. In the time between 2001 and 2016,
the number of master’s degrees conferred grew from 473,502 to 785,595 – an increase of 66% (U.S. Department of Education, 2017). As master’s degrees continue to gain popularity and new programs are developed, attention should be given to the needs and desires of mid-career professionals who enroll in these programs.

There are numerous reasons why master’s degrees are desirable. Enhanced prestige and career connections may lead to improved working conditions and higher compensations for master’s graduates (Belasco et al., 2014). Faculty, alumni, and students engaged in graduate programs provide a professional community of practice as well as cultural and social capital that attract prospective students to apply and enroll (Cable et al., 2014; English & Umbach, 2016). Master’s degree programs in medical school environments allow students in biomedical sciences to explore different career options while providing opportunities for hospital faculty to teach specialized master’s courses and receive incentive funds (Ingoglia, 2009). By capitalizing on affiliated hospitals for faculty and part-time students, master’s programs can attract a community of learners to engage in formal and informal learning activities (ASHE, 2005; Ingoglia, 2009; Magnus, 2002).

Participants in a study on mid-career adaptability stressed the need to stay abreast with their field’s developing knowledge base through a range of informal methods such as online learning and formalized master’s degrees (Brown & Bimrose, 2014). Participants in this study noted that they were driven by a desire for sense-making and developing their professional and personal identities. While they acknowledged that a master’s degree was a valuable credential for their work, their own interest in learning and personal development was the primary motivation for participation. Consistent with SDT, extrinsic factors impact motivation to pursue advanced education, yet intrinsic and autonomous motivation yields a stronger force.
Watkins (2011) described two types of applicants to a master’s in nursing studies program: the “personal-challenge seekers” and the “professional-challenge seekers”. Personal-challenge seekers want to prove they can perform academically, may be driven by the degree’s prestige, and may also seek to fit in with their more educated colleagues, such as doctors. Professional-challenge seekers are looking for credibility in the work setting, career enhancement, and improved knowledge and skills. In a study of nurses and midwives, personal motivations, such as a desire to continue learning, and professional factors, such as career progression and supervision, were noted as reasons for enrolling in a master’s program (Spencer, 2006). Experiences in personal life, such as the death of a family member, and experiences in daily work with patient care, can also be powerful motivators for learning (Pool et al., 2016).

Goal content theory suggests that pursuing goals involving growth, connection, and contribution rather than money, beauty, and popularity as well as goals that are personally meaningful and not those which are forced or pressured result in greater well-being and happiness (Sheldon, Ryan, Deci, & Kasser, 2004). Both the goal and the reason for the goal impact motivation (Deci & Ryan, 2000).

Learning motivation must be stronger than the obstacles that present themselves. In a qualitative study of twenty-six mid-career Army officers, career requirements and aspirations, family considerations, and previous academic experiences influenced the decision to enroll in a master’s program (Vance, 2015). Mentors and colleagues can also motivate others to pursue education (Agger-Gupta & Etmanski, 2014). In a study of 337 college graduates, Seibert, Kraimer, Holtom, and Pierotti (2013) found that those with intrinsic career goals, such as growth and contribution to others, were more likely to express an intention to pursue graduate education. A desire to satisfy personal goals, including professional growth, career advancement, and skill-
building began the decision-making process of thirty public health nurses who considered an advanced degree (Drevdahl & Canales, 2017). Students must consider costs such as tuition and fees, foregone earnings, family stress, time, and anxiety about debt (Belasco et al., 2014). Other obstacles include a lack of employer support, being unaware of degree options, an absence of a suitable program in the geographic area, and the challenges of balancing work and academics (Drevdahl & Canales, 2017; Hardré & Hackett, 2015; Pool et al., 2015). As prospective students consider a master’s degree at mid-career, potential benefits must be weighed with personal circumstances, goals, and budgets. Human resource managers may consider developing policies or programs to encourage employees to participate in advanced education through part-time enrollment, flexible schedules, and tuition support. Programs may also consider how to inform potential students about their programs and options to make the degree more accessible to part-time students.

O’Connor & Wolfe (1991) found that participants in a study of men and women experiencing midlife transitions who were also enrolled in degree programs were more involved in the process of paradigm shifting that those who were not enrolled. Higher education programs challenge students to question their assumptions and provide alternative frameworks for making sense of one’s personal experience and options for moving forward in a new light. Another study of mid-career professionals who completed a master’s degree found that participants strongly valued developing interpersonal capacities through group process and creative problem solving (Fenwick, 2002). These students shared that mixing different professions and work cultures led to powerful learning experiences with face-to-face interactions being of prime importance. While the learning process may take time and start out “crude and clumsy” (O’Connor & Wolfe, 1991,
p. 326), positive emotional tone and enthusiasm for career often follow the paradigm shift and increased competence that typically result from graduate education.

A study of the perceptions of 1,704 master and doctoral students found the highest positive perceptions reported at the beginning of the program with a drop at mid-point and somewhat higher scores at completion (Hardré & Hackett, 2015). This may indicate that students experience “unexpected challenges, self-doubt, and a drop in the belief that they are fully equipped and adequately supported” (Hardré & Hackett, 2015, p. 465). Being mindful of this pattern may be beneficial for program planners who strive to maintain motivation and confidence while challenging students to develop new meaning perspectives.

**Conclusion**

Years of training and education are required to enter and continue in the health professions. Adult learners are self-directed, seeking practical and relevant knowledge with a desire to make meaning and improve their work settings. Many options exist for continued professional development including work-based learning, on-line learning, conferences, and formal education programs. Master’s degrees serve as a bridge between work and academia. Benefits of a master’s degree include enhanced prestige, personal development, credibility, interest, and gaining a community of practice. While obstacles to attain an advanced degree exist for mid-career professionals, those who complete an advanced degree may find positive tone and career excitement follow. Pursuing a master’s degree at mid-career may lead to increased wellness through the fulfillment of psychological needs to competence, relatedness, and autonomy.
Bioethics

Bioethics is an emerging and rapidly growing interdisciplinary area of study that combines philosophy, theology, law, social science, clinical expertise, and the life sciences to solve ethical problems arising through advances in medicine and biomedical research (Avci, 2017b; Faden, 2004; Magnus, 2002; United States, 2016). It is a form of applied ethics using moral norms and concepts to resolve practical questions and challenges which give bioethics meaning within the wider medical and socioeconomic context (Vaughn, 2013; Willard, 2015). Questions addressed through bioethics include topics such as human subjects research protections, genetic engineering and human cloning, assisted reproduction and surrogacy, controlling death and sustaining life, withholding nontherapeutic treatment, informed consent, abortion, vaccination refusal and response, and determining recipients of scarce life-saving organs (United States, 2016; Vaughn, 2013; Willard, 2015).

Professionals likely to engage with bioethics include doctors, nurses, social workers, attorneys, research scientists, politicians, chaplains, and journalists (Faden, 2004; United States, 2016). In addition, community members, students, teachers, and guardians benefit from the new perspective and insights made possible by integrating multiple disciplinary lenses to challenging health care questions (Willard, 2015). The diversity of professionals engaged in bioethics is considered a “key strength” of the discipline (United States, 2016, p. 55). Most often, bioethicists have primary training in a field such as medicine, law, nursing, science, or philosophy and gain “dual competence” through additional bioethics training in academic inquiry, policy analysis, and practical guidance related to science, technology, and health (Magnus, 2002; United States, 2016).
Bioethics Education

Bioethics education is an ongoing, transformative process that seeks to increase ethical knowledge, strengthen ethical sensitivity, awareness and judgment, develop ethical behavior, and promote cultural competence (Avci, 2017b). Ethics literacy is essential for guiding and informing both individuals and governing groups (United States, 2016). Bioethics education can be effective in enhancing ethical awareness and reasoning skills to prepare everyone for the difficult conversations and decisions facing health professionals and the greater population (Avci, 2017b; United States, 2016; Willard, 2015). It is vital that people are educated to discuss and debate the role of science to preserve and safeguard human dignity while promoting beneficial medical innovation (Chowning, Griswold, Kovarik, & Collins, 2012).

A broad-based ethics education should start early so that its foundation can be built upon through different dimensions over time (United States, 2016). Bioethics lessons can be paired with various subjects and competencies developed in elementary, high school, and post-secondary schools. Incorporating ethical dilemmas into the classroom through bioethical case studies has been found to increase motivation and engagement into science content (Chowning et al., 2012). Ethical arguments require more than just empirical evidence. They also rely on the ethical principles of respect for persons (autonomy), minimizing harms while maximizing benefits (beneficence), utility (most favorable balance of good over bad) and fairness (justice) (Chowning et al., 2012; Vaughn, 2013). Decision-making frameworks, structured analysis tools, and case studies can be used in the classroom to teach students how to scaffold arguments and apply reasoning and justification skills (Chowning et al., 2012). In 2009, the National Institute of Health sponsored the development and publishing of a curriculum guide to introduce bioethics in high school science classes (Solomon, Vannier, Chowning, Miller, & Paget, 2016). As of Jan
2016, approximately 15,000 educators have requested copies of the “Exploring Bioethics” curriculum and 75,000 people have accessed the online modules illustrating a widespread interest in incorporating bioethics lessons into the high school curriculum. Training teachers in bioethics education has yielded positive results in improving students’ abilities to develop well-reasoned arguments and increasing motivation and engagement with science content (Chowning et al., 2012). However, many teachers lack time, expertise, and curriculum support to appropriately implement bioethics into their classrooms (Avci, 2017c; Chowning et al., 2012; Willard, 2015). Positive strides are being made for younger students, yet bioethics was not included as a field of inquiry or embedded into the curriculum in the 1980s or 90s when many mid-career professionals were in school.

While a physician-driven “Do no harm” approach of moral norms has guided medicine since the time of Hippocrates, the systematic teaching of ethics by medical schools began in the 1970s (Avci, 2017b). Medical students should learn the values and norms regulating medical practice and develop the virtues of a “good doctor” such as the capacity to recognize ethical issues that arise in clinical practice and the ability to balance competing priorities and perspectives (Giubilini, Milnes, & Savulescu, 2016). In 2000, a study found that only 78% of the ninety-one responding U.S. and Canadian medical schools required ethics instruction in preclinical courses with inconsistent content, method, faculty support, and funding for ethics education (Lehmann, Kasoff, Koch, & Federman, 2004). A study of 1,215 nurses and social workers found that only 57% had ethics education in their professional training program with 14% reporting no ethics education at all (Grady et al., 2008). It is likely that many practicing health professionals did not receive adequate ethics training during their professional school experience.
Feeling competent in bioethics can be vital in supporting patients and their families during a health-care crisis. Professionals with ethics education have increased moral confidence and moral action, and are more likely to use ethics resources (Grady et al., 2008). Ethics education can take many forms and should be integrated into the health care workplace. Regularly scheduled ethics rounds with a clinical ethicist can lead to greater education and empowerment of professionals on the floor. This form of continuous education and conversation encourages clinicians to “habitually see and evaluate cases from an ethical point of view” (Morgenstern & Richter, p. 224). Rather than reactively deferring responsibility to a clinical ethicist, educated and empowered clinicians gain competence and autonomy in handling and responding to ethical issues on the floor (Morgenstern & Richter, 2013). By motivating and supporting mid-career health-care professionals in ethics training programs, hospitals can improve the response and confidence that professionals have in making decisions about challenging ethical dilemmas that impact patient care.

Moral distress occurs when professionals cannot carry out what they feel is the ethically appropriate action; it is a discrepancy between what one thinks should be done and what is actually done (Epstein & Hurst, 2017; Grady et al., 2008). Moral distress may lead to burn out, feelings of diminished integrity and employee turnover (Epstein & Hurst, 2017; Grady et al., 2008). Causes of moral distress include a lack of voice, poor ethical organizational collaboration and climate, low work satisfaction and engagement, and low psychological empowerment and autonomy (Epstein & Hurst, 2017; Lamiani, Borghi, & Argentero, 2017) “Moral hazard” is defined as being made to bear the burden of another’s decision such as an administrative decision to stop cancer treatment for those unable to pay or continuing with a life-sustaining, and often pain-inflicting, treatment when there is no hope of recovery (Epstein & Hurst, 2017).
When employees question whether the delivery of patient care is causing harm, inaction may hurt the patient, other health-care providers, and future patients. Professionals who have ethics education are less likely to experience moral distress (Grady et al., 2008). When they are empowered to speak up and access ethics resources, patient care and hospital policies may be improved (Grady et al., 2008). Health professionals must not be afraid to speak their concerns to organizational leaders who should listen in a non-defensive, improvement-oriented manner (Sabin, 2017). Engaging in ethical deliberation can help address moral distress by showing clinicians that they are not alone in their concerns or that they may be missing information or mistaken, and that there is not a clear right or wrong answer to the issue (Epstein & Hurst, 2017). Implementing and supporting ethics education at an organizational level can reduce moral distress, improving clinician well-being and patient care.

**The Master of Bioethics**

Graduate programs have been developed to advance the study of bioethics and to prepare practitioners to address the challenges brought about by advances in science and medicine (Faden, 2004; Kuczewski & Parsi, 2002; Lee & McCarty, 2016; Magnus, 2002; United States, 2016). Through these programs, academic scholars from varied professions and graduate students explore bioethical issues in distinct, interdisciplinary ways. Students in a master of bioethics program are encouraged to offer opposing views and to challenge each other’s perspectives in a supportive environment with experienced faculty from a variety of disciplines yielding a more positive student experience (Newswander & Borrego, 2009; Sisti, 2002). Participating part-time allows students to digest and grapple with theoretical principles in a classroom in the evening while applying that knowledge to practical situations in their work settings (Kuczewski & Parsi, 2002). This immediate application may keep students motivated.
through difficult times in the program and at work. As students graduate, they will continue to engage in deliberations with their expanded network of diverse professional colleagues, patients, families, and community members with a stake in healthcare and bioethical concerns.

A 2001 survey conducted by the Association of Bioethics and Humanities (ASBH) showed a strong increase in the numbers and size of bioethics graduate programs (Magnus, 2002). Faden (2004) noted that along with this growth, bioethics is transitioning from scholarly field to a more applied and practical one aimed at working professionals. Magnus (2002) notes that many mid-career professionals enter bioethics degree programs for “personal enrichment and enhanced value in the position they already hold” (p. 11). Lee and McCarty (2016) analyzed the data on degree program completion available from the public-use Integrated Postsecondary Education Data System (IPEDS) published by the National Center for Education Statistics. They considered degrees earned with the CIP code for bioethics/medical ethics (51.3201) introduced in 2000 and applied and professional ethics (38.0104) introduced in 2010. Between 2002 and 2013, the number of bioethics/applied ethics degrees granted in the United States grew from 44 to 417 with the number of U.S. institutions granting master’s degrees in bioethics/applied ethics increasing from four to thirty (Lee & McCarty, 2016). Applying the same strategy, the IPEDs data for 2017 reports an increase to thirty-one U.S. institutions granting master’s degrees in bioethics/applied ethics with a steady rise of degrees granted with 241 granted in 2014, 268 in 2015, 296 in 2016, and 340 granted in 2017 (U.S. Department of Education, n.d.). This includes the master of bioethics degree launched by Northeast Medical School (pseudonym) in 2015 that graduated its first class of 10 students in 2016 and 27 students in 2017.

As the number of professionals holding master’s degrees in bioethics rises, more health care institutions may require the degree for certain positions (Faden, 2004). If a graduate degree in
bioethics does become a prerequisite for certain professions, SDT suggests that a force or pressure to gain the degree would decrease autonomy and intrinsic motivation. However, this requirement may also result in a higher number of students being attracted to the degree and greater support from work organizations who want to fill positions with qualified candidates. Faculty with ethics education will be needed to fill teaching roles created with the growing demand of students. Some mid-career professionals who attain a master’s degree in bioethics may choose to transition to an academic career or teach part-time (Magnus, 2002). Mid-career graduates who join faculty exhibit “dual competence” in bioethics and may attract future students from their profession to aspire to earn their MBE. Programs must consider how faculty will attract, engage, and support mid-career professional students.

As an advanced degree, the master of bioethics is available only to those already possessing at minimum a bachelor’s degree (ASHE, 2005). Those possessing terminal or professional degrees prior to attaining the master of bioethics are common (Magnus, 2002). The poor and least formally educated face the most personal and social barriers to participation in higher education (Ginsberg & Wlodkowski, 2010). Although a master of bioethics degree may be attainable only by highly educated people who have financial means or scholarship support, the knowledge that students gain through this education benefits many of the most vulnerable populations. In their roles as health-care providers, master’s recipients are empowered to take action and ensure that families have the information and support they need to make difficult decisions during health crises (Grady et al., 2008). They advocate for ethical deliberation, the use of ethics committees, fairness in clinical trials and human subject research, and draw upon their moral foundation to deal with their individual cases and address wider scale issues of injustice (Grady et al., 2008; Sisti, 2002).
The Northeast Medical School MBE

Northeast Medical School (pseudonym) is a private, selective professional school that provides education for future health care providers. It is one of twelve degree-granting schools that make up Northeast University, considered to be one of the most elite universities in the United States. Students may be attracted to Northeast for both the educational and reputational opportunities available as the extremely high prestige that can lead to greater financial and social capital (Dolan, 2007). The Medical School has been a “leader in medical education since 1782” (website, accessed October 20, 2015) and has seventeen affiliated hospitals and research institutions within close proximity to the campus.

Over the past seven years, six master’s degree programs have launched at the medical school with others being considered for the near future. The master of bioethics (MBE), was proposed shortly after the launch of the Bioethics Center in May 2014. The Bioethics Center evolved from the Division of Medical Ethics that was formerly housed within the Department of Global Health and Social Medicine. The Center organizes numerous educational events for affiliated hospital employees and the community at large, including weekly consortia on clinical, research, and policy ethics, an annual bioethics conference, a fellowship program, and a clinical bioethics certificate course for training hospital ethics committees. The master of bioethics degree program was approved by the Northeast Board of Trustees in February 2015 and enrolled its inaugural class of twenty-two students that fall.

The MBE at Northeast Medical School was designed to attract the mid-career professional. It can be completed in one-year full-time or over two years, part-time. The program is comprised of thirty-two credits of in-class instruction and a four-credit capstone field experience and project. Although some MBE programs are offered in a flexible, on-line format
(Kuczewski & Parsi, 2002), all of the required classes and program advising for the Northeast MBE are completed on the medical school campus. The cost of the degree is over $50,000 with no program scholarship support available. Students are paired with a faculty advisor and capstone mentor(s) and have many other networking opportunities to ensure they have the support and mentorship required to attain their next professional endeavor. The program strives to recruit and educate a majority of students who are mid-career professionals. While a larger number of applicants each year are seeking to enroll shortly after completing a bachelor’s degree, the program makes considerable efforts to attract and enroll a students with professional experience.

Conclusion

Bioethics is a growing interdisciplinary field that engages a wide range of professions to resolve practical questions in health care and the life sciences. Increasing ethical competence for all people is a valuable endeavor to prepare to respond to ethical issues that impact both professional and personal lives. Education in bioethics should start as early as possible and many teachers and schools are including bioethics in elementary, high school, college, medical, and professional school curricula. However, many mid-career professionals lack formalized ethics training. Competency in bioethics is vital in supporting patients and families during health crises and for minimizing harm in health care and research. Ethics training along with regular communication and dialogue about ethical issues on the floor reduce moral distress and increase moral action. This improves the wellness of health professionals, patients, and health care organizations.

The Master of Bioethics is becoming a widespread degree with more students graduating each year. These programs have become more practical and focused on working professionals
seeking to gain dual competence. The MBE at Northeast Medical School offers a comprehensive classroom and practical field experience, mentoring and networking opportunities, and a prestigious degree. However, students must arrange to attend all classes on campus and pay tuition. While recent college graduates outnumber mid-career applicants for admissions, the program values the deliberation and community that can be fostered with a majority of students being experienced professionals. A greater understanding of the motivating factors of mid-career professionals to pursue an MBE at Northeast Medical School is warranted.

Summary

Health professionals are driven by an intrinsic motivation to help people and do important and meaningful work. However, challenges in the work environment may lead to burnout and a reconsideration of career direction. At mid-career, professionals may consider new learning and development goals to improve autonomy, competence, and relatedness leading to enhanced wellness. Mid-career professionals bring a variety of life and educational experiences with them and have a desire to immediately apply what they learn to their work and personal lives. Many options exist for continued professional development including work-based learning, on-line learning, conferences, and formal education programs, including master’s degrees.

Master’s degrees serve as a bridge between work and academia and can provide credibility, prestige, personal development, and community for graduates. While obstacles exist and seem greater for those at mid-life, many find renewed career excitement, positive tone, and wellness through the attainment of a master’s degree. The Master of Bioethics is an interdisciplinary degree focused on ethical issues arising in research, medicine, and health care. Through the MBE, mid-career professionals may gain dual competency to apply ethical
reasoning directly to the challenges they face in their work settings including end-of-life issues, health care justice, and protection of vulnerable populations. They become empowered to handle ethical issues and speak up when a case requires deliberations.

By motivating and supporting mid-career health professionals to attain a graduate degree in bioethics, the poor and least formally educated may receive improved access to resources and support through empowered and morally competent providers. Graduates who transition from a clinical role to careers in public policy, public engagement, and/or advocacy, may use their experience, education, and voice locally and globally to inform health policy, governance, and institutional best practices. While increasing numbers of students are graduating from bioethics programs that are targeted at mid-career professionals, no empirical studies have considered the motivation of mid-career professionals to attain these degrees. By determining what factors lead mid-career health professionals to attain master of bioethics degrees, academic program leaders and health care organizations can structure recruitment and educational support efforts to attract and educate professionals who will be empowered and prepared to respond to the moral and social justice problems that continue to arise in medicine and the life sciences.
Chapter Three: Research Design

As health care systems adapt and shift in response to political and financial pressures and medical innovation, mid-career health professionals can feel a sense of dissatisfaction or burnout in their career. Bioethics education may alleviate feelings of moral distress, yet many of these professionals have not received adequate ethics training. Engaging mid-career professionals in understanding and applying the principles of bioethics in their work through the attainment of a master of bioethics degree can invigorate hospital systems. This may improve the lives of health professionals themselves, as well as the patients and families for whom they provide care.

Many master’s programs have been designed specifically to attract mid-career professionals seeking to gain dual competence to complement their already established profession. However, no empirical studies have been conducted to determine what motivates mid-career professionals to seek out a master of bioethics degree. A better understanding of the factors involved in the decision to pursue a master of bioethics degree at mid-career would enable faculty and administrators to enhance outreach and programmatic supports for this population of students. This study explores how and why mid-career health-care professionals decide to enroll in a master of bioethics degree and how the degree impacts their sense of well-being. To explore the decision-making experiences of alumni who have completed the degree at mid-career, Interpretative Phenomenological Analysis (IPA) was utilized.

The following information in this chapter is included to describe the methods used to understand, make sense of, and elucidate the motivation of participants who have completed the MBE at mid-career. This section will first describe qualitative research and the IPA approach along with how this approach compares to other empirical approaches and aligns with the present
study. This is followed by a discussion of study participants and the specific methods used to collect, analyze, protect, and report the data that explores mid-career learning motivation.

**Qualitative Research Approach**

Researchers choose between quantitative, qualitative, or mixed-method approaches to collect, analyze, and interpret data depending on the questions they want to answer. Quantitative methods are used to measure and analyze causal or correlational relationships between variables that can be applied to a population in order to make predictions or prove/disprove a theory (Creswell, 2014). These studies are concerned with counting occurrences and require phenomena to be reduced to numerical values in order to carry out statistical analysis (Pietkiewicz & Smith, 2014). Qualitative researchers are concerned with meaning and the methods used are designed to describe and interpret context-specific experiences using the participants’ own words (Pietkiewicz & Smith, 2014; Ponterotto, 2005). Qualitative researchers ask simple questions that yield rich answers, then share their data and methods in a narrative report that brings meaning to the experiences and perspectives of a specific group of participants (Chenail, 1995; Creswell, 2013).

A number of research schemas or paradigms are available for researchers to conceptualize and classify their research. A paradigm is the worldview or basic belief system that guides a researcher in their fundamental choices of method and ontological and epistemological assumptions (Guba & Lincoln, 1994). The constructivist-interpretivist paradigm was used for this study. This paradigm assumes that there are multiple, subjective realities constructed in the minds of individuals that are influenced by context and experiences (Ponterotto, 2005). Subconscious meaning may be brought out, constructed, and refined through reflection and researcher-participant dialogue (Guba & Lincoln, 1994). Data collection is
facilitated through naturalistic designs, flexible and adaptive interviews, and getting to know the context of the participants (Ponterotto, 2005). Findings are jointly created with participants, highly subjective, and may differ significantly from another person’s reality (Guba & Lincoln, 1994; Ponterotto, 2005).

**Interpretative Phenomenological Analysis**

The Interpretative Phenomenological Analysis approach was developed in the mid-1990s in Jonathan Smith’s study of women’s experiences in transition to motherhood (McNabb, 2007; Smith, 2017). Smith (2017) sought to develop a “rigorous and systematic” approach that allows for “exploration and creativity” (p. 303). IPA draws on Husserl’s phenomenology, a philosophical approach and range of research methods focusing on the study of the human experiences (Eatough & Smith, 2011; Smith, 2017). A blend of phenomenology, hermeneutics, and idiography, or the focus on the particular, IPA seeks to operationalize hermeneutic phenomenology using the “hermeneutic circle” to explore meaning and understanding as interpreted first by the participant and then by the researcher as articulated by Heidegger (Eatough & Smith, 2011; McNabb, 2007; Smith, 2017). A third hermeneutic level, the eventual reader of an IPA report, considers a third person trying to make sense of the researcher trying to make sense of a participant’s meaning making process (Smith, Flowers, & Larkin, 2012b). Aspects of phenomenology and hermeneutics are combined to create a descriptive method that lets things speak for themselves, recognizes that phenomena require interpretation, and offers in-depth analysis of single cases and individual perspectives in unique contexts (Pietkiewicz & Smith, 2014).

The majority of published work using IPA has been in the fields of psychology, education, management, and the humanities (Brocki & Wearden, 2006; Reid, Flowers, & Larkin,
As a qualitative research method grounded in psychology, IPA has many similarities to other approaches. It is a phenomenological research method focused on the individual’s subjective experience and understanding the ways we engage in the world (Brocki & Wearden, 2006; Eatough & Smith, 2011). Like discursive psychology, IPA recognizes the dynamic, active nature of conversations and how language and culture shape reality (Eatough & Smith, 2011). However, IPA is more attuned to the meaning-making process brought forth through sharing stories and reflecting on experiences while discourse analysis focuses on the structure of the context itself (Eatough & Smith, 2011; Smith et al., 2012b). While all qualitative approaches involve researcher reflexivity, IPA brings the researcher’s lens and meaning-making further into the process (Brocki & Wearden, 2006).

There are important differences between IPA and other phenomenological approaches. Husserl’s phenomenology seeks to study things “as they appear” in the immediate consciousness prior to reflection (Dowling, 2007, p. 132). Giorgi’s empirical phenomenological psychology emphasizes the “psychological essence” of an experience and establishing relationships between variations in order to delineate a general structure of the phenomenon along with common features and underlying differences (Eatough & Smith, 2011). Phenomenologists seek to create a comprehensive description of an experience through the analysis of themes across multiple cases (Dowling, 2007). IPA, on the other hand, is more attuned to variability and micro analysis of a small number of narratives (Eatough & Smith, 2011). While phenomenology focuses on the study of the experience reduced to pure phenomenon (Dowling, 2007), IPA focuses on the researcher’s interpretation of how participants make meaning from the experience, a process also referred to as a “double hermeneutic” (Smith, 2017).
A disciplinary split in health psychology between quantitative, variable-centered methods and qualitative, phenomenological approaches presented an opportunity for “cross-fertilization” and the development of IPA (Smith, 1996). Unlike quantitative methods, IPA uses inductive reasoning and does not test hypotheses (Reid et al., 2005). By exploring the meaning of situations to the participants experiencing them, IPA studies can enrich models developed through quantitative methods (Smith, 1996). While many traditional empirical methods correlate a larger sample size with greater reliability, IPA values smaller, more homogeneous groups and maintains the participants’ context and voice within the results (Reid et al., 2005).

Alignment with Research Study

The IPA method was used in this study for a number of important reasons. First, the primary interest was the perspective of professionals who attained a master of bioethics degree at mid-career and how they make sense of their motivation to do so. According to Eatough and Smith (2011),

IPA studies explore existential matters of considerable importance for the participant. These matters are often transformative, bringing change and demanding reflection and (re)interpretation for the individuals concerned…Significant events and topics have an inevitable effect on the sense of self and IPA’s detailed fine-grained analyses of individual lived experiences enable these effects to come to the fore” (p. 12).

Completing a degree program can be transformative and significant. At mid-career, it is expected that the reasons for pursuing a degree will be varied and colored by each student's career path and life story. Upon reflection and conversation, participants may make meaning of the experiences that have led them to this decision and how this has impacted their sense of self.
The meaning of this experience is unique to each participant and IPA’s idiographic approach retains this significance.

As the manager of the MBE program and a mid-career student herself, the researcher brought a unique lens and prolonged engagement allowing for greater understanding of the study’s context (Cohen & Crabtree, 2006). Data for the study was collected through personal interviews along with requesting current copies of participant curriculum vitae. Open-ended questions encouraged the participants to share in depth accounts of their career motivation and the meaning they gave to their MBE experience. The analysis involved listening to the recordings and reading interview transcripts multiple times followed by reflection, note-taking, and analysis to find the meaning in the narratives.

Participants

Participants in this study were mid-career health professionals who completed the master of bioethics degree at Northeast Medical School since its first class graduated in 2016. In order to gain in-depth analysis of the participants’ lived experience, this research utilized individual semi-structured interviews followed a detailed and time consuming case-by-case analysis (Pietkiewicz & Smith, 2014). The IPA method recommends a small and homogeneous sample of participants who have experienced the phenomenon being studied with ten or fewer participants most common (Brocki & Wearden, 2006; Pietkiewicz & Smith, 2014; Reid et al., 2005). The sample size in this study was five.

The researcher sought to include alumni from a specific master’s degree program. As of May 2018, there were sixty-five total program alumni. Twenty-three were born prior to 1980 and considered mid or late career. From this group, purposeful sampling as described by Creswell (2014) was utilized to recruit health care professionals (nurses, social workers, doctors,
and physician assistants) that were born prior to 1980 and currently employed in health care organizations. Approximately eight alumni fit these criteria and were contacted by email and invited to participate in the study. Non-responders were contacted a second time with attempts ceasing after continued non-response.

**Participant Demographics**

Five of the eight alumni contacted agreed to participate. The participants were Roxanne, Gabrielle, Sarah, Neela, and Allison. The health professions represented in the group were nursing, social work, and medicine. All of the participants entered the program in its inaugural year, were women, and were currently employed in an organization. The following paragraphs provide a brief description of each participant.

Roxanne is a former social worker in her 50s who completed the degree part-time over two years. She is currently working as a training specialist at a non-profit guardianship agency and adjunct instructor in social work at a state university. When she applied to the MBE program, she was a medical social worker at a regional medical center. She is White, married, and comes from a poor, rural community in Appalachia.

Gabrielle is a registered nurse in her 50s who works in the emergency department of a large, urban teaching hospital affiliated with Northeast Medical School. She has served in this role for over fifteen years. She completed the degree part-time over two years. She is Black, immigrated from Haiti as a child, is married, and has two children.

Sarah is a nurse director in her 40s who works in the cancer center of a large, urban teaching hospital affiliated with Northeast Medical School. When she applied to the program, she was a staff nurse at this same hospital. She is White, completed the degree full-time in one year, and is married with one adult and two teenage children.
Neela is a neurologist in her 50s who now works at a national hospital network as director of a subspecialty program in epilepsy, an ethics consultant to the network, and chair of a hospital-based ethics committee. When she applied to the program, she was working full-time as the director of a subspecialty program for women with epilepsy, and was co-chair of the ethics advisory committee at a large, urban teaching hospital affiliated with Northeast Medical School. She completed the degree full-time in one year while working full-time. She was born in India and is married with three high-school aged children.

Allison is an assistant professor of pathology, anatomy, and cell biology at a medical school in the Atlantic. She is in her 40s and completed the degree part-time over two years. She was a commissioned military officer in medical school and completed her service in 2012. When she applied for the program, she was completing a fellowship at a large, urban teaching hospital affiliated with Northeast Medical School. She is White, married, and has two elementary school aged children.

Procedures

Consistent with IPA, this study’s procedures allowed participants to offer “a rich, detailed, first-person account of their experiences” (Smith, Flowers, & Larkin, 2012, p. 56). The first step in the research process was to gain approval from the Northeastern University Institutional Review Board (IRB) using the form and process outlined by the College of Professional Studies. This process involved obtaining written permission from the Northeast Medical School Bioethics Center to contact program alumni using data available to the researcher through her position. After gaining IRB approval, the researcher followed the recruitment process described previously. The following section describes how data were
collected and analyzed along with ethical considerations to avoid potential harm to human subjects.

**Data Collection**

Data collection for an IPA study is most often accomplished through the use of semi-structured, one-on-one interviews allowing for in-depth and personal discussion (Brocki & Wearden, 2006; Eatough & Smith, 2008; Online QDA - Methodologies, n.d.; Reid et al., 2005; Smith, 1996). Each participant in this study was interviewed for approximately 60 minutes. Three interviews were conducted in person and two were conducted via videoconference. Prior to each interview, the researcher reviewed and collected the Northeastern University Informed Consent form describing the purpose of the study and the requirements for participation. A copy of the consent form is included as Appendix A. She then requested a Curriculum Vitae (CV) to get a better picture of each participant’s educational and professional career path before scheduling the interview. This allowed interviews to delve more deeply into each participant’s perspective and get to their “inner voice” (Seidman, 2006, p. 79).

Master of bioethics alumni were articulate and open, making them ideal candidates for one-on-one interviews (Creswell, 2014). An interview protocol with open-ended questions (see Appendix B) was used to guide the discussion, with the participant adopting the role of storyteller while the researcher listened, asked follow-up questions, and came to the research question sideways (Brocki & Wearden, 2006; Eatough & Smith, 2011; Smith et al., 2012b). The interview schedule helped insure that questions were prepared and planned, data collection remained flexible and non-prescriptive, and participants were given discretion to explore their lived experiences as they saw fit (Eatough & Smith, 2011). During the interview, the researcher took handwritten notes on the protocol form to plan for follow up and record impressions.
(Seidman, 2006). Interviews were audio-taped and then each file was uploaded to Temi.com for transcription while the researcher typed up initial interview reflections (“Online QDA - Methodologies,” n.d.; Smith et al., 2012a). The CVs, hand-written notes, and memos with initial reflections were stored in a file to be used along with the transcripts during analysis.

**Data Analysis**

The analysis that began during the interviews continued as the researcher reflected on interview and reviewed the transcripts to identify, describe, clarify, interpret, and contextualize the data (Larkin, Eatough, & Osborn, 2011). A cyclical, inductive process involved listening to the audio-files and several close readings of the transcripts while noting points of significance, and integrating with themes and outside ideas (Brocki & Wearden, 2006; Eatough & Smith, 2011). The researcher analyzed each participant’s transcript along with other data collected independently before moving on to the next analysis. As the researcher navigated between empathic (experiential) and critical (hermeneutic) levels of interpretation, she first sought to make sense of the experience from the participant’s perspective and then from a higher, more abstract, stand-point (Eatough & Smith, 2011; Reid et al., 2005). Examples of the stages of analysis and audit trail are provided in Appendix C.

IPA offered flexible guidelines for data analysis, typically moving from descriptive to interpretative, that could be adapted according to the researcher’s objectives (Brocki & Wearden, 2006; Pietkiewicz & Smith, 2014). The first step involved actively engaging in the data, by reading the transcript multiple times, reflecting on the interview experience, and even re-listening to audio-recording (Pietkiewicz & Smith, 2014; Smith et al., 2012b). Many possible ideas and connections emerged which were bracketed off and recorded in memos (Smith et al., 2012b). Preliminary note making involved noting anything of interest within the transcript using three different foci:
descriptive, linguistic and conceptual (Smith et al., 2012b). Descriptive comments are key words or phrases used by participant. Linguistic comments describe language used by the participant (metaphors, repetitions, pauses). Conceptual comments are interpretative and interrogative and open a range of provisional meanings and may move away from the original words of the participant (Smith et al., 2012b). This was captured using pen and pencil on paper copies of the transcripts.

At the next stage, the researcher transformed notes into emerging themes (Pietkiewicz & Smith, 2014). The researcher started by uploading the transcripts into the NVivo qualitative software analysis program and creating a “case” for the participant. Demographic data including profession, birth decade, gender, and full or part-time status was stored in the software for each participant. Then the researcher utilized the software and paper transcripts to highlight and assign initial “nodes” to sections of the interview transcripts. Nodes were words or phrases that stood out to the researcher during initial analysis such as: “feeling pulled”, “itching for a little more”, and “I don’t belong here”. Some parts of the interview were assigned multiple “nodes” while others did not yield themes. After the initial coding, nodes were merged into themes. This was done for one participant and transcript before moving to other cases. Before moving to the next participant’s analysis, a reflection memo was written and stored in NVivo along with the “codes/phrases” and initial participant themes. Parent nodes were created with the participant’s name to hide the nodes during the next participant’s analysis so that each case was analyzed on its own.

Once all participants data were analyzed and coded, the analysis moved on to seeking relationships and clustering themes (Pietkiewicz & Smith, 2014). To begin this analysis, the researcher printed her analysis memos and removed the parent nodes from NVivo to see all the nodes that had emerged through analysis. The researcher sought connections across emergent
themes and organized, integrated, interpreted and refined them into superordinate themes by merging and renaming the nodes in NVivo (Reid et al., 2005; Smith et al., 2012b). A table was developed that allowed the researcher to look across cases for patterns and visually pull together a persuasive, coherent, and integrated story (Brocki & Wearden, 2006). As themes and interconnections were developed, the researcher returned to the original transcripts for further context and analysis (Eatough & Smith, 2011).

The final stage of the Interpretative Phenomenological Analysis study involved presenting the findings. According to Reid, Flowers, and Larkin (2005), “a successful analysis is: interpretative (and thus subjective) so the results are not given the status of facts; transparent (grounded in example from the data); and plausible (to participants, co-analysts, supervisors, and general readers)” (p. 20). Themes were selected not only for their prominence in the analysis, but some were also included due to a passage’s eloquence or explanatory nature (Brocki & Wearden, 2006; Smith, 2017). The table that was developed during analysis was used to provide focus and show similarities and deviations between cases (Reid et al., 2005). It also served as a guide as the researcher selected excerpts from the transcripts in the participants’ own words to illustrate themes and findings. During this process, the table and the theme names were revised multiple times to evolve into the final summary.

**Ethical Considerations**

Ethical considerations were taken into account to avoid harm to participants. Upon IRB approval, the researcher began recruiting participants via email communication by sharing the goals of the study and requirements for participation. While this research did not include a vulnerable population such as children or incarcerated persons, participants shared intimate stories about their mid-career motivation and experiences in health-care. Prior to participation,
each party was given a consent form outlining how their data would be used, their option to choose not to answer questions, and options to discontinue participation at any time (Appendix A). Due to the small number of possible participants that fit the inclusion criteria, careful planning was done to allow for retraction or removal from the study if disclosure could result in harm (Tracy, 2010). Although all participants shared that they were not concerned about confidentiality, the researcher refrained from sharing confidential information, kept paper files and transcripts secured, and used password protection for electronic files. All participants were sent a copy of the final analysis prior to defense and were offered the opportunity to correct any errors they noted.

Trustworthiness

This study aimed to explore how health professionals who completed a master of bioethics at mid-career make sense of their educational motivation and workplace well-being. The researcher sought to provide rich, detailed accounts of the participants’ subjective experience. Rather than quantitative methods that value numeric data and statistical analysis (Creswell, 2014), qualitative methods are measured by their trustworthiness. Trustworthiness involves establishing credibility, transferability, dependability and confirmability (Cohen & Crabtree, 2006; Lincoln & Guba, 1985). The theoretical framework described in chapter one was used as a guide for the interviews and analysis, yet the process remained flexible throughout. As IPA sampling is purposive and broadly homogeneous, conclusions drawn are specific to that group (Brocki and Wearden, 2006).

Credibility. Methods utilized to establish credibility are important for increasing confidence in the “truth” of the study (Cohen & Crabtree, 2006). By nature of the researcher’s work in launching and managing this particular master’s program, much time and energy has been
spent learning about the school, the center, and the field of bioethics, speaking with and developing relationships among the students, alumni, faculty, administrators, and prospective students. This time and energy yielded “prolonged engagement” or spending adequate time to comprehend and appreciate the culture, circumstances, or phenomenon being studied (Lincoln & Guba, 1985). In addition, her experience as a mid-career student herself and her attentiveness and interest in this phenomenon allowed for “persistent observation” or focusing deeply on situational elements and characteristics most relevant to mid-career learners (Lincoln & Guba, 1985).

Transferability. “Thick description” is the use of in-depth, generous detail to reveal the data’s complexity and allow readers to draw their own conclusions (Tracy, 2010). This technique allows readers to assess whether and how extensively conclusions may transfer to other settings, situations, and communities (Cohen & Crabtree, 2006). Specifically, the knowledge generated in this study may be helpful to other master of bioethics programs, other academic programs seeking to recruit mid-career professionals, and health care organizations seeking to increase wellness and moral agency amongst their employees.

Dependability. A study is considered dependable when findings are logical and methods could be replicated (Cohen & Crabtree, 2006). Throughout the process, multiple drafts, field notes, charts, and other data were collected. Each file was dated and uploaded to a personal DropBox to ensure a back-up copy was retained. Paper copies with hand-written notes were dated and preserved in the researcher’s home office for a specified period of time until they can be destroyed. NVivo and a personal research journal were kept for tracking ideas, methods, and themes from the beginning of the study through final analysis.

Confirmability. The findings of a trustworthy study should be shaped by the participants’ data and not by the interests, motivation, or biases of the researcher (Cohen &
Crabtree, 2006). Researcher positionality and the study’s context clarifies that the study reflects a third-person perspective of the participants’ first-person accounts (Larkin et al., 2011). Awareness of areas of researcher bias helped to ensure that the research design, data collection, and analysis delved beneath the surface to explore issues that may have been assumed, implicit, or part of the participants’ common sense. The researcher listened to understand their perspective instead of substituting her own ideas and judgment for theirs. This was achieved through bracketing, drafting reflective memos, and returning to the data to check on assumptions. By calling out biases and checking to ensure the use of thick description in drawing conclusions, the researcher’s positionality may strengthen the study.

**Potential Research Bias**

A central focus in an IPA study is the researcher engaging in the inquiry (Smith et al., 2012b). A personal reflection on the researcher’s personal interest and curiosity about mid-career educational motivation provides a frame for understanding potential biases and blind spots. Three areas of consideration included the researcher’s pride in the MBE program, her experiences in health care, and her status as a mid-career professional and student.

**Pride in MBE program.** I have managed the MBE program at Northeast Medical School since its launch in 2015. Tremendous energy has been spent developing a foundation for the program’s future success which gives me a sense of intense pride. I worked with each of the participants through the admissions process, as master’s students, and continue to work with them as members of our bioethics community. It is possible that they may have shielded their narratives for fear of harming our relationship or that I overlooked critical perspectives due to my sense of pride.
Health care experiences. My experience with medicine has always been as a patient or family member. While I am privileged to have access to high-quality health-care and greatly respect health-care professionals, I have no medical training or experience. Misunderstandings may have arisen due my having a “deficit perspective” (Carlton Parsons, 2008).

Mid-career professional and part-time student. Like my participants, I am a mid-career professional, balancing work and family responsibilities along with my education. This perspective allowed me to understand the challenges faced by the participants to keep progressing at work and in their education. While I have much in common with my subjects from a mid-career student perspective, their backgrounds, aspirations, and motivations to pursue this degree differ from my own.

Limitations

This study utilized alumni from one master’s degree program at a medical school in New England. All participants in the study were women who had enrolled in the inaugural year of the program. Their perspectives and motivations are likely different from graduates who are male or who completed the degree program in later years. This program offers only on-the ground (not on-line) instruction and does not provide scholarship support. Participants of this study were able to overcome financial and scheduling challenges to complete the program. They had successful academic and work careers prior to being accepted and enrolling. Their experiences and perspectives are likely quite different from those of people who attend a different type of degree program, those who complete programs prior to gaining work experience, and those who wished to enroll in a master’s program, but were unable to due to financial or scheduling conflicts. The results of this study reflect the experiences of a limited number of mid-career
female health professionals who completed a master of bioethics degree at Northeast Medical School.

Summary

This chapter provided an explanation of the methods employed to explore the motivations and sense of well-being in health professionals who completed a master of bioethics degree at mid-career. The chapter explained how the Interpretative Phenomenological Analysis method aligned with the research question. Participant descriptions were provided and the specific procedures followed were described along with criteria utilized to assess the trustworthiness of the study. Limitations for the study and researcher bias were explained to clarify research validity. As IPA provided the structure for collecting, analyzing, and presenting the data, the following chapter shares the findings and analysis.
Chapter Four: Findings and Analysis

The research presented here was conducted to explore how mid-career health professionals perceive their motivation to pursue a master of bioethics degree and how the degree’s attainment has impacted their sense of well-being in the workplace. There were five participants from the following professions: social work, nursing, and medicine. Open-ended interviews yielded rich data. Throughout the interviews and analysis, many themes and ideas presented themselves. The most common or pronounced themes have been classified as sub-themes. These subthemes were then grouped into superordinate themes including: (1) Intrinsic and Career Motivators, (2) Something New (3), The Student Experience, and (4) Post MBE-Career Transitions. All of the themes are displayed in Table 1 below. This chapter will describe each theme and show how participants made sense of their experiences as narrated through these themes.

Table 1: Emergent Themes and their Prevalence among Participants

<table>
<thead>
<tr>
<th>Superordinate themes</th>
<th>Subthemes</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic and Career Motivators</td>
<td>Helping Others</td>
<td>All participants</td>
</tr>
<tr>
<td></td>
<td>Struggling for Answers</td>
<td>All participants</td>
</tr>
<tr>
<td></td>
<td>Feeling Stuck</td>
<td>G, N, S</td>
</tr>
<tr>
<td></td>
<td>Degree as &quot;Winning&quot;</td>
<td>N</td>
</tr>
<tr>
<td>Something New</td>
<td>Fascination with Bioethics</td>
<td>All participants</td>
</tr>
<tr>
<td></td>
<td>Inaugural Class</td>
<td>G, N, R, S</td>
</tr>
<tr>
<td></td>
<td>Not the Typical Master's</td>
<td>A, N, R, S</td>
</tr>
<tr>
<td>The Student Experience</td>
<td>Juggling Responsibilities</td>
<td>A, R, S</td>
</tr>
<tr>
<td></td>
<td>Fears of Failure</td>
<td>G, N, R, S</td>
</tr>
<tr>
<td></td>
<td>Broadened Perspectives</td>
<td>All participants</td>
</tr>
<tr>
<td></td>
<td>Community and Connections</td>
<td>All participants</td>
</tr>
<tr>
<td>Post MBE Career Transitions</td>
<td>Improved competence and confidence</td>
<td>All participants</td>
</tr>
<tr>
<td></td>
<td>Incorporating Ethics and Moving Beyond</td>
<td>All participants</td>
</tr>
<tr>
<td></td>
<td>professional boundaries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of extrinsic rewards</td>
<td>A, G</td>
</tr>
</tbody>
</table>
Intrinsic and Career Motivators

In speaking with the participants of the study, it was clear that they were intrinsically motivated to help others through their chosen career. As mid-career health professionals, they had engaged in their work environment for some time and had participated in on-the-job learning and other educational pursuits. However, there was something missing. The feelings they described about their work environments ranged from complacency and curiosity, to feeling bullied or depressed. Their sense of well- or ill-being at work significantly impacted how they made sense of their decision to pursue an advanced degree and their intentions to use the degree to improve their competence, increase their promotion prospects, or leave an unhealthy work environment. While many aspects of the workplace context impacted the motivation to pursue the MBE, the four subthemes that yielded the most vivid data included helping others, struggling for answers, feeling stuck, and “winning”. While the first two subthemes were expressed by all participants, neither Allison nor Roxanne expressed concerns about feeling stuck. This is likely due to their being already engaged in other training programs when they chose to apply. One participant also relayed a strong desire for ego-preservation or reparation afforded by the opportunity to enroll in a master’s degree.

Helping Others

As health professionals, it is not surprising to see that all participants valued helping others through their work. As they described how they chose their careers and decided to “do” bioethics, much of what was discussed was a desire to help others. This seemed to be ingrained in their upbringing and remained an important aspect of who they are as people. The “others” that they helped ranged from patients, to family members, other professionals, and further to more universal societal benefits (making the world a better place).
Roxanne grew up in a “poverty stricken” area and saw the difficulties of people in that area. Her “very firm, Christian foundation” motivated her to become a social worker in order to help people in a time of need. “I have this thing, you know, I just don't think anybody should ever be alone... Just being able to again, move somebody, sort of like to turn the, the tide just a little bit so that they can get some help and get services or a companion.”

Gabriella spoke about how her career in nursing came naturally to her in light of her mother’s care-taking mentality. She believed helping others was “the biggest, greatest satisfaction that we want”. She continued,

It doesn't need to be a big thing, it can be a little thing, you know, as long as I feel like this one thing was, um, made, made a difference in somebody else's life that day, it doesn't matter how big or how small I am, I feel fulfilled.

She spoke about a time when she advocated for a patient with special needs. She relayed,

I felt good because I intervened in his, you know, for him. I provided him with a voice while he was nonverbal. I was glad that he finally get the care that he needed, you know? There are many things that really made me feel like, oh, well, you know, uh, I, there was a reason for me to be there.

The other nurse, Sarah, shared how she became attracted her to a career in nursing.

I wandered into a nurse session during like a high school career day. It wasn't my intention. And I listened to two nurses talk about caring for people at a time of need. And it was like a light switch and I was like, ‘oh my gosh, I'm going to be a nurse’.
She later spoke about her desire to help other nurses and patients deal with complex issues in care. “I just knew at some point it wasn't about me. I wasn't going to get a master's degree for me, but how could I help other nurses, and maybe you know, ultimately somehow help patients in a broader sense.”

Allison decided to pursue being a doctor while in college.

I wanted to be able to go into a career where I felt like I was making a direct impact and improving something. So, it kind of came to me in a flash and I think a lot of it was just having enough confidence to actually even think of myself as pursuing that kind of a career option.

Neela felt that her cultural upbringing confined to two acceptable career options, either medicine or engineering. She was also raised to believe that “we're here to make the world a better place for others” and to “leave a legacy wherein the world was better, because I was pursuing that course of action.” She described feeling wonderful about the neurology career path she fell into where she had “tangible evidence of the good work you were doing, namely a bunch of babies who were healthy. So that was incredibly rewarding and allowed me to, you know, really have again, um, concrete evidence of the legacy that existed because I existed”.

All participants shared how helping others was a motivator and gave them a sense of satisfaction and fulfillment in their careers. Neela felt pushed toward a career in medicine by her parents, but aspired to use this career to improve the world. Allison gained confidence in college and felt like she could make a direct impact through a career in medicine. Unlike Roxanne, Sarah, and Gabriella who were satisfied knowing that their efforts to care for others made even a small difference, Neela looked for tangible evidence for validation.
Struggling for Answers

Most of the participants described stressful situations at work or in their personal lives that led them to feel conflicted about making decisions or providing care. Most often, the situations highlighted ethics issues (such as end of life care or moral distress). They described times where they didn’t know which course of action was correct and that they lacked support or knowledge to make the “right” decision. They expressed hope that getting an education in bioethics would help them make sense of these challenges and improve their decision-making ability for future events.

Gabriella described the challenges she faced as an emergency department nurse treating dying patients. She said, “Sometimes patients will come and they will have um, advanced directive in place. A family member will decide against it or they will want to change it. And it was hard for me to, to know, what to do without having the expertise and the knowledge”.

Sarah was also questioning how to deal with issues arising in end-of-life care and futile treatments.

One of the things that I always grappled with, and it's funny in hindsight today to know that I had no idea how much other people grapple much more consistently with, those times where we'd be in an emergency and it would be a very frail elderly patient and we'd be doing chest compressions on somebody that really had a very poor prognosis. And why were we doing this? And for nurses, that was always, um, it caused a lot of moral distress and so I thought, there's gotta, something in this program, will, will be able to help me help others.

Through tears, Roxanne relayed her personal experience of watching her father die while her mother struggled to make end-of-life decisions for him.
I remember her words to this day were, ‘Oh my God, what have I done to you?’ By having him go through all of that stuff, all of those procedures that were futile in the end. And so, when she said that to me, that was when it clicked. It was that very phrase, ‘What have I done to you?’, that I realized if I can do something to help one family or one person not go through this to help them understand quality versus quantity and futile treatments and you know, and, and that you may want this procedure, but what does that look like on the other side? And so that was when, and I was only halfway through my master’s degree in social work, but I knew right then I was going to go back and I wanted to go into bioethics.

The above passages illustrate how the participants’ struggles impacted their feelings of well-being. They shared a sentiment of feeling powerless and disturbed by the issues they faced in their work and personal lives. At the same time, each participant expressed a belief that knowledge and learning could make things better for their future patients, family members, and selves.

Allison denied that anything was missing in her workplace, but shared that she really missed the humanities that she loved in college. When she applied for the MBE program, she was completing her fellowship in pathology, an area of medicine that is “much more heavy on the behind the scenes sciences and less with direct patient care”. She described an “intense curiosity and wanting to elevate my own viewpoint in terms of big picture medicine and how it fits into the broader human context”. She desired to think “about things in a different way that I never have to on a day to day basis” and “dabble into like more of the cutting-edge stuff.” As Allison was just starting her career in pathology, her struggles were more angled toward how to
incorporate her love for philosophy, literature, and history with the science-heavy area of her medical specialization.

A lack of direction and feedback from supervisors and colleagues in Neela’s workplace led to high anxiety and frustration of her psychological need for competence, relatedness, and autonomy. She used an analogy to elucidate her plight, which may also serve as a way to frame her distress through an ego-protective lens.

There was never any positive feedback. So, the only feedback was negative. So, you didn't really know. You know what I think of the, um, kind of experiment with rats in a cage where portions of the cage floor heated up. And you're trying to teach that rat to sort of walk a pathway. But the sections that are heated keep changing. And that stress of the unpredictable is what's so deleterious to the rat's well-being. Here it was kind of the same thing where you didn't know if the path you were taking was the correct one until you got negative feedback. Um, and so you know, how much forward progress do you make? Certainly, you don't make it as boldly as you would if you knew what the path looked like. Um, and so were my forward steps tolerated? Were they appreciated? Or were they denigrated? I only ever knew if they were sort of denigrated.

While Neela’s struggles with decision-making are not necessarily related to ethical or moral questions, this passage highlights how the workplace context called her to question her competence and led to a sense of ill-being. Her decision to enroll in the MBE program may indicate a desire to satisfy her needs for relatedness, competence, and autonomy outside of her workplace in order to regain a sense of well-being.

The participants were struggling for answers to many different questions. How to provide care to dying patients and loved ones, how to gain acceptance at work, and how to
incorporate their whole selves into their specialty. These questions led them to consider educational options for help finding answers.

**Feeling stuck**

Three participants relayed a sense of feeling stuck in their positions at work. They were no longer learning, were growing tired of doing the same things, or were looking to move into higher level positions. Sarah noted that “I was just getting a little bored doing the same thing for ten years and I was somebody who was itching for a little more.” She was no longer learning and growing at work which led to frustration and boredom. She also shared, “I just knew for me there was going to be a next step. I just didn't know what the next step was going to be”. Sarah needed new challenges and changes in her work setting to remain satisfied.

Gabriella shared how a lack of advancement and growth impacted her sense of vitality at work. She shared, “at one point I felt like I was not moving forward and it was in a way depressing. Very depressing for me. I got to a point that I would even have nightmares before going to work. So, it was very hard for me to get up and go to work every day.” Due to a lack of growth and excitement about work, Gabriella felt depressed. She needed something to change the situation so that things would get better.

Neela felt held back by her workplace relationships. She noted:

I think back on my very long time there and I am honestly not sure I ever really fit in. Um, but again, if you have no other frame of reference, you just keep reimagining yourself progressively to fit in a narrower and narrower window when as professionals we are expected to grow and develop. Right? Um, and so unbeknownst to me, I think it's very evident in hindsight that my growth and development was stunted.
Gabrielle, Sarah, and Neela were frustrated by a lack of growth and development in the workplace. This resulted in feelings of boredom, depression, and being stunted when professionals should be making forward progress in their career. As Neela tries to make sense of her efforts to “fit in” to an environment that wasn’t conducive to her professional growth, she realizes how much she constricted herself instead of flourishing.

**Degree as “Winning”**

Although the prior three subthemes represent altruistic and intrinsic motivators, Neela expressed an alternate driving force. Her sense of well-being was dramatically impacted by a hostile work environment. The MBE degree represented not only an opportunity to explore bioethics and help others, it also provided a way for her to utilize department funds that she had earned for her own personal development. She explained:

I've given my blood, sweat and tears and years of my life to this organization. You know, I'll be darned if I leave $60,000 on the table. Is there anything that they'll let me do with this, that I could walk away and again, feel like at least, you know, I hadn't left it behind? …Really, I was just so beaten down. Really emotionally, maybe even a little cognitively. You know, I think if you're so in that well. You just can't, your, your brain does not work like it, like it should. Um, and it was almost a feeling like I could, I could stick it to my boss. You know, do a bait and switch, figure out how to get this money from, you know, from, from under his clutches in a way that would just have me win that game. I hadn't won anything else. Was I going to win this?

Neela seemed desperate to come out of her situation with her head held high. The work conflict she was experiencing dramatically hurt her sense of well-being. She wasn’t thinking clearly and really wanted to “win” what she perceived as a fight. It seemed in a way, that her
career in medicine and desire for tangible evidence of a legacy were ways in which she was complying with cultural and familial expectations. She was pessimistic about her prospects of getting accepted and hurt that her supervisor would not write her a letter of recommendation. Persevering through the MBE allowed her to repair a beaten down ego and start to re-write her career narrative in a truly remarkable way. Although this subtheme was only evident in one participant, it was so pervasive to her story. While it would be natural to focus on the “good” or “right” reasons to pursue an MBE, it is valuable to give this alternate viewpoint consideration.

**Conclusion.** Health professionals share a common desire to help and care for others and to improve the world around them. While some participants looked for concrete evidence of their value, others were comfortable seeing small ways in which they made an impact. All shared a sentiment that helping others helped them feel satisfied at work.

Most participants shared some negative aspects of work that played a role in their motivation to complete the MBE degree. Situations in the participants’ personal and professional lives left them struggling for answers and seeking additional knowledge. They all expressed a hope that the MBE program would help them improve their work situations for themselves and to make things better for others.

Sarah, Gabriella, and Neela shared varying levels of feeling stuck at work. While Sarah enjoyed learning to nurse on different hospital floors and the opportunities her flexible schedule allowed for managing her family responsibilities, she was “itching to do more” and believed that a master’s degree was a prerequisite for moving up. Gabriella was depressed about her lack of advancement and growth which made it hard for her to go to work. Neela had been working in the same department for her entire career and was unable to envision life outside that hospital. All of these women had a desire to improve their situation, but weren’t sure how to do so.
For all of these participants, it seemed that the MBE offered a way to re-write the script they were living. While they still had a strong desire and need to help people, perhaps they could do so in another way. By finding a way to answer their challenging questions, they could get unstuck and move forward. Allison can find a way to incorporate her love for humanities into her pathology career. Neela can preserve her ego and find the courage to move to a new work setting. Allison, Gabrielle, and Roxanne can handle complex end-of-life cases and find ways to learn and grow at work. All of the participants were looking for a change in position, competence, or frame of reference. The MBE was an option to bring them that change.

As the participants attempted to make sense of their decision to enroll in an advanced degree at mid-career, they also needed to make sense for why they chose to enroll in this particular degree at this time.

**Something New**

The second superordinate theme that emerged was the novelty and diversity of the degree program itself. The Master of Bioethics degree is relatively new compared to a Master of Nursing, Master of Social Work, or Master of Public Health. The degree didn’t necessarily fit into a proscribed career path for a doctor, social worker, or nurse. None of the participants had planned to pursue this degree during their initial professional training and many of them had heard of the degree through random means. All of the participants joined the program during its inaugural year and therefore didn’t have the luxury of speaking with others who held the degree.

**Fascination with Bioethics**

All participants shared that they had become “fascinated” with bioethics before or during the admissions process. They discovered the program during its inaugural admissions process and shared an attraction to the program’s interdisciplinary nature. For various reasons, they were
excited by learning bioethics and felt an urgency to gain admission. Allison, who was completing a pathology residency at an affiliated teaching hospital, thought the program sounded “fascinating”. She saw it as “probably my last opportunity to revisit the humanities” and “see the bigger picture” before moving into real-life.

Gabriella had stumbled upon a clinical ethics residency for nurses program through reading her hospital’s magazine and thought “sounds interesting”. She applied for and completed the ten-month residency program and learned that she could use her training every day. She became immersed in bioethics opportunities through joining the American Society of Bioethics and Humanities, getting involved in the ethics in clinical practice committee at her hospital, and attending a three-day clinical ethics training offered by the Northeast Medical School Bioethics Center. When she heard about the newly launching Master of Bioethics program during the three-day course, she exclaimed, “Yep. More for me!” Her previous experiences in ethics had left her wanting more, but also feeling more competent to care for her patients and improve her workplace satisfaction.

As Neela became engaged in her hospital’s Institutional Review Board (IRB) and clinical ethics committee, she felt a disconnect between what she was reading about ethics in the literature and her hospital’s decision-making process. She shared:

Sitting down and, you know, reading the Belmont Principles, which were principles, ethical principles. And thinking, well, now, I'm in these meetings twice a month. We don't ever talk about these principles. We talk about the code of federal regulations. Now how do those connect? You know, no one's ever talked to me about autonomy in clinical trials. So that was sort of the beginning of a little glimmer of this disconnect between regulatory and ethics.
As Neela learned about and reflected upon ethical principles and her roles in these committees, she felt a desire to apply these principles and an ethical lens in making decisions. Further, she was asked to develop programs for the human subjects’ protection office and realized that the hospital didn’t want her asking ethical questions. As she struggled with this conflict, the MBE degree offered her an opportunity to explore these quandaries and conflicts in greater detail in a supportive educational environment.

Roxanne shared that typically “social workers have their own issues” to deal with before they can help others. After the loss of her father, she became focused on learning about death and dying issues.

I remember at that point, I started researching on my own bioethics, stuff in bioethics and, and then I learned that there were again, like social work, there are a lot of different fields in bioethics and um, but the end-of-life issue was, I was like right on target with that. So much so that every paper I wrote was about death and dying [laughing]. And I think my instructors were like ‘What is going on?’

Her fascination with bioethics and dying may have been an attempt to make sense of and resolve the painful memories from her father’s death. She also shared that she was always drawn to the elder population and her resolve that “nobody should die alone”. While she struggled to articulate this concern early in her career, her fascination and focus on these issues continued to grow.

After completing her nursing shift one evening, Sarah received a broadcast email about the MBE program from a palliative care list serve. She shared:

I was like, a Master of Bioethics? ... but, I had never heard of it. And I started reading about, um, you know, looking into all aspects of healthcare and policy and research. And
like, each word felt like it was jumping off of the email at me. And I thought, ‘This is a thing? I can't believe this actually exists.’ And then I thought, ‘Well, who are they looking for?’ And then went on to see that it was this multidisciplinary degree program. I mean, truly I had chills, so this can't be real. A nurse can apply for this. This feels amazing. And I instantly forwarded it to my husband and said, ‘I'm doing this’. I didn't say, ‘Let's talk about this.’ I just said, ‘I'm doing this’. Like, I knew it. This was my program and I didn't know what it would mean. I didn't know what I would do with it, but I just knew I wanted it. And I had made up my mind that I was going to apply and if I didn't get in, I was going to just keep reapplying [laughter].

Sarah went on to explain that she often got broadcast emails from palliative care and didn’t open them. She felt that reading this message and learning about the program was fate. Although she had never considered a degree in bioethics, she knew the program was right for her and decided to apply without giving it a second thought.

**Inaugural Class**

All participants in this study applied to the MBE program knowing that they would join the inaugural class at Northeast Medical School. Neela exclaimed “I will always, always, always be grateful to have been part of that first group. I think my experience here would have been vastly different, probably less rewarding and transformative had I been part of any other year.” Roxanne spoke about the honor and privilege of being in the first class “as much as it would be overwhelming, but I also felt that it would be so engaging and the opportunity to be in a program that was brand new, that was a startup and to be the only social worker in it. I felt like, what a privilege. What an honor!”
Sarah also spoke about the excitement of being in the inaugural class and helping to develop the program:

There was a sense of pride of being in that first class, too. Not just to say, not the historic part of it, but that class…When we would section off, I was proud to be with the group that was the full time…I debated like, after the fact, like would this have been better to do in a couple of years when the program was a little like, you know, ‘cause we were kind of helping groom it, and figure out what it was, but um, but not enough to like make me change my mind. And I didn't have that sort of insight until after I was well into it.

There was a general excitement to being the first students. These early adopters were willing to invest both time and money in a program that hadn’t been tested. Their willingness to engage in a program while it was still being built and refined indicates an openness to ambiguity and imperfection.

**Not the Typical Master’s**

Allison, Neela, Sarah, and Roxanne shared a sentiment that, although they had considered other Master’s degrees before ending up in the Master of Bioethics program, none of the other options seemed right. Many had considered a Master of Public Health (MPH), but all spoke of more well-established degrees. Gabriella was initially resistant to embarking on a formal master’s degree due to her daughter approaching college age herself. All participants were drawn to the MBE program in a very strong and different way and seemed to believe that if they were admitted, everything would work out fine.

Allison shared, “One of the natural things for me was to have done maybe a Master in Public Health or something in health policy or something and, you know, that went really well with my actual clinical work. But then this program was announced and I love that sort of thing.
I was like, this sounds fascinating.” Neela shared a similar sentiment, “One of the things I'd always wanted to do was get an MPH. I had always thought about that. Um, the opportunity never worked well career-wise. So, I thought, well here's this master’s of bioethics. It's ethics and something that I'm interested in and maybe I'll apply”.

Sarah believed that a master’s degree was necessary to move up in her nursing career. However, none of the degree options that she had been aware of seemed right for her:

[The master’s] didn't always have to be in nursing, which is why…I didn't worry that it wouldn't help advance my career in nursing, because I know nurses who have MPHs, MBAs, you know… Statistically speaking they would like to have master’s in nursing, but that's a percentage, so I could be in that other percentage that wasn't.

She reflected on her decision to pursue an advanced degree and the challenge she experienced finding the right fit.

I knew I had to go back to school at some point in time, but I just couldn't figure out what that was. And it was such a frustration at one point, you know, I was just going to go through an NP track even though I didn't want to be an NP just to have the master's degree and that didn't feel great. I just, I knew I didn't want to practice as a nurse practitioner. Um, and the, the clinical nurse specialist tracks weren't particularly appealing to me either… I knew I wanted something else, but I couldn't, I couldn't put my hands on what that something else was. I couldn't identify it. So, I couldn't find a program that would get me there.

Roxanne enrolled in a few other degree programs centered on ethics before stumbling upon the MBE at Northeast Medical School. She began a program aligning with her Christian background at a nearby seminary, but found the medical component lacking. She subsequently
switched to a hybrid program in bioethics at a different seminary in Chicago, but needed to take
time off from her studies to care of her aging mother. After taking two semesters off, she shared:

That was when I really started to think, okay, do I really at this point in my life, because I
was older, do I really want to do this? Or is it, or is it a need that I can fulfill by a
different method? By different means? You know, maybe I can volunteer at a hospice or
something to kind of fill that, that need. I had that desire, but I just felt like if I applied to
the bioethics program at Northeast and I got accepted that it would all just come together.
And I really truly believed that I would be learning from people who are on the cutting
eedge of bioethics in the world. I really did believe that. And I still do. It was true!

Conclusion. It was clear that each of the participants had intrinsic motivation to learn
bioethics. The way they each learned about the program and the field of bioethics differed.
Each of them shared a sentiment that studying bioethics may help them resolve questions or
concerns from practice. Each of them related that they believed that learning bioethics would
help them improve in their work. However, none of the participants saw the MBE being
specifically aligned with their professional career path. In fact, they were attracted to the
interdisciplinary nature of the course. Although they had varying degrees of knowledge about
the field of bioethics, they relied on an internal confidence and trust that embarking on this
degree program at this time made sense. How they make sense of this decision in retrospect
varied among participants.

Being a member of an inaugural class of a new degree was certainly an exciting prospect
for these women. They spoke about being honored and privileged to be a part of that class.
However, joining this class required a huge leap of faith on each of their sides. While the
participants were intrigued by the historical and trailblazing aspects of joining this degree
program, they did not have a clear picture of what to expect. The fact that Northeast Medical School is well-established and has a prestigious reputation may have alleviated some of their worries. Many of the participants voiced doubts that they would be admitted, yet saw this as a once in a lifetime opportunity to be a part of something special.

In addition to joining the class in its inaugural year, the participants enrolled in a relatively unknown degree program. They each shared that they were intrigued by the subject matter, but that other options would have made more sense for their career progression. None of them had spoken to MBE degree holders or had been promised promotions for completing the degree. Allison seemed to still be making sense of her decision and may have some dissonance with it. Although she shares that she learned and is a better educator, she struggles to find a practical relevance and external justification that is important for mid-career professionals (Hopstock, 2008; Miller et al., 1998; Watkins, 2011). While the new and shiny nature of the MBE program was intriguing and motivating for participants in this study, the learning experience offered by the program was an important area for this study.

The Student Experience

The third superordinate theme concerns how the educational program and experience impacted motivation. The degree program itself brought students together to learn and apply concepts of bioethics. The participants spoke freely about the community and connections they made, how the experience broadened their perspectives, and how they overcame fears, juggled responsibilities, and applied their learning to their work or prior experiences.

Juggling responsibilities

As mid-career professionals, Allison, Roxanne, and Sarah shared the challenges they faced with juggling work, school, and home life. Allison considered:
I have two little munchkins. They've already been through so much with my clinical training and here I am adding on a Master's degree. Of course, this...was stressful on my husband who was already doing more than his lion's share at home. Um, so I think besides the professional, 'okay, how, how would I make this work?' There was also like, 'I'm already almost done with my training and here I'm adding on something at the finish line.' It was, it was the home life, too. How am I going to make this work at home? Long hours. I did a lot of really late nights studying and, um, much less sleeping and, um, you know, my husband would hold down the fort while I'm commuting, commuting back and forth to different places.

Prior to entering the program, Roxanne debated between the one and two-year options and considered how working as a social worker in a hospital would impact her studies.

I knew if I did it in one year, there's no way I could work and do it. So, then I decided, okay, I'm going to do it two years because I didn't want to do it and just get through it. I really wanted to learn. So, I decided two years and then I had to figure out in my mind, can I work and also go to school? Because I knew it was going to be a lot of work. Um, so I took two months to try to figure that part out. And what I decided was that I could work, but I didn't think I could work at the hospital. And the reason was because, um, it's very intense doing, um, work in an area of where people are dying, you know, um, either in the intensive care or in an oncology unit. And so, I just didn't know that I could do both of those at the same time. So, so while I knew I could work, as a social worker, that was not the environment that I could work in.
Sarah noted that she and her family didn’t know what they were getting into when she decided to enroll in the MBE program full-time, while working part-time as a nurse, and raising teenagers. She recounts:

When we were in it, it was really hard. Um, and there were some really tense moments. Those were the times where I felt like maybe I need to stop, because I was missing... I remember coming to work the night before Easter and had a breakdown when I got here, because I had forgotten to get the Easter, Easter baskets ready. And they, my kids were older. There was no worry that they were, it was just like, I hadn't even got candy. … I just sat there and like just lost it and they [nursing supervisors] were like, ‘You're burning the candle at both ends. We're going to go to CVS right now.’ And one of them took me and we went to CVS together and like we got everything. Um, so I don't, I don't think I could have tangibly known what it was going to mean when we had the discussions about me going to school full time.

Roxanne, Sarah, and Allison all recognized going in that there would be challenges involved in becoming a student at mid-career. They relied on their loved ones and colleagues to help them hold down the fort and manage their multiple responsibilities. Roxanne chose to quit her hospital job to focus on her studies. With the support of her supervisor, Sarah was able to adjust her work schedule to attend classes. While they each made adjustments prior to entering, they didn’t really know how this would impact their lives. In retrospect, they acknowledged the importance of flexibility and supportive families and colleagues.

**Fears of Failure**

Many participants spoke about “imposter syndrome” or feeling unworthy among their peers in the program. They each needed to overcome these thoughts. Gabrielle shared stories of
her mother’s encouragement to take risks. She relayed that her mom always told her to “go and try and you'll find out if you can or if you can't. If you can't it's fine. But at least you tried.” She shared that she gives this advice to her children and needed to keep it in mind for herself when she applied to the program. She was very nervous to start, especially in light of the school’s reputation.

It's a name that always gives you pause. ... Northeast. And in my mind, I was like, I, I got in and I'm not gonna, I'm not a quitter. I'm not going to quit. I'm not gonna say no, I'm not going. But how am I going to...to do? And I didn't want to fail and I did not. I knew it was going to be rigorous and I had doubts about, would I be able to stand the pressure and finish? So, it did. That did give me pause.

As the only social worker in the group, Roxanne shared concerns that she would not fit in and keep up with her peers.

The low points were probably, um, self-confidence issues, because in class you realize like, I was with physicians and attorneys and you know, a theologian, and um, nurses, and while I had a medical background, it was as a social worker. And so, I just thought, ‘wow, there's, I'm really going to be, you know, sort of odd man out here’. So that was difficult in the beginning, but after a while it was fine. You know, we all just jelled so well and it worked out fine.

Sarah felt anxious about her relative lack of ethics knowledge prior to entering the program.

Those were the moments where I'm like, ‘I do not belong here. I did not know this was happening in the world.’ So, I didn't have any kind of ethics background going in and I was really a clean slate. And you know, it makes me like embarrassed that I applied for
the program sometimes thinking that I had no idea. So, there were times of true, truly
unworthy, but the other times I was like, I don't care. I'm here so I'm going to suck it up
and I'm going to learn as much as I can and I'm going to find ways to kind of spread this.
Half way through her first term, Neela felt lost in the subject matter being taught and
shared her confusion with the faculty and other students. She shared:

I was just so worn out that I raised my hand and said, embarrassingly, ‘Karen, I gotta
admit to you, I have absolutely no idea what you're talking about. And frankly, I have not
understood anything for the last seven weeks.’ And was mortified that those words were
coming out, but then everybody laughed and three or four other people were like, ‘Thank
you. Because we really haven't understood anything either!’ Sort of a pivotal moment for
me, transformed the experience of this program. First time in a long time that people
were laughing with me. Yeah. In an overt way that made me feel like I was part of a
community.

Each of these women found the strength to move past their fears. Gabriella’s
determination not to be a quitter in addition to her family’s encouragement to take risks allowed
her to persevere. Sarah’s resolve to soak it in and learn and much as she could pushed her
forward. Neela’s willingness to be vulnerable and ask for help not only benefitted her, but made
others in the class feel that they were not alone in their confusion. In concert with supportive
faculty, other students and their own internal motivation, Gabrielle, Sarah, and Neela were able
to lean in and push through their discomfort. This allowed them to overcome their insecurities
and take full advantage of the learning opportunity.

**Broadened Perspectives**
All of the participants shared that they learned a tremendous amount through the program. This learning brought about different ways of approaching their work and seeing themselves as people and professionals. Sarah shared how unaware she was about healthcare issues prior to the program and how the education opened her eyes.

I didn't understand the world that was out there in bioethics at all. And so, every day was like a discovery for me once I was there. Like, oh my gosh, this is all being talked about at the global level, at the federal, state, and local level. Like I just was so unaware, um, even, even research, I didn't understand the, the entire enterprise of research. So truly it was like not only an education in bioethics, but it was an education in healthcare, that I was so unaware of. Completely oblivious to!

Gabrielle spoke about how the program caused her to look for alliances and opportunities to expand her work. She shared, “It would be fair to say that the program has, has broadened my horizons so to speak…The program has opened the world to me and then I can see…I'm looking now for allies and you know, people that can help me move the causes that I'm passionate about following.”

Neela, who came from a tenuous work environment, spoke about how her conception of conflict and relationships had shifted. She spoke about “unlearning” the professional behaviors that had been indoctrinated over her 20 years of practice and reflected that the program, “Sort of broke barriers, imposed barriers to behavior that we had been taught.” She noted that it:

Allowed me to see that conflict didn't have to be a bad thing. It didn't have to be brutal and in fact it could enhance relationships to be able to bring conflict out, which I then took back to my office practice, um, and experienced such an incredible deepening of relationships with my patients. In a way that again, allowed for rejuvenation in that way.
Um, which was so antithetical to kind of what I'd been taught in medical school about maintaining a sort of polite distance, you know. Being sure that we were, um, being logical and reasonable and rational and never really delving into the emotional content of medical care… At what point do we acknowledge our, our personhood, in the relationship? It's something we really talked about here.

Roxanne shared that in addition to gaining bioethics knowledge, the program increased her confidence, changed who she was as a person, and helped her make connections with others. Yeah, it changed. Yeah. My, my sense of self. Um, I had a little more confidence than when I came in. Probably not a lot more, but a little more. And I just, um, I learned so much about a topic that I didn't even know. Um, it opened me to a lot of other areas, and not just in the field of clinical ethics, but research and, um, you know, reproduction and, and, um, like organizational ethics and, and all that stuff. It was really, it's just the exposure that it gave me has just been great, to this day and it still continues in the connections even after graduation that I still have.

By gaining exposure to different areas of healthcare, a new world had been opened for the participants. They started to look for alliances and opportunities to change the world for the better. Their perspectives of conflict and relationships with patients had changed, allowing them to bring their whole selves to their work. This led to a new passion and energy and ability to respond to issues at the bedside and more broadly with higher levels of action.

**Community and Connections**

Sarah notes that the small class and relationships helped motivate her to take advantage of the learning opportunities available and get the most out of the academically rigorous curriculum
I was exposed to some of the most brilliant people I've ever met in my life. And so, there were, there was this sense of trying to soak it all in and then plenty, plenty of experiences of feeling like, ‘I do not belong here among these people’. So, they helped me get through, I would say everybody, both from faculty to even support staff and the students. I mean, we really had a phenomenal group and I know I'm biased, but I mean, because we were so small, we were just all together, all the time.

This learning seemed to be magnified by the relationships and vulnerability shared within the group of students. Neela reflected, “There were some amazing moments, I think, over that year where people were very comfortable revealing how much their thoughts had changed. Just dramatic! Like where is that ever going to happen in your life where somebody says, ‘I came in thinking this and as a consequence of being with you guys, I now think this’? Huge!”

Roxanne expanded on the appreciation of multiple perspectives brought about by students from various backgrounds.

I really believe that you learn best in community. And, so I was so excited. And then when I found out I was the only social worker in the class, I actually, that was a little intimidating at first, but once classes started it was great and the other students really wanted to know my perspective and what I thought.

Allison shared how valuable it was to have diverse outlooks in class – especially from other mid-career professionals.

Having the mix of older professionals was for me, um, the most stimulating part of having a classroom environment… I just think of a few of my classmates who would say something and be like, ‘Wow, yeah, that, that was your perspective.’ Like, yeah, as a journalist with Andrea or something and you're like, ‘Okay, you know, I see where you're
coming from.’ That, that just opened up so much for me. You know?... Sitting in a classroom with other older, like been-there, done-that sort of folks just made it so rich.

In addition to connections with the other students, participants shared the network of faculty and associates of the Bioethics Center could help them in their future career paths. Sarah shared:

There was kind of this little internal crisis that was happening and I just remember sitting in a class during J term…and it just dawned on me like, I'll be fine…This program is so rich in resources and connections and networking that, that I feel like I'm safe now. Like it's, I'll be okay. I don't know what's going to happen, but I think I'll be okay, because I am now connected to some of, you know, leading researchers in the world and you know, experts in this and they're gonna, they're gonna protect me and they're going to help me find out what I can do with this.

The connections expanded even further from the NMS campus and affiliated hospitals, as explained by Neela:

As part of my capstone work, I had an opportunity to, um, you know, meet some real thought leaders. It's a lovely community to be part of! So different say than I've, again, I've experienced in neurology, right? I feel like I have a little bit of hero worship. When I sent out the emails for my project and had, you know, incredible people like email me back almost instantly, certainly within 24 hours. Right? That's also remarkable. And, and you know, the people that are one degree separated from the faculty here. It’s like the 1% of the ethics community!

All participants referred to the community they experienced as brilliant, diverse, and supportive. They valued the varying perspectives that each member brought to discussion and
reflected on how these conversations changed their understanding of important issues. They also saw how joining this community connected them to something bigger. These connections helped reassure them that there was a place for them as a student and also within the community after graduation.

**Conclusion.** Many of the participants shared a trepidation about balancing their lives to complete the degree over one or two years. Allison had spent years in medical school and was completing her fellowship in pathology with two small children at home when she decided to enroll in the master’s program. She shared how this decision impacted her family and didn’t feel fair. Sarah didn’t really know what to expect in regards to juggling her work, family, and school. However, thanks to the support of her supervisors and flexibility to adjust her work schedule, she was able to successfully engage in the program. Roxanne resigned from her job as a hospital social worker in order to engage in the program over two years requiring the support of her husband as well as a huge leap of faith that more compatible employment would be secured. All of these women spoke with gratitude about the support they received at home, in their workplaces, and through the program.

Fears of failure or not fitting in were prevalent. Although participants were attracted to the interdisciplinary aspect of the degree, they needed to overcome insecurities about their professional training and diverse backgrounds. Roxanne was concerned about being the only social worker and reflected on dealing with her own issues. Sarah believed that her lack of ethics knowledge meant that she didn’t belong amongst the others. Gabrielle also shared that the prestige of Northeast Medical School was intimidating.

As the participants overcame their fears and obstacles to engage in coursework and ethical discourse, their perspectives were broadened to new areas previously unexplored. They
learned to relate to others with different perspectives and found new ways to interpret and respond to ethical issues. Their willingness to put themselves in vulnerable positions and their resolve to persevere and trust the process allowed them to move past previously imposed barriers to consider alternate future paths.

The community and connections made during the program were instrumental in the participants’ learning and their feelings of support and well-being. These connections allowed them to see themselves in new roles and to learn from others in the ethics community. Being a part of this community enhanced their feelings of relatedness and increased their confidence that their contributions to the learning environment and professional field were valued. The learning and connections gained through the MBE program continued to impact the careers of the participants event after attaining the degree.

**Post MBE Career Transitions**

All of the participants discussed how the MBE has impacted their careers. Most participants have changed positions and/or workplaces since receiving their degrees. Neela now works for a network of hospitals as a director of epilepsy and ethics consultant. Sarah served a position in quality and safety before moving to a position as a nurse director in the cancer center at her same institution. Allison began working as an assistant professor and medical director of clinical microbiology at a medical college and teaching hospital in Pennsylvania. Roxanne was hired as an education and training specialist to work with newly appointed guardians; a project she began as her capstone. Gabriella remained in the same workplace as an emergency department nurse, sharing that she hasn’t sought a new position.
**Improved Competence and Confidence**

All participants shared that they feel better prepared to do their jobs since attaining the MBE. In discussing how it impacted her career, Gabrielle shared, “The degree positioned me better to do my job as a nurse, as an advocate for my patients, as a voice for the voiceless. That's all there is to it. If something else, you know, comes my way, trust me. I would not say no. But, I did not go and expect that I will graduate and I come out, I'll be, uh, that brand new, whatever it is.” She explained that she feels more confident and willing to speak up regarding the ethics situations that she faces “every day”, sharing:

The program changed me in a way. It made me more aware of certain things, um, in terms of... Advocacy, uh, regulations and um, end-of-life care. In a way, I think now I can articulate my thoughts about these topics in a way that, um, that is knowledgeable, responsible, and ethical [laughs]. I feel like when I, I see something, I, I'm more vocal in a way about these things, because I can relate and I can tell them why I think it's wrong. And um, why I feel like either I should be part of something or not be part of something.

Allison shared:

I feel like I have maybe more tools, better arguments, you know, um, I can, I can see something, uh, from different viewpoints. Like I can just maybe formulate my thought process around a certain topic a little bit better, especially if there's any sort of controversy or disagreement on an approach. Um, so yeah, I think it benefited that perspective.

Neela shared a newfound sense of happiness and courageousness.

I definitely feel...I don't know if happier is the right word. I don't know if that's a strong enough word...I feel like I have more cognitive skills now, more bandwidth than I did
before. I feel like, um, I'm not afraid to approach something that may cause conflict. I'm not afraid of that. Um, yeah, I think I, I also allow myself to sort of sink in more to conversations. I extend myself much more than I ever did before in ways that aren't always comfortable, but that I feel like I have some courage to try… I for sure feel almost smarter now. Yeah, smarter. Like I can, I can think, think more creatively than I did before. Uh, and I do, I do every so often find myself regretting that it took me this long. Again, it's that same sense of, you know, failure. Well, I failed at realizing this earlier. But I don't know that another experience would have existed like this for me at any other juncture.

Now a nurse director, Sarah shared how a conversation she had in class prepared her to support one of her nurses through the death of a patient.

I remember sitting in Clinical Ethics [class] one day and Tom was there as a guest speaker talking about double effect. It was very hypothetical for a lot of people, not Tom, obviously he's done it many times. But I said, ‘it's hard when, when we talk about physician-assisted suicide and morphine drips in hospice, all being okay.’ I said, ‘I'm struggling with that in a way I never did before, because I've given that last dose of morphine that worked immediately.’ And Tom referred to it as the smoking gun. ‘Does it feel like you have the smoking gun?’ And that's what I was able to bring to her is, I had had this exact conversation. You know, I think she felt better when she left, but I just like, again, I'm supposed to be here. This is supposed to happen. I have been given the tools to have this conversation…I would have felt a little bit on rocky ground if I were just trying to make her feel better without truly the expertise that I have now. You know,
that I have foundational, evidence-based, you know, knowledge to draw on to say this is okay. And like, you know, you didn't do anything wrong.

She also shared a strong desire to gain competence in her current role before moving forward in other ways. “I have no idea [what's next]. I think I really want to feel competent in this role. Um, which some days I do and some days I don't.”

The improved competence and confidence shared by participants resulted in improved wellness at work. Each of them was able to frame how their learning impacted their attitude and ability to help others. It also gave them the confidence to seek new roles and explore new areas of expertise at work.

In addition to feeling more competent and capable to do their work, participants shared a desire to incorporate their newfound ethics expertise into their careers and move beyond their professional boundaries as nurses, social workers, and physicians.

Reflecting on a report she heard about skyrocketing insulin prices, Gabriella notes:

I feel I can make a difference in the health care disparity that is going on in the population that I serve...I don't know why I always feel like I'm leading, this thing in me, is leading me down this path... Maybe uh, it has something to do with that Bioethics Advocacy [class] that I took. I don't know or it's something that was in me and this kind of brought it out in the open.

In her new role as assistant professor in pathology, Allison described the pace at work as “frenetic”. Yet, she shared a longing for more. “Eventually I would like to sit down and assess, okay, is this everything that I can do? Have I made any sort of a positive impact? You know?”
You just want to feel like you've done something good.” While ethics isn’t a formal part of her position, she has found opportunities to incorporate it. She states:

It's like secretly interwoven into my daily work, you know. It's not like, ‘let me write, you know, a beautiful paper on an argument…’ It's not so obvious right now. But it definitely has a role. Yeah. I mean, I think I’m a better thinker. I'm a better educator. I'm a better manager.

Sarah shared how she decided to apply for a position in quality and safety after completing her MBE. She thought, “Maybe somehow this is a foot in the door to the cancer center. There has to be a place for someone with the Master of Bioethics in the cancer center.” During her quality and safety interview, the director shared, “Part of quality is taking care of our staff” and encouraged her to start an ethics group. Sarah continued, “I knew almost nothing about oncology, um, or quality and safety, they felt like, we can teach you this.” Through her experiences in quality and safety, Sarah learned a great deal, but missed working with patients and nurses. She shared:

I was constantly working with the nurse directors in oncology to help me understand, because I didn't know oncology… All the things that go wrong in the cancer center all filtered through me. And so, I would spend so much time with them and I would see them both in their element and in meetings and hear them talk. So passionate, uh, from the point of advocating for nursing. And all of a sudden, like I just went, oh my gosh, I think I want to be a nurse director!

Soon after this epiphany, Sarah learned of a nurse director vacancy at the Cancer Center. She shared:
After a very, very long and tedious process, eight interviews with thirty different people, um, I was given the position and I started the first week of September. I had no idea how fulfilling this would be. I truly every day say, I can't believe I get paid for this!

Roxanne spoke about her career transition. She stated:

I went from an environment where I was nonstop on the go all the time, you know, going from floor to floor, from patient room to patient room. It was perpetual motion all the time…Then I got an office job basically. And, and I don't think I'd ever had an office job. Although the transition started slow, she shared, “I have a lot of things going on where I can now see the fruit of the labor that I put in.” She continued:

I'm doing trainings and I've also been very fortunate and that I've been able to go to conferences…It makes me feel like I'm contributing to guardians now who, um, have always said, you know, ‘we need this, we need this support or we need that.’ And when, when I interviewed all my guardians for my capstone, a lot of those conversations… So much of that is now incorporated into the training. So that is, that is so rewarding to see that what started one day when I went into Karen's office and said, I want to help train guardians to where I'm at now. It is just amazing!

Obtaining the MBE and changing jobs resulted in a new professional identity for Roxanne. She shared:

I'm not a social worker anymore for my work, although I will always be a social worker. I think it's allowed me to take all of my experiences in the past and um, and, and really use it for something beyond being a social worker, which that's a great thing.

Moving beyond social work, however, doesn’t feel entirely natural for Roxanne. She expanded upon her shifting identity noting:
I don't know what to call myself! Well, you know why? It's because, so if you're a doctor and you do this program, you're still a doctor. You know, if you're a nurse, you're still nurse, if you're an attorney, you're still an attorney. So, I really struggled with, I'm not doing, I'm not in a social work role anywhere… What's interesting is I do find myself responding to things as a social worker in my job who has social workers. I do... And, um, and I have to kind of, you know, step back from that because it's like, that's not my job, you know? So yeah, it's still a struggle.

After completing the master of bioethics, Neela was recruited by another organization and found a way to formally incorporate ethics into her position.

So, I negotiated to have an ethics role at the corporate level, not at the hospital level…to sorta say to them, you know, I have this training. Yeah, it could be valuable to one hospital, but why stop there? If I have this role at a network level, I can develop programs that can help, hopefully serve as a repository so that any hospital could have access to these. So, I think my value to the organization jumped right up to process to begin with. Neela aspires to also bring her ideas about process and sustainability in ethics to a larger audience. She shares:

I need to write about that. I need to, to really articulate in some more pervasive way. Um, the things that I am doing now that are different because of what I've learned… if my legacy to the world of bioethics is helping people understand how to be sustainable in this place, the space of bioethics, I feel like that's, that would be tremendously valuable.

Neela returns to her cultural need to leave a legacy and make a difference in the world as she finds her niche in bioethics.
Each of the participants shared a common calling to move beyond their professional boundaries and incorporate ethics. For some, this was secretly interwoven through their improved thinking and communication skills. Their willingness to learn and try new things allowed them to expand their roles and move into more fulfilling work. The risks they took in attaining the degree allowed them to put themselves out there for new opportunities. As they moved into these new roles, they each needed to consider how this changed their identity. Not only did they see themselves differently, they needed to reconcile this with how to express themselves and make meaning of their new professional lives.

**Lack of Extrinsic Rewards**

Two participants stated that the MBE degree did not provide any external value for their work or career. Allison spoke at length about how her decision to pursue this degree did not make sense in her career trajectory. While her mentors supported her, the financial and time costs to attaining this degree were factors that she needed to make sense of:

Actually, it was a huge risk to do this. Yeah. And I think it might have hurt my prospects in, in, uh, in other ways, because it took my time and attention from the normal trajectory. So, you know, I had to have like this, this, didn't make sense. Doing this program did not make sense to the trajectory…. Like for me it was like, ‘what the hell are you doing? What kind of degree?’… So no, there were no external promotions, incentives or ‘man, this would be a boost!’ In fact, if anything, it probably hurt me initially in the beginning.

She went on to explain how the “odds are stacked against somebody” doing the program at mid-career due to the lack of practical relevance. She laments, “I don't know what I would say to
somebody. I think it totally depends on their internal motivation to do something that they love. Rather than it be of direct practical job benefit.”

Gabriella chuckled about the lack of external rewards or acknowledgement she received as a nurse at her hospital.

It's funny you asked that. There is absolutely no reward. None whatsoever. I could not even put my credentials on my ID and I still can't have my credentials on my ID, because it's not recognized by the... uh, ID department at [my hospital]. So, there was no rewards in me getting this degree. No, it was, well, I should rephrase that. There was no external reward about, for me getting this degree. It was just personal.

She would tell others considering the degree:

If it's something that they're passionate about, to do it. If it's something that they just going to do. Um, I don't know, because someone told them to do it or because it sounds good to say that you have a master's in bioethics. Don't do it. Because if I, I believe, if I had gone into it, because someone had told me to do it, I would have, I think I would have gone into it with different, different expectations. Um, thinking that maybe after I graduated, graduated from the program, I would have had a different position or it would have been, um, it would have brought me some type of external rewards. Seeing that it's not materializing, it would have made me sad or depressed, you know what I mean? But that was not my idea. And now that's not why I went into the program. I did so because I wanted to do so and I felt like it was the right thing to do. And I, I, it's something that I'm passionate about. So, the outcome is completely different for me.

These two participants illustrate the importance of passion and intrinsic motivation to overcome the lack of tangible, external rewards and concerns about the normal career trajectory.
They also highlight the importance of realistic expectations to avoid regret or disappointment should external rewards not follow the degree attainment.

**Conclusion.** The participants in this study all discussed how their increased competence and confidence through the study of bioethics positively impacted their careers and sense of well-being. They gained the courage to seek out new opportunities to incorporate ethics and move beyond the professional roles that had previously been confined to. Most participants had found work to be more fulfilling and that they were able to continue growing and developing after the degree. While these changes resulted in changing identity for many of the participants, they were generally positive about the direction of their careers.

While two of the participants shared a frustration about the lack of external rewards, none of the participants was disappointed about the intrinsic rewards they gained. The lack of relevance shared by Allison was not a concern for the others. In addition, as more people attain an MBE degree, it is possible that its value for employers will be more recognized and lead to external rewards. While intrinsic rewards have been found to be more motivating, extrinsic rewards are also important.

**Conclusion**

This chapter has described and relayed data collected from interviews with five graduates of the inaugural Master of Bioethics degree program from Northeast Medical School. The study sought to investigate how mid-career professionals make sense of their motivation to pursue a master of bioethics degree. The analysis of the interviews led to four superordinate themes including intrinsic and career motivators, something new, the student experience, and post MBE-career transitions. The participants in this study shared numerous ways in which their work and intrinsic desires played a role in their motivation to earn a Master of Bioethics degree.
The Master of Bioethics degree leveraged the motivation of mid-career health professionals to help and care for others through their work. At mid-career, health professionals may feel stuck, struggle for answers, or have unresolvable conflicts with the supervisors and colleagues. The study of bioethics as a field can be fascinating. The interdisciplinary nature of the degree brings together multiple perspectives resolving ethical challenges in healthcare. An opportunity to earn a new degree that wasn’t part of a professional’s originally career trajectory may be a way to re-write that person’s narrative and move into a new direction. While mid-career professionals must overcome challenges in juggling responsibilities and confidence, engaging in a degree program can broaden their perspective and enhance their connections to a rich community. Taking the learning and network back to the workplace offers mid-career professionals a way to embark in new directions and re-energize their careers. By gaining this insight from alumnae from one master of bioethics degree program, recommendations may be drawn to improve the program and enhance the experience for future students.
Chapter Five: Discussion and Implications for Practice

The purpose of this Interpretative Phenomenological Analysis (IPA) study was to understand and describe the motivation of mid-career health professionals who completed a master of bioethics degree at a medical school in the Northeast. The study considers how these alumnae make sense of their decision to enroll in the MBE program and how the degree has impacted their sense of well-being in the workplace. The theoretical framework for this study was derived from self-determination theory (SDT) which has been widely used for over 30 years in a wide variety of settings including, most notably for the present study, education, healthcare, and employment (Ryan & Deci, 2017). SDT offers a broad framework for the study of human motivation, fulfillment, and psychological wellness and considers how social, environmental, and individual factors impact people’s sense of initiative and performance through the satisfaction of their psychological needs for competence, relatedness, and autonomy (Deci et al., 2017).

The method utilized in this study was Interpretative Phenomenological Analysis (IPA). This form of qualitative inquiry involves in-depth exploration of participants’ lived experience and how they make sense of these experiences with conclusions evolving through intersubjective conversation, reflection, and analysis (Eatough & Smith, 2011). The idiographic nature of IPA offers “detailed, nuanced analyses of particular instances of lived experiences” (Smith, Flowers, & Larkin, 2012b, p. 37) that are less concerned with generalizability or universality. Using the IPA methodology and the SDT framework, interview data from a small sample of nurses, doctors, and a social worker who completed an MBE degree at Northeast Medical School in 2016 or 2017 were analyzed. Four themes presented themselves, including: Intrinsic and Career Motivators, Something New, The Student Experience, and Post MBE Career Transitions.
This final chapter consists of three parts. First, the findings are discussed and situated within the current research and this study’s theoretical framework. Second, implications and recommendations for practice are described. Finally, suggestions for future research based on this study’s findings are made.

**Intrinsic and Career Motivators**

The participants in this study each had personal reasons that led them to careers in health care and to the eventual pursuit of a master of bioethics. The reflections shared about their original career selection processes align with prior research on health professions career decision-making. The nurses cited general interest and a desire help and care for others (Jirwe & Rudman, 2012; Newton et al., 2009) (2012). Doctors aspired to help people and mankind, had a general interest in medicine, and noted either family support or pressure to pursue a medical career (Madara & Burkhart, 2015; McHarg et al., 2007). The social worker was motivated to help those in distress and deal with her “own issues” (Buchbinder, 2007). The present research adds a mid-career retrospective view to this prior research. In regards to their motivation to pursue the MBE at mid-career, the three most common reasons described by participants were helping others, struggling for answers, and feeling stuck or unwell at work. They saw the MBE degree as a way to increase their helping potential, answer the difficult questions they encountered, and set themselves up for a career transition.

The positive feelings associated with helping others, or benevolence, has been evaluated and considered within the SDT framework (Ryan & Deci, 2017). A number of studies have been conducted to understand the connection between the positive effects of pro-social behavior and the fulfillment of psychological needs. These studies showed that the satisfaction of autonomy, competence, relatedness and beneficence needs independently predict well-being, vitality, and an
underlying sense of meaning. (Martela & Ryan, 2016b; Martela, Ryan, & Steger, 2018). Even anonymous and invisible acts of pro-social behavior have been shown to result in more positive affect, meaningfulness, and vitality (Martela & Ryan, 2016a). While beneficence hasn’t been widely incorporated or accepted into the SDT framework, the findings that participants in the present study shared a common aspiration to help others (patients, hospitals, mankind) through their work and felt good when they did so lend support to the current research on beneficence and well-being.

The struggle for answers described by participants in this study is consistent with transformative learning theory’s “disorienting dilemma” that begins the process of perspective transformation in adulthood (Mezirow, 1978). Critical reflection and transformation may occur when “trigger events” cause an adult to realize that their “old ways of knowing cannot make sense” (Mezirow, 1990, p. 5). Each of the participants in this study shared a triggering moment such as the death of a parent or challenging work conflict where they realized that they needed a different way to think and understand the problems they faced. This disorientation motivated them to pursue advanced education to resolve these challenging questions. These stories align with transformative learning theory literature and the disorienting dilemma as a catalyst for learning (Kitchenham, 2008; Mezirow, 1990, 1991, 1997; Taylor, 2007). While recent studies have discussed transformative learning in medical school (Greenhill, Richards, Mahoney, Campbell, & Walters, 2018) and nursing school (McAllister, 2011), the present study concerns disorienting dilemmas in mid-career health professionals which lead them to pursue formal education.

Participants shared concerns about cases at work where they felt they were providing futile or contraindicated care leaving them feeling the effects of moral distress. Prior studies
have defined moral distress as when professionals cannot carry out what they feel is the ethically appropriate action. This may be caused by a lack of voice, poor ethical organizational collaboration and climate, low work satisfaction and engagement, and low psychological empowerment and autonomy (Epstein & Hurst, 2017; Grady et al., 2008; Lamiani et al., 2017). Participants also shared concerns regarding personal and interpersonal frustration on the job and varying degrees of burnout; defined as diminished personal accomplishment and chronic stress. This frustration and inability to move forward, feel competent, or relate to others, gave the participants a sense of feeling stuck and support research on work stress and burnout in health professionals (Arnetz, 2001; Bochatay et al., 2017; Epstein & Hurst, 2017; Havaei et al., 2016; Pakkala, 2010a; Salyers et al., 2017; Shanafelt et al., 2017; West et al., 2018). Self-determination theory has consistently shown that various factors in the workplace context may support or thwart an individual’s basic psychological needs, impacting motivation and performance (Deci et al., 2017; Deci & Ryan, 2000; Ryan & Deci, 2017). Turnover of health professionals is a significant issue with huge costs to hospitals and health care organizations (Coshow et al., 2009; Havaei et al., 2016; Shanafelt & Noseworthy, 2017; Yarbrough, Martin, Alfred, & McNeill, 2017b). It remains important to consider how workplaces can satisfy workers’ autonomy, competence, and relatedness needs so that they do not feel stuck, unwell, or distressed in the workplace (Deci et al., 2017).

The findings in the present study support the SDT hypothesis that there are three basic psychological needs, the satisfaction of which is essential to optimal development, integrity, and well-being. Failure to satisfy any of these needs will be manifested in diminished growth, integrity and wellness. In addition, need frustration, typically due to the hindering of basic needs is associated with greater ill-being and depleted functioning. Participants shared their stories
about lacking knowledge or understanding (competence needs), feeling unable to act in ways consistent with their beliefs or full capacity (autonomy needs), and unable to relate or grow with colleagues (relatedness needs). While not all three needs may have been missing at all times for all participants, the lack of any of these needs resulted in feeling stuck, struggling for answers, and incapable of helping others to their full potential. These findings further support the SDT framework and research on benevolence, health professionals, burnout, and moral distress. In the next section, the data surrounding novelty and change are discussed.

**Something New**

The participants all shared a fascination for bioethics and felt excited and energized by the prospect of earning a degree they had never heard of before. They reported no external pressure to attain the degree and were unsure how or if it would impact their career path. They saw the MBE as an opportunity to learn and do something different.

All participants were fascinated by the study of bioethics and immediately grew enthusiastic about the opportunity to pursue an advanced degree in the subject. They spoke about feeling chills, stimulation, and wanting to know more. SDT’s organismic view considers humans as naturally driven to engage in interesting activities, to develop their abilities, and to make sense of their thoughts and experiences (Deci & Ryan, 2000). Intrinsically motivated behaviors are freely engaged out of interest, fun, or challenge while extrinsically motivated actions are done to comply with an external regulation or achieve a reward (Ryan & Deci, 2000a). Research has consistently found that intrinsic motivations are the most pervasive in learning and development (Deci et al., 2001; Deci & Ryan, 2000; Ryan & Deci, 2000b; Van den Broeck et al., 2011). The fact that all participants in this study were driven by an internal
“fascination with bioethics” and a desire to learn above any external forces, pressures, or rewards, supports the prior research on intrinsic learning motivation.

The participants in this study considered tried and true degree options and were attracted to the novelty of this degree. They were not satisfied continuing to do the same things and wanted to try something new. Novelty has been proposed as a fourth psychological need to accompany competence, relatedness, and autonomy (Ryan & Deci, 2017). Novelty has been shown to predict life satisfaction and intrinsic motivation in physical education independent of the other three basic psychological needs (González-Cutre, Sicilia, Sierra, Ferriz, & Hagger, 2016). Studies have also found that people into their 50s may be more likely to seek novel experiences through analyzing and solving conceptual and tangible problems or through physical pursuits (Reio & Choi, 2004). A contrasting view is that a focus on novelty and creativity may overshadow the potential of learning and experience to drive change (Tanggaard & Wegener, 2016). In the present study, the participants were motivated by a new way of learning and the opportunity to be in a different type of program. However, they also wanted to use their past experiences to resolve dilemmas they had faced. While novelty hasn’t been accepted as a fourth psychological need in SDT, the findings of this and prior studies illustrate the value of novelty and variety on motivation in adults.

Most participants in this study shared that they considered other, more established degree programs before settling on the master of bioethics. While the other options did not feel right, the decision to pursue the MBE was personal and not controlled by any external forces. This supports research that providing choice enhances intrinsic motivation, effort, task performance, and perceived competence. (Patall, Cooper, & Robinson, 2008). Other studies have found that making choices may be more desirable and may further enhance motivation when individuals
feel an initial sense of competence (Patall, Sylvester, & Han, 2014). High autonomous
motivation and personal initiative has also been shown to positively predict performance (Grant,
Nurmohamed, Ashford, & Dekas, 2011). The participants in the present study felt competent of
their abilities and took initiative to enroll in the MBE program. This carried them through the
rigorous and, at times, challenging program providing insight into the pervasiveness of choice
and autonomy on motivation.

The participants embarked upon a relatively new and different degree program in order to
pursue their growing fascination in bioethics. As mid-career professionals and learners, their
perspectives on the student experience shed light on how the program structures, content, and
community impacted their motivation.

The Student Experience

The mid-life challenges and “juggling of responsibilities” shared by participants in this
study such as balancing work, family, finances, boredom, and exhaustion from work conflicts
align with prior research on mid-career professionals (Kim et al., 2018; Lachman et al., 2015;
Maddox-Daines, 2016; Pool et al., 2015; Vance, 2015). In addition to their challenges as mid-
career professionals, adult learners bring unique needs and characteristics to the classroom that
has led to theories and research in adult education (Boucouvalas & Lawrence, 2010; Elias &
Merriam, 2004; Hansman & Mott, 2010; Kitchenham, 2008; Merriam et al., 2007; Mezirow,
1990, 1991, 1997). This study brings a self-determination theory lens to adult education studies
and the mid-career context.

In order to manage their conflicting priorities and the transition into the academic setting,
participants relied on support from partners, family members, co-workers, managers, and the
MBE program faculty and staff. McClusky’s theory of margin notes that adults seek balance
between the “load” that depletes energy and “power” that allows them to function (Merriam et al., 2007). Life responsibilities, family and social supports, and accumulated skills and abilities comprise the margin of load and power. Participants in this study shared how partners and colleagues provided positive feedback and assurance that they could complete the degree and assumed additional family and work responsibilities to enable them to do so. This supports SDT’s contention that close relationships provide a sense of security which allows intrinsic motivation to flourish and makes the innate growth tendency more pervasive (Deci & Ryan, 2000; Ryan & Deci, 2017). It also illustrates how external challenges and supports can impact a person’s ability to engage in a formal degree program at mid-career.

Overcoming fears of failure and imposter syndrome was a common theme in the present study. Much has been written about the negative impacts of imposter syndrome and perfectionism, including research on graduate students (Cowie, Nealis, Sherry, Hewitt, & Flett, 2018), nurses (Robinson-Walker, 2011), and physicians (LaDonna, Ginsburg, & Watling, 2018). Research has shown that women display greater levels of imposter syndrome than men (Cowie et al., 2018; Robinson-Walker, 2011) which may indicate a bias from this study’s sample of all women participants. Fears of failure have been shown to negatively impact academic achievement via performance avoidance and intrinsic motivation (Dinger, Dickhäuser, Spinath, & Steinmayr, 2013). While “shame” can prevent adults from partaking in educational programs, these fears of failure may also incite self-reflection and be powerful motivators for learning and development (Walker, 2017). Recommendations to decrease the negative aspects of imposter syndrome include acknowledgement, support, and “doing it anyway” (Robinson-Walker, 2011). According to SDT’s organismic integration theory, introjection involves behaving in a certain way in order to avoid embarrassment. It is a self-imposed form of control that emphasizes
internal judgements and conditional feelings of worth (Ryan & Deci, 2017). Participants in this study demonstrated a move through the autonomy continuum as overcame their fears of embarrassment and internalized a new way of thinking that they integrated with their sense of self. They also highlighted how their acknowledgement, reflection and resolve to “do it anyway” motivated them to push through their fears.

Learning relevant topics and skills was particularly important to participants in this study. According to Miller, Bligh, Stanley, and Al Shehri (1998), competence in learning applied immediately to personal and professional problem-solving increases learning motivation. Numerous studies have found perceived value and relevance strongly correlated with motivation to learn in adulthood with no evidence of a decrease of learning motivation with age (Bengtsson & Ohlsson, 2010; Gegenfurtner & Vauras, 2012; Hopstock, 2008). The present study provides new insight on how mid-career professionals are motivated by knowledge that is both practically and theoretically relevant in an interdisciplinary context.

Participation in the MBE program broadened the participants’ views and perspectives allowing them to see things differently and learn areas of healthcare that they had previously not explored. Higher education programs offer alternative frameworks for making sense of one’s personal experience and help facilitate a “personal paradigm shift” during midlife transitions where a questioning of beliefs, values, and assumptions are adapted and evolve into a higher level of meaning (O’Connor & Wolfe, 1991). Mezirow’s transformative learning theory describes a broadened “new meaning perspective” in which previous ways of understanding are replaced with “a more inclusive, discriminating, permeable, and integrative perspective” (Mezirow, 1990, p.5). Critical reflection, awareness of frames of reference, and participation in discourse are teaching tools used in transformative learning (Mezirow, 1997). The participants
in the present study shared numerous stories about how these tools impacted their education in the MBE program. Recent studies have found that transformative learning theory can be supported in the workplace through education of employees and managers to think and act in new ways, increasing autonomy, interaction, and learning (Wilhelmson, Åberg, Backström, & Olsson, 2015). Not only did participants in the present study share how their broadened perspective allowed them to gain practical wisdom, they also spoke about how their worldview became more inclusive and understanding of the perspectives of others.

An important finding was the value of the bioethics community and personal connections that were instrumental in the participants’ learning motivation and sense of security. This supports prior studies in relatedness, learning in community, and connectedness. Studies have shown that group learning is valuable to understand different perspectives, to manage conflict, to gain self-awareness, team spirit, leadership, and confidence (Fenwick, 2002; Jackson et al., 2014). Communities of practice have been defined as “groups of people who share a common concern for something they do and learn how to do it better as they interact regularly” (p.1) and extend learning outside the classroom and into life itself (Wenger-Trayner & Wegner-Trayner, 2015). The master’s cohort fosters collective knowledge and wisdom and offers opportunities to develop communication, conflict resolution skills, and commitment (Lawrence, 2002). Recent studies have found that communities of practice offer resources, safety, and support that enables learners to engage in education and reflective perspective-taking (Davis & Coryell, 2019). While many benefits are associated with the support received through relationships, giving support to others was found to be even more powerful than receiving support in improving the quality of close friendships and satisfying the needs for relatedness (Deci, La Guardia, Moller, Scheiner, & Ryan, 2006). Even the sensation of working together has been found to foster intrinsic
motivation (Carr & Walton, 2014). In addition to the close friendship that students developed with their cohort, the support they received from faculty and others associated with the program allowed students to feel supported and connected to a community of practice. Together, the sense of belonging conveyed by the bioethics community facilitated the students’ need for relatedness as described by Ryan & Brown (2003). This finding extends current research on communities of practice, group learning, and relatedness in adult learning motivation.

The learning, transformation, and connections that developed through the MBE program translated into the participants’ sense of well-being and competence in the workplace. It also helped them expand their careers into new directions.

**Post MBE Career Transitions**

The learning and experiences brought forth through the MBE program impacted the participants’ professional positions and feelings of well-being at work. They became more confident, incorporated their ethics training into their roles, and moved beyond their professional boundaries. While they experienced many positive results, some shared a sentiment that there was a lack extrinsic rewards associated with their degree attainment.

The first finding in this theme was a sense of improved confidence and competence. All participants believed that their completion of the MBE improved their abilities at work and gave them confidence to speak up and act when appropriate. They experienced increased wellness and vitality at work through doing new and interesting things with increased capacity. Better occupational health for physicians can be fostered by health care work environments that support autonomous motivation (Moller, Jager, Williams, & Kao, 2019). Autonomous motivation has also been attributed to greater work satisfaction, commitment, and performance, whereas controlled motivation has led to depleted fulfillment and achievement (Deci et al., 2017). Career
excitement, greater feelings of enjoyment, and a more positive future outlook has been associated with personal paradigm shifts and reframed thinking at mid-career (O’Connor & Wolfe, 1991). Higher self-esteem was also reported by the present study’s participants which is not in itself a psychological need (Ryan & Brown, 2003), yet has been proposed as deriving from fulfillment of a person’s psychological needs for competence, autonomy, and relatedness (Ryan & Deci, 2001).

Since completing the program all study participants have found ways to incorporate their ethics education into their careers. This has been accomplished in various ways, such as responding more confidently to the issues they experience “every day”, negotiating a formal ethics component into their position, and having their knowledge “subtly interwoven” in their responses. Bioethics education enhances ethical awareness and reasoning skills to prepare health professionals for the difficult conversations and decisions they are facing today and in the future (Avci, 2017b; United States, 2016; Willard, 2015). Quality in bioethics education has been defined as a “transformative process to: increase ethical knowledge; improve ethical skills to strengthen ethical sensitivity, awareness and judgement; develop ethical behavior; and promote cultural competence” (Avci, 2017, p. 209).

The participants in the present study discussed how they were transformed by the education and gained increased awareness, sensitivity, and cultural competence that they could apply directly to their professional roles. Findings in this study support prior studies about empowering health professionals to speak up, engage in ethical deliberation, and bring concerns to leadership to improve patient care and hospital policies (Epstein & Hurst, 2017; Grady et al., 2008; Morgenstern & Richter, 2013; Sabin, 2017). The present research contributes to the large and growing literature in bioethics education (Avci, 2017b, 2017a; Chowning et al., 2012; Faden,
and brings a qualitative approach to study the impact and results of formal bioethics education on mid-career health professionals.

In addition to incorporating ethics, participants in this study described how their bioethics education enabled them to move beyond professional boundaries. The process they described supports the mid-career reframing model (Brown, 2015b) in which learning occurs with opportunity, involves shifts away from initial occupational identities, and involves emotional, practical, relational, and intellectual development. Studies on career motivation and transition have found that being drawn to a career (perceiving a calling) predicted a sense of life meaning and career alignment which resulted in greater life satisfaction (Duffy, England, Douglass, Autin, & Allan, 2017). A recent IPA study on career changes motivated by a sense of calling found that transitions prompted by altruistic motives and the pursuit of intrinsic rewards resulted in greater satisfaction with career change, enthusiasm about work, and feeling blessed to live out their calling (Ahn, Dik, & Hornback, 2017). Higher levels of education were positively related to having and living a calling with those in leadership positions more strongly able to feel and live their calling (Hirschi, Keller, & Spurk, 2018). The participants in the present study shared intrinsic motivations that drew them to their career (a calling) and altruistic motives for bringing in an ethics component. Their positive feelings about their transitions align with prior studies on mid-career reframing and living a calling.

A lack of extrinsic rewards associated with the degree was noted by two participants. They did not receive recognition from their employer’s ID office, advance their career, or receive a boost in status. Extrinsic reasons to pursue a master’s degree include enhanced prestige and
higher compensation (ASHE, 2005; Belasco et al., 2014; Watkins, 2011). Although all participants in the present study spoke of intrinsic reasons for pursuing the master of bioethics, there were examples of external rewards that emerged through completing the degree, including recognition from others, that allowed them to attain new positions within their organizations or elsewhere. However, the reasons they expressed for wanting these new positions were more growth oriented (intrinsic) than prestige or financially motivated (extrinsic). Goal contents theory (GCT) theorizes that greater well-being results from the pursuit of goals that are interesting and personally important and involve growth, connection, and contribution rather goals that feel forced or pressured such as money, beauty, and popularity. This is due to extrinsic goals being more controlling and less satisfying of the basic psychological needs (Ryan & Deci, 2017).

Van den Broeck, Van Ruysseveldt, Smulders, and De Witte (2011) found that intrinsically motivated employees who participated in professional learning opportunities were less emotionally exhausted than employees who favored extrinsic aspirations. Students may aspire to earn an advanced degree for extrinsic (prestige, money, recognition from others) or intrinsic (personal development, community contributions, connection to others) reasons (ASHE, 2005; Vance, 2015; Watkins, 2011). Although both intrinsic and extrinsic reasons factor into one’s decision to pursue a master’s degree at mid-career, according to GCT, students who have intrinsic aspirations will likely be more satisfied after attaining the degree. Although some participants lamented about the lack of extrinsic rewards they received, they clarified that their motivation to pursue the degree was intrinsic and they were satisfied with the many positive internal rewards they experienced.
Conclusion

This study sought to understand the perspectives and motivations of health professionals who completed a master of bioethics at mid-career. Conversations with these five women have been analyzed and placed within the context of the current literature on motivation, adult learning, and bioethics education. The goal of this study was to help administrators, faculty, colleagues, mentors, and supervisors understand and support this group of professionals in their educational pursuits.

Several reasons were given for this study. They include improving recruitment methods and program support structures aimed at these students, increasing competence of mid-career health professionals in the workplace, and preparing leaders to address and manage the complex bioethics issues facing society today and into the future. Many mid-career health professionals experience burn-out and moral distress in the workplace resulting in feelings of ill-being and negatively impacting patient care. Education in bioethics may alleviate their frustration, expand their career into new directions, and further their abilities to address moral dilemmas in their workplaces and communities. As the master of bioethics as a degree option grows in popularity and notoriety, it was important to consider how mid-career professionals can be supported and encouraged to pursue this path.

Overall, the findings in this study suggest that health professionals are drawn to a career in health care by an intrinsic desire to help others. As they settle into mid-career, they find that something is missing that leaves them struggling for answers, feeling stuck, or unwell in the workplace. The MBE becomes a goal or pursuit to resolve these issues. The choice to pursue an MBE emerges through intrinsic interest or fascination with bioethics, but also through the relevance it has to so many areas of health care. In order to be successful in the program,
participants shared how they juggled responsibilities and overcame self-esteem and fears of failure. They discovered new ways of thinking and areas of practice, while building a supportive network of bioethics colleagues and community of practice. The improved competence and confidence they gained through the MBE program allowed these alumnae to move beyond their professional boundaries and to incorporate their ethics training at work. Through doing this, they resolved prior dilemmas and gained a sense of well-being, vitality, and meaning. This improved their ability to help others and improve patient care, and make a difference in the world. As their goals for attaining the degree derived from intrinsic motivation, they are satisfied with their decision and how it has impacted their career and sense of self. From these results and in concert with previously published research, several recommendations for practice are discussed followed by suggestions for future research.

**Recommendations for Practice**

The findings from this study align with prior research on mid-career learning and motivation and provide several areas in which administrators, faculty, and supervisors can improve the potential for mid-career health professionals to earn a master of bioethics. The first recommendation aims to utilize a key strength of the program, the alumni, to serve as ambassadors for the program. Doing so, they can support prospective applicant’s relatedness needs and provide a realistic view of the potential impact the MBE could have on their career. Although the participants in this study relied on their internal barometer, the medical school’s reputation, and marketing materials for information, they lacked a clear understanding of what the MBE could offer them. There are now almost 100 program alumni at various career stages and sectors around the globe that can speak to the program’s benefits and challenges. Many alumni want to stay engaged and give back. Alumni should be invited to campus events, such as
the fall welcome reception, spring capstone symposium, accepted student lunch, and public lectures and conferences hosted by the Bioethics Center. Engaging alumni remotely through LinkedIn, social media, and email newsletters will ensure the Center remains updated on alumni career and life transitions allowing for geographic and professional connections to be fostered. As the MBE program gains popularity and the list of alumni grows, prospective students will feel less concern about the degree’s novelty and may seek to join the community of practice it offers.

The second recommendation involves connecting the degree program with workplaces that may benefit from employee participation. The MBE program provided an answer for participants struggling with complex ethical concerns emerging from their professional work. Their desire to learn bioethics and apply their knowledge to solving these issues resulted in improved workplaces and greater well-being for the participants. The increased bioethics competency available to address these complex issues is a true asset to health care organizations. The increased employee vitality and sharing of knowledge through ethics rounds and workplace development may alleviate moral distress, burnout, and employee turnover. Health care organizations should be encouraged to support their employees to attain advanced education by providing flexible schedules, tuition support, and supervisor recognition. The program should reach out to local hospital human resource departments and managers to share the benefits of the MBE. In addition, the program should request information on hospital policies that support advanced education. Targeted marketing of the MBE program to hospital employees may align with these benefits to encourage communication between prospective students, their managers, and the MBE program. Doing so may ensure that applicants have a realistic understanding of the support in place through their employer and how they could make the degree a realistic undertaking.
The third recommendation involves challenges with the mid-career student experience. Mid-career students need support in juggling multiple responsibilities and in overcoming their fears of failure. They need to adjust work schedules and plan for family responsibilities so that they can attend classes and study. Having the academic calendar and course schedules available as soon as possible will allow mid-career students to make these arrangements. Assignment deadlines and criteria should be clearly defined so that students can make plans to complete schoolwork during their available time. Where possible, allowing choice in assignments will support student’s intrinsic motivation and autonomy. Instructors should also look for opportunities to make content relevant to the various disciplines in class. To support students’ competence needs, faculty should allow opportunities for students to ask questions either in class, or privately during office hours, over email, or by making phone or video chat appointments. Students should also be introduced to their resources on campus and be connected to their program manager, capstone mentor, faculty advisor, and faculty director for support and guidance.

To overcome a sense of imposter syndrome or not fitting in, the program should break down barriers as soon as possible. After admission, incoming students should be invited to an admitted student luncheon and the capstone symposium where they can meet current students, faculty, and alumni. At these events, they will learn about the various backgrounds in the MBE community and possible areas of ethical inquiry through the graduating students’ poster presentations. During orientation, a book with student headshots and short biographies is distributed to all students and faculty. In order to break down the professional barriers and support relatedness among peers, hobbies or pastimes should be included for each student along with their professional and academic overview. Throughout the year, opportunities for social and
professional networking should continue to support the community building and relationships that are so important to all students in the program.

The final recommendation concerns the perceived lack of extrinsic rewards. While much has been said about the higher value of intrinsic motivation to pursue a degree in bioethics, extrinsic rewards are still an important consideration for mid-career professionals. As much time, effort, and expense must be given to attain the master of bioethics, certain benefits should be available to alumni. The recognition of an MBE denotation on business cards and hospital identification badges would give credibility to others (patients, colleagues, subordinates) of the advanced training that was completed. Certainly, as mid-career professionals weigh different degree options, they will consider the benefits along with the costs. They must also justify the expense and time commitment that are necessary to important others who may be taking on more responsibilities or supporting the degree financially. It would be worthwhile for the program and for organizations that want to increase their ethical competency to consider what rewards may incentivize the degree pursuit for the best employees and students.

**Recommendations for Future Research**

This study set out to explore and describe the educational motivation of mid-career health professionals who complete a master of bioethics degree at a medical school in the Northeast. Two significant deficits to this research include the lack of male participants and the fact that all of the participants began the program during its inaugural year. While this provided a homogeneous group for this IPA study, a future study should attempt to remove the gender bias that may be attributed to the lack of a male voice. Additionally, by including perspectives from later cohorts, conclusions may be drawn about word of mouth and other forms of marketing that were lacking in the first cohort. As the program seeks to attract professionals from many fields,
a study incorporating the views of attorneys, research scientists, theologians, and other health-related fields may provide valuable insight into the multiple motivational perspectives that are drawn to a master’s degree in bioethics.

The American Society of Bioethics and Humanities (ASBH) launched a certification program in 2017 entitled Healthcare Ethics Consulting Certification (HEC-C). Designed to provide recognition of a fundamental ethics skillset, the HEC-C credential requires 400 hours of ethics experience and passing a national certification examination (“HEC-C Eligibility | Certification | ASBH,” n.d.). As of August 2019, 232 people have earned the HEC-C credential. Some MBE students, alumni, and faculty have already signed on for this certification and the program is considering how this credential aligns with the MBE curriculum. While external recognition of the skillset and experience of ethics consultants may be valuable, a study into the educational motivation of HEC-C consultants may provide insights into how control and oversight impact intrinsic and extrinsic motivation. How does this credential impact their sense of well-being in the workplace and how they feel they are perceived by others?

A third area of study would involve interviewing mid-career professionals who started an application or were accepted to the MBE program, but elected not to attend. An important area of inquiry is what prevents mid-career professionals who have expressed interest in attaining an MBE from matriculating into the program at Northeast Medical School. Perhaps a study of this type would yield data valuable for hospitals and programs to coordinate and support employees who would benefit from this education, but need assistance in the form of tuition funds, flexible schedule, or mentorship. It may also yield important data regarding how other MBE programs and opportunities compare to the Northeast Medical School program in the decision-making
process of mid-career applicants. It may also provide insight into how the post MBE-career transitions compare to the group that did not enroll in the NMS program.

A fourth area of study may be to meet with alumni who completed a master of bioethics immediately following their undergraduate degrees to see how their motivation and experiences compare to those of mid-career professionals. Were their motivations intrinsic or extrinsic and did they struggle with similar questions? Many post-baccalaureate alumni proceed directly from the MBE program into medical or law school prior to moving into the workforce. It may also be valuable to hear how their MBE education prepared them for their advanced professional training. It would be interesting to hear them reflect upon how their MBE education impacted their career paths and sense of well-being once they enter the workforce.
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Appendix A: Consent Form

Northeastern University, Doctor of Education
Name of Investigator(s): Principal Investigator, Joseph McNabb, PhD; Student Researcher, Brooke Tempesta
Title of Project: An Exploration of the Motivation of Health Professionals Who Completed a Master of Bioethics at Mid-Career

Informed Consent to Participate in a Research Study

We are inviting you to take part in a research study. This form will tell you about the study, but the student researcher will explain it to you first. You may ask this person any questions that you have. When you are ready to make a decision regarding your participation, you may tell the student researcher if you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, the student researcher will ask you to sign this statement and will give you a copy to keep.

Why am I being asked to take part in this research study?
We are asking you to be in this study because you:
- Completed the MBE at XXXX since 2016; and
- Are a health professional currently employed in an organization; and were
- Born prior to 1980 (mid-career)

Why is this research study being done?
The purpose of this study is to understand and describe the motivation of mid-career health professionals who complete a master of bioethics degree at a medical school in Boston. A better understanding of these factors would enable faculty and administrators to enhance outreach and programmatic supports for this population of students.

What will I be asked to do?
If you decide to volunteer to be a part of the study, you will send a copy of your CV/resume to the researcher and then set up a time for an interview with the student researcher to identify motivating factors that drew you to the MBE degree program and how the engagement with and completion of the MBE degree impacted your sense of well-being at work and in other life arenas.

Where will this take place and how much of my time will it take?
Participants will engage in a 60 minute interview with potential for a second interview (for the purpose of clarity or further questions). The total time commitment will not exceed two hours. Interview(s) will take place at a location you choose, and will be recorded and transcribed.

Will there be any risk or discomfort to me?
There are no foreseeable risks or discomforts for your taking part of this research study.

Will I benefit by being in this research?
There will be no direct benefits for your participation in this research study; however, your responses may aid in identifying what support services and marketing efforts are beneficial to recruiting and support future mid-career MBE students.
Who will see the information about me?
Your participation in the study will be kept confidential and secure. You will be given the opportunity to select a pseudonym for the purpose of identity protection so that only the student researcher and the Principal Investigator (the student’s academic advisor) will know about your participation. If you do not wish to be identified in this research study, any materials or future publications resulting from this research will not identify you as being part of this study.

The student researcher will store all the information electronically on her personal computer using a password protected Dropbox account. Physical documents will be scanned and originals will be shredded. In rare occurrences, authorized personnel may request to view the research information about you and other participants in the study for the sole purpose of ensuring the research was conducted properly. Only personnel from Northeastern University, such as the Institutional Review Board, would be permitted to review this information.

Can I stop my participation in this study?
Your participation is entirely voluntary. You can terminate your participation at any time during the research study. In addition, you may refuse to answer any question asked by the student researcher.

Who can I contact if I have questions or problems?
Please feel free to contact Brooke Tempesta, the person mainly responsible for the research study at tempesta.b@husky.neu.edu You can also contact the Principal Investigator, Dr. Joseph McNabb, j.mcnabb@northeastern.edu.

Who can I contact about my rights as a participant?
If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, Mail Stop: 560-177, 360 Huntington Avenue, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

Will I be paid for my participation?
You will not be paid for your participation in the study.

Will it cost me anything to participate?
There are no costs to participate in the study.

Is there anything else I need to know?
You must be at least 18 years old to participate in the study.

Signature of person agreeing to take part _______________________________ Date ________________

Printed name of person above __________________________________________

Signature of person who explained the study to the participant above and obtained consent _______________________________ Date ________________

Printed name of person above __________________________________________
Appendix B: Sample Interview Schedule

An Exploration of the Motivation of Health Professionals Who Completed a Master of Bioethics at Mid-Career

Introductory Protocol
You have been selected to speak with me today because you have been identified as someone who has completing the Master of Bioethics degree at mid-career. My research project focuses on the experiences of mid-career health professionals who enroll in a Master of Bioethics degree program. Through this study, we hope to gain more insight into the motivations of mid-career professionals to attain an MBE. Hopefully this will allow us to identify ways in which we can attract these types of professionals to our program and support them as they attain their degrees.

Because your responses are important and I want to make sure to capture everything you say, I would like to audio tape our conversation today. Do I have your permission to record this interview? [If yes, thank the participant, let them know you may ask the question again as you start recording, and then turn on the recording equipment]. I will also be taking written notes. All responses will be confidential and a pseudonym will be used when quoting from the transcripts. I will be the only one with access to the audio files which will be eventually destroyed after they are transcribed. To meet our human subjects requirements at the university, you must sign the form I have with me [provide the form*] Essentially, this document states that: (1) all information will be held confidential, (2) your participation is voluntary and you may stop at any time if you feel uncomfortable, and (3) we do not intend to inflict any harm. Do you have any questions about the interview process or how your data will be used? This interview should last about 45-60 minutes. During this time, I have several questions that I would like to cover. If time begins to run short, we may discuss options to continue longer or schedule a follow-up meeting. Do you have any questions at this time?

Questions:
1. What drew you to your career as a [nurse, doctor, social worker, physician’s assistant, in medicine]?
   a. Prompts: aspirations/goals (intrinsic/extrinsic)

2. What have been some high or low points in your career?
   a. Prompts: challenges? Greatest satisfaction?

3. Describe how you felt in your work setting when you decided to apply for the MBE program.
a. Prompts: What were some of the challenges you were experiencing at work? How were your interactions with colleagues/supervisors?

4. What drew you to apply for the MBE program?
   a. Prompts: What were you looking to gain or achieve through the program?

5. Were your motivations mainly from within or did external factors such as regulations and work requirements play a role?

6. Who was involved in your decision to apply for the MBE program?
   a. Personal/Professional? Mentor? Family/partner?
   b. How did they impact your motivation to pursue the degree?

7. What was your thought process when you were accepted? What did you weigh into the decision to enroll?
   a. Prompts: How did family or other relationship factors impact your decision-making?
   b. Did you receive any support or concerns from people at your work?
   c. Thoughts about returning to school?

8. What were some high or low points as you completed the program?
   a. Prompts: did you notice any differences to how you approach your work?
      Home life? Challenges? Satisfaction of Autonomy/competence/relatedness needs?

9. In what ways has the degree program changed you?

10. What would you tell a friend who was considering enrolling in the MBE program?
11. What do think will be next for you or your career? What goals do you have for the future?

12. What else would you like to share about your motivation or decision to complete your Master of Bioethics degree?

Ask participant if they have any questions and thank them for their participation.
Appendix C: Audit Trail Sample

Neela: I was just so worn out that I raised my hand and said, embarrassingly, "Karen, I gotta admit to you, I have absolutely no idea what you're talking about. And frankly, I have not understood anything for the last seven weeks". And was mortified that those words were coming out, but then everybody laughed and three or four other people were like, "Thank you. Because we really haven't understood anything either!" Sort of a pivotal moment for me, transformed the experience of this program. First time in a long time that people were laughing with me. Yeah. In an overt way that made me feel like I was part of a community.

Roxanne: I'm not a social worker, anymore for my work, although I will always be a social worker. I think it's allowed me to take all of my experiences in the past and um, and, and really use it for something beyond being a social worker, which that's a great thing.

Sarah: I knew I wanted something else, but I couldn't, I couldn't put my hands on what that something else was. I couldn't identify it so I couldn't find a program that would get me there.

Embarrassed about lack of understanding. Mortified and lost.

Fears of Failure lead to vulnerability.

Struggle and support from peers and faculty transformed her educational experience.

She has moved beyond social work, but she says she will ALWAYS be a social worker.

She is struggling with her professional identity while moving beyond her professional boundaries.

She didn't know what her next step was going to be. Nothing seemed right.

Nothing seemed right since she had never heard of the MBE. She wanted "something new".